2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Northridge Hospital Medical Center Service Region

Sponsored by
Dignity Health – Northridge Hospital Medical Center

Dignity Health®
A member of CommonSpirit

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

CommonSpirit Health Commitment & 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.

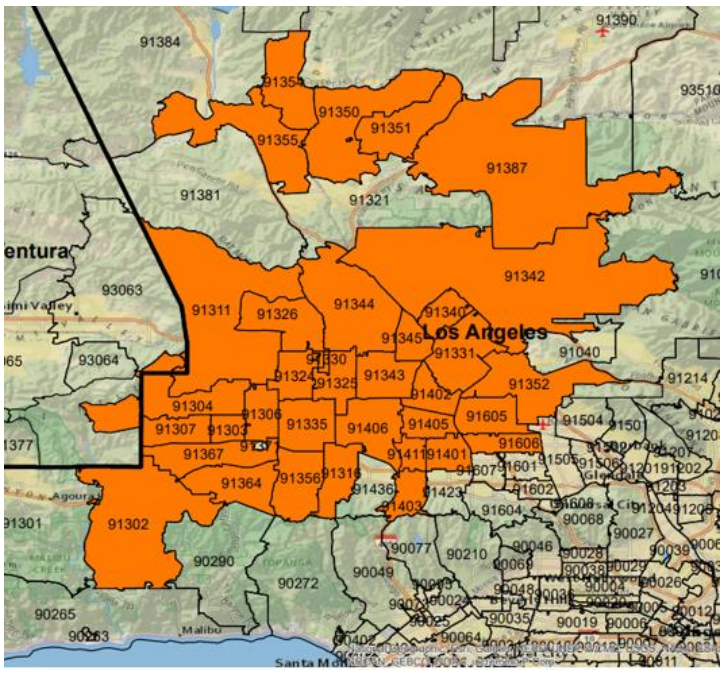
CHNA Collaborators

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

Community Definition

The study area for this assessment (referred to as "NHMC Service Region" in this report) reflects communities throughout the San Fernando and Santa Clarita Valleys in Los Angeles, inclusive of the following ZIP Codes: 91302, 91303, 91304, 91306, 91307, 91311, 91316, 91324, 91325, 91326, 91330, 91331, 91335, 91340, 91342, 91343, 91344, 91345, 91350, 91351, 91352, 91354, 91355, 91356, 91364, 91367, 91387, 91401, 91402, 91403, 91405, 91406, 91411, 91605, and 91606.

This community definition, determined based on the ZIP Codes of residence of recent patients of Dignity Health – Northridge Hospital Medical Center, is illustrated in the adjacent map.



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 trending and 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); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the 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 Online Key Informant Survey.

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

1. **MENTAL HEALTH** ► Key informants identified this as a top concern in the community. Survey findings revealed needs related to treatment for mental health issues.
2. **HOUSING** ► Key informants identified social determinants of health (including and especially housing) as a top concern in the community. Survey findings revealed needs related to housing conditions.
3. **DIABETES** ► Key informants identified this as a top concern in the community. Existing data revealed needs related to diabetes deaths and kidney disease deaths.
4. **CLIMATE, NATURE & HEALTH** ► Key informants identified this as a top concern in the community. Roughly 85% of residents recognize a connection between climate and health risks.
5. **SUBSTANCE USE** ► Key informants identified this as a top concern in the community. Existing data revealed needs relative to alcohol-induced deaths and unintentional drug-induced deaths.

Other health needs identified in this assessment include:

- NUTRITION, PHYSICAL ACTIVITY & WEIGHT
- ACCESS TO HEALTH CARE SERVICES
- DISABLING CONDITIONS
- HEART DISEASE & STROKE
- INJURY & VIOLENCE
- RESPIRATORY DISEASE
- SEXUAL HEALTH

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 Dignity Health – Northridge Hospital Medical Center community board in June 2025.

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

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	32
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	124
Part V Section B Line 3d How data was obtained	7
Part V Section B Line 3e The significant health needs of the community	15
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	26
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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)	129

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 – Northridge Hospital Medical Center and PRC and is similar to the previous survey used in the region, allowing for data trending.

Community Definition

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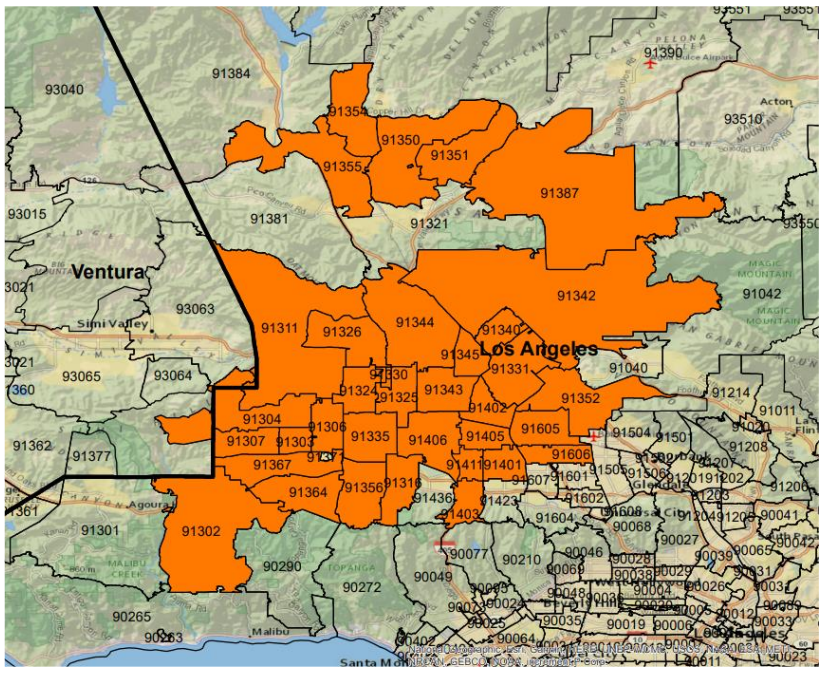


Sample Approach & Design

A precise and carefully implemented 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 targeted surveys conducted between October and December 2024 by PRC via telephone (landline and cell phone) or through online questionnaires, as well as a community outreach component promoted by NHMC through social media posting and other communications.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 300 surveys throughout the service area.

COMMUNITY OUTREACH SURVEYS (Dignity Health – Northridge Hospital Medical Center) ► PRC also created a link to an online version of the survey, and Dignity Health – Northridge Hospital Medical Center promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 17 surveys to the overall sample.

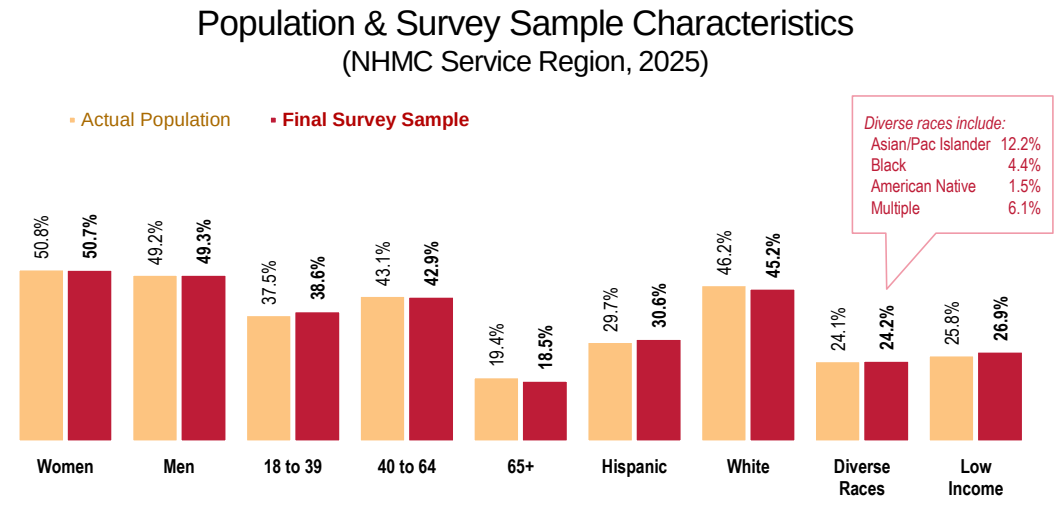
In all, 317 surveys were completed through these mechanisms. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the NHMC Service Region as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 317 respondents is ±5.7% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses might contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics might have been slightly oversampled, might contribute the same weight as 0.9 respondents.

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



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (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 February and March 2025 as part of this process. A list of recommended participants was provided by Dignity Health – Northridge Hospital Medical Center; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 24 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
Public Health Representatives	5
Other Health Providers	3
Social Services Providers	12
Other Community Leaders	4

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

- Adults not eligible for social services
- African-Americans
- Armenians
- Asians
- Children
- Disabled
- Elderly
- Elderly with cognitive issues
- Hispanics
- Homeless
- Immigrants/refugees
- Injured workers
- Kinship households
- LGBTQIA+
- Low-income residents
- Medicare/Medicaid patients
- Minority populations
- Neurodivergent
- Rural
- Those with limited transportation
- Those with mental health issues
- Those with special needs
- Uninsured/underinsured
- Veterans
- Women

Final participation included representatives of the organizations outlined below.

- Alzheimer's Association – California Southland Chapter
- Boys and Girls Club of the West Valley
- Care Harbor
- Center for Living and Learning
- Hillview Mental Health Center
- Los Angeles County Department of Health Services
- Los Angeles County Department of Mental Health
- Los Angeles County Department of Public Health
- Northeast Valley Health Corporation
- ONEgeneration
- Pueblo y Salud
- Samuel Dixon Family Health Center
- San Fernando Valley Community Mental Health Center
- San Fernando Community Health Center
- Smile Dental Services
- Southern California Neuropsychology Group
- St. Mary Pharmacy
- UBS Financial Services
- University of California, Los Angeles
- Vision y Compromiso

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 NHMC Service Region 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 of the secondary data are only available at the county level (Los Angeles County). Refer to chart labels to understand the geography presented.

Benchmark Comparisons

Trending

A similar survey was administered in the NHMC Service Region in 2022 by PRC on behalf of Dignity Health – Northridge Hospital Medical Center. Trending data are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

California Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level 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

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

SUMMARY OF FINDINGS

Summary Tables: Comparison With Benchmark Data

Reading the Summary Tables

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

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2022. Note that survey data reflect the ZIP Code-defined NHMC Service Region.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

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. Note that some secondary data reflect Los Angeles County data, marked [County-Level Data].

SOCIAL DETERMINANTS	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	9.3	7.2	3.9		
Population in Poverty (Percent)	13.2	12.0	12.4	8.0	
Children in Poverty (Percent)	17.2	15.2	16.3	8.0	
No High School Diploma (Age 25+, Percent)	18.9	15.4	10.6		
Unemployment Rate (Age 16+, Percent)	5.8	5.3	4.0		9.8
% Unable to Pay Cash for a $400 Emergency Expense	26.6		34.0		21.6
% Worry/Stress Over Rent/Mortgage in Past Year	47.4		45.8		45.6
% Unhealthy/Unsafe Housing Conditions	21.7		16.4		23.6
Population With Low Food Access (Percent)	9.0	13.3	22.2		
% Food Insecure	37.8		43.3		38.4
% Treated Worse Than Other Races in Health Care Settings	8.7				5.5
% Disagree That the Community is Welcoming to All Races/Ethnicities	5.1				6.4
		better	similar	worse	

OVERALL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	18.7	20.8	15.7		16.1
		better	similar	worse	

ACCESS TO HEALTH CARE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS			
		vs. CA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**9.5**	8.9	8.1	7.6	8.2
% Difficulty Accessing Health Care in Past Year (Composite)	**47.7**		52.5		54.6
% Cost Prevented Physician Visit in Past Year	**16.8**	10.7	21.6		18.7
% Cost Prevented Getting Prescription in Past Year	**15.5**		20.2		16.1
% Difficulty Getting Appointment in Past Year	**31.9**		33.4		34.1
% Inconvenient Hrs Prevented Dr Visit in Past Year	**23.3**		22.9		22.5
% Difficulty Finding Physician in Past Year	**23.2**		22.0		22.7
% Transportation Hindered Dr Visit in Past Year	**11.9**		18.3		14.6
% Language/Culture Prevented Care in Past Year	**3.0**		5.0		5.6
% Stretched Prescription to Save Cost in Past Year	**16.0**		19.4		19.1
% Difficulty Getting Child's Health Care in Past Year	**10.2**		11.1		11.7
Primary Care Doctors per 100,000	**75.4**	81.1	74.9		
% Have a Specific Source of Ongoing Care	**62.1**		69.9	84.0	65.2
% Routine Checkup in Past Year	**62.6**	74.5	65.3		56.6
% [Child 0-17] Routine Checkup in Past Year	**82.7**		77.5		72.3
% Two or More ER Visits in Past Year	**15.4**		15.6		12.6

ACCESS TO HEALTH CARE (continued)	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% "Extremely/Very Likely" to Use Telemedicine	**46.5**				46.7
% Rate Local Health Care "Fair/Poor"	**16.9**		11.5		13.1
		better	similar	worse	

CANCER	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	**147.7** [County-Level Data]	153.5	182.5	122.7	142.4
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	
Colorectal Cancer Deaths per 100,000	**14.7** [County-Level Data]	14.3	16.3	8.9	
Cancer Incidence per 100,000	**368.0**	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	**8.8**	9.5	7.4		7.2
% [Women 50-74] Breast Cancer Screening	**77.7**		64.0	80.5	70.2

CANCER (continued)	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% [Women 21-65] Cervical Cancer Screening	67.5		75.4	84.3	62.5
% [Age 45-75] Colorectal Cancer Screening	76.9		71.5	74.4	78.1
		better	similar	worse	

CLIMATE, NATURE & HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% Consider Climate and Health Risk to Be Connected	84.9				
% Health/Well-Being Impacted by Weather in the Past 3 Years	36.4				
% Access to Nature, Parks, or Greenspaces is "Fair/Poor"	19.9				
% Visit Nature, Parks, or Greenspaces Less Than Monthly	35.0				
		better	similar	worse	

DIABETES	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	36.2 [County-Level Data]	29.4	30.5		23.6
% Diabetes/High Blood Sugar	13.7	11.5	12.8		12.7
% Borderline/Pre-Diabetes	14.7		15.0		13.1
Kidney Disease Deaths per 100,000	16.6 [County-Level Data]	12.4	16.9		11.2
		better	similar	worse	

DISABLING CONDITIONS	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	**31.6**		38.0		30.0
% Activity Limitations	**25.5**		27.5		28.6
% High-Impact Chronic Pain	**17.2**		19.6	6.4	17.0
Alzheimer's Disease Deaths per 100,000	**47.6** [County-Level Data]	43.5	35.8		35.2
% Caregiver to a Friend/Family Member	**23.1**		22.8		27.0
		better	similar	worse	

HEART DISEASE & STROKE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000	**175.8** [County-Level Data]	168.0	209.5	127.4	158.1
% Heart Disease	**7.1**	5.2	10.3		5.4
Stroke Deaths per 100,000	**40.4** [County-Level Data]	46.9	49.3	33.4	34.9
% Stroke	**3.3**	2.9	5.4		4.3
% High Blood Pressure	**32.9**	30.6	40.4	42.6	32.4
% [Those With HBP] Check Blood Pressure "Occasionally/Not At All"	**79.2**				
% High Cholesterol	**35.3**		32.4		27.8
% 1+ Cardiovascular Risk Factor	**79.6**		87.8		85.7
		better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)	**14.1**	14.8	22.3		14.0
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	**3.6** [County-Level Data]	4.0	5.6	5.0	4.0
		better	similar	worse	

INJURY & VIOLENCE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000	**44.8** [County-Level Data]	53.8	67.8	43.2	23.5
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	5.9
% Firearm In or Around the Home	**17.4**				
% [Households w/ Firearms] Gun is Unlocked	**37.4**				
% Victim of Violent Crime in Past 5 Years	**11.0**		7.0		6.7
% Victim of Gang Violence in Past 5 Years	**2.7**				
% Victim of Intimate Partner Violence	**19.5**		20.3		14.6
% Victim of Intimate Partner Violence in Past 3 Years	**8.4**				
% Victim of Emotional Harm by Intimate Partner in Past 3 Years	**15.8**				

INJURY & VIOLENCE (continued)	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% Forced Into Sexual Activity in Past 3 Years	5.2				
% [Adults] Victim of Chilhood Abuse or Neglect	32.0				
		better	similar	worse	

MENTAL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	26.0		24.4		28.3
% Diagnosed Depression	26.5	17.0	30.8		24.1
% Symptoms of Chronic Depression	43.9		46.7		47.3
% Typical Day Is "Extremely/Very" Stressful	21.0		21.1		23.0
Suicide Deaths per 100,000	8.8 [County-Level Data]	10.8	14.7	12.8	8.2
Mental Health Providers per 100,000	275.4	327.5	312.5		
% Receiving Mental Health Treatment	21.7		21.9		14.8
% Unable to Get Mental Health Services in Past Year	13.4		13.2		13.4
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS			
		vs. CA	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	25.5		30.0		23.3
% No Leisure-Time Physical Activity	21.5	22.9	30.2	21.8	27.3
% Meet Physical Activity Guidelines	32.1	30.1	30.3	29.7	27.4
% [Child 2-17] Physically Active 1+ Hours per Day	32.5		27.4		21.5
% Overweight (BMI 25+)	59.9	64.0	63.3		63.2
% Obese (BMI 30+)	28.1	27.7	33.9	36.0	32.9
% [Child 5-17] Overweight (85th Percentile)	29.7		31.8		31.2
% [Child 5-17] Obese (95th Percentile)	11.0		19.5	15.5	18.3
		better	similar	worse	

ORAL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS			
		vs. CA	vs. US	vs. HP2030	TREND
% Dental Visit in Past Year	64.8		56.5	45.0	55.8
% [Child 2-17] Dental Visit in Past Year	85.5		77.8	45.0	80.7
		better	similar	worse	

RESPIRATORY DISEASE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000	**26.8** [County-Level Data]	30.2	43.5		29.3
Pneumonia/Influenza Deaths per 100,000	**18.3** [County-Level Data]	12.8	13.4		20.7
% Received a COVID-19 Vaccine or Booster in the Past 12 Months	**43.7**				
% Asthma	**12.5**	8.8	17.9		9.3
% [Child 0-17] Asthma	**7.9**		16.7		3.6
% COPD (Lung Disease)	**7.8**	4.2	11.0		7.8
		better	similar	worse	

SEXUAL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	**610.7**	418.7	386.6		
Chlamydia Incidence per 100,000	**588.1**	493.6	495.0		
Gonorrhea Incidence per 100,000	**290.7**	205.6	194.4		
		better	similar	worse	

SUBSTANCE USE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000	**17.4** [County-Level Data]	17.7	15.7		12.3
Cirrhosis/Liver Disease Deaths per 100,000	**18.1** [County-Level Data]	17.2	16.4	10.9	
% Excessive Drinking	**17.8**	15.4	34.3		25.2
Unintentional Drug-Induced Deaths per 100,000	**23.3** [County-Level Data]	26.6	29.7		6.5
% Used an Illicit Drug in Past Month	**4.3**		8.4		4.4
% Used a Prescription Opioid in Past Year	**9.2**		15.1		12.6
% Ever Sought Help for Alcohol or Drug Problem	**8.7**		6.8		3.9
% Personally Impacted by Substance Use	**38.9**		45.4		35.6
		better	similar	worse	

TOBACCO USE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	**14.2**	8.5	23.9	6.1	16.4
% Someone Smokes at Home	**13.3**		17.7		14.1
% Use Vaping Products	**12.2**	5.9	18.5		10.1
		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); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the 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	▪ Receiving Treatment for Mental Health ▪ Key Informants: *Mental Health* ranked as a top concern.
2	HOUSING	▪ Housing Conditions ▪ Key Informants: *Social Determinants of Health (especially Housing)* ranked as a top concern.
3	DIABETES	▪ Diabetes Deaths ▪ Kidney Disease Deaths ▪ Key Informants: *Diabetes* ranked as a top concern.
4	CLIMATE, NATURE & HEALTH	▪ Key Informants: *Climate, Nature & Health* ranked as a top concern.
5	SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ Key Informants: *Substance Use* ranked as a top concern.

Other health needs identified in this assessment include:

- NUTRITION, PHYSICAL ACTIVITY & WEIGHT
- ACCESS TO HEALTH CARE SERVICES
- DISABLING CONDITIONS
- HEART DISEASE & STROKE
- INJURY & VIOLENCE
- RESPIRATORY DISEASE
- SEXUAL HEALTH

Hospital Implementation Strategy

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

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

COMMUNITY DESCRIPTION

DEMOGRAPHIC SUMMARY

The NHMC Service Region, the focus of this Community Health Needs Assessment, encompasses 362.31 square miles and houses a total population of 1,500,327 residents, according to latest census estimates.

The NHMC Service Region is predominantly urban.

Note the following demographic makeup of our community.

Core Demographic Summary

	NHMC Service Region
Urbanization	99.0% Urban
Total Population Size	1,500,327
Race & Ethnicity — *Hispanic*	47.8%
White	32.5%
Asian	11.5%
Black	4.0%
Native Hawaiian/Pacific Islander	0.2%
American Indian or Alaska Native	0.2%
Average Household Income	$126,219
Percent of Population Living in Poverty (Below 100% FPL)	13.2%
Unemployment Rate (December 2024)	5.8%
Percent of People Age 5 and Older Who are Non-English Speaking	9.3%
Percent of People Without Health Insurance	9.4%
Percent of People with Medicaid	32.5%
Health Professional Shortage Area	Primary, Dental, and Mental Health
Medically Underserved Areas/Populations	Yes
Medically Underserved, Low Income, or Minority Populations	Multiple
Number of Other Hospitals Serving the Community	14

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 population survey 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.

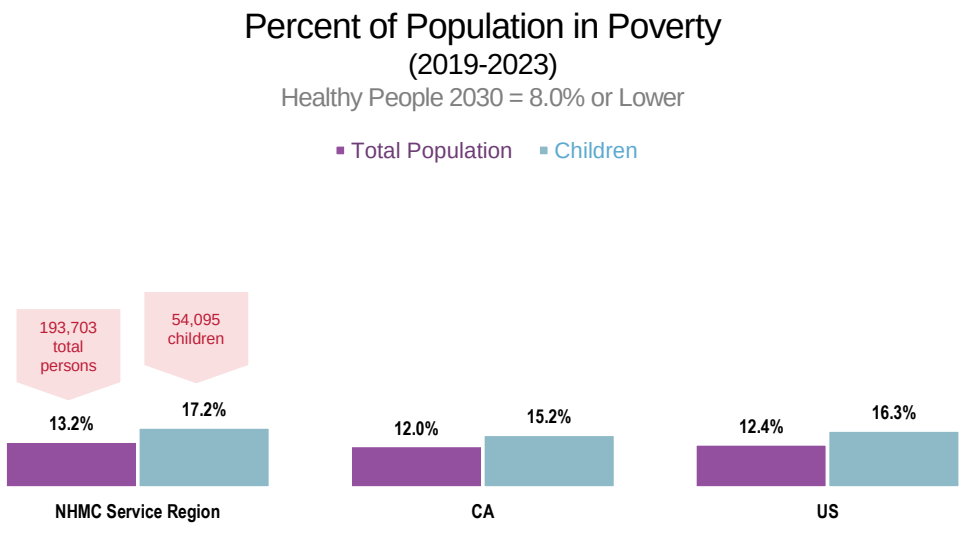
– Healthy People 2030 (https://health.gov/healthypeople)

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.

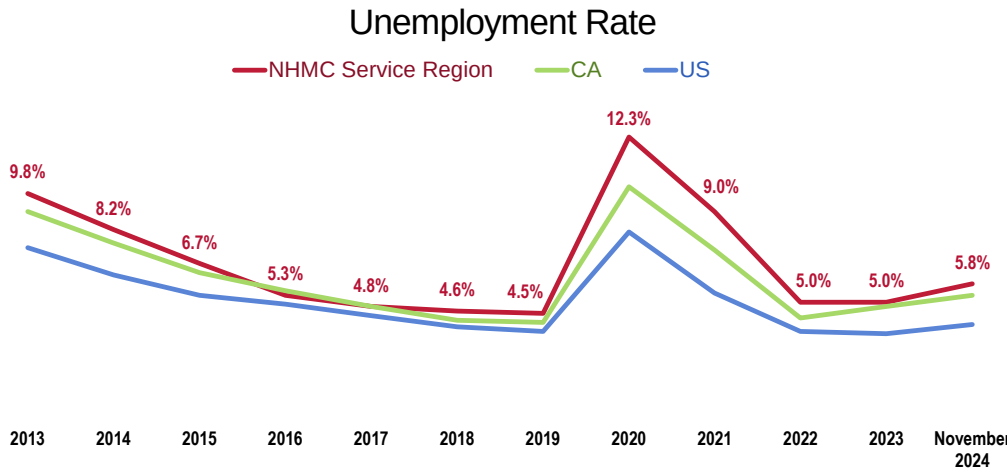
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.



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

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 February 2025 via SparkMap (sparkmap.org).

