2016 Community Health Needs Assessment

Kaiser Foundation Hospital West Los Angeles

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Approved by KFH Board of Directors

September 21, 2016

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Kaiser Permanente Southern California Region
Community Benefit
CHNA Report for KFH-West Los Angeles

AUTHORS

The Center for Nonprofit Management (CNM) was established in 1979 by the corporate and foundation community as the Southern California source for management education, training, and consulting within the nonprofit community. From core management fundamentals to executive coaching, in-depth consulting and analyses, CNM enables individuals to become better leaders of more effective organizations. CNM's research and networking efforts distribute knowledge and thought to nonprofit organizations so they are prepared to face today's known tasks and tomorrow's unknown challenges. CNM seeks to shape how nonprofit leaders approach problems so they can more effectively pursue their missions. CNM helps individuals and their organizations evolve, adapt and thrive.

The CNM team has been involved in and conducted CHNAs for hospitals throughout Los Angeles County and throughout Southern California for over twelve years. The CNM team was involved in the 2004, 2007 and 2010 assessments for the Metro Hospital Collaborative (California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital Los Angeles, Queens Care, and St. Vincent Medical Center). Key members of the CNM team also worked on the 2007 CHNAs for St. Francis Medical Center and the Franciscan Clinics. CNM conducted the 2013 CHNAs for three Kaiser Foundation hospitals and one non-Kaiser Foundation hospital in the greater Los Angeles area, three Glendale hospitals and the 2013 Metro Hospital Collaborative (California Hospital Medical Center, Good Samaritan Hospital and St. Vincent Medical Center) and assisted an additional two Kaiser Foundation Hospitals (Panorama City and San Diego) in community benefit planning based on the needs assessments. More recently, the CNM team conducted the 2014 CHNA for a specialty hospital, Casa Colina Hospital and Centers for Health Care, where the team modified a process to capture the specialized needs of its service area and population.

CNM team members

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

Jessica Vallejo, M.S., JVallejo@cnmsocal.org

Gigi Nang, GNang@cnmsocal.org

Heather Tunis, HTunis@cnmsocal.org

Leslie Robin, MUP, LRobin@cnmsocal.org

Jeniffer DeLara Vallejo, JDVallejo@cnmsocal.org

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

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- Yesenia Monsour, Public Affairs Director
- Celia A. Brugman, Community Benefit Health Manager
- Jennifer P. Bales, Public Affairs Representative
- Jacqueline Rangel, Community Benefit, Kaiser Permanente, Southern California Region
- Lynda Lee, Community Benefit, Kaiser Permanente, Southern California Region
- Patrick Burkhardt, Community Benefit Programs, Kaiser Permanente, Southern California, Region
- Mehrnaz Davoudi, Community Benefit, Kaiser Permanente Southern California Region
- Caroline Rivas, Research Action Design
- Chris Schweidler, Research Action Design

Community Stakeholders

A great many organizations and agencies contributed their time to assist in the KFH-West Los Angeles 2016 community health needs assessment. CNM and KFH-West Los Angeles would like to thank the following community organizations and partners:

- 1736 Family Crisis Center
- Airport Marina Counseling Service
- American Heart Association
- APLA Health & Wellness (AIDS Project Los Angeles)
- Black Women for Wellness
- Brotherhood Crusade
- California Black Women's Health Project
- CASA of Los Angeles (Court Appointed Special Advocates)
- Cedars-Sinai
- Celebrate Life Cancer Ministry
- Centinela Youth Services, Inc.
- Children's Defense Fund—Los Angeles
- Children's Institute, Inc.
- CLARE Foundation
- Climate Resolve
- Community Clinic Association of Los Angeles County
- Community Coalition
- Crenshaw Chamber of Commerce
- Didi Hirsch Mental Health Services
- Emmanuel Turner AME Church
- Esperanza Community Housing
- FAME Church Los Angeles (First African Methodist Episcopal)
- Food & Nutrition Management Services, Inc.

- Holman United Methodist Church
- iDREAM for Racial Health Equity
- Jewish Family Services of Los Angeles
- Junior Blind of America
- JWCH Institute (John Wesley County Hospital)
- Korean American Family Services (KFAM)
- Los Angeles City Department of Recreation and Parks
- L.A. Conservation Corps
- Lennox School Unified District
- Los Angeles County Board of Supervisors
- Los Angeles County Department of Public Health
- Los Angeles County Department of Regional Planning
- Los Angeles County Probation Adult Day Reporting Center
- Los Angeles Unified School District
- Los Angeles Urban League
- MALDEF (Mexican American Legal Defense and Educational Fund)
- March of Dimes
- Meals On Wheels West
- NAMI—Urban Los Angeles (National Alliance on Mental Illness)
- New Mount Calvary Baptist Church
- Ocean Park Community Center (OPCC)
- Para Los Niños
- People Assisting The Homeless (PATH)
- Planned Parenthood of Los Angeles
- Project Angel Food
- Radio Zion
- Saban Community Clinic
- Santa Monica Chamber of Commerce
- Seeds of Hope
- Self-Help And Recovery Exchange (SHARE!)
- South Bay Family Health Care Center
- Southern California Gas Company
- St. John's Well Child & Family Center
- The Achievable Foundation
- The AMAAD Institute (Arming Minorities Against Addiction & Disease)
- The Bakewell Company
- The Brotherhood Crusade
- The L.A. Trust
- The Laurel Foundation
- The Promises Foundation
- UCLA Health System
- University Muslim Medical Association Community Clinic
- Univision Communications Inc.
- Venice Family Clinic
- Watts Gang Taskforce
- Watts Healthcare Corporation (Includes House of Uhuru)
- Weingart YMCA Wellness and Aquatics Center
- West Adams Work Source

- West Angeles Community Development Corporation
- Westchester Family YMCA
- Westside Family Health Center
- WISE & Healthy Aging
- Women of Color Breast Cancer Survivors' Support Project
- Worker Education and Resource Center
- Worksite Wellness L.A.
- YMCA—Urban Council
- YMCA of Metropolitan Los Angeles

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I. EXECUTIVE SUMMARY

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), the Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. KFH-West Los Angeles serves diverse and vibrant communities including the cities of Beverly Hills, Culver City, El Segundo, Inglewood, Malibu, Santa Monica, West Hollywood, the City of Los Angeles including the communities of Baldwin Hills, Cheviot Hills, Crenshaw, Hyde Park, Jefferson Park, La Tijera, Leimert Park, Mar Vista, Mid City, Miracle Mile, Ocean Park, Pacific Palisades, Palms, Playa Del Rey, Rancho Park, Rimpau, University Park, Venice, Vermont Knolls, West Adams, Westchester, Westwood, Wilshire, and unincorporated areas such as, Ladera Heights, Lennox, Marina del Rey, View Park, Westmont and Windsor Hills, among others.

This report documents the community health needs assessment (CHNA) conducted for KFH-West Los Angeles. The results of the CHNA will inform the development of KFH-West Los Angeles's implementation strategies to address health needs found in the community. This executive summary provides a high level snapshot of the CHNA regulations governing hospitals, the list of prioritized health needs found in the report, the methodology used to identify those health needs, and a summary of the overall assessment.

A. Community Health Needs Assessment (CHNA Background)

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals to maintain their tax-exempt status. These provisions were the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

B. Summary of Prioritized Needs

Health outcomes and drivers are interconnected and can negatively or positively affect individual health. Drivers include social and economic factors that often contribute to the ability or inability of certain populations or groups to access the care needed to diagnose, treat, and prevent poor health. Therefore, it is important that drivers be taken into consideration when health strategies and programs are developed to address health needs.

The following list of prioritized health needs resulted from the analysis of primary and secondary data, observations of disparities, and review of the 2013 KFH-West Los Angeles CHNA findings.

Prioritized Health Needs

	Health Needs	
1	Mental Health	Outcome
2	Diabetes	Outcome
3	Obesity/Overweight	Outcome
4	Access to Care	Driver
5	Homelessness and Housing	Driver
6	Preventative Health Care	Driver
7	Economic Security	Driver
8	Violence and Injury Prevention	Driver
9	Cardiovascular Disease/Heart Disease	Outcome
10	Access to Healthy Foods	Driver
11	Healthy Behaviors	Driver
12	Alcohol Abuse, Substance Abuse and Tobacco Use	Driver
13	Hypertension	Outcome
14	Oral Health	Outcome
15	Legal Status	Driver
16	Physical Environment	Driver
17	Cancer (includes breast, colorectal, lung, and prostate)	Outcome
18	Cultural and Linguistic Barriers	Driver
19	Asthma	Outcome
20	Cholesterol	Outcome
21	Transportation	Driver
22	Sexually Transmitted Disease	Outcome
23	Dental Care Access	Driver
24	Disease Management	Driver
25	Respiratory Disease (includes COPD)	Outcome
26	Maternal and Infant Health	Outcome
27	HIV/AIDS	Outcome
28	Alzheimer's Disease	Outcome
29	Communicable Diseases (including Hepatitis A and B)	Outcome

C. Summary of Needs Assessment Methodology and Process

For the purposes of the CHNA, Kaiser Permanente defines a “health need” as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

Identification

The 2016 CHNA needs assessment methodology and process involved a mixed-method approach that included the collection of both secondary data and primary data. Over 400 secondary data indicators on a variety of health, social, economic, and environmental topics were collected by ZIP Code, Service Planning Area (SPA)[1], county, and state levels (as available). The consultant team queried data on indicators through the Kaiser Permanente CHNA Data Platform and obtained the data rates for the

[1] A Service Planning Area, or SPA, is a specific geographic region within Los Angeles County. SPAs were created to help divide Los Angeles County into distinct areas that allow the Los Angeles County Department of Public Health develop and provide more relevant and targeted public health and clinical services to treat specific health needs of residents in those areas. (Retrieved from http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm).

KFH-West Los Angeles Medical Center Area. The Kaiser Permanente common indicator data is calculated to obtain unique service area rates. In most cases the service area values represent the aggregate of data of smaller geographic units (e.g., ZIP Codes, census tracts) which fall within the service area boundary. When one or more geographic units are not entirely encompassed by a service area, the measure is aggregated proportionally. The options for weighing "small area estimations" are based on total area, total population, and demographic group population. The specific methodology for how service area rates are calculated for each indicator can be found on the Kaiser Permanente CHNA Data Platform. Additional indicators were collected from other sources to supplement the CHNA Data Platform. Each KFH facility, individually or with a collaborative, also collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most affected the health of the community. The CHNA process also included an identification of existing community assets and resources to address the identified health needs.

Primary data were collected through five focus groups and 29 phone interviews with over 100 stakeholders, including community representatives, health experts, local government representatives, local business owners, and social and health service providers. These informants assisted in identifying the most severe health outcomes and associated drivers and health disparities, as well as community assets and resources available in the KFH-West Los Angeles service area to address the identified health outcomes and drivers. Primary data were input into a Microsoft Excel spreadsheet to assist in organizing the data, coding and identifying major themes, and collecting quotes.

To narrow those lists, a health outcome and driver had to meet two requirements: it needed to be mentioned in the primary data collection more than once *and* a secondary data indicator associated with the health outcome and/or driver needed to perform poorly against a designated benchmark (county average, state average, or Healthy People 2020 goal).

Prioritization

Prioritization of the identified needs is essential to the community benefit planning process. CNM engaged with a total of 68 community stakeholders through two community forums held in December 2015 and January 2016 to assist with the prioritization of the identified health outcomes and drivers. During the community forum, attendees reviewed a summary of the secondary data indicators and responses from stakeholders and participated in a guided group activity to share insights and perspectives with their colleagues. At the end of the community forum, attendees were asked to complete a survey in which they prioritized each health outcome and health driver according to five criteria:

- Magnitude: how many community members were affected
- Severity: how much community members were affected
- Change over time: whether an issue has improved or gotten worse over time
- Resources: amount of resources available in the community to address an issue
- Disparities: the level of impact on a specific vulnerable population group

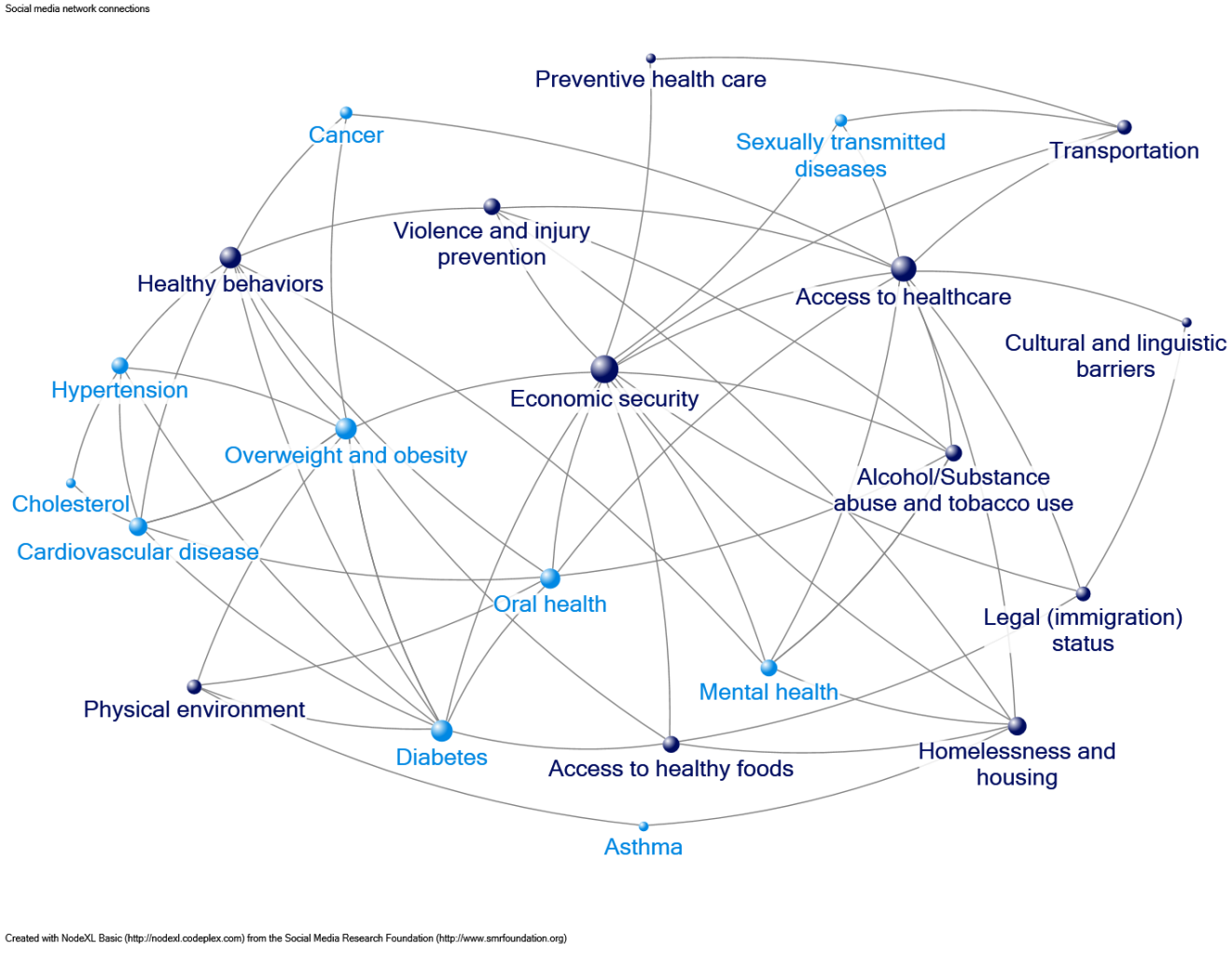
In addition, attendees voted using ten sticker dots (five for health outcomes and five for drivers) to indicate which they believe most severely affect the community surrounding the KFH-West Los Angeles service area. Those unable to attend a community forum could participate in the process by completing an online version of the prioritization survey disseminated at the community forms. A link to the online survey and supplemental materials shared at the forums were emailed to stakeholders; a total of 16 people completed the online survey. Overall composite scores were calculated, for both in-person and online surveys, by averaging the responses to the criteria questions. The resulting scores were put into a matrix through which other factors (or considerations) were taken into account including observed population disparities by ethnicity, age, gender, and geography through secondary or primary data;

noted trends from a review of the 2013 KFH-West Los Angeles CHNA (worsening or improving); and their order in priority ranking. The matrix served as a way to centralize all composite scores and considerations, further demonstrating the severity of each health outcome and driver.

Summary

The overall CHNA process was rigorous, taking into consideration over 400 secondary health, social, and economic data indicators and input from over 100 community stakeholders through in-person meetings and an online survey. All the data and information collected were analyzed and the result of the analysis was a prioritized list of identified health needs. The information collected through the CHNA process will be used by KFH-West Los Angeles to help inform the development of their 2016 Implementation Strategy Plan for the next three years.

Community assets and resources were identified through focus groups and interviews in the identification phase of the CHNA process. Stakeholders were asked to share, by health need, community organizations, programs, and other resources they knew of and/or had experience with related to the specific health need. To view these community assets and resources please refer to Appendix D—Health Need Profiles.



The KFH-West Los Angeles CHNA process yielded informative data that will provide useful guidance for the development of their 2016 Implementation Strategy Plan. The data analysis led to an understanding, and a visual representation, of the interconnectedness of the health outcomes and

drivers identified during the process. “Connecting the dots” between the outcomes and drivers revealed that all of the service area’s priority health needs are connected to each other through at least one relationship—there are no isolated outcomes or drivers in this system. The figure illustrates these relationships among 19 of the top priority health outcomes (light blue) and health drivers (dark blue) identified during the process.

The health outcomes that are connected to the most drivers and other outcomes include overweight and obesity, diabetes, and mental health. Though they are in slightly different order, these are also the top three outcome priorities identified in the 2016 and 2013 CHNA processes. While overweight and obesity numbers have increased since the 2013 report, diabetes and mental illness-related data show decreased rates of both.

The health drivers that are related to the most outcomes and other drivers include economic security, access to health care and healthy behaviors. The importance of economic security as a driver is also apparent in the demographic data, which show relatively large increases in poverty, unemployment and homelessness within the SPAs for the KH-West Los Angeles service area since the 2013 report. On the positive side, there are fewer uninsured and a higher percentage of those with a usual source of care among the same population.

There are indications of increased assets and resources within the service area, though there is perhaps a need to increase awareness of them. For example, there were several health needs that had several related assets within the community, but focus group members and interviewees were not able to identify any of them. With continued collaboration and effort among resource providers and community members, the KHF West Los Angeles service area is positioned to see improvements—new and increased—in the health priorities identified within the communities.

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II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

a. Prepaid health plans, which spread the cost to make it more affordable
b. A focus on preventing illness and disease as much as on caring for the sick
c. An organized coordinated system that puts as many services as possible under one roof—all connected by electronic medical records

Kaiser Permanente is an integrated health care delivery system composed of Kaiser Foundation Hospitals (KFH), the Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grant making to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health needs in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health needs such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sus-

tainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the CHNA Report

i. To advance community health

Community Health Needs Assessments (CHNAs) have been integral to learning about the health of the communities Kaiser Permanente serves. We are committed to building on CHNAs and relationships in the community to deepen our knowledge of the community-specific needs, resources, and leaders in the community. This deeper knowledge enables us to develop a new approach by engaging differently and addressing specific community needs in collective action with the community. This new approach will leverage our existing and new community partnerships and harness the power of all Kaiser Permanente assets—economics, relationships, and expertise—to positively affect community health.

ii. To implement ACA Regulations

The Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010, included new requirements for nonprofit hospitals to maintain their tax-exempt status. These provisions were the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at www.kp.org/chna.

D. Kaiser Permanente Approach to CHNA

Kaiser Permanente has conducted CHNAs for many years, often as part of longstanding community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency, and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and—whenever possible—collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, our intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform—and in some cases other local sources—each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most affected the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in its community. Once all the community health needs were identified, they were all prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH-West Los Angeles will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

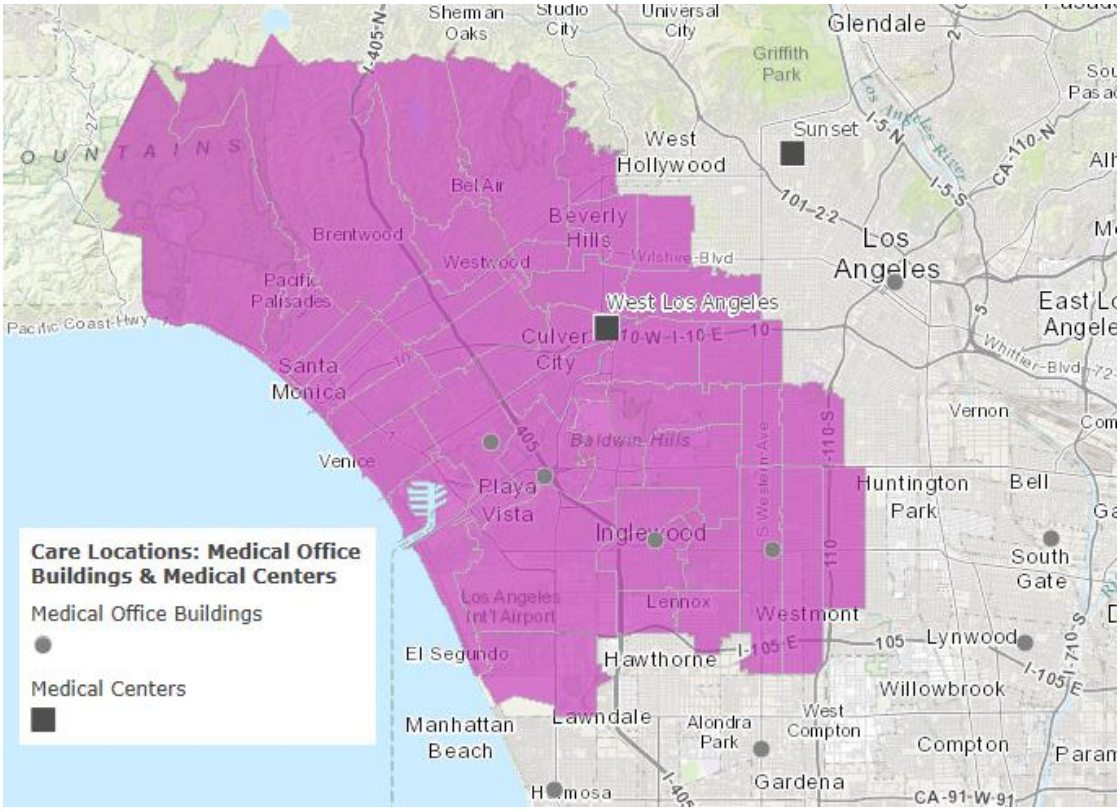
III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

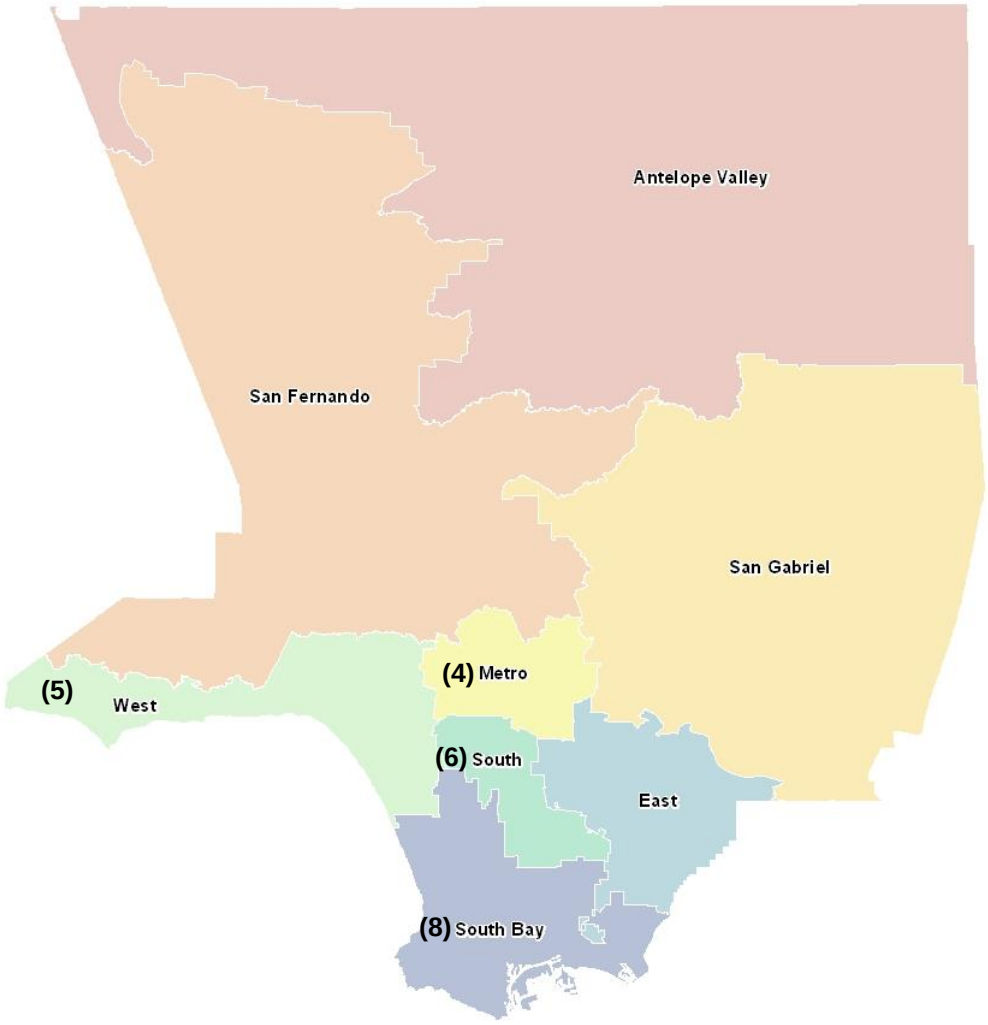
Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Maps and Description of Community Served

i. Maps



Map of the KFH-West Los Angeles service area by ZIP Code



Map of Service Planning Areas (SPAs) in Los Angeles County

The KFH-West Los Angeles service area encompasses large areas of SPAs 5 and 6 (West and South), and to a lesser extent SPAs 4 and 8 (Metro and South Bay).

ii. Geographic description of community served (towns, county, and/or ZIP Codes)

The KFH-West Los Angeles service area is shown in the table below by city/community, ZIP code, and Service Planning Area (SPA)[2]. The KFH-West Los Angeles service area encompasses all or portions of 44 communities/cities, 46 standard post office ZIP Codes, and four SPAs. The service area is situated in western Los Angeles County and includes distinct physical characteristics such as beaches and coastline, the Santa Monica Mountains, and numerous urban areas.

[2] A Service Planning Area, or SPA, is a specific geographic region within Los Angeles County. SPAs were created to help divide Los Angeles County into distinct areas that allow the Los Angeles County Department of Public Health to develop and provide more relevant and targeted public health and clinical services to treat specific health needs of residents in those areas. (Retrieved from http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm.)

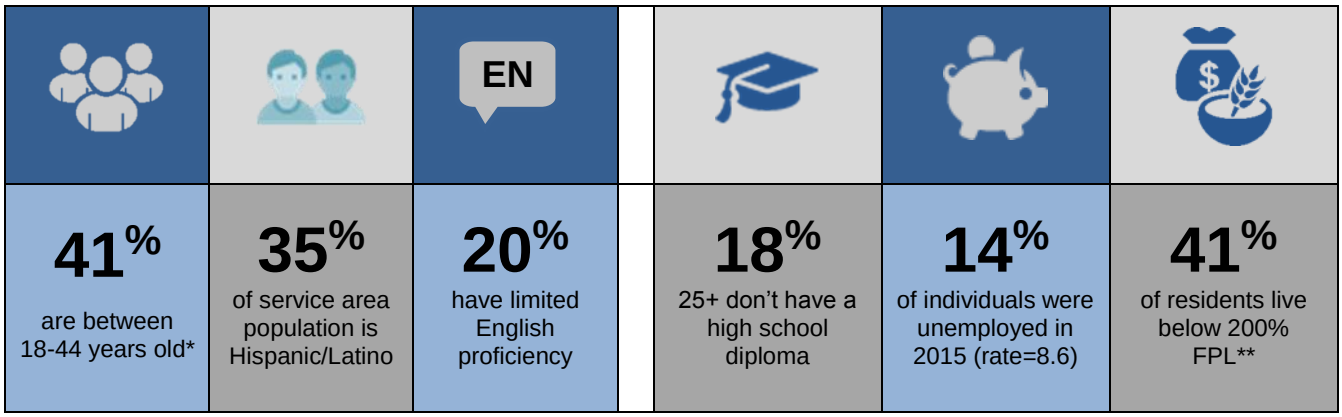
City/Community	ZIP Code	Service Planning Area (SPA)
Arlington Heights	90019	4–Metro Los Angeles
Baldwin Hills, Crenshaw, Leimert Park	90008	6–South
Bel Air Estates, Beverly Glen, Brentwood	90049, 90077	5–West
Beverly Hills	90210, 90211, 90212	5–West
Century City	90067	5–West
Cheviot Hills, Rancho Park	90064	5–West
Culver City	90066, 90230, 90232	
El Segundo	90245	8–South Bay
Fairfax/Farmers Market, Miracle Mile, Melrose, Wilshire–La Brea, Park La Brea	90036	4–Metro Los Angeles
Hyde Park, View Park, Windsor Hills	90043	6–South
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay
Jefferson Park, Leimert Park	90018	6–South
Ladera Heights	90056	5–West
Los Angeles International Airport, Westchester	90045	5–West
Marina Peninsula, Marina del Rey	90292	5–West
Pacific Palisades, Pacific Highlands	90272	5–West
Palms	90034	5–West
Playa Del Rey	90293	5–West
Playa Vista	90094	5–West
Santa Monica	90402, 90403, 90404	5–West
Santa Monica—Downtown	90401	5–West
Santa Monica—Ocean Park	90405	5–West
Sawtelle, West Los Angeles	90025	5–West
South Los Angeles, Broadway Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay
Venice	90291	5–West
West Adams	90016	6–South
West Fairfax	90035	5–West
West Hollywood, West Beverly	90069, 90048	4–Metro Los Angeles
Westwood	90024	5–West

iii. Demographic profile of community served

A description of the community served by KFH-West Los Angeles is provided in the following narrative, tables, charts, and images. Given the available data sources, KFH-West Los Angeles information is presented as representing the entirety of the service area; the individual cities/places that make up the service area; or Service Planning Areas 4, 5, 6 and 8, portions of which are served by KFH-West Los Angeles. Information is detailed in the current and following sections: Community Health Index, Community Health Significant Morbidity and Mortality (Health Outcomes), and Significant Health Drivers.

Overall, the population in the KFH-West Los Angeles service area has increased since the 2013 KFH-West Los Angeles CHNA and is projected to continue to increase. There are many negative trends within the demographic numbers since the previous report, but there have been some positive changes in some areas. In education, more of the population has earned a high school diploma (or equivalent),

and nearly half (47.2%) have earned an Associate's degree or higher (16.7% of whom have earned a graduate degree). There is, however a negative trend in poverty rates, unemployment, and homelessness in the service area. The following graphic shows a quick description of the KFH- West Los Angeles service area population.



*Reflects largest age group of the service area population

*For 2015, the Federal Poverty Level (FPL) for one person was $11,770 and $24,250 for a family of four

The following subsections provide more detail on pertinent demographic measures and changes where data were available.

Population

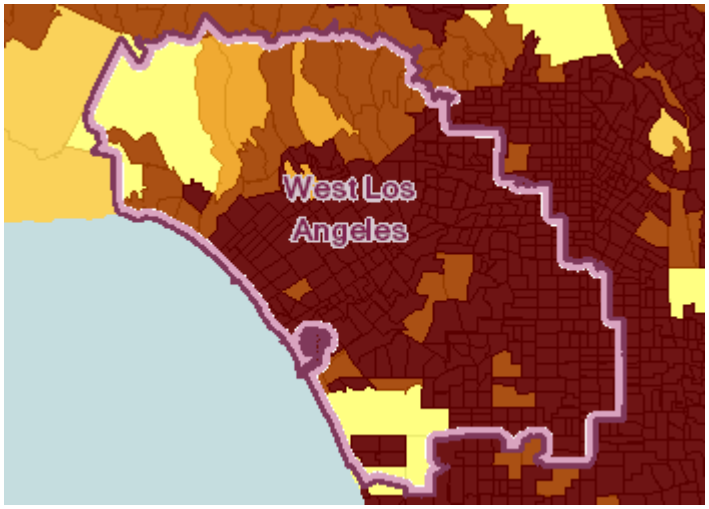
The KFH-West Los Angeles service area has a total population of 1,332,454, representing 13.1% of the total population of Los Angeles County (10,136,509) and 3.4% of the total population in California (38,822,536). The KFH-West Los Angeles service area total population is expected to increase by 3.7% by 2020, similar to the expected increase in the total population in Los Angeles County (3.6%) though slightly lower than the expected increase of 4.2% statewide.

Total Population, 2015

Service Area	2015 Total Population	2020 Projected Population	Percent Change
KFH-West Los Angeles service area	1,332,454	1,383,639	3.7%
Los Angeles County	10,136,509	10,510,281	3.6%
California	38,822,536	40,505,730	4.2%

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Population density per square mile indicates that most of the population within the KFH-West Los Angeles service area resides in its central and southernmost area.



Population, Density (Persons per Square Mile) by Tract, ACS 2010–14

- Over 5,000
- 1,001–5,000
- 501–1,000
- 51–500
- Under 51
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract.

Gender

Since the 2013 report, the ration of females to males has remained steady, and nearly divided in half by females (51.6%) and males (48.4%). The same is true in Los Angeles County (50.7% and 49.3%, respectively) and California (51.3% and 49.7%, respectively).

Gender, 2015

Service Area	Male		Female	
	Number	Percent	Number	Percent
KFH-West Los Angeles service area	644,543	48.4%	687,911	51.6%
Los Angeles County	5,001,632	49.3%	5,134,877	50.7%
California	19,297,189	49.7%	19,525,347	51.3%

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Age

The age distributions in the KFH- West Los Angeles service area remained relatively even with the 2013 report's age distributions and parallel those of Los Angeles County and California. The only age group to change by more than one percentage point was between 65 and 74 years old (up to 7.3% from 6.2%). Youth ages 0 to17 comprise 21.0% of the KFH-West Los Angeles service area, adults ages 18 to 64 comprise 66.1%, and senior adults (65 years and older) make up 12.8% of the population. Similar percentages are noted in Los Angeles County (23.4%, 64.5%, and 12.2%, respectively) and California (23.9%, 63.2%, and 12.9%, respectively).

