Dignity Health.
California Hospital
Medical Center

Community Health Needs Assessment & Implementation Plan Summaries 2014

Description of Community Served by the Hospital

California Hospital Medical Center is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID #04011) (Census tract 2240.10). While CHMC is located in Service Planning Area (SPA) 4 of Metro Los Angeles, its service area, also includes parts of SPA 6 (South) and SPA 8 (South Bay). The CHMC service area encompasses a large area that includes all or portions of the following SPAs, Health Districts and cities:

California Hospital Medical Center (CHMC) Service Area

City/Community	Primary ZIP Codes*	Secondary ZIP Codes*	Service Planning Area
Crenshaw	90003	90001	4 – Metro
Los Angeles	90006	90002	5 – West
Pico-Union	90007	90004	6 – South
South Central	90011	90005	8 – South Bay
Westlake	90015	90008	
Wilshire	90016	90010	
	90018	90017	
	90019	90020	
	90037	90026	
	90044	90043	
	90062	90047	
	90071	90057	

Over one-half million people (650,103) live in CHMC's primary service area and a total of 1.2 million live in its primary and secondary service area. A majority of residents are Latino (62%) and are of Mexican origin (60%). The remaining population is mostly African-American (20%). Compared to the County there is a higher concentration of Latinos and African Americans in the CHMC service area. Two-thirds of the population in CHMC's service area speaks a language other than English at home.

Children under the age of 18 accounted for 26.4% of the population, while only 8.9% are seniors. 40.8% of the residents have not received a high school diploma, and household incomes are generally low with a median household income of only $32,127, nearly 40% less than the County median. Twice as many households (24.8% and 21.3%, respectively) have an annual income of <$15,000 compared to LA County (12.9%). A majority of residents living below the poverty level are under 65 years of age. A third of households are experiencing food insecurity.

Three quarters of the housing units in CHMC's service area are renter-occupied, significantly higher than the LA County rate of 52%. Moreover, the majority of homes in CHMC's service area were built in 1939 or earlier (26%), between 1940-49 (17.6%) or between 1950-59 (17.4%) and are far older than housing structures in the rest of LA County. A fifth of households do not have a vehicle. Over half of the population are unemployed or not in labor force. A quarter of the population ages 0-64 residing in CHMC's service area is uninsured. In zip code 90017, 1 in 3 people are uninsured.

45% of Los Angeles County's homeless population lives in CHMC's service area; only a third are sheltered while the rest live in streets, parks, vehicles, abandoned buildings, etc. 60% of homeless people are adult males, 32% adult females, and 8% children. 47% are African American, 29% Hispanic/Latinos, and 8% White.

The not-for-profit hospital/medical centers in or near CHMC's service area include:

- Children's Hospital Los Angeles 7 miles north of CHMC
- Good Samaritan Hospital 2 miles west
- Kaiser Foundation Hospital – Los Angeles 7 miles north
- LAC+USC Medical Center 5.5 miles east
- St. Vincent Medical Center 3 miles west
- White Memorial Medical Center 5 miles east

2013 Demographics
PSA: California Hospital Medical Center
Level of Geography: Zip Code

- Population: 1,571,248
- Diversity: 5.8% Caucasian | 65% Hispanic | 7.9% Asian/PI | 19.6% African American | 1.7% Other
- Average Income: $47,328
- Uninsured: 30.5%
- Unemployment: 10.9%
- No HS Diploma: 40.6%
- Renters: 74.0%
- CNI Score: 5
- Medicaid Patients: 35.0%
- Other Area Hospitals: 6

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Who Was Involved in the Assessment

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

For the **2014 CHNA**, three hospitals in metropolitan Los Angeles — California Hospital Medical Center, Good Samaritan Hospital, and St. Vincent Medical Center — collaborated, as they have in the past, to work with the Center for Nonprofit Management consulting team in conducting the CHNA.

How Was the Assessment Conducted

In the initial phase of the CHNA process, community input was collected through 10 focus groups and 29 interviews with key stakeholders, including health care professionals, government officials, social service providers, community residents, leaders, and other relevant individuals. The purpose of the primary data collection component of the CHNA is to identify broad health needs and key drivers, as well as assets and gaps in resources, through the perceptions and knowledge of varied and multiple stakeholders. These stakeholders represented a wide range of health and social service expertise as well as representatives from diverse ethnic backgrounds including African-American, Chinese, Filipinos, Koreans and Latinos (Appendix A)

The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each; the conversations were confidential and interviewers adhered to standard ethical research guidelines. The interview protocol was designed to collect reliable and representative information about health and other needs and challenges faced by the community, access and utilization of health care services, and other relevant topics. Focus groups took place in a range of locations throughout the service area, with translation and interpretation services provided when appropriate. Focus group sessions were 45 to 60 minutes each. As with the interviews, the focus group topics also were designed to collect representative information about health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic disease management and other community issues. The identified health needs and drivers of health were then presented during a community forum to allow for a richer discussion of secondary data and additional considerations.

Concurrently, over 100 indicators of secondary data were collected and compared to relevant benchmarks including Healthy People 2020, Los Angeles County or California rates or statistics when possible. Secondary data were collected from a wide range of local, county, and state sources to present demographics, mortality, morbidity, health behaviors, clinical care, social and economic factors, and physical environment. These categories are based on the Mobilizing Action Toward Community Health (MATCH) framework, which illustrates the interrelationships among the elements of health and their relationship to each other, including social and economic

factors, health behaviors, clinical care, physical environmental, and health outcomes. The data were also collected for smaller geographies, when possible, to allow for more in-depth analysis and identification of community health issues. In addition, prior CHNAs were reviewed to identify trends and ensure that previously identified needs were not overlooked. Primary and secondary data were compiled into a scorecard to present health needs and health drivers with benchmarks included for comparison; when an indicator for CHMC fell below the comparison benchmark (Healthy People 2020, Los Angeles County and California indicators) it is shaded in black. The scorecard was designed to allow for a comprehensive analysis across all data sources and for use during the prioritization phase of the CHNA process.

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

The Simplex Method was selected as the approach for the health needs prioritization process. A Simplex Method is the process in which input is gathered through a close-ended survey where respondents rate each health need and driver using a set of criteria. This approach was selected because of its inclusivity of stakeholders, its ease of use, and to involve a moderate amount of rigor.

Community Prioritization Forum

The community forum was designed to provide the opportunity for a range of stakeholders to engage in a discussion of the data and participate in the prioritization process. All individuals who were invited to take part in the primary data collection, irrespective of whether or not they had participated in that phase, were invited to attend a community forum. The forum included a brief presentation that provided an overview of the CHNA data collection and prioritization processes to date, and a review of the documents to be used in the facilitated discussion.

Participants were provided a list of identified health needs and drivers in the scorecard format, developed from the matrix described previously in this report, and a narrative document that included brief summary descriptions of the identified health needs. Participants then engaged in a facilitated discussion about the findings as presented in the scorecard and the narrative summaries, and prioritization of the identified health needs and drivers. Each participant was then asked to complete a survey and to rank each health need according to several criteria, as described below.

Community forum participants were asked to complete a questionnaire after the forum, rating each health need and driver according to scales for severity, change over time, resources available to address the needs and/or drivers, and the community's readiness to support initiatives to address the needs and/or drivers.

The responses to the 31 completed questionnaires were compiled and analyzed using Microsoft Excel. As described above, averages were computed for each criterion. The overall average was calculated by adding the total across 3 of the criteria severity (total possible score equals 4), change over time (total possible equals 4), and resources (total possible equals 4) for each survey (with a total possible score of 12). The total scores were divided by the total number of surveys for which data was provided, resulting in an overall average per health need.

Prioritized Community Health Needs and Drivers

Community health needs are conceptually divided into drivers and conditions. Drivers are considered the structural and social factors that correlate with health status. Conditions refer to the diseases and health concerns experienced by community members.

Table 1. Prioritized Drivers of Health

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

Table 2. Prioritized Health Needs

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

Note: Health needs are in prioritized ranking order.

Community Assets Assessment

The assessment identified a number of strong community assets. Community assets are documented in the *Hope Street Family Center's Bilingual* (English/Spanish) *Resource Guide* that is updated annually. Additionally, community resources can be accessed using L.A. County's 2-1-1 system, the largest information and referral (I&R) service in the nation, helping approximately 500,000 individuals and families in Los Angeles County each year. Since 1981, 211 LA County has provided free, confidential services 24 hours a day, 7 days a week in English, Spanish and more than 140 other languages via a tele-interpreting service. Services are also provided for individuals with hearing impairments.