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

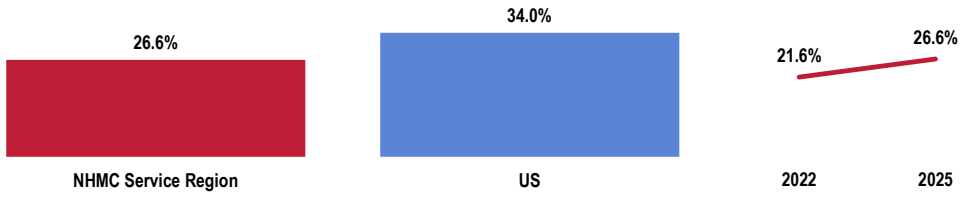
Financial Resilience

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 charts detail "no" responses in the NHMC Service Region 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

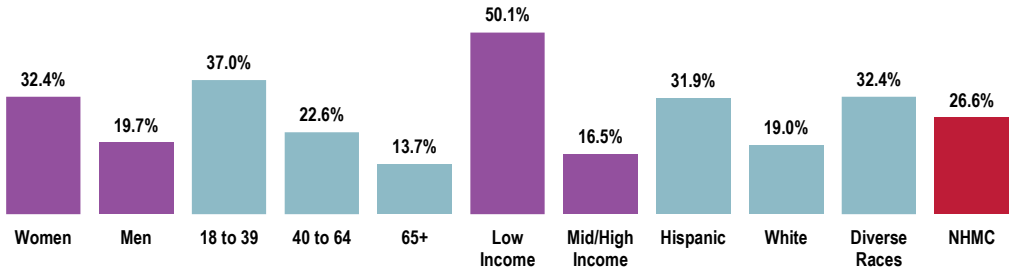
NHMC Service Region



Sources:
- 2025 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.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
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

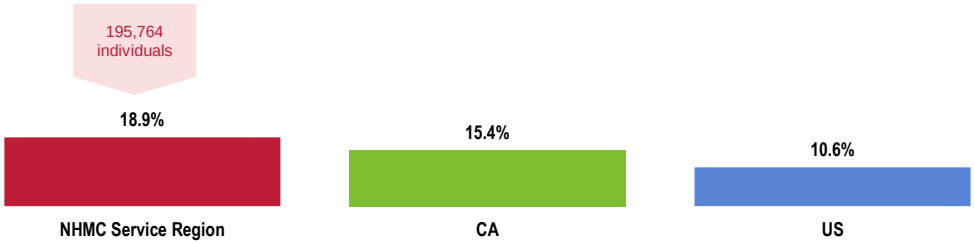
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 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. “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.

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.

Population With No High School Diploma
(Adults Age 25 and Older; 2019-2023)



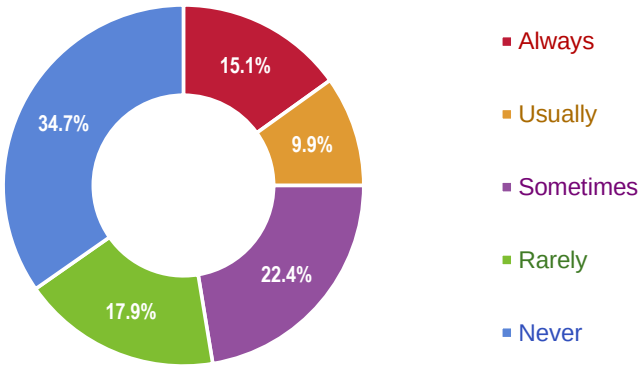
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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
(NHMC Service Region, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]

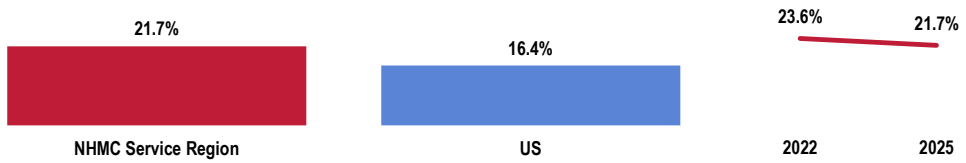
Notes:
- Asked of all respondents.

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

NHMC Service Region

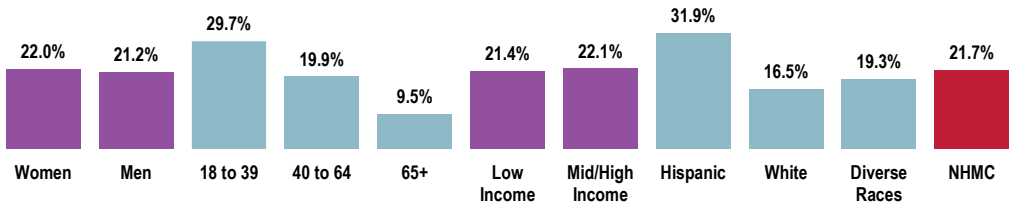


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

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.

Unhealthy or Unsafe Housing Conditions in the Past Year
(NHMC Service Region, 2025)

Among homeowners	12.0%
Among renters	30.4%



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]

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

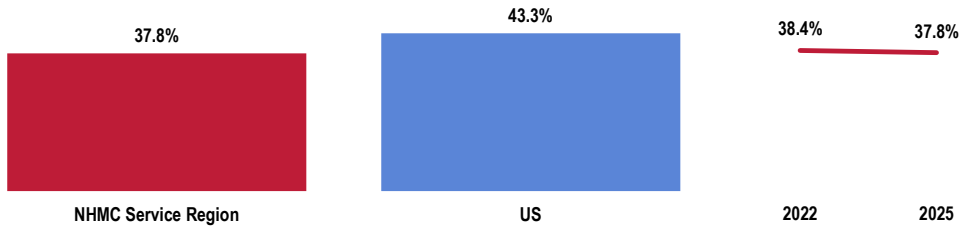
PRC SURVEY ► "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- '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.

Food Insecure

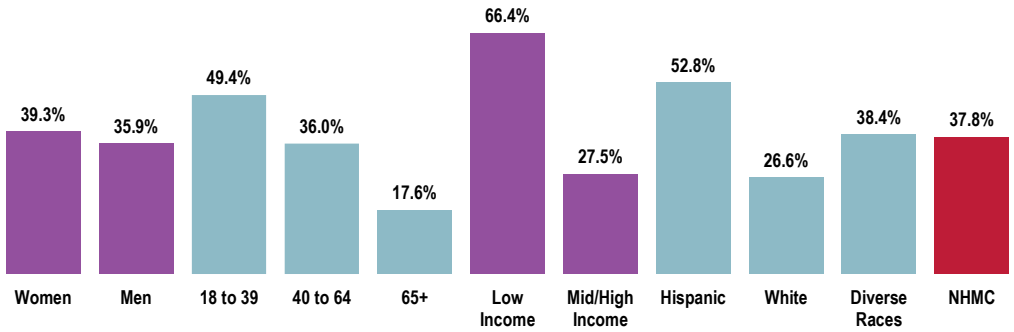
NHMC Service Region



Sources:
- 2025 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.

Food Insecure
(NHMC Service Region, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 98]

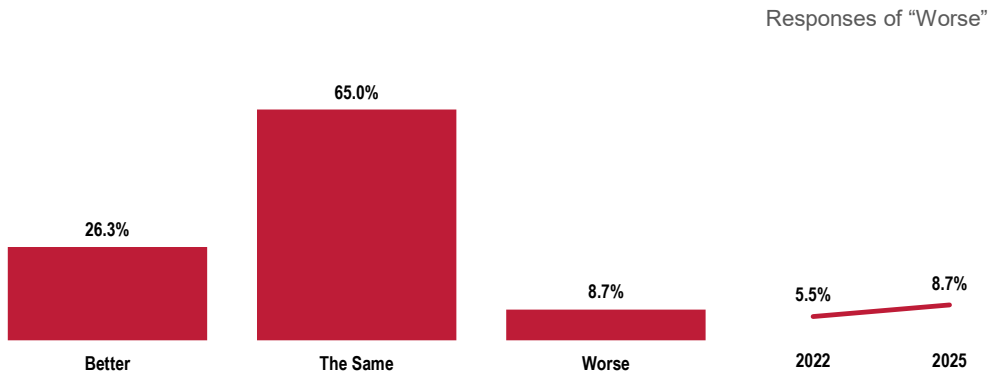
Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Equity

Treatment in Health Care Settings Based on Race/Ethnicity

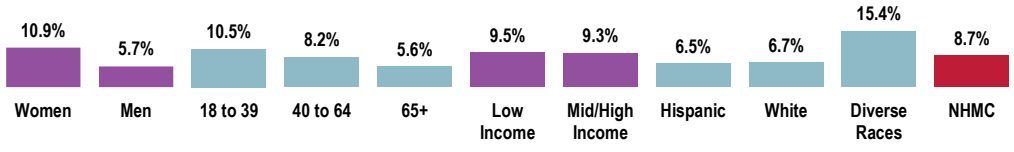
PRC SURVEY ► "And now thinking about all of your health care experiences in the past 12 months, in general, do you feel your experiences were 'better,' 'the same,' or 'worse' than those of other races or ethnicities?"

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



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.

Respondents Who Feel They Were Treated Worse in Health Care Settings Over the Past Year in Comparison with People of Other Races/Ethnicities
(NHMC Service Region, 2025)

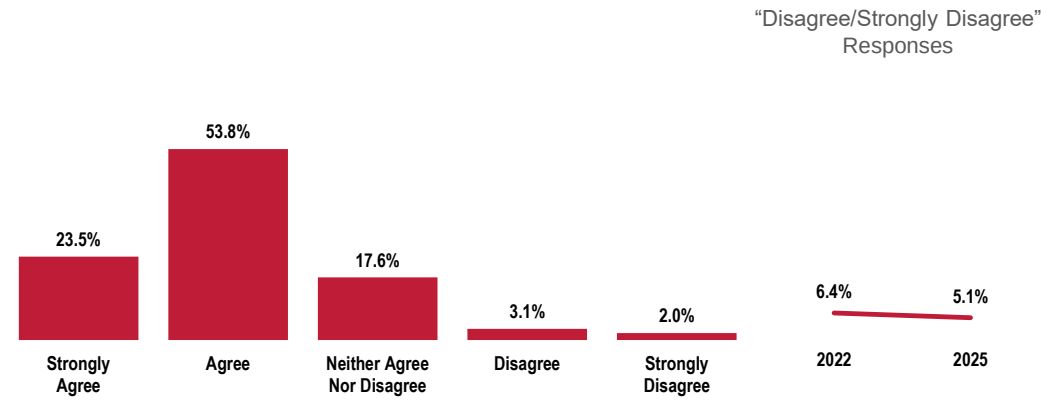


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.

Community as Welcoming Place for All Races/Ethnicities

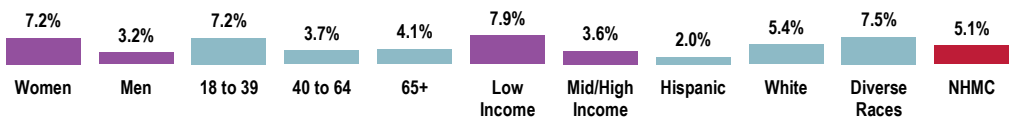
PRC SURVEY ► "Please tell me your level of agreement or disagreement with the following statement: 'I feel that my community is a welcoming place for people of all races and ethnicities.' Do you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree?"

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



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: ● Asked of all respondents.

Disagree That the Community is a Welcoming Place for All Races/Ethnicities
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: ● Asked of all respondents.
● Percentages represent combined responses of "Disagree" and "Strongly Disagree."

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.

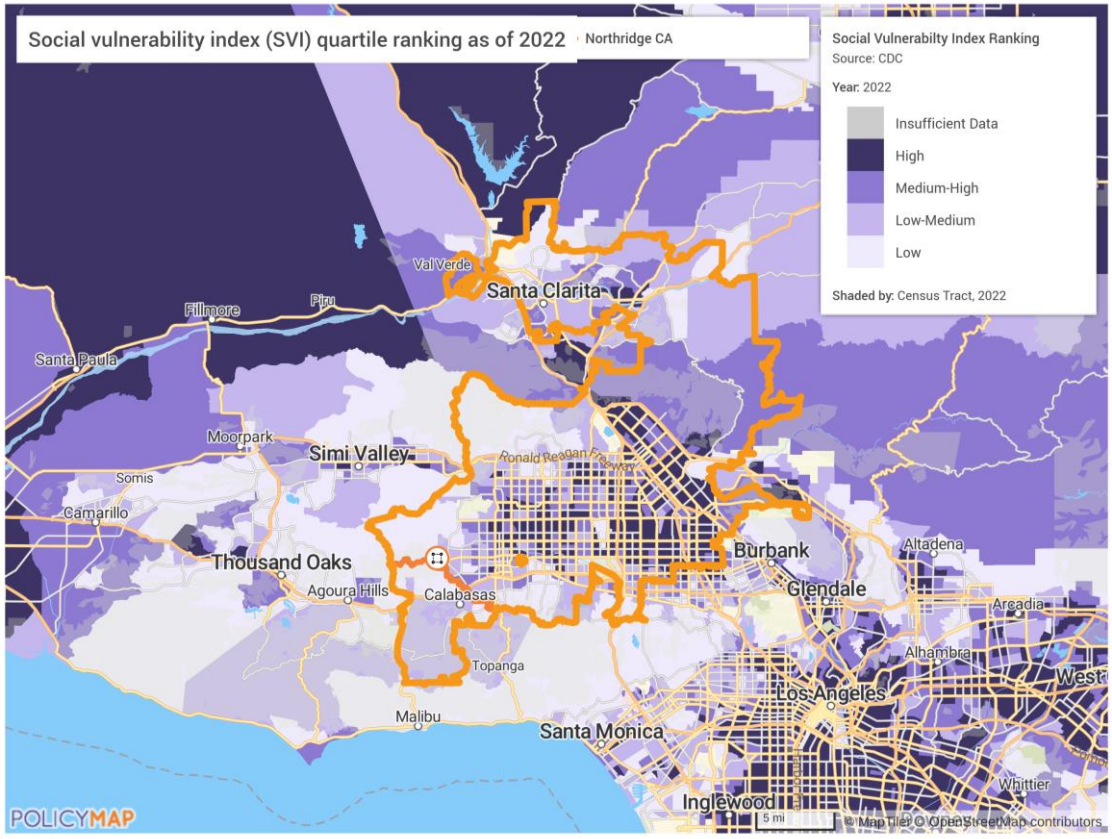
The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 US census variables to help local officials identify communities that may need support before, during, or after disasters.

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 NHMC Service Region with the highest social vulnerability.

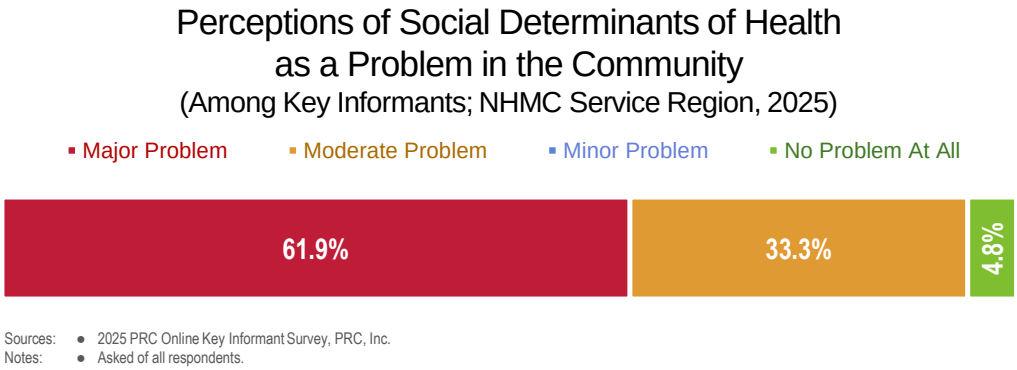
Social Vulnerability



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

Key Informant Input: Social Determinants of Health

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



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

Income/Poverty

> Many residents in our community live below the federal poverty level, and nearly half of residents report experiencing housing burdens. Our community also has a large unhoused population. Additionally, some areas in our community live in housing that pose high lead exposure risks. — Public Health Representative
>
> Low income. High prices in rent and buying houses. The dollar has lost its value. High increase in cost of basic foods for the family. High rates in health/auto insurance that a family with so many members cannot afford. High tuition in higher education for students. Legal status of immigrants. Students lack resources in our community. Illegal trafficking of drugs in the schools, now starting in the elementary schools. The above are some of the examples that our community is facing that, in a moment of the life of an individual, is going to become a health, mental, and violence problem in our community. In the long term, people affected by these won't have the funds and resources to take care of themselves, and then we are going to face, as a community in general, a health problem. — Social Services Provider
>
> Lower social economic status of a larger percentage of the community. Multiple families living together to manage income vs. expenses. — Community Leader
>
> Disappearing middle class. Polarization of wealth. — Social Services Provider
>
> Lack of resources and large number of families that are unemployed or making low wages, contributing to lack of basic needs and high stress. — Social Services Provider

Housing

> Social determinants of health are a major barrier in San Fernando Valley and Santa Clarita Valley. There are high housing costs, low wages in some areas, sometimes food desert areas, and ongoing racial discrimination. — Social Services Provider
>
> It will be difficult (if not impossible) for low-income individuals and families to meet their health care needs if they are grappling with housing and/or are fearful of being judged (or detained!) based on the color of their skin and/or the sound of their voice. — Social Services Provider
>
> Lack of access to: affordable housing, mental health, transportation for those with physical limitations (not public buses), access to food, in-home support services. — Social Services Provider

Vulnerable Populations

> Just the overwhelming numbers. It is not a good time to be undocumented, but they deserve to be well. There are demonstrable differences in health access by ethnicity, which are rooted in societal perceptions. Social and economic determinants are all related. We can always find exceptions — black women can go to a clinic for prenatal and pregnancy care, but it might involve three bus rides, and if the system worked, then why are infant mortality rates so much higher for Blacks? It isn't genetics. — Health Care Provider

Food Insecurity

> Social determinants of health are key to many of the health issues that the community deals with. A person who is food insecure, lacks secure housing and/or fears to ask for assistance due to current policies will suffer from the results with ill health, both physical and mental. — Social Services Provider

Government/Politics

> In recent years, there has been a change in government leadership that makes it okay to discriminate against people, which creates a fear of seeking help when needed. — Social Services Provider

Homelessness

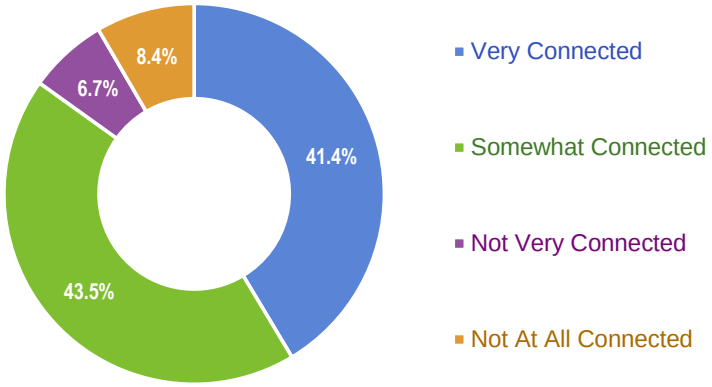
> Homelessness. — Social Services Provider

CLIMATE, NATURE & HEALTH

Climate/Health Connection

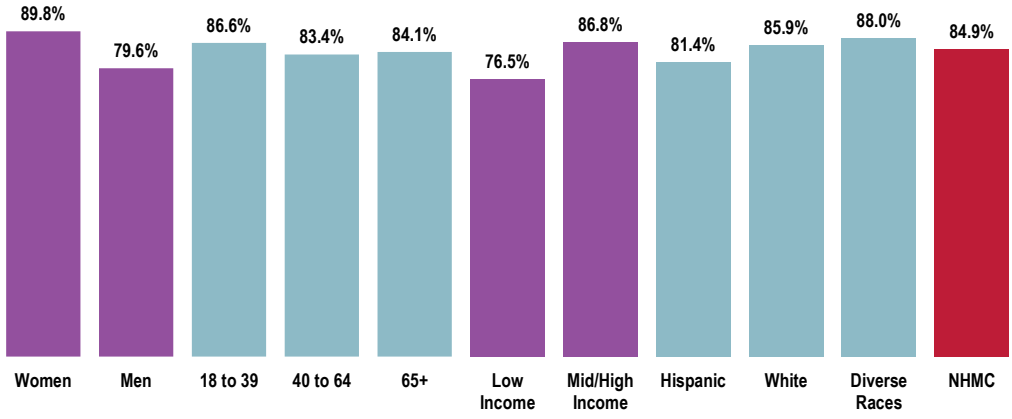
PRC SURVEY ► "To what extent do you feel that climate is connected to health risks? Would you say it is very connected, somewhat connected, not very connected, or not at all connected?"

Perception of Climate's Connection to Health Risks
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: ● Asked of all respondents.
● In this case, climate refers to general weather conditions in an area or over a long period of time, such as storms, tornadoes, extreme heat, flooding, or drought.

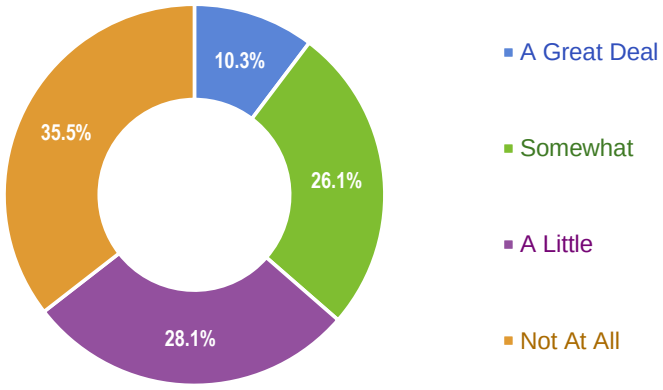
Climate and Health Risk Are "Very/Somewhat Connected"
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: ● Asked of all respondents.
● In this case, climate refers to general weather conditions in an area or over a long period of time, such as storms, tornadoes, extreme heat, flooding, or drought.

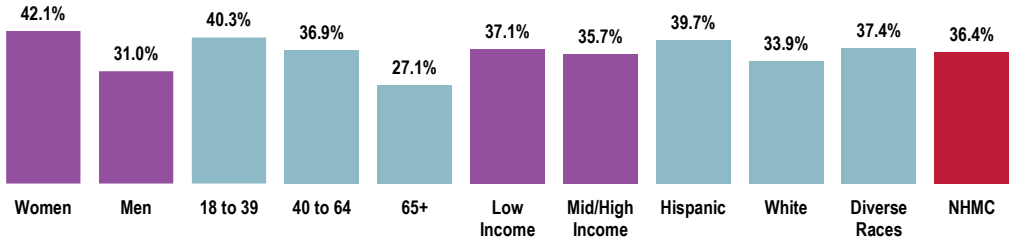
PRC SURVEY ▶ "In the past three years, to what extent has your health or well-being been impacted by weather events? Would you say a great deal, somewhat, a little, or not at all?"

Health or Well-Being Has Been Impacted by Weather in the Past Three Years
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 314]
Notes: ● Asked of all respondents.

Health or Well-Being Has Been Impacted "A Great Deal/Somewhat" by Weather in the Past Three Years
(NHMC Service Region, 2025)

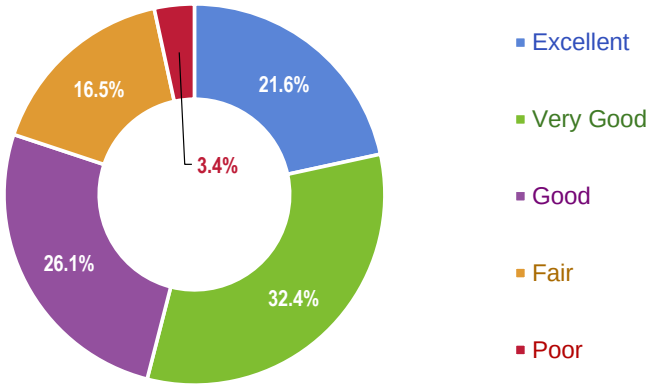


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 314]
Notes: ● Asked of all respondents.

Access to Nature, Parks & Greenspaces

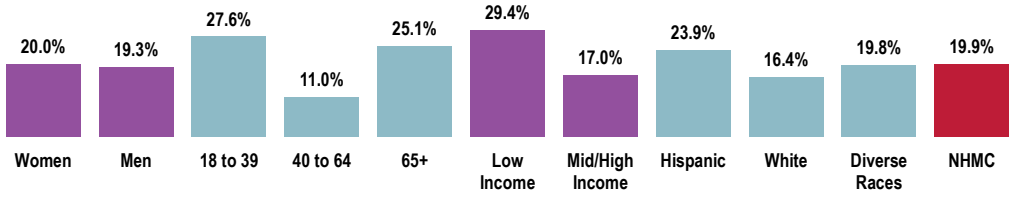
PRC SURVEY ► "How would you rate access to nature, parks, or greenspaces in your area? Would you say excellent, very good, good, fair, or poor?"

Rating of Access to Nature, Parks, or Greenspaces
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 315]
Notes: ● Asked of all respondents.