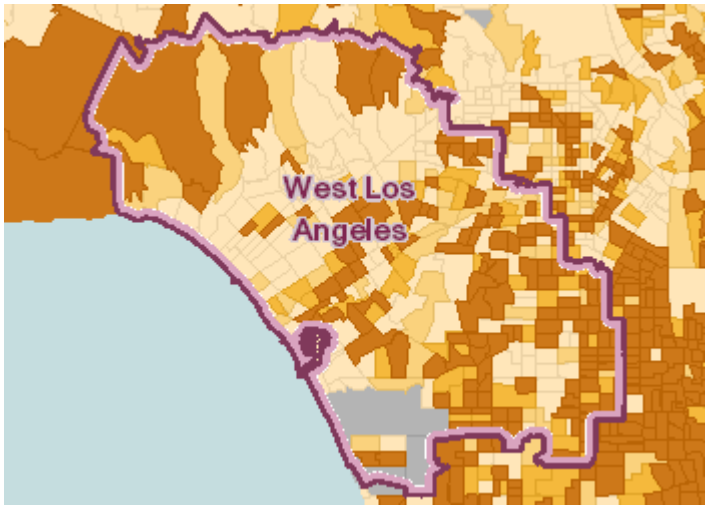
Population by Age, 2015

Age Groups	KFH-West Los Angeles Service Area		Los Angeles County		California	
	Number	Percent	Number	Percent	Number	Percent
0–4 years	78,463	5.9%	646,631	6.4%	2,539,809	6.5%
5–9 years	79,316	6.0%	644,054	6.4%	2,557,240	6.6%
10–14 years	74,224	5.6%	645,536	6.4%	2,560,955	6.6%

Age Groups	KFH-West Los Angeles Service Area		Los Angeles County		California	
	Number	Percent	Number	Percent	Number	Percent
15–17 years	47,036	3.5%	423,205	4.2%	1,628,601	4.2%
18–20 years	56,358	4.2%	434,374	4.3%	1,668,798	4.3%
21–24 years	74,881	5.6%	600,348	5.9%	2,280,145	5.9%
25–34 years	221,858	16.7%	1,528,334	15.1%	5,562,298	14.3%
35–44 years	196,851	14.8%	1,425,378	14.1%	5,194,225	13.4%
45–54 years	180,101	13.5%	1,391,740	13.7%	5,242,968	13.5%
55–64 years	149,969	11.3%	1,158,885	11.4%	4,588,352	11.8%
65–74 years	97,182	7.3%	704,979	7.0%	2,875,073	7.4%
75–84 years	50,532	3.8%	365,908	3.6%	1,458,980	3.8%
85 years and older	25,683	1.9%	167,137	1.6%	665,092	1.7%
Total	**1,332,454**	**100.0%**	**10,136,509**	**100.0%**	**38,822,536**	**100.0%**

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

When the service area is examined by community, the southernmost area of the KFH-West Los Angeles service area has a greater concentration of infants and young children ages 0 to 4 years. The areas with the greatest percentages (over 7.0%) of infants and young children include (but are not limited to) the communities of Culver City, Crenshaw, Inglewood, Leimert Park, Lennox, Playa Vista, Santa Monica, South Los Angeles, West Athens, and Westmont.

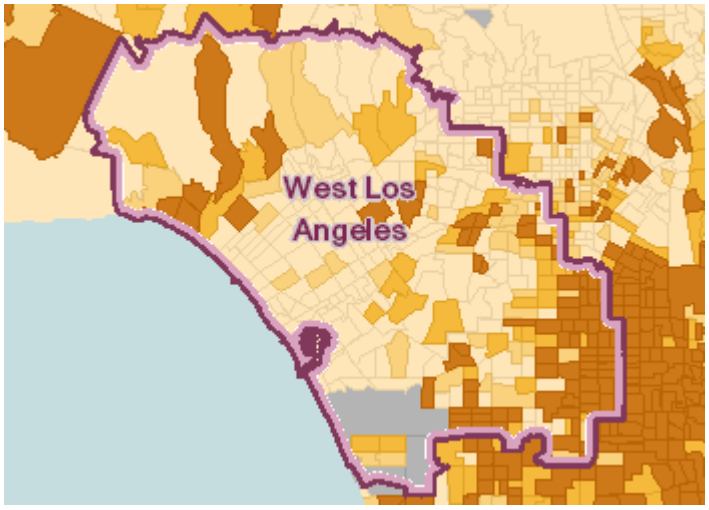


Population Age 0–4, Percent by Tract

- Over 7.0%
- 6.1–7.0%
- 5.1–6.0%
- Under 5.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract.

In addition, a large concentration of youth ages 5 to 17 resides in the southeast area of the KFH-West Los Angeles service area. The areas with the greatest percentages (over 19.0%) of youth include (but are not limited to) the communities of Inglewood, Lennox, South Los Angeles, West Athens, and Westmont, plus pockets in the northwest section of the service area.

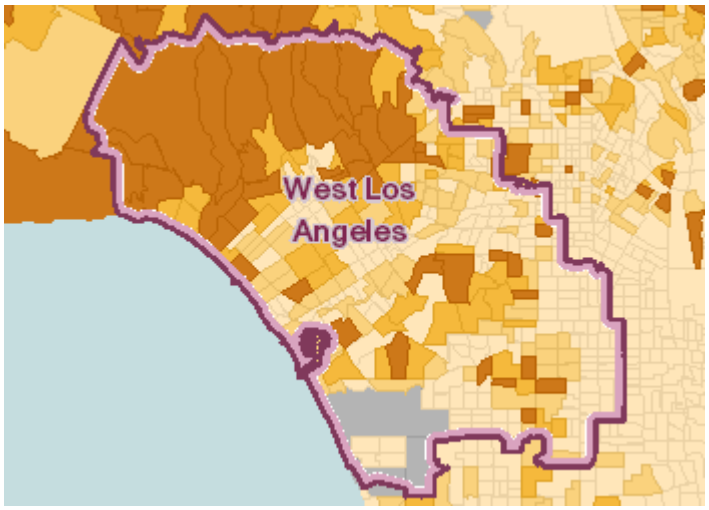


Population Age 5–17, Percent by Tract

- Over 19.0%
- 17.1–19.0%
- 15.1–17.0%
- Under 15.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract.

A large concentration of adults age 65 and older reside in the northernmost area of the KFH-West Los Angeles service area, with some areas of concentration in the southernmost area as well. The areas with the largest percentages (over 20.0%) of older adults include (but are not limited to) the communities of Bel Air, Beverly Hills, Culver City, Inglewood, Santa Monica, Westmont, and Westwood.



Population Age 65 , Percent by Tract

- Over 20.0%
- 16.1–20.0%
- 12.1–16.0%
- Under 12.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract.

Median Age

The average age in the KFH-West Los Angeles service area is 38.2 years—slightly higher than the Los Angeles County average of 37.3 year and state average of 37.5 years. The median age in the service area is also slightly higher (36.7 years) than in the county (36.0 years) and state (36.2 years).

Median Age, 2015

Age	KFH-West Los Angeles Service Area	Los Angeles County	California
Average age	38.2 years	37.3 years	37.5 years
Median age	36.7 years	36.0 years	36.2 years

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Race and Ethnicity

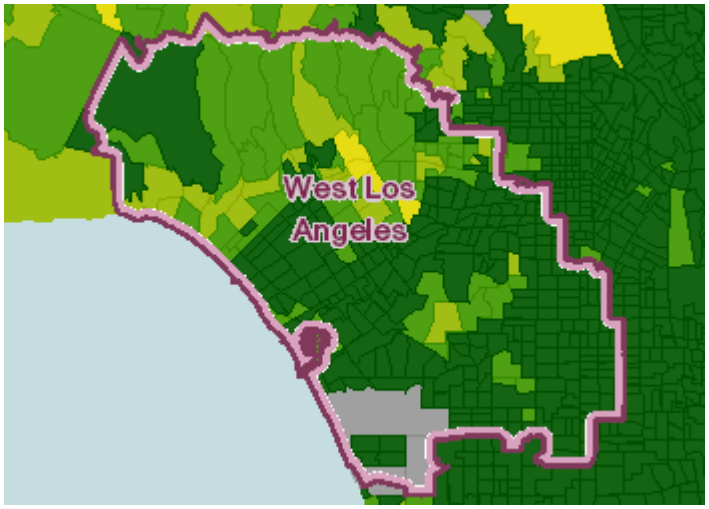
The entire KFH-West Los Angeles service area is quite diverse, with the largest ethnic groups being Hispanics/Latinos (34.7%), Caucasians/Whites (33.9%), and African-American/Blacks (19.8%). These numbers parallel Los Angeles County's in terms of Hispanics/Latinos and Caucasians/Whites (48.8% and 26.4%, respectively) and California's as well (39.2% and 38.0%, respectively). The third largest ethnic group in the KFH-West Los Angeles service area is African-American/Blacks (19.8%), however, while the third largest ethnic group in Los Angeles County and California is Asians/Pacific Islanders (14.3% and 13.6%, respectively).

Race and Ethnicity, 2015

Race/Ethnicity Groups	KFH-West Los Angeles Service Area		Los Angeles County		California	
	Number	Percent	Number	Percent	Number	Percent
African-American/Black	263,292	19.8%	812,168	8.0%	2,185,751	5.6%
American Indian/Alaskan Native	2,184	0.2%	19,188	0.2%	163,329	0.4%
Asian/Pacific Islander	109,166	8.2%	1,444,878	14.3%	5,294,790	13.6%
Caucasian/White	451,148	33.9%	2,677,924	26.4%	14,766,513	38.0%
Hispanic/Latino	462,726	34.7%	4,941,730	48.8%	15,236,977	39.2%
Other	5,224	0.4%	25,676	0.3%	87,137	0.2%
Two or more races	38,714	2.9%	214,945	2.1%	1,088,039	2.8%
Total	**1,332,454**	**100.0%**	**10,136,509**	**100.0%**	**38,822,536**	**100.0%**

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

The largest percentage (over 10.0%) of the Hispanic/Latino population lives in the southernmost part of the service area, including (but not limited to) the communities of Culver City, Crenshaw, Inglewood, Lennox, Santa Monica, South Los Angeles, Westmont, and West Athens.



Population, Hispanic or Latino, Percent by Tract, ACS 2010–14

- Over 10.0%
- 5.1–10.0%
- 2.1–5.0%
- Under 2.1%
- No Hispanic Population Reported
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract.

Language

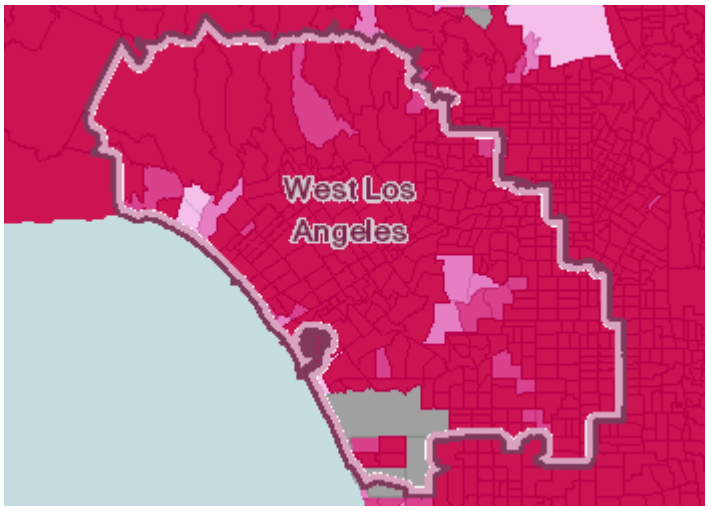
Changes in the primary language spoken in the home reflect the racial/ethnic changes seen in the service area. Just over half of the population 5 years and older in the KFH-West Los Angeles service area speak primarily English at home (54.9%), which is down 3.2%. Spanish, on the other hand is up 3.6% to 30.8% of households. The rest of the languages held steady since the last report.

Language Primarily Spoken in the Home, 2015

Language	KFH-West Los Angeles Service Area		Los Angeles County		California	
	Number	Percent	Number	Percent	Number	Percent
English	688,532	54.9%	4,067,879	42.9%	20,289,930	55.9%
Asian	65,690	5.2%	1,032,342	10.9%	3,524,513	9.7%
Indo-European	89,963	7.2%	529,352	5.6%	1,633,563	4.5%
Spanish	386,327	30.8%	3,754,192	39.6%	10,494,386	28.9%
Other	23,479	1.9%	106,113	1.1%	340,335	0.9%
Total	**1,253,991**	**100.0%**	**9,489,878**	**100.0%**	**36,282,727**	**100.0%**

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Given that a large percentage of the population over the age of 5 years in the KFH-West Los Angeles service area primarily spoke a language other than English at home, it is important to understand where in the service area this is most often the case. Spanish was the most common language spoken at home other than English, and the map below shows that most communities in the service area have limited English proficiency (over 4.0%). Communities where 30% or more of the area had limited English proficiency also included Arlington Heights, Inglewood, Jefferson Park, and South Los Angeles among others.



Population with Limited English Proficiency, Percent by Tract, ACS 2010–14

- Over 4.0%
- 2.1–4.0%
- 1.1–2.0%
- Under 1.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract.

Household Income

The largest percentages of households in the KFH-West Los Angeles service area had incomes of either $15,000 and below (15.5%) or between $50,000 to $74,999 (15.5%). In both Los Angeles County and California (16.9%), the largest percentage of household incomes was between $50,000 and

$74,999. The third largest percentage (11.9%) in the KFH-West Los Angeles service area was household incomes between $35,000 and $49,999, but the third largest percentage of households in Los Angeles County and California (11.5% and 12.0%, respectively) reported much higher household incomes of $75,999 to $99,999. Comparisons with the previous CHNA report are not presented because those data were from 2009, which is too long ago to provide any meaningful insights for 2015 numbers. A look at poverty numbers, which follow, will provide more insight.

Household Income, 2015

Income Level	KFH-West Los Angeles Service Area		Los Angeles County		California	
	Number	Percent	Number	Percent	Number	Percent
$15,000 and below	81,150	15.5%	440,017	13.1%	1,493,600	11.4%
$15,000–$24,999	54,182	10.4%	368,258	11.0%	1,304,534	10.0%
$25,000–$34,999	47,577	9.1%	324,780	9.7%	1,201,323	9.2%
$35,000–$49,999	61,998	11.9%	439,461	13.1%	1,642,087	12.5%
$50,000–$74,999	80,770	15.5%	564,594	16.9%	2,214,004	16.9%
$75,000–$99,999	54,738	10.5%	384,054	11.5%	1,570,986	12.0%
$100,000–$124,999	40,478	7.7%	272,585	8.1%	1,154,086	8.8%
$125,000–$149,999	24,523	4.7%	166,270	5.0%	745,959	5.7%
$150,000–$199,999	29,108	5.6%	181,675	5.4%	840,512	6.4%
$200,000–$249,999	12,247	2.3%	65,904	2.0%	305,213	2.3%
$250,000–$499,999	23,146	4.4%	100,559	3.0%	433,380	3.3%
$500,000 and above	12,512	2.4%	40,774	1.2%	191,865	1.5%
Total	**522,429**	**100.0%**	**3,348,931**	**100.0%**	**13,097,549**	**100.0%**

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Poverty

Understanding the extent to which the KFH-West Los Angeles service area is affected by poverty is important. Poverty greatly influences overall health and creates barriers to everyday necessities including healthy and affordable foods, health care, and other basic needs.

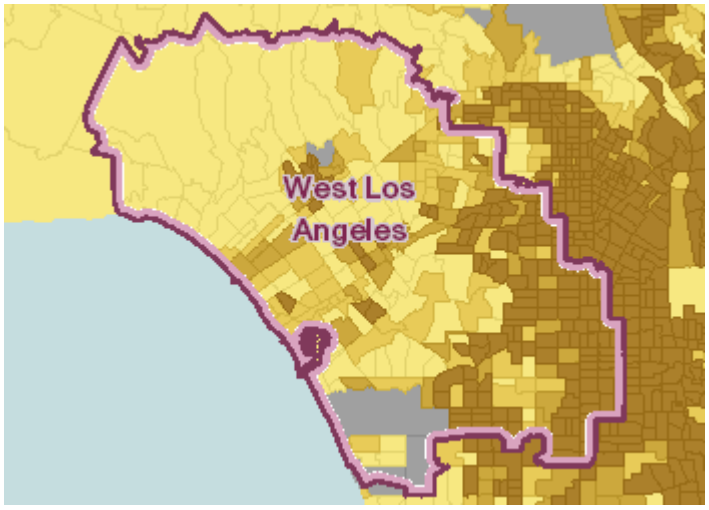
Among the residents in the KFH-West Los Angeles service area, one in five (20.3%) live in households that are at or below 100% of the Federal Poverty Level (FPL)—more than in Los Angeles County (18.4%) or California (16.4%).

Population Living Below 100% Federal Poverty Level, 2014

Report Area	Number	Percent
KFH-West Los Angeles	1,383,615	20.3%
Los Angeles County	9,819,397	18.4%
California	37,323,128	16.4%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Communities living 100% below the FPL include Arlington Heights, Baldwin Hills (including Crenshaw and Leimert Park), Hyde Park, Inglewood, Jefferson Park, Lennox, South Los Angeles, West Athens, West Adams, Westmont, and Westwood among others.



Population Below the Poverty Level, Percent by Tract, ACS 2010–14

Over 20.0%
15.1–20.0%
10.1–15.0%
Under 10.1%
No Data or Data Suppressed
Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

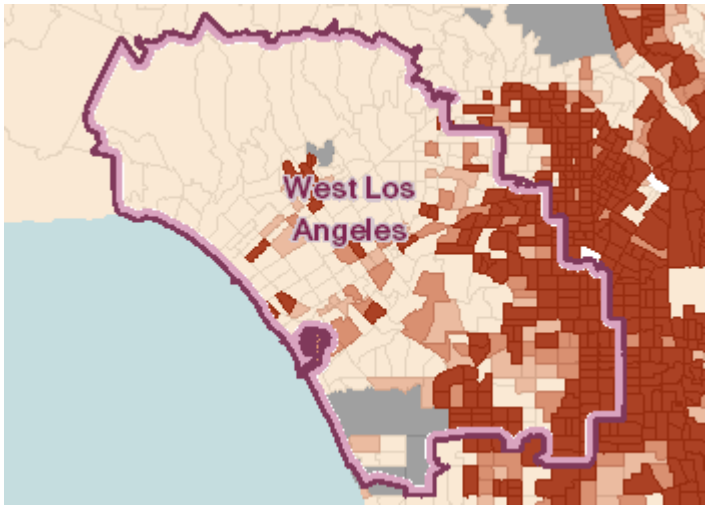
A higher proportion of families with children live in poverty in the KFH-West Los Angeles service area than in Los Angeles County and California. Of households living 100% below the FPL, nearly a third (29.4%) have children between the ages of 0 and 17, higher than the percentage reported for Los Angeles County (26.0%) and much higher than in California (22.7%).

Children Living Below 100% Federal Poverty Level, 2014

Report Area	Number	Percent
KFH-West Los Angeles	287,664	29.4%
Los Angeles County	2,314,447	26.0%
California	9,072,050	22.7%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Communities in the southeast portion of the service area have the largest percentages (over 30.0%) of households with children living 100% below the FPL, particularly the communities of Arlington Heights, Baldwin Hills (including Crenshaw and Leimert Park), Inglewood, Jefferson Park, Lennox, South Los Angeles, and West Adams among others.



Population Below the Poverty Level, Children (Age 0–17), Percent by Tract, ACS 2010–14

- Over 30.0%
- 15.1–22.5%
- 22.6–30.0%
- Under 15.1%
- No Population Age 0–17 Reported
- No Data or Data Suppressed
- Report Area

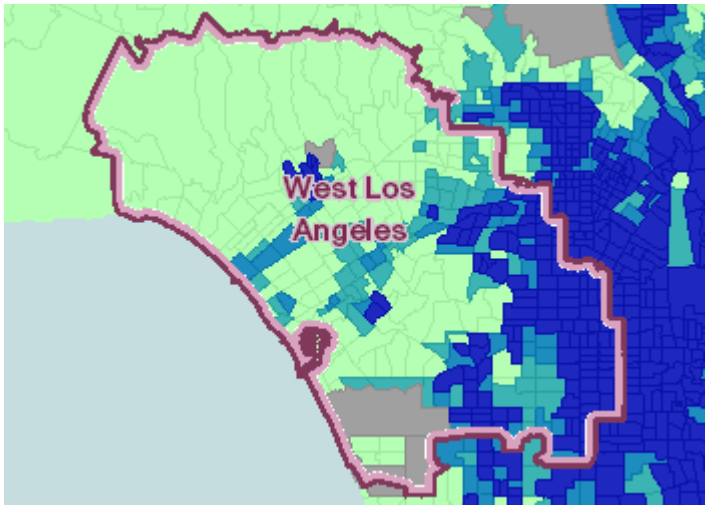
The KFH-West Los Angeles service area has a large percentage of households (40.5%) living below 200% of the FPL, which is also up from the 2013 report by 5.4%. It is, however, similar to that reported in Los Angeles County (40.9%) and yet higher than that reported in California (36.4%).

Population Living Below 200% Federal Poverty Level, 2014

Report Area	Number	Percent
KFH-West Los Angeles	560,530	40.5%
Los Angeles County	4,014,863	40.9%
California	13,576,255	36.4%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Communities with more than 50.0% of households living 200% below the FPL include Arlington Heights, Jefferson Park, Inglewood, South Los Angeles, and West Adams.



Population Below 200% Poverty Level, Percent by Tract, ACS 2010–14

- Over 50.0%
- 38.1–50.0%
- 26.1–38.0%
- Under 26.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Homelessness

The homeless counts used in this section are for the entire service planning areas (SPAs) that span the KFH-West Los Angeles service area, and likely provide an overrepresentation of homelessness. Most of the KFH-West Los Angeles service area falls in SPA 5–West and SPA 6–South, with only small portions being in SPA 4–Metro and SPA 8–South Bay.

As of 2015, an estimated 44,359 homeless resided in Los Angeles County, most of whom were in SPA 4–Metro (44.1%) and SPA 6–South (28.4%).

Total Homeless, 2015

Report Area	Number	Percent
SPA 4–Metro	11,681	44.1%
SPA 5–West	4,276	16.2%
SPA 6–South	7,513	28.4%
SPA 8–South Bay	3,006	11.4%
Los Angeles County	44,359	100.0%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Most of the sheltered homeless reside within SPA 4–Metro (49.2%) and SPA 6–South (26.9%); those unsheltered are within SPA 4–Metro (41.8%) and SPA 6–South (29.0%). According to a more recent release of the 2015 report by the Los Angeles Homeless Services Authority on homelessness in Los Angeles County (which provides a recent count of homeless with limited detail on specific communities), there were approximately 5,393 homeless on the day of that particular count within the KFH--West Los Angeles service area.

Sheltered/Unsheltered Homeless, 2015

Report Area	Sheltered Homeless		Unsheltered Homeless	
	Number	Percent	Number	Percent
SPA 4–Metro	4,001	49.2%	7,680	41.8%
SPA 5–West	1,274	15.7%	3,002	16.4%
SPA 6–South	2,189	26.9%	5,324	29.0%
SPA 8–South Bay	660	8.1%	2,346	12.8%
Los Angeles County	13,341	30.1%	31,018	69.9%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

As shown in the table below, most of the homeless were individuals living within SPA 4–Metro (45.7%) and SPA 6–South (26.7%). According to the Los Angeles Homeless Services Authority, individuals include single adults, adult couples with no children, and groups of adults over the age of 18. Of the identified homeless families most are within SPA 4–Metro (36.7%) and SPA 6–South (35.5%). Of the 185 homeless minors under the age of 18 in all SPAs, most reside within SPA 6–South (51.4%) and SPA 4–Metro (39.5%).

Homeless by Type, 2015

Report Area	Homeless Individuals		Homeless Families		Homeless Unaccompanied Minors	
	Number	Percent	Number	Percent	Number	Percent
SPA 4–Metro	9,958	45.7%	1,650	36.7%	73	39.5%
SPA 5–West	3,561	16.3%	711	15.8%	4	2.2%
SPA 6–South	5,826	26.7%	1,592	35.5%	95	51.4%
SPA 8–South Bay	2,456	11.3%	537	12.0%	13	7.0%
Los Angeles County	33,389	75.3%	7,505	16.9%	280	0.6%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

According to the Los Angeles Homeless Services Authority, chronic homelessness is defined as that experienced by an individual or family who has been homeless for a year or more. Most of the chronically homeless individuals in the four SPAs are within SPA 4–Metro (41.9%) and SPA 6–South (25.0%), but most chronically homeless *families* are within SPA 5–West (29.5%) and SPA 4–Metro (29.4%).

Chronically Homeless by Type, 2015

Report Area	Individuals		Families	
	Number	Percent	Number	Percent
SPA 4–Metro	3,323	41.9%	339	29.4%
SPA 5–West	1,498	18.9%	340	29.5%
SPA 6–South	1,979	25.0%	225	19.5%
SPA 8–South Bay	1,122	14.2%	249	21.6%
Los Angeles County	12,356	27.9%	1,817	4.1%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Most homeless veterans reside within SPA 4–Metro (39.0%) and SPA 5–West (28.0%), a greater percentage than in Los Angeles County as a whole (9.1%).

Homeless Veterans, 2015

Report Area	Number	Percent
SPA 4–Metro	1,237	39.0%
SPA 5–West	888	28.0%
SPA 6–South	472	14.9%
SPA 8–South Bay	575	18.1%
Los Angeles County	4,016	9.1%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

SPA 4–Metro has the highest percentage of homeless who are mentally ill (43.3%), have substance abuse issues (44.7%), are HIV-positive (65.7%), or are physically disabled (40.5%). These percentages are slightly higher than in Los Angeles County. All KFH-West Los Angeles service area SPAs have greater percentages of HIV-positive homeless relative to Los Angeles County (1.7%).

Homeless by Special Population, 2015

Report Area	Mentally Ill		With Substance Abuse Issues		With HIV		Physically Disabled	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
SPA 4–Metro	3,408	43.3%	2,843	44.7%	372	65.7%	2,035	40.5%
SPA 5–West	1,748	22.2%	1,147	18.0%	75	13.3%	1,077	21.4%
SPA 6–South	1,894	24.1%	1,284	20.2%	94	16.6%	1,349	26.8%
SPA 8–South Bay	825	10.5%	1,084	17.0%	25	4.4%	569	11.3%
Los Angeles County	12,253	27.6%	10,388	23.4%	757	1.7%	8,148	18.4%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Employment Status

Of individuals age 16 and older in the KFH-West Los Angeles service area, 14.2% are unemployed, as opposed to 27.8% in Los Angeles County. Unemployment rates in the service area and in Los Angeles County are both 8.6, higher than in California (8.3), and down from the 2013 report.

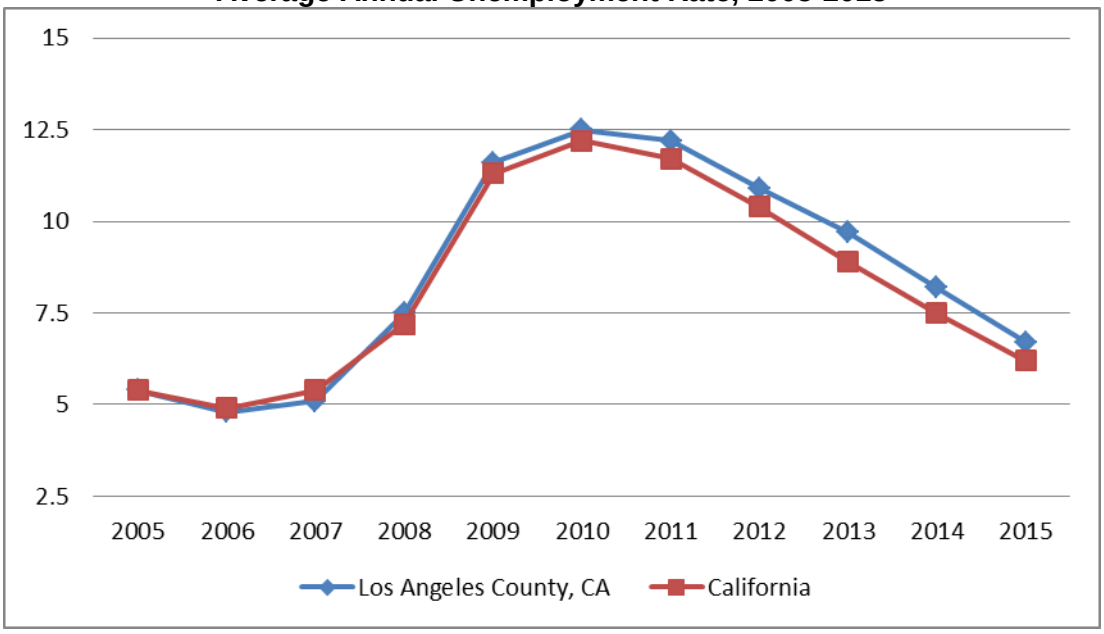
Unemployment Rate, December 2015

Report Area	Number	Percent	Rate
KFH-West Los Angeles service area	61,351	14.2%	8.6
Los Angeles County	433,392	27.8%	8.6
California	1,561,117	100.0%	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

However, the annual unemployment rate in Los Angeles County as well as California has been steadily decreasing since 2010. Los Angeles County has experienced a decrease from 12.5 to 6.5.

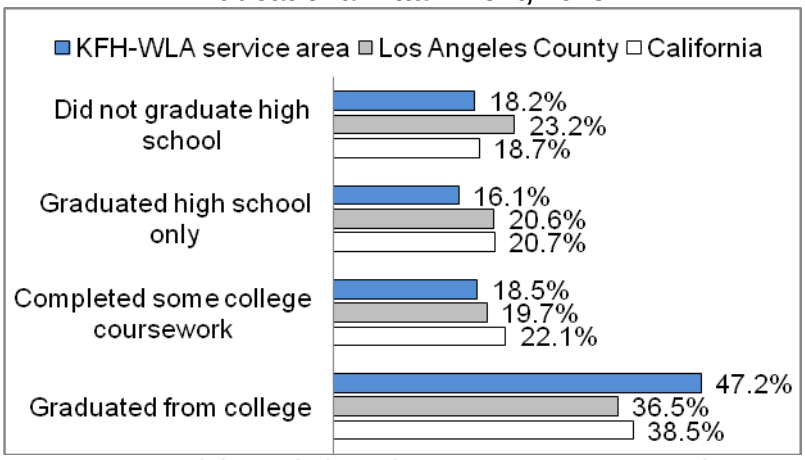
Average Annual Unemployment Rate, 2005-2015



Educational Attainment

Overall, 47.2% of the population in the KFH-West Los Angeles service area has a college degree, including Associate, Bachelor's, Master's, Professional, and/or =Doctorate degrees. This percentage is higher than both Los Angeles County's (36.5%) and California's (38.5%). By contrast, nearly a fifth (18.2%) of adults 25 and older did not complete high school (including completing less than the ninth grade), less than that reported in Los Angeles County (23.2%) and on a par with California (18.7%).

Educational Attainment, 2015



Source: Nielsen Claritas Site Reports, 2015, ZIP Code

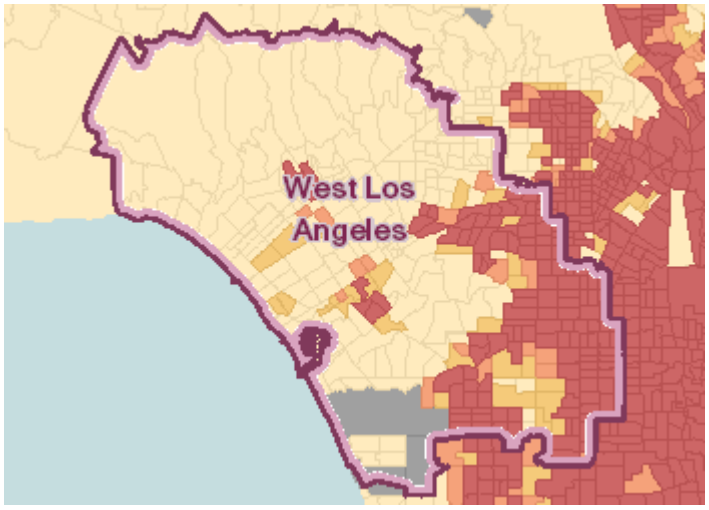
Overall, level of educational attainment has improved with a slight decrease in the percentage of those with less than a 9th grade degree and increases in all other categories.

Educational Attainment, 2015

Education Level	KFH-West Los Angeles Service Area		Los Angeles County		California	
	Number	Percent	Number	Percent	Number	Percent
Less than ninth grade	96,090	10.4%	906,958	13.5%	2,612,169	10.2%
Some high school	72,033	7.8%	654,609	9.7%	2,172,356	8.5%
High school graduate	148,782	16.1%	1,391,643	20.6%	5,301,306	20.7%
Some college	170,992	18.5%	1,326,948	19.7%	5,648,154	22.1%
Associate's degree	51,451	5.6%	456,371	6.8%	1,999,126	7.8%
Bachelor's degree	229,201	24.9%	1,317,163	19.5%	4,955,242	19.4%
Master's degree	89,145	9.7%	445,148	6.6%	1,904,337	7.5%
Professional school degree	44,181	4.8%	160,247	2.4%	586,956	2.3%
Doctorate degree	20,301	2.2%	83,274	1.2%	374,342	1.5%
Total	**922,176**	**100.0%**	**6,742,361**	**100.0%**	**25,553,988**	**100.0%**

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Communities in the service area with the largest percentage (over 21%) of the population 25 years old and older without a high school diploma or higher degree include Arlington Heights, Jefferson Park, Inglewood, Lennox, South Los Angeles, West Adams, West Athens, and Westmont among others.



Population with No High School Diploma (Age 25), Percent by Tract, ACS 2010–14

Over 21.0%
16.1–21.0%
11.1–16.0%
Under 11.1%
No Data or Data Suppressed
Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Disability

The percentages used in this section are for the entire service planning areas (SPAs) that span the KFH-West Los Angeles service area. Most of the KFH-West Los Angeles service area falls in SPA 5–West and SPA 6–South, with only small portions being in SPA 4–Metro and SPA 8–South Bay.

Having a disability can present complications that may be exacerbated by the absence of appropriate assistance. Having a disability can also lead to other health needs such as poor mental health. In SPA 6–South, a higher percentage (39.4%) of the population reported having a physical, mental, or emotion-associated disability when compared to Los Angeles County (28.6%) and California 28.5%).