Developing the Hospital's Implementation Plan
The Community Benefit Planning Work Group comprised of key community stakeholders and *promotoras* residing in CHMC's service area uses a process that focuses on two levels of decision-making to determine how identified health issues will be addressed:

- Content Areas
    - Size of the problem
    - Severity of the problem
    - Economic feasibility
    - Available expertise
    - Necessary time commitment
    - External salience
- Project Activities
    - Target population
    - Number of people (i.e., How many people will be helped by this intervention?)
    - Estimated effectiveness/efficiency
    - Existing efforts (i.e., Who else is working on this? What is our role? How can we best complement/enhance an existing effort?)

The Work Group considered the following documents as it began its deliberations:

- 2014 CHMC Community Health Needs Assessment especially the Prioritized Health Needs
- 2012 Hope Street Family Center Community Needs Assessment
- CHMC Strategic Plan
- Problems linked to high utilization rates at CHMC
- Prevention Requirements of Level II Trauma Center
- Requirements of Stroke Program

Plan to Address Prioritized Community Health Needs

Prologue: Each of the programs listed below that address the identified needs has its own evaluation plan that is monitored at least annually, particularly since the majority of programs are grant-funded. Moreover, the programs are continuously monitored for performance and quality with ongoing improvement to facilitate their success. Programs developed in response to the current Community Health Needs Assessment are guided by the following five core principles:

- **Disproportionate Unmet Health-Related Needs**
  Seek to accommodate the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention**
  Address the underlying causes of persistent health problem.
- **Seamless Continuum of Care**
  Emphasize evidence-based approaches by establishing operational links between clinical services and community health improvement activities.
- **Build Community Capacity**
  Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance**
  Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

In response to identified unmet health-related needs in the community health needs assessment, during FY 14 CHMC focused increasing access to health care for the broader and underserved disadvantaged members of the surrounding community. Major community benefit activities for FY14 focused on health coverage enrollment assistance, outreach health education and health screenings for common chronic conditions at over 55 sites in the community, referring individuals and families to local community clinics for on-going primary health care, and health education workshops for common chronic conditions both at some of the community clinics as well as at local schools, churches, and other community centers.

Health education was selected as a priority to address prevention of disease, to empower community members to assume responsibility for their health and to educate people about various medical conditions and the ability they have to make wise choices.

Self-management workshop series included: Healthier Living aka Chronic Disease Self-Management Program (CDSMP); Food, Fitness, and Diabetes Prevention; Living with Diabetes; Healthy Eating Lifestyle Program (addressing pediatric obesity); and Heart H.E.L.P.

The Healthy Eating and Lifestyle Program (H.E.L.P.) is a 5 week educational program for families with children ages 5-12 years who are at risk of being overweight or obese. Parents must participate with their child(ren) who qualifies(y) for this program. The primary goal is to help these families adopt healthier eating habits and increase physical activity. The emphasis is on long-term lifestyle changes (such as making better food and beverage choices, integrating activity into their daily lives, and decreasing screen time to < 2 hr/d), rather than short-term diets. Each module is highly interactive so that program participants are able to both learn and apply the facts, principles, and concepts being taught. The Olympic Food Guide is a tool that was developed to help participants make healthier food choices. Foods belonging in the Gold category are packed with nutrients and are relatively low in fat and calories whereas foods in the Brick group are mainly fat and sugar and have many calories per bite and fewer vitamins or minerals.

Food, Fitness and Diabetes Prevention Program is designed to emphasize the importance of making healthy lifestyle changes to prevent diabetes. This program encourages participants to take an active role in leading healthy lives. Topics covered over the four weekly 2-hr sessions include how to prevent chronic conditions such as diabetes, heart disease, and high cholesterol and how these conditions are associated with poor eating habits and physical inactivity. Participants learn about the six important nutrients, choosing correct portion sizes, what a healthy breakfast is and why it's important, how to read food labels and how to be a smart shopper. Following completion of this educational program, participants are encouraged to enroll in the year-long Diabetes Prevention Program at their local YMCA to maintain their momentum.

Living with Diabetes is designed for individuals who have been diagnosed with type 2 diabetes mellitus. Topics covered during the five weekly 2-hr workshops include the difference between type 1 and type 2 diabetes and the signs, symptoms, and complications associated with this chronic illness. Participants learn the importance of managing diabetes using the *Diabetes Health Record*; this record helps them understand basic care guidelines, self-monitoring of blood sugar levels and the importance of regular health care visits. Workshop topics also include understanding the diabetic diet, the plate method, carbohydrate counting, reading food labels, healthy cooking, recipes, the importance of physical activity, and preventing complications and understanding your medications. Participation in Living with Diabetes Program has resulted in a 100% reduction in hospitalizations and ED visits for glucose control in the 6 months following program participation compared to the 6 months prior to participation.

People with diabetes, especially those with poorly controlled diabetes, are more likely to have periodontal disease than people without diabetes. In fact, periodontal disease is often considered the sixth complication of diabetes and may make it more difficult for people with diabetes to control their blood sugar. What happens when you treat periodontal disease? Meta-analysis demonstrated a 0.46% fall in HbA1c with nonsurgical treatment of periodontal disease; a 0.4% fall in HbA1c per Cochrane Review in 2010. (For reference, a 1% fall in HbA1c represents 30 mg/dl fall in mean plasma glucose) The **Community Dental Partnership** is collaboration between Eisner Pediatric and Family Medical Center's dental clinic, the Southside Coalition of Community Health Centers, and CHMC to provide access to free basic dental services and periodontal services for uninsured adults with medication-dependent type 2 diabetes living in Central Los Angeles. Participants must have their medical home at one of the clinics of the Southside Coalition and must complete the *Living with Diabetes* workshop series (or equivalent education classes at their medical home) and the Oral Hygiene class.

In September 1992 the **Hope Street Family Center (HSFC)** was established as a collaborative effort between the University of California Los Angeles (UCLA) and Dignity Health, dba CHMC to address several critical factors impacting the community: extreme poverty, predominant immigrant population, very low literacy rates, poor quality schools, high rates of disabilities in young children, gang violence, lack of access to health care including prenatal care and pediatric care, insufficient licensed child care, and the need for family mental health services. Today this collaboration has grown to include partnerships with over 30 community agencies. The HSFC exemplifies the mission of Dignity Health to empower and strengthen families by providing health services, education, and access to community resources through a seamless, flexible, comprehensive, culturally-sensitive, and responsive array of services free of charge to meet a family's individual and changing needs. HSFC's services are both hospital- and community-based and include: Early Head Start Program, three licensed early care and education centers, the Hope Street Youth Center, Family Childcare Network, Family Literacy Program, Nurse Family Partnership Program, Pico Union Family Preservation Network, Early Intervention Program, Family Wellness Center, and Behavioral Health Clinic. The HSFC celebrated its belated 20th anniversary in October 2013, by moving into its new $16 million home, a four story building on the corner of Hope St and Venice Blvd, the Hope Street Margolis Family Center.

CHMC has been a leader in perinatal services for over half a century. Therefore, it seemed only natural to become the host agency for the **Los Angeles Best Babies Network (LABBN) Center for Healthy Births**. The mission of the Center is to provide the infrastructure, programs, advocacy and support to enhance the capacity of the network of community stakeholders working to achieve healthy births throughout Los Angeles County. The Network leads Care Quality Improvement activities to help perinatal care providers

implement evidence-based practice guidelines and to link health care providers to community-based services and resources; coordinates and institutionalizes a broad perinatal health policy agenda working with community stakeholders and others to build sustainable improvement of pregnancy and birth outcomes; promotes health literacy skill building through the use of *Baby Basics*; and partners with the Los Angeles County Perinatal Mental Health Task Force to promote universal screening for perinatal depression. On March 1, 2013 LABBN was selected as the Family Strengthening Oversight Entity by First 5 LA to oversee and support the implementation and standardization of First 5 LA's Welcome, Baby! universal perinatal and early childhood home visitation program at 14 additional birthing hospitals across Los Angeles County. LABBN also provides training, technical assistance and support to the new Select Home Visitation Programs working with these hospitals and developed referral pathways between Welcome, Baby!, Select Home Visitation Programs, and other existing perinatal home visiting programs in each Best Start Community.

The Esperanza Healthy Breathing Program is for children with asthma who have been seen in our emergency department or hospitalized at CHMC. Our program coordinator identifies potential candidates for this program and obtains written consent from the child's parent. Promotoras from the Esperanza Housing Corporation provide home visits after the child's release/discharge from CHMC in order to provide asthma education, explain how to use the spacer and peak flow meter, explain their medications, and inspect the home for possible asthma triggers, such as pet dander, evidence of vermin or cockroaches, mold, excess dust, etc. The parents learn how to mitigate these household triggers in order to improve the health of their child. The Promotoras also make sure that the child has a medical home and attends regularly. They also make sure the child has medication both at home and at school and understands when and how to take them.