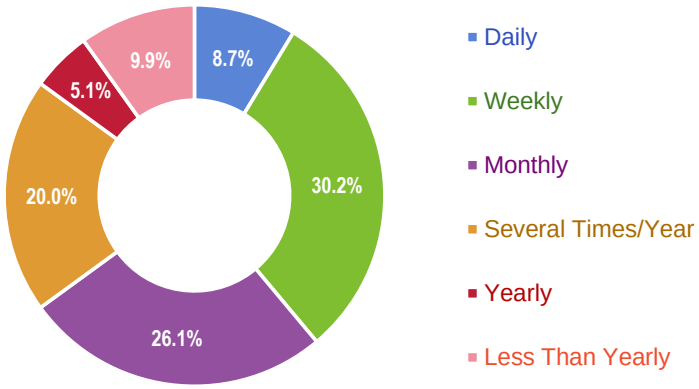
Access to Nature, Parks, or Greenspaces is "Fair" or "Poor"
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 315]
Notes: ● Asked of all respondents.

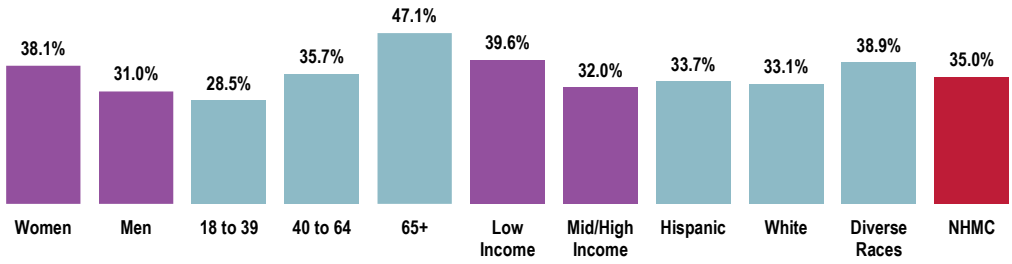
PRC SURVEY ► "How often do you spend time in nature, parks, or greenspaces in your area?"

Frequency of Time Spent in Nature, Parks, or Greenspaces
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 316]
Notes: ● Asked of all respondents.

Visit Nature, Parks, or Greenspaces Less Than Monthly
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 316]
Notes: ● Asked of all respondents.

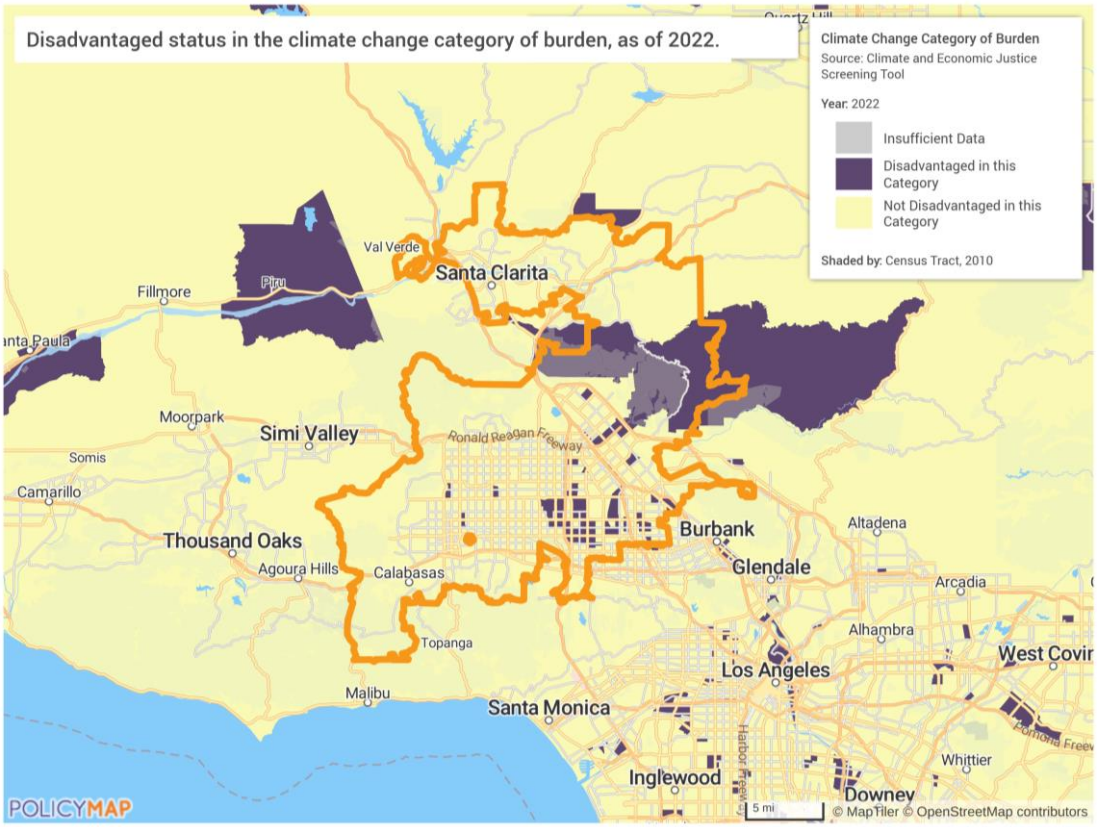
Climate Change Burden

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 NHMC Service Region with the highest burden relative to climate change.

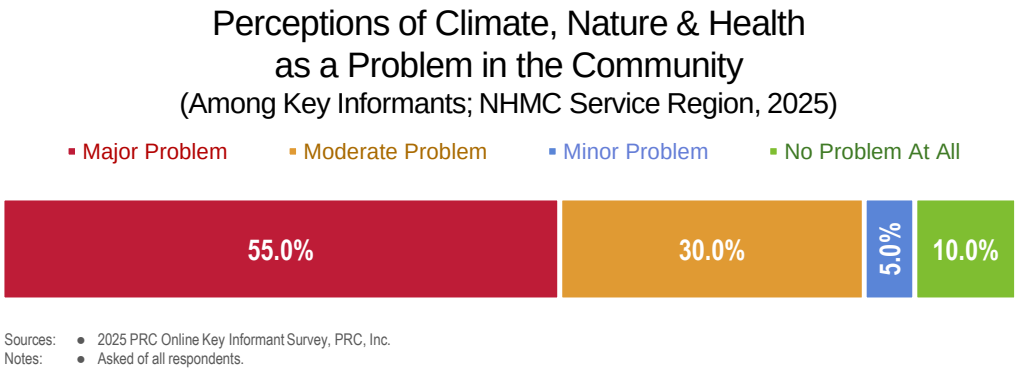
Disadvantaged Status for Climate Change Category of Burden



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

Key Informant Input: Climate, Nature & Health

The following chart outlines key informants' perceptions of the severity of *Climate, Nature & Health* as a problem in the community:



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

Wildfires

> As seen in LA fires, a lot of natural disasters and emergencies are intensifying and are more widespread and spread quickly once initiated. They are also more costly, displacing people, which in itself is a crisis. Also, even without the emergencies, heat illness is on the rise, as are volatile weather patterns, leading to unexpected or prolonged cold spells, rain, etc. — Public Health Representative
>
> Climate change has become a major challenge, especially from fire risk. Both the San Fernando Valley and Santa Clarita Valley areas were hit hard with fires this January 2025 due to extreme drought and dry conditions. The area is heating up, and there is a continued risk from this issue. When there are fires, there is ash, smoke, and other concerns for respiratory health. Additionally, people's mental health suffers when they are worried about wildfire. — Social Services Provider
>
> We are not equipped to respond or to the effects of climate emergencies, such as the recent Palisades fire and heavy rains, which encroached into our community and caused confusion, death, and property damage, as well as impacting air and water quality. — Social Services Provider
>
> Climate change has increased the number of fires and flooding in our areas, which contributes to higher insurance rates and loss of homes. This impacts cost of living, which also contributes to homelessness in our communities. — Social Services Provider
>
> Recent fires and floods. — Community Leader
>
> Fires, lack of water and resources, drought. — Social Services Provider

Extreme Heat

> We have seen drastic changes in the weather in the last years. Longer periods of extreme heat, less and shorter raining periods. Winter temperatures that feel like springtime. Winds stronger than in previous decades. — Social Services Provider
>
> Temperatures are rising, creating issues for seniors and vulnerably housed individuals. The hot, dry weather is also leading to more severe fire risk throughout the San Fernando and Santa Clarita Valleys, which is made worse by more significant winds. Stronger rains like atmospheric rivers leave burn areas vulnerable to landslides. — Public Health Representative
>
> Climate change is expected to bring increasing temperatures and more wildfires. Throughout Los Angeles County, we've already seen the impacts of climate change, including severe storms, temperature extremes, drought, and destructive wildfires. Our community is an area known for hot summers, wildfire risk, and strong winds. In the San Fernando/Santa Clarita Valleys, hotter, longer heat waves caused by climate change are one of the major threats to the health and well-being of our communities. — Public Health Representative
>
> I believe climate change is a major problem because we are faced with unusual types of inclement weather. This includes extreme heat waves and fires. What we have seen with recent fires is that people can become homeless overnight, and/or become exposed to toxins. Heat waves and fires can also lead to death. — Social Services Provider

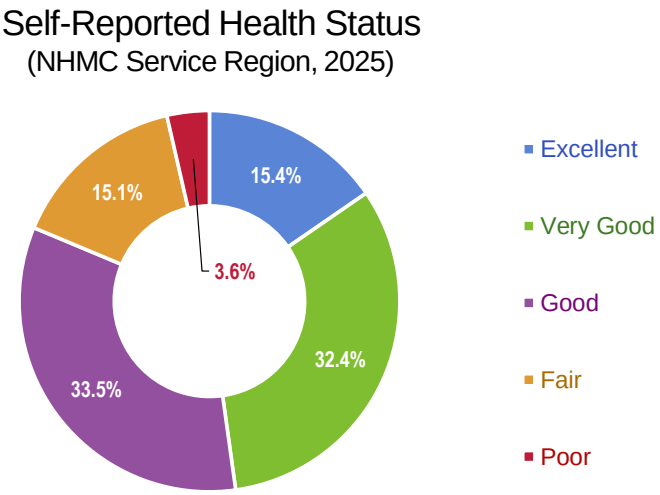
Environmental Health Related Issues

> Environmental health-related issues. The community is struggling with various concerns related to the two landfills serving the San Fernando and Santa Clarita valleys. These communities are also often plagued with poor air quality. — Public Health Representative
>
> The absolute overwhelming number of scientists have come to the same conclusion. My community, like all other communities, is on planet Earth. If the planet goes, we go. — Health Care Provider

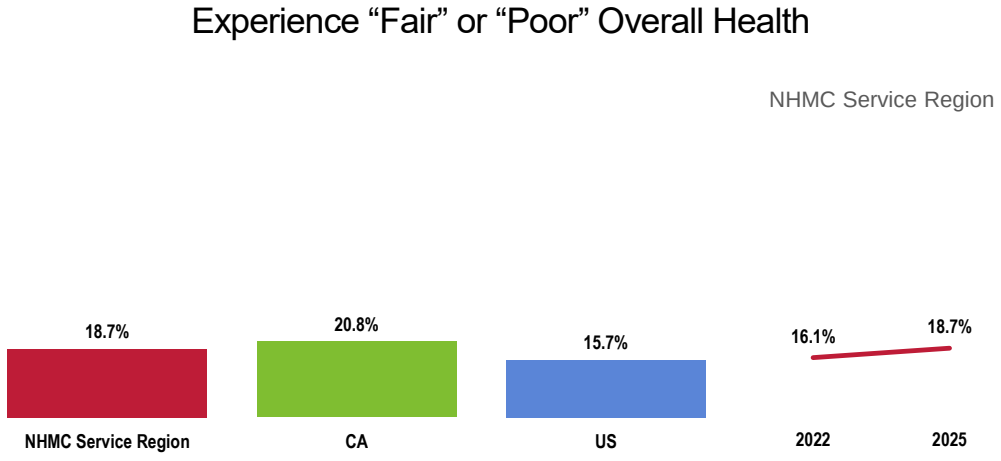
HEALTH STATUS

Overall Health

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

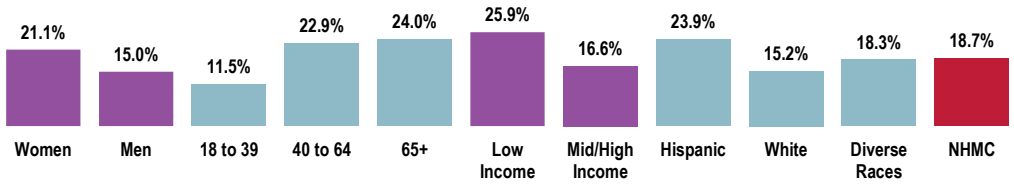


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2025 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
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

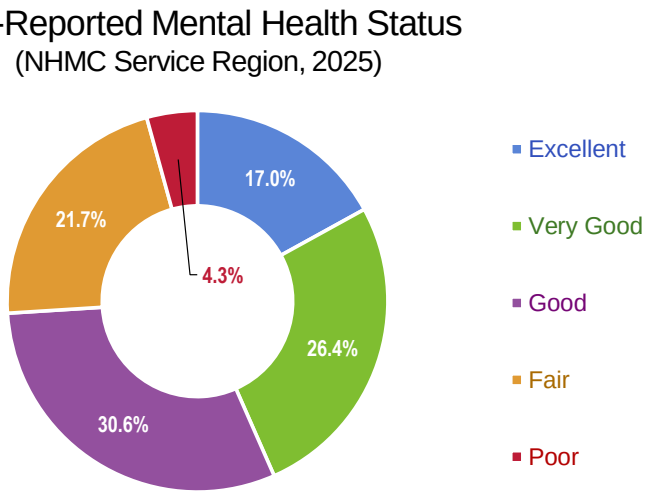
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

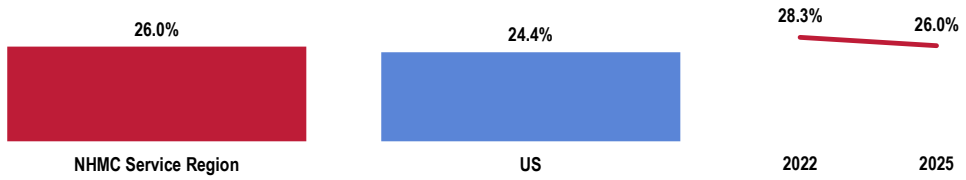
PRC SURVEY ► "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

NHMC Service Region



Sources:
- 2025 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

NHMC Service Region

Sources:
- 2025 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 Been Diagnosed With a Depressive Disorder

NHMC Service Region

Sources:
- 2025 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.

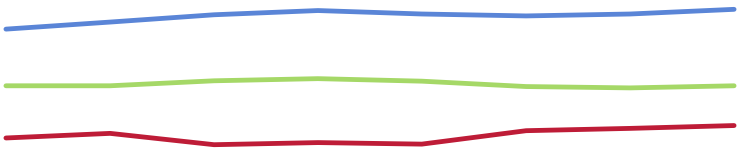
Suicide

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

Suicide Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	8.2	8.4	7.8	7.9	7.9	8.5	8.7	8.8
CA	10.8	10.8	11.1	11.2	11.0	10.8	10.7	10.8
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

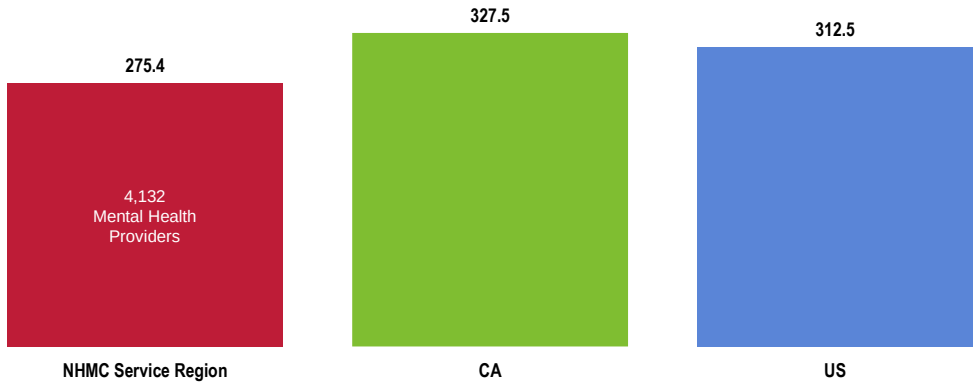
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Mental Health Treatment

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.

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

Number of Mental Health Providers per 100,000 Population
(2024)

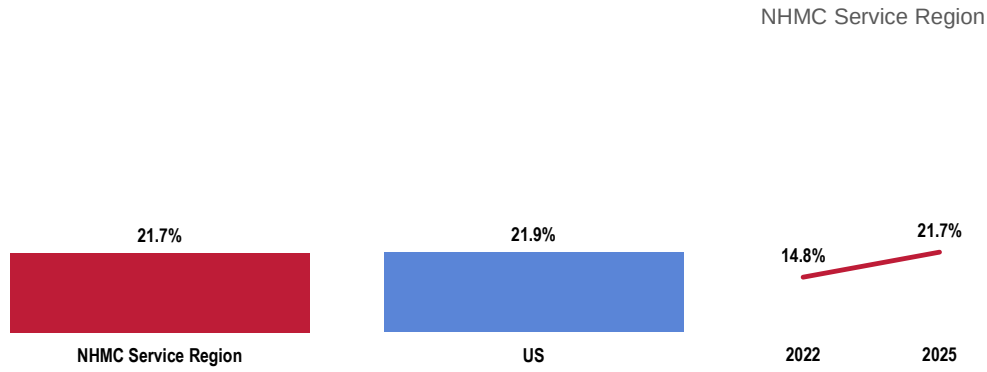


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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

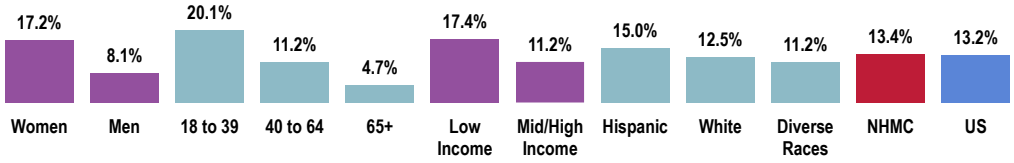


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those 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
(NHMC Service Region, 2025)



Sources: ● 2025 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:

Perceptions of Mental Health as a Problem in the Community
(Among Key Informants; NHMC Service Region, 2025)

Sources: ● 2025 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

> Lack or inadequate access to mental health/behavioral health services. — Public Health Representative
>
> Access to mental health care and mental health providers. We are a big community, and the mental health service needs are greater than the mental health providers available. — Public Health Representative
>
> Lack of access to resources, needing stronger support systems, high amount of physical health issues, co-occurring, substance use/abuse. — Social Services Provider
>
> Lack of accessible, no-cost mental health resources that meet the community where they are vs. the public having to actively seek out mental health support. Services that are accessible need to be for both low-income and non-low-income individuals. — Social Services Provider

Incidence/Prevalence

> Growth in mental days requested from staff and incidents with adolescents. — Community Leader
>
> Mental health. Both the prevalence of chronic depression and stress and other mental disorders. And the stigma that is attached to mental health issues by many ethnic groups. — Health Care Provider

> The epidemic of loneliness and isolation that has been widely documented and publicized in recent years. — Social Services Provider

Co-Occurrences

> Mental health is a challenge because, if untreated, it can lead to other conditions, including substance abuse, as well as exacerbate other chronic health conditions, such as diabetes and hypertension. — Social Services Provider

> Mental health/community well-being, vaping among teens. — Social Services Provider

Lack of Providers

> The largest challenge is the lack of mental health providers in a particular community who are culturally sensitive to a community's needs. It is a workforce issue. — Social Services Provider

> Not enough licensed affordable mental health providers available. — Social Services Provider

Youth

> It is a major problem for the youth community. This is the separation of mind and soul and the lack of family values and attention at an early stage of our children, and discipline that starts at home. (The young don't believe in their own faith and the spiritual inner self). They are constantly attacked through the media and cellular phones to motivate them to start consuming marijuana and other illegal substances at an early age, or the rap music that is only violent lyrics promoting drugs and sex. The brain of youth gets affected by all the above factors, and from it, their mental health issues start to increase. — Social Services Provider

Diagnosis/Treatment

> Substance abuse and mental health treatment programs are limited in duration, and people are often unable to establish solid sobriety in the allowed timeframe. Sick people living on the street are treated like animals. There is still such a stigma surrounding mental health issues that people often don't seek treatment until a crisis occurs. — Social Services Provider

Due to COVID-19

> The mental health crisis has increased since the pandemic. People do not feel safe, have worries over their housing, utilities, child care costs, health care costs, and more. It is very common to see many individuals who are anxious or depressed or both over the level of stress in their life. Mental health is especially an issue in adolescents and older adults where there is increased isolation and loneliness. — Social Services Provider

Alcohol/Drug Use

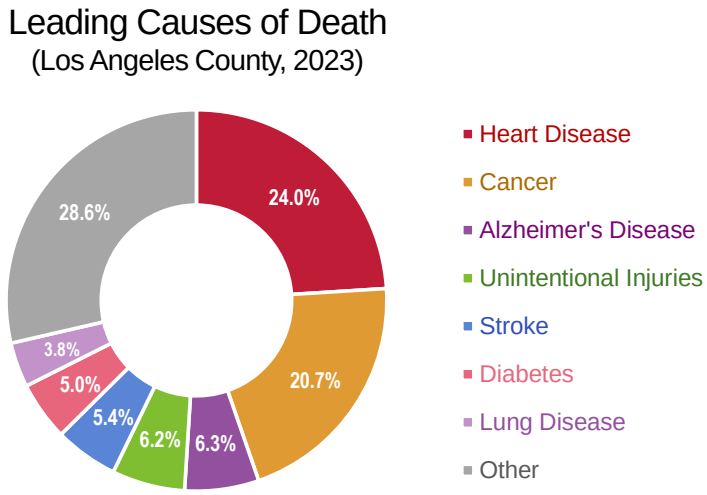
> Drug abuse and homelessness. — Social Services Provider

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the community. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 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. [COUNTY-LEVEL DATA]

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

	Los Angeles County	CA	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 Deaths	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 February 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 in our community. [COUNTY-LEVEL DATA]

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

Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	34.9	36.6	36.9	37.3	38.6	39.6	40.9	40.4
CA	37.9	39.9	41.0	41.9	43.2	45.0	46.5	46.9
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

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

Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	34.9	36.6	36.9	37.3	38.6	39.6	40.9	40.4
CA	37.9	39.9	41.0	41.9	43.2	45.0	46.5	46.9
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

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

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

NHMC Service Region

Sources:
- 2025 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

NHMC Service Region

Sources:
- 2025 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 ► [Among those with high blood pressure] **"How often do you check your blood pressure? Would you say daily, occasionally, or not at all?"**

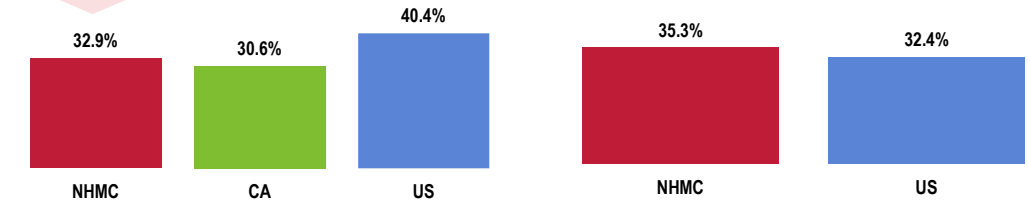
PRC SURVEY ► "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower

Of those with high blood pressure, 20.8% check their blood pressure **daily**, while the rest do so "occasionally" (61.4%) or not at all (17.8%).

Prevalence of High Blood Cholesterol



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29, 30, 303]
- 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.