Population With a Disability, 2014

Report Area	Percent
SPA 4–Metro	26.3%
SPA 5–West	25.5%
SPA 6–South	39.4%
SPA 8–South Bay	27.3%
Los Angeles County	28.6%
California	28.5%

Source: California Health Interview Survey, 2014, SPA

Infant and Maternal Health

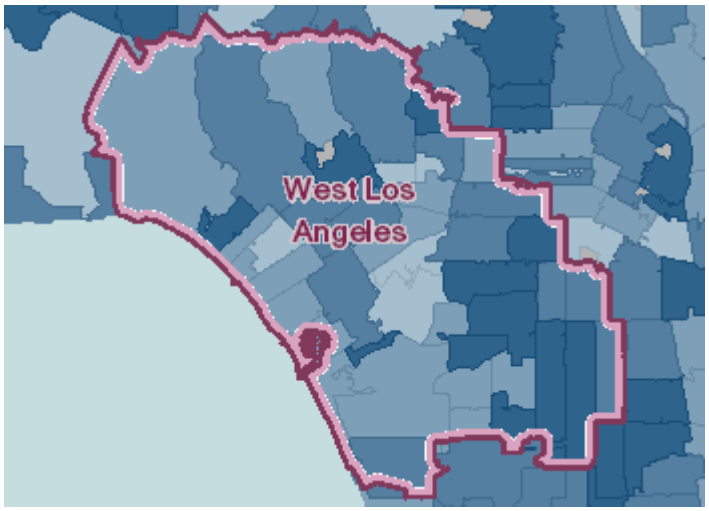
The well-being of mothers, infants, and children is critical to assuring the health of the next generation, and understanding infant and maternal health needs can assist with planning the future of public health. Infants born with a low birthweight (under 2,500 grams) are at a higher risk for health problems. In the KFH-West Los Angeles service area, low birthrate has remained relatively unchanged at 8.2% of the births (under 2,500 g). This percentage was higher when compared to Los Angeles County (7.3%) and California (6.8%).

Low Birthweight, 2011

Report Area	Number	Percent
KFH-West Los Angeles	1,545	8.2%
Los Angeles County	9,721	7.3%
California	34,692	6.8%

Source: California Department of Public Health (CDPH)
Birth Profiles by ZIP Code, 2011, ZIP Code

Communities in the KFH-West Los Angeles service area with a higher percentage (over 8.6%) of birthweights under 2,500 grams were mostly in the southeast portion and included Baldwin Hills, Hyde Park, Inglewood, Jefferson Park, Santa Monica, South Los Angeles, West Athens, and Westmont among other communities.



Low Birthweight Babies, Percent by ZCTA, CDPH 2011

Over 8.6%
6.9–8.6%
5.1–6.8%
Under 5.1%
No Data or Data Suppressed
Report Area

Source: California Department of Public Health (CDPH), Birth Profiles by ZIP Code, 2011, ZIP Code

Teen Births

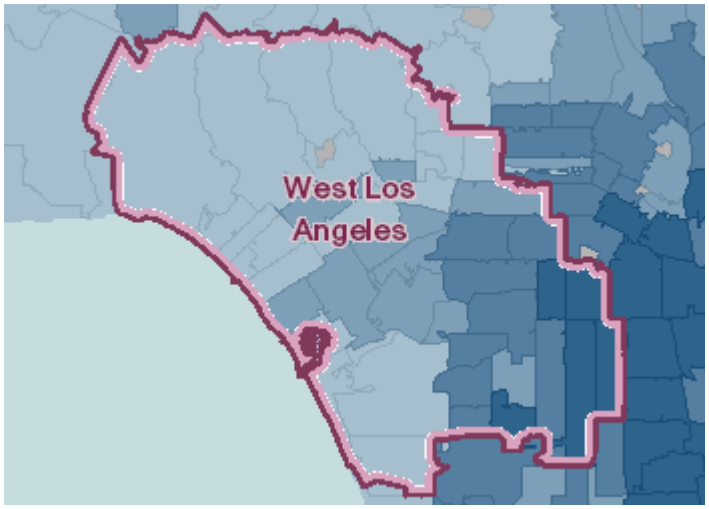
Teen births have many implications including social, economic, and health needs. In the KFH-West Los Angeles service area, the rate of teen births was 8.5 per 1,000 females under the age of 20, similar to that reported in California (8.5) and slightly lower than in Los Angeles County 8.8).

Teen Birth Rate per 1,000 Teens, 2011

Report Area	Rate
KFH-West Los Angeles	8.5
Los Angeles County	8.8
California	8.5

Source: California Department of Public Health (CDPH)
Birth Profiles by ZIP Code, 2011, ZIP Code

Communities with a higher percentage (over 12.0%) of teen births were mostly in the southeast portion of the service area, including Inglewood, South Los Angeles, West Athens, and Westmont among others.



Births to Females Under Age 20, Rate (Per 1,000 Population) by ZCTA, CDPH 2011

Over 12.0%
7.1–12.0%
2.1–7.0%
Under 2.1%
No Data or Data Suppressed
Report Area

Source: California Department of Public Health (CDPH), Birth Profiles by ZIP Code, 2011, ZIP Code

Breastfeeding

The percentages used in this section are for the entire service planning areas (SPAs) that span the KFH-West Los Angeles service area. Most of the KFH-West Los Angeles service area falls in SPA 5–West and SPA 6–South, with only small portions being in SPA 4–Metro and SPA 8–South Bay.

Breastfeeding is critical to newborn development and overall health. In SPA 4–Metro and SPA 8–South Bay, greater percentages (52.5% and 54.6%, respectively) of mothers breastfed their children for at least six months when compared to Los Angeles County (44.9%). However, a smaller percentage of mothers who breastfed their children at least six months were reported in SPA 6–South (42.4%) and SPA 5–West (43.8%).

Breastfeeding for At Least Six Months, 2011

Report Area	Percent
SPA 4–Metro	52.5%
SPA 5–West	43.8%
SPA 6–South	42.4%
SPA 8–South Bay	54.6%
Los Angeles County	44.9%

Source: California Department of Public Health (CDPH) Birth Profiles by ZIP Code, 2011, ZIP Code

Infant Mortality

Since the 2013 CHNA, the infant mortality rate in the overall service area has decreased by 1.7 points from 5.1 to 3.4 per 1,000 births. The current rate is lower when compared to Los Angeles County (4.3) and California (4.5), however, infant mortality rates were twice as high in the communities of Baldwin Hills (11.0) and West Adams (10.7). Rates were also much higher in Cheviot Hills (9.9), Playa Del Rey (7.5) and Ocean Park (7.4).

Infant Mortality Rate per 1,000 Births, 2012

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	2.4
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	11.0
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	0.0
Beverly Hills	90210, 90211, 90212	5–West	0.0
Century City	90067	5–West	0.0
Cheviot Hills	90064	5–West	9.9
Culver City	90066, 90230, 90232	5–West	1.0
El Segundo	90245	8–South Bay	5.7
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	3.8
Hyde Park, View Park, Windsor Hills	90043	6–South	1.7
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	5.6
Jefferson Park, Leimert Park	90018	6–South	4.2
Ladera Heights	90056	5–West	0.0
Los Angeles International Airport, including Westchester	90045	5–West	4.8
Marina Peninsula, Marina del Rey	90292	5–West	3.6
Pacific Palisades, including Pacific Highlands	90272	5–West	6.5
Palms	90034	5–West	7.0
Playa Del Rey	90293	5–West	7.5
Playa Vista	90094	5–West	0.0
Santa Monica	90402, 90403, 90404	5–West	1.2
Santa Monica—Downtown	90401	5–West	0.0
Santa Monica—Ocean Park	90405	5–West	7.4
Sawtelle, including West Los Angeles	90025	5–West	1.8
South Los Angeles, including Broadway/Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	4.9
Venice	90291	5–West	0.0
West Adams	90016	6–South	10.7
West Fairfax	90035	5–West	0.0

Community	ZIP Code	Service Planning Area (SPA)	Rate
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	2.1
Westwood	90024	5–West	0.0
KFH-West Los Angeles service area			3.4
Los Angeles County			4.3
California			4.5

Source: California Department of Public Health, 2012, ZIP Code.

Foster Youth

Foster care placement and the related instability in a young person's home life can lead to the development of a number of health and social issues, including mental or physical harm, family violence, and other factors that may lead to poor overall health. In the KFH-West Los Angeles service area, a total of 1,394 youth between the ages of 0 and 17 entered the foster care system in 2013, representing 13.3% of those who entered foster care throughout Los Angeles County.

Communities in the service area experiencing a larger number of youth entering into foster care included South Los Angeles (n=857), Inglewood (n=124), and West Adams (n=94).

The foster care incidence rate per 1,000 youth between the ages of 0 and 17 is lower (2.5) in the service area when compared to Los Angeles County (4.5) and California (3.5). Specific communities in the KFH-West Los Angeles service area, however, experience higher rates of youth entering foster care, including South Los Angeles (8.6), West Adams (7.7), and Hyde Park (7.2).

Youth Ages 0–17 Entering Foster Care and Incidence Rate per 1,000 Youth, 2013

Community	ZIP Code	Service Planning Area (SPA)	Number	Incidence Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4-Metro Los Angeles	32	2.3
Baldwin Hills, including Crenshaw and Leimert Park	90008	6-South	46	6.6
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5-West	0	0.0
Beverly Hills	90210, 90211, 90212	5-West	2	0.2
Century City	90067	5-West	0	0.0
Cheviot Hills	90064	5-West	9	1.8
Culver City	90066, 90230, 90232	5-West	13	0.5
El Segundo	90245	8-South Bay	0	0.0
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4-Metro Los Angeles	6	1.0
Hyde Park, including View Park and Windsor Hills	90043	6-South	74	7.2

Community	ZIP Code	Service Planning Area (SPA)	Number	Incidence Rate
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8-South Bay	124	3.2
Jefferson Park	90018	6-South	73	5.5
Ladera Heights	90056	5-West	2	1.5
Los Angeles International Airport, including Westchester	90045	5-West	5	0.7
Marina Peninsula	90292	5-West	1	0.4
Pacific Palisades, including Pacific Highlands	90272	5-West	1	0.2
Palms	90034	5-West	20	2.0
Playa Del Rey	90293	5-West	1	0.7
Playa Vista	90094	5-West	0	0.0
Santa Monica	90402, 90403, 90404	5-West	1	0.1
Santa Monica—Downtown	90401	5-West	1	1.9
Santa Monica—Ocean Park	90405	5-West	12	3.1
Sawtelle, including West Los Angeles	90025	5-West	6	1.1
South Los Angeles, including Broadway Manchester	90037, 90044, 90047, 90062, 90003	6-South, 8-South Bay	857	8.6
Venice	90291	5-West	1	0.3
West Adams	90016	6-South	94	7.7
West Fairfax	90035	5-West	5	0.9
West Hollywood, including West Beverly	90069, 90048	4-Metro Los Angeles	7	2.3
Westwood	90024	5-West	1	0.3
KFH-West Los Angeles service area			1,394	2.5
Los Angeles County			10,478	4.5
California			31,979	3.5

Source: California Department of Social Services & University of California Berkeley, Child Welfare Dynamic Report System, 2013, ZIP Code.

Leading Causes of Death

In the KFH-West Los Angeles service area, the top two causes of death were coronary heart disease and stroke, the same that led the list in Los Angeles County. In SPA 6–South and SPA 8–South Bay, the third leading cause of death was lung cancer, just as reported in Los Angeles County, but the third leading causes of death were different in SPA 4–Metro (diabetes) and SPA 5–West (Alzheimer's disease).

Leading Causes of Death, 2012

Report Area	Ranking #1	Ranking #2	Ranking #3	Ranking #4	Ranking #5
SPA 4–Metro	Coronary heart disease	Stroke	Diabetes	Pneumonia/ influenza	Lung cancer
SPA 5–West	Coronary heart disease	Stroke	Alzheimer's disease	Lung cancer	COPD
SPA 6–South	Coronary heart disease	Stroke	Lung cancer	Diabetes	COPD
SPA 8–South Bay	Coronary heart disease	Stroke	Lung cancer	COPD	Pneumonia/ influenza
Los Angeles County	Coronary heart disease	Stroke	Lung cancer	COPD	Alzheimer's disease

Source: Los Angeles County Department of Public Health, 2012, SPA.

Leading Causes of Premature Death

In the KFH-West Los Angeles service area, the leading cause of premature death was coronary heart disease, the same as reported in Los Angeles County. In SPA 6–South, however, the leading cause of premature death was homicide. The second leading causes of premature death varied across the service area: SPA 4–Metro reported drug overdose as second, followed by homicide; SPA 5–West reported suicide followed by drug overdose; SPA 6–South reported coronary heart disease followed by motor vehicle crashes; SPA 8–South Bay reported homicide followed by motor vehicle crashes (the same causes as those reported in Los Angeles County).

Leading Causes of Premature Death, 2012

	Ranking #1	Ranking #2	Ranking #3	Ranking #4	Ranking #5
SPA 4–Metro	Coronary heart disease	Drug overdose	Homicide	Liver disease/ cirrhosis	Suicide
SPA 5–West	Coronary heart disease	Suicide	Drug overdose	Lung cancer	Liver disease/ cirrhosis
SPA 6–South	Homicide	Coronary heart disease	Motor vehicle crash	Liver disease/ cirrhosis	Diabetes
SPA 8–South Bay	Coronary heart disease	Homicide	Motor vehicle crash	Suicide	Liver disease/ cirrhosis
Los Angeles County	Coronary heart disease	Homicide	Motor vehicle crash	Liver disease/ cirrhosis	Suicide

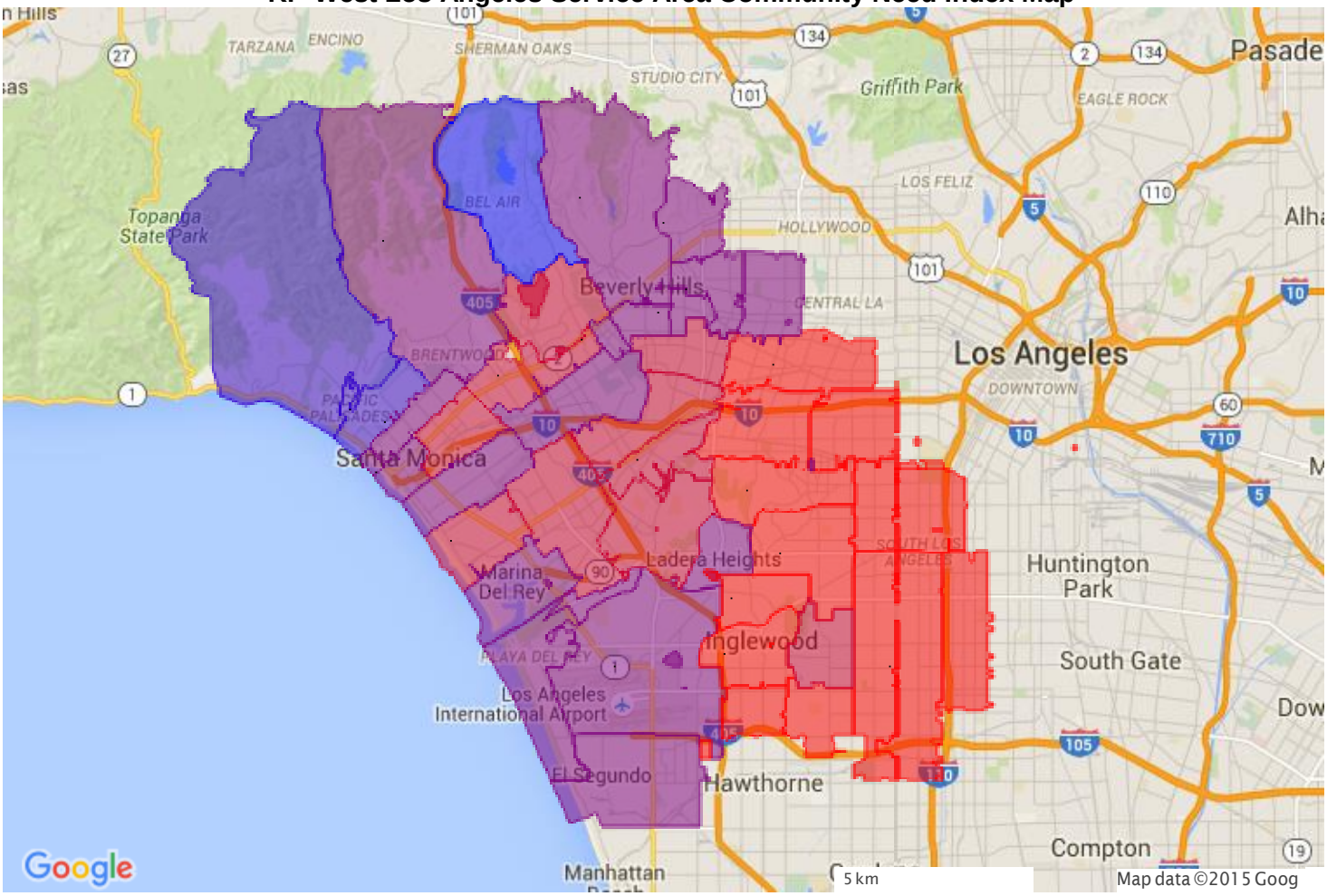
Source: Los Angeles County Department of Public Health, 2012, SPA.

iv. Community Health Index

To augment the data used in this report, the Dignity Health Community Need Index (CNI) was also used. This index was created to help identify areas within a community with the highest health needs. To do this, the CNI examines five of the most common barriers associated with health care access including income, cultural/language issues, education, insurance status, and housing. Within those five areas or barriers, the online CNI tool analyzes nine indicators by a user-designated geography, and compiles scores (aggregated and individual ZIP codes, cities/communities, etc.) on a scale of 1 (lowest need; experiencing the lowest socio-economic barriers) to 5 (highest need; experiencing the most

socio-economic barriers)[3]. The CNI can be used to help KFH-West Los Angeles and its community partners strategically develop programs and services that address underlying issues causing health disparities within a communities. In the KFH-West Los Angeles service area, the lower southeast portion had the highest CNI scores in comparison to the rest of the service area.

KP-West Los Angeles Service Area Community Need Index Map



Community Need Index Scale

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

Source: Dignity Health's Community Need Index, 2015, ZIP Code

Communities with the highest CNI scores (between 4.2 and 5.0)—indicating the highest social and economic disparities and health need—were South Los Angeles (including Broadway/Manchester), Jefferson Park, South Los Angeles, West Adams, Baldwin Hills, Crenshaw, Leimert Park, Arlington Heights (including Country Club Park and Mid-City), Hyde Park (including View Park and Windsor Hills), and Inglewood among others. The communities with the second-highest CNI scores (between 3.4 and 4.1) included Palms, Westwood, Culver City, Santa Monica (east of Wilshire and west of Pico), Sawtelle, West Los Angeles, West Fairfax, and Venice among others. Knowing which communities and

[3] Ibid.

cities within the KFH-West Los Angeles service area have the highest disparities and health needs can contribute to the decision-making process in terms of making strategic investments that will yield the highest impact on overall community health.

KP-West Los Angeles Service Area Community Need Index Scores By ZIP Code and Community/City

	CNI Score	ZIP Code	Community/City
Highest Need (HNI Scores 4.2–5.0)			
	5.0	90003	South Los Angeles including Broadway/Manchester
	5.0	90018	Jefferson Park
	5.0	90037	South Los Angeles
	5.0	90044	South Los Angeles
	4.8	90016	West Adams
	4.8	90062	South Los Angeles
	4.6	90008	Baldwin Hills, Crenshaw, Leimert Park
	4.6	90019	Arlington Heights, Country Club Park, Mid-City
	4.6	90043	Hyde Park, View Park, Windsor Hills
	4.6	90047	South Los Angeles
	4.6	90303	Inglewood
	4.6	90304	Inglewood
	4.4	90301	Inglewood
	4.2	90302	Inglewood
2nd-Highest Need (HNI Scores 3.4–4.1)			
	4.0	90034	Palms
	3.8	90024	Westwood
	3.8	90230	Culver City
	3.8	90305	Inglewood
	3.6	90066	Culver City
	3.6	90404	Santa Monica (north of Pico and south of Wilshire)
	3.4	90025	Sawtelle, West Los Angeles
	3.4	90035	West Fairfax
	3.4	90232	Culver City
	3.4	90291	Venice
Mid-level Need (HNI Scores 2.6–3.3)			
	3.2	90036	Fairfax/Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea, Park La Brea
	3.2	90045	Los Angeles International Airport, Westchester
	3.2	90401	Santa Monica—Downtown
	3.2	90048	West Hollywood, West Beverly
	3.2	90069	West Hollywood
	3.0	90064	Cheviot Hills
	3.0	90067	Century City

	CNI Score	ZIP Code	Community/City
	3.0	90094	Playa Vista
	3.0	90212	Beverly Hills
	3.0	90292	Marina Del Rey
	3.0	90405	Santa Monica—Ocean Park
	2.8	90056	Ladera Heights
	2.8	90210	Beverly Hills
	2.8	90211	Beverly Hills
	2.8	90403	Santa Monica (north of Wilshire and south of Montana)
	2.6	90049	Bel Air Estates, Brentwood
	2.6	90245	El Segundo
	2.6	90293	Playa Del Rey
2nd-Lowest Need (HNI Scores 1.8–2.5)			
	2.4	90402	Santa Monica (north of Montana)
	1.8	90272	Pacific Palisades
Lowest Need (HNI Scores 1–1.7)			
	1.6	90077	Bel Air Estates, Beverly Glen

Source: Dignity Health's Community Need Index, 2015, ZIP Code

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of Hospitals that collaborated on the assessment

The 2016 KFH-West Los Angeles CHNA was primarily conducted independently by the medical center. However, a collaborative was formed with Cedars-Sinai Medical Center, University of California Los Angeles (UCLA) Medical Center, and Saint John's Health Center in an effort to avoid duplication in the collection of phone interview data, as the medical centers share a common service area.

B. Other partner organizations that collaborated on the assessment

There were no partner organizations that collaborated with consultants in conducting the KFH-West Los Angeles CHNA for the purpose of this report.

C. Identity and qualification of consultants used to conduct the assessment

The Center for Nonprofit Management (CNM) was established in 1979 by the corporate and foundation community as the Southern California source for management education, training, and consulting within the nonprofit community. From core management fundamentals to executive coaching, in-depth consulting, and analyses, CNM enables individuals to become better leaders of more effective organizations. CNM's research and networking efforts distribute knowledge and thought to nonprofit organizations so they are prepared to face today's known tasks and tomorrow's unknown challenges. CNM

seeks to shape how nonprofit leaders approach problems so they can more effectively pursue their missions. CNM helps individuals and their organizations evolve, adapt, and thrive.

The CNM team has been involved with CHNAs for hospitals throughout Los Angeles County and Southern California for more than ten years. The CNM team conducted the 2004, 2007, and 2010 assessments for the Metro Hospital Collaborative (California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital Los Angeles, Queens Care, and St. Vincent Medical Center). Key members of the CNM team also worked on the 2007 CHNAs for St. Francis Medical Center and the Franciscan Clinics. CNM conducted the 2013 CHNAs for three Kaiser Foundation hospitals and one non-Kaiser Foundation hospital in the greater Los Angeles area, three Glendale hospitals, and the 2013 Metro Hospital Collaborative (California Hospital Medical Center, Good Samaritan Hospital and St. Vincent Medical Center), and assisted an additional two Kaiser Foundation Hospitals (Panorama City and San Diego) in community benefit planning based on the needs assessments. More recently, the CNM team conducted the 2014 CHNA for a specialty hospital, Casa Colina Hospital and Centers for Healthcare, where the team modified the process to capture the specialized needs of its service area and population.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Secondary Data

i. Sources and dates of secondary data used in the assessment

KFH–West Los Angeles used the Kaiser Permanente (KP) CHNA Data Platform (www.chna.org/kp) to review over 135 indicators from publicly available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. For details on specific sources and dates of the data used, please see Appendix A.

In addition to using the Kaiser Permanente's CHNA Data Platform, KFH-West Los Angeles also collected additional data on over 300 indicators from local and national sources to supplement the 135 indicators collected on the KP platform. This was necessary for a few reasons. First, newer and more local data were made available through a number of sources, including the California Health Interview Survey. Second, the data on the KP platform were not available at the geographic level (i.e., ZIP Code and Service Planning Area). Third, additional health and social issues became apparent during primary data collection that made it necessary to identify and collect additional secondary data to supplement primary data collection findings. A literature review was also conducted as a means to collect contextual information for the health needs and drivers and provide KFH-West Los Angeles and CHNA readers a more holistic perspective of the issues identified through the needs assessment process. For details on specific sources and dates of the data used, please see Appendix A.

Additional secondary data tools were used to help organize secondary data and prepare for analysis. Those included the Dignity Health Community Need Index Tool and Kaiser Permanente's Community Benefit data analysis tools.

Representation of SPA-Level Data in the Report and Scorecard

SPA-level data were represented in two ways depending on the type of document. In the report, SPA-level data represents the entire SPA. In the Scorecard, SPA-level data were represented in two ways. When data were available at the ZIP Code level, ZIP Codes were aggregated according to the SPA they were located in and an average was created to represent a SPA. When data were *not* available at the ZIP Code level then data for the entire SPA was used. Interpreting data at the SPA level makes it challenging to obtain an accurate representation of issues within the KFH-West Los Angeles service

area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8. Please see Appendix B.

Kaiser Permanente's Community Benefit Data Analysis Tools

Kaiser Permanente developed community benefit data analysis tools to help organize all data collected through the CHNA process. The first tool helped organize the 135 KP common indicators[4] for California by health-need labels and demographics to distinguish the health-need topics that the secondary data set explores. For example, indicators related to depression, suicide rates, and poor mental health describe the health need Mental Health. Each health-need topic is assigned a score based on the relative variance of the data values in the hospital service area compared to three benchmarks: Los Angeles County statistics, California state statistics, and statistics for the KP Southern California Region. This tool was used to help identify disparities by health need and to confirm the health needs identified.

The second tool organized the KP common indicators and compared them against 14 common health needs[5], using a combination of morbidity/mortality and health-driver indicators. For example, the health need of Mental Health is described by indicators such as lack of social or emotional support, depression, and suicide. Each health-need topic in this tool is assigned a score based on the difference between the data values at the hospital service area level and the California state benchmark. In both tools, the health-need scores provided information about which health-need topics may be performing better or worse based on benchmark analyses. To further assist in the prioritization process, this tool was modified to keep track of all pieces of data and information collected around each health outcome and driver. The different pieces of information contained in this tool included the health topic, associated secondary indicators, number of times an outcome or driver was mentioned in the primary data, disparities (by sub-population and geography), and whether the need was identified in the 2013 CHNA report.

Dignity Health Community Need Index Tool

Health cannot be solely defined as the absence of disease, but instead must be looked at in a holistic way that includes the socio-economic environment.[6] With this goal in mind, Dignity Health developed and standardized a Community Need Index (CNI) tool that examines five of the most common barriers associated with health care access, including income, cultural/language issues, education, insurance status, and housing. Within those five areas or barriers, the online CNI tool analyzes nine indicators by a user-designated geography and compiles scores (aggregated and individual ZIP Codes, cities/communities, etc.) on a scale of 1 (lowest need; experiencing the lowest socio-economic barriers) to 5 (highest need; experiencing the most socio-economic barriers).[7] Because of its rigor, the online CNI tool was used to assist with identifying geographic areas of highest need and contribute to the identification of health needs and determinants of health.

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[4] The full list can be found at http://assessment.communitycommons.org/chna/Datalist.aspx?reporttype=overview&dataarea=0.

[5] The common health needs are access to care, asthma, cancers, climate and health, CVD/stroke, economic security, HIV/AIDS/STDs, maternal and infant health, mental health, obesity/HEAL/diabetes, oral health, overall health, substance abuse/tobacco, and violence/injury prevention.

[6] Dignity Health. Improving Public Health & Preventing Chronic Disease—Dignity Health's Community Need Index. San Francisco, CA. Available at https://www.dignityhealth.org/stjosephs/about-us/community-benefit/community-building/documents/dignity-health-community-need-orindex-brochure. Accessed August 8, 2015.

[7] Ibid.

Other Tools

In addition to the Kaiser Permanente tools, CNM created a secondary data database and primary data database using Microsoft Excel. These databases were used to house all data collection and to help organize the data by topic. The secondary data indicator database was used to organize data for over 300 indicators by ZIP Code, Service Planning Area, and community. It also included benchmarks to compare each indicator against county averages, state averages, and Healthy People 2020 goals, when possible. The primary data database was used to help organize all data collected from stakeholders by health outcome and drivers and associated disparities, community assets and resources, and quotes.

ii. Methodology for collection, interpretation and analysis of secondary data

Secondary data were collected from various online sources and organized in a Microsoft Excel database. The types of data indicators collected included the (1) Kaiser Permanente common indicators available on the Kaiser Permanente CHNA data platform; (2) indicators collected for the 2013 CHNA; and (3) the identification of new available data indicators that were relevant and useful for the 2016 CHNA. For example, the California Health Interview Survey published new data in 2015 that expanded on access to care primarily around the Affordable Care Act. The geographic level at which these were collected included ZIP Code, Service Planning Area, or county, depending on availability. In addition, benchmark data were collected for each data indicator for the county, state, and/or Healthy People 2020.

Data indicators were then organized by topic (i.e., access to care, cancer, poverty, etc.) to assure alignment with the MATCH framework. The Mobilizing Action Toward Community Health (MATCH) model is a population health model that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. These factors include the mortality and morbidity status of the community and the four key sets of drivers that affect that status: access to health care, healthy behaviors, socio-economic factors, and the physical environment. Other pieces of information tracked in this tool included the number of times a health outcome or driver were mentioned in the primary data, its number of votes (i.e., stickers dots) a health need or driver received during the primary data collection, disparities by sub-population and geography noted in both the secondary and primary data, and whether the need was identified and its priority ranking (as applicable) in the 2013 CHNA report. The Dignity Health Index Tool was used as an additional piece of information to help confirm geographic disparities in the KFH-West Los Angeles service area.

B. Community Input

i. Description of the community input process

Community input was provided by a broad range of community members through the use of key informant interviews, focus groups, and/or surveys. Individuals with knowledge, information, and/or expertise relevant to the health needs of the community were consulted, including representatives from state, local, tribal, or other regional governmental public health departments (or equivalent agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, other individuals with expertise in local health needs were consulted where applicable. For a complete list of individuals who provided input during the CHNA process, see Appendix C.

More specifically, primary data were collected during October 2015 through the conduct of five focus groups and 29 phone interviews. Focus group participants were identified with the assistance of KFH-West Los Angeles and included community representatives such as youth, social and health service

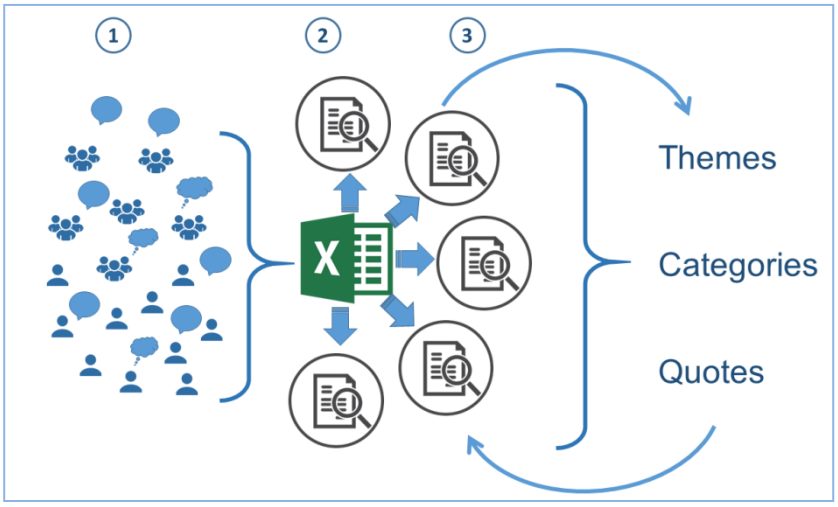
providers, community health workers or *promotoras*, community leaders (including faith-based), and a group of nontraditional stakeholders that included local business representatives. Focus groups were designed to collect information on health-related topics and community assets, and resources in and around the community addressing identified health needs. Focus groups—approximately 60 to 90 minutes in length—took place throughout the KFH-West Los Angeles service area in English and Spanish, as needed.

To provide additional data to assist in the prioritization of the health needs identified during the focus groups, participants were each given a total of ten sticker dots and asked to vote for the five most severe health needs and the five most severe health factor/drivers on a grid created during the focus group. For the purpose of the participant voting activity, severity was defined as the level a health need or health factor/driver affects the health and lives of those in the community.

In addition to the five focus groups, a total of 29 phone interviews were conducted. To help identify potential interview participants, KFH-West Los Angeles engaged with a collaborative of three hospitals that share a common service area—Cedars-Sinai Medical Center, UCLA, and Saint John's Health Center. Phone interviews took approximately 30 to 45 minutes each and were conducted using standard ethical research guidelines. Much as in the focus groups, information on health-related issues and community assets and resources in and around the community addressing each health need were identified. However, the purpose of the interview was to collect in-depth, expert information and perspective from stakeholders including public health experts, local government representatives, and other key stakeholders. As in the focus groups, interview participants were asked to rate each health need identified based on severity and importance. Each health need was ranked on scale from 1 to 5 with 1 indicating least severe/important and 5 indicating most severe/important.

ii. Methodology for interpretation and analysis of primary data

CNM used a three-step process for analyzing and interpreting primary data: 1) all information gathered during focus groups and interviews were entered into Microsoft Excel, 2) spreadsheet data were reviewed multiple times using content analysis to begin sorting and coding the data, and 3) through the coding process, themes, categories and quotes were identified. Steps two and three are repeated as often as necessary to recognize as many connections and patterns within the data as possible.



This approach provides a systematic way to identify broad themes within a large set of qualitative data and begin coding and categorizing data around those themes (e.g., access to care, poverty, cultural barriers). Responses were reviewed and coded so that common themes pulled from the data can be combined with quantitative data to form conclusions.

C. Written Comments

Kaiser Permanente provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. Written community input on the facility's most recently conducted CHNA Report will continue to be accepted at this email address.

As of the time of this CHNA report development, KFH-West Los Angeles had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate facility staff.

D. Data limitations and information gaps

The Kaiser Permanente CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, their data have some limitations, as is true with any secondary data. Some data were available only at a county or service planning area (SPA) level, making an assessment of health needs at a neighborhood level challenging. When interpreting data at this geography it can be challenging to obtain an accurate representation of issues within the KFH-West Los Angeles service area. The KFH-West Los Angeles service area encompasses large areas of SPAs 5 and 6 (West and South), and to a lesser extent SPAs 4 and 8 (Metro and South Bay).Also, disaggregated data on age, ethnicity, race, and gender are not always available for all data indicators, which limited the ability to examine health disparities within the service area. Data are not always collected on a yearly basis, meaning that some data are several years old. It is also important to keep in mind that primary data collected through focus groups, interviews, and surveys may not be entirely representative of the KFH-West Los Angeles service area. Some responses may be biased and represent the views of those who were able to participate in the primary data collection.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY HEALTH NEEDS: PROCESS AND KEY FINDINGS

A. Identifying Community Health Needs

i. Definition of Health Need

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions or health drivers that contribute to a defined health outcome. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

A mixed-method approach involving primary and secondary data was employed to identify health outcomes and drivers. As described above, primary data were collected from a variety of stakeholders through phone interviews and focus groups to identify the most severe health needs and drivers in the KFH-West Los Angeles service area, as well as geographic disparities, sub-population disparities, and community assets and resources available to address the identified health needs and drivers. Five focus groups and 29 phone interviews were conducted to collect primary data from over 100 stakeholders that included community representatives, health experts, local government

representatives, local business owners, and social and health service providers. Primary data were input into Microsoft Excel spreadsheets to assist in organizing the data, coding and identifying major themes, and collecting quotes.