Heart H.E.L.P. is designed to reduce risk, delay the onset and/or reduce the progression of cardiovascular disease among those participating in its five weekly 2-hr workshops. These workshops focus on modifiable risk factor reduction, especially in the areas of nutrition (DASH diet), physical activity, and smoking cessation. The fifth class focuses on congestive heart failure. Participation in Heart HELP has resulted in a 100% reduction in hospitalizations and a 100% reduction in ED visits for cardiovascular disease in the 6 months following participation compared to the 6 months prior to participation.

Description of What CHMC Will Do to Address Community Needs.

California Hospital Medical Center's community benefit program reflects our commitment to improve the quality of life in the community we serve. The community benefit planning process is shaped by our Mission and Core Values, which emphasize collaboration, justice, stewardship, dignity of each person, and excellence. We seek to promote a healthier community by supporting partnerships with others. In keeping with our tradition of Catholic health care, we do this with special concern for the poor and disenfranchised.

The Community Benefit Committee of the Community Board consists of: Hospital President, Foundation President, and Senior Vice President of Business Development, Director of Community Benefit, Director of Grants and Contracts, and two members of the Community Board. This committee provides oversight and policy guidance for all charitable services and activities supported by the hospital and makes sure that the Board is regularly briefed on community benefit activities and developments. In addition, the entire Community Board is responsible for review and approval of the annual Hospital Community Benefit Report and Plan.

The Community Board has the following expectations regarding the Community Benefits Planning Process:

- The Plan should be responsive to the Community Needs Assessment and, when possible, to CHMC's Strategic Plan.
- To the extent possible, the Plan should be budget neutral, i.e., the majority of the programs should be grant funded.
- Programs should be culturally-sensitive and evidence-based.
- Programs should have measurable objectives and should be continuously monitored.

The Community Board delegates the following decisions to the Foundation President and his staff: budget decisions, program content, program design, program targeting, securing outside funding, program continuation or termination, and program monitoring. Any major deviations from the approved Community Benefit Implementation Plan must be brought back to the Community Advisory Board for its consideration and approval.

California Hospital Medical Center is also committed to **Dignity Health's annual community grants program** which supports the continuum of care in the community offered by other not-for-profit organizations. The director of community benefit oversees this program. Each summer a request for Letters of Intent (LOIs) is widely circulated to non-profits in the community who are asked to focus on specific needs identified in the hospital's Community Health Needs Assessment. This year we focused on 1) access to mental health services for the uninsured, 2) oral health, 3) substance abuse, 4) diabetes mellitus, and 5) obesity/overweight. LOIs and

later full proposals are reviewed and scored by the Grant Review Committee that included the director of Community Benefit, Foundation President, Chairman of the Community Board and two members of the Community Board. The top three proposals are then forwarded to Corporate for funding.

In order to complete a 2014 Community Health Needs Assessment, California Hospital Medical Center pooled its resources with two other hospitals to collect information about the health and well-being of residents in our service community. This group, called the Los Angeles Metropolitan Hospital Collaborative, includes: CHMC, Good Samaritan Hospital, and St. Vincent Medical Center. The Collaborative contracted with the Center for Nonprofit Management to collect and analyze the necessary data, conduct interviews and focus groups, and write an individualized Community Health Needs Assessment for each participating hospital.

In January 2009 and again in 2012 the Hope Street Family Center (HSFC) completed its own Community Needs Assessment for its service area, which is a subset of CHMC's primary service area. This Needs Assessment primarily focused on children, especially those aged 0-5 years, and their families.

The HSFC has its own Community Advisory Board comprised of: three members of the CHMC Community Board, six members of the CHMC Foundation Board, three members from Dignity Health Corporate Office, two professors from UCLA, two members involved in community development, one former HSFC participant, CHMC's President and Foundation President, and the Director of Community Benefits.

Action Plans

Mental Health

Data Documenting the Need

- In 2011-2012 a slightly larger percentage (8.1%) of adults in CHMC service area reported experiencing serious psychological distress in the past year when compared to LA County (8.0%), with an even larger percentage (9.6%) reported in SPA 4. SPA 6 (8.7%) also experienced a larger percentage of adults experiencing serious psychological distress in the past year when compared to LA County.
- The percentage of the population in the CHMC service area diagnosed with depression was slightly lower (12.1%) when compared to LA County (12.2%). However, the percentages were higher in SPA 4 (13.4%) and 5 (13.4%) when compared to the CHMC service area (12.1%) and LA County (12.2%).
- In 2010 the mental health hospitalization rate per 100,000 adults in the CHMC service area was much higher (763.1) than in CA (551.7). Most ZIP codes in the service area were higher when compared to CA with the highest rates in ZIP codes 90044 (979.9), 90018 (973.4), 90037 (969.9), and 90016 (916.0) in CHMC's primary service area and ZIP codes 90043 (1,205.7) and 90008 (924.9) in CHMC's secondary service area.
- Similarly the mental health hospitalization rate per 100,000 youth under 18 yrs. of age was much higher (343.5) in CHMC's service area when compared to CA (256.4). Rates were highest in ZIP codes 90037 (572.4) and 90062 (489.9) in CHMC's primary service area and in ZIP codes 90047 (613.7) and 90010 (520.8) in CHMC's secondary service area.

The Action Plan to Improve Access to Mental Health Services

- Health Ministry Program
- Hope Street Family Center
    - Early Head Start Program
    - Nurse Family Partnership
    - Welcome Baby Program
    - Pico Union Family Preservation Program
    - Hope Street Youth Center
    - CA Behavioral Health Clinic
    - Early Intervention Program

    - Family Wellness Center
- Clinical experience for social work students
- Los Angeles Best Babies Network
    - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
    - Care Quality Collaborative Program
- Dignity Health Community Grants Program
    - Community Wellness Collaborative Project
    - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities
    - 10th Decile Project: Health Care and Supportive Housing for Chronically Homeless Frequent Users

Oral Health

Data Documenting the Need

- In 2011, 11.3%, 14.9% and 12.1% of children in SPAs 4, 6, and 8 respectively did not obtain dental care (including check-ups) in the past year because they could not afford it.
- In 2011, 37.6%, 35.0%, and 27.4% of adults in SPAs 4, 6, and 8 respectively did not obtain dental care (including check-ups) because they could not afford it.
- In 2011, most adults in CA County were unable to afford dental care regardless of age. However, a larger percentage of adults between the ages of 25-29 (38.7%), 30-39 (35.0%), and 50-59 (33.0%) were unable to afford dental care.
- By ethnicity, over a third of African-American (38.0%) and Latino (36.6%) adults were unable to afford dental care, as were over a quarter of Asian/PI (27.3%) and American Indian/Alaskan Native adults (25.6%) and close to a quarter of White adults (21.0%).
- Although DentiCal was partially restored in May 2014 resulting in improved access for Medi-Cal eligible adults, the LA County Board of Supervisors cut funding for dental services through Healthy Way LA resulting in no access to dental services for undocumented immigrants.

The Action Plan to Improve Access to Oral Health Care and Oral Health Status

- Hope Street Family Center
    - Partnership with USC Dental Program
    - Family Wellness Center
        - Oral Hygiene Classes
- Health Ministry Program
    - Oral Hygiene Classes
- UniHealth Community Dental Partnership for Uninsured Adults with Medication-Dependent Diabetes
    - Basic and periodontal services provided through a collaboration of:
        - Southside Coalition of Community Health Centers
        - CHMC
        - Eisner Pediatric and Family Medical Center's Dental Department

Substance Abuse and Alcoholism

Data Documenting the Need

- The density of alcohol outlets is associated with healthy drinking, drinking and driving, higher rates of motor vehicle-related pedestrian injuries, child abuse and neglect, and other violence. In 2012, the average alcohol outlet rate per 1,000 persons in CHMC's service area was 1.8. Higher rates were reported in CHMC's secondary service area (2.3) than in CHMC's primary service area (1.1). Specifically, zip code 90010 (11.8) in CHMC's secondary service area had more than six times the rate of CHMC's overall service area.

- In 2011, half (54.3%) of the population in CHMC service area consumed more alcohol than in LA County (51.9%).
- A slightly larger percentage (3.8%) of the population in CHMC service area reported drinking heavily when compared to LA County (3.5%), with SPAs 4 (4.6%) and 8 (4.6%) reporting a higher percentage. A higher percentage (17.2%) of the population in CHMC service area also reported binge drinking when compared to LA County (15.4%) – and notably higher in SPA 4 (19.2%)
- In 2011, a larger percentage of teens between the ages of 12 and 17 reported using marijuana in the past year (14.2%) in the CHMC service area than in LA County (10.2%). Over a quarter of teens in SPA 4 (26.3%) reported using marijuana in the past year, larger than the CHMC service area (14.2%) and twice as many as in LA County (10.2%).
- In 2010, the rate per 100,000 adults of alcohol- and drug-induced mental illness in the CHMC service area was lower (102.0) when compared to CA (109.1). However, rates were especially high in ZIP code 90016 (132.4) in CHMC's primary service area and ZIP code 90001 (190.9), 90010 (157.9), and 90057 (135.6) in CHMC's secondary service area.