Prevalence of
High Blood Pressure
(NHMC Service Region)
Healthy People 2030 = 42.6% or Lower

Prevalence of
High Blood Cholesterol
(NHMC Service Region)

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

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

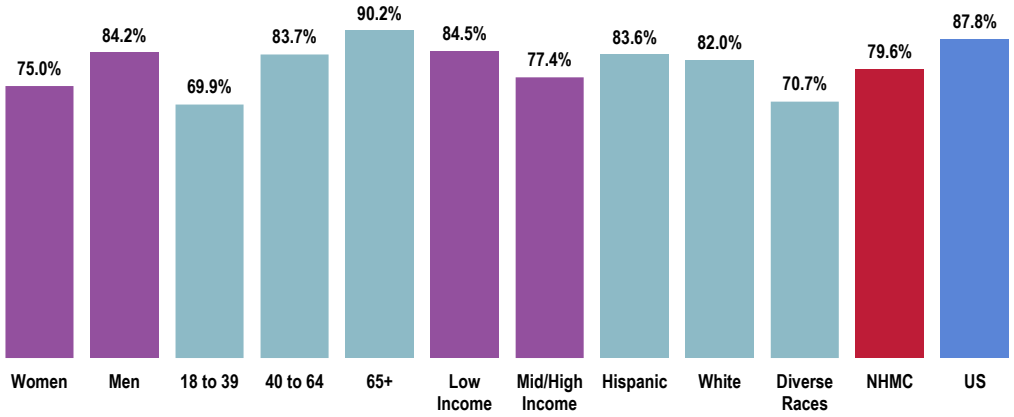
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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

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

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

Exhibit One or More Cardiovascular Risks or Behaviors
(NHMC Service Region, 2025)



Sources:
- 2025 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:

Perceptions of Heart Disease & Stroke as a Problem in the Community
(Among Key Informants; NHMC Service Region, 2025)

Sources:
- 2025 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

> Heart disease is still the number one underlying cause of death in LA County; stroke is not too far behind. — Public Health Representative
>
> Data from the LA County Public Health Community Health Profiles shows that our community has a high level of mortality from coronary heart disease compared to the rest of LA County and is much higher than the Healthy People 2030 target goal. — Public Health Representative
>
> Heart disease and stroke are rampant in this community. Lack of exercise, nutritious food, and social determinants of health create issues where people are not serving their bodies well, in addition to chronic stressors and lifestyle choices. Heart disease and stroke also put people at risk for other chronic diseases, like dementia. — Social Services Provider
>
> Hear often about individuals with high cholesterol and high blood pressure, as well as heart attacks. — Social Services Provider

Lifestyle

> The stress of life, the way we eat, the fast food industry, the lack of exercise, and the use of technology as cellphones are major factors that add to this problem. As a community, we have to have a big campaign to keep us educated in how to take care of our body, soul, and mind by being active, exercising, and learning to eat well. — Social Services Provider

Leading Cause of Death

> Heart disease and stroke are major problems because I think they are among the leading causes of death. — Social Services Provider

Access to Affordable Healthy Food

> Back to my statement about fast food chains targeting our communities: Healthy food is more expensive than unhealthy food. — Social Services Provider

Cancer

ABOUT CANCER

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

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

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

Cancer Deaths

The following chart illustrates cancer mortality (all types). [COUNTY-LEVEL DATA]

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	142.4	143.6	144.3	145.0	145.9	145.3	146.6	147.4
CA	151.5	151.5	151.2	150.9	151.3	151.3	152.8	153.5
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

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

Female breast cancer is the leading cause of cancer deaths. [COUNTY-LEVEL DATA]

Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

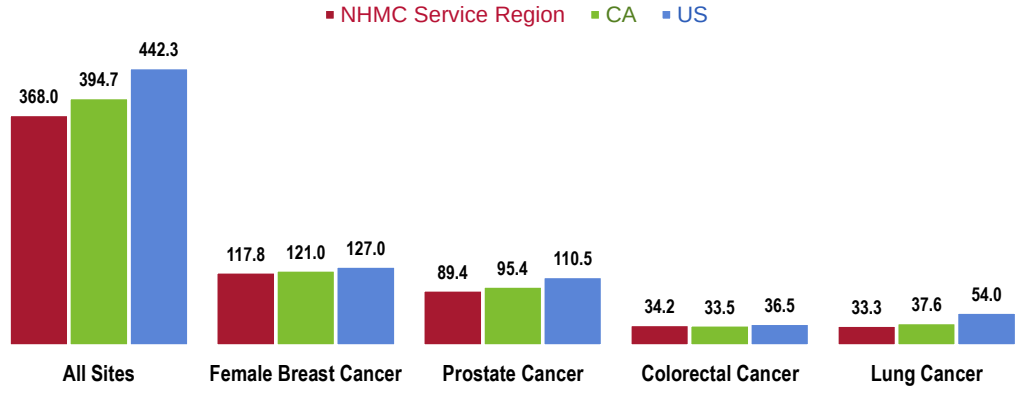
	Los Angeles County	CA	US	HP2030
ALL CANCERS	147.4	153.5	182.5	122.7
Female Breast Cancer	23.9	23.3	25.1	15.3
Lung Cancer	23.2	26.0	39.8	25.1
Prostate Cancer	18.2	19.9	20.1	16.9
Colorectal Cancer	14.7	14.3	16.3	8.9

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

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)

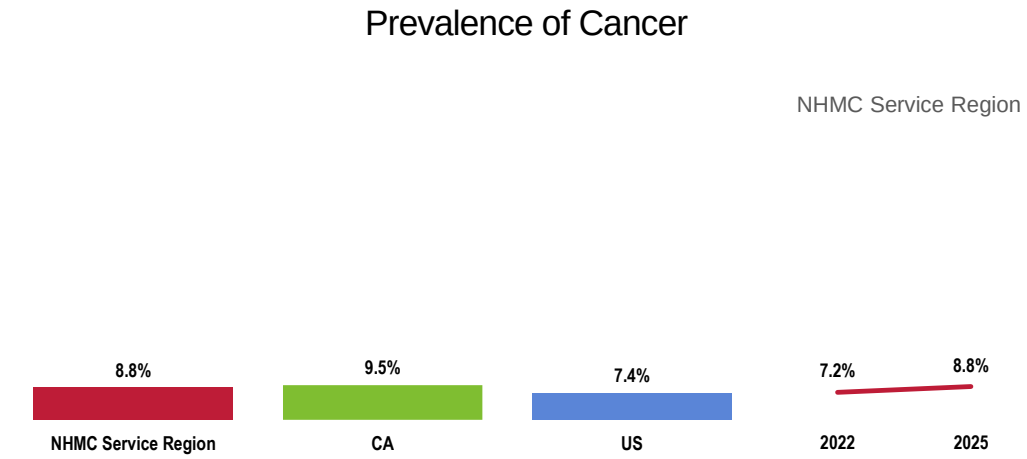


Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

FEMALE BREAST CANCER

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

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women 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:

Breast Cancer Screening

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

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

Cervical Cancer Screening

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?"**

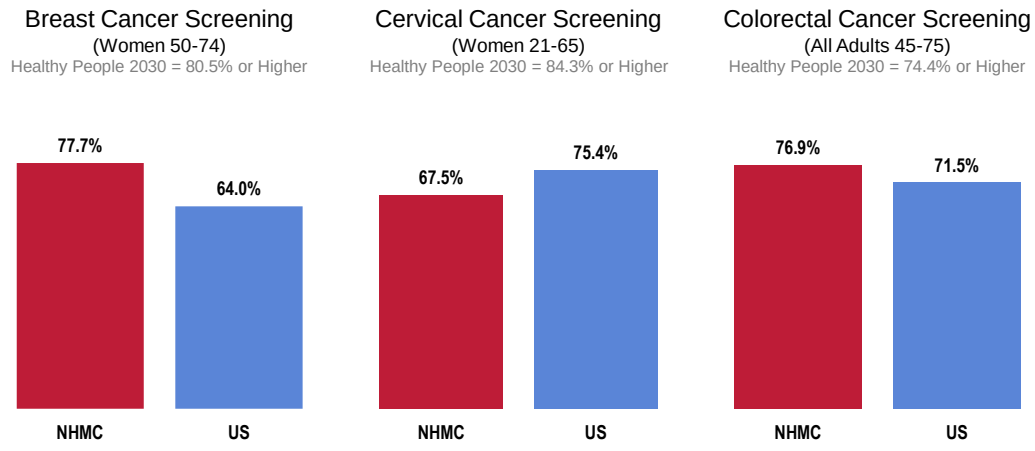
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

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?"

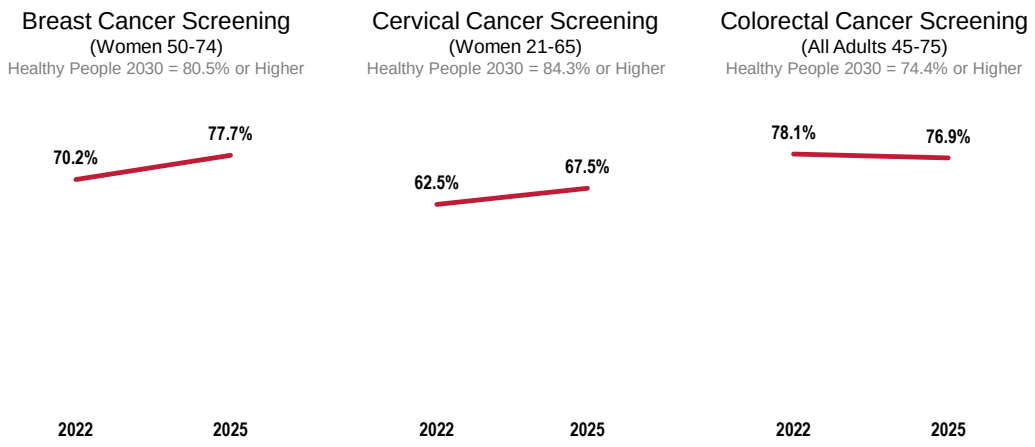
PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes adults age 45 to 75 with a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- 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.

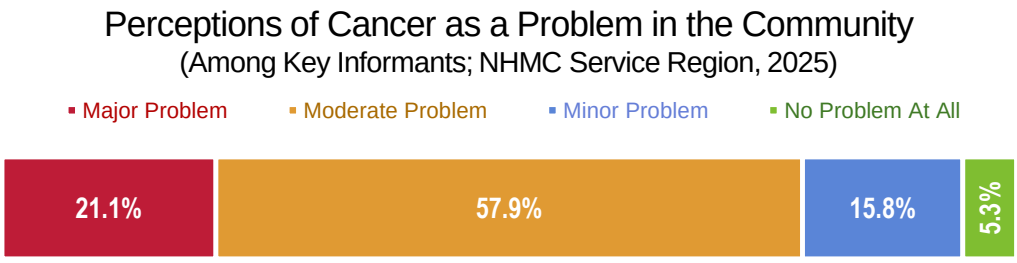


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

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



Sources:
- 2025 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

> Because the statistics have been increasing a lot in the past decade. I believe that the reason is the food that we consume: fast food, processed foods, engineering altered foods. For example, the chickens and cows are fed with steroids and artificial food to be able to feed the whole nation. The water that we drink is recycled after we used it, with special chemicals that harm our health. Also, because we are always working and busy, and we don't take the time to prepare healthy food to consume. Also, the abuse of drugs, marijuana, and alcohol can contribute to cancer disease. — Social Services Provider
>
> It's widespread, and I hear about new people being diagnosed every day. Also, the environment has so many toxins in the San Fernando Valley; that definitely seems to be contributing to this. — Social Services Provider
>
> Growth in the number of cases we've become aware of in the past six months. — Community Leader

Prevention

> Most cancer is curable if we detect it early enough or preventable if we live healthier lifestyles. But a great many people are dying needlessly. — Health Care Provider

Respiratory Disease

ABOUT RESPIRATORY DISEASE

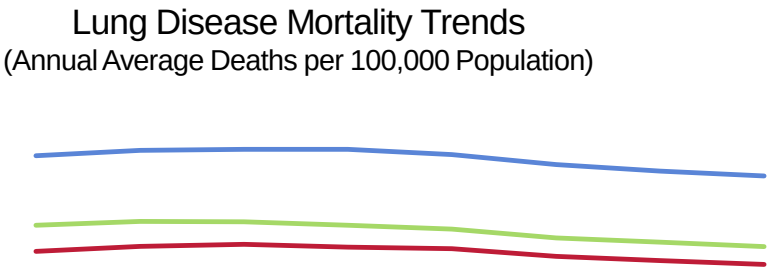
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million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

– 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]



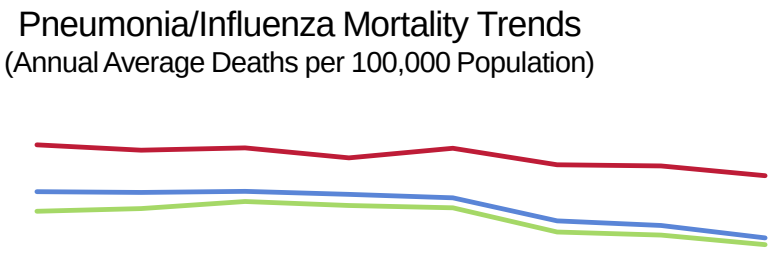
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	29.3	30.2	30.6	30.1	29.8	28.3	27.5	26.8
CA	34.2	34.9	34.8	34.2	33.5	31.8	31.0	30.2
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

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

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- 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.

Pneumonia/Influenza Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	20.7	20.3	20.5	19.7	20.4	19.1	19.0	18.3
CA	15.5	15.7	16.2	15.9	15.7	13.8	13.6	12.8
US	17.0	16.9	17.0	16.8	16.5	14.7	14.3	13.4

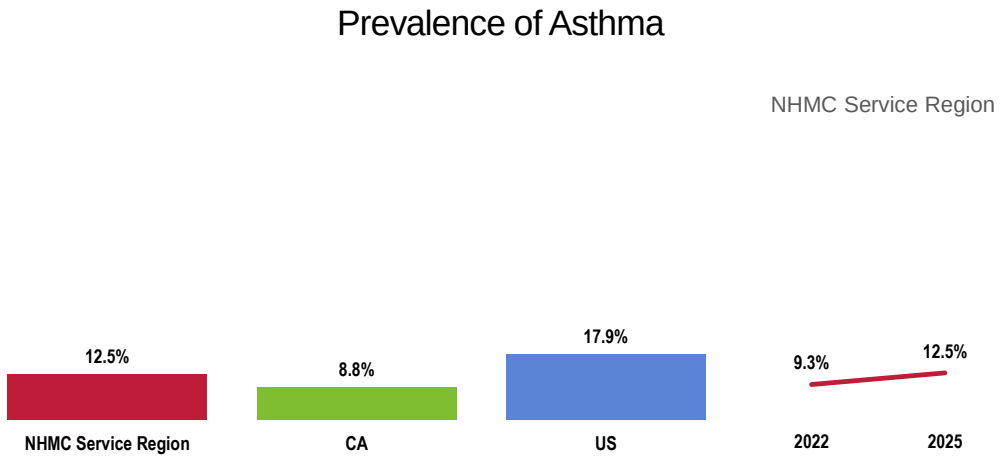
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

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?"



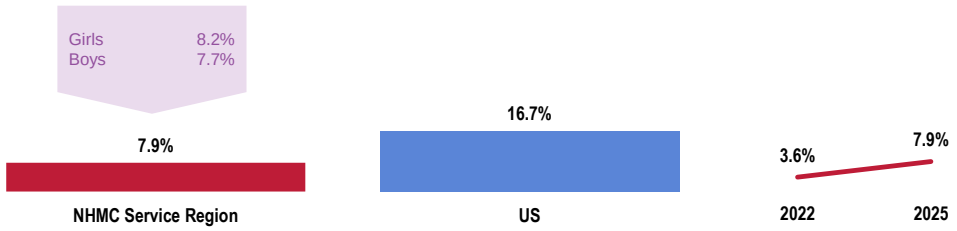
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► [Among parents of children age 0-17] **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

Prevalence of Asthma in Children
(Children 0-17)

NHMC Service Region



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

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

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ► **"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"**

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

NHMC Service Region

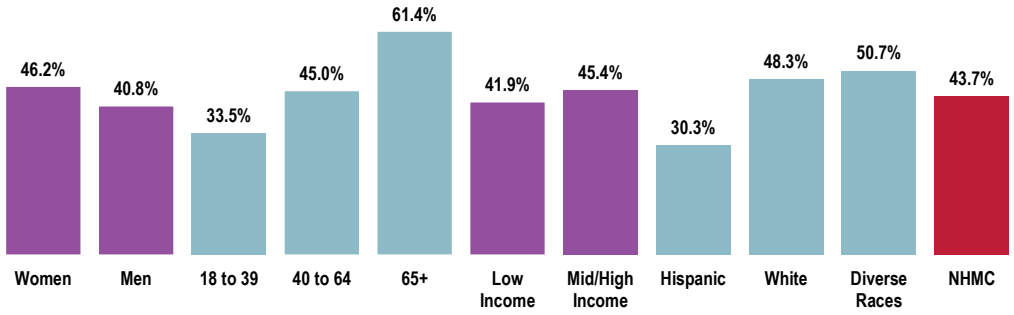
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

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

COVID-19 (Coronavirus Disease) Vaccination

PRC SURVEY ► "In the past 12 months, have you received a COVID-19 vaccine or booster?"

Received a COVID-19 Vaccination or Booster in the Past 12 Months
(NHMC Service Region, 2025)

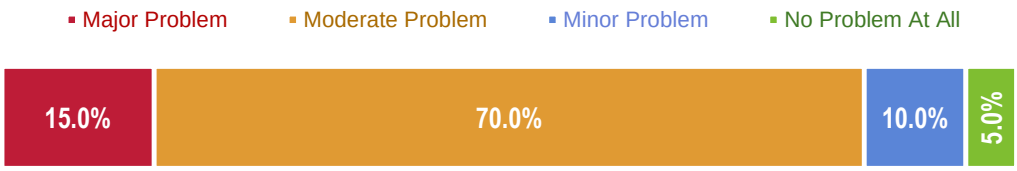


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 317]
Notes: ● Asked of all respondents.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Disease as a Problem in the Community
(Among Key Informants; NHMC Service Region, 2025)



Sources: ● 2025 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:

Prevention/Screenings

> Respiratory diseases remain an issue in the community due to the low vaccination rates for many due to the misinformation widely circulating in the community. — Social Services Provider

Air Quality

> Poor air quality in the San Fernando Valley. — Social Services Provider

Injury & Violence

ABOUT INJURY & VIOLENCE

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

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

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

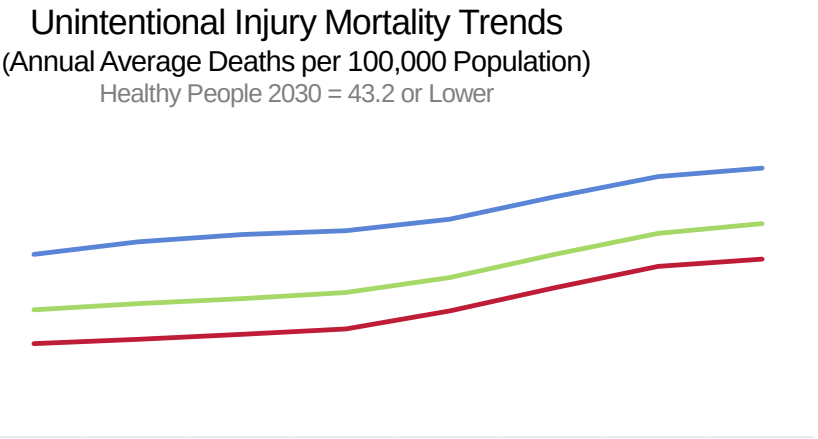
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Unintentional Injury Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	23.5	24.6	25.9	27.2	31.8	37.5	43.0	44.8
CA	32.0	33.6	34.8	36.4	40.2	46.0	51.3	53.8
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

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

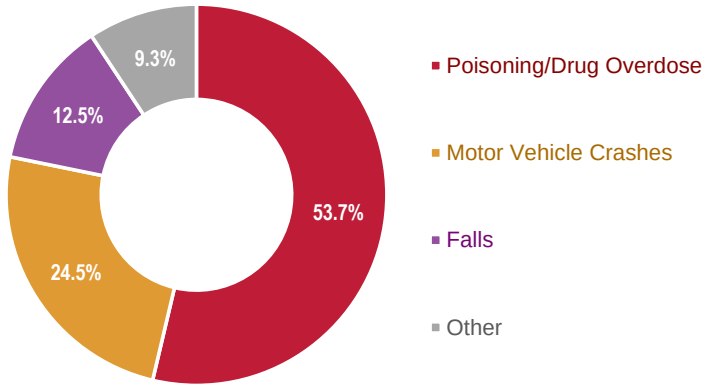
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Leading Causes of Unintentional Injury Deaths

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

The following outlines leading causes of accidental death in the area. [COUNTY-LEVEL DATA]

Leading Causes of Unintentional Injury Deaths
(Los Angeles County, 2021-2023)



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

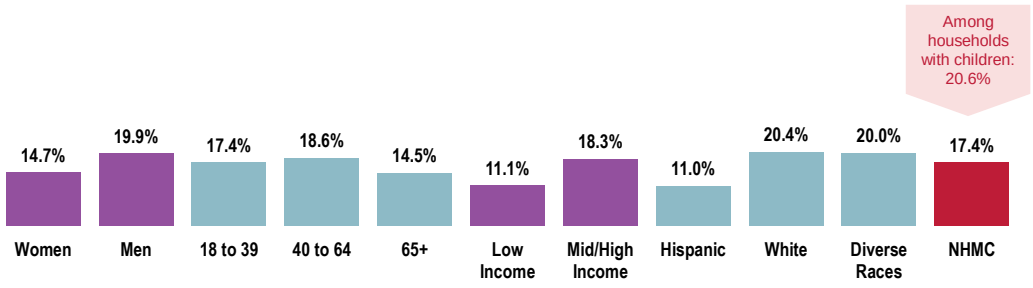
Gun Safety

PRC SURVEY ► "Firearms include pistols, shotguns, rifles, and other types of guns. This does not include starter pistols, BB guns, or guns that cannot fire. Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car?"

PRC SURVEY ► [Among those with firearms] **"An unlocked firearm is one that does not need a key or combination to get to the gun or fire it. The safety is not counted as a lock. Are any of these firearms unlocked?"**

Have a Firearm Kept In or Around the Home
(NHMC Service Region, 2025)

Of those with firearms, 37.4% report that at least one is kept unlocked.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 309-310]

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
- An unlocked firearm is one that does not need a key or combination to get the gun or fire it. The safety is not counted as a lock.

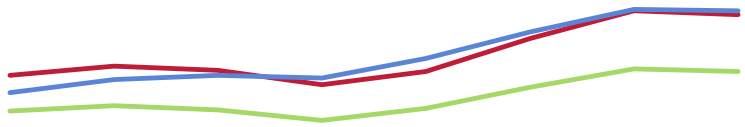
Intentional Injury (Violence)

Homicide Deaths

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

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

Homicide Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	5.9	6.2	6.1	5.7	6.0	6.9	7.6	7.5
CA	5.0	5.2	5.1	4.8	5.1	5.6	6.1	6.0
US	5.5	5.8	5.9	5.9	6.4	7.0	7.6	7.6

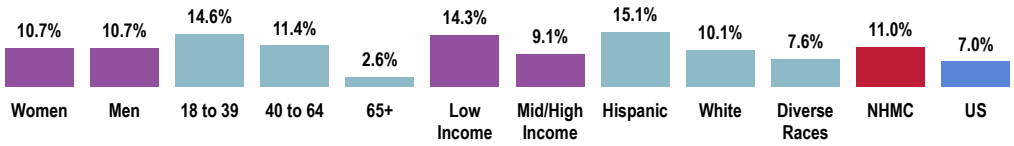
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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
(NHMC Service Region, 2025)



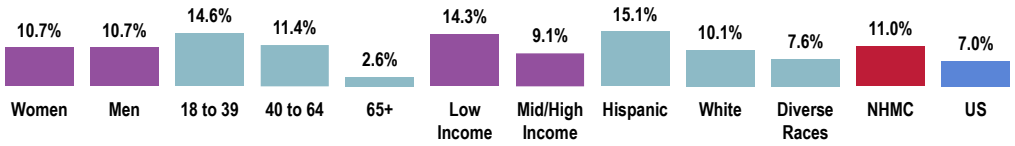
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Gang Violence

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

Victim of a Violent Crime in the Past Five Years
(NHMC Service Region, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Intimate Partner Violence

All survey respondents were informed that information and referrals regarding abuse and neglect are available by calling the National Domestic Violence Hotline at 1-800-799-SAFE, or 1-800-799-7233.

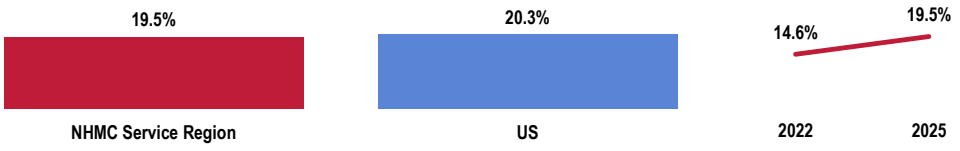
PRC SURVEY ► "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

PRC SURVEY ► "Has this happened in the past three years?"

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

More specifically, 8.4% of respondents report being a victim of intimate partner violence within the past three years.

NHMC Service Region



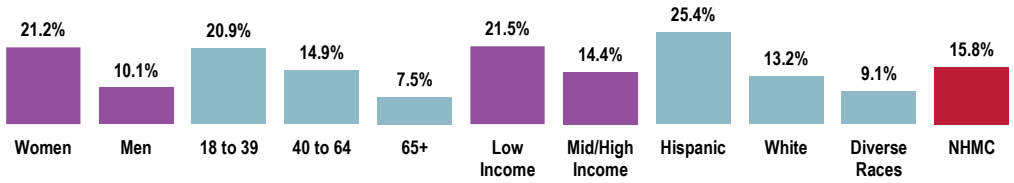
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 33, 305]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Emotional Harm/Control

PRC SURVEY ► "In the past 3 years, has an intimate partner hurt you emotionally through put-downs or belittling, isolated you from friends and family, or tried to control you or your finances?"