Secondary data were collected from multiple local and national sources on health and socio/economic statistics (described above), which were compared against designated benchmarks including county, state, and Healthy People 2020 statistics. In addition, the Dignity Health Online Community Need Index (CNI) tool[8] was used to help confirm and identify geographic disparities in the service area. Secondary data were input into a Microsoft Excel spreadsheet where over 300 indicators were organized by topic (diabetes, obesity, poverty, education level, etc.) and compared to benchmarks including county averages, state averages, and Healthy People 2020 goals (where available).

Once secondary and primary data were collected and organized, a modified Kaiser Permanente data analysis tool was used as a check list for all data that performed poorly against a set benchmark.

To help identify health outcomes and drivers as health needs, two requirements needed to be met. A health outcome or driver had to be mentioned in the primary data collection more than once *and* a secondary data indicator associated with it had to perform poorly against a designated benchmark (county averages, state averages, or Healthy People 2020 goals). Once a health outcome or driver met both requirements, it was designated as an identified health outcome or driver. Through this process, 29 health needs were identified.

Prioritized Health Needs

	Health Needs	
1	Mental Health	Outcome
2	Diabetes	Outcome
3	Obesity/Overweight	Outcome
4	Access to Care	Driver
5	Homelessness and Housing	Driver
6	Preventive Health Care	Driver
7	Economic Security	Driver
8	Violence and Injury Prevention	Driver
9	Cardiovascular Disease/Heart Disease	Outcome
10	Access to Healthy Foods	Driver
11	Healthy Behaviors	Driver
12	Alcohol Abuse, Substance Abuse and Tobacco Use	Driver
13	Hypertension	Outcome
14	Oral Health	Outcome
15	Legal Status	Driver
16	Physical Environment	Driver
17	Cancer (includes breast, colorectal, lung, and prostate)	Outcome
18	Cultural and Linguistic Barriers	Driver
19	Asthma	Outcome
20	Cholesterol	Outcome
21	Transportation	Driver
22	Sexually Transmitted Disease	Outcome
23	Dental Care Access	Driver

[8] Dignity Health. Improving Public Health & Preventing Chronic Disease—Dignity Health's Community Need Index. San Francisco, CA. Available at https://www.dignityhealth.org/stjosephs/about-us/community-benefit/community-building/documents/dignity-health-community-need-index-brochure. Accessed August 8, 2015.

24	Disease Management	Driver
25	Respiratory Disease (includes COPD)	Outcome
26	Maternal and Infant Health	Outcome
27	HIV/AIDS	Outcome
28	Alzheimer's Disease	Outcome
29	Communicable Diseases (including Hepatitis A and B)	Outcome

B. Process and criteria used for prioritization of the health needs

Prioritizing the identified needs is essential to the community benefit planning process. CNM engaged with a total of 68 community stakeholders through two community forums held in December 2015 and January 2016 to assist with prioritizing the 18 identified health outcomes and 14 drivers. During the community forum, attendees reviewed a summary of the secondary data indicators and responses from stakeholders, and participated in a guided group activity to share insights and perspectives with their colleagues. At the end of the community forum, attendees were asked to complete a survey in which they prioritized each health outcome and health driver according to five criteria:

- Magnitude: how many community members were affected
- Severity: how much community members were affected
- Change over time: whether an issue has improved or gotten worse over time
- Resources: amount of resources available in the community to address an issue
- Disparities: the level of impact on a specific vulnerable population group

Of the 68 attendees, 55 completed surveys. Some attendees did not complete a survey for a variety of reasons, including feeling that they were unfamiliar with the health outcomes of the community. Some attendees left the forums early and did not complete the survey despite efforts to have them do so prior to leaving.

Those unable to attend the community forums had the opportunity to participate in the prioritization process by completing an online prioritization survey (identical to the survey disseminated at the community forums). A link to the online survey and supplemental materials shared at the forums were emailed to stakeholders; a total of six people completed the online survey. These surveys were added to the database of surveys collected at the forum. Overall composite scores were calculated by averaging the individual criteria scores for a particular health outcome or driver. In addition, forum attendees voted using ten sticker dots (five for health outcomes and five for drivers) to vote for the health outcomes and drivers that they believed most severely impact the community surrounding the KFH-West Los Angeles service area. The counts were tabulated and used to confirm the prioritized health outcomes and drivers. Thus, the prioritized list was developed by sorting the health needs by composite criteria scores from the survey. The sum of the dots was used as a tie breaker in the cases where ratings scores for more than one issue were equal.

The table below provides a combined list of health outcomes and drivers in order of priority. For planning purposes, the above lists of health outcomes and drivers were combined and prioritization scores calculated for the combined list.

Prioritized Health Needs

	Health Needs	
1	Mental Health*	Outcome
2	Diabetes	Outcome
3	Obesity/Overweight	Outcome
4	Access to Care	Driver
5	Homelessness and Housing	Driver
6	Preventative Health Care	Driver
7	Economic Security	Driver
8	Violence and Injury Prevention	Driver
9	Cardiovascular Disease/Heart Disease*	Outcome
10	Access to Healthy Foods	Driver
11	Healthy Behaviors	Driver
12	Alcohol Abuse, Substance Abuse and Tobacco Use	Driver
13	Hypertension	Outcome
14	Oral Health	Outcome
15	Legal Status	Driver
16	Physical Environment	Driver
17	Cancer (includes breast, colorectal, lung, and prostate)	Outcome
18	Cultural and Linguistic Barriers	Driver
19	Asthma	Outcome
20	Cholesterol	Outcome
21	Transportation	Driver
22	Sexually Transmitted Disease	Outcome
23	Dental Care Access	Driver
24	Disease Management	Driver
25	Respiratory Disease (includes COPD)	Outcome
26	Maternal and Infant Health	Outcome
27	HIV/AIDS	Outcome
28	Alzheimer's Disease	Outcome
29	Communicable Diseases (including Hepatitis A and B)	Outcome

*Directly related to or one of the five leading causes of premature death in KFH West Los Angeles service area.

When compared to the previous KFH-West Los Angeles CHNA, seven health outcome priorities rose in rakings, four fell in rank, and three saw no change. The greatest increase in rank came from sexually transmitted disease (+7). All the health outcomes that fell in rank only did so by one place. Outcomes related to leading causes of premature death are marked by an asterisk in the table.

C. Prioritized description of all the community health needs identified through the CHNA

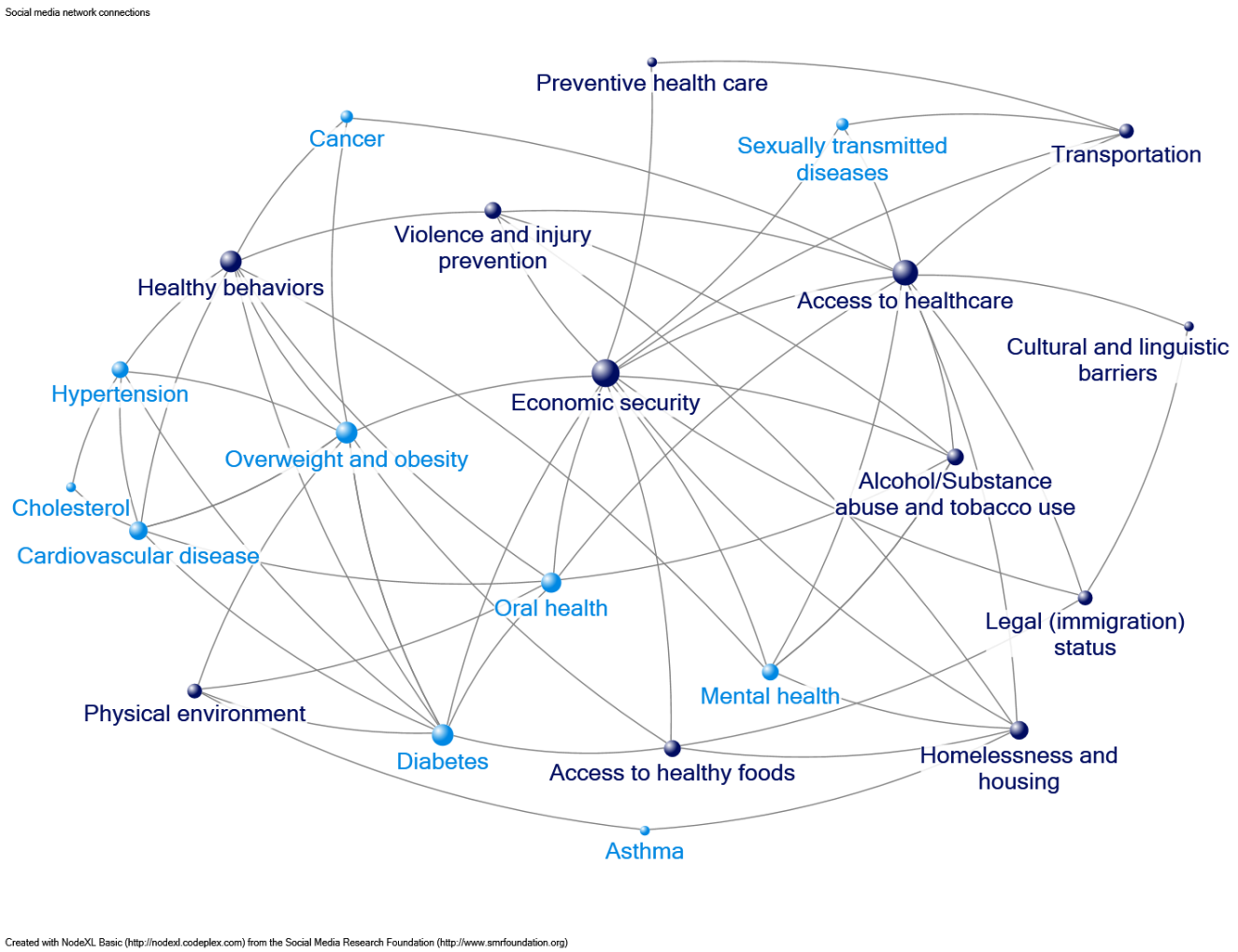
i. Community Health Landscape and Trends

This section describes the top ten prioritized health outcomes and fourteen drivers. Significant health outcomes and health drivers listed in this section were determined by the primary and secondary data collection and analysis (as described in Section V).

a. Significant Morbidity and Mortality (Health Outcomes)

The following section provides descriptions and overviews of the top ten health outcomes identified through the secondary and primary data analysis, and prioritized by stakeholders. Alphabetically, the list of health outcomes includes:

- Asthma
- Cancer
- Cardiovascular Disease/Heart Disease
- Cholesterol (note that Cholesterol is incorporated into the Cardiovascular Disease/HeartDisease section)
- Diabetes
- Hypertension (note that Hypertension is incorporated into the Cardiovascular Disease/Heart Disease section)
- Mental Health
- Obesity/Overweight
- Oral Health
- Sexually Transmitted Diseases



The KFH West Los Angeles CHNA process yielded informative data that will provide useful guidance for the development of their 2016 Implementation Strategy Plan. The data analysis led to an understanding, and a visual representation, of the interconnectedness of the health outcomes and drivers identified during the process. “Connecting the dots” between the outcomes and drivers revealed that all of the service area’s priority health needs are connected to each other through at least one relationship—there are no isolated outcomes or drivers in this system. The figure above illustrates these relationships among 19 of the top priority health outcomes (**light blue**) and health drivers (**dark blue**) identified during the process.

The health outcomes that are connected to the most drivers and other outcomes include overweight and obesity, diabetes, and mental health. Though they are in slightly different order, these are also the top three outcome priorities identified in the 2016 and 2013 CHNA processes. While overweight and obesity numbers have increased since the 2013 report, diabetes and mental illness-related data show decreased rates of both.

The health drivers that are related to the most outcomes and other drivers include economic security, access to health care, and healthy behaviors. The importance of economic security as a driver is also apparent in the demographic data, which show relatively large increases in poverty, unemployment and homelessness within the SPAs for the KH-West Los Angeles service area since the 2013 report. On the positive side, there are fewer uninsured and a higher percentage of those with a usual source of care among the same population.

The following subsections provide an overview of the individual health outcome components.

Asthma

Asthma is a disease that affects the lungs and is one of the most common long-term diseases of children. Adults also may suffer from asthma and the condition is considered hereditary. In most cases, the causes of asthma are not known, and no cure has been identified. Although asthma is always present in those with the condition, attacks only occur when the lungs are irritated. Asthma symptoms include wheezing, breathlessness, chest tightness, and coughing. Some asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroach allergen, pet dander, mold, smoke, other allergens and certain infections known to cause asthma such as the flu, colds, and respiratory related viruses. Other contributing factors include exercising, certain medication, bad weather, high humidity, cold/dry air, certain foods and fragrances[9].

Hospitalizations

In 2012, the asthma hospitalization rate per 100,000 youth in the KFH-West Los Angeles service area was much higher (103.7) than in California (84.5). The communities with the greatest asthma hospitalization rates were Baldwin Hills, including Crenshaw and Leimert Park (225.2), South Los Angeles, including Broadway/Manchester (215.7) and Jefferson Park (199.0).

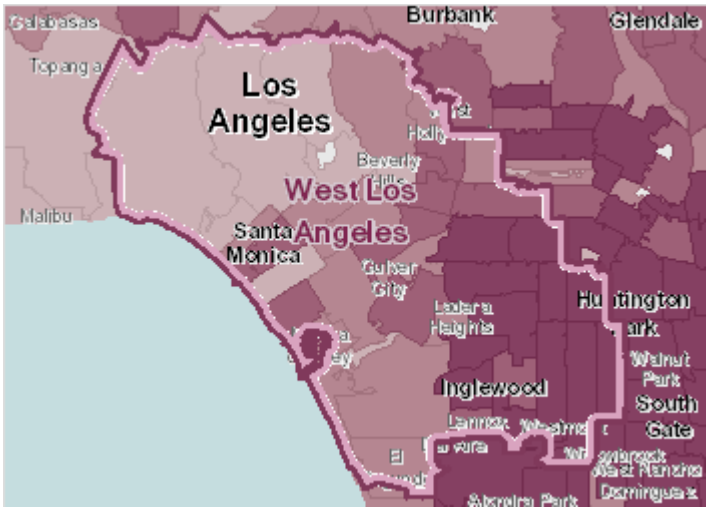
[9] Centers for Disease Control and Prevention (CDC). (2016). *Asthma-Basic Information*. Atlanta, GA. Available at [http://www.cdc.gov/asthma/faqs.htm]. Accessed [May 26, 2016].

Asthma Hospitalization Rate per 100,000 Population, 2012

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	115.4
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	225.2
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	26.1
Beverly Hills	90210, 90211, 90212	5–West	62.6
Century City	90067	5–West	40.5
Cheviot Hills	90064	5–West	46.8
Culver City	90066, 90230, 90232	5–West	73.1
El Segundo	90245	8–South Bay	47.6
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	61.5
Hyde Park, including View Park and Windsor Hills	90043	6–South	198.2
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	169.7
Jefferson Park	90018	6–South	199.0
Ladera Heights	90056	5–West	99.0
Los Angeles International Airport, including Westchester	90045	5–West	66.6
Marina Peninsula	90292	5–West	43.8
Pacific Palisades, including Pacific Highlands	90272	5–West	31.7
Palms	90034	5–West	80.3
Playa Del Rey	90293	5–West	33.5
Playa Vista	90094	5–West	32.7
Santa Monica	90402, 90403, 90404	5–West	37.9
Santa Monica—Downtown	90401	5–West	132.8
Santa Monica—Ocean Park	90405	5–West	45.0
Sawtelle, including West Los Angeles	90025	5–West	36.8
South Los Angeles, including Broadway/Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	215.7
Venice	90291	5–West	55.4
West Adams	90016	6–South	198.0
West Fairfax	90035	5–West	74.6
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	108.4
Westwood	90024	5–West	33.7
KFH-West Los Angeles service area			103.7
California			84.5

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code

The map below illustrates that much of the southeast portion of the service area experiences higher rates of asthma-related hospital discharges.



Asthma Hospital Discharges, Rate (Per 10,000 Pop.) by ZCTA, OSHPD 2011

- Over 10.0
- 6.1 - 10.0
- 3.1 - 6.0
- Under 3.1
- No Data or Data Suppressed
- Report Area

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011, ZIP Code

Cancer

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year[10]. In 2009, cancer incidence rates per 100,000 persons indicated that the three most common cancers among men in the United States were prostate cancer (137.7), lung cancer (64.3), and colorectal cancer (42.5). The leading causes of cancer death among men are lung cancer (62.0), prostate cancer (22.0), and colorectal cancer (19.1). Among women, the leading causes of cancer death are breast cancer (123.1), lung cancer (54.1), and colorectal cancer (37.1).[11]

Research has demonstrated that early detection through regular screenings can help reduce the number of new cancer cases and, ultimately, deaths from cancer.[12] Research has also shown that cancer is associated with certain other diseases and behaviors including obesity; the use of tobacco, alcohol, and certain chemicals; some viruses and bacteria; a family history of cancer; poor diet; and a lack of physical activity.[13]

Incidence

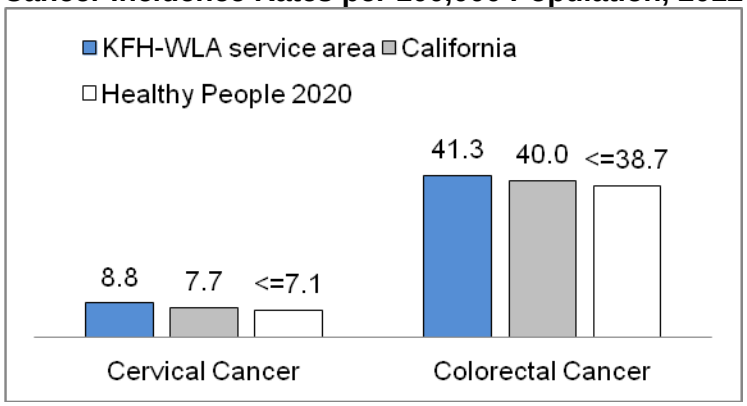
In the KFH-West Los Angeles service area, the incidence rate of cervical cancer per 100,000 population has decreased from 9.8 in the 2013 report to 8.8. However, it remains higher than in California (7.7) and in relation to the Healthy People 2020 goal of <=7.1. Similarly, the colorectal incidence rate per 100,000 population has decreased from 45.2 to 41.3 in the KFH-West Los Angeles

[10] Centers for Disease Control and Prevention. (2015). *Using Science to Reduce the Burden of Cancer.* Atlanta, GA. Available at http://www.cdc.gov/Features/CancerResearch/. Accessed December 1, 2015.
[11] Centers for Disease Control and Prevention. (2013). *Invasive Cancer Incidence.* Atlanta, GA. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a1.htm. Accessed December 1, 2015.
[12] Centers for Disease Control and Prevention. (2015). *Cancer Prevention*. Atlanta, GA. Available at http://www.cdc.gov/cancer/dcpc/prevention/index.htm. Accessed December 1, 2015.
[13] National Cancer Institute. (2015). *Cancer Prevention Overview*. Available at http://www.cancer.gov/cancertopics/pdq/prevention/overview/patient/page3. Bethesda, MD. Available at December 1, 2015.

service area, though it remains higher than in California (40.0) and per the Healthy People 2020 goal of <=38.7.

Stakeholders added that African-American and low-income women are most affected by breast cancer. They added that low-income people are most often affected by colorectal cancer and prostate cancer is most common among African-Americans.

Cancer Incidence Rates per 100,000 Population, 2012



Source: National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2008–12, County

Mortality

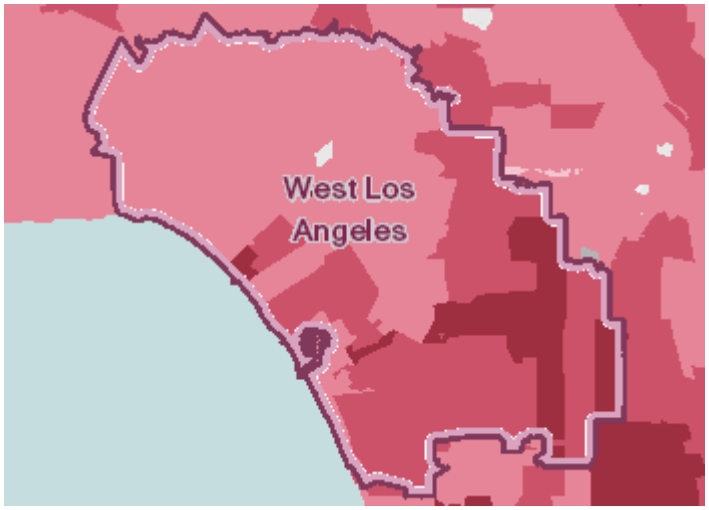
In 2012, a total of 19,732 people died from cancer in the KFH-West Los Angeles service area at a rate of 164.8 per 100,000 population. This is an increase from the 2013 report where the rate was 154.5 (increase of 10.3). This rate is also higher than Los Angeles County (153.0), which decreased from the 2013 report (156.5). The rate is again higher than California (157.1) and the Healthy People 2020 goal of <=160.6.

Cancer Mortality Rate per 100,000 Population, 2012

Report Area	Number	Rate
KFH-West Los Angeles	19,732	164.8
Los Angeles County	41,970	153.0
California	169,867	157.1
Healthy People 2020		<=160.6

Source: University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health (CDPH) Death Public Use Data, 2010–12, ZIP Code

The map below shows that certain communities in the KFH-West Los Angeles service area experience higher cancer mortality rates, including Crenshaw, Ladera Heights, Leimert Park, Inglewood, South Los Angeles, and Santa Monica.



Cancer Mortality, Age-Adjusted Rate (Per 100,000 Population) by ZCTA, CDPH 2010–12

Over 250.0
200.1–250.0
150.1–200.0
100.1–150.0
Under 100.1
No Data or Data Suppressed
Report Area

Source: University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health (CDPH) Death Public Use Data, 2010–12, ZIP Code

Cardiovascular/Heart Disease

Cardiovascular/heart disease—also known as heart disease and coronary heart disease—includes several health conditions related to plaque buildup in the walls of the arteries, or atherosclerosis. As plaque builds up, the arteries narrow, restricting blood flow and creating a risk of heart attack. Currently, more than one in three adults (81.1 million) in the United States live with one or more types of cardio-vascular/heart disease. In addition to its being one of the leading causes of death in the United States, heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.[14] Cardiovascular/heart health is also significantly influenced by physical, social, and economic factors including maternal and child health, access to educational opportunities, availability of and access to healthy foods, physical activity, access to safe and walkable communities, and access to affordable, high-quality health care.[15]

Prevalence

The prevalence rates presented in this section are for the SPAs that span the KFH-West Los Angeles service area. Please keep in mind that most of the KFH-West Los Angeles service area falls in SPA 5 – West and SPA 6 – South, and small portions of SPA 4 – Metro and SPA 8 – South Bay. A greater percentage of people diagnosed with heart disease was reported in SPA 6 –South (8.6%) compared to Los Angeles County (5.7%) and California (6.1%). SPA 6 – South is also the only area where the average percentage of heart disease prevalence is higher than reported in the 2013 CHNA, which was 5.8%.

Stakeholders added that African-Americans, Hispanics/Latinos, Asians, smokers, and those who live in poverty are most often affected by heart disease.

[14] U.S. Department of Health and Human Services. (2015). *Heart Disease and Stroke.* Washington, DC. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21. Accessed November 30, 2015.
[15] U.S. Department of Health and Human Services. (2015). *Heart Disease and Stroke.* Washington, DC. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21. Accessed January 26, 2015.

Heart-Disease Diagnosis, 2014

Report Area	Percent
SPA 4–Metro	2.4%
SPA 5–West	4.8%
SPA 6–South	8.6%
SPA 8–South Bay	5.7%
Los Angeles County	5.7%
California	6.1%

Source: California Health Interview Survey, 2014, SPA

Hospitalizations

In the KFH-West Los Angeles service area, the heart disease hospitalization rate per 100,000 population was much higher (397.1) when compared to Los Angeles County (366.6) and California (339.0). However, this number is almost a third of the rate reported in the 2013 CHNA (1,129.9). In Century City (930.8) and Baldwin Hills (728.9), hospitalization rates were more than twice as high as in the service area overall. Other communities experiencing high rates of hospitalization for heart disease include Hyde Park (572.3), South Los Angeles (561.1), Ladera Heights (556.8), and Jefferson Park (515.8). This may indicate a lack of awareness in the population about recognizing the symptoms of heart disease, receiving regular care to monitor heart health, and leading a healthy lifestyle.

Mortality

Though they remained about the same as the 2013 reported numbers, heart disease–related death rates in the KFH-West Los Angeles service area were also high when compared to California—19.4 deaths per 10,000 population as compared to 15.5 for the state. Rates were higher in the southeast portion of the service area, and two or more times higher in Century City (60.7) and Ladera Heights (36.6).

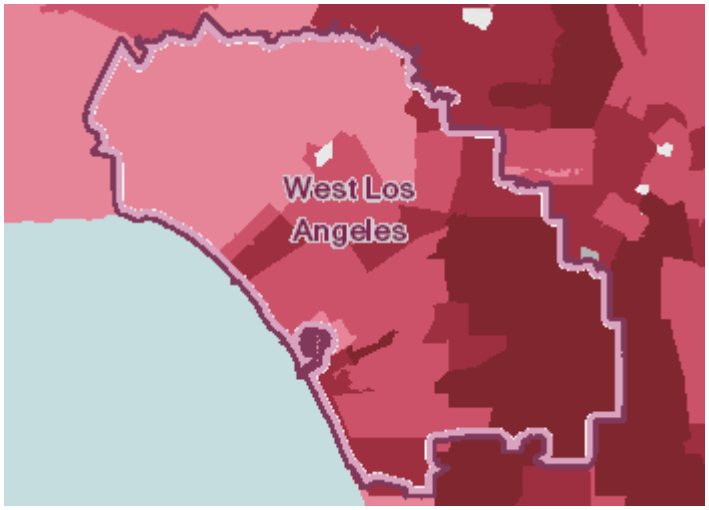
Heart-Disease Hospitalization Rate per 100,000 Population and Mortality Rate per 10,000 Population, 2012

Community	ZIP Code	Service Planning Area (SPA)	Hospitalization Rate	Mortality Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	358.6	17.0
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	728.9	26.6
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	256.4	20.8
Beverly Hills	90210, 90211, 90212	5–West	389.1	20.5
Century City	90067	5–West	930.8	60.7
Cheviot Hills	90064	5–West	335.4	22.2
Culver City	90066, 90230, 90232	5–West	343.9	19.8
El Segundo	90245	8–South Bay	220.2	14.9

Community	ZIP Code	Service Planning Area (SPA)	Hospitalization Rate	Mortality Rate
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	245.8	15.0
Hyde Park, including View Park and Windsor Hills	90043	6–South	572.3	23.2
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	475.0	14.5
Jefferson Park	90018	6–South	515.8	22.4
Ladera Heights	90056	5–West	556.8	36.6
Los Angeles International Airport, including Westchester	90045	5–West	312.6	16.1
Marina Peninsula	90292	5–West	241.0	14.5
Pacific Palisades, including Pacific Highlands	90272	5–West	362.1	23.1
Palms	90034	5–West	228.8	13.2
Playa Del Rey	90293	5–West	201.0	19.3
Playa Vista	90094	5–West	212.7	11.5
Santa Monica	90402, 90403, 90404	5–West	289.2	19.2
Santa Monica—Downtown	90401	5–West	369.0	10.3
Santa Monica—Ocean Park	90405	5–West	296.3	21.0
Sawtelle, including West Los Angeles	90025	5–West	225.5	13.4
South Los Angeles, including Broadway Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	561.1	17.1
Venice	90291	5–West	207.9	9.4
West Adams	90016	6–South	487.7	19.6
West Fairfax	90035	5–West	393.4	20.4
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	437.9	26.3
Westwood	90024	5–West	231.5	15.2
KFH-West Los Angeles service area			397.1	19.4
Los Angeles County			366.6	
California			339.0	15.5

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code
Source: California Department of Public Health, Death Statistical Master File, 2012, ZIP Code

The map below shows the southeast portion of the KFH-West Los Angeles service area as the most affected by high heart disease mortality rates, including Ladera Heights and Century City, as well as Crenshaw, Inglewood, Leimert Park, Lennox, South Los Angeles, Westmont, and West Athens among others.



Heart-Disease Mortality, Age-Adjusted Rate (Per 100,000 Population) by ZCTA, CDPH 2010–12

Over 200.0
160.1–200.0
120.1–160.0
80.1–120.0
Under 80.1
No Data or Data Suppressed
Report Area

Source: University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health (CDPH) Death Public Use Data, 2010–12, ZIP Code

Cholesterol

High cholesterol is associated with health issues such as diabetes and overweight/obesity. In addition, certain unhealthy behaviors contribute to the development of high cholesterol including physical inactivity, an unhealthy diet, tobacco use, and alcohol abuse.[i] A stakeholder observed that cholesterol is kept under control through education and access to health care.

Diabetes[ii] and obesity[iii] increase the risk for cholesterol. Similarly, lifestyle choices can increase a person's risk for high cholesterol: persons who consume diets high in saturated fats, trans-fat, and cholesterol have been linked to high cholesterol and related conditions, such as heart disease[iv]. Genetic factors likely play some role in high cholesterol, heart disease, and other related conditions. However, it is also likely that people with a family history of high cholesterol share common environmental and other potential factors that increase their risk[v].

In the KFH-West Los Angeles (KFH-WLA) Service Area, almost a quarter (24.6%) of the population was diagnosed with high cholesterol.

Hypertension

Hypertension, related to cardiovascular disease was also identified as a health outcome. Hypertension is defined as a blood pressure reading of 140/90 mmHg or higher, affects one in three adults in the United States.[16] With no symptoms or warning signs and the ability to cause serious damage, the condition has been called a silent killer. If untreated, high blood pressure can lead to blood vessel aneurysm, chronic kidney disease (which may lead to kidney failure), cognitive changes (including memory loss), eye damage, heart attack, heart failure, peripheral arterial disease, and stroke.[17] High

[16] National Institutes of Health. (2013). *Hypertension (High Blood Pressure).* Bethesda, MD. Available at http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97. Accessed December 1, 2015.
[17] National Heart, Lung, and Blood Institute. (2015). *What are the Signs and Symptoms of Blood Pressure? Bethesda, MD.* Available at http://www.nhlbi.nih.gov/health/health-topics/topics/hbp/signs.html. Accessed December 1, 2015.

blood pressure can be controlled through medication and lifestyle changes; however, lack of patient adherence to treatment regimens is a significant barrier to controlling the condition.[18]

Changes in the body's normal functions may cause hypertension, including changes to kidney fluid and salt balances, the renin-angiotensin-aldosterone system (a complex system involving hormonal control of blood pressure and fluid balance), sympathetic nervous system activity, and blood vessel structure and function.[19] Other causes of hypertension include unhealthy lifestyle habits, the use of certain medicines, and other health outcomes such as obesity or being overweight, diabetic, or having chronic kidney disease. People with diabetes or chronic kidney disease are advised to maintain blood pressure readings below 130/80 mmHg.[20]

Prevalence

The percentages represented in this section are for the SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8.Greater percentages of persons diagnosed with hypertension were reported in SPA 6–South (35.7%) and SPA 8–South Bay (34.0%) when compared to Los Angeles County (27.3%), California (28.5%), and the Healthy People 2020 goal of <=26.9%. SPA 5–West had a lower percentage (26.8%) relative to the county and state and met the Healthy People 2020 goal.

Stakeholders added that hypertension is most common among Hispanics/Latinos and African-Americans. In addition, stakeholders indicated the condition is common among those with developmental delays because of their inability to properly care for themselves and lead healthy lifestyles.

Diagnosed with Hypertension, 2014

Report Area	Percent
SPA 4–Metro	28.6%
SPA 5–West	26.8%
SPA 6–South	35.7%
SPA 8–South Bay	34.0%
Los Angeles County	27.3%
California	28.5%
Healthy People 2020	<=26.9%

Source: California Health Interview Survey, 2014, SPA

Stroke

Strokes are a leading risk factor for cardiovascular/heart disease and share many of the same risk factors. In the KFH-West Los Angeles service area, the mortality rate (3.4 per 10,000 population) is similar to that in California (3.5). Certain communities experience much higher rate of stroke, however, including Santa Monica (5.5), Hyde Park (4.9), West Adams (4.6), Ocean Park (4.5), and Pacific Palisades (4.5). Stakeholders also added that African-Americans and Native Americans most often experience strokes.

Stroke Mortality Rate per 10,000 Population, 2012

[18] National Institutes of Health. (2013). *Hypertension (High Blood Pressure).* Bethesda, MD. Available at http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97. Accessed December 1, 2015.
[19] National Institutes of Health. (2015). *Causes of High Blood Pressure.* Bethesda, MD. Available at: http://www.nhlbi.nih.gov/health/health-topics/topics/hbp/causes. Accessed January 25, 2016.
[20] National Institutes of Health. (2015). *Description of High Blood Pressure*. Bethesda, MD. Available at https://www.nhlbi.nih.gov/health/health-topics/topics/hbp. Accessed January 25, 2016.

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	3.1
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	3.8
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	3.9
Beverly Hills	90210, 90211, 90212	5–West	4.0
Century City	90067	5–West	0.0
Cheviot Hills	90064	5–West	3.9
Culver City	90066, 90230, 90232	5–West	3.9
El Segundo	90245	8–South Bay	2.4
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	3.7
Hyde Park, including View Park and Windsor Hills	90043	6–South	4.9
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	2.7
Jefferson Park	90018	6–South	2.3
Ladera Heights	90056	5–West	0.0
Los Angeles International Airport, including Westchester	90045	5–West	4.4
Marina Peninsula	90292	5–West	2.6
Pacific Palisades, including Pacific Highlands	90272	5–West	4.5
Palms	90034	5–West	1.2
Playa Del Rey	90293	5–West	2.5
Playa Vista	90094	5–West	1.6
Santa Monica	90402, 90403, 90404	5–West	5.5
Santa Monica—Downtown	90401	5–West	3.0
Santa Monica—Ocean Park	90405	5–West	4.5
Sawtelle, including West Los Angeles	90025	5–West	3.2
South Los Angeles, including Broadway/Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	3.6
Venice	90291	5–West	3.5
West Adams	90016	6–South	4.6
West Fairfax	90035	5–West	1.7
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	4.1
Westwood	90024	5–West	4.0
KFH-West Los Angeles service area			3.4
California			3.5

Source: California Department of Public Health, Death Statistical Master File, 2012, ZIP Code.