The Action Plan for Primary Prevention of Substance Abuse and Alcoholism

- Prevention of Child Abuse and Neglect and Family Violence Prevention
    - Hope Street Family Center
        - Pico Union Family Preservation Program
        - Early Head Start Program
        - Nurse Family Partnership Program
        - Welcome Baby Program
        - Licensed Childcare Centers
        - Family Childcare Network
        - CA Behavioral Health Clinic
        - Early Intervention Program
        - Family Wellness Center
    - Los Angeles Best Babies Network
        - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
        - LA County Perinatal and Early Childhood Home Visitation Consortium's Policy Subcommittee
    - Dignity Health Community Grants Program
        - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities
        - Community Wellness Collaborative Project

The Action Plan for the Treatment of Substance Abuse and Alcoholism

- Treatment of Substance Abuse and Alcoholism
    - Hope Street Family Center
        - Pico Union Family Preservation Network
        - Early Head Start Program
        - Nurse Family Partnership Program
        - Welcome Baby Program
        - CA Behavioral Health Clinic
        - Family Wellness Center
    - Los Angeles Best Babies Network
        - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
    - Dignity Health Community Grants Program
        - 10th Decile Project: Health Care and Supportive Housing for Chronically Homeless Frequent Users

Diabetes mellitus

Data Documenting the Need

- In 2011, the prevalence of diabetes among those 18 yrs. and older was 7.3%, 10.1%, and 9.8% in SPAs 4, 6, and 8 respectively.
- In 2009, 90.7%, 69.4%, and 96.7% of those with diabetes taking medications for control felt confident that they were able to manage their condition in SPAs 4, 6, and 8 respectively.
- The diabetes hospitalization rate per 100,000 adults in the CHMC service area (228.2) was much higher when compared to CA (145.6), but rates among adults were twice as high in ZIP codes 90044 (356.4) and 90016 (355.1) in CHMC's primary service area and ZIP codes 90008 (371.2), 90043 (363.9), 90002 (343.6), and 90047 (337.4) in CHMC's secondary service area when compared to CA.
- In 2010, 9.8 per 10,000 persons died as a result of diabetes- five times as many as those who died of diabetes in CA (1.9) Much higher mortality rates were reported in ZIP codes 90044 (21.0) and 90016 (17.0) in CHMC's primary service area and in ZIP code 90047 (19.0) in CHMC's secondary service area.

The Action Plan for the Prevention of Diabetes

- Prevention of Diabetes
    - Health Ministry Program
        - Food, Fitness, and Diabetes Prevention
        - Referrals to YMCA's Diabetes Prevention Program
    - Hope Street Family Center
        - Family Wellness Center
            - Food, Fitness, and Diabetes Prevention
            - Healthy Cooking Demonstrations
            - Referrals to YMCA's Diabetes Prevention Program
    - Los Angeles Best Babies Network
        - CDC Community Transformation Grant & Good Hope Medical Foundation Grant: Healthy Weight Perinatal Care Quality Collaborative
        - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
    - Dignity Health Community Grants Program
        - Community Wellness Collaborative
        - Pico Union Healthy Living Program

The Action Plan for the Treatment of Diabetes

- Treatment of Diabetes
    - Health Ministry Program
        - Living with Diabetes Program
        - Diabetes Support Group
    - Hope Street Family Center
        - Family Wellness Center
            - Healthy Cooking Demonstrations
            - Chronic Disease Self-Management Program (CDSMP)
    - Dignity Health Community Grants Program
        - South Central Family Health Center's Exercise and Nutrition Program for Adults with Diabetes
        - St. Barnabas Senior Center of Los Angeles: Diabetes Self-Management Program
    - UniHealth Community Dental Partnership for Uninsured Adults with Medication-Dependent Diabetes
        - Basic and periodontal services provided through a collaboration of:
            - Southside Coalition of Community Health Centers
            - CHMC
            - Eisner Pediatric and Family Medical Center's Dental Department
    - CCF Coordinated Care Initiative

- Selected FQHCs in the Centinela Valley: UMMA, South Central Family Health Center, T.H.E. Clinic
- CHMC

Overweight/Obesity

Data Documenting the Need

- In 2011, 29.4% of adults in CHMC's service area were overweight, fewer than in LA County (34.2). However, a larger percentage of those who are overweight were reported in SPA 8 (36.3%). Also a smaller percentage of adults (15.7%) were obese in the CHMC service area compared to LA County (24.7%) and the Healthy People 2020 goal (≤ 30.5%); however, the prevalence of obesity in SPAs 6 and 8 were 20.7% and 20.3% respectively.
- A slightly smaller percentage (13.6%) of teens between the ages of 12 and 17 in the CHMC service area was overweight or obese when compared to LA County (17.1) with SPA 6 having a larger percentage (19.0%).
- A slightly smaller percentage (12.0%) of children ages 2-11 in the CHMC service area were overweight when compared to LA County (13.3%) with SPAs 6 (17.1) and 4 (15.0%) having larger percentages.
- By ethnicity, larger percentages of American Indians/Alaskan Native (45.2%) and Latinos (40.6%) in LA County are overweight, as well as over a third of African Americans (38.9%), Whites (34.0%), and Asian/Pacific Islanders (32.9%). Also over a quarter of Latinos (31.6%) and African Americans (31.0%) in LA County are obese, along with over a quarter (25.8%) of American Indians/Alaskan Natives.

The Action Plan for Improving Physical Activity and Dietary Habits and Reducing Overweight/Obesity

- Health Ministry Program
  - Food, Fitness, and Diabetes Prevention
  - Referrals to YMCA's Diabetes Prevention Program
- Hope Street Family Center
  - Early Head Start Program
  - Nurse Family Partnership Program
  - Welcome Baby Program
  - Hope Street Youth Center
  - Licensed Childcare Centers
  - Family Childcare Network
  - Youth Fitness Program
  - Family Wellness Center
    - Healthy Eating Lifestyle Program
    - Healthy Cooking Demonstrations
    - Referrals to YMCA's Diabetes Prevention Program
- Dignity Health Community Grants Program
  - Community Wellness Collaborative
  - Pico Union Healthy Living Program
- Los Angeles Best Babies Network
  - CDC Community Transformation Grant and Good Hope Medical Foundation Grant: Healthy Weight Perinatal Care Quality Collaborative

Cardiovascular Disease

Data Documenting the Need

- In 2011, the prevalence of heart disease in SPAs 4, 6, and 8 was 20.4%, 28.4%, and 24.5% respectively.
- Of those in the CHMC service area with heart disease; nearly three quarters (71.0%) receive assistance from a care provider in managing their disease. SPA 6 has an even larger percentage (75.9%) of those who receive

assistance from a care provider in managing their disease than in the CHMC service area (70.6%) and LA County (73.3%)
- In 2010 the hospitalization rate resulting from heart failure was much higher (445.3) per 100,000 persons in the CHMC service area when compared to CA (367.1). The highest heart failure hospitalization rates were reported in CHMC's secondary service area in ZIP codes 90047 (860.0), 90008 (730.0) and 90043 (723.4). High rates were also reported in the CHMC primary service area in ZIP codes 90062 (649.0), 90018 (644.9), 90016 (626.1), and 90044 (601.5). These rates were two or more times higher than CA (367.1)
- In 2010, a much higher heart disease mortality rate per 10,000 persons was reported in the CHMC service area (68.3) when compared to CA (15.6). The highest heart disease mortality rates were reported in ZIP code 90044 (137.0) in the CHMC primary service area and 90047 (136.0) in the CHMC secondary service area – nine times the rate in CA (15.6).