Have Been Hurt Emotionally or Controlled by an Intimate Partner in the Past Three Years
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.
● Includes instances of put-downs or belittling, isolation from friends and family, personal control, and/or financial control.

Sexual Violence

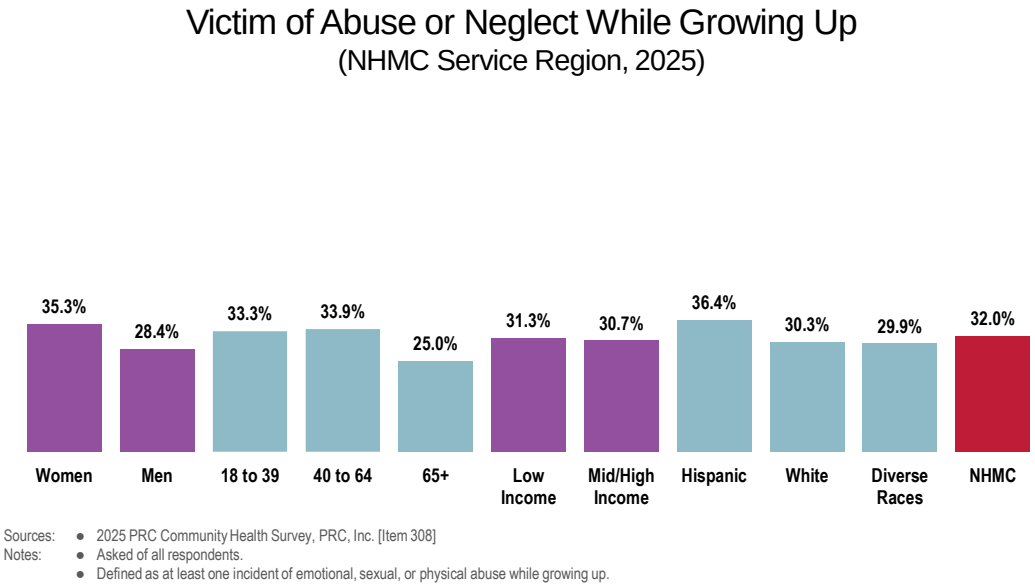
PRC SURVEY ► "In the past 3 years, has anyone forced you to engage in sexual activity that you did not want?"

Have Been Forced Into Unwanted Sexual Activity in the Past Three Years
(NHMC Service Region, 2025)

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: ● Asked of all respondents.

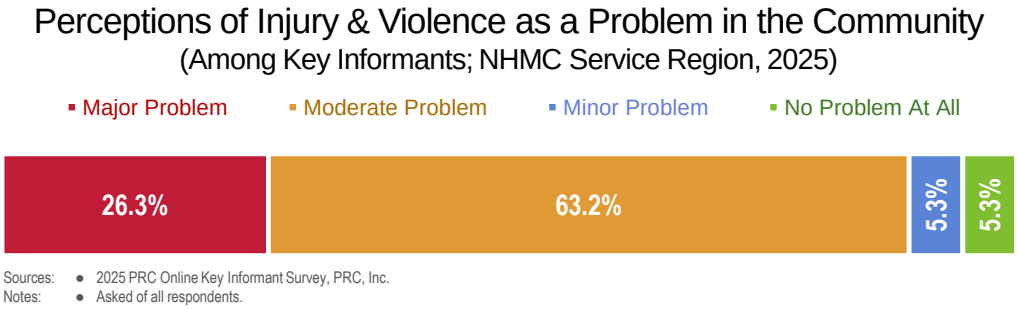
Childhood Abuse/Neglect

PRC SURVEY ► "While you were growing up, do you feel that you were ever neglected or abused, whether emotionally, sexually, or physically, even if this only happened once?"



Key Informant Input: Injury & Violence

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



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

Vulnerable Populations

> This still exists in so many families, and this matter is not brought to the attention of the authorities because most of the people that suffer in this situation are illegal in this country and are under the control of somebody who takes advantage of the situation. There is still prevalent machismo in the Latino communities. — Social Services Provider

Incidence/Prevalence

> The high number of clients we see who have experienced and/or witnessed violence. — Social Services Provider

Income/Poverty

> Because poverty rates and homelessness are so pervasive and continue to grow. — Social Services Provider

Diabetes

ABOUT DIABETES

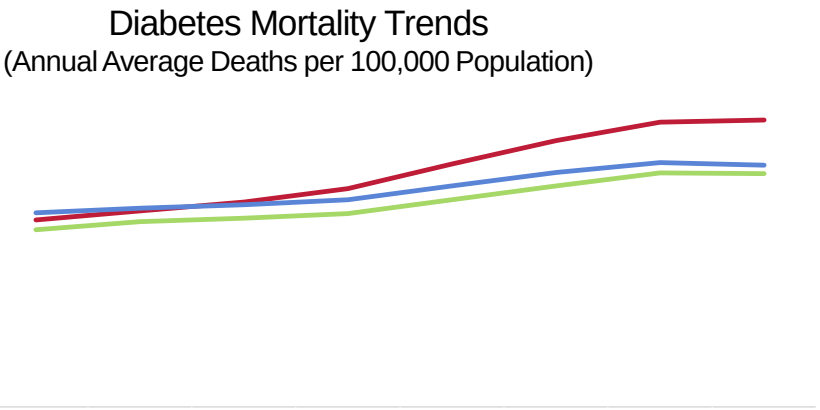
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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

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

Diabetes Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	23.6	24.8	25.9	27.5	30.6	33.6	35.9	36.2
CA	22.4	23.4	23.8	24.4	26.2	27.9	29.5	29.4
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

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

Prevalence of Diabetes

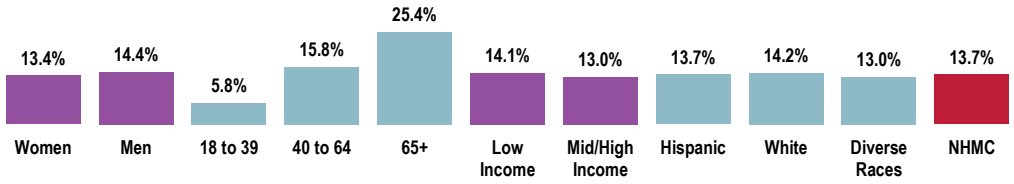
Another 14.7% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

NHMC Service Region

Sources:
- 2025 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).

Prevalence of Diabetes
(NHMC Service Region, 2025)

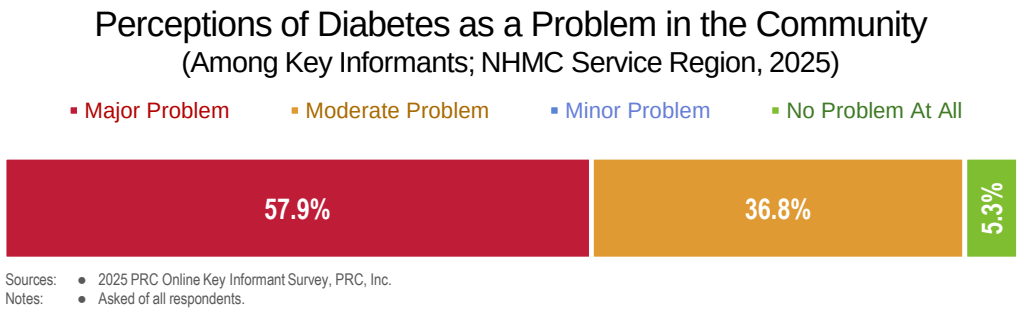


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]

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:

Access to Affordable Healthy Food

> Lack of access to healthy food. Fast food is cheaper than healthy food. Lack of time to cook or lack of knowledge in how to cook healthy but still savory food. — Social Services Provider
>
> Access to affordable, high-quality, nutrient-dense fresh foods, as well as lack of knowledge of what a healthy, balanced diet consists of. Additionally, research has shown that sugary drinks such as sodas are the highest source of sugar in the U.S. diet. Sugar-sweetened beverages are very popular and extremely easy to access in our community. — Public Health Representative
>
> Fast food chains set up shops in our lower-income neighborhoods and target our community. Low-cost healthy food options are limited. It is more expensive to eat healthy food than quick fast food. — Social Services Provider
>
> Healthy eating options. — Public Health Representative

Awareness/Education

> Lack of nutritional guidance, coaching, and support. — Health Care Provider
>
> The biggest challenge is knowing how to prepare meals that are nutritious, as well as finding time to exercise. It can also be difficult for patients with diabetes to make follow-up medical appointments if they lack access to transportation. — Social Services Provider
>
> Understanding two things: its progressive severity and its manageability. So much of it can be prevented or managed with simple practices and programs. People need to be convinced of the efficacy. — Health Care Provider
>
> Lack of information about how to live with a chronic disease on a day-by-day basis. Diabetes is endemic in some of the populations in our communities. Though much could be addressed by lifestyle changes, these are sometimes the most difficult to maintain without support from family. Access to timely health care at the appropriate level of care is also an issue. — Social Services Provider

Nutrition

> The food that we consume is saturated with sugar and carbohydrates. We don't have the discipline to eat correctly, and the fast-food industry and Coca-Cola or any soda company saturated their products with high fructose to sweeten them. The lack of exercise and cellular devices play a very crucial role in the life of the people only sitting and not exercising to keep their weights and the levels of sugar under control. We need more health education in the schools and other institutions to advocate for residents for better choices when they eat. — Social Services Provider

Affordable Medications/Supplies

> Cost of diabetic supplies. — Social Services Provider

Generational

> Genetics and stress. — Community Leader

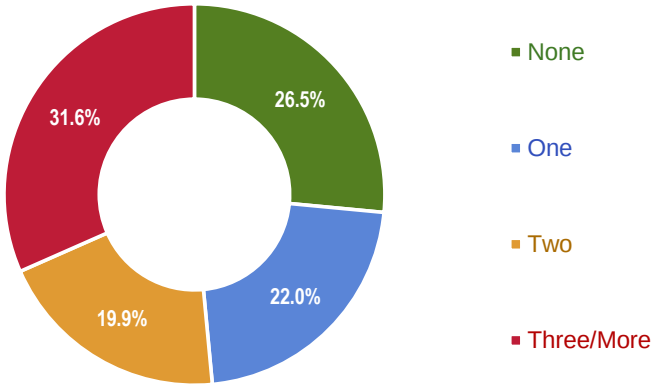
Disabling Conditions

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.

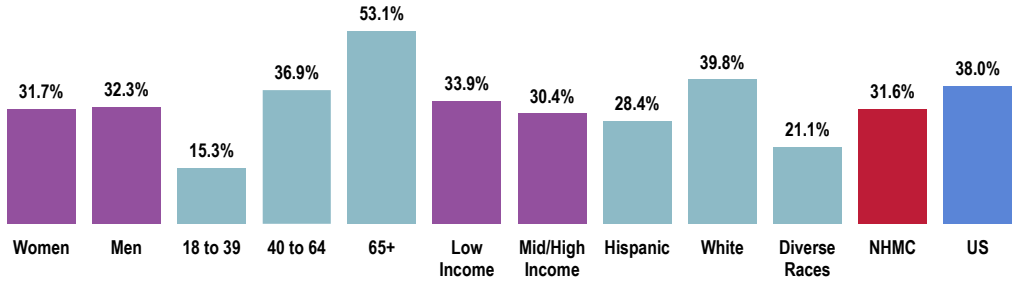
For the purposes of this assessment, chronic conditions include:

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



Sources:
- 2025 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 stroke.



Sources:
- 2025 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

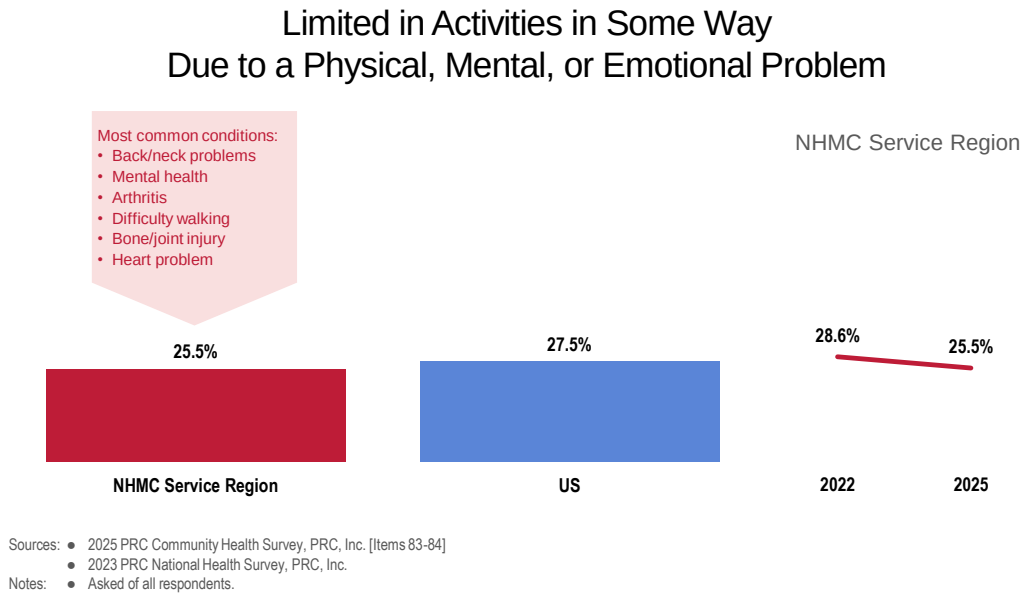
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

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)

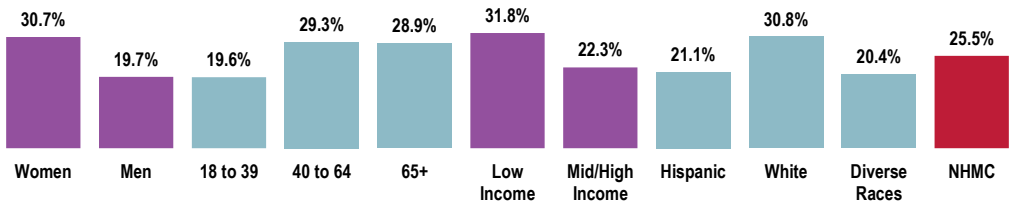
PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

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



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
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
(NHMC Service Region, 2025)
Healthy People 2030 = 6.4% or Lower

Sources: ● 2025 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

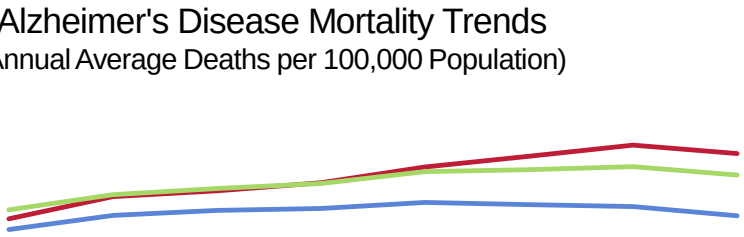
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

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]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	35.2	39.4	40.5	42.0	45.0	47.0	49.2	47.6
CA	36.9	39.8	40.9	41.9	44.1	44.5	45.1	43.5
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

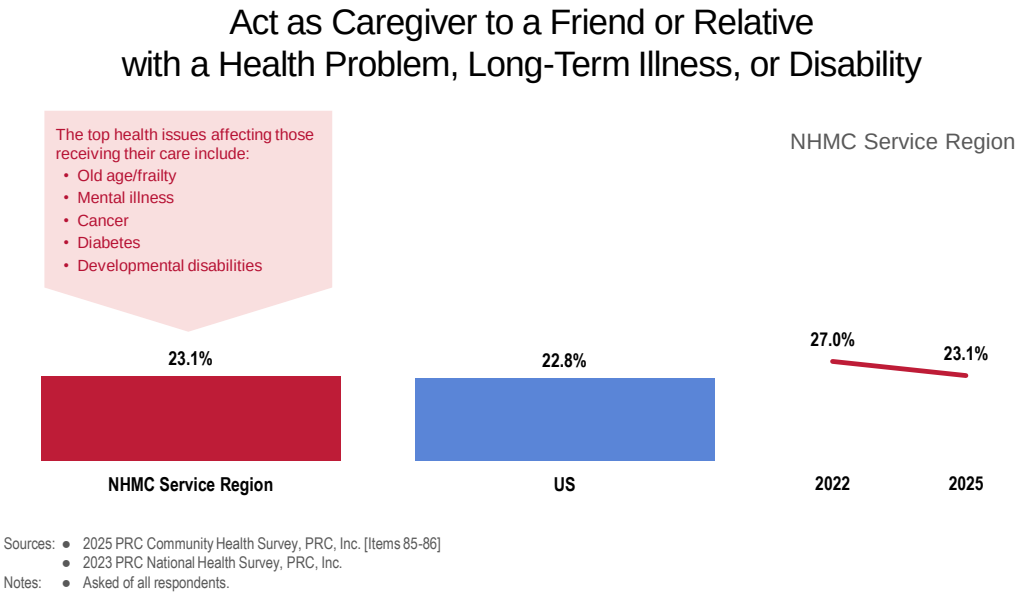
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

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

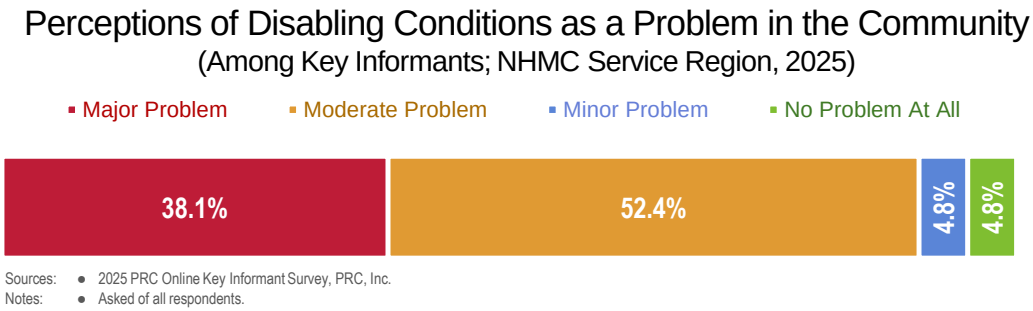
PRC SURVEY ► "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

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



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:

Incidence/Prevalence

> Disabling conditions are a major concern in the community. Working for the Alzheimer's Association, I see the devastation of dementia everywhere. Financially, emotionally, and physically, dementia is extremely hard on caregivers with a loved one with dementia. There is not enough respite care for caregivers and not enough support for individuals receiving the diagnosis. People need to know more about the resources that can help them in the community in many languages. The aging population is just growing, and there is not enough support for their needs as they become more dependent in society. — Social Services Provider

> Many residents in our community have activity limitations and require assistive devices (wheelchairs, walkers, canes) for mobility. Additionally, many residents suffer from chronic conditions, such as diabetes, that affect mobility and vision. Lastly, our community has a higher population of adults living with disabilities compared to all of LA County, as well as a higher population of adults over age 65 (increased risk of dementia) compared to all of LA County. — Public Health Representative

Access to Care/Services

> There are limited resources in the community for those with dementia who don't have family support and have limited financial resources. Chronic pain is a major problem for people as they age, which causes isolation and lack of desire to access services other than medication when other things such as exercise program might be more helpful. — Social Services Provider

> Not enough resources available to the community. Over the years, there has been an increase in multicultural communities, which is great, but I believe we need to provide more resources for them. — Social Services Provider

Vulnerable Populations

> I can talk about the residents of my community. There are a lot of people that don't have legal status in the country, and it’s difficult to get this kind of service, and they don't have the funds to pay. I know a man who doesn't have insurance, and he needs to live with macular dystrophy because he cannot afford to see the eye doctor. That is very expensive when you go in for treatment. — Social Services Provider

Aging Population

> Population is aging in LA County. Physical and cognitive declines are major issues that require better infrastructure and caregiver support, but these are resources that are often overlooked by health care, public health, social services, cities, etc. — Public Health Representative

Awareness/Education

> Not enough resources that people know about. — Public Health Representative

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.

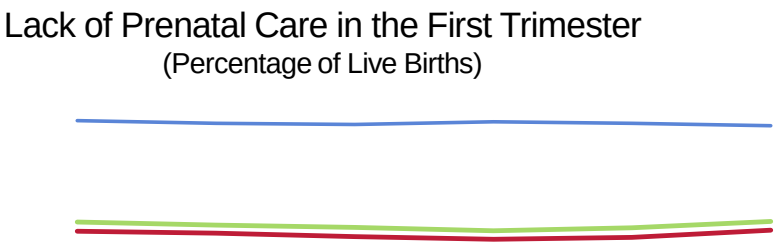
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– 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. [COUNTY-LEVEL DATA]



	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023	2021-2023
Los Angeles County	14.0%	13.8%	13.5%	13.3%	13.5%	14.1%
CA	14.7%	14.5%	14.3%	14.0%	14.2%	14.8%
US	22.7%	22.5%	22.4%	22.6%	22.5%	22.3%

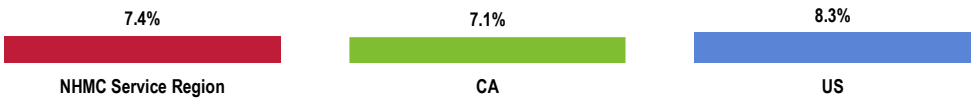
Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: ● This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

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)

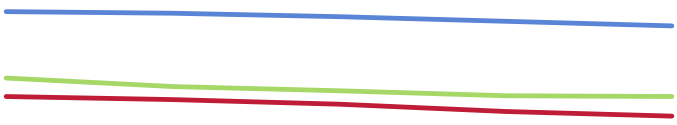


Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than 1 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]

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Los Angeles County	4.0	4.0	3.9	3.7	3.6
CA	4.4	4.3	4.2	4.1	4.0
US	5.9	5.9	5.8	5.7	5.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2025.
● Centers for Disease Control and Prevention, National Center for Health Statistics.
● 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 … family planning services can help increase the length of time between pregnancies, which can improve health for women and their infants.

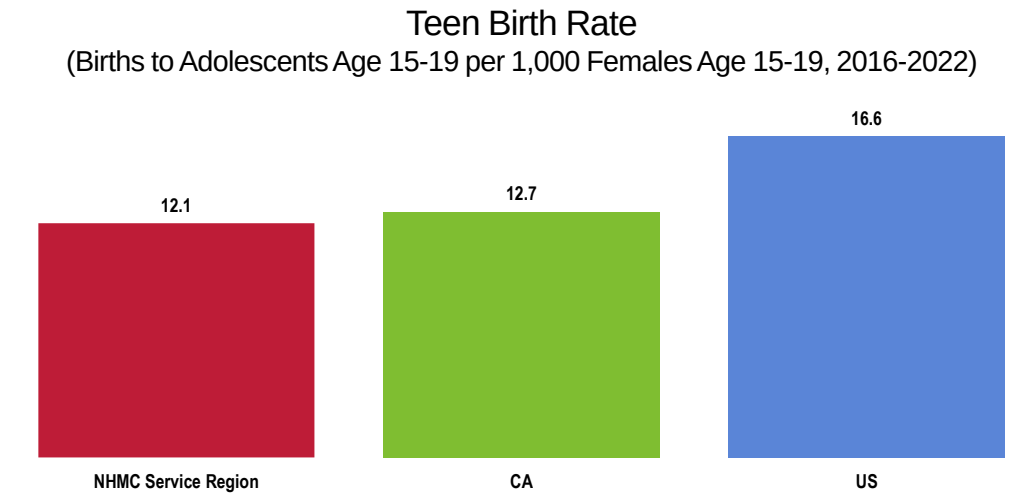
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

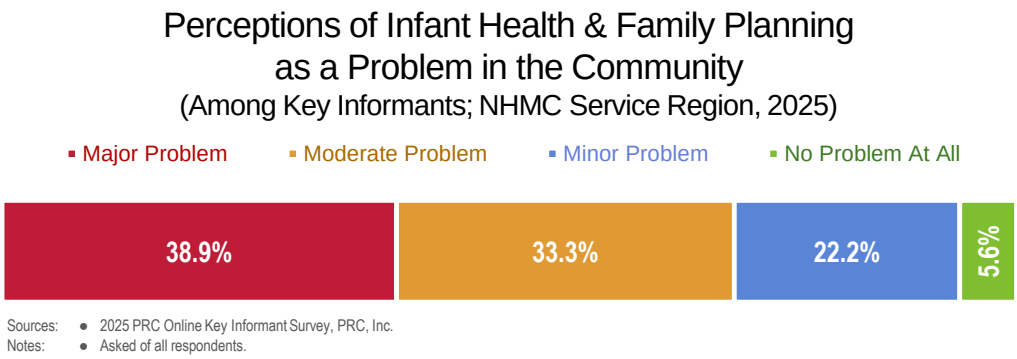


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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:



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

Vulnerable Populations

> Black babies in Los Angeles County die at more than three times the rate of White or Asian babies. Black pregnant and postpartum people are also at three times the risk of death when compared to their White counterparts. This racial inequity is not entirely explained by differences in access to prenatal care or levels of education and income. Research suggests that chronic stress associated with both historical and ongoing racism are important contributing factors. Additionally, data shows that our community has a higher incidence of teen pregnancy compared to all of LA County. — Public Health Representative

> Infant health is impacted by the social determinants of health that many of our community members deal with on a daily basis. Infants and young children are disproportionately impacted by poverty, food insecurity, and lack of safe housing. Access to culturally sensitive family planning is also an issue. — Social Services Provider

Access to Care/Services

> Lack of resources, transportation, fear of immigration as this applies. — Social Services Provider

> Limited care facilities in community. I see staff and families struggle with cost-effective care. — Community Leader

Teen Pregnancy

> Because there are high statistics of teen moms that have kids at an early age, when they cannot have a way to take care of themselves or the funds to raise a baby. Sexual education and prevention of pregnancy will be a good option for this matter in our community and family values that are already lost in the family and community. — Social Services Provider

Need for Culturally Diverse Services

> Our communities have become more diverse, and resources need to be tailored to these communities. — Social Services Provider

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

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

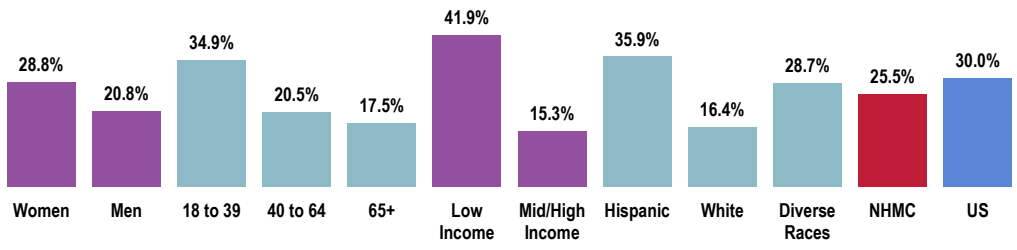
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

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
(NHMC Service Region, 2025)

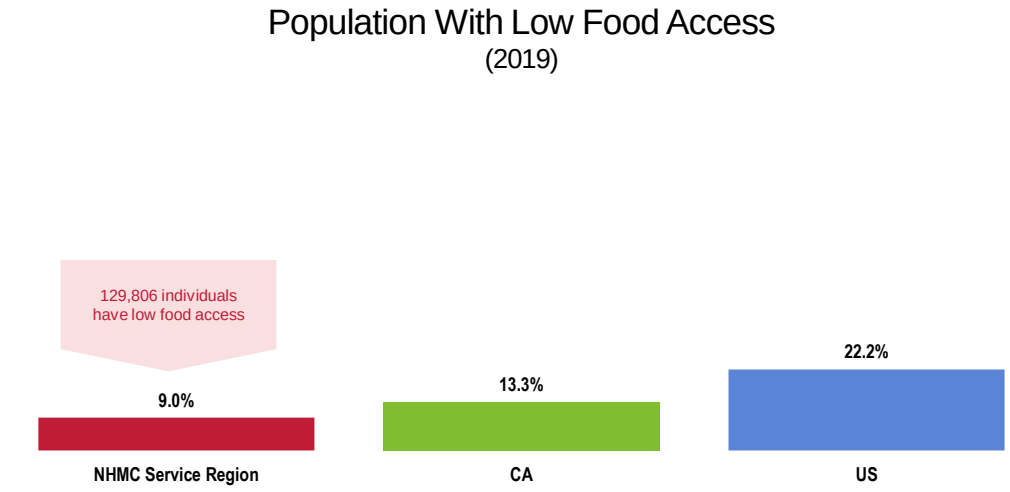


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

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.