Diabetes

Diabetes affects an estimated 23.6 million people and is the seventh leading cause of death in the United States. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputation, and adult-onset blindness.[21] A diabetes diagnosis can also indicate an unhealthy lifestyle (a risk factor for other health outcomes) and is also linked to obesity. Given the steady rise in the number of people with diabetes and the earlier onset of Type 2 diabetes, there is growing concern in the health provider and policy fields about substantial increases in diabetes-related complications and their potential to overwhelm the health care system. There is a clear need to take advantage of recent discoveries about the individual and societal benefits of improved diabetes management and prevention by bringing those findings into wider practice and complementing them with efforts in primary prevention among those most at risk for developing diabetes. Diabetes is associated with health outcomes like heart disease and is also closely linked to social, economic, and environmental factors regarding access to health care, healthy food and green space, exercise, and healthy eating.[22]

Prevalence

The percentages represented in this section are for the SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8. Higher percentages of populations diagnosed with diabetes were reported in SPA 6–South (14.7%), SPA 4–Metro (11.1%), and SPA 8–South Bay (10.4%) when compared to Los Angeles County (10.0%) and California (8.9%). SPA 5–West had the lowest reported percentage, less than half of that reported for Los Angeles County.

Stakeholders added that youth and people living in poverty are more often affected by diabetes. In addition, stakeholders shared that diabetes-related complications including kidney failure are common among Hispanics/Latino and African-Americans living in the service area.

Diagnosed with Diabetes, 2014

Report Area	Percent
SPA 4–Metro	11.1%
SPA 5–West	4.6%
SPA 6–South	14.7%
SPA 8–South Bay	10.4%
Los Angeles County	10.0%
California	8.9%

Source: California Health Interview Survey, 2014, SPA

Hospitalizations

Diabetes-related hospitalizations may indicate a lack of awareness of having the condition, not following a designated health management plan, and/or not leading a healthy lifestyle. In the KFH-West Los Angeles service area, the diabetes-related hospitalization rate per 100,000 adults decreased greatly since the 2013 report, from 200.2 to 160.0. The current rate is higher than California (142.6) but

[21] U.S. Department of Health and Human Services. (2015). Office of Disease Prevention and Health Promotion. *Diabetes.* Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/diabetes. Accessed November 30, 2015.
[22] U.S. Department of Health and Human Services. (2015). *Diabetes.* Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/diabetes. Accessed November 30, 2015.

lower than Los Angeles County (171.7). Certain communities in the service area are experiencing much higher rates including Jefferson Park (363.2), Baldwin Hills (353.5), West Adams (314.7), and South Los Angeles (307.2).

Youth under the age of 18 in the service area are being hospitalized for diabetes at a lower rate (27.2 per 100,000 youth) when compared to Los Angeles County (27.7) and California (31.2). However, youth in certain communities experience much higher rates of hospitalization, including in the Marina Peninsula (71.2), Playa Vista (48.9), and Ladera Heights (45.1).

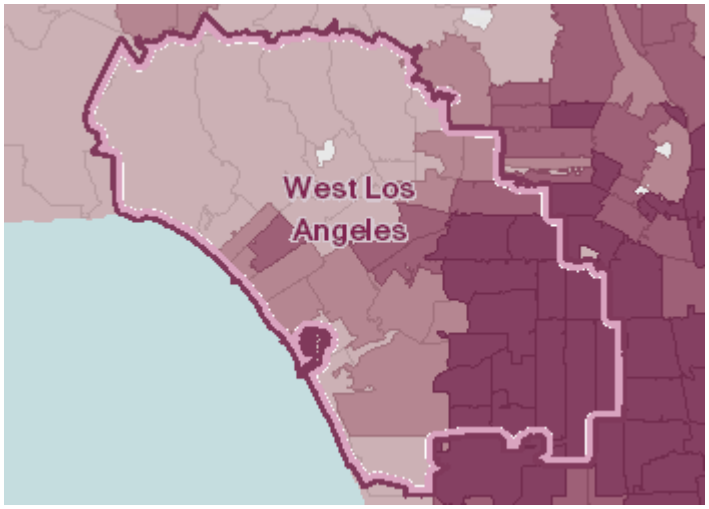
Diabetes Hospitalization Rate per 100,000 Population, 2012

Community	ZIP Code	Service Planning Area (SPA)	Adults	Youth
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	193.3	11.2
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	353.5	36.7
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	33.3	6.0
Beverly Hills	90210, 90211, 90212	5–West	58.9	16.6
Century City	90067	5–West	121.4	*Not available*
Cheviot Hills	90064	5–West	85.8	14.3
Culver City	90066, 90230, 90232	5–West	107.5	30.3
El Segundo	90245	8–South Bay	95.2	9.3
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	109.5	11.7
Hyde Park, including View Park and Windsor Hills	90043	6–South	298.4	39.7
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	276.7	36.3
Jefferson Park	90018	6–South	363.2	9.9
Ladera Heights	90056	5–West	272.2	45.1
Los Angeles International Airport, including Westchester	90045	5–West	107.6	4.5
Marina Peninsula	90292	5–West	48.2	71.2
Pacific Palisades, including Pacific Highlands	90272	5–West	45.3	31.0
Palms	90034	5–West	112.7	9.5
Playa Del Rey	90293	5–West	58.6	27.8
Playa Vista	90094	5–West	16.4	48.9
Santa Monica	90402, 90403, 90404	5–West	70.8	22.2
Santa Monica—Downtown	90401	5–West	265.7	*Not available*
Santa Monica—Ocean Park	90405	5–West	63.8	8.9

Community	ZIP Code	Service Planning Area (SPA)	Adults	Youth
Sawtelle, including West Los Angeles	90025	5–West	87.5	27.2
South Los Angeles, including Broadway/Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	307.2	34.5
Venice	90291	5–West	114.4	25.5
West Adams	90016	6–South	314.7	26.5
West Fairfax	90035	5–West	98.4	18.3
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	119.0	15.1
Westwood	90024	5–West	37.9	39.7
KFH-West Los Angeles service area			160.0	27.2
Los Angeles County			171.7	27.7
California			142.6	31.2

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code
Not available = data were not available or reported for the geography.

The map below illustrates that much of the southeast portion of the service area experiences higher rates of diabetes-related hospitalizations—in addition to the communities mentioned above, Crenshaw, Inglewood, Leimert Park, Lennox, South Los Angeles, Westmont, and West Athens.



Diabetes Hospital Discharges, Rate (Per 10,000 Population) by ZCTA, OSHPD 2011

- Over 12.0
- 7.1–12.0
- 4.1–7.0
- Under 4.1
- No Data or Data Suppressed
- Report Area

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011. Source geography: ZIP Code

Nearly twice as many people (8.2 per 100,000 population) in the KFH-West Los Angeles service area have been hospitalized with uncontrolled diabetes when compared to Los Angeles County (4.5), an incidence rate that is three times higher than in California overall (2.8). Even higher rates were reported in Culver City (15.1), Hyde Park (9.2), and South Los Angeles (9.0) among others.

Uncontrolled Diabetes Hospitalization Rate per 100,000 Population, 2012

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	2.2
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	*Not available*
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	*Not available*
Beverly Hills	90210, 90211, 90212	5–West	*Not available*
Century City	90067	5–West	*Not available*
Cheviot Hills	90064	5–West	*Not available*
Culver City	90066, 90230, 90232	5–West	15.1
El Segundo	90245	8–South Bay	*Not available*
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	*Not available*
Hyde Park, including View Park and Windsor Hills	90043	6–South	9.2
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	6.8
Jefferson Park	90018	6–South	*Not available*
Ladera Heights	90056	5–West	*Not available*
Los Angeles International Airport, including Westchester	90045	5–West	*Not available*
Marina Peninsula	90292	5–West	*Not available*
Pacific Palisades, including Pacific Highlands	90272	5–West	*Not available*
Palms	90034	5–West	*Not available*
Playa Del Rey	90293	5–West	*Not available*
Playa Vista	90094	5–West	*Not available*
Santa Monica	90402, 90403, 90404	5–West	*Not available*
Santa Monica—Downtown	90401	5–West	*Not available*
Santa Monica—Ocean Park	90405	5–West	*Not available*
Sawtelle, including West Los Angeles	90025	5–West	*Not available*

Community	ZIP Code	Service Planning Area (SPA)	Rate
South Los Angeles, including Broadway/Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	9.0
Venice	90291	5–West	8.5
West Adams	90016	6–South	*Not available*
West Fairfax	90035	5–West	*Not available*
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	*Not available*
Westwood	90024	5–West	*Not available*
KFH-West Los Angeles service area			8.2
Los Angeles County			4.5
California			2.8

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code
Not available = data were not available or reported for the geography.

Mental Health

Mental illness is a major and complex health need which—if left untreated—may put individuals at risk for substance abuse, self-destructive behavior, and even suicide. Additionally, mental health disorders can have a serious impact on physical health and can be associated with the prevalence, progression, and outcome of chronic diseases.[23]

Suicide is considered a major preventable public health problem in the United States. In 2010, suicide was the tenth leading cause of death among Americans of all ages, and the second leading cause of death among people between the ages of 25 to 34.[24] An estimated 11 attempted suicides occur for every suicide death. Research shows that more than 90 percent of those who die by suicide suffer from depression, other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders).[25]

New mental health needs have emerged among some special populations, such as veterans who have experienced physical and mental trauma; people in communities with psychological trauma caused by natural disasters; and older adults, as the awareness, understanding, and treatment of dementia and mood disorders continues to improve.[26] The stigma associated with mental health results in prejudice,

[23] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28. Accessed January 22, 2016.
[24] Centers for Disease Control and Prevention. *10 Leading Causes of Death by Age Group, United States – 2010*. Available at http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf. Accessed January 22, 2016.
[25] National Institute of Mental Health. *Suicide in the U.S.: Statistics and Prevention*. Available at http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml. Accessed January 22, 2016.
[26] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28. Accessed January 22, 2016.

avoidance, rejection, and discrimination directed at people believed to have an illness, disorder, or other trait perceived to be undesirable. Such stigma causes suffering, potentially causing a person to deny symptoms, delay treatment, and refrain from daily activities. Stigma can also exclude people from access to housing, employment, insurance, and appropriate medical care. Stigma can interfere with prevention efforts, and examining and combating stigma is a public health priority.[27]

Prevalence

The percentages represented in this section are for the SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8. A third of teens age 14 to 17 in SPA 5–West (30.1%) and SPA 6 –South (30.4%)—representing larger areas of the service area—reported being at risk for depression. Percentages in these SPAs are well above the average for Los Angeles County (23.1%) and California (21.0%). Adults were also at risk for depression, though not as much as teens. However, a greater percentage of adults in SPA 6–South (13.3%) and SPA 4–Metro (11.6%) reported being at risk for depression than in Los Angeles County (10.4%).

At Risk for Depression, 2011, 2014

Report Area	Teens[1]	Adults[2]
SPA 4–Metro	22.0%	11.6%
SPA 5–West	30.1%	5.8%
SPA 6–South	30.4%	13.3%
SPA 8–South Bay	18.8%	9.3%
Los Angeles County	23.1%	10.4%
California	21.0%	

Source: California Health Interview Survey, 2014, SPA[1]
Source: Los Angeles County Health Survey, 2011, SPA[2]

Higher percentages of adults were diagnosed with depression in SPA 4 (13.4%) and SPA 5 (13.4%) than in Los Angeles County (12.2%), and higher percentages were diagnosed with anxiety in SPA 5 (13.7%) and SPA 4 (12.0%) than in Los Angeles County (11.3%).

Stakeholders added that mental health issues are increasingly common among Hispanics/Latinos, youth, and those with a disability.

Mental Health Diagnoses, 2011

Report Area	Depression	Anxiety
SPA 4–Metro	13.4%	12.0%
SPA 5–West	13.4%	13.7%
SPA 6–South	10.8%	10.1%
SPA 8–South Bay	10.7%	10.2%
Los Angeles County	12.2%	11.3%

Source: Los Angeles County Health Survey, 2011, SPA

Alcohol and drug use can often contribute to the development or worsening of a mental health issue. In the KFH-West Los Angeles service area, a higher rate (168.6 per 100,000 population) of alcohol- and

[27] U.S. Department of Health & Human Services. Centers for Disease Control and Prevention. *Stigma and Mental Illness*. Atlanta GA. Available at http://www.cdc.gov/mentalhealth/basics/stigma-illness.htm. Accessed January 22, 2016.

drug-induced mental health disease was reported than in Los Angeles County (125.8) and California (102.5). Particularly high rates were reported in the communities of Beverly Hills (602.9) and Ocean Park (303.8).

Alcohol- and Drug-Induced Mental Health Disease Rate per 100,000 Population, 2012

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4-Metro LA	92.0
Baldwin Hills, including Crenshaw and Leimert Park	90008	6-South	172.1
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5-West	65.4
Beverly Hills	90210, 90211, 90212	5-West	602.9
Century City	90067	5-West	80.9
Cheviot Hills	90064	5-West	113.1
Culver City	90066, 90230, 90232	5-West	199.1
El Segundo	90245	8-South Bay	107.1
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4-Metro LA	98.9
Hyde Park, including View Park and Windsor Hills	90043	6-South	115.8
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8-South Bay	93.3
Jefferson Park	90018	6-South	85.0
Ladera Heights	90056	5-West	136.1
Los Angeles International Airport, including Westchester	90045	5-West	87.1
Marina Peninsula	90292	5-West	232.3
Pacific Palisades, including Pacific Highlands	90272	5-West	212.7
Palms	90034	5-West	141.7
Playa Del Rey	90293	5-West	92.1
Playa Vista	90094	5-West	65.4
Santa Monica	90402, 90403, 90404	5-West	125.3
Santa Monica—Downtown	90401	5-West	487.1
Santa Monica—Ocean Park	90405	5-West	303.8

Community	ZIP Code	Service Planning Area (SPA)	Rate
Sawtelle, including West Los Angeles	90025	5-West	105.9
South Los Angeles, including Broadway/Manchester	90037, 90044, 90047, 90062, 90003	6-South, 8-South Bay	83.2
Venice	90291	5-West	259.9
West Adams	90016	6-South	164.7
West Fairfax	90035	5-West	88.2
West Hollywood, including West Beverly	90069, 90048	4-Metro LA	248.1
Westwood	90024	5-West	54.7
KFH-West Los Angeles service area			168.6
Los Angeles County			125.8
California			102.5

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code

Hospitalizations

Mental health hospitalizations can be caused by a number of factors, including a lack of awareness or education about mental health, an unhealthy lifestyle, and/or a gap in preventive services. In the KFH-West Los Angeles service area, mental health hospitalizations are comparatively high among youth and adults. Youth in the service area experience a higher rate (388.0 per 100,000 adults) of mental health hospitalizations when compared to Los Angeles County (377.1) and California (294.8). However, much higher rates were reported in Ladera Heights (946.6), Downtown Santa Monica (938.0), and Century City (836.8). Adults in the service area experience a higher rate (657.2 per 100,000 adults) of mental health hospitalizations when compared to California (540.9) but fewer than Los Angeles County (677.0). Much higher rates were reported in Downtown Santa Monica (2,081.2), West Adams (1,386.0), Jefferson Park (1,323.3), Hyde Park (1,109.0), and Baldwin Hills (1,107.4).

Mental Health Hospitalization Rates per 100,000 Population, 2012

Community	ZIP Code	Service Planning Area (SPA)	Youth	Adults
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	302.5	703.1
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	463.0	1,107.4
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	216.7	314.5
Beverly Hills	90210, 90211, 90212	5–West	527.4	311.9
Century City	90067	5–West	836.8	768.9
Cheviot Hills	90064	5–West	370.6	413.4

Community	ZIP Code	Service Planning Area (SPA)	Youth	Adults
Culver City	90066, 90230, 90232	5–West	374.5	604.5
El Segundo	90245	8–South Bay	361.5	333.3
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	198.7	774.8
Hyde Park, including View Park and Windsor Hills	90043	6–South	522.5	1,109.0
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	257.6	514.1
Jefferson Park	90018	6–South	360.7	1,323.3
Ladera Heights	90056	5–West	946.6	705.3
Los Angeles International Airport, including Westchester	90045	5–West	246.6	397.2
Marina Peninsula	90292	5–West	142.5	425.1
Pacific Palisades, including Pacific Highlands	90272	5–West	359.7	393.8
Palms	90034	5–West	644.1	623.2
Playa Del Rey	90293	5–West	111.3	134.0
Playa Vista	90094	5–West	391.4	294.5
Santa Monica	90402, 90403, 90404	5–West	535.8	481.8
Santa Monica—Downtown	90401	5–West	938.0	2,081.2
Santa Monica—Ocean Park	90405	5–West	348.0	585.1
Sawtelle, including West Los Angeles	90025	5–West	217.5	423.5
South Los Angeles, including Broadway Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	466.9	908.7
Venice	90291	5–West	204.1	363.9
West Adams	90016	6–South	320.9	1,386.0
West Fairfax	90035	5–West	299.7	949.7
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	382.8	675.1
Westwood	90024	5–West	387.4	345.2
KFH-West Los Angeles service area			388.0	657.2
Los Angeles County			377.1	677.0
California			294.8	540.9

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code

Suicide

Suicide is closely linked with mental health outcomes such as depression. The percentages represented in this section are for SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPA 5–West and SPA 6–South, with only small portions being in SPA 4–Metro and SPA 8–South Bay. Higher percentages of adults in SPA 4–Metro and SPA 8–South Bay reported having thoughts of suicide at some point in their life (9.7% and 9.2%, respectively) than in Los Angeles County (7.2%) and California (7.8%).

Suicidal Thoughts, 2014

Report Area	Percent
SPA 4–Metro	9.7%
SPA 5–West	6.9%
SPA 6–South	5.2%
SPA 8–South Bay	9.2%
Los Angeles County	7.2%
California	7.8%

Source: California Health interview Survey, 2014, SPA

The suicide rate was slightly higher (1.1 per 100,000 youth) in the KFH-West Los Angeles service area when compared to California (1.0) and the Healthy People 2020 goal of <=1.0. However, suicide rates were two or more times higher in Downtown Santa Monica (5.9), Playa Del Rey (2.5), and El Segundo (2.4).

Suicide Rate per 100,000 Youth, 2012

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	0.6
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	0.6
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	1.3
Beverly Hills	90210, 90211, 90212	5–West	1.6
Century City	90067	5–West	0.0
Cheviot Hills	90064	5–West	2.0
Culver City	90066, 90230, 90232	5–West	0.9
El Segundo	90245	8–South Bay	2.4
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	1.1
Hyde Park, including View Park and Windsor Hills	90043	6–South	0.7
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	0.9
Jefferson Park	90018	6–South	0.6
Ladera Heights	90056	5–West	1.2
Los Angeles International Airport, including Westchester	90045	5–West	1.0

Community	ZIP Code	Service Planning Area (SPA)	Rate
Marina Peninsula	90292	5–West	1.8
Pacific Palisades, including Pacific Highlands	90272	5–West	0.9
Palms	90034	5–West	1.0
Playa Del Rey	90293	5–West	2.5
Playa Vista	90094	5–West	0.0
Santa Monica	90402, 90403, 90404	5–West	1.3
Santa Monica—Downtown	90401	5–West	5.9
Santa Monica—Ocean Park	90405	5–West	1.9
Sawtelle, including West Los Angeles	90025	5–West	1.2
South Los Angeles, including Broadway/Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	0.4
Venice	90291	5–West	1.4
West Adams	90016	6–South	0.2
West Fairfax	90035	5–West	1.0
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	1.7
Westwood	90024	5–West	0.6
KFH-West Los Angeles service area			1.1
California			1.0
Healthy People 2020			<=1.0

Source: California Department of Public Health, Death Statistical Master File, 2012

Overweight and Obesity

Obesity is defined as having a body mass index (BMI) of 30.0 or higher; being overweight is defined by a BMI between 25.0 and 29.9. Excess weight is a significant national problem and indicates unhealthy lifestyles that influences further health needs. Obesity reduces life expectancy and causes devastating and costly health problems, increasing the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases.[28] Being overweight or obese results from a combination of causes and contributing factors, including behavior and genetics.[29] Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures. Additional contributing factors include food and physical activity, environment, education and skills, and food marketing and promotion. Some Americans have less access to stores and markets that provide healthy, affordable food such as fruits and vegetables, especially in rural, minority, and lower-income neighborhoods.[30]

Obesity in particular is a serious concern, associated with a reduced quality of life and many serious diseases and health conditions, including diabetes, heart disease, stroke, high blood pressure (hypertension),

[28] National Cancer Institute. (2012). *Obesity and Cancer Risk*. Bethesda, MD. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed November 30, 2015.
[29] Centers for Disease Control and Prevention. (2015). *Adult Obesity Causes & Consequences.* Atlanta, GA. Available at http://www.cdc.gov/obesity/adult/causes.html. Accessed January 22, 2016.
[30] Ibid.

high cholesterol, and mental illnesses such as clinical depression and anxiety.[31] Findings suggest that obesity also increases the risks for cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types.[32]

Prevalence

The percentages represented in this section are for the SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8. More than a third of the population in all the SPAs reported being overweight—a BMI between 20.00 and 29.99. SPA 5 (38.8%) and SPA 4 (37.0%) reported the greatest percentages of overweight adults, overtaking percentages for California (35.5%) and Los Angeles County (36.2%). Although SPA 5 reported the greatest percentage of overweight adults (38.8%), it also reported the lowest percentage of obese adults (a BMI of 30 or higher). This is more than percentages reported for Los Angeles County (27.2%) and California (27.0%), but it met the Healthy People 2020 goal of <=30.5%. Higher percentages of adults were obese in SPA 6 (38.6%) and SPA 8 (30.2%)

Stakeholders noted that being overweight or obese was most common among Hispanics/Latino and youth as young as 12 years of age.

Overweight and Obese Adults, 2014

Report Area	Overweight (20.00–29.99 BMI)	Obese (30 or higher BMI)
SPA 4–Metro	37.0%	29.1%
SPA 5–West	38.8%	14.5%
SPA 6–South	35.9%	38.6%
SPA 8–South Bay	34.1%	30.2%
Los Angeles County	36.2%	27.2%
California	35.5%	27.0%
Healthy People 2020		<=30.5%

Source: California Health Interview Survey, 2014, SPA

A larger percentage (23.9%) of youth in the same grade levels were classified as obese when compared to Los Angeles County (21.5%) and California (19.0%). However, this is a drop of 12.7% from the 2013 CHNA report (36.6%)

Overweight Youth, 2014

Report Area	Percent
KFH-West Los Angeles service area	20.7%
Los Angeles County	20.0%
California	19.3%

Source: California Department of Education
FITNESSGRAM® Physical Fitness Testing, 2013–14, School District

A larger percentage (23.9%) of youth in the same grade levels were classified as obese when compared to Los Angeles County (21.5%) and California (19.0%).

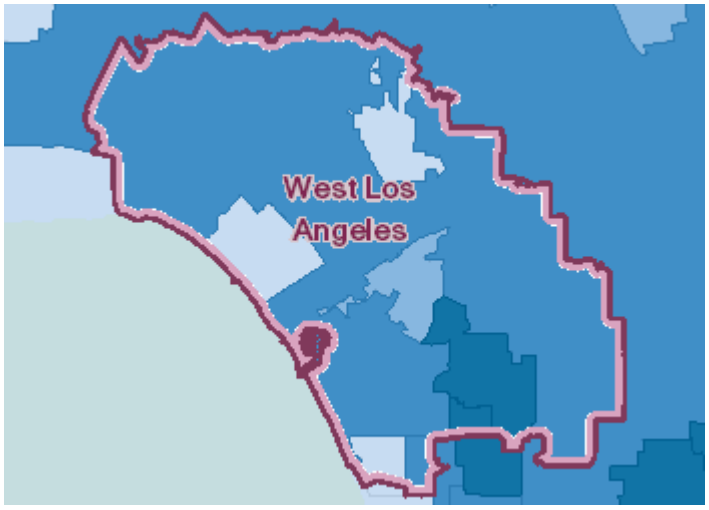
[31] Ibid.
[32] National Cancer Institute. (2012). *Obesity and Cancer Risk*. Bethesda, MD. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed November 30, 2015.

Obese Youth, 2014

Report Area	Percent
KFH-West Los Angeles service area	23.9%
Los Angeles County	21.5%
California	19.0%

Source: California Department of Education
FITNESSGRAM® Physical Fitness Testing, 2013–14, School District

The map below illustrates that over 26.0% of youth living in the south portion of the service area, including in Inglewood and Lennox, were obese or at risk for becoming obese.



Students Obese/in 'High Risk' Zone for Body Composition , Percent by School District (Elementary), FITNESSGRAM 2013–14

- Over 26.0%
- 18.1–26.0%
- 10.1–18.0%
- Under 10.1%
- No Data or Data Suppressed
- Report Area

Source: California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013–14, School District

Being overweight or obese appears to be common across the SPAs, regardless of age. Of teens between 14 and 17 years old, more than a third (37.2%) in SPA 8 and close to a quarter (24.0%) in SPA 5 were overweight. These percentages are much larger than in Los Angeles County (14.4%) or California (16.3%). Close to a quarter (24.4%) of teens in SPA 4, 21.9% of teens in SPA 6, and another 16.7% of teens in SPA 5 were obese—all greater percentages than reported for Los Angeles County (14.9%) and California (14.6%).

Overweight and Obese Teens, 2014

Report Area	Overweight	Obese
SPA 4–Metro	10.7%	24.4%
SPA 5–West	24.0%	16.7%
SPA 6–South	2.0%	21.9%
SPA 8–South Bay	37.2%	11.3%
Los Angeles County	14.4%	14.9%
California	16.3%	14.6%

Source: California Health Interview Survey, 2014, SPA

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. STD prevention is an essential primary care strategy for improving reproductive health. Despite the burdens, costs, and complications—and their being preventable to a certain extent—STDs remain a significant public health problem in the United States, greatly under-recognized by the public, policymakers, and health care professionals. STDs have the potential to cause many harmful, often irreversible clinical complications, including having an impact on reproductive health, fetal and perinatal health problems and cancer, and the transmission of HIV. The spread of STDs is directly affected by social, economic, and behavioral factors. Obstacles to STD prevention include access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, a historical experience with segregation and discrimination exacerbates the influence of these factors. Many studies document the association of substance abuse with STDs. The introduction of illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the spread of STDs.[33]

Adolescents ages 15 to 24 account for nearly half of the 20 million new cases of STDs each year in the United States. Today, four in 10 sexually active teen girls in the United States have had an STD with the potential to cause infertility and even death. Regular screenings are critical, as STDs often have no obvious signs or physical symptoms. Also, certain racial and ethnic groups (mainly African-American, Hispanic/Latino, and American Indian/Alaska Native populations) have high rates of STDs compared with Whites. Race and ethnicity in the United States are correlated with other determinants of health status such as poverty, limited access to health care, fewer attempts to get medical treatment, and living in communities with high rates of STDs.[34]

Prevalence

The percentages represented in this section are for the SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8. In SPA 6 and SPA 4, the incidence rate of chlamydia per 100,000 population was higher (968.0, and 628.8, respectively) when compared to Los Angeles County (521.3). Higher rates of incidence for gonorrhea were also reported in SPA 4 (271.8) and SPA 6 (233.0) when compared to Los Angeles County (122.9). The rate of incidence for syphilis in SPA 4 (30.0) was more than twice the rate in the KFH-West Los Angeles service area and in Los Angeles County (9.4).

Stakeholders added that the prevalence of sexually transmitted diseases was on the rise among teenagers, young adults age 20 and older, women, and gay and bisexual men.

Oral Health

Oral health is essential to overall health, and is relevant as a health need because engaging in preventive behaviors decreases the likelihood of developing future oral health and other related health

[33] Centers for Disease Control and Prevention. (2015). *Sexually Transmitted Diseases*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed December 8, 2015.
[34] Centers for Disease Control and Prevention. (2015). *Sexually Transmitted Diseases*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed December 8, 2015.

problems. In addition, oral diseases such as cavities and oral cancer cause pain and/or disability for many Americans35.

Prevalence

In 2006 to 2010, 11.6% of adults age 18 or older in Los Angeles County self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection. Further, in 2013 to 2014 over a third of adults age 18 and older (34.5%), and 17.9% of children age 2-11 self-reported that they have not visited a dentist, dental hygienist or dental clinic within the past year.[36]

A greater percentage of adults in SPA 6–South (16.2%) and SPA 4–Metro (10.1%) had not attended a dentist in more than 5 years, while 7.9% of residents in SPA 4–Metro had never been to a dentist. Within the span of a year, the majority of residents in SPA 5–West (79.0%) had attended the dentist for a visit.

Time since last dental visit, adults, 2014

Report Area	Never been to dentist	Up to 1 year ago	More than 1 year up to 2 years ago	More than 2 years up to 5 years ago	More than 5 years ago
SPA 4–Metro	7.9%	64.5%	7.7%	9.9%	10.1%
SPA 5–West	2.2%	79.0%	9.0%	4.0%	5.7%
SPA 6–South	0.3%	58.1%	14.9%	10.5%	16.2%
SPA 8–South Bay	1.7%	68.0%	10.6%	12.2%	7.5%
California	2.2%	69.5%	10.2%	9.5%	8.6%

Source: California Health interview Survey, 2014, SPA

In 2014, almost twice as many children ages 2-11 in SPA 8–South Bay (20.7%) had never been to the dentist relative to the other SPA areas reported (11.3% to 12.7%).

Additional related information can be found in the access to dental services section in section on drivers.

b. Significant Health Drivers

The following section provides a detailed description and overview of the health drivers identified through secondary and primary data analysis. The nine health drivers described below represent those most often cited as having the most impact on the overall health of individuals and the community. These drivers are organized by MATCH categories, access to care, health behaviors, physical environment, and socioeconomic factors:

[35] U.S. Department of Health and Human Services. (2015). *Oral Health.* Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32]. Accessed [May 26, 2016].
[36] Community Commons. *Kaiser Permanente Community Health Needs Assessment, CHNA In-Depth Report, West Los Angeles*. http://assessment.communitycommons.org/chna/report.aspx?page=13&id=513&reporttype=standard&groupid=660.. Accessed May 26, 2016.

Access to Care
- Access to health care
- Dental care access
- Preventive health care

Health Behaviors
- Alcohol, substance abuse, and tobacco use
- Disease management
- Healthy behaviors

Physical Environment
- Access to healthy foods
- Built environment

Socioeconomic Factors
- Cultural and linguistic barriers
- Economic security
- Homelessness and housing
- Legal status
- Transportation
- Violence and injury prevention

i. Access to Care

Some of the data related to access to care are reported for SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8.

Access to Health Care

Access to comprehensive, high-quality health care services is important for achieving health equity and increasing the quality of a healthy life for everyone. A lack of access to health services can lead to unmet health outcomes, delays in receiving appropriate care, the inability to benefit from preventive services, and preventable hospitalizations.[37]

Health Care Coverage

In the KFH-West Los Angeles service area, the percentage of the population who do not have health coverage (19.3%) is slightly smaller than in Los Angeles County (20.9%), and slightly larger than in California (18.9%). The current percentage in the service area is down 5.3% from the 2013 report (24.6)

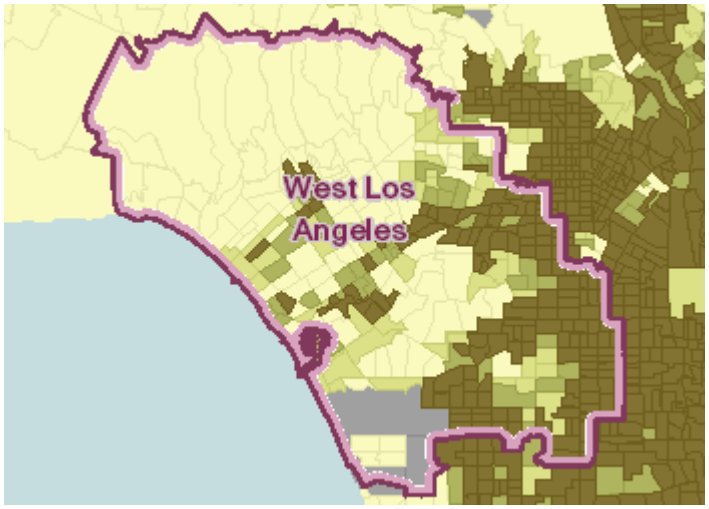
[37] Office of Disease Prevention and Health Promotion, (2014). *Access to Health Services*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services. Accessed December 1, 2015.

The southeast portion of the service area appears to be most affected by the lack of health coverage, particularly the communities of Inglewood, Lennox, South Los Angeles, Westwood, and West Adams among others. Stakeholders added that those most likely to experience a lack of access to primary care include the poor, Hispanics/Latinos, Blacks/African-Americans, and those residing in the southeast part of the KFH-West Los Angeles service area, particularly in the areas of Inglewood, Lennox, Westmont, West Athens, and the southeast section of West Los Angeles.

Uninsured Population, 2014

Report Area	Percent
KFH-West Los Angeles service area	19.3%
Los Angeles County	20.9%
California	18.9%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract



Uninsured Population, Percent by Tract, ACS 2010–14

- Over 20.0%
- 15.1–20.0%
- 10.1–15.0%
- Under 10.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Medi-Cal, Medicare, and Healthy Families

Knowing the portion of the population who are receiving Medi-Cal and Medicare benefits can assist in identifying vulnerable populations that often have multiple health needs and can experience a lack of access to needed health care or high-quality health care, and common issues associated with poverty. Over half (54.3%) of those living in SPA 6 and over a third (33.1%) living in SPA 4 are Medi-Cal recipients, more than the percentages reported for Los Angeles County (28.1%) and California (25.5%). - Larger percentages of Medicare recipients were reported in SPA 4 (2.8%) and SPA 8 (2.3%) than in Los Angeles County (1.4%) or California (1.4%).

Health Coverage, 2014

Report Area	Medi-Cal Recipients	Medicare Recipients
SPA 4–Metro	33.1%	2.8%
SPA 5–West	7.6%	0.5%

Report Area	Medi-Cal Recipients	Medicare Recipients
SPA 6–South	54.3%	0.4%
SPA 8–South Bay	18.9%	2.3%
Los Angeles County	28.1%	1.4%
California	25.5%	1.4%

Source: California Health Interview Survey, 2014, SPA

A greater percentage of those under the age of 65 who are eligible for Medi-Cal was reported in SPA 4 (7.8%) relative to Los Angeles County (5.8%) and California (6.4%). Of those under the age of 65 who are eligible for Healthy Families, 18.2% in SPA 5 are not recipients—a much higher percentage than in Los Angeles County (3.9%) or California (3.4%).

Medi-Cal and Healthy Families Eligibility, 2014

Report Area	Eligibility of uninsured under 65 for Medi-Cal (Pre-ACA)	Eligibility of uninsured under 65 for Healthy Families (Pre-ACA)
SPA 4–Metro	7.8%	0.0%
SPA 5–West	0.0%	18.2%
SPA 6–South	3.1%	2.3%
SPA 8–South Bay	0.0%	0.0%
Los Angeles County	5.8%	3.9%
California	6.4%	3.4%

Source: California Health Interview Survey, 2014, SPA

Although most of the population in the service area has a usual source of care—defined as a regular location to receive health care—SPA 4 (76.9%) has a lower percentage of care from a primary doctor (or usual source of care) and does not meet the Healthy People 2020 goal of >=83.9%. The percentage of the population with a usual source of care in SPA 4 – Metro has also decreased since the 2013 report, down 3.8% from 80.7%.