The Action Plan for the Prevention and Treatment of Cardiovascular Disease

- Health Ministry Program
    - Smoking Cessation Assistance Program
    - Heart H.E.L.P.
    - Living with Diabetes Program
- Heart H.E.L.P. Program
- Living with Diabetes Program
- Chronic Disease Self-Management Program
- Hope Street Family Center
    - Family Wellness Center
        - CDSMP
        - Healthy Cooking Demonstrations
- Dignity Health Community Grants Program
    - Community Wellness Collaborative
    - Pico Union Healthy Living Program

- CCF Coordinated Care Collaborative
    - Selected FQHCs in Centinela Valley; UMMA, South Central Family Health Center, T.H.E. Clinic
    - CHMC

Access to Health Care

Data Documenting the Need

- In 2011, over a quarter (28.3%) of the CHMC service area population was uninsured and slightly lower when compared to LA County (28.5%) and the Healthy People 2020 goal of 0.0%. SPAs 6 (38.2%) and 4 (35.5%) had higher percentages of its population who were uninsured.
- In 2011, a slightly larger percentage (5.3%) of children in the CHMC service area did not have health insurance when compared to LA County (5.0%) and the service area did not meet the goal of Healthy People 2020 (0.0%). More specifically SPAs 6 (8.6%) and 4 (6.6%) had higher percentages of children without health insurance than the overall CHMC service area (5.3%) and LA County (5.0%).
- In 2011 the percentage of adults who lacked a consistent source of primary care was slightly larger (21.8%) in the CHMC service area when compared to LA County (20.9%). Specifically SPAs 6 (26.5%) and 4 (22.8%) had larger percentages of those who lacked a consistent source of primary care when compared to the overall CHMC service area (21.8%) and LA County (20.9%).
- A slightly larger percentage of adults (32.0%) in the CHMC service area had a difficult time accessing medical care when compared to LA County (31.7%). Specifically, more adults in SPAs 6 (44.6%) and 4 (38.0%) had a difficult time accessing medical care when compared to the overall CHMC service area (32.0%) and LA County (31.7%).

- A smaller percentage (11.1%) of children between the ages of 0 and 17 in the CHMC service area have a difficult time accessing medical care when compared to LA County (12.3%). A larger percentage of children in SPA 6 (17.7%) have a difficult time accessing medical care than those in the overall CHMC service area (11.1%) and LA County (12.3%).

The Action Plan for Improving Access to Health Care

- *Para Su Salud*
- Health Ministry Program
- Charity Care for uninsured/underinsured and low income residents
- Clinical experience for medical professional students
- Dignity Health Community Grant Program
    - 10th Decile Project: Health Care and Supportive Housing for Chronically Homeless Frequent Users

Preventing and/or Managing Other Chronic Health Conditions

Data Documenting the Need

- In 2011, the percentage of those diagnosed with asthma in the CHMC service area was lower (7.5%) than in Los Angeles County (9.0%). SPAs 8 (11.5%) and 6 (9.4%) have higher percentages than the CHMC service area (6.9%) and LA County (9.0%).
- Children are the most severely impacted sub-population.
- Poor housing conditions (i.e., living with cockroaches, mites, asbestos, mold, etc.) and living in apartment buildings where multiple people smoke contribute to asthma exacerbations.
- In 2009, the breast cancer incidence rate per 100,000 persons was slightly lower in LA County (116.0) than CA (122.0) but still five times higher than the Healthy People 2020 goal (≤ 20.6).
- In 2008, the breast cancer mortality rate per 100,000 persons was slightly lower in the CHMC service area (17.1) than in CA (21.2). Breast cancer mortality rates were highest in ZIP codes 90043 (48.0), 90008 (42.3), and 90057 (32.2) in CHMC's secondary service area and ZIP codes 90019 (29.9), 90016 (28.7), and 90018 (28.0) in CHMC's primary service area.
- In 2010, the cervical cancer incidence rate per 100,000 persons was higher in LA County (9.4) than in CA (8.0) and four times higher than the Healthy People 2020 goal (≤ 2.2). The cervical cancer mortality rate per 100,000 persons was lower in LA County (3.0) than in CA (5.3).
- Similarly, the prostate cancer incidence rate per 100,000 persons in LA County was higher (140.3) than CA (134.3) and was six times higher than the Healthy People 2020 goal (≤ 21.2). The prostate cancer mortality rate per 100,000 persons was slightly lower in LA County (15.4) than in CA (15.8).
- In 2011, the percentage of the CHMC service area with arthritis was smaller (16.3%) when compared to LA County (17.4%). The prevalence of arthritis in SPAs 4, 6, and 8 is 16.0%, 15.7%, and 15.7% respectively.

The Action Plan for Preventing and/or Managing Other Chronic Health Conditions

- Health Ministry Program
    - Chronic Disease Self-Management Program (CDSMP)
- Komen Breast Cancer Diagnostic Program
- UniHealth Esperanza Healthy Breathing Project for Children with Asthma
    - CHMC
    - Esperanza Housing Corporation

Births

Data Documenting the Need

- In 2011 there were a total of 18,664 births in the CHMC service area, making up 14.5% of the births in LA County (129,087). Most births in CHMC's primary service area occurred in ZIP codes 90011 (2,269) and 90003 (1,448). Also most births in CHMC's secondary service area occurred in ZIP codes 90001 (1,189) and 90002 (1,146).

- In 2010, most births in CHMC's primary service area were to women between the ages of 20-29 (48.2%) and those between the ages of 30-34 (24.0%). Similarly, most births in CHMC's secondary service area were to women between the ages of 20-29 (49.9%) and those between the ages of 30-34 (22.3%). These trends were similar for LA County.
- By ethnicity, most births in CHMC's primary service area were to Hispanic mothers (70.0%), followed by African American mothers (11.4%). Similarly, in CHMC's secondary service area most births were to Hispanic mothers (78.4%) and African American mothers (8.5%).
- In CHMC's primary service area, 715 babies were born with low birth weight and another 150 with very low birth weight. In ZIP code 90011, a fifth (20.7%), and in ZIP code 90044 17.5% of babies were low birth weight. Another fifth (19.3%) of babies in ZIP code 90044 were born with very low birth weight followed by 16.7% of babies in ZIP code 90003. In CHMC's secondary service area, nearly a fifth (17.7%) of babies in ZIP code 90002 were born with low birth weight. And in ZIP codes 90001 and 90026 13.0% were born very low birth weight.

The Action Plan for Improving Birth Outcomes

- Hope Street Family Center
    - Early Head Start Program
    - Nurse Family Partnership Program
    - Welcome Baby Program
- Los Angeles Best Babies Network
    - CDC Community Transformation Grant and Good Hope Medical Foundation Grant: Healthy Weight Perinatal Care Quality Collaborative
    - Incorporating *Baby Basics* into Prenatal Healthcare Delivery
    - LA County Perinatal and Early Childhood Home Visitation Consortium
    - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County

Health Literacy

Data Documenting the Need

- Overall, over a third (40.8%) of the population in CHMC's service area does not have any formal education – did not graduate from high school or has less than a ninth-grade education – than in LA County (24.2%). In CHMC's primary service area nearly half (46.1%) of the population did not graduate from high school or has less than a ninth grade education while only a third (34.6%) of those in CHMC's secondary service area did not graduate from high school or has less than a ninth grade education. On the other hand, a slightly larger percentage of the population in CHMC's service area graduated from high school or obtained a GED (21.7%) when compared to LA County (20.4%).

The Action Plan for Improving Health Literacy

- Hope Street Family Center
    - Family Literacy Program
    - Early Head Start Program
    - Licensed Childcare Centers
    - Family Childcare Network
    - Hope Street Youth Center
- Los Angeles Best Babies Network
    - Incorporating *Baby Basics* into Prenatal Healthcare Delivery

Injury Prevention

Data Documenting the Need for Gang Prevention

- Pico Union has over 10 gangs that formed in the early 1980s, and the original 18th Street gang that formed as a click of an older Clanton gang 50 years ago.
- Hispanic gangs in Los Angeles are geographically dispersed in the City of Los Angeles:

    - Central [34 gangs]
    - Boyle Heights [21 gangs]
    - Hollywood [9 gangs]
    - North East LA [14 gangs]
    - San Fernando Valley [46 gangs]
    - San Pedro, Wilmington & Harbor [9 gangs]
    - South LA W/S S/S [22 gangs]
    - South LA E/S S/S [43 gangs]
    - West LA [8 gangs]

    There are roughly 70 Bloods sets County wide and they represent about 1/3 of the Black gang population in Los Angeles, being outnumbered significantly by the Crips. The Crips though have serious internal rivalries that nullify their numerical dominance and in some neighborhoods in Los Angeles, the Crip infighting is stronger than Crip vs. Blood rivalries.

    There are approximately 100 Crip gangs in the City of Los Angeles. Within the City, black gangs were most concentrated in South Los Angeles, but other areas impacted by Crip gangs include Mid City, West LA and San Pedro. The South Los Angeles communities include the areas of West Adams, Watts, Jefferson Park, Leimert Park, Hyde Park, Crenshaw, University Park and several other areas.