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 February 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.

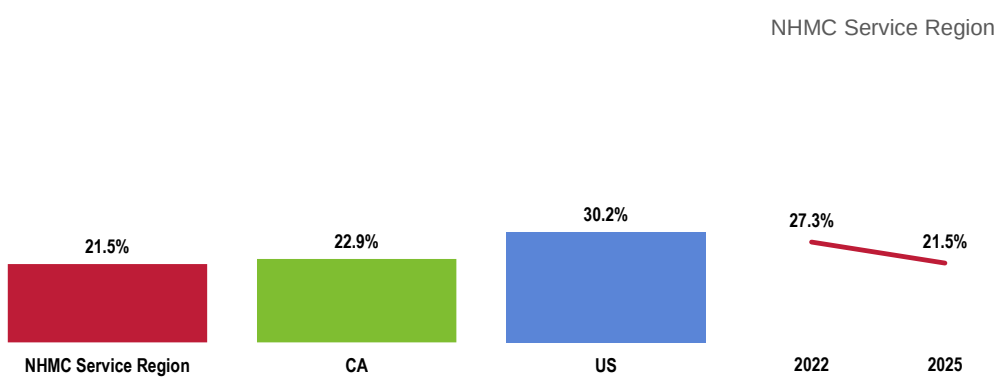
– Healthy People 2030 (https://health.gov/healthypeople)

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:
- 2025 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?"

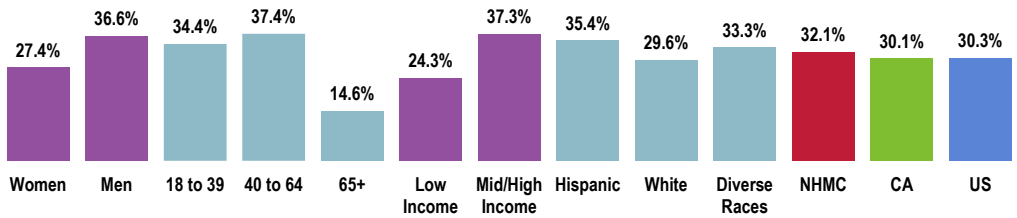
PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

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?"

Meets Physical Activity Recommendations
(NHMC Service Region, 2025)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2025 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

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

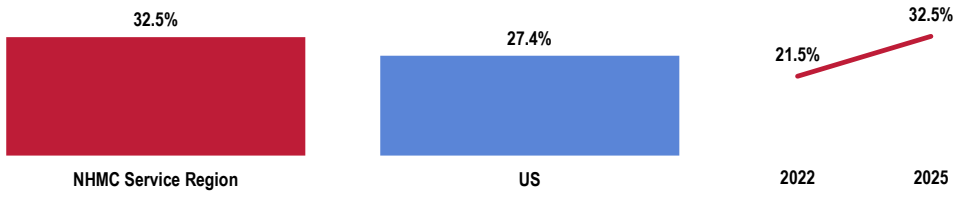
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

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

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?"

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

NHMC Service Region



Sources:
- 2025 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.

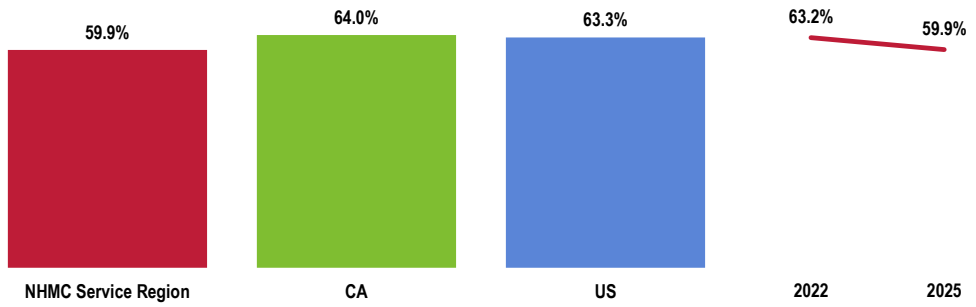
PRC SURVEY ► "About how much do you weigh without shoes?"

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)

NHMC Service Region



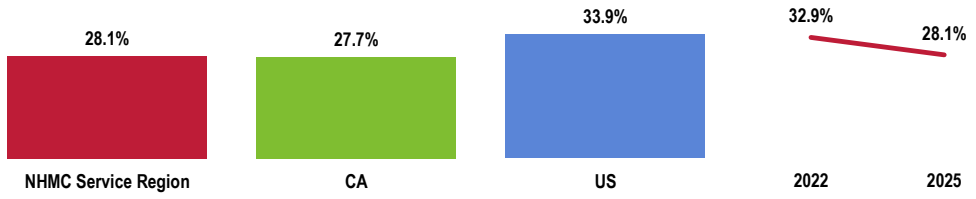
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, 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

Healthy People 2030 = 36.0% or Lower

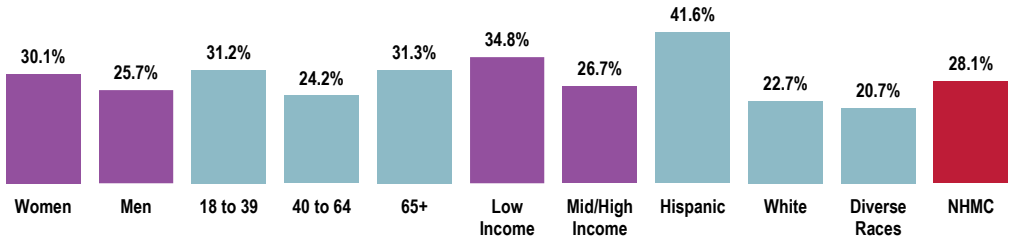
NHMC Service Region



Sources:
- 2025 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.

Prevalence of Obesity
(NHMC Service Region, 2025)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- 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

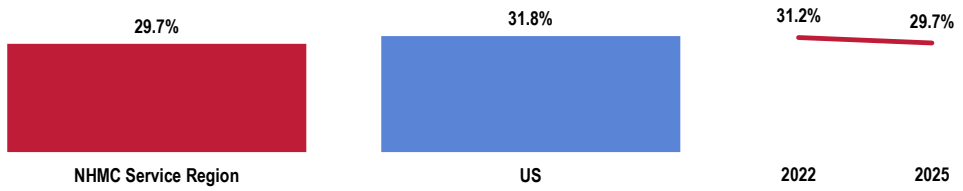
The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC SURVEY ► [Among parents of children age 5-17] **"How much does this child weigh without shoes?"**

PRC SURVEY ► [Among parents of children age 5-17] **"About how tall is this child?"**

Prevalence of Overweight in Children
(Children 5-17)

NHMC Service Region



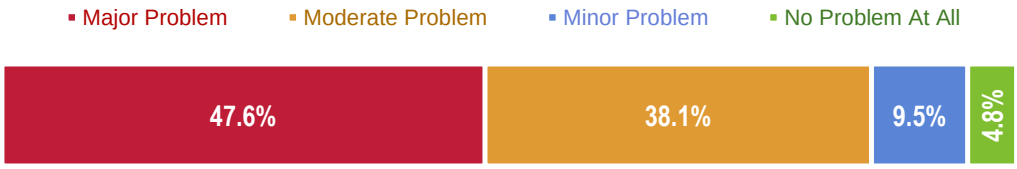
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

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:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Among Key Informants; NHMC Service Region, 2025)



Sources:
- 2025 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 Affordable Healthy Food

> The food that the low-income community consumes is not quality. There are not enough free centers where the kids can go and exercise or do physical activity. Kids are introduced to fast food at a very early age, and later, they refuse to eat healthily. The use of devices has been causing a lot of damage in physical activities and weight gain in the youth and adult community. We prefer to spend hours of time wasting with the media sitting in our home rather than take a walk or do any physical activity. — Social Services Provider
>
> Poor food, and healthy food is more expensive. — Social Services Provider
>
> Healthy food options are too expensive, and technology are contributing to less physical activity. — Social Services Provider
>
> Food insecurity and costs leads to poor nutrition. Lack of appropriate greenspace and other safe places to exercise is also an issue. Both, added to the fast food and carb-centric diets for many of the lower-income population, has produced a community that tends to be overweight and lack exercise and nutritional information. — Social Services Provider

Lifestyle

> Being physically active and eating healthy are often considered lifestyle choices that are under individual control, but these "choices" are strongly influenced by community environments. For example, it is difficult for people to be physically active if their communities do not have available and safe places for recreation. Likewise, it is very challenging for people to have a healthy diet if they have limited access to nutritious and affordable food options. — Public Health Representative
>
> People are working a lot and not eating well or exercising regularly. This has created an obesity epidemic, and people need ways to learn about healthy eating and physical activity. — Social Services Provider

Awareness/Education

> Lack of real, believable information. Every day, there seems to be another conflicting study on nutrition. Coffee is bad for you, then better for you, then bad for you. Our answer to the incredible percentage of overweight and clinically obese people in this country is to feature them in TV commercials and develop new products for them. It seems like, to some extent, we celebrate and reinforce this problem. Instead of miracle medicines to melt fat, we need to educate people — something our media and providers don't seem very good at. Overweight people are a market, meant to be flattered and pandered to. — Health Care Provider

Access to Recreational Facilities

> Access to physical activity opportunities are limited due to lack of open space in the community or due to unsafe neighborhoods. Food resources, e.g., access to affordable healthy food, are not always available, especially in underserved areas. — Public Health Representative

Children

> Higher weight in children. — Community Leader

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.

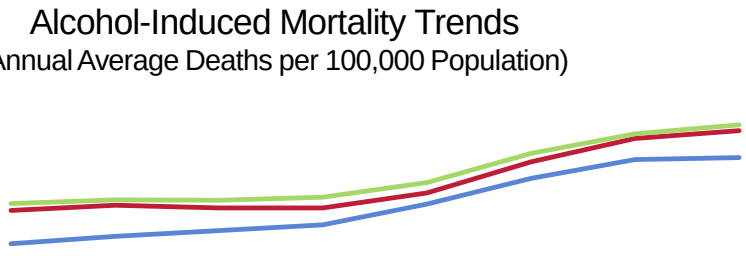
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Alcohol

Alcohol-Induced Deaths

The following chart outlines alcohol-induced mortality in the area. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	12.3	12.7	12.5	12.5	13.4	15.4	16.9	17.4
CA	12.8	13.0	13.0	13.2	14.1	15.9	17.2	17.7
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

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

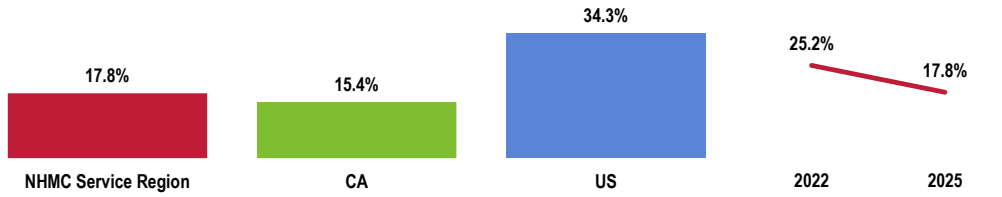
PRC SURVEY ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

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

NHMC Service Region



Sources:
- 2025 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.

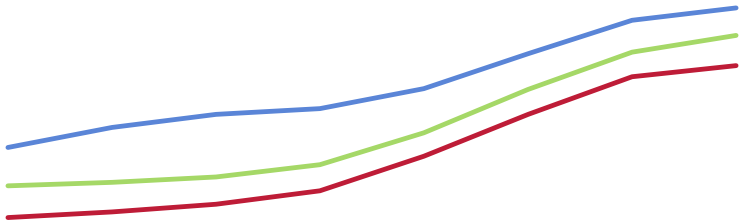
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more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

Unintentional Drug-Induced Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Los Angeles County	6.5	7.2	8.0	9.5	13.3	17.9	22.1	23.3
CA	10.0	10.4	11.0	12.4	15.9	20.7	24.8	26.6
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

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

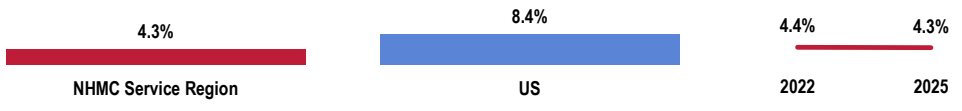
Illicit Drug Use

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?"

Illicit Drug Use in the Past Month

NHMC Service Region



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

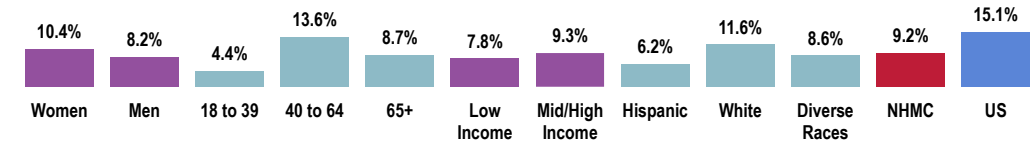
Notes:
- Asked of all respondents.

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
(NHMC Service Region, 2025)



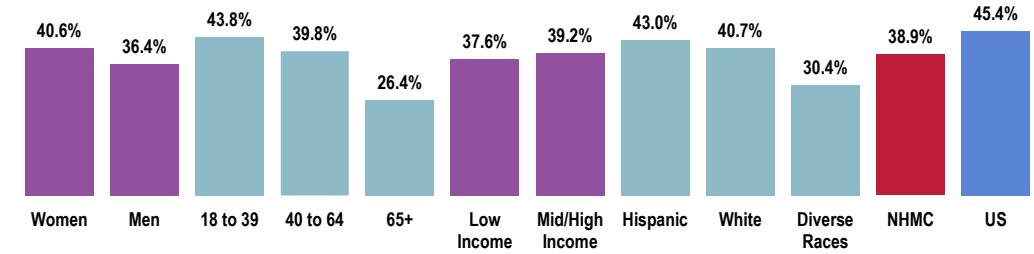
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

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)
(NHMC Service Region, 2025)

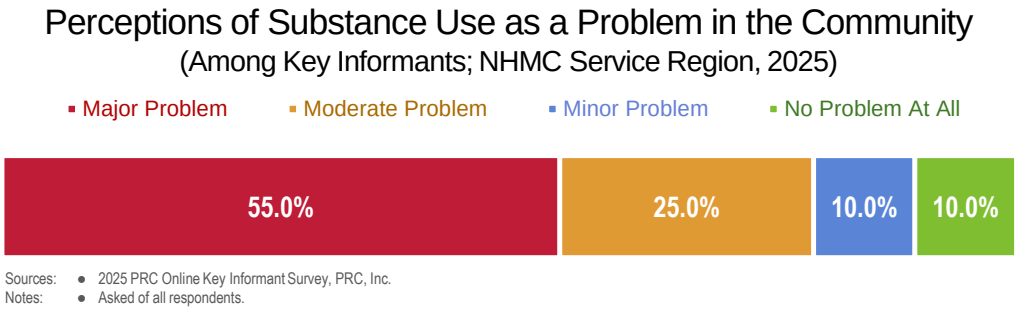


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

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

Awareness/Education

> Lack of knowledge of resources and shortage of providers. — Social Services Provider
>
> People don't know what to expect from treatment programs, so they are afraid to seek help. Funding is also a source of fear. Stories of treatment centers that are not legit and trap people by victimizing them and leading them deeper into the throes of addiction. — Social Services Provider
>
> Preventative education and education on resources. — Social Services Provider

Access to Care/Services

> Illegal status, age could be other barriers to get this service. — Social Services Provider
>
> The need for substance use treatment is greater than the availability of services provided. Additionally, many people who would benefit from substance use treatment either don't want it or believe they don't need it. — Public Health Representative

Denial/Stigma

> The greatest barrier to accessing substance abuse treatment is stigma and lack of outpatient facilities to provide SUD care. — Social Services Provider
>
> The stigma of asking for help, or the denial of needing help. This is also a workforce and facilities issue. There are not enough providers in this field, and there are not enough SUD beds in the community when needed. — Social Services Provider

Diagnosis/Treatment

> Some doctors are still quick to offer prescription drugs to patients, knowing that they are addictive and not creating a long-term solution to pain management other than to medicate. — Social Services Provider

Addiction

> Addiction, including opioid overdose, is a major problem across LA County, cutting across all different groups. — Public Health Representative

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.

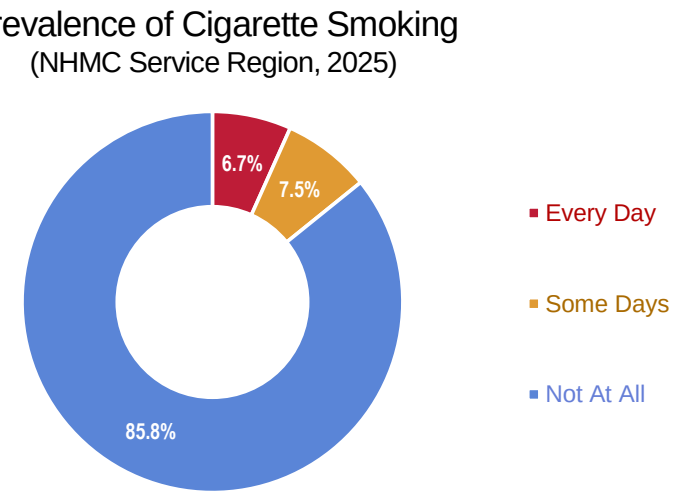
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including 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.")



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

NHMC Service Region

Sources:
- 2025 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 those who smoke cigarettes every day or on some days.

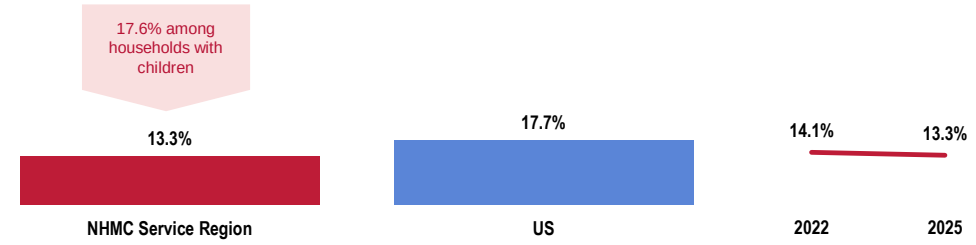
Environmental Tobacco Smoke

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

NHMC Service Region



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

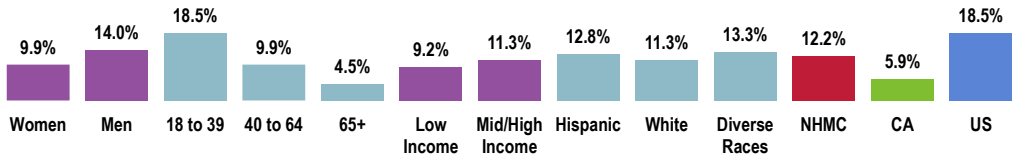
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

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
(NHMC Service Region, 2025)



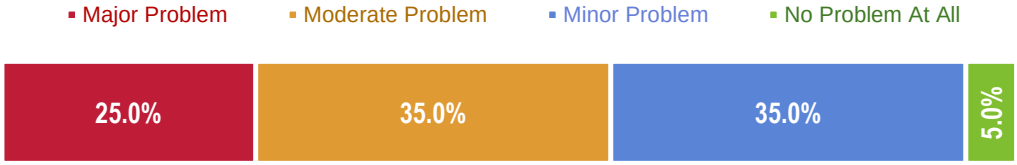
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products 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:

Perceptions of Tobacco Use as a Problem in the Community
(Among Key Informants; NHMC Service Region, 2025)



Sources:
- 2025 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:

E-Cigarettes

> More than tobacco is the vape, an electronic cigar that contains marijuana and other harmful substances. Also, because this became a norm among young people, they think that is healthy to do it. — Social Services Provider

Incidence/Prevalence

> Commonly used. — 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).

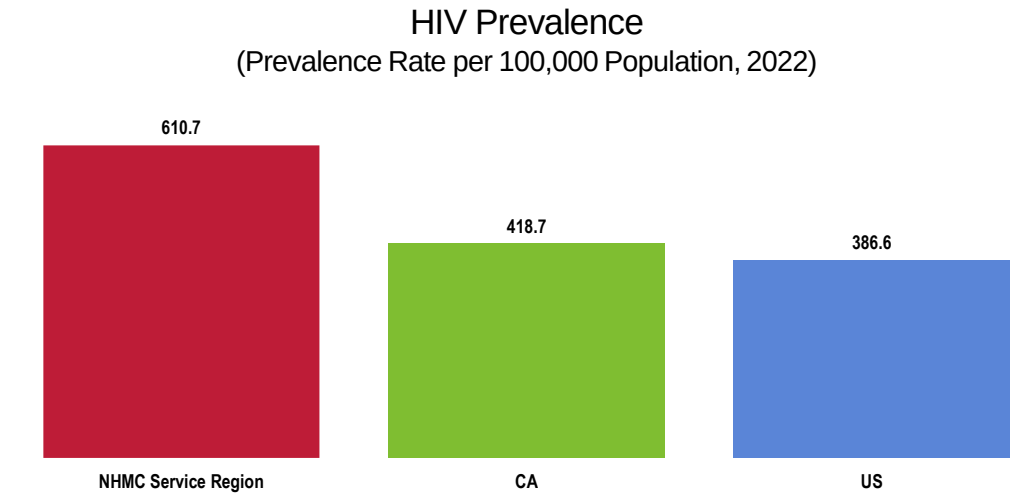
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV.