Usual Source of Care, 2011–2012

Report Area	Percent
SPA 4–Metro	76.9%
SPA 5–West	91.1%
SPA 6–South	86.5%
SPA 8–South Bay	88.5%
Los Angeles County	83.8%
California	85.8%
Healthy People 2020	>=83.9%

Source: Los Angeles County Health Survey, 2011–2012, SPA

One reason some residents may not have a usual source of care is difficulty with accessing necessary care. SPA 4 (5.8%) and SPA 5 (5.1%) reported a higher percentage of the population experiencing a difficult time obtaining primary care relative to Los Angeles County overall (4.7%), but only slightly higher than California overall(4.6%).

Difficulty Accessing Primary Care, 2014

Report Area	Percent
SPA 4–Metro	5.8%
SPA 5–West	5.1%
SPA 6–South	3.9%
SPA 8–South Bay	4.0%
Los Angeles County	4.7%
California	4.6%

Source: California Health Interview Survey, 2014, SPA

When individuals need to see a medical specialist to treat an illness, some experience difficulties for a number of reasons, including lack of health coverage or cost. In the KFH-West Los Angeles service area, approximately a quarter (24.4%) of the population reported the need to see a medical specialist in 2014, with SPA 5 (47.0%) and SPA 8 (38.7%) reporting higher percentages than Los Angeles County (33.9%) or California (36.3%). Of residents having difficulty accessing a medical specialist, only SPA 4 reported a higher percentage (15.9%) than Los Angeles County (11.1%) or California (10.8%). This wide variation might be due to the sampling method, the way in which the questions were asked, self-report data or perhaps due to fact that there are a greater number of community clinics in SPA 6.

Specialty Care, 2014

Report Area	Needed to see a medical specialist in past year	Difficult time accessing specialist
SPA 4–Metro	24.4%	15.9%
SPA 5–West	47.0%	5.5%
SPA 6–South	31.8%	3.2%
SPA 8–South Bay	38.7%	9.7%
Los Angeles County	33.9%	11.1%
California	36.3%	10.8%

Source: California Health Interview Survey, 2014, SPA

As mentioned previously, one of the barriers to accessing necessary health care can be a lack of health insurance or coverage. In SPA 5 and SPA 6 (the two SPAs that largely represent the KFH-West Los Angeles service area), 4.6% and 4.3% of the population, respectively, reported that their primary care doctor did not accept their insurance in the past year— slightly higher than in Los Angeles County (4.2%) and in California (4.1%). Percentages of individuals reporting that medical specialists did not accept their insurance varied more widely, with SPA 6 (0.8%) and SPA 5 (11.9%) at the low and high ends of the range—compared to Los Angeles County (7.7%) and California (9.0%).

Insurance Not Accepted, 2014

Report Area	Insurance not accepted by general doctor in past year	Insurance not accepted by medical specialist in past year
SPA 4–Metro	4.0%	5.8%
SPA 5–West	4.6%	11.9%
SPA 6–South	4.3%	0.8%
SPA 8–South Bay	3.9%	9.0%
Los Angeles County	4.2%	7.7%

Report Area	Insurance not accepted by general doctor in past year	Insurance not accepted by medical specialist in past year
California	4.1%	9.0%

Source: California Health Interview Survey, 2014, SPA

Provider Shortage

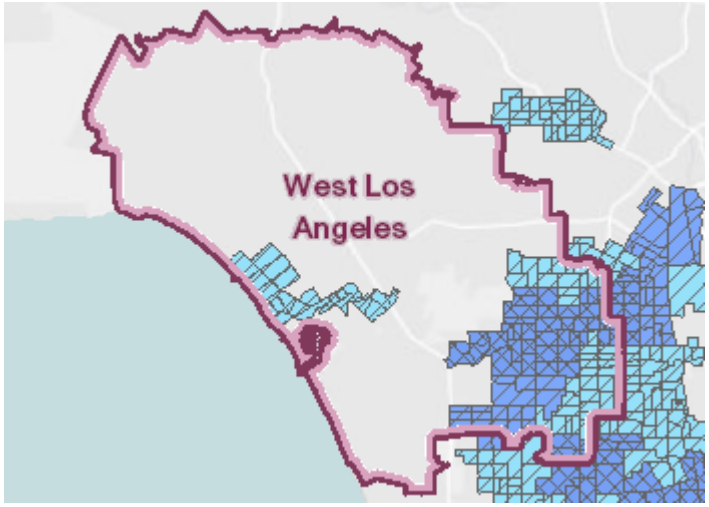
Having sufficient health professionals available to meet the demand is essential to keeping a community healthy. In the KFH-West Los Angeles service area, a greater percentage (37.1%) of the population lived in a Health Professional Shortage Area (HPSA) when compared to Los Angeles County (31.4%) and California (25.2%). However, this is far less than the 67.3% that was reported in the 2013 KFH-West Los Angeles CHNA.

Living in a Health Professional Shortage Area, 2015

Report Area	Percent
KFH-West Los Angeles service area	37.1%
Los Angeles County	31.4%
California	25.2%

Source: U.S. Department of Health & Human Services
Health Resources and Services Administration, March 2015, HPSA

Communities of the KFH-West Los Angeles service area most affected by the HPSA shortage (lacking sufficient medical care and dental or mental health professionals) include Crenshaw, Inglewood, Leimert Park, Lennox, and South Los Angeles.



Primary Care HPSA Components, Type and Degree of Shortage by Tract/County, HRSA HPSA Database March 2015

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1–20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1–20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Report Area

Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, March 2015, HPSA

Federally Qualified Health Centers

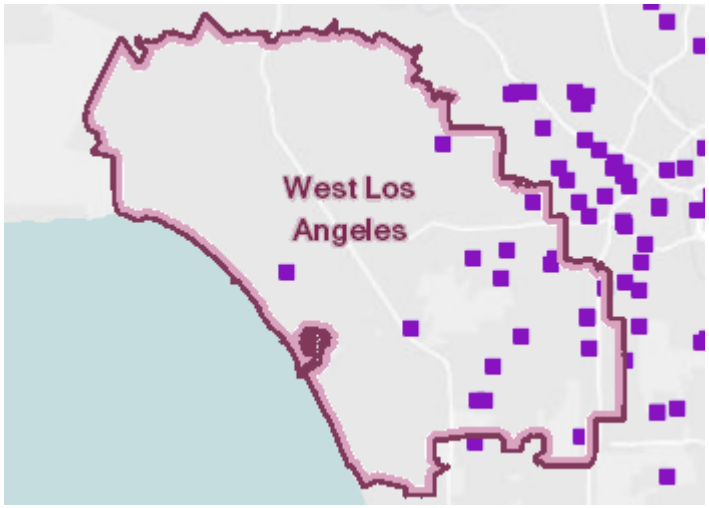
Federally Qualified Health Centers (FQHCS) are community assets that provide health care to vulnerable populations. There are 19 FQHCs in the service area, which is 14.2% of those located in Los Angeles County and an increase of 11 since the 2013 CHNA. Of the additional 33 FQHC created in Los Angeles county, and a full third of the facilities were located in KFH-West Los Angeles service area.

Federally Qualified Health Centers per 100,000 Population, September 2015

Report Area	Number	Rate
KFH-West Los Angeles service area	19	3.7
Los Angeles County	134	1.4
California	735	2.0

Source: U.S. Department of Health & Human Services
Center for Medicare & Medicaid Services
Provider of Services File, September 2015, Address

Most FQHCs in the service area are located in the southeast portion where the most vulnerable populations live.



Federally Qualified Health Centers, POS September 2015

Report Area

Source: U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, September 2015, Address

Emergency Room Use

There were 6,030 admissions into the KFH-West Los Angeles medical center's emergency department in 2014, making up 0.3% of the emergency room admission reported in California. The average length of stay for someone admitted into the emergency department at KFH-West Los Angeles was 3.9 days, lower than the average reported in California (4.7 days).

Emergency Room Use, 2014

Report Area	Number	Average Length of Stay
KFH-West Los Angeles service area	6,030	3.9 days
California	1,817,237	4.7 days

Source: Office of Statewide Health Planning and Development
KFH-West Los Angeles Emergency Department Report, 2014, KFH-West Los Angeles Medical Center

Affordable Health Care

Another common barrier to accessing health care is cost. Over half (≥55.5%) of the population in SPA 4 – Metro (69.9%), SPA 5 – West (58.3%) and SPA 6 – South (55.5%) delayed getting necessary care due to the cost or lack of insurance. These percentages are a great deal higher than the average percentage for the service area reported in the 2013 CHNA (12.0%), and they are higher than Los Angeles County (44.8%) and California (51.3%). Additionally, 8.8% of the population in SPA 6 – South reported delays in receiving medicine, or not receiving prescribed medicine at all. This is more than in Los Angeles County (7.9%) and California (8.7%).

Delayed Care Due to Cost, 2014

Report Area	Delayed care due to cost or lack of insurance	Delayed or didn't get prescribed medicine in past 12 months
SPA 4–Metro	69.9%	7.0%
SPA 5–West	58.3%	4.4%
SPA 6–South	55.5%	8.8%
SPA 8–South Bay	37.5%	7.7%
Los Angeles County	44.8%	7.9%
California	51.3%	8.7%

Source: California Health Interview Survey, 2014, SPA

In 2010, the Affordable Care Act was enacted with the goal of improving access, affordability, and the quality of health care in the United States.[38] In California, an online portal—Covered California—was created for Californians to access health insurance and potentially receive federal assistance to help purchase private health insurance or receive health insurance through Medi-Cal.[39] However, some people still experience difficulty obtaining affordable health care through Covered California. Most of those living in SPA 4 (91.3%) and more than two-thirds of those living in SPA 8 (67.8%) were not able to find an affordable health plan through Covered California—larger percentages than in Los Angeles County (57.3%) and California (54.7%). Of those who were able to find an affordable plan, 92.6% in SPA 4 reported not being able to find one with the needed coverage—a much higher percentage than in Los Angeles County (57.6%) or California (55.0%).

Unable to Obtain Needed Health Coverage, 2014

Report Area	Difficulty finding affordable plan through Covered California	Difficulty finding plan with needed coverage through Covered California
SPA 4–Metro	91.3%	92.6%
SPA 5–West	42.3%	54.6%
SPA 6–South	5.8%	63.1%
SPA 8–South Bay	67.8%	41.3%
Los Angeles County	57.3%	57.6%
California	54.7%	55.0%

Source: California Health Interview Survey, 2014, SPA

[38] U.S. Department of Health and Human Services. (2016). *Health Care*. Washington, DC. Retrieved from http://www.hhs.gov/health care/. Accessed February 23, 2016.
[39] Covered California (2016). *About Covered California*. Sacramento, CA. Retrieved from http://www.coveredca.com/about/. Accessed February 23, 2016.

Dental Care Access

Oral health is essential to overall health; engaging in preventive behaviors decreases the likelihood of developing future deficiencies in oral health that can contribute to other health problems, including heart disease. Common barriers to accessing dental care include the limited availability of dental services, a lack of awareness of the need for oral care, the fear of dental care/procedures, and the cost of dental services.[40]

Dental Insurance

Overall, more adults and youth age 0 to17 in the KFH-West Los Angeles service area than elsewhere do not have dental insurance, cannot afford dental care, or have never been to a dentist. Fewer adults in SPA 4 (38.9%) and SPA 6 (37.1%) had dental insurance when compared to the overall service area and Los Angeles County (48.2%).

Adults with Dental Insurance, 2011

Report Area	Percent
SPA 4–Metro	38.9%
SPA 5–West	60.6%
SPA 6–South	37.1%
SPA 8–South Bay	50.7%
Los Angeles County	48.2%

Source: Los Angeles County Health Survey, 2011, SPA

Slightly fewer youth age 0 and 17 had dental insurance in SPA 4 (75.7%), SPA 5 (71.6%), and SPA 6 (75.8%) than in Los Angeles County (78.2%).

Youth Age 0–17 with Dental Insurance, 2011

Report Area	Percent
SPA 4–Metro	75.7%
SPA 5–West	71.6%
SPA 6–South	75.8%
SPA 8–South Bay	81.5%
Los Angeles County	78.2%

Source: Los Angeles County Health Survey, 2011, SPA

Dental Care Affordability

More than a third of adults in SPA 4 (37.6%) and SPA 6 (35.0%) could not afford dental care, which is greater when compared to Los Angeles County (30.3%). The need was not as acute in SPA 5, which had a smaller percentage of adults (19.4%) not able to afford dental care.

[40] U.S. Department of Health and Human Services. (2015). *Oral Health.* Washington, DC. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32. Accessed November 30, 2015.

Adults Who Could Not Afford Dental Care, 2011

Report Area	Percent
SPA 4–Metro	37.6%
SPA 5–West	19.4%
SPA 6–South	35.0%
SPA 8–South Bay	27.4%
Los Angeles County	30.3%

Source: Los Angeles County Health Survey, 2011, SPA

The same was true for youth between the ages of 0 and 17 years. A slightly smaller percentage of youth in SPA 5 – West (8.5%) and SPA 4 – Metro (11.3%) were able to afford dental care, as compared to Los Angeles County (12.6%). All percentages for the SPAs in this service area are higher than 2013 report percentages, which ranged from 6.1% to 8.0%.

Youth Age 0–17 Who Could Not Afford Dental Care, 2011

Report Area	Percent
SPA 4–Metro	11.3%
SPA 5–West	8.5%
SPA 6–South	14.9%
SPA 8–South Bay	12.2%
Los Angeles County	12.6%

Source: Los Angeles County Health Survey, 2011, SPA

Never Been to a Dentist

Given that more adults in the KFH-West Los Angeles service area did not have dental insurance and could not afford dental care when compared to those in the county overall, a greater percentage of adults in SPA 4 (7.9%) had never been to a dentist—nearly twice the percentage of Los Angeles County (4.1%) and more than three times that of California (2.2%).

Adults Who Have Never Been to a Dentist, 2014

Report Area	Percent
SPA 4–Metro	7.9%
SPA 5–West	2.2%
SPA 6–South	0.3%
SPA 8–South Bay	1.7%
Los Angeles County	4.1%
California	2.2%

Source: California Health Interview Survey, 2014, SPA

A larger percentage of youth had never been to a dentist in SPA 8 (20.7%) than in California (15.3%).

Youth Age 0–17 Who Have Never Been to a Dentist, 2014

Report Area	Percent
SPA 4–Metro	11.3%
SPA 5–West	11.3%
SPA 6–South	12.7%

Report Area	Percent
SPA 8–South Bay	20.7%
Los Angeles County	16.0%
California	15.3%

Source: California Health Interview Survey, 2014, SPA

Preventive Health Care

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

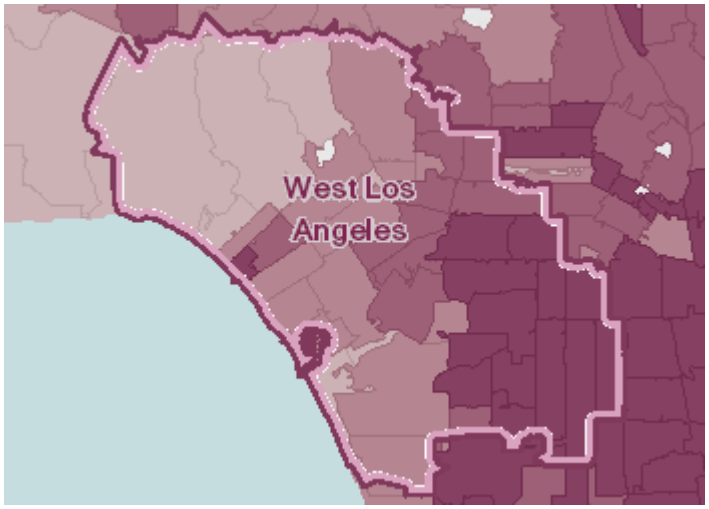
In the KFH-West Los Angeles service area, the hospital discharge rate for preventable hospital events was higher (119.9 per 10,000 population) than in Los Angeles County (92.2) and California (102.9).

Preventable Hospital Events Rate per 10,000 Population, 2011

Report Area	Number	Rate
KFH-West Los Angeles	31,274	119.9
Los Angeles County	199,046	92.2
California	396,260	102.9

Source: California Office of Statewide Health Planning and Development
OSHPD Patient Discharge Data
Additional data analysis by CARES, 2011, ZIP Code

The highest rates were reported in communities in the southeast portion of the service area, including Inglewood, South Los Angeles, Westmont, and West Athens among others. Stakeholders added that immigrants and non–English speaking populations have the most difficult time accessing preventive care because of their lack of access to affordable health care.



Preventable (ACS) Condition Hospital Discharges, Rate (Per 10,000 Population) by ZCTA, OSHPD 2011

- Over 120.0
- 80.1–120.0
- 50.1–80.0
- Under 50.1
- No Data or Data Suppressed
- Report Area

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES, 2011, ZIP Code

Cancer Screenings

In the KFH-West Los Angeles service area, the percentage of women receiving cervical cancer screenings in the past three years was higher in all SPAs except for SPA 4 (82.0%), when compared to Los Angeles County (82.8%). However, these percentages did not meet the Healthy People 2020 goal of >=93.0%.

Mammogram screening statistics within the SPAs also do not meet the Healthy People 2020 goal of >=81.1%. Mammogram rates were lowest for women living in SPA 4 (59.1%) and SPA 8 (56.6%), which represent smaller portions of the KFH-West Los Angeles service area.

Cancer Screenings, 2011, 2012

Report Area	Cervical cancer screening (Pap smear) in last 3 years[1]	Breast cancer screening (mammogram) in the last 2 years[2]
SPA 4–Metro	82.0%	59.1%
SPA 5–West	83.5%	66.6%
SPA 6–South	87.4%	69.8%
SPA 8–South Bay	83.3%	56.6%
Los Angeles County	82.8%	61.8%
California	n/a	65.1%
Healthy People 2020	>=93.0%	>=81.1%

Source: Los Angeles County Health Survey, 2011, SPA[1]
California Health Interview Survey, 2012, SPA[2]

ii. Health Behaviors

Some of the data related to health behaviors are reported for SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8.

Alcohol Abuse, Substance Abuse, and Tobacco Use

Alcohol and substance abuse have a major impact on individuals, families, and communities. The effects of alcohol and substance abuse contribute significantly to costly social, physical, mental, and public health problems, including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), violence, crime, homicide, and suicide.[41]

Alcohol Abuse

Over half the population in SPA 4 (50.6%), SPA 5 (68.7%), and SPA 8 (55.4%) reported alcoholic beverage consumption in the past month; for two SPAs, this is higher than in Los Angeles County (51.9%). Heavy drinking (two or more drinks per day for men and one drink per day for women) was reported in slightly larger percentages in SPA 4 (4.6%) and SPA 8 (4.6%) than in Los Angeles County (3.5%). All SPAs reported much higher percentages of binge-drinking (five or more drinks in two hours for men and four or more drinks for women) relative to Los Angeles County's 15.4%, with the highest being in SPA 4 (19.2%).

[41] U.S. Department of Health and Human Services. (2015). Office of Disease Prevention and Health Promotion. *Substance Abuse*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse. Accessed December 01, 2015.

Alcohol Use, 2011

Report Area	Alcohol use in past month	Heavy drinking in past month	Binge-drinking in past month
SPA 4–Metro	50.6%	4.6%	19.2%
SPA 5–West	68.7%	3.4%	16.5%
SPA 6–South	42.6%	2.5%	16.9%
SPA 8–South Bay	55.4%	4.6%	16.3%
Los Angeles County	51.9%	3.5%	15.4%
California	50.6%	4.6%	19.2%

Source: Los Angeles County Health Survey, 2011, SPA

Substance Abuse

Substance abuse is also prevalent in the KFH-West Los Angeles service area. A greater percentage of teens in SPA 8 (21.6%) and SPA 4 (17.2%) reported using marijuana in the past year when compared to Los Angeles County (9.4%) and California (8.6%). A large percentage of adults also reported having ever used marijuana, cocaine, sniffing glue, or another type of drug in SPA 6 (31.9%)—greater than double the percentage for Los Angeles County (14.7%) and California (12.4%).

Stakeholders indicated an increase in alcohol and drug used among teens and in South Los Angeles.

Substance Use, 2012

Report Area	Teens who used marijuana in the past year	Ever tried marijuana, cocaine, sniffed glue, or other drugs
SPA 4–Metro	17.2%	18.2%
SPA 5–West	14.3%	14.3%
SPA 6–South	3.5%	31.9%
SPA 8–South Bay	21.6%	23.4%
Los Angeles County	9.4%	14.7%
California	8.6%	12.4%

Source: California Health Interview Survey, 2012, SPA

Tobacco Use

Only SPA 5 had a lower reported percentage (7.0%) of smokers than Los Angeles County (10.0or and California overall (10.8%). The largest percentage of smokers lived in SPA 6 (10.9%). A much larger percentage reported ever smoking electronic cigarettes in SPA 8 (33.6%) than in the other SPAs, Los Angeles County (11.3%), and California (10.3%).

Tobacco Use, 2014, 2015

Report Area	Currently Smoked[1]	Ever smoked electronic cigarettes[2]
SPA 4–Metro	10.5%	4.7%
SPA 5–West	7.0%	4.4%
SPA 6–South	10.9%	3.2%
SPA 8–South Bay	10.3%	33.6%
Los Angeles County	10.0%	11.3%
California	10.8%	10.3%

Source: California Health Interview Survey, 2014, SPA[1]
California Health Interview Survey, 2015, SPA[2]

Disease Management

Disease management provides patients with a plan and guide for dealing with their medical issues, can decrease and contain costs associated with chronic diseases, and can improve health outcomes and quality of life.

The percentage of adults who reported taking their medicine to manage their high blood pressure was lower for SPA 6 (55.5%), SPA 5 (60.6%), and SPA 4 (66.2%) than in California (68.5%), and did not meet the Healthy People 2020 goal of >=69.5%.

Adults Who Take Medicine to Manage Their High Blood Pressure, 2014

Report Area	Percent
SPA 4–Metro	66.2%
SPA 5–West	60.6%
SPA 6–South	55.5%
SPA 8–South Bay	79.5%
Los Angeles County	67.2%
California	68.5%
Healthy People 2020	>=69.5%

Source: California Health Interview Survey, 2014, SPA

Healthy Behaviors

Healthy behaviors are closely linked to overall health, and include preventive health care, healthy eating, exercising, and other behaviors that contribute to good health. However, it is important to consider cultural practices and traditions and their contribution to healthy behaviors.[42]

Vaccinations

Annual vaccinations such as influenza and pneumonia inoculations can help prevent sickness and death for particular age groups. In the KFH-West Los Angeles service area, a third (32.4%) of adults age 18 and older received an influenza vaccination. Only SPA 5, however, reported higher percentages of seniors receiving influenza vaccinations (70.1%) and pneumonia vaccinations (64.1%) than in the

[42] U.S. National Library of Medicine. (2016). *Eating habits and behaviors*. Bethesda, MD. Available at https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000349.htm. Accessed February 18, 2016.

county and state (64.2%, and 61.3%, respectively); all other SPAs had lower vaccination percentages relative to Los Angeles County.

Vaccinations, 2011

Report Area	Influenza Vaccinations (Adults)	Influenza Vaccinations (Seniors)	Pneumonia Vaccinations (Seniors)
SPA 4–Metro	32.6%	60.4%	61.0%
SPA 5–West	37.7%	70.1%	64.1%
SPA 6–South	25.9%	51.7%	53.9%
SPA 8–South Bay	33.3%	63.9%	62.9%
Los Angeles County	33.7%	64.2%	61.3%

Source: Los Angeles County Health Survey, 2011, SPA

Healthy Eating

Following a healthy diet is essential to living a healthy life and to maximum life expectancy. Over half of youth in SPA 6 (53.3%) consumed at least one soda or sweetened drink per day, and over a third in SPA 8 (40.4%) and SPA 4 (32.7%) did so as well; consumption in SPAs 6 and 8 exceeded that of Los Angeles County (38.3%). Over half (56.8%) of adults in SPA 6 consumed at least one soda or sweetened drink per day, again greater than in Los Angeles County (38.8%) or California (38.6%).

Soda or Sweetened Drink Consumption, 2011, 2014

Report Area	Youth[1]	Adults[2]
SPA 4–Metro	32.7%	35.3%
SPA 5–West	21.9%	35.2%
SPA 6–South	53.3%	56.8%
SPA 8–South Bay	40.4%	35.6%
Los Angeles County	38.3%	38.8%
California	n/a	38.6%

Source: Los Angeles County Health Survey, 2011, SPA[1]
California Health Interview Survey, 2014, SPA[2]

Over half of youth in SPA 6 (60.7%) and SPA 8 (52.9%) consumed fast food at least once a week—more than in Los Angeles County (50.5%). Adult trends were similar, with adults in SPA 6 (25.2%) and SPA 8 (27.5%) having the greatest percentages of fast food consumption, higher than Los Angeles County's (21.6%) or California's (20.6%).

Fast-Food Consumption, 2011, 2014

Report Area	Youth[1]	Adults[2]
SPA 4–Metro	41.6%	17.8%
SPA 5–West	31.6%	17.6%
SPA 6–South	60.7%	25.2%
SPA 8–South Bay	52.9%	27.5%
Los Angeles County	50.5%	21.6%
California	n/a	20.6%

Source: Los Angeles County Health Survey, 2011, SPA[1]
California Health Interview Survey, 2014, SPA[2]

In terms of adequate fruit and vegetable consumption, a larger percentage of youth in all SPAs but SPA 4 (55.9%) consumed the recommended five or more fruits and vegetables a day when compared to Los Angeles County (57.3%). The largest percentage of youth consumption was found in SPA 5 (69.3%), which was larger than in both Los Angeles County and California (63.3%). SPA 5 also had the largest percentage of adequate fruit and vegetable consumption in adults (22.1%), as well as the highest affordability of these goods(82.7%). The lowest percentages of adequate fruit and vegetable consumption in adults were in SPA 4 (16.9%) and SPA 6 (11.4%), where the lowest percentages of affordability were also observed (69.4% and 67.4%, respectively). This situation may contribute to the high percentages of youth and adults in the same SPAs who did not adequately consume fruits and vegetables.

Fruit and Vegetable Consumption and Affordability, 2011–2012, 2014

Report Area	Youth[1]	Adults[2]	Affordability[2]
SPA 4–Metro	55.9%	16.9%	69.4%
SPA 5–West	69.3%	22.1%	82.7%
SPA 6–South	60.1%	11.4%	67.4%
SPA 8–South Bay	61.7%	17.2%	74.5%
Los Angeles County	57.3%	16.2%	75.2%
California	63.3%	n/a	78.1%

Source: California Health Interview Survey, 2011–2012, SPA[1]
California Health Interview Survey, 2014, SPA[2]

Physical Activity

Physical activity is also essential to living a healthy life style and a long and healthy life.

A smaller percentage of youth (6-17 years old) in SPA 5–West (22.6%) participated in daily physical activity when compared to youth in Los Angeles County (28.7%). A slightly smaller percentage of adults participated in aerobic and strengthening activities in SPA 6 (28.1%) than in Los Angeles County (29.7%), but participation rates in SPA 4 (31.3%) and SPA 8 (31.7%) were greater.

Physical Activity, 2011, 2014

Report Area	Youth[1]	Adults[2]
SPA 4–Metro	27.8%	31.3%
SPA 5–West	22.6%	37.4%
SPA 6–South	32.0%	28.1%
SPA 8–South Bay	33.4%	31.7%
Los Angeles County	28.7%	29.7%

Source: Los Angeles County Health Survey, 2011, SPA[1]
California Health Interview Survey, 2014, SPA[2]

iii. Physical Environment

Some of the data related to the physical environment are reported for SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8.

Access to Healthy Foods

Following a well-balanced diet and nutritional plan is essential to good health, disease prevention, and the healthy growth and development of children. Maintaining a healthy diet can help reduce the incidence of health outcomes such as heart disease, cancer, obesity and diabetes.[43]

The inability to access fresh, affordable healthy food options is detrimental to health. In all the SPAs of the KFH-West Los Angeles service area, larger percentages of the population were unable to afford enough food than in Los Angeles County (38.2%). SPA 8 had the highest percentage, at 46.1%.

Affordability of Food, 2014

Report Area	Unable to afford enough food
SPA 4–Metro	38.3%
SPA 5–West	44.1%
SPA 6–South	40.1%
SPA 8–South Bay	46.1%
Los Angeles County	38.2%

Source: California Health Interview Survey, 2014, SPA

Stakeholders added that those who most often did not have access to or could not afford healthy foods were those living in low-income communities, as well as the elderly, homeless, youth, and the working poor.

[43] Centers for Disease Control and Prevention. (2010). *Healthy Food Environment.* Atlanta, GA. Available at http://www.cdc.gov/healthyplaces/healthtopics/healthyfood_environment.htm. Accessed February 18, 2016.

Built Environment

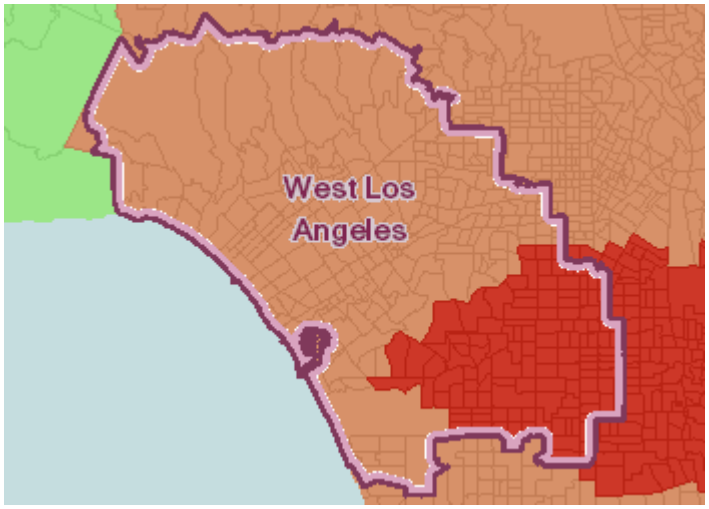
The quality of a community's physical environment can affect an individual's overall health, in particular contributing to existing respiratory issues or to the development of respiratory issues. The KFH-West Los Angeles service area experienced 17.6 (or 5.1%) days a year of poor air quality in 2008, which is higher than the number reported in Los Angeles County (12.5, or 3.4%) and California (15.5, or 4.2%).

Days with Particulate Matter 2.5 Levels Above the National Ambient Air Quality Standard (35 Micrograms Per Cubic Meter) Per Year, 2008

Report Area	Days	Percent
KFH-West Los Angeles	17.6	5.1%
Los Angeles County	12.5	3.4%
California	15.5	4.2%

Source: Centers for Disease Control and Prevention
National Environmental Public Health Tracking Network, 2008, Tract

The southeast portion of the service area seems to experience more days of poor air quality when compared to the rest of the service area; these communities include Inglewood, Lennox, South Los Angeles, Westmont, and West Athens. Stakeholders added that the air quality is particularly bad in communities surrounded by freeways.



Fine Particulate Matter Levels (PM 2.5), Percent Days Above NAAQ Standards by Tract, NEPHTN 2008

- Over 6.0%
- 1.1–6.0%
- 0.51–1.0%
- Under 0.51%
- No Days Above NAAQS Standards
- No Data or Data Suppressed
- Report Area

Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008, Tract

iv. Socioeconomic Factors

Some of the data related to socioeconomic factors are reported for SPAs that span the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8.

Cultural and Linguistic Barriers

Culturally influenced communications can be important considerations in people's ideas, understanding, and barriers to health, health literacy, and health practices.

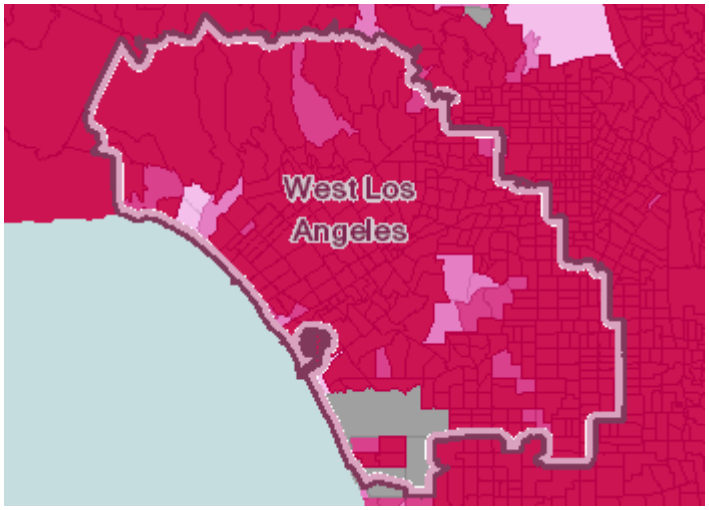
A greater percentage of individuals living in SPA 6 (4.1%) and SPA 4 (3.7%) had difficulties communicating with and understanding their doctor than in Los Angeles County (3.2%) and California (3.1%).

Difficulty Understanding Doctor, 2014

Report Area	Percent
SPA 4–Metro	3.7%
SPA 5–West	0.3%
SPA 6–South	4.1%
SPA 8–South Bay	1.2%
Los Angeles County	3.2%
California	3.1%

Source: California Health Interview Survey, 2014, SPA

A larger percentage (19.6%) of the population in the KFH-West Los Angeles service area had limited English proficiency when compared to California as a whole (19.1%).[44] As shown in the map below, most of the service area's population had limited English proficiency (not speaking English very well or having someone in the home who did not speak English very well). However, particular communities experienced this situation to a greater degree (30% or higher), including Arlington Heights, Inglewood, Jefferson Park, and South Los Angeles.



Population with Limited English Proficiency, Percent by Tract, ACS 2010–14

- Over 4.0%
- 2.1–4.0%
- 1.1–2.0%
- Under 1.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract.

Stakeholders reported that cultural and linguistic barriers were most often experienced among Hispanics/Latinos, Asians, African-Americans, and immigrants.

Economic Security

Economic security (including poverty, educational attainment, and employment) and health are closely linked and a lack of it can contribute to poor health. Barriers to positive health outcomes attributable to poverty include the ability to obtain necessary medical care, access to healthy foods, and other basic needs.[45] Overall, the KFH-West Los Angeles service area is characterized by high poverty, low

[44] U.S. Census Bureau, American Community Survey, 2010-14, Tract.
[45] Murray, S. (2006). *Poverty and health*. CMAJ : Canadian Medical Association Journal, 174(7), 923. Available at http://doi.org/10.1503/cmaj.060235. Retrieved February 18, 2016.

educational attainment, and high unemployment rates; certain communities are more affected than others.