The Action Plan for Gang Prevention

- Hope Street Family Center
    - Hope Street Youth Center
    - Youth Fitness Program
    - Nurse Family Partnership Program
    - CA Behavioral Health Clinic

Data Documenting the Need for Pedestrian Safety

- Nationwide, pedestrian deaths comprised 14 percent of all traffic fatalities. In L.A., pedestrian deaths accounted for 41 percent of all killed in car crashes
- Hit-and-run crashes appear to be a big part of L.A.'s own pedestrian fatality problem

The Action Plan for Pedestrian Safety

- Health Ministry Program

The Action Plan for Child Car Seat Safety

- Maternity Tours
- Free car seats for all new parents delivering at CHMC
- First 5 LA *Kit for New Parents*

The Action Plan for Child Abuse and Neglect Prevention

- Hope Street Family Center
    - Pico Union Family Preservation Program

    - Early Head Start
    - Nurse Family Partnership Program
    - Welcome Baby Program
    - Licensed Childcare Centers
    - Family Childcare Network
    - CA Behavioral Health Clinic
    - Early Intervention Program
- Los Angeles Best Babies Network
    - LA County Perinatal & Early Childhood Home Visitation Consortium
    - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
- Dignity Health Community Grants Program
    - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities

The Action Plan for Family Violence Prevention

- Health Ministry Program
- Hope Street Family Center
    - Family Preservation Program
    - Early Head Start Program
    - Nurse Family Partnership Program
    - Welcome Baby Program
    - Early Intervention Program
    - CA Behavioral Health Clinic
    - Family Wellness Center
- Los Angeles Best Babies Network
    - LA County Perinatal & Early Childhood Home Visitation Consortium
    - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
- Dignity Health Community Grants Program
    - Community Wellness Collaborative
    - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities

Priority Needs Not Being Addressed and the Reasons

Alzheimer's Disease

- In 2010 the Alzheimer's mortality rate in CHMC service area was three times higher (9.8) than California (2.9)
- Only 8.9% of the residents in CHMC's primary and secondary service areas are seniors.

- **Rationale for not addressing Alzheimer's Disease**
- The average age of the populations in our service area was in the mid-thirties, slightly younger than in Los Angeles County.
- The Alzheimer's Association's CA Southland Chapter has a 54 page Resource Directory for LA County; it can be accessed at http://www.alz.org/socal/documents/helpingyou_Directory.pdf

Allergies

- In 2007 just over a quarter of teens (27.1%) in CHMC overall service area was diagnosed with allergies – slightly higher compared to Los Angeles County (24.9%).
- Larger percentages of teens were diagnosed with allergies in SPAs 6 (45.6%) and 8 (29.5%) when compared to the CHMC overall service area and Los Angeles County.

- **Rationale for not addressing allergies**

- Children's Hospital Los Angeles and Harbor-UCLA Medical Center both have pediatric departments that address allergies.

- Assisting adolescents to establish a medical home will likely enable them to access specialty care for their allergies.

Cancer

- In Los Angeles County, 34,335 residents were diagnosed with cancer in 2010. Most cancer incidents were attributed to breast cancer, colon cancer, and cervical cancer. Since 2007, cancer screening rates continues to improve and cancer incidence rates have remained steady.
- In CHMC's primary and secondary service areas, more than two-thirds of women 40 years and older reported having a mammogram in 2007 or the previous two years. And nearly three-fourths of women 50 years and older reported having a mammogram in 2007 or the previous two years.
- Colon screening rates varied across Los Angeles County, from a low 35.6% in CHMC's SPA 4 to a high 43.3% in CHMC's SPA 6, compared to median 38.1% for Los Angeles County.
- All of CHMC's SPAs reported higher rates of cervical (Pap smear) screenings among women than Los Angeles County.

- **Rationale for not addressing Cancer**
- Cancer screening rates in our service area are fairly good and are likely to improve if we can assist individuals to establish a medical home.
- Many cancers are increased in individuals who are overweight and obese and are likely to decrease if we can help individuals lose weight and/or maintain a healthy weight by eating a healthy diet and being physically active.
- We can help combat smoking by collaborating with the LA County Department of Public Health that provides smoking cessation aides (nicotine patches, gum, etc.) and by continuing to provide Freedom from Smoking Classes through our Health Ministry Program.

HIV/AIDS

- The number of HIV/AIDS cases decreased from 2007 to 2010. However, a disproportionate number of cases were reported among people of color and youths. Hispanic and immigrant groups lacked awareness in HIV prevention and proper use of HIV medication.
- In 2009, SPA 4 had the highest number of adolescents diagnosed with AIDS (74) than other SPAs in Los Angeles County. SPA 6 had the second highest number at 58.
- Although the number of HIV/AIDS cases has decreased, the number of individuals living with HIV has increased as many people living with HIV are living longer as a result of better medication.

- **Rationale for not addressing HIV/AIDS**
- In 1983, physicians at Children's Hospital Los Angeles identified the first case of pediatric AIDS in Southern California. Since then, Children's Hospital Los Angeles has become the largest pediatric AIDS and HIV care provider in the western United States, currently treating more than 300 children, adolescents and their families in the Hemophilia, Adolescent Medicine and Allergy/Immunology programs. The Children's AIDS Center is a multidisciplinary, coordinated and comprehensive program for the treatment of AIDS and HIV infections in youth between the ages of 12 and 23. The program focuses on the multiple and unique needs of HIV-infected children through a family-centered approach.
- Both LAC+USC Medical Center and Harbor-UCLA Medical Center have comprehensive treatment centers for patients with HIV/AIDS including HIV-positive pregnant women and their children and partners.
- West Hollywood has a plethora of resources for individuals with HIV/AIDS including:
    1. AID for AIDS that provides financial support for persons disabled by AIDS to pay for rent, utilities, security deposits, pharmaceuticals, food, and transportation
    2. AIDS Education for the Deaf that provides case management, advocacy, and interpretation services
    3. AIDS Healthcare Foundation that provides medical services
    4. AIDS Project LA that provides case management, HIV prevention & education and treatment advocacy, in-home health care, dental care, insurance/benefits advocacy, mental health and the Necessities of Life program
    5. AIDS Research Alliance that provides information about enrollment in drug trials and protocols
    6. Being Alive that provides peer support, peer counseling and programming, wellness center, acupuncture, chiropractic services, ceramic arts, social events and educational forums for persons living with HIV/AIDS
    7. HIV/LA, an online directory of HIV/AIDS services in LA County

8. Life Group LA, a coalition of people dedicated to the education, empowerment, and emotional support of persons both infected and affected by HIV/AIDS so that they may make informed choices and decisions re their healthcare and personal wellbeing
9. LA Gay and Lesbian Center that provides primary care for persons living with HIV/AIDS
10. PAWS/LA that assists low-income pet owners who are seniors or living with HIV/AIDS or other life-threatening illness to keep and car for companion animals.
11. CHIRP/LA is a program of PAWS that provides free housing referrals and information for emergency, transitional, permanent housing and other supports.
12. Project Angel Food that provides home-delivered meals for people living with HIV/AIDS, cancer, and other life-threatening illnesses
13. Project Chicken Soup that prepares and delivers free, nutritious kosher meals two Sundays each month to people living with HIV/AIDs throughout LA County
14. Project New Hope that provides housing services and vocational training for people living with HIV/AIDS
15. The Saban Free Clinic that provides free confidential rapid HIV counseling, testing and referrals
16. WEHO Life, an AIDS information and prevention program

Sexually Transmitted Diseases

- **Rationale for not addressing STDs**
- By helping people establish a primary medical home, we indirectly improve their access to necessary immunizations and screening for STDs.
- The LA County Department of Public Health's Acute Communicable Disease Control's mission is to reduce the incidence of communicable disease (other than TB, STDs, and AIDS) in Los Angeles County through prevention, surveillance, and outbreak control. People with TB and STDs can access free testing and treatment services at local Public Health Clinics located throughout LA County.

Approval

Each year the California Hospital Medical Center Community Board of Directors review and approve the annual Community Benefit Report and Implementation. This CHNA and Implementation Plan were approved on October 16, 2014.