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 February 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

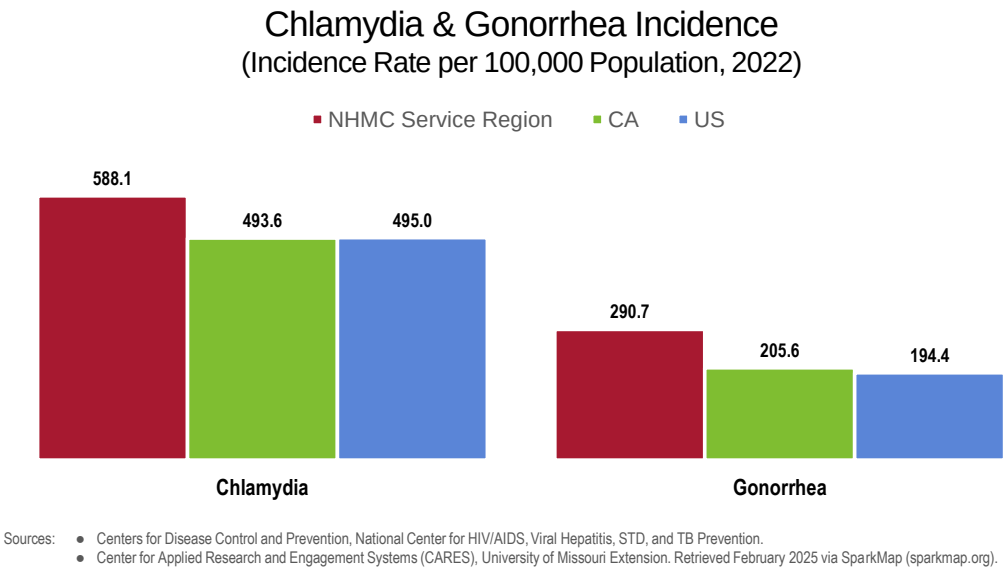
Chlamydia

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

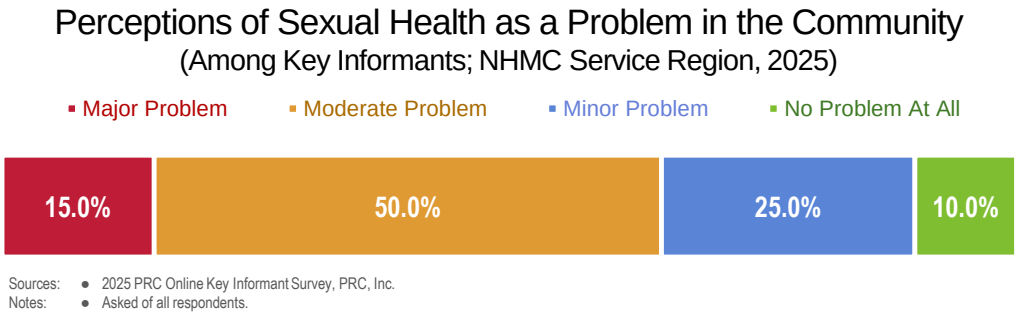
Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.



Key Informant Input: Sexual Health

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



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

Incidence/Prevalence

> STDs, HIV, etc., are a major problem because they are on the rise. There are some alarming HIV diagnosis trends among Latino men, as well as among persons experiencing homelessness. This is disconcerting, given that our new federal administration is looking at cutting funding for HIV prevention, specifically PrEP. — Social Services Provider

Media

> Because of the instigation of brainwashing in the younger generation, adults, and all of us (through the media and rap music that motivates to see by watching the sexually graphic movies and program) makes us think that getting involved with everybody, having sex without thinking of the consequences is normal, if we don't get protection. Again, this is due to the lack of family values. — Social Services Provider

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

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

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

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

Lack of Health Insurance Coverage

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 18-64)

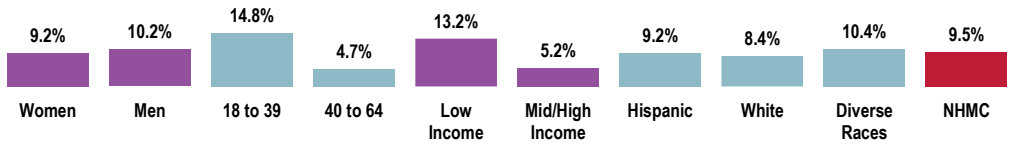
Healthy People 2030 = 7.6% or Lower

NHMC Service Region

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- 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:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; NHMC Service Region, 2025)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

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?"

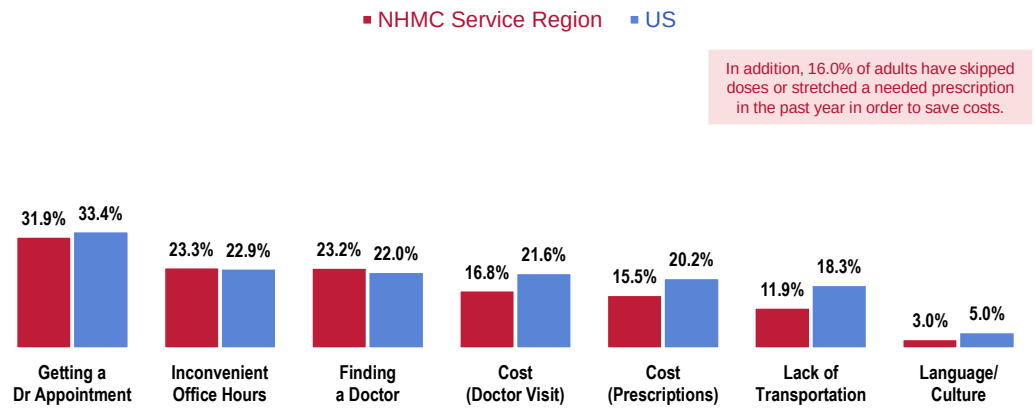
PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

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.

Barriers to Access Have Prevented Medical Care in the Past Year

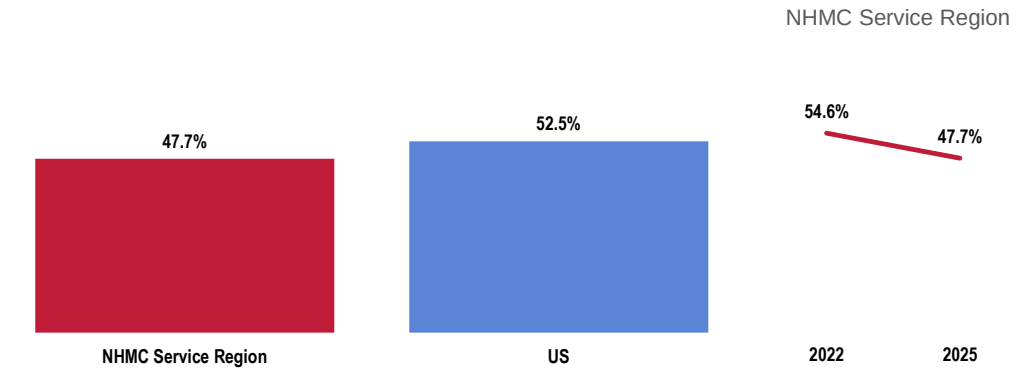


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

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.

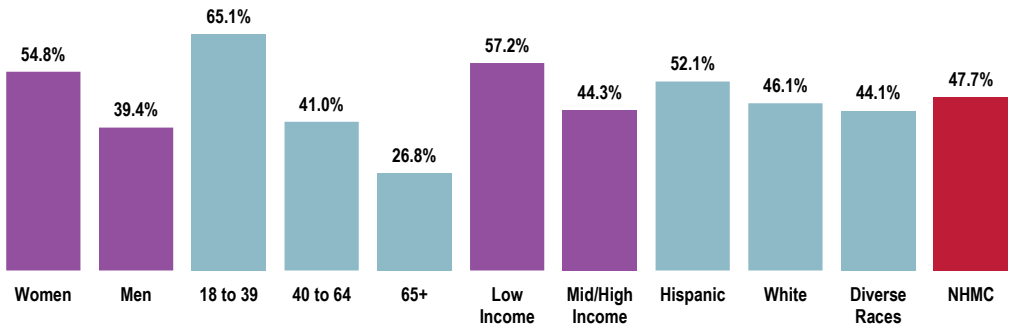
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2025 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.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(NHMC Service Region, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]

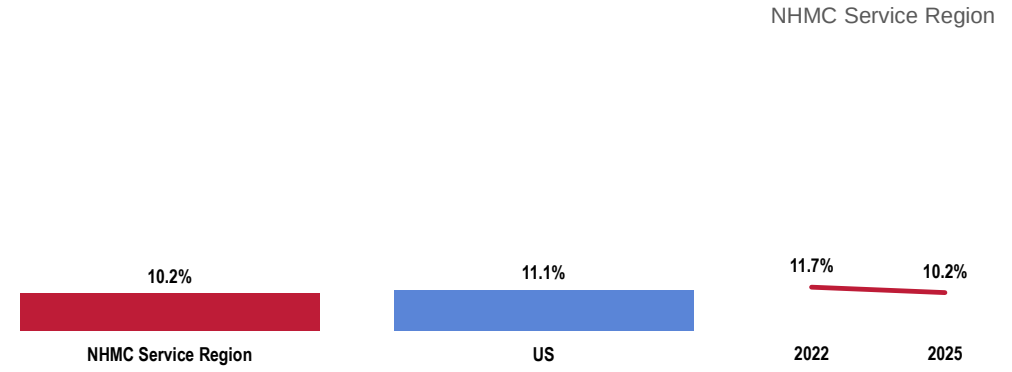
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

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 ► [Among parents of children age 0-17] **"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
(Children 0-17)

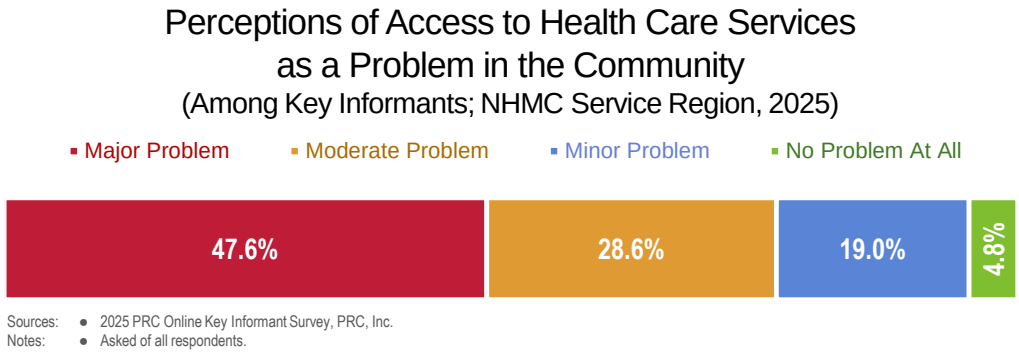


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 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:

Insurance Issues

> Lack of or inadequate health coverage. Language barriers that impede understanding of how to navigate the health system and health insurance coverage. — Public Health Representative
>
> Rates of uninsured adults and children remain high in some communities, particularly among low-income Latinos. — Public Health Representative
>
> Insurance prices that make sense with what we earn because there is a disparity between what we are paid and what we earn in the middle working class. — Social Services Provider

Affordable Care/Services

> A lot of the people who live in the San Fernando Valley, especially in Pacoima, San Fernando, Sylmar and North Hills, cannot afford to pay to have access to health care needs. Most of these people have to go to Tijuana to get these services because here in California, the industry and monopolies of health insurance are very expensive. This applies to the middle class, that is the one that gets charged more, because low-income families can get it for free and rich people have the funds to pay for it. — Social Services Provider
>
> Though there are many medical offices and even many community clinics, the majority of the communities we serve still have difficulty accessing the health care services they require in a timely manner that is affordable. Much of this has to do with health care workforce issues unique to California and Southern California, in particular. The current atmosphere of fear being created has compounded the issue. — Social Services Provider

Awareness/Education

> People do not know where to go to access health care and do not know what health care options are available to them. Language is still a large barrier to health care, and so is fear of immigration status. There needs to be more promotion of the resources to access quality, local health care. Also, many people are not aware of Medi-Cal changes that have been made that allow more individuals to access Medi-Cal. — Social Services Provider
>
> People are not educated on how to use the health care system properly and end up accessing care through the emergency rooms. — Social Services Provider

Lack of Providers

> Lack of PCP availability. — Health Care Provider
>
> Not enough mental health and physical health providers to meet the numbers of people and specific/specialty needs of individuals. — Social Services Provider

Federally Qualified Health Centers

> Biggest challenge is that there is a lack of FQHC sites in some of the most underserved areas of SPA 2, including the West Valley. Also, many low-income families tend to prioritize having other social needs met, i.e., food, housing, etc., over health care. — Social Services Provider

Socioeconomic Barriers

> Social and economic barriers to accessible care. Too much emphasis on treating chronic diseases after they begin producing symptoms rather than early detection and prevention. — Health Care Provider

Primary Care Services

ABOUT PREVENTIVE CARE

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

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

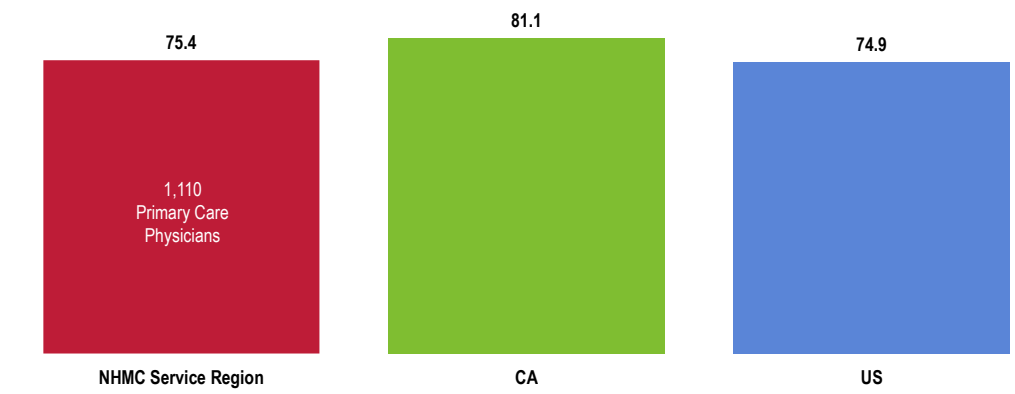
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

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

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

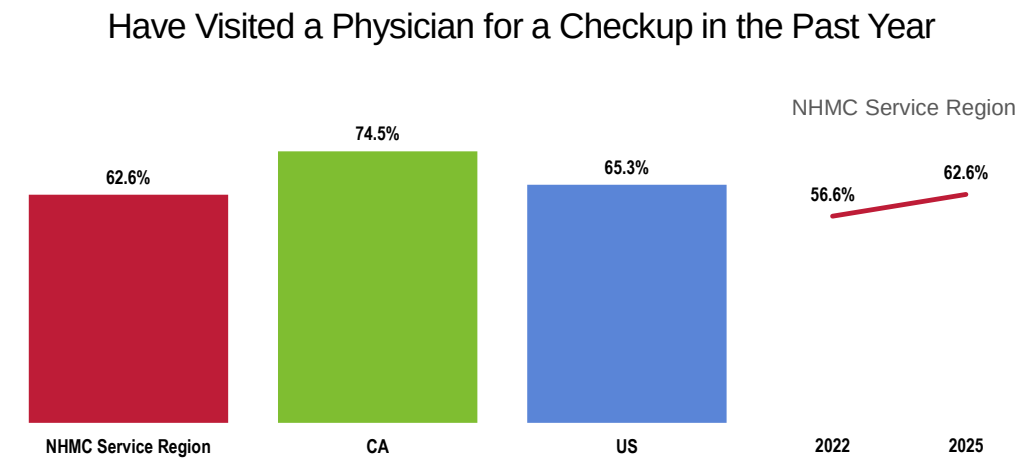


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

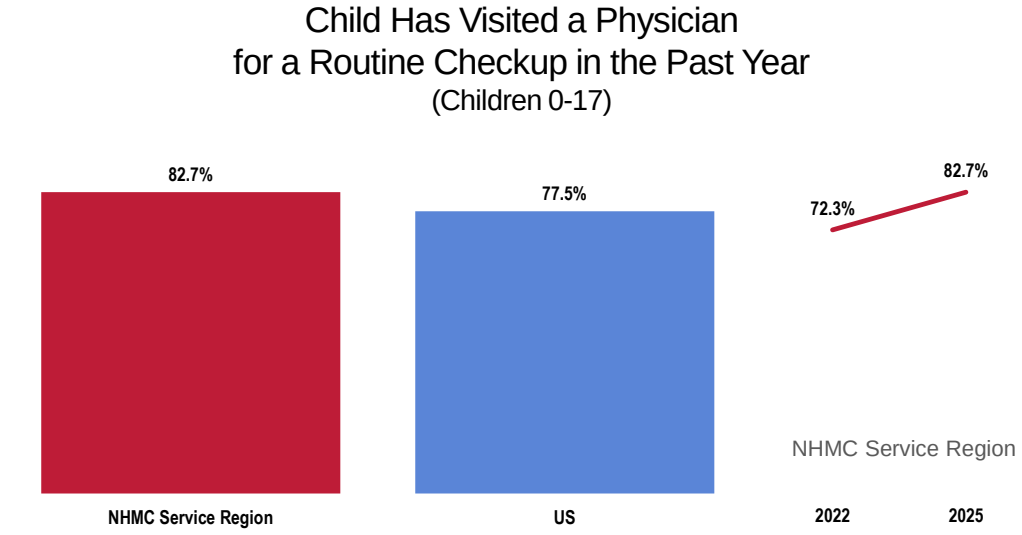
PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2025 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 ► [Among parents of children age 0-17] **"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?"**



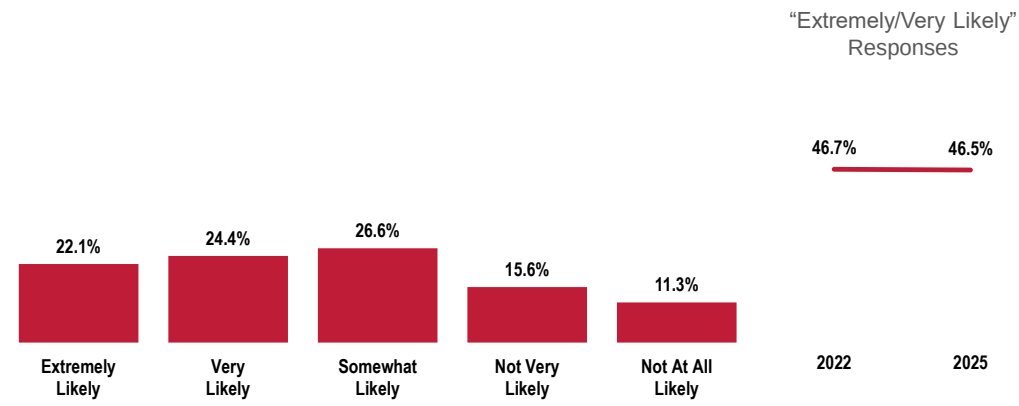
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

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

Willingness to Use Telemedicine

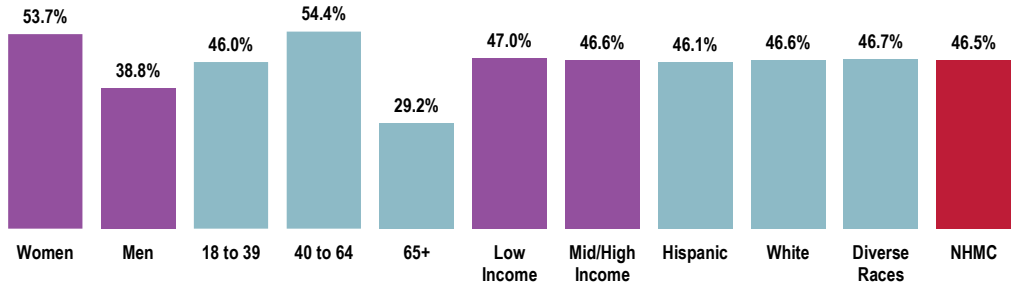
PRC SURVEY ► "Doctors and other medical providers sometimes use telemedicine or tele-health to evaluate, diagnose, or treat a patient using a computer, smartphone, or telephone to communicate in real time without being face-to-face. In the future, how likely would you be to use telemedicine instead of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

Likelihood of Using Telemedicine for Routine Health Care
(NHMC Service Region)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.
● During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a health care professional in real time without being face to face.

"Extremely Likely/Very Likely" to Use Telemedicine for Routine Health Care
(NHMC Service Region, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.
● During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a health care professional in real time without being face to face.

Oral Health

ABOUT ORAL HEALTH

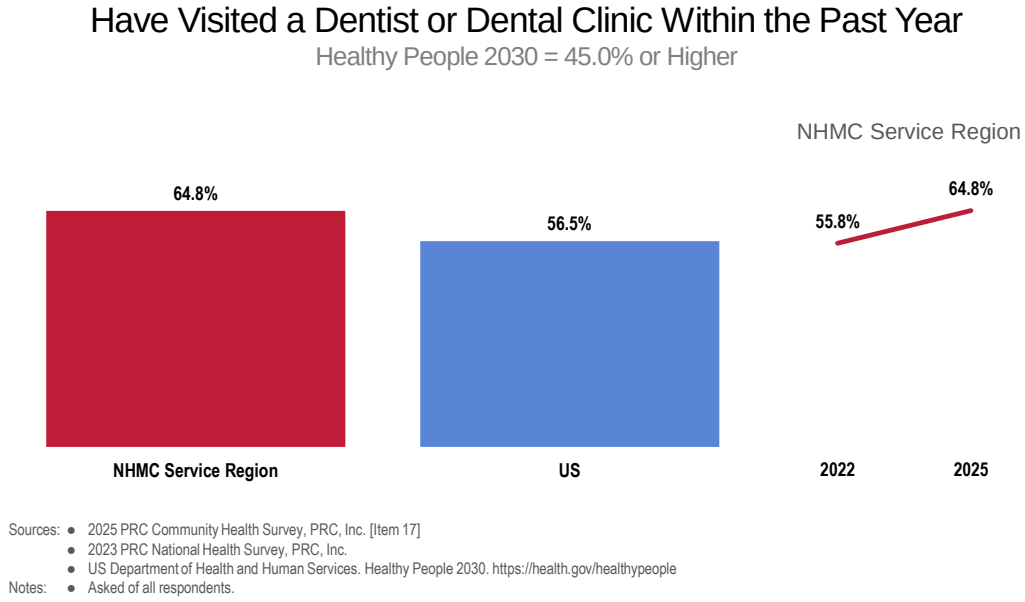
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems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

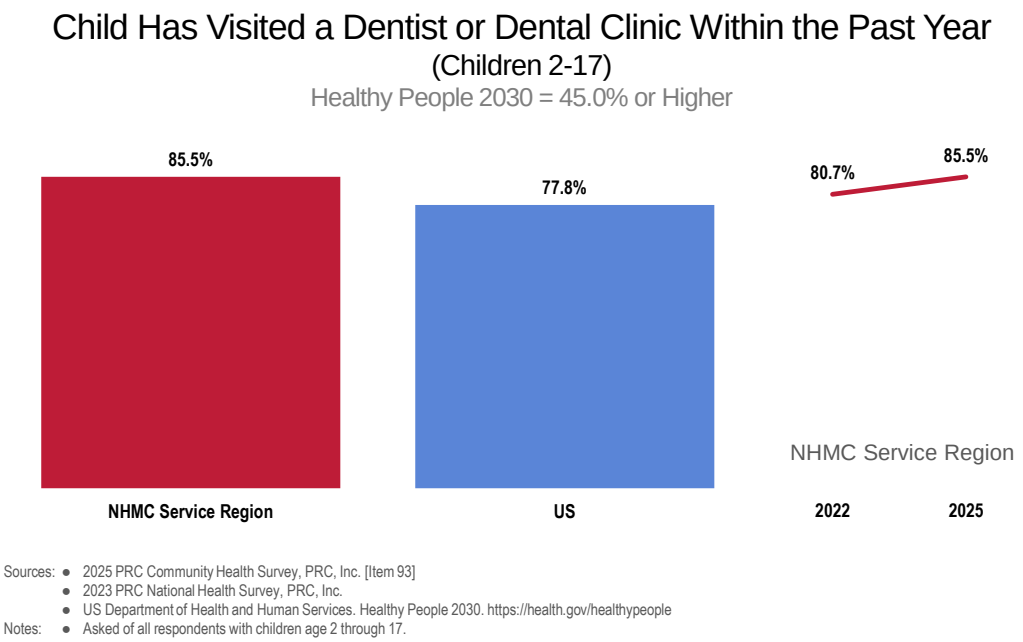
PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



Sources:
- 2025 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

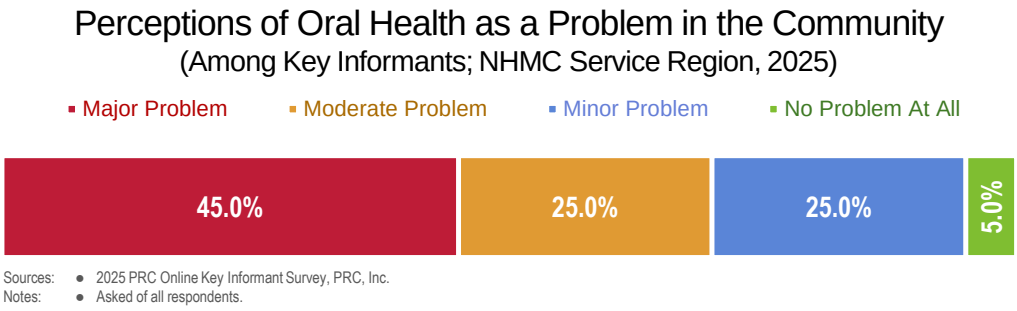
Notes:
- Asked of all respondents.