Poverty

A large percentage of the population in the KFH-West Los Angeles service area (20.3%) live in households whose incomes are 100% below the Federal Poverty Level (FPL)—a higher percentage than in Los Angeles County (18.4%) or California (16.4%). Communities with the greatest percentage of households living 100% below the FPL include Arlington Heights, Baldwin Hills (including Crenshaw and Leimert Park), Hyde Park, Inglewood, Jefferson Park, Lennox, South Los Angeles, West Athens, West Adams, Westmont, and Westwood among others.

Population Living Below 100% Federal Poverty Level, 2014

Report Area	Number	Percent
KFH-West Los Angeles	1,383,615	20.3%
Los Angeles County	9,819,397	18.4%
California	37,323,128	16.4%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Almost a third (29.4%) of the households living at 100% below the FPL include children age 0 to 17—higher than in Los Angeles County (26.0%) or California (22.7%). Communities in the southeast portion of the service area have the largest percentage of households with children living at 100% below the FPL, particularly Arlington Heights, Baldwin Hills (including Crenshaw and Leimert Park), Inglewood, Jefferson Park, Lennox, South Los Angeles, and West Adams among others.

Households with Children Living Below 100% Federal Poverty Level, 2014

Report Area	Number	Percent
KFH-West Los Angeles service area	287,664	29.4%
Los Angeles County	2,314,447	26.0%
California	9,072,050	22.7%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

The service area also includes a large percentage of households (40.5%) living at 200% below the FPL—similar to that reported for Los Angeles County (40.9%) but higher than in California (36.4%). Communities in the service area with the largest percentage of households living at 200% below the FPL include Arlington Heights, Jefferson Park, Inglewood, South Los Angeles, and West Adams among others.

Population Living Below 200% Federal Poverty Level, 2014

Report Area	Number	Percent
KFH-West Los	560,530	40.5%
Los Angeles County	4,014,863	40.9%
California	13,576,255	36.4%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

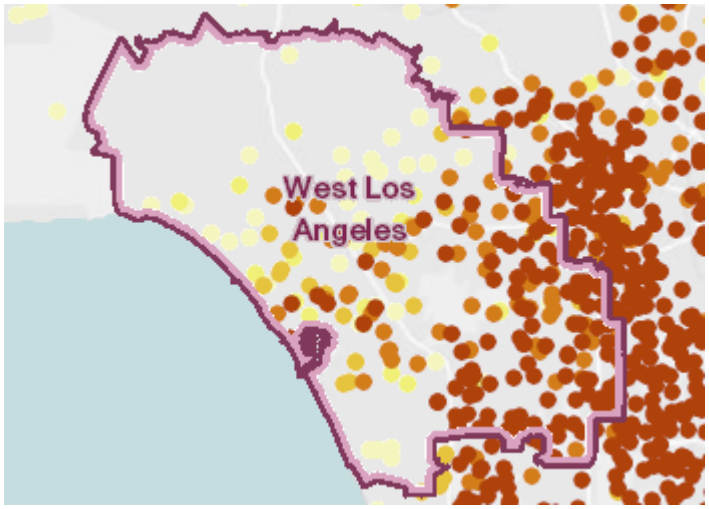
The percentage of youth in the service area eligible to receive a free or reduced-price lunch is higher (64.5%) than in California (58.1%).

Youth Eligible for a Free or Reduced Price Lunch, 2014

Report Area	Number	Percent
KFH-West Los Angeles service area	104,000	64.5%
Los Angeles County	1,030,344	66.9%
California	3,610,385	58.1%

Source: National Center for Education Statistics (NCES)
Common Core of Data, 2013–14, Address

The southeast portion of the service area had a greater percentage of youth (over 80% of all youth) eligible for a free or reduced price lunch. These disparities are important as indicators of poverty and may assist in identifying gaps in eligibility and enrollment in the lunch program.



Students Eligible for Free or Reduced-Price Lunch, NCES CCD 2013–14

- Over 80.0%
- 60.1–80.0%
- 40.1–60.0%
- 20.1–40.0%
- Under 20.1%
- Not Reported
- Report Area

Source: Source: National Center for Education Statistics, NCES—Common Core of Data, 2013–14, Address

Unemployment

Unemployment is an issue in the KFH-West Los Angeles service area, with a total of 61,351 individuals age 16 and older unemployed. The unemployment rate in the service area and Los Angeles County is 8.6, higher than that in the state overall (8.3). Within the KFH-West Los Angeles, 20.3% of the population lived in households with income below 100% the Federal Poverty Level (FPL). Hispanic/Latino populations have the greatest percent (28.7%) of the population below 100% FPL, followed by Black/African-Americans (24.31%), and Native Americans (24.0%).

Unemployment Rate, December 2015

Report Area	Number	Percent	Rate
KFH-West Los Angeles service area	61,351	14.2%	8.6
Los Angeles County	433,392	27.8%	8.6
California	1,561,117	100.0%	8.3

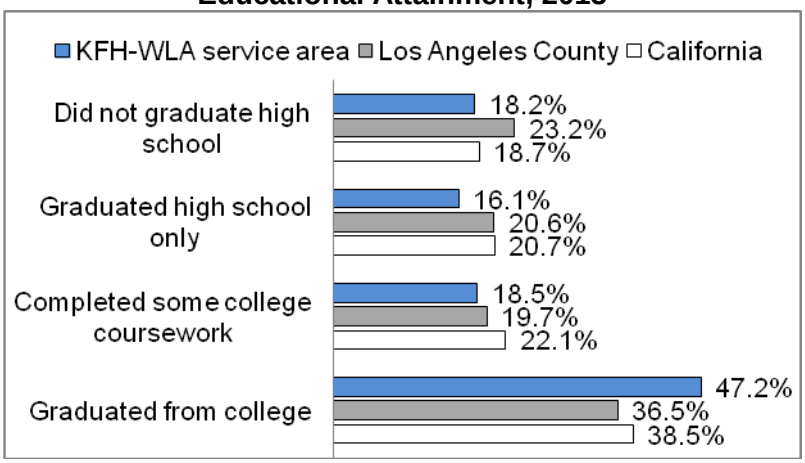
Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Education Level

A large portion of the population in the service area age 25 and older has either not graduated from high school or has only a high school education. Although most people in the service area have a college degree (47.2%) from associate to doctoral levels, 18.2% did not complete high school (including

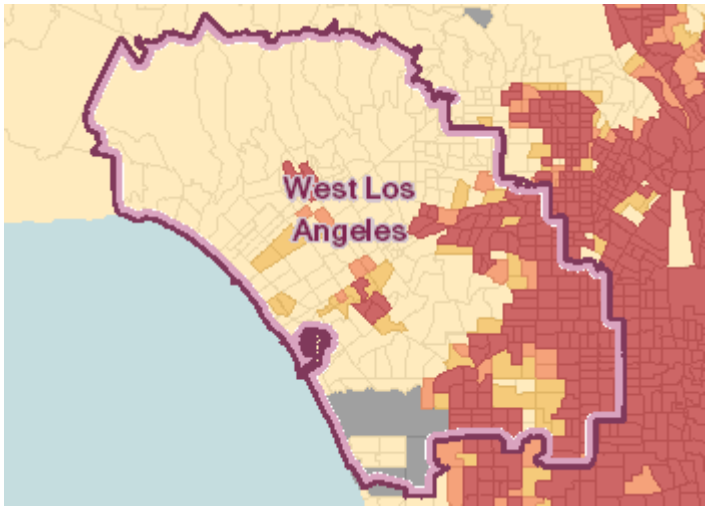
completing less than the ninth grade), a lower percentage than that reported in Los Angeles County (23.2%) and California (18.7%).

Educational Attainment, 2015



Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Communities in the service area with the largest percentage (over 21%) of the population age 25 and older without a high school diploma or higher degree include Arlington Heights, Jefferson Park, Inglewood, Lennox, South Los Angeles, West Adams, West Athens, and Westmont among others.



Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2010–14

Over 21.0%
16.1–21.0%
11.1–16.0%
Under 11.1%
No Data or Data Suppressed
Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

In the KFH-West Los Angeles service area, the percentage of children in the fourth grade with reading-skills scores below proficiency level on the English Language Arts portion of the California Standard Test was higher (39.0%) than in Los Angeles County and California (both at 36.0%), and does not meet the Healthy People 2020 goal of <=36.3%.

Reading Level Below Proficiency, 2013

Report Area	Percent
KFH-West Los Angeles service	39.0%
Los Angeles County	36.0%
California	36.0%
Healthy People 2020	<=36.3%

Source: California Department of Education, 2012–13, School District

The rate of Head Start program facilities in the KFH-West Los Angeles service area was much lower (4.5 per 10,000 youth under age 5) than in Los Angeles County (7.2) or California (6.3). Having access to early education is key to a youth's development and can influence future economic success and other lifestyle factors.

Head Start Program Facilities Rate per 10,000 Youth Under 5 Years Old, 2014

Report Area	Number	Rate
KFH-West Los Angeles service area	44	4.5
Los Angeles County	502	7.2
California	1,886	6.3

Source: U.S. Department of Health & Human Services Administration for Children and Families, 2014, Point

Homelessness and Housing

Homelessness and poor housing conditions are intertwined with health in many ways. A health condition can lead to homelessness and vice versa. Homelessness can make someone susceptible to worsening of health conditions because of the inability to sustain a healthy diet and/or obtain necessary preventive care.[46] Poor housing conditions can also contribute to poor health and lead to the development or worsening of a health condition.[47]

Homelessness

The homeless counts represented in this section are for whole service planning areas and do not provide accurate representations of homelessness in the KFH-West Los Angeles service area. Most of that service area falls in SPAs 5 and 6, with only small portions being in SPAs 4 and 8.

As of 2015, Los Angeles County had an estimated 44,359 homeless people. Most homeless in the service area are within SPA 4 (44.1%) and SPA 6 (28.4%).

Total Homeless, 2015

Report Area	Number	Percent
SPA 4–Metro	11,681	44.1%
SPA 5–West	4,276	16.2%
SPA 6–South	7,513	28.4%

[46] National Health Care for the Homeless Council. (2011). *Homelessness and Health: What's the Connection?.* Nashville, TN. Available at http://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf. Accessed February 18, 2016.

[47] World Health Organizations. (2016). *Housing and Health*. Geneva, Switzerland. Available at http://www.who.int/hia/housing/en/. Accessed February 18, 2016.

Report Area	Number	Percent
SPA 8–South Bay	3,006	11.4%
Los Angeles County	44,359	100.0%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Most of the sheltered homeless reside within SPA 4–Metro (49.2%) and SPA 6–South (26.9%); those unsheltered are within SPA 4–Metro (41.8%) and SPA 6–South (29.0%). According to a more recent release of the 2015 report by the Los Angeles Homeless Services Authority on homelessness in Los Angeles County (which provides a recent count of homeless with limited detail on specific communities), there were approximately 5,393 homeless on the day of that particular count within the KFH-West Los Angeles service area.

Sheltered/Unsheltered Homeless, 2015

Report Area	Sheltered Homeless		Unsheltered Homeless	
	Number	Percent	Number	Percent
SPA 4–Metro	4,001	49.2%	7,680	41.8%
SPA 5–West	1,274	15.7%	3,002	16.4%
SPA 6–South	2,189	26.9%	5,324	29.0%
SPA 8–South Bay	660	8.1%	2,346	12.8%
Los Angeles County	13,341	30.1%	31,018	69.9%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Most of the homeless population were individuals who reside within SPA 4 (45.7%) and SPA 6 (26.7%). According to the Los Angeles Homeless Services Authority, individuals included single adults, adult couples with no children, and groups of adults over the age of 18. Of the estimated homeless families in the service area most also reside in SPA 4 (36.7%) and SPA 6 (35.5%). The 185 homeless minors under the age of 18 in the service area mostly reside in SPA 6 (51.4%) and SPA 4 (39.5%).

Homeless by Type, 2015

Report Area	Homeless Individuals		Homeless Families		Homeless Unaccompanied Minors	
	Number	Percent	Number	Percent	Number	Percent
SPA 4–Metro	9,958	45.7%	1,650	36.7%	73	39.5%
SPA 5–West	3,561	16.3%	711	15.8%	4	2.2%
SPA 6–South	5,826	26.7%	1,592	35.5%	95	51.4%
SPA 8–South Bay	2,456	11.3%	537	12.0%	13	7.0%
Los Angeles County	33,389	75.3%	7,505	16.9%	280	0.6%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

According to the Los Angeles Homeless Services Authority, the condition of being chronically homeless is defined as an individual or family having been homeless for a year or more. At total of 7,922 individuals and 1,153 families are categorized as chronically homeless. Most of the chronically homeless individuals in the service area reside in SPA 4 (41.9%) and SPA 6 (25.0%), but most chronically homeless *families* are within SPA 5 (29.5%) and SPA 4 (29.4%).

Chronically Homeless by Type, 2015

Report Area	Individuals		Families	
	Number	Percent	Number	Percent
SPA 4–Metro	3,323	41.9%	339	29.4%
SPA 5–West	1,498	18.9%	340	29.5%
SPA 6–South	1,979	25.0%	225	19.5%
SPA 8–South Bay	1,122	14.2%	249	21.6%
Los Angeles County	12,356	27.9%	1,817	4.1%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Of the identified homeless in the four SPAs, 3,172 are veterans, most residing in SPA 4 (39.0%) and SPA 5 (28.0%).

Homeless Veterans, 2015

Report Area	Number	Percent
SPA 4–Metro	1,237	39.0%
SPA 5–West	888	28.0%
SPA 6–South	472	14.9%
SPA 8–South Bay	575	18.1%
Los Angeles County	4,016	9.1%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Of the identified homeless in the four SPAs, 29.7% are mentally ill and 24.0% are dealing with substance abuse issues. Another 19.0% are physically disabled and 2.1% are HIV-positive. These percentages are slightly higher than those reported for Los Angeles County (27.6%, 23.4%, 18.4%, and 1.7%, respectively).

Homeless by Special Population, 2015

Report Area	Mentally Ill		With Substance Abuse Issues		With HIV		Physically Disabled	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
SPA 4–Metro	3,408	43.3%	2,843	44.7%	372	65.7%	2,035	40.5%
SPA 5–West	1,748	22.2%	1,147	18.0%	75	13.3%	1,077	21.4%
SPA 6–South	1,894	24.1%	1,284	20.2%	94	16.6%	1,349	26.8%
SPA 8–South Bay	825	10.5%	1,084	17.0%	25	4.4%	569	11.3%
Los Angeles County	12,253	27.6%	10,388	23.4%	757	1.7%	8,148	18.4%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2015, SPA

Housing

Substandard housing conditions include 1) a lack of complete plumbing facilities, 2) a lack of complete kitchen facilities, 3) having 1.01 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. In the KFH-West Los Angeles service area, over half (54.3%) the population

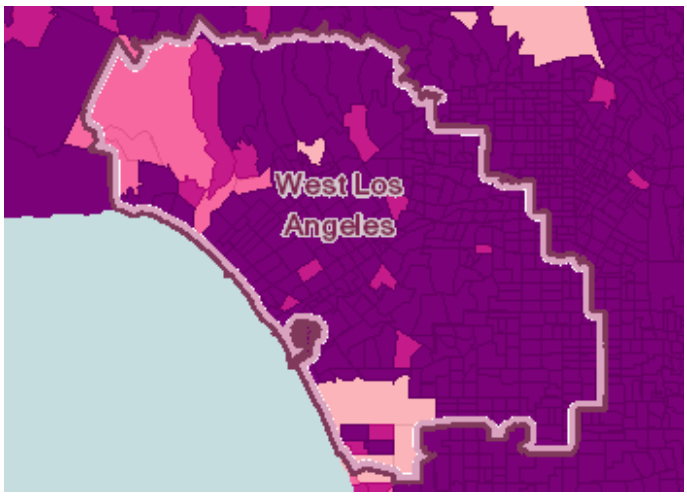
lives in housing with one or more of these conditions, a similar percentage to that reported for Los Angeles County (54.0%) and higher than in California (47.5%).

Occupied Housing Units with One or More Substandard Conditions, 2014

Report Area	Number	Percent
KFH-West Los Angeles service area	296,338	54.3%
Los Angeles County	1,749,173	54.0%
California	5,998,826	47.5%

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

The map below shows that over 34% of housing units in the service area had one or more substandard condition. However, a much larger percentage (65% or higher) of households in the southeast portion of the service area are characterized by one or more of these substandard conditions.



Substandard Housing Units, Percent of Total by Tract, ACS 2010–14

- Over 34.0%
- 28.1–34.0%
- 22.1–28.0%
- Under 22.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Legal Status

Citizenship status can have an impact on an individual's level of health care access and the quality of medical services received. Over a third (30.7%) of the population living in SPA 6 and another quarter in SPA 4 (27.9%) were not United States citizens. These percentages are higher than those reported for Los Angeles County (17.3%) and California (14.0%).

Stakeholders added that many residents in the service area are undocumented and unable to receive health care service at all, let alone good-quality health care.

Not a United States Citizen, 2014

Report Area	Number	Percent
SPA 4–Metro	310,000	27.9%
SPA 5–West	38,000	6.1%
SPA 6–South	310,000	30.7%
SPA 8–South Bay	140,000	9.1%
Los Angeles County	1,714,000	17.3%
California	5,262,000	14.0%

Source: California Health Interview Survey, 2014, SPA

Transportation

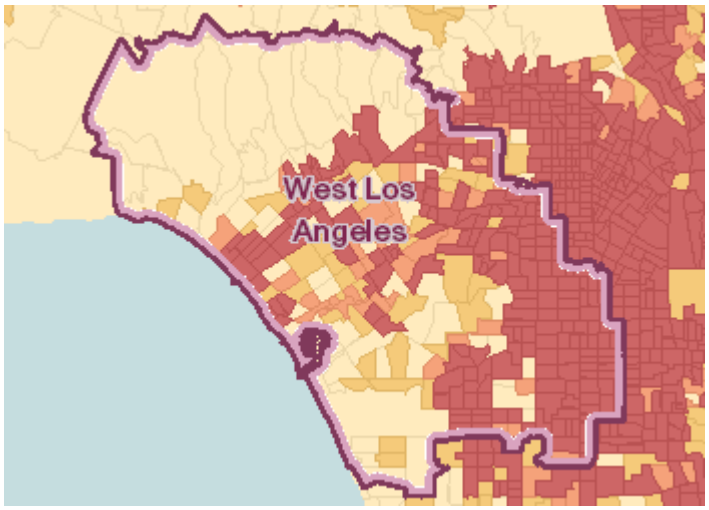
Access to transportation is often essential to an individual's ability to access work, child care, health care, and other basic necessities. In the KFH-West Los Angeles service area, 10.8% of households did not have a motor vehicle, a larger percentage than in Los Angeles County (9.7%) and California (7.7%).

Households with No Motor Vehicle, 2015

Report Area	Number	Percent
KFH-West Los	56,282	10.8%
Los Angeles County	325,842	9.7%
California	1,012,795	7.7%

Source: Nielsen Claritas Site Reports, 2015, ZIP Code

An even greater percentage of households (20% or more) in the southeast portion of the service area do not have at least one vehicle.



Households with No Vehicle, Percent by Tract, ACS 2010–14

- Over 8.0%
- 6.1–8.0%
- 4.1–6.0%
- Under 4.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Stakeholders noted disparities with regard to motor vehicles among low-income communities such as South Los Angeles, immigrants, the disabled, senior citizens, Latinos, and African-Americans.

Violence and Injury Prevention

Violence affects everyone from infants to the elderly and is a serious public health issue. Both intentional and unintentional injuries may be caused by events including motor vehicle accidents and physical assault. Regardless of the circumstances, injuries can have serious, painful, and debilitating consequences on physical and emotional health, many long-term or permanent, including hospitalization, brain injury, poor mental health, disability, and premature death.[48]

Community Safety

[48] U.S. Department of Health and Human Services. (2015). *Injury and Violence.* Washington DC. Available at http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Injury-and-Violence. Accessed December 8, 2015.

Neighborhood safety is closely associated with community residents leading healthy lifestyles and feeling comfortable using common green spaces such as nearby parks for walking and exercising. This is particularly important for youth.

Larger percentages of teens age 12 to17 reported receiving threats of violence or physical harm from peers in the past year in SPA 8 (27.6%) and SPA 4 (21.5%) than in Los Angeles County (14.7%) or California (16.2%). A larger percentage of teens in SPA 6 (22.8%) feared being attacked at school in the past year than in either Los Angeles County (17.1%) or California (14.3%). Larger percentages of teens also reported not feeling safe in parks or playgrounds in their neighborhoods during the day in SPA 8 (25.6%) and SPA 6 (22.1%) than in Los Angeles County (11.7%) or California (9.5%).

Stakeholders added that violence in the KFH-West Los Angeles service area, particularly in South Los Angeles, was rising due to an ongoing gang war and mostly affected youth and young adults.

Teens Perception of Neighborhood and School Safety, 2012, 2015

Report Area	Received threats of violence or physical harm from peers in past year[1]	Feared of being attacked at school in the past year[1]	Felt unsafe in nearby park or playground during the day[2]
SPA 4–Metro	21.5%	18.7%	7.0%
SPA 5–West	8.8%	14.3%	3.1%
SPA 6–South	11.7%	22.8%	22.1%
SPA 8–South Bay	27.6%	19.6%	25.6%
Los Angeles County	14.7%	17.1%	11.7%
California	16.2%	14.3%	9.5%

Source: California Health interview Survey, 2012, SPA[1]
California Health interview Survey, 2014, SPA[2]

Firearm Injuries

High levels of violence can be indicated by high rates of firearm-related injuries, which create an unsafe environment for community residents. Overall, the KFH-West Los Angeles service area has experienced a non-fatal firearm hospitalization rate (12.2 per 10,000 youth) more than twice as high as Los Angeles County (5.4) and almost three times higher than California (4.2). Communities in the service area that have experienced the highest non-fatal firearm hospitalization rates included Ladera Heights (22.5), South Los Angeles (17.1), Hyde Park (15.3), and Inglewood (14.8).

Non-Fatal Firearm Hospitalization Rates per 10,000 Youth, 2012

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	6.7
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	*Not available*

Community	ZIP Code	Service Planning Area (SPA)	Rate
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	*Not available*
Beverly Hills	90210, 90211, 90212	5–West	*Not available*
Century City	90067	5–West	*Not available*
Cheviot Hills	90064	5–West	*Not available*
Culver City	90066, 90230, 90232	5–West	3.3
El Segundo	90245	8–South Bay	*Not available*
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	*Not available*
Hyde Park, including View Park and Windsor Hills	90043	6–South	15.3
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	14.8
Jefferson Park	90018	6–South	12.4
Ladera Heights	90056	5–West	22.5
Los Angeles International Airport, including Westchester	90045	5–West	4.5
Marina Peninsula	90292	5–West	*Not available*
Pacific Palisades, including Pacific Highlands	90272	5–West	*Not available*
Palms	90034	5–West	3.2
Playa Del Rey	90293	5–West	*Not available*
Playa Vista	90094	5–West	*Not available*
Santa Monica	90402, 90403, 90404	5–West	*Not available*
Santa Monica—Downtown	90401	5–West	*Not available*
Santa Monica—Ocean Park	90405	5–West	*Not available*
Sawtelle, including West Los Angeles	90025	5–West	*Not available*
South Los Angeles, including Broadway/ Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	17.1
Venice	90291	5–West	8.5
West Adams	90016	6–South	5.3
West Fairfax	90035	5–West	6.1
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	*Not available*
Westwood	90024	5–West	*Not available*
KFH-West Los Angeles service area			12.2
Los Angeles County			5.4
California			4.2

Source: Office of Statewide Health Planning and Development (OSHPD), 2012, ZIP Code

Mortality

Deaths caused by unintentional (accidental) injuries is lower (2.1 per 10,000 population) in the KFH-West Los Angeles service area when compared to California (2.8). However, higher rates were reported for specific communities, including Ladera Heights (6.2), Baldwin Hills (4.1), and Century City (4.1).

Unintentional Injury Mortality Rate per 10,000 Population, 2012

Community	ZIP Code	Service Planning Area (SPA)	Rate
Arlington Heights, including Country Club Park and Mid-City	90019	4–Metro Los Angeles	0.9
Baldwin Hills, including Crenshaw and Leimert Park	90008	6–South	4.1
Bel Air Estates, including Brentwood and Beverly Glen	90049, 90077	5–West	2.8
Beverly Hills	90210, 90211, 90212	5–West	1.5
Century City	90067	5–West	4.1
Cheviot Hills	90064	5–West	2.3
Culver City	90066, 90230, 90232	5–West	2.7
El Segundo	90245	8–South Bay	1.8
Fairfax, including the Fairfax Farmers Market, Miracle Mile, Melrose, Wilshire-La Brea and Park La Brea	90036	4–Metro Los Angeles	1.3
Hyde Park, including View Park and Windsor Hills	90043	6–South	3.3
Inglewood	90301, 90302, 90303, 90304, 90305, 90311	8–South Bay	1.3
Jefferson Park	90018	6–South	1.7
Ladera Heights	90056	5–West	6.2
Los Angeles International Airport, including Westchester	90045	5–West	1.5
Marina Peninsula	90292	5–West	0.9
Pacific Palisades, including Pacific Highlands	90272	5–West	2.7
Palms	90034	5–West	2.2
Playa Del Rey	90293	5–West	0.8
Playa Vista	90094	5–West	0.0
Santa Monica	90402, 90403, 90404	5–West	2.0
Santa Monica—Downtown	90401	5–West	1.5
Santa Monica—Ocean Park	90405	5–West	2.6
Sawtelle, including West Los Angeles	90025	5–West	1.6
South Los Angeles, including Broadway/ Manchester	90037, 90044, 90047, 90062, 90003	6–South, 8–South Bay	2.0

Community	ZIP Code	Service Planning Area (SPA)	Rate
Venice	90291	5–West	2.4
West Adams	90016	6–South	2.5
West Fairfax	90035	5–West	2.7
West Hollywood, including West Beverly	90069, 90048	4–Metro Los Angeles	2.0
Westwood	90024	5–West	1.1
KFH-West Los Angeles service area			2.1
California			2.8

Source: California Department of Public Health (CDPH), 2012, ZIP Code

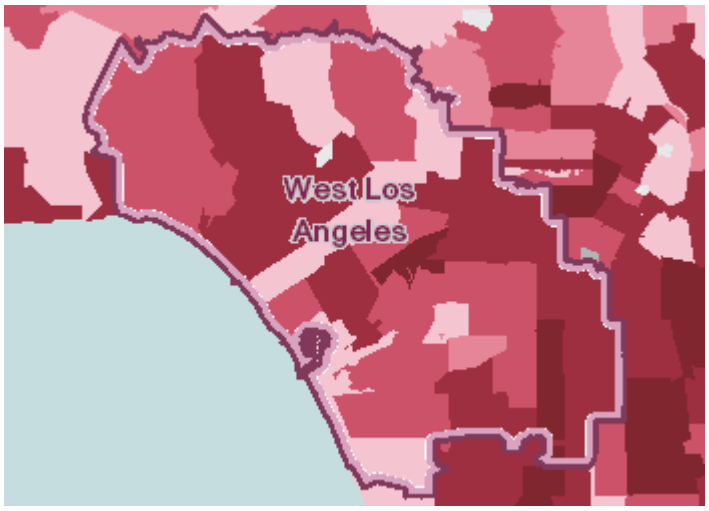
The rate of pedestrian deaths caused by motor vehicles was higher (2.9 per 100,000 population) in the KFH-West Los Angeles service area than in either Los Angeles County (2.3) or California (2.0), and more than twice the Healthy People 2020 goal of <=1.3. More specifically, pedestrian deaths caused by motor vehicles were higher (2.9 per 100,000 population) in the KFH-WLA service area when compared to Los Angeles County (2.3) and California (2.0), and it has increase since the 2013 report (1.5 per 100,000 population). In addition, the rate for the service area (2.9) was more than two times

Pedestrian Motor Vehicle Mortality Rate per 100,000 Population, 2012

Report Area	Number	Rate
KFH-West Los Angeles service area	339	2.9
Los Angeles County	660	2.3
California	3,902	2.0
Healthy People 2020	2,250	<=1.3

Source: University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health (CDPH) Death Public Use Data, 2010–12, ZIP Code

The map below indicates the particular areas with higher rates of pedestrian deaths caused by motor vehicles—specifically, Culver City and South Los Angeles.



Pedestrian Motor Vehicle Accident Mortality, Age-Adjusted Rate (Per 100,000 Population) by ZCTA, CDPH 2010–12

- Over 6.0
- 3.1–6.0
- 1.1–3.0
- Under 1.1
- No Pedestrian Motor Vehicle Deaths
- No Data or Data Suppressed
- Report Area

Source: University of Missouri, Center for Applied

Research and Environmental Systems. California Department of Public Health (CDPH) Death Public Use Data, 2010–12, ZIP Code

ii. Prioritized list of health outcomes

The table below provides a list of the identified needs in order of priority.

Prioritized Health Needs

	Health Needs	
1	Mental Health	Outcome
2	Diabetes	Outcome
3	Obesity/Overweight	Outcome
4	Access to Care	Driver
5	Homelessness and Housing	Driver
6	Preventative Health Care	Driver
7	Economic Security	Driver
8	Violence and Injury Prevention	Driver
9	Cardiovascular Disease/Heart Disease	Outcome
10	Access to Healthy Foods	Driver
11	Healthy Behaviors	Driver
12	Alcohol Abuse, Substance Abuse and Tobacco Use	Driver
13	Hypertension	Outcome
14	Oral Health	Outcome
15	Legal Status	Driver
16	Physical Environment	Driver
17	Cancer (includes breast, colorectal, lung, and prostate)	Outcome
18	Cultural and Linguistic Barriers	Driver
19	Asthma	Outcome
20	Cholesterol	Outcome
21	Transportation	Driver
22	Sexually Transmitted Disease	Outcome
23	Dental Care Access	Driver
24	Disease Management	Driver
25	Respiratory Disease (includes COPD)	Outcome
26	Maternal and Infant Health	Outcome
27	HIV/AIDS	Outcome
28	Alzheimer's Disease	Outcome
29	Communicable Diseases (including Hepatitis A and B)	Outcome

iii. Community assets, capacities and resources potentially available to respond to the identified health needs

Community assets and resources were identified through focus groups and interviews in the identification phase of the process. Stakeholders were asked to share, by health need, the names of community organizations, programs, and other resources they knew of and/or had experience with to address specific health needs. Following the identification of assets, Internet research was conducted to validate each resource and collect up-to-date information for each. A name, brief description, and website (as available) were provided for each asset and resource identified. Please refer to Appendix D. Health Need Profiles.

VII. KFH WEST LOS ANGELES 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy Evaluation of Impact

KFH-West LA's 2013 Implementation Strategy report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-West LA's Implementation Strategy report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit https://share.kaiserpermanente.org/wp-content/uploads/2013/10/IS-Report-West-Los-Angeles.pdf . For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH-West LA in the 2013 Implementation strategy report.

1. Chronic disease prevention and management with emphasis on obesity, diabetes, and cardiovascular disease (including hypertension and cholesterol), and asthma
2. Access to mental health and intervention programs with emphasis on youth well-being and the prevention of alcohol and substance abuse, violence, and homelessness
3. Access to health care, diagnostic and preventive services with emphasis on HIV-AIDS, chlamydia, and cancer
4. Broader Health Care System Needs in Our Communities - Research and Workforce

KFH-West LA is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-West LA tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, KFH-West LA had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-West LA will continue to monitor impact for strategies implemented in 2016.

B. 2013 Implementation Strategy Evaluation of Impact Overview

In the 2013 IS process, all KFH planned for and drew on a broad array of resources and strategies to improve the health of communities and vulnerable populations, such as grant making, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- **Medicaid:** Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
- **Medical Financial Assistance:** The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
- **Charitable Health Coverage:** Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- **Workforce Training:** Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.
- **Research:** Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes.

- **Grant-making:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH-West LA had 85 grant payments amounting to a total of $621,000 in service of 2013 health needs. Additionally, KFH-West LA has funded significant contributions to a donor advised fund (DAF), managed by the California Community Foundation, in the interest of funding effective long-term, strategic community benefit initiatives. During 2014-2015, a portion of money managed by this foundation was used to support 55 grant payments totaling $8,031,789 in service of 2013 health needs. An illustrative list of active grants is provided in each health need section below.

- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, KFH-West LA donated several in-kind resources in service of 2013 Implementation Strategies and health needs; an illustrative list is provided in each health need section below.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFH-West LA engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs; an illustrative list is provided in each health need section below.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

KFH-West LA Priority Health Need: Chronic disease prevention and management with emphasis on obesity, diabetes, and cardiovascular disease (including hypertension and cholesterol), and asthma

- Increase healthy behaviors related to obesity, diabetes, cardiovascular disease (including hypertension and cholesterol), and asthma among at-risk and vulnerable populations.
- Improve chronic disease management among vulnerable populations diagnosed with obesity, diabetes, cardiovascular disease (including hypertension and cholesterol), and asthma.