Appendix A

Focus Group Participants (Identification)

	Group Size	Description of Leadership, Representative, or Member Role	What Group(s) Do They Represent?
1.	6 participants	Health care providers	Health access, children, youth and families, minority populations
2.	6 participants	Promotoras	Minority populations, underserved, dental care, reproductive care, outreach
3.	10 participants	Residents and clients	Latino, minority, and underserved populations
4.	4 participants	Residents and clients	Pilipino, Tagalog-speaking, minority, and underserved populations
5.	6 participants	Residents and clients	Chinese/Mandarin-speaking, minority, and underserved populations
6.	16 participants	Social service providers	Social service providers serving low-income, minority, chronic disease populations
7.	3 participants	Business and education leaders	Serving youth, business development, and land use
8.	16 participants	Residents and clients	Latino, minority, and underserved populations
9.	9 participants	Promotoras	Minority populations, underserved, dental care, reproductive care, outreach
10.	9 participants	Residents and clients	Latino, minority, and underserved populations

Interviews Participants (Identification)

	Name (Last First)	Title	Affiliation	Public Health Knowledge/ Expertise
1.	Alexander, Patricia	Community Liaison Representative	Los Angeles County Department of Public Health	Public health and health services
2.	Alfaro, Verenisa	Clinical Social Worker	LAUSD Parent & Community Engagement	Social services
3.	Anderson, Margot	CEO	The Laurel Foundation	Business management, camp management, serving youth and families with HIV/AIDS
4.	Ballesteros, Al	CEO	JWCH Institute (John Wesley Community Health)	FQHC, primary care, mental health care for homeless and dual-diagnosis, HIV services
5.	Blakeney, Karen	Executive Director	Chinatown Service Center	Serving Asian Pacific immigrant and Latino communities (family resource center, clinics, workforce development)
6.	Boller, Robert	Director of Programs	Project Angel Food	Men, women, and children affects by HIV/AIDS, cancer, and other life-threatening illnesses.
7.	Bryan, Cynthia	Vice President, Human Resources	Didi Hirsh Mental Health Services	Human resource management
8.	Chidester, Cathy	Director of EMS	Los Angeles County ER Services	Public health and health services, emergency response services
9.	Coan, Carl	Executive Director	Eisner Pediatric Child and Family Center	Public health, health care administration, and management
10.	Cox, Debra	Senior Director Foundation Relations	American Heart Association	Health equity, research and funding
11.	Donovan, Kevin	Staff Analyst	Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs	Maternal, child, and adolescent health
12.	Kappos, Barbara	Executive Director	East Los Angeles Women's Center	Domestic violence, sexual assault and HIV
13.	Kim, Chrissy InHwe	Director of Health Program	American Cancer Society	General cancer education, research and resources
14.	Mandel, Susan, Ph.D.	President, CEO	Pacific Clinics	Clinical management and administration
15.	Marin, Maribel	Los Angeles Executive Director	211	Information and referral service serving LA County
16.	Martinez, Margie	CEO	Community Health Alliance of Pasadena	Public health
17.	Mondy, Cristin	Health Officer	Los Angeles County Department of Public Health	Public health and health services
18.	Munoz, Randy	Vice Chair	Latino Diabetes Association	Diabetes, preventive medicine, low-income, undocumented, and un/underinsured
19.	Murphy, Colleen	Director of Community Initiatives	PATH	Homeless population
20.	Nathanson, Niel, DDS	Associate dean	USC School of Dentistry	Low-income dental care services including children, youth and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent. Includes homeless adults
21.	Portillo, Cesar	VP Advancement	LA Child Guidance Center	Low-income health care services including children, youth, and adults. Primary populations are low-income, disadvantaged and/or indigent.

	Name (Last First)	Title	Affiliation	Public Health Knowledge/ Expertise
22.	Rayfield, Beth	Director of Development	Coalition for Humane Immi-grant Rights of Los Angeles	International labor union; organizing, working conditions, and contractual rights
23.	Reyna, Franco	Associate Director	American Diabetes Association	Diabetes, preventive medicine, low-income, undocumented, and un/underinsured
24.	Sayno, Jeanette H.	Bi-lingual Community Outreach Development Worker	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.
25.	Schiffer, Wendy MSPH	Director of Planning and Evaluation	California Children's Medi-cal Services	Public health and health services

Individuals Consulted from Federal, Tribal, Regional, State or Local Health Departments or Other Departments or Agencies with Current Data or Other Relevant Information

	Name (Last, First)	Title	Affiliation	Type of Department
1.	Chidester, Cathy MSN	Director of EMS	Los Angeles County Emergency Medical Services (EMS)	Coordinating emergency services, including fire department, hospitals, and ambulance companies
2.	Donovan, Kevin	Staff Analyst	Los Angeles County Department of Public Health– Maternal, Child and Adolescent Health Programs	Local health department
3.	Murata, Dennis	Deputy Director	Los Angeles County Department of Mental Health	Local health department

Prioritization Participants

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertise	Prioritization Session	Prioritization Survey
1.	Bantug, Shirley B.	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors	Yes	Yes
2.	Boller, Robert	Project Angel Food	Men, women, and children with HIV/AIDS, Cancer, and life-threatening illnesses	No	Yes
3.	Brown, Tony	Heart of Los Angeles (HOLA)	Underserved youth living in high-risk communities	Yes	Yes
4.	Cervantes, Rachel	Alexandria House	Women and children in need of transitional housing and services	Yes	Yes
5.	Coan, Carl	Eisner Pediatric and Family Medical Center	Public health, human genetics, health care administration, and management	Yes	Yes
6.	del Rosario, Jesse	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.	Yes	Yes
7.	Diaz, Carmen Molina	USC School of Dentistry	Low-income dental care services including children, youth, and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent.	No	Yes
8.	Donahue, Carole	SOSMentor	At-risk and underserved youth, health education, and advocacy	No	Yes
9.	Forman, Linda	Alliance for Housing and Healing	Men, women, children and families living with HIV/AIDS	Yes	Yes
10.	Gibb, Gordon	St. Barnabas Senior Services	Ageing population, nutrition and health education	Yes	Yes
11.	Goddard II, Terry	Alliance for Housing and Healing	Men, women, children and families living with HIV/AIDS	No	Yes
12.	Gorman, Dale	Kids Community Dental Clinic	Low-income children and their families in need of oral health care services	No	Yes
13.	Gramajo, Lilian	St. Vincent Medical Center	Public health and health services	No	Yes
14.	Guzman, Laura M.	Braille Institute	Blind and visually impaired both	Yes	Yes
15.	Hoh, John MD	Asian Pacific Health Care Venture, Inc	Health services including general diagnosis and treatment, behavioral health services, walk-in pregnancy testing, testing for HIV/AIDS and STIs, and screenings for bone density, breast, and cervical cancer.	No	Yes

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertise	Prioritization Session	Prioritization Survey
16.	Howland, Susan	Alzheimer's Association	Alzheimer's disease and dementia	Yes	Yes
17.	Joe, Connie Chung	Korean American Family Services (KFAM)	Health and social services for Korean-American families	Yes	Yes
18.	Jordan, Christine	Toberman Neighborhood Center	Social support services and program for at-risk children and families	No	Yes
19.	Krowe, William	Alexandria House	Women and children in need of transitional housing and services	Yes	Yes
20.	Leal, Jesus	St. Vincent Medical Center, Casa de Amigos Community Learning Center	Public health and health services	No	Yes
21.	Lee, Susan	CSH - Corporation for Supportive Housing	Housing support services for at-risk populations	No	Yes
22.	**Martin, Margaret**	**Harmony Project**	**At-risk youth in underserved communities**	**Yes**	**Yes**
23.	Matos, Veronica	Heart of Los Angeles (HOLA)	Underserved youth living in high-risk communities	Yes	Yes
24.	Nathason, Niel	USC School of Dentistry	Low-income dental care services including children, youth, and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent.	No	Yes
25.	Nunez, Trini E.	A Window Between Worlds	Domestic violence support services	Yes	Yes
26.	Pardo, Luis	Worksite Wellness LA	Low-income, underserved families; health education	No	Yes
27.	Portillo, Cesar	Los Angeles Child Guidance Center	Low-income health care services including children, youth, and adults. Primary populations are low-income, disadvantaged and/or indigent.	Yes	Yes
28.	Reyes, Perla S.	Mother Movement	At-risk mothers	Yes	Yes
29.	Rivera, Jennifer	Los Angeles County Department of Public Health - Community Health Service	Public health and health services	Yes	Yes
30.	Sayno, Jeanette H.	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.	Yes	Yes
31.	Striekland, Myungeum	Angelus Plaza Senior Housing	Low-income seniors	Yes	Yes