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

> It's considered a high cost or cosmetic usage by many in our community. Not as a regular medical check-in. — Community Leader
>
> Because of the expense of oral health care and lack of affordable, accessible alternatives for care, many in our community do not either see a dentist or only access care in an emergency. — Social Services Provider
>
> People do not have access to affordable dental care. Fear of the dentist. — Social Services Provider

Access to Care for Uninsured/Underinsured

> Many residents in our community are uninsured and do not have access to dental care. Additionally, areas in our community have a shortage of dental health professionals, which exacerbates the issue of access to dental care. — Public Health Representative

Impact on Quality of Life

> Dental health is a major problem because, if untreated, people can lose their teeth, which will make it difficult to eat. Also, conditions such as periodontitis, if untreated, can exacerbate risks for cardiovascular disease. — Social Services Provider

Co-Occurrences

> Oral health, especially for older adults, is a major risk factor for cardiovascular disease and for malnutrition. — Public Health Representative

Diagnosis/Treatment

> Not prioritizing getting to dentist. Families are unaware that Medi-Cal insurance covers dental care. — Social Services Provider

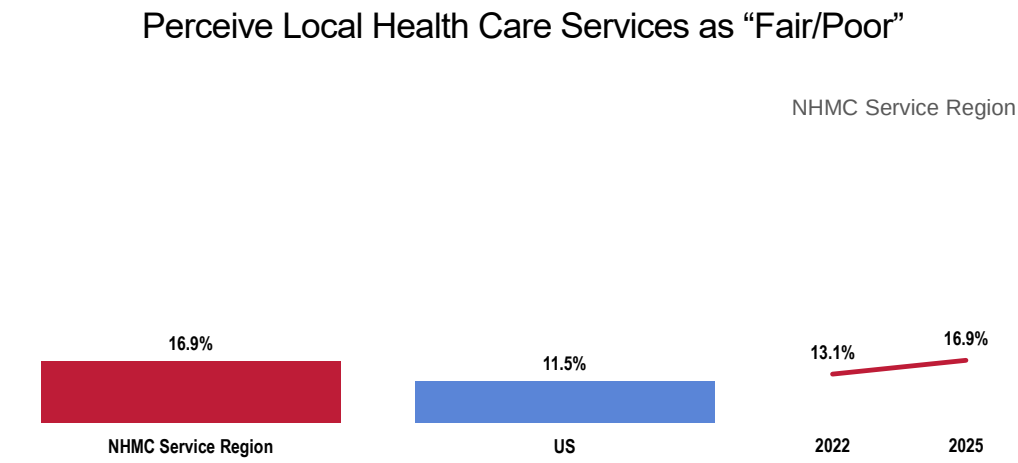
Fear

> Fear of the dentist and not enough oral health education programs that educate on the importance of dental care and how it ties into overall health. — Social Services Provider

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: ● 2025 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

- Affordable Care Act Exchange Resources
- Bet Tzedek
- Child and Family Guidance Center
- Community Clinics
- El Centro de Amistad
- El Projecto Del Barrio
- Encino Hospital
- Federally Qualified Health Centers
- Hathaway Sycamores
- Health Coverage Enrollment
- Hope of the Valley
- Hospitals
- LA Care
- LA Family Housing North Hollywood Campus
- Meet Each Need with Dignity
- Mid-Valley Comp Health Center
- Northeast Valley Health Corporation
- Olive View-UCLA Medical Center
- Samuel L Dixon Community Health Clinic
- San Fernando Valley Community Health Clinic
- San Fernando Valley Community Mental Health Center
- The Help Group
- UCLA Medical Center
- Valley Presbyterian Hospital
- West Valley Food Pantry

Cancer

- American Cancer Society
- Health Centers
- Ovarium Cancer Society
- Susan G Komen for the Cure

Climate, Nature & Health

- CEMO
- Churches
- Cities
- Cooling Centers
- Discovery Cube
- Fire Departments
- Government
- Health Systems
- Hospitals
- LA County 2045 Climate Action Plan
- LA County Department of Public Health
- Los Angeles Department of Water And Power
- Nonprofit Organizations
- Pacoima Beautiful
- Promotoras Comunitarias
- Public Health Department
- Red Cross
- School System
- Sierra Club
- SoCal Gas Company
- TreePeople
- Waste Management
- World Central Kitchen

Diabetes

- American Diabetes Association
- Breakthrough Diabetes
- California State University
- Community Based Organizations
- Community Clinics
- Diabetes Association
- Government
- Health Centers
- Health Department
- Hospitals
- LA County Department of Public Health
- Mission Community Hospital
- Northeast Valley Health Corporation
- Partners in Care Foundation
- Promotoras Comunitarias
- Providence Community Health
- San Fernando Valley Community Health Clinic
- Valley Community Healthcare

Disabling Conditions

- Alzheimer's Association
- Alzheimer's Los Angeles
- Area Agencies on Aging
- Bet Tzedek
- Family Caregiver Resource Center
- LA County Aging and Disability Department
- Leeza's Care Connection
- Meet Each Need with Dignity

Heart Disease & Stroke

- American Heart Association
- American Stroke Association
- California Right Meds Collaborative
- Dignity Health - Northridge Hospital Medical Center
- Doctors' Offices
- Health Centers
- Northeast Valley Health Corporation
- Parks and Recreation
- Providence Community Health
- Public Health Department
- Safer Roadways

Infant Health & Family Planning

- Child Care Resource Center
- Child Development Center
- Federally Qualified Health Centers
- First Five LA
- Health Centers
- Health Department
- Hope the Mission
- LA County Department of Public Health
- Meet Each Need with Dignity
- San Fernando Valley Community Mental Health Center
- Strength United
- The Help Group

Injury & Violence

- Center for Living and Learning
- Child and Family Guidance Center
- Chrysalis
- Goodwill
- Hathaway Sycamores
- San Fernando Valley Community Mental Health Center
- School System
- The Help Group

Mental Health

- Child and Family Guidance Center
- CRI-Help, Inc.
- Crisis Text Lines
- Didi Hirsch
- Dignity Health
- El Centro de Amistad
- El Nido Family Centers
- Encino Hospital
- Federally Qualified Health Centers
- Hospitals
- LA County Department of Mental Health
- Mental Health
- National Alliance on Mental Illness
- Northeast Valley Health Corporation
- Olive View-UCLA Medical Center
- ONEgeneration Senior Center
- Private Treatment Centers
- San Fernando Valley Community Mental Health Center
- Santa Clara Mental Health
- Tarzana Treatment Centers, Inc
- Teen Line
- The Help Group
- West Valley Department of Mental Health

Nutrition, Physical Activity, & Weight

- California State University
- Doctors' Offices
- Hospitals
- Meet Each Need with Dignity
- Northeast Valley Health Corporation
- Parks and Recreation
- Providence Community Health
- Samuel L Dixon Family Health Centers
- San Fernando Valley Community Health Clinic
- Supplemental Nutrition Assistance Program

Oral Health

- Dental Offices
- Federally Qualified Health Centers
- Northeast Valley Health Corporation
- Samuel L Dixon Family Health Centers

Respiratory Diseases

- Community Clinics
- Doctors' Offices
- LA County Department of Public Health

Sexual Health

- Las Memoria's
- Northeast Valley Health Corporation

Social Determinants of Health

- Access Transportation
- Bridge to Home
- Child and Family Guidance Center
- Churches
- Family Promise
- Financial Literacy Programs
- Hathaway Sycamores
- LA County Department of Public Health
- LA Homeless Service Authority
- Maravilla Foundation
- Marijuana Outlets
- Media
- Menorah Housing Foundation
- Northeast Valley Health Corporation
- ONEgeneration Senior Center
- Parks and Recreation
- Public Health Department
- San Fernando Valley Community Mental Health Center
- Santa Monica Mountains Conservancy
- School System
- The Help Group
- Valley Intercommunity Council
- West Valley Food Pantry

Substance Use

- Child and Family Guidance Center
- County/City Programs
- CRI-Help, Inc.
- Didi Hirsch
- Doctors' Offices
- Encino Hospital
- LA County Department of Public Health
- Northeast Valley Health Corporation
- Olive View-UCLA Medical Center
- Phoenix House
- San Fernando Valley Community Mental Health Center
- Tarzana Treatment Centers, Inc

Tobacco Use

- Doctors' Offices
- Pueblo y Salud, Inc.
- San Fernando Partnership
- Tarzana Treatment Centers, Inc

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

Over the past three years, Dignity Health Northridge Hospital Medical Center has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Administering free programs to the community and providing grants to community-based organizations.
- Providing free and subsidized medical care to vulnerable patients.

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

Addressing Significant Health Needs

Dignity Health Northridge 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 Dignity Health Northridge Hospital Medical Center would focus on developing and/or supporting strategies and initiatives to improve:

- Mental Health
- Substance Abuse
- Diabetes
- Oral Health
- Access to Healthcare Services
- Nutrition, Physical Activity, and Weight
- Respiratory Diseases (including COVID-19)
- Heart Disease and Stroke
- Potentially Disabling Conditions (Dementia and Alzheimer's)
- Sexual Health Including Violence Prevention
- Cancer

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

Evaluation of Impact

Priority Area: Mental Health	
Community Health Need	Mental health is a crucial factor in overall health and was identified as a top priority by the community..
Goal(s)	● To reduce mental illness, suicidal tendencies, and substance use among youth with emotional and major depressive disorders. ● Increase the skills and awareness of local community organizations and residents to promote and instill mental health resiliency, especially among children and youth of color, and those serving the unhoused who are dealing with mental health and where significant health disparities exist.

Strategy 1: Develop the Adverse Childhood Experiences Screening (ACES) program as a partnership between the Center for Healthier Communities and Dignity Health Family Medicine.	
Strategy Was Implemented?	Yes
Target Population(s)	Children ages 0-5 years old
Partnering Organization(s)	Dignity Health Family Medicine Northeast Valley Health Corporation The HELP Group Dept. of Children and Family Services L.A. County
Results/Impact	● Completed 224 ACE's screenings with 209 negative screenings and 15 positive screenings.

Strategy 2:Implement the San Fernando Valley Healing Project - Mental Health Awareness Training (MHAT).	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals with mental illness who are unhoused or experiencing housing instability within SPA 2 of Los Angeles County
Partnering Organization(s)	Substance Abuse and Mental Health Services Administration
Results/Impact	● Conducted MHFA/YMHFA training that reached 318 individuals. ● QPR training was completed with 237 people. ● There were 311 mental health referrals made by individuals who completed the training sessions.

Strategy 3:Develop a program to address behavioral health and mental well-being of at-risk youth and adults. Support community partnerships with local mental health providers to deliver evidence-based training.	
Strategy Was Implemented?	Yes
Target Population(s)	At-risk youth and adults in Los Angeles County
Partnering Organization(s)	UniHealth Foundation National Alliance for Mental Illness San Fernando Valley Community Mental Health, Inc.
Results/Impact	● Question, Persuade and Refer (QPR) Training was completed with 174 staff from the Department of Children and Family Services.. ● Two Mental Health First Aid Trainings completed with 38 people trained.

Strategy 4:Develop Positive Action that is an evidence-based curriculum using real-life concepts to foster social-emotional learning and develop a positive self-concept.	
Strategy Was Implemented?	Yes
Target Population(s)	Students within Los Angeles Unified School District
Partnering Organization(s)	Los Angeles Unified School District Sites
Results/Impact	● Ninety-eight schools and school mental health personnel trained in Positive Action. ● Over 2,500 students attended the Positive Action student assemblies. ● Conducted 37 workshops to reach 378 school personnel and parents. ● Fifty-eight counseling referrals were generated. ● There were over 22,700 individuals participating in the Great Kindness Challenge.

Priority Area: Substance Abuse	
Community Health Need	A major concern in the community is the prevalence of fentanyl in many drugs and the high rate of preventable overdose deaths.
Goal(s)	● To reduce the death rate of those living with addiction by providing patients admitted to the Emergency Department a warm handoff to staff to encourage them to work with one of the MAT licensed providers in the E.D.

Strategy #1: The Medicated Assisted Treatment (MAT) Program is a member of CA Bridge which utilizes a trained social worker/substance use navigator to provide a psychosocial assessment, counseling, and referral to treatment facilities for additional care.	
Strategy Was Implemented?	Yes
Target Population(s)	Patients dealing with substance misuse at NHMC
Partnering Organization(s)	Tarzana Treatment Center Discovery House Cri-Help ProWellness Academy
Results/Impact	● The program serves over 700 patients with substance misuse annually.

Priority Area: Diabetes	
Community Health Need	Through focus groups and community surveys participants identified diabetes as a major health issue for themselves or family members. Key concerns include the high cost of insulin and insufficient education on self-management.
Goal(s)	• Work to increase knowledge on diabetes self-management with reductions in glucose levels, cholesterol, and A1C levels. • Reduce rates of morbidities due to uncontrolled diabetes and use Community Health Educators to support pre-diabetes patients.

Strategy #1: Implement Prevention Forward Diabetes Wellness that includes the National Diabetes Prevention Program (NDPP) and Diabetes Education and Empowerment Program (DEEP).	
Strategy Was Implemented?	Yes
Target Population(s)	Persons at-risk or who have diabetes
Partnering Organization(s)	Local Churches Community Organizations Serving Low-Income Persons Los Angeles Unified School District Parent Centers
Results/Impact	• Eight people completed the National Diabetes Prevention Program. • Sixty participants were enrolled in the Prevention Forward Program. • Attended 25 outreach events to provide information and education to 1,109 people.

Strategy #2:Continue the multi-disciplinary team-based approach to address diabetes through the provision of ADCES Diabetes Care and Education Curriculum and working to expand the capacity of local pharmacies to become recognized as ADA providers.	
Strategy Was Implemented?	Yes
Target Population(s)	Persons with diabetes
Partnering Organization(s)	St. Mary's Pharmacy, churches, LAUSD sites, and community-based nonprofits
Results/Impact	• Five ADCES cohorts offered reaching 29 people. • Assisted St. Mary's Pharmacy and its two locations to get ADA recognition.

Priority Area: Oral Health	
Community Health Need	The community expressed concern about access to affordable dental care and limited knowledge of oral hygiene.
Goal(s)	• Dignity Health Northridge Hospital Medical Center will expand health promotion and education sessions to increase knowledge about oral health. • The Medical Center will expand partnerships with two local clinics providing dental health

Strategy #1: Provide oral health promotion workshops and information to LAUSD schools and support the work of clinics offering oral health services to youth.	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income youth and their families
Partnering Organization(s)	Los Angeles Unified School District Schools Kids Community Dental Clinic San Fernando Community Health Center
Results/Impact	● Disseminated 5 quarterly School Wellness Newsletters to include oral health education to over 250 LAUSD school professionals. ● Provided community benefit grants to San Fernando Community Health Center and the Kids Community Dental Clinic.

Priority Area: Access to Healthcare Services	
Community Health Need	Community feedback indicates that access to health care is still a priority. Barriers include challenges in securing appointments and accessing affordable medications.
Goal(s)	● Dignity Health Northridge Hospital Medical Center has partnered on several initiatives to improve access to health care services, with the focus on identifying and treating health issues early. ● The Medical Center will continue to assist people in helping to access and navigate the health care system.

Strategy #1: Partner with local community clinics to expand access to health care services in the community to the uninsured and underinsured through outreach and pop-up clinics.	
Strategy Was Implemented?	Yes
Target Population(s)	Uninsured and underinsured
Partnering Organization(s)	Health Resources Services Administration Northeast Valley Health Corporation Comprehensive Community Health Services San Fernando Valley Community Health Center
Results/Impact	● There were over 304,000 outreach engagement encounters completed. ● A total of 124 pop-up clinics were organized with 5,082 people vaccinated.

Strategy #2: Cover the costs of recuperative care expenses for patients discharged from Dignity Health Northridge Hospital Medical Center who would benefit from a non-acute setting in which to recover for those who are unhoused.	
Strategy Was Implemented?	Yes
Target Population(s)	Economically disadvantaged and unhoused patients
Partnering Organization(s)	Harbor Care Foundation, Inc.
Results/Impact	● Over $36,170 in recuperative care services have been provided to patients since the 2022 CHNA. ● A grant was given by Dignity Health Northridge Hospital Medical Center of $36,000 to the Harbor Care Foundation, Inc.

Priority Area: Nutrition, Physical Activity, and Weight	
Community Health Need	The last CHNA included feedback from the community that inactivity and weight gain during the COVID-19 pandemic, along with decreased food security due to inflation, have exacerbated this issue.
Goal(s)	● Working together with community partners, Dignity Health Northridge Hospital Medical Center will work with parents and families to increase knowledge about the significance of maintaining a healthy diet, engaging in physical activity, and stress management.

Strategy #1:Collaborate with the Los Angeles Unified School District to provide wellness workshops and education covering topics such as healthy eating, the importance of physical activity, and how to effectively manage stress. The Medical Center has also worked with the schools to create the Quarterly School Wellness Newsletter.	
Strategy Was Implemented?	Yes
Target Population(s)	Youth and families
Partnering Organization(s)	Los Angeles Unified School District American Heart Association
Results/Impact	● Five School Wellness Newsletters have been published and disseminated since 2022. ● Over 16,700 adults and youth received health education on healthy eating, the importance of physical activity, and managing stress.

Strategy #2: Continue to partner with the American Heart Association to distribute free produce to the community once a month.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals and families living in the San Fernando Valley
Partnering Organization(s)	American Heart Association Dignity Health Northridge Hospital Medical Center Employees
Results/Impact	● Since the last CHNA, $240,150 of in-kind services have been provided as part of the monthly produce distribution.

Priority Area: Respiratory Diseases (including COVID-19)	
Community Health Need	When the last CHNA was conducted, the community saw an abundance of COVID-19 cases with many still ill from the disease. The Medical Center continues to partner with the County of L.A. to provide outreach and education, connection to free/low-cost vaccinations, and navigation to resources for those most impacted.
Goal(s)	● Working together with the L.A. County Dept. of Public Health, local health centers, and the Medical Center joined forces to reduce the unfair impact of COVID-19. The organizations have worked together to develop a community-centered approach to provide the vaccine to those most in need.

Strategy #1: Through county, federal, and sub-award funding, Dignity Northridge Hospital Medical Center is able to carry out activities to provide outreach and education regarding COVID-19.	
Strategy Was Implemented?	Yes
Target Population(s)	At-risk individuals in the San Fernando Valley
Partnering Organization(s)	Health Resources Services Administration L.A. County Department of Public Health Meet Each Need with Dignity Northeast Valley Health Corp. San Fernando Community Health Center Comprehensive Community Health Centers
Results/Impact	● Over 11,400 active engagement encounters were completed. ● There were 266 social media posts sent encouraging individuals to get vaccinated.. ● A total of 124 vaccine pop-up clinics were organized. ● Passive engagement encounters such as email blasts and distributed flyers totaled 649.

Priority Area: Heart Disease and Stroke	
Community Health Need	Individuals remain concerned about heart disease, recognizing that it continues to remain one of the leading causes of death in the community. Dignity Health Northridge Hospital Medical Center maintains partnerships in the community to tackle heart disease and stroke through primary prevention education and training.
Goal(s)	● Increase knowledge regarding what leads to cardiovascular disease and how to prevent and manage existing heart disease. Focus on reducing the risk factors of new-onset cardiovascular disease. Attempt to get more people screened and increase awareness of risk factors for stroke and diabetes.

Strategy #1: Provide Activate Your Heart curricula in community settings to reduce the risk of heart disease and stroke in the community.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of Service Planning Area 2 of L.A. County
Partnering Organization(s)	Los Angeles Unified School District HeartBeat CA California Department of Public Health
Results/Impact	● Conducted 10 AYH workshops reaching 23 people completing the cohort. ● Participated in community outreach events reaching over 600 people.

Strategy #2: Offer a train-the-trainer model to community health workers and residents that shows how to accurately self-monitor their blood pressure to reduce hypertension and the risk of heart disease and stroke.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of Service Planning Area 2
Partnering Organization(s)	African American Leadership Organization California Department of Public Health
Results/Impact	● Conducted 4 blood pressure self monitoring cohorts with 4 professionals completing the training. ● Completed 601 referrals to chronic disease management programs. ● Twelve people were enrolled and completed the HeartBeat program.

Priority Area: Potentially Disabling Conditions (Dementia & Alzheimer's)	
Community Health Need	Focusing on dementia and Alzheimer's is essential due to their growing prevalence and significant impact on individuals and families. Early intervention and education can improve the quality of life and provide essential support for caregivers. Raising awareness regarding dementia and Alzheimer's helps reduce stigma and promotes better community resources for those affected.
Goal(s)	● Review and coordinate services for elderly cases referred for services through case review meetings. ● Conduct caregiver education workshops targeted to medical professionals and done in collaboration with community partners. ● Lead community awareness events intended to reach at least 150 residents.

Strategy #1: Continue to grow the Local Elder Abuse Prevention Education Multidisciplinary Team in Los Angeles (LEAP-EMDT LA)	
Strategy Was Implemented?	Yes
Target Population(s)	Seniors residing in Service Planning Area 2
Partnering Organization(s)	Alzheimer's Association Bet Tzedek Los Angeles County Adult Protective Services Los Angeles City Attorney's Office Local Law Enforcement Community Based Nonprofits ONEgeneration Office for Victims of Crime WISE and Healthy Aging
Results/Impact	● Conducted scam and fraud workshops reaching 83 participants. ● Conducted social isolation workshops with 60 people. ● Hosted Alzheimer's workshops in the community with over 3,800 attendees. ● Training of law enforcement personnel by the Alzheimer's Association to 338 individuals. ● Hosted EMDT working group meetings with 16 individuals attending. ● Organized elder abuse awareness events in the community reaching over 370 people. ● Recruited 4 new members to the EMDT.

Priority Area: Sexual Health Including Violence Prevention	
Community Health Need	Addressing sexual health and violence prevention is vital for fostering safe and healthy communities. Providing education and resources empowers individuals to make informed choices and to seek help when needed. Supporting the community in these areas promotes awareness, reduces stigma, and encourages prevention efforts.
Goal(s)	● Increase capacity to serve victims of sexual and domestic abuse and assault, child maltreatment, and human trafficking victims. Deliver a coordinated community response, and enhance awareness and expertise of service providers and community groups around domestic violence, sexual assault, and human trafficking. Reduce violence and victimization of youth and older adults.

Strategy #1: Provide schools with the tools they need to recognize, respond quickly to, and prevent acts of violence. This will be accomplished through community partnerships, evidence-based classes, staff training, and engagement and training of school law enforcement.	
Strategy Was Implemented?	Yes
Target Population(s)	Youth Residing in SPA-2
Partnering Organization(s)	Boys and Girls Club LAUSD School Sites LAUSD Police Staff Strength United Area Youth Service Providers Mental Health Services Oversight and Accountability
Results/Impact	● Eighty-seven school personnel trained in Safe Dates. ● Reached 375 students through Safe Dates Cohorts. ● Over 700 students reached through bullying prevention awareness events. ● The San Fernando Valley Resourceful Adolescent Program was initiated by the Medical Center. Since initiating the program, 11 students and 14 parents have attended the trainings.

Strategy #2: The Center for Assault Treatment Services (CATS) will provide compassionate, comprehensive medical examinations and forensic interviews to victims of sexual assault, domestic/partner violence, child maltreatment, and human trafficking. Conduct community outreach and education to mandated reporters on how to report abuse, the signs and symptoms of abuse, and short and long-term consequences of abuse.	
Strategy Was Implemented?	Yes
Target Population(s)	Victims of abuse or those at-risk of abuse living in Los Angeles
Partnering Organization(s)	Medical Safe Haven Haven Hills L.A. Police Department Domestic Violence Division Neighborhood Legal Services Strength United Los Angeles District Attorney
Results/Impact	● The Center for Assault Treatment Services offered care to over 10,200 persons in the past 3 years. ● CATS provided education and outreach to over 5,500 individuals during this same period.

Priority Area: Cancer	
Community Health Need	Residents living in the Medical Center's service area have expressed concerns about cancer because of the significant impact it has on health and wellbeing. Early detection and education can lead to better outcomes and reduce mortality rates. Raising awareness and providing resources empowers individuals to take proactive steps in cancer prevention and care.
Goal(s)	● Educate individuals in the community regarding breast cancer. Work with local organizations around outreach and education and develop new partnerships focused on cancer prevention and care.

Strategy #1: Offer breast cancer screening and breast health education to women in the community and provide patient navigator services to help eliminate barriers to care.	
Strategy Was Implemented?	Yes
Target Population(s)	Uninsured and underinsured women in the San Fernando Valley
Partnering Organization(s)	Carole Pump Women's Center at Dignity Health Northridge Hospital Medical Center American Cancer Society Local Community Organizations
Results/Impact	● Over 1,000 people were served by the free cancer workshops and screenings provided by the Medical Center. ● A Patient Navigator is available to cancer patients to help eliminate barriers to care and assist them during their treatment..