Chronic disease prevention and management with emphasis on obesity, diabetes, and cardiovascular disease (including hypertension and cholesterol), and asthma Grant-Making Highlights

Grant-Making Snapshot During 2014-2015, there were 30 KFH grant payments, totaling $200,000, addressing the priority health need in the KFH-West LA service area. In addition, a portion of the money managed by a donor advised fund (DAF), The California Community Foundation, was used to support 23 grant payments, totaling $2,161,789; DAF grants are denoted by asterisks (*). Donor advised fund (DAF) grants may cover multiple KFH service areas and address multiple health needs. All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
Los Angeles Regional Food Bank	$47,500*	The Promoting Healthy Eating and Living in Los Angeles County project seeks to develop and implement a nutrition-focused food policy, increase their nutrition education offerings, and conduct CalFresh Program outreach and enrollment.	The Los Angeles Regional Food Bank has developed and implemented a nutrition-focused food policy. They have supported a CalFresh outreach and enrollment program that resulted in 305 approved applications and conducted 24 nutrition education opportunities for children and families.
Community Partners Los Angeles Food Policy Council	$50,000 *	Community Partners serves as the fiscal agent for Los Angeles Food Policy Council (LAFPC) to support the promotion and adoption of healthy and sustainable food systems. The grant supports the core efforts undertaken by LAFPC, which will increase access to healthy food options for underserved communities.	LAFPC is continuing to manage and guide the Urban Agriculture Working Group in the development of water-sensitive urban agriculture policies and programs. They are assisting the Street Food Vendor Steering Committee in contributing to the development of a city-wide permit system for sidewalk vending. Additionally, they are supporting the Farmers' Markets Working Group to help the city achieve universal acceptance of Electronic Benefit Transfer and Women Infant Child (EBT/WIC) at all farmers' markets. They are also strengthening and supporting the expansion of the

Grantee	Grant Amount	Project Description	Results to Date
			first healthy food purchasing cooperative to 12 neighborhood markets.
City of Los Angeles Department of Recreation and Parks	$240,000*	This Operation Splash program provides swim lessons, extended swim season passes, junior lifeguard training and water safety, and a healthy drink campaign for low-income youth and families.	The City of Los Angeles has partnered in the Operation Splash program since 2006. In 2014 and 2015, it provided approximately 6,000 swim lessons and 800 junior guard trainings on an annual basis. The Rethink your Drink campaign is promoted year round with banners posted at all pool sites and reusable water bottles that encourage drinking water. This campaign has an annual estimated reach of over 700,000 individuals.
Lennox School District	$21,297*	This Thriving Schools projects aims to a) revise, implement and monitor a district wide wellness policy and b) improve the cafeteria environment in order to promote healthy foods and beverages.	The school district has a) revised the school wellness policy, b) increased the promotion of healthy beverages and food consumption through cafeteria branding and providing digital menu boards, c) installed one hydration station, and d) launched a district wide promotion through the Rethink your Drink campaign. This project is being implemented in five (5) Elementary Schools, one (1) Middle School and potentially reaches 5,154 students.
Social Justice Learning Institute Inc.	$10,000	Social Justice Learning Institute Inc. aims to encourage support and commitment from stakeholders regarding the sustainability and viability of a Inglewood Certified Farmers Market. Manage and execute stakeholder convenings and produce 10-12 'pop-up' markets in downtown Inglewood.	Social Justice Learning Institute (SJLI) has organized four pop-up farmers' markets in Inglewood just in the last six months. Approximately 600 to 1,500 individuals have attended each market day. About 10 farmers have participated in each market reaching $1,000 in sales per day. In total more than 3,700 shoppers have been served and over 30 SNAP shoppers have visited the market and more than 500 have

Grantee	Grant Amount	Project Description	Results to Date
			participated in weekly nutrition classes. Additionally, SJLI has met with the City of Inglewood and a local funder to discuss specific efforts to formalize commitments to support the market. SJLI has requested the issuing of a City RFP as well as zoning changes and fee reductions to make the market more sustainable. More than five funding partners have been identified and have provided additional funding or in-kind services to support the Inglewood Farmers' Market.
Community Partners, for benefit of Rootdown LA	$5,000	The South LA Youth-driven Diabetes Support Network project will train local youth to respond to the nutrition needs of community members who are at risk for, or diagnosed with, diabetes. Youth participants interview family members and design and conduct an eight-week intervention to help them improve eating habits. Youth also develops communications materials for community members to increase diabetes testing at Jefferson HS. Wellness Center	A full-time culinary/nutrition instructor was hired for the duration of this grant period at the WECAN/Augustus HawkinsYouth-driven Neighborhood Food System site. The instructor provided a 13 week workshop to train youth to design, install, maintain, and distribute food from networks of neighborhood gardens. Additionally, August Hawkins students and neighbors participated in after-school cooking and nutrition classes. Two interns were employed at the site to work in maintaining installed gardens. They made regular produce distributions to at least 20 families at this site. They also conducted outreach to over 600 students and community members providing in-school vegetable tastings. Rootdown has initiated two new partnerships with a local church and St. John’s Wellness center to begin surveying adult pre-diabetic residents to inform the development of a diabetes curriculum. These partnerships will facilitate surveying 40 to 60 people and conducting a four week

Grantee	Grant Amount	Project Description	Results to Date
			nutrition workshop at the wellness site. An additional paid youth intern will be added in February 2016 and the hosting a weekly farm stand at community sites will commence. The organization is in the process of developing marketing materials specific for pre-diabetic and diabetic individuals to be utilized at the farm stand.
University Muslim Medical Association, Inc.	$10,000	UMMA's Triple Threat Impact Initiative's goal is to decrease the prevalence of diabetes, obesity, and hypertension and improve healthcare outcomes through a team-based approach and the utilization of community-based interventions.	UMMA currently serves 1,242 diabetic patients and 1,305 hypertensive patients. During the grant period, UMMA has expanded two evidence-base programs to address diabetes: CDC's Enhanced Diabetes Care Management Initiative and the Wellness RX Patient Navigation program. Through these programs and the Triple Threat initiative, 200 hundred patients were targeted to participate in a 24-month multi-disciplinary chronic disease prevention and management program through referrals, nutrition and exercise classes, peer to peer support groups, as well as health screenings and disease management consultations. These services utilize culturally appropriate materials to effectively serve the large Latino population at this clinic. UMMA Quality Improvement Committee is working on specific steps to improve data collection and strengthen health education programs, to facilitate the full implementation of the program.
Students Run America	$5,000	Students Run America provides a structured six-month training program for the ASICS LA Marathon, SRLA mentors at-risk	During the 2015-16 season, with the support of 500 volunteer teachers, the program has directly reached more than 3,200 middle

Grantee	Grant Amount	Project Description	Results to Date
		secondary students, teaching them discipline and the healthy habits of regular physical activity and nutritional eating.	and high school students through its youth mentoring and marathon-training program. The students train, on average, for 10 hours each week. Due to grants support, this program can now be found at 16 schools and community police programs, serving more than 280 students.
Heal One World	$5,000	The HEAL One World Fit Right In program is a preventative self-care program taught in supportive environment, for lifetime healthy choices and habit formation through exercise, nutrition and greater self-awareness.	To date, 44 individuals have participated in 30 weekly sessions and have had a total of 75-95 classes each since August 2015. All participants have improved their diets and reported to be 30% to 100% more active than prior to the beginning the program. The program also offered opportunities for creating supportive relationships to incorporate new and healthier habits. As a group, participants lost a combined 102 inches from the waist and 294 pounds.
Breathe California of Los Angeles County	$10,000	Breathe California's program, Lung Power for Parents and Guardians, will provide adult caregivers of children with asthma the skills and understanding needed to avoid exacerbation and improve their children's quality of life.	In partnership with the Training and Research Foundation, Breathe LA has conducted 13 Lung Power workshops with a total of 109 participants and an additional workshop just outside the service area with another 9 participants. Program participants experienced a 20% increase in knowledge about asthma and asthma management. Parents learned how to communicate effectively with their children's physicians in English and in Spanish to ensure their children's asthma conditions were properly diagnosed and treated. Approximately 82% of parents showed confidence in managing their child's asthma through

Grantee	Grant Amount	Project Description	Results to Date
			medications and peak flow meters.
Black Women For Wellness	$5,000	Kitchen Divas is a series of interactive food preparation/cooking demonstrations, classes and workshops focusing on health, risk reduction, lifestyle changes and physical activity and family involvement.	Black Women for Wellness (BWW) implemented a new site in the Kaiser West Los Angeles service area at the L.I.F.E. Center at Weingart YMCA Wellness and Aquatic Center (located in 90044). By offering several classes each month at this site, Kitchen Divas (KD) reached over 50 unduplicated participants over 17 separate workshops. These classes built a following of returning KD participants in addition to attracting new attendees. Each 2 hour class involved interactive food demonstrations, shopping tips, educational nutritional information, and problem solving for daily menu planning. BWW continues to increase outreach and education about nutrition, physical activity and disease prevention through positive lifestyle change. BWW distributed recipes and other guides to class participants and through general outreach in the community at popular events including KJLH Taste of Soul, CicLaVia and Martin Luther King Jr. Day parade among other activities.
South Bay Family Healthcare Center	$10,000	SBFHC's program for reducing the impact of diabetes in the community provides diagnosis, treatment intervention, health education, and care management for patients at risk of or suffering from diabetes.	SBFHC's provided health care services to identify, educate and manage individuals who are at-risk for or diagnosed with Type-2 diabetes at the Dr. Claudia Hampton Clinic in the city of Inglewood. During the funding period SBFHC worked with a cohort of 808 diabetic patients, obtaining the following results: 455 or 56% of patients maintained A1c level less than; 663 or 82% of

Grantee	Grant Amount	Project Description	Results to Date
			patients maintained blood pressure under control; and 241 or 30% of patients had LDL equal to or less than 100mg/dl. The clinic expects a reduction in complications associated with Type-2 diabetes, including cardiovascular disease, kidney failure and amputations, thus improving individual quality of life and preventing mortality from diabetes related complications.
Chronic disease prevention and management with emphasis on obesity, diabetes, and cardiovascular disease (including hypertension and cholesterol), and asthma Collaboration/Partnership Highlights			
Organization/Collaborative Name		**Collaborative/Partnership Goal**	**Results to Date**
Los Angeles Department of Public Health SPA8 Regional Network		The Department of Public Health SPA8 Regional Network seeks to bring community stakeholders together to share information, resources and best practices to improve community health.	The SPA 8 DPH network was formed as part of the LA DPH Community Health Improvement Planning process. Stakeholders continue to meet quarterly and communicate activities through a web-based platform to support their individual work. KFH-West LA participated in the advisory planning committee in conjunction with South Bay. Additionally, Roberta Tinajero, Regional Community Benefit Manager Health Eating Active Living (HEAL), presented on lessons learned in our Kaiser Permanente HEAL Zones grant initiative.
Community Council - South LA Healthcare Leadership Roundtable.		The South LA Healthcare Leadership Roundtable was formed to establish and support a collaboratively designed coordinated system of care in alignment with the unique needs of South LA residents.	From 2012 to 2015, the South LA Healthcare Leadership Roundtable implemented the Enhanced Diabetes Care Management Initiative, with the support of a Kaiser Permanente grant. Through this initiative, mid- level providers were

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
		trained to deliver culturally competent care and care management to patients with high HbA1c levels across seven FQHCs in South LA. KFH West LA Assistant Medical Group Administrator has shared best practices and knowledge with South LA providers on efficient use of Advanced Practice Providers.

Chronic disease prevention and management with emphasis on obesity, diabetes, and cardiovascular disease (including hypertension and cholesterol), and asthma
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
Multiple Faith-Based Organizations	In 2013 and 2014 KFH-West LA implemented a pilot with two churches to improve the management of chronic conditions among church patrons. More than 200 individuals participated and 35 volunteers were trained as diabetes health coaches. In 2015, Southside Church of Christ conducted five health dialogue events reaching more than 150 participants and including new topics such as Women's Health and Healthy Eating for the Holidays. KFH-West LA provided a training to prepare Church Health Coaches to conduct the evidence based workshop Healthier Living with Chronic Conditions. Twenty health coaches were trained representing 9 organizations, 6 churches and 3 organizations working with faith-based partners. Additionally, KFH-West LA provides license, books, posters and giveaways to support the implementation of workshops.
South Central Family Health Center	Kaiser Permanente technical support experts James Dudl, MD, and Maria Urena, FNP, MSN, MHA, Clinical Quality Consultant, provided physicians of the South Central Family Health Center with an in-depth explanation of the clinical benefits of an evidence-base protocol for reducing the risk of CVD and stroke. The purpose/goal of their engagement was to share clinical protocols and effective care coordination models and to improve the clinics capacity for diagnosing and treating patients with targeted chronic conditions.
Service Area Community Based Organizations and Schools	KFH- West LA provides health education materials to community partners free of cost. In 2014 about 19,380 publications were distributed to 18 community organizations reaching an estimated population of 13,790 individuals. In 2015, about 24,000 health literature brochures and pamphlets were distributed to 17 organizations. Topics include healthy eating, managing high blood pressure, diabetes, stroke prevention, mental health, cancer, and asthma among others. The purpose/goal is to increase access

Recipient	Description of Contribution and Purpose/Goals
	to health literature on management of targeted chronic conditions.

Impact of Regional Initiatives Addressing
Chronic disease prevention and management with emphasis on obesity, diabetes, and cardiovascular disease (including hypertension and cholesterol), and asthma

In addition to the illustrated grants listed above, Kaiser Permanente designs Regional Health Initiatives that are implemented in one or more KFH service areas to address the priority health needs. These initiatives are multi-year investments that support policy, advocacy and/or system changes in communities, including support for clinic systems to enhance capacity, service provision and or coordination. Kaiser Permanente invests in external evaluation for Regional Health Initiatives, and where possible, the results to date will reflect the most recent evaluation findings.

Kaiser Permanente's Thriving Schools initiative expands Kaiser Permanente's commitment to the total health of members and the communities it serves through work with local schools and school districts. It is an effort to improve healthy eating, physical activity and school climate in K-12 schools in Kaiser Permanente's service areas, primarily through a focus on policy, systems and environmental changes that support healthy choices and a positive school climate. For the specific project implemented in KFH-West Los Angeles and the results to date, please see the Thriving Schools listing above under Lennox School District.

KFH-West LA Priority Health Need: Access to mental health and intervention programs with emphasis on youth well-being and the prevention of alcohol and substance abuse, violence, and homelessness

- Improve access to mental health and intervention programs for vulnerable populations.
- Reduce opportunities for violence and gang involvement among at-risk youth.
- Improve capacity and resources of community-based organizations to respond to community mental health needs.

Access to mental health and intervention programs with emphasis on youth well-being and the prevention of alcohol and substance abuse, violence, and homelessness
Grant-Making Highlights

Grant-Making Snapshot During 2014-2015, there were 35 KFH grant payments, totaling $291,000, addressing the priority health need in the KFH-West LA service area. In addition, a portion of the money managed by a donor advised fund (DAF), the California Community Foundation, was used to support 2 grant payments, totaling $75,000; DAF grants are denoted by asterisks (*). Donor advised fund (DAF) grants may cover multiple KFH service areas and address multiple health needs. All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
The Promises Foundation	$5,000	Miriam's House is a one year sober living residential program for low income mothers and their children in West Los Angeles.	The program offers structured mental health services to support 14 mothers who are in the process of recovery and are trying to keep custody of their

Grantee	Grant Amount	Project Description	Results to Date
			children. As of December 22, 2015 the in house therapist providing mental health services has met with the residents of Miriam's House individually an average of 6.5 times each month. In total that is an average of 98 hours of mental health services each month. In the last 6 months, 92% of residents in the Miriam's House program have remained sober. In the last 6 months, 96% of residents entering their 3rd phase of the program have either secured employment or enrolled in school (this is calculated upon two factors - obtaining work or enrolling in school and maintaining that enrollment/employment). The women of Miriam's House continue to experience the security of maintaining a relationship with the same psychotherapist during their residency.
Special Service for Groups Inc.	$56,000	HOPICS Emergency Room Outreach Program (HERO) will help stabilize homeless individuals and reduce their visits to Emergency Rooms by providing: case management, crisis housing, benefits establishment, and linkages to behavioral health.	A part-time homeless service navigator was hired, trained and on-boarded in October 2015 at KP West LA Medical Center to provide services at the Emergency Department (ED). ED Social Workers refer homeless individuals to the program based on their having visited the ED three or more times in the previous year or twice in the last month. At least 37 individuals have been referred to the program as of the end of 2015 and are receiving case management. The navigator's duty is to gain trust and cooperation to complete the Coordinated Entry System (CES) survey for each individual as well as to develop an individualized case plan. The CES survey provides an opportunity for accessing county services, including permanent supportive housing. About 18 individuals have completed the survey. Additionally, the navigator works with individuals on other goals, such as

Grantee	Grant Amount	Project Description	Results to Date
			getting proper IDs, attending substance abuse counseling, mental health services and transitioning to a medical home to receive primary care and preventive services. The navigator provides field- based services to help individuals accomplish these goals. At the moment, seven individuals are ready for permanent housing when available, ten are eligible for rapid rehousing and four have been referred to transitional living. Mid- term outcome data will be available in April 2016.
Antioch University	$5,000	Colors LGBTQ Youth Counseling Center provides free LGBTQ-affirmative counseling and healing psychotherapeutic services to youth under 25 and their families in the greater Los Angeles area, and also provides training on Clinical Psychology LGBT Specialization.	Between July 2015 and December 2015, 61 clients have been served by this program. With the support of this grant, one additional supervisor was on-boarded in September, 2015, resulting in a reduction in waiting time from 4 weeks to 1 - 2 weeks. Additionally, Colors has increased outreach activities by reaching out to various leaders, school counselors, principals and assistant principals informing them of the work the center is doing for the LGBTQ community. Colors participated in more than nine events hosted by various community partners serving LGBTQ Youth.
Airport Marina Counseling Service	$10,000	Psychiatric Services for Adults and At-Risk Families and Youth Program provides low income people of all ages with access to low-cost highly specialized mental health intervention (psychiatry, psychotherapy) to promote well-being and reduce risk factors associated with violence, substance abuse, and homelessness. Funds support the salary of a psychiatrist.	Currently 73% of Marina Airport Counseling Service (AMCS) clients are improving their well-being as evidenced by an increase in daily functioning or a decrease in symptoms. More than 57 youth have received services in the last six months; specific services include individual therapy, family therapy or case management services. Twelve of them have attended group sessions and three received individual psychiatric treatment. Approximately 93 adults have received psychiatric services and 46 have attended group sessions. AMCS has been serving an average of 328 clients in recent

Grantee	Grant Amount	Project Description	Results to Date
			months. Nearly 225 new clients have been assessed from August to December 2015. They have been connected to anger management, parenting classes, substance abuse treatment centers and food banks according to their needs. About 30 therapists have received training at this organization in the last six months. In particular, 15 of them have been trained to work with at-risk families. They have and continue to receive training to identify families and youth that are at-risk as well as training on how to establish therapeutic rapport to help engage the family in treatment. Therapists are also trained on a variety of teen and adolescence disorders including Conduct Disorder, Attachment Disorder, Parent/Child Relational Problems, Depression, Disruptive Disorders and Adjustment Disorders.
The AMAAD Institute	$5,000	The AMAAD Institute provides counseling/case management based on a harm-reduction approach to South LA LGBT youth who are at risk for homelessness, substance use, and/or who may have been diagnosed with HIV-AIDS and/or substance abuse disorder.	More than 23 African American and Latino gay youth age 18-24 have participated in this program, developing individualized actions plans to improve their lives and avoid risky behaviors. About 11 participants have received licensed clinical treatment to help manage mental health conditions. Participants received support to improve their resumes, apply to at least five jobs per week, take action to repair family relationships and obtain housing through Section 8 applications. They have worked to develop coping and behavioral negotiating skills by highlighting their internal strengths, intended to facilitate choosing alternatives to substance abuse and violence.
Wise & Healthy Aging	$10,000	Wise & Healthy Aging's Mental Health Services program addresses the mental well-being	WISE and Healthy Aging provided mental health services to 148 clients during the grant period. Of these, 70

Grantee	Grant Amount	Project Description	Results to Date
		needs of older adults through individual and group psychotherapy, psychiatry, medication management and case management.	(47%) were considered living at poverty or low-income (41 clients earn $12,000 or less annually; 17 clients earn $17,988 or less annually and 12 clients earn $23,988 or less annually). Clients exhibiting complex mental health histories continue therapy services for five years or more and receive psychiatric services as needed. Other health issues treated include substance abuse and exposure to domestic violence. There were no reports of elderly abuse cases during this grant period.
West Angeles Community Development Corp.	$5,000	The West Angeles CDC Young N LA Program is a life-changing youth and young adult intervention program designed to motivate and propel at-risk young men to achieve an education and valuable work experience through life coaching and mentorship.	During the reporting period, a total of 131 justice system involved young African American men enrolled in the work readiness program in six (6) small cohorts on a rolling basis. Participants are assessed and assigned a case manager who consistently monitors their progress. As a result, six (6) young men obtained full-time employment, ten (10) more were enrolled in community colleges, and one (1) was enrolled in a four-year university. Additionally, 13 were engaged in unpaid internships and 45 were placed in paid internships. The program successfully recruited, prepared, and connected youth to a network of employers.
Centinela Youth Services Inc.	$5,000	CYS' counseling program helps youth deal with complex emotional issues, identifying youth who require greater mental health assistance. The program provides family mediation with volunteers to reduce conflict and negative behavior to divert youth from the juvenile justice system. Client referrals sources include schools, Probation and Inglewood Restorative Justice Center. Mediation sessions last	CYS has provided FARS Parent-Teen mediations to 250 families during the grant period, about ten are funded by this grant at an average at least two (2) sessions per youth. On average 80% of the participants will not have further involvement with the juvenile justice system for one year as measured by police reports in the Juvenile Automated Index (the state operated data-base on juvenile crime). At least 22 Volunteers received 40 hours of FARS training in June 2015 plus 3 in-

Grantee	Grant Amount	Project Description	Results to Date
		two hours weekly for three to four weeks. The organization provides one three-day comprehensive volunteer training per year.	service trainings. Of those trained this year, 15 have already successful mediated cases. 100% of trainees rated the training as very good or excellent and 90% of trainees were evaluated as proficient in field practice. During fiscal year ending June 30, 2015, 45 families were referred by the Every Child Restorative Justice Center (ECRJ) to FARS, FARS referred 28 families to the ECRJ Center. The Center referred 80 families to outside mental health partners for counseling. There was a 150% increase in the mutual referral rate as a result of the leadership of the new CYS Director and a significant increase of unified staff review of program improvement strategies benefiting many more families.

Access to mental health and intervention programs with emphasis on youth well-being and the prevention of alcohol and substance abuse, violence, and homelessness Collaboration/Partnership Highlights		
Organization/Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**
Mid-Town Los Angeles Homeless Coalition	The Mid Town Los Angeles Homeless Coalition is a group of individuals and organizations, including neighborhood councils, businesses and service providers working together to link homeless individuals to services and increase resources.	The Coalition conducted a series of street outreach events to survey individuals experiencing homelessness in the mid-town area. Outreach volunteers complete the County Coordinated Entry System (CES) survey in order to facilitate access to housing and other resources. KFH- West LA hosted one of the events. The coalition aims to house 10 individuals by assessing 75 in a 100 day period. To date, more than 25 volunteers participated and assessed about 15 homeless individuals. Efforts to house individuals are underway and depend on housing availability and individual

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
		priority scores. Furthermore, KFH- West LA has provided seed funding in the amount of $1,400 to assist the coalition in developing a fundraising strategy to help support their ongoing efforts.

Access to mental health and intervention programs with emphasis on youth well-being and the prevention of alcohol and substance abuse, violence, and homelessness
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
Community Coalition Kinship Program	Watts Counselors and Interns provided Psychoeducational sessions to caregivers participating in Kingship program led by Community Coalition. The goal of the sessions is to support participants function as relative caregivers and to increase awareness and early detection of mental health symptoms in community settings. Ten sessions were conducted between January and May 2015. Topics included Youth Development, DCFS Navigation, Adult Self-Care, Domestic Violence and Grief. Sessions were offered in English and Spanish. Participants in need of counseling were provided a warm hand off to Watts Learning and Counseling Center to receive one- on- one free of cost therapy.
Senior Service Organizations	KFH West LA counselors and physicians conduct mental health presentations to increase awareness about mental health issues among senior citizens in partnership with organizations serving seniors. Two health dialogue sessions on Brain Health and Development were conducted by Counselors David Bruce and Nancy Walker in 2014 in partnership with Wise and Healthy Aging (95 participants) and with Westchester Playa Village (20 participants). In 2015, more than 100 seniors attended a health dialogue on “Understanding the Natural Process of Aging and Tips to Preserving a Youthful Mind” conducted by Dr. Jeffrey de Castro Mariano, WLA Assistant Chief Geriatrics Palliative Medicine & Continuing Care and Dr. Kaori Nakasone.
Multiple Organizations Working with Youth	In 2014, more than 35 parents attended a presentation on brain health and substance abuse at Fremont High School conducted by KFH-West LA addiction medicine counselors Michael Newman, Edward Tovar and Priscilla De Leon. The purpose/goal of these presentations is to increase awareness about substance abuse among at-risk youth and families. In 2015, counselors Edward Tovar and David Bruce conducted four presentations in partnership with West Angeles Housing Corporation Young in LA program, Community Coalition Youth Leadership and Freedom School Program, and Fremont High School Health Leaders Program. More than 50 students and 28 parents benefited from these lectures on Brain Health and Substance Abuse.
General Public	Kaiser Permanente’s Watts Counseling and Learning Center (WCLC) provides mental health and counseling services, assistance for children with learning

Recipient	Description of Contribution and Purpose/Goals
	disabilities, and pre-employment training for youth. WCLC also operates a nationally accredited, state-licensed preschool and other community outreach services in English and Spanish. In 2014 and 2015 WCLC provided services to an average of 1,200 residents per year. Many of the low-income individuals or families who participate in WCLC programs reside in the KFH-West LA service area.

KFH-West LA Priority Health Need: Access to health care, diagnostic and preventive services with emphasis on HIV-AIDS, chlamydia, and cancer

- Increase access to primary care.
- Increase access to diagnostic testing and specialty care.
- Increase health care coverage to low-income individuals and the underserved.
- Improve timely access to needed medical care.
- Facilitate professional development of community clinic providers.
- Reduce workforce shortages.

Access to health care, diagnostic and preventive services with emphasis on HIV-AIDS, chlamydia, and cancer
KFH Administered Program Highlights

KFH Program Name	KFH Program Descriptions	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• In 2014, $12,603,197 was spent on the Medicaid program and 15,126 Medi-Cal managed care members were served. • In 2015, $28,802,872 was spent on the Medicaid program and 23,778 Medi-Cal managed care members were served.
Medical Financial Assistance	The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• In 2014, $9,481,076 was expended for 8,462 MFA recipients. • In 2015, $6,163,557 was expended for 7,605 MFA recipients.
Charitable	Charitable Health Coverage (CHC) programs	• In 2014, $713,585 was

Health Coverage	provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	spent on the CHC program and 1,290 individuals received CHC. • In 2015, $709,780 was spent on the CHC program and 1,711 individuals received CHC.

Access to health care, diagnostic and preventive services with emphasis on HIV-AIDS, chlamydia, and cancer
Grant-Making Highlights

Grant-Making Snapshot During 2014-2015, there were 20 KFH grant payments, totaling $130,000, addressing the priority health need in the KFH-West LA service area. In addition, a portion of the money managed by a donor advised fund (DAF), the California Community Foundation, was used to support 26 grant payments, totaling $4,595,000; DAF grants are denoted by asterisks (*). Donor advised fund (DAF) grants may cover multiple KFH service areas and address multiple health needs. All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
Martin Luther King, Jr. Community Health Foundation	$2,000,000*	Complete the Martin Luther King Jr Community Hospital's (MLK) *Healthy babies Healthy Beginnings Campaign* which expands maternity services.	Overall, construction was completed for the following including the integration of technology: 2 dedicated operating rooms for C-sections, 18 delivery and postpartum beds, and 2 nurseries including an expansion of 11 bassinets. In addition, the clinical agreement for obstetrics and midwife services was finalized with the Eisner Pediatric and Family Medical Center, renowned for its work in women's health, and MLK hired experienced nursing staff.
California Family Health Council Inc**.**	$75,000*	The California Family Health Center (CFHC) Quality Improvement (QI) project advances the use of family planning performance measures and integrates them throughout service delivery within its statewide Title X clinic system. This grant assists community health centers to develop action plans and provide technical assistance to advance quality in service	To date, CFHC has provided data-related technical assistance and clinical training through a pilot project to promote the expanded provision of family planning services by primary care clinicians in five Federally Qualified Health Care Centers (FQHCs) in Los Angeles County. The grant has enabled CFHC to test best practices in incorporating family planning performance measures into primary care QI systems. In addition, CFHC has continued efforts to identify and test integration models and build on lessons learned and expand to five additional

Grantee	Grant Amount	Project Description	Results to Date
		delivery.	health centers. Regular meetings are conducted by CFHC to monitor and evaluate the progress of each Title X health centers.
St. Johns Well Child and Family Center Inc.	$95,000*	The California Family Health Center (CFHC) Quality Improvement (QI) project advances the use of family planning performance measures and integrates them throughout service delivery within its statewide Title X clinic system. This grant assists community health centers to develop action plans and provide technical assistance to advance quality in service delivery.	To date, CFHC has provided data-related technical assistance and clinical training through a pilot project to promote the expanded provision of family planning services by primary care clinicians in five Federally Qualified Health Care Centers (FQHCs) in Los Angeles County. The grant has enabled CFHC to test best practices in incorporating family planning performance measures into primary care QI systems. In addition, , CFHC has continued efforts to identify and test integration models and build on lessons learned and expand to five additional health centers. Regular meetings are conducted by CFHC to monitor and evaluate the progress of each Title X health centers.
Community Partners	$512,500*	Please see description for the Specialty Care Initiative under Impact of Regional Initiatives.	Please see description for the Specialty Care Initiative under Impact of Regional Initiatives.
Community Clinics Health Network	$175,000*	Please see description for the ALL HEART program under Impact of Regional Initiatives.	Please see description for the ALL HEART program under Impact of Regional Initiatives.
T.H.E. Clinic, Inc.	$10,000	T.H.E. Clinics' Wellness Center provides primary care, family planning, and reproductive health services (including screening/treatment for HIV/AIDS/STIs) to Crenshaw High School students, their families, and residents of neighborhoods surrounding the campus.	This grant expanded T.H.E. health education into the classroom and the community and provided much-needed HIV/STI education, screenings and treatment to approximately 75 % percent of Crenshaw High School students. The majority of ninth graders - up to 80 percent - received preventive health education in their classrooms, assemblies and at the T.H.E. Wellness Center. Through outreach efforts (Crenshaw activities, community health fairs, etc.), the Wellness Center staff

Grantee	Grant Amount	Project Description	Results to Date
			served 1,200+ family and community members.
Venice Family Clinic	$10,000	VFC's Breast Cancer Screening and Detection Program provides 9,000 women annually, age 20 and older, with comprehensive breast cancer prevention and detection services, including screenings, case management and social support.	Each year, VFC refers 140 unduplicated women to Western Imaging for these diagnostic services. Social workers also provide on-call and in-therapy support for patients as needed. Additionally, during each grant year, Venice Family Clinic will serve 9,000 adult women, age 20 and older. The patients served have low incomes, are uninsured or underinsured and reside in Los Angeles County. They are 52% Hispanic, 32% Caucasian, 11% African American and 3% Asian. Generally speaking, breast cancer screening services are provided to patients age 20 and above and are completed every one to three years, per the guidelines from the American College of Obstetrician and Gynecologists. It is anticipated that at least 11% of patients screened will be under the age of 40.
South Bay Family Healthcare Center	$5,000	South Bay Family Healthcare Center (SBFHC) seeks to provide more than 200 HIV tests and 600 STD tests to low-income and underinsured residents of Kaiser Permanente West Los Angeles' Service Area. This grant increases HIV and STD preventive services at SBFHC Inglewood site. Funds requested support salaries for a Nurse Practitioner and a Medical Assistant as well as lab costs.	The clinic has administered approximately 99 HIV tests between August 1, 2015 through December 23, 2015. About 219 STD tests were administered between August 1, 2015 through December 23, 2015. Patients served at the clinic are low-income, ethnically diverse, and under insured residents. This program has helped detect, monitor, and manage STDs in numerous patients, including Chlamydia and HIV in an area impacted by health disparities. As a result of the program, patients not only improved their symptoms and quality of life, but also reduced their future risks of transmission. They also prevented painful and expensive health outcomes.
The Achievable Foundation	$5,000	The Achievable Health Center provides culturally appropriate, coordinated and comprehensive clinical and	In calendar year 2015, the Achievable Health Center provided healthcare services to over 1,271 patients, with over 3,456 encounters. This grant provides

Grantee	Grant Amount	Project Description	Results to Date
		diagnostic services to meet the needs of LA area individuals with developmental disabilities who lack sufficient access to care.	female patients 24-64 with preventive pap tests to screen for cervical cancer and patients 50-75 with colorectal cancer screening. More than 38% of patients have some type of developmental disability, and these patients account for approximately 44% of all patient visits. Cervical cancer screenings are a challenge with some patients with developmental disabilities. Training of medical assistants and other clinic staff have improved success of providing such services to developmental disabled patients. Similar steps have been taken to make sure physicians ask every patient in the appropriate age range about their history of colorectal cancer.
University Muslim Medical Association, Inc.	$3,500	UMMA supports high school aged students with leadership development and public health skills.	This program was implemented in the Fremont HS Wellness Center. About 11 students attended 60 hours of training and learned basic public health terminology, social determinants of health, public health statistics and policies, and participated in several health education workshops. These students organized six events and participated in 10 community fairs promoting Wellness Center health services and sharing their knowledge with all Fremont School students and many parents and neighbors about STDs and HIV-AIDS among other topics.
Planned Parenthood Los Angeles	$5,000	Planned Parenthood LA (PPLA) addresses the need for quality reproductive and sexual health care and preventive services among the underserved, underinsured and uninsured residents of South Los Angeles. Services include HIV testing, diagnosis, prevention and referral, a full range of family planning methods and STI screening, prevention and	PPLA provided quality reproductive health services and information to 6,086 unduplicated clients at the Baldwin Hills/Crenshaw Health Center during the grant period. Many of these clients returned to the clinic during the grant period. This clinic provided a total of 9,927 family planning visits that include a wide range of options in birth control, as well as education. Additionally, the clinic provided 4,447 chlamydia tests. Chlamydia testing for the age group with the highest rate of infection (18-26)

Grantee	Grant Amount	Project Description	Results to Date
		treatment.	exceeded 90% during the grant year. PPLA provided 2,239 HIV tests, including Rapid HIV Testing and offered referrals for appropriate follow up care for individuals with positive results. The number of patient visits increased by 8 percent over the previous one-year period. The increase in the popularity of PPLA's Baldwin Hills/Crenshaw Health Center is the result of an expansion in service that included Saturday hours, as well as enhanced grassroots community outreach. During the grant period, PPLA built on the achievements of their Performance Improvement Effort (PIE), providing increased appointment through time and efficiency of patient visits, increasing access to care for clients with limited time and heavy work and child care responsibilities.
St. Johns Well Child and Family Center Inc.	$5,000	SJWCFC's Breast Cancer Screening Program will expand access to and provide mammography services to low-income and uninsured women age 50 and older in South Los Angeles.	Over the program year, SJWCFC successfully established and implemented an internal formal referral process for all women over age 50 to receive an annual mammogram as part of their routine annual physical. SJWCFC's Mammography Technician provided 2,252 mammograms to low-income women 50 years of age or older at the Frayser Health Center. Additionally 3,815 women patients over age 50 received breast cancer screening education. There is currently and increased demand for services with 5,512 internal referrals for mammograms having been entered during the grant period. More than 2,000 women are already scheduled to receive services and Community health promoters are following up with about 500 women who missed appointments. This program provided increased access to cost – effective preventive care and early intervention and reduced waiting time from months to two weeks on average.
Access to health care, diagnostic and preventive services with emphasis on HIV-AIDS,			

chlamydia, and cancer Collaboration/Partnership Highlights		
Organization/Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**
Venice Family Clinic Westside Health Access Collaborative	This collaborative seeks to create an improved system of health care services for low income individuals living in Service Planning Area 5, as well as for homeless individuals and mentally ill patients who inappropriately utilize emergency room services.	In 2014, the collaborative identified three pilot projects to develop in 2015. One of the projects focuses on integrating care coordination resources between hospital emergency rooms, health plans and community clinics to improve care and services for homeless individuals and mentally ill patients. In 2015, KFH- West LA implemented a Homeless Navigation pilot program in the Emergency Department to provide homeless individuals with linkage and follow-up services. The KFH-West LA CB manager provides regular updates, shares data and lessons learned with collaborative members. Additionally, KFH- West LA has identified two opportunities for new specialty access programs with collaborative members, Retinopathy Screening and Hepatitis C Infectious Disease Physician collaboration. These initiatives