Appendix B

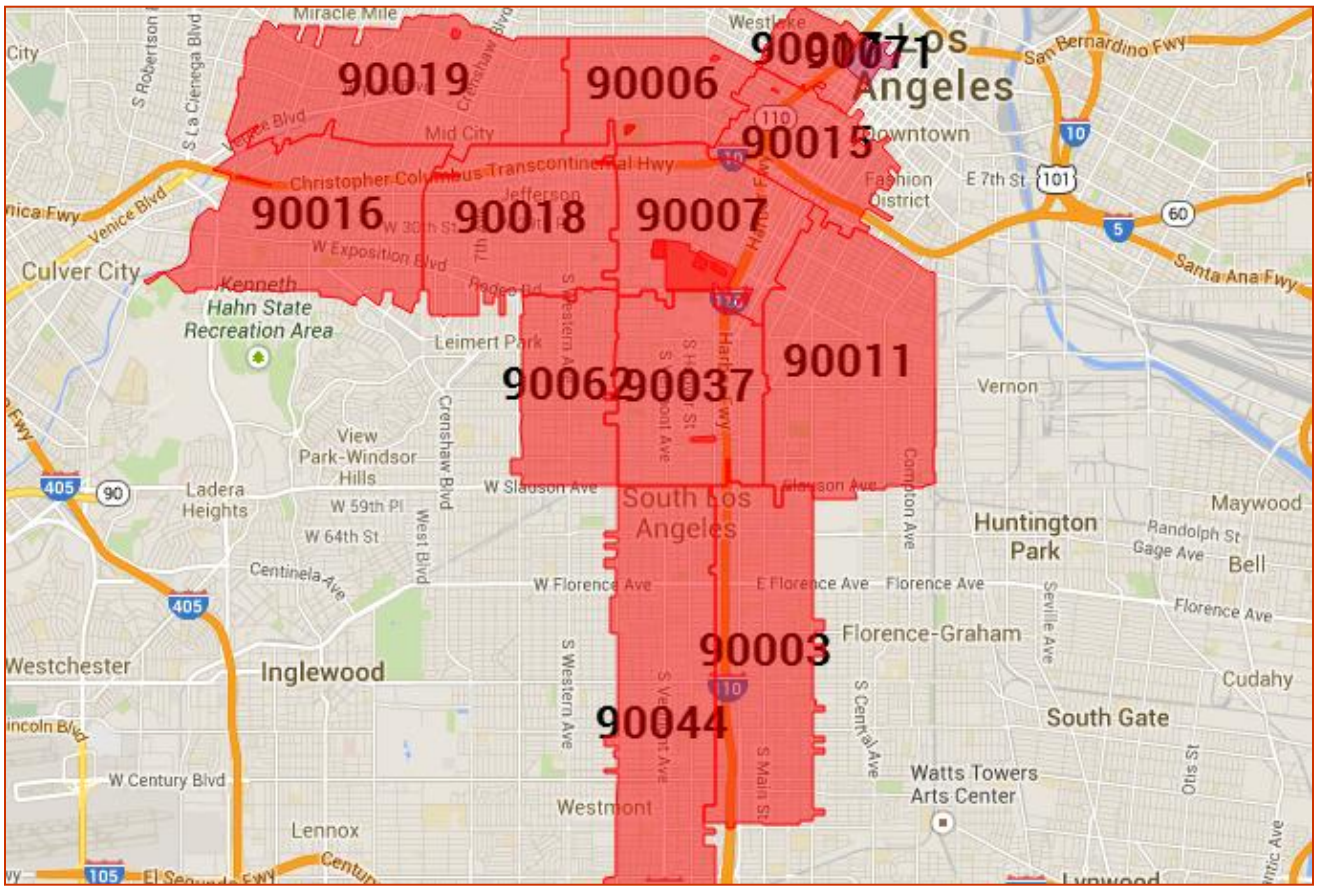
California Hospital Medical Center

Community Need Index

CALIFORNIA HOSPITAL MEDICAL CENTER (PSA)

Lowest Need — **Highest Need**

1 - 1.7 Lowest	1.8 - 2.5 2nd Lowest	2.6 - 3.3 Mid	3.4 - 4.1 2nd Highest	4.2 - 5 Highest

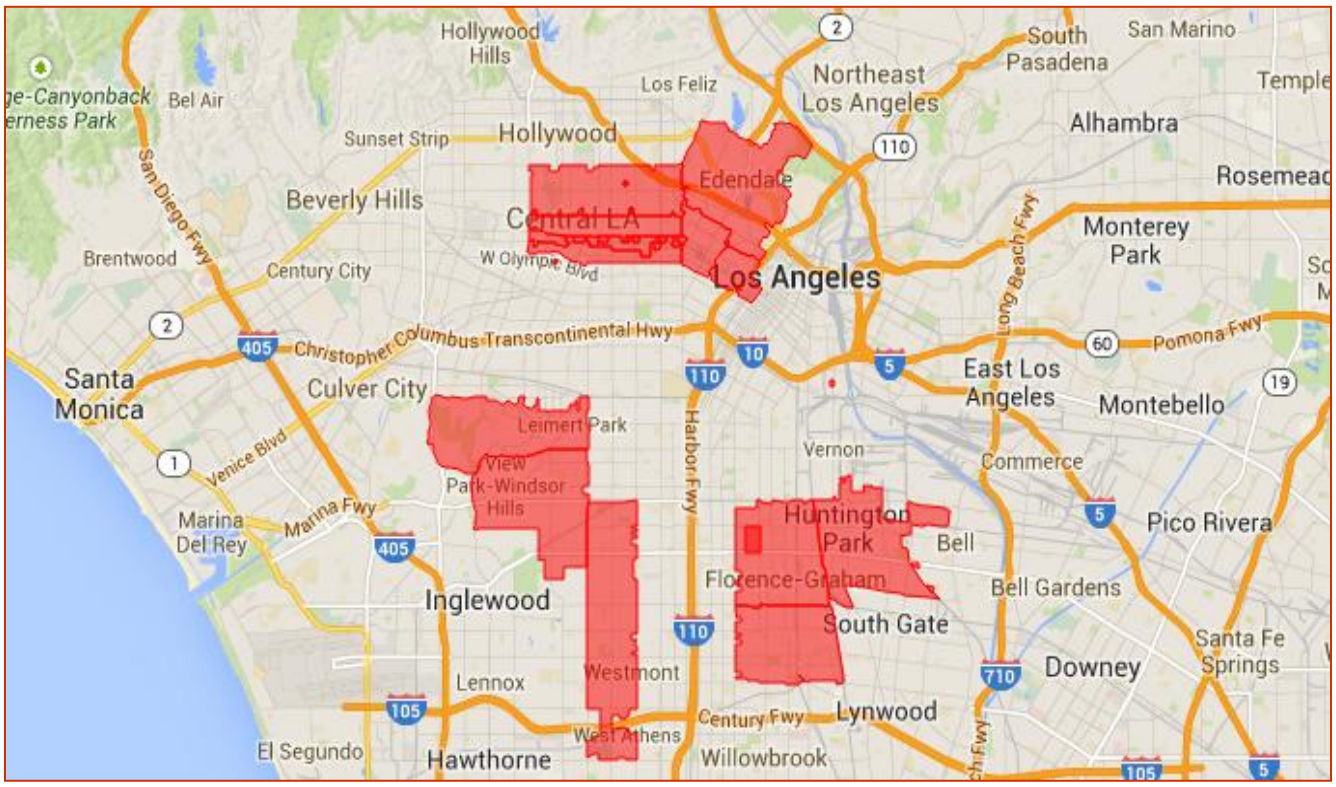


Zip Code	CNI Score	Population	City	County	State
90003	5	65,340	Los Angeles	Los Angeles	California
90006	5	65,883	Los Angeles	Los Angeles	California
90007	5	45,541	Los Angeles	Los Angeles	California
90011	5	105,737	Los Angeles	Los Angeles	California
90015	5	20,059	Los Angeles	Los Angeles	California
90016	4.8	48,122	Los Angeles	Los Angeles	California
90017	5	27,771	Los Angeles	Los Angeles	California
90018	4.8	50,916	Los Angeles	Los Angeles	California
90019	4.8	69,091	Los Angeles	Los Angeles	California
90037	5	58,832	Los Angeles	Los Angeles	California
90044	5	90,371	Los Angeles	Los Angeles	California
90062	5	28,914	Los Angeles	Los Angeles	California
90071	4	5	Los Angeles	Los Angeles	California

CALIFORNIA HOSPITAL MEDICAL CENTER (SSA)

Lowest Need **Highest Need**

1 - 1.7 Lowest	1.8 - 2.5 2nd Lowest	2.6 - 3.3 Mid	3.4 - 4.1 2nd Highest	4.2 - 5 Highest



CNI MEDIAN SCORE: 5

Zip Code	CNI Score	Population	City	County	State
90001	5	56,616	Florence-Graham	Los Angeles	California
90002	5	47,989	Los Angeles	Los Angeles	California
90004	5	70,385	Los Angeles	Los Angeles	California
90005	5	44,897	Los Angeles	Los Angeles	California
90008	4.4	31,365	Los Angeles	Los Angeles	California
90010	4.6	5,018	Los Angeles	Los Angeles	California
90017	5	27,771	Los Angeles	Los Angeles	California
90020	4.8	44,817	Los Angeles	Los Angeles	California
90026	5	74,336	Los Angeles	Los Angeles	California
90043	4.6	44,199	Los Angeles	Los Angeles	California
90047	4.8	47,809	Los Angeles	Los Angeles	California
90057	5	47,533	Los Angeles	Los Angeles	California
90255	4.8	80,282	Huntington Park	Los Angeles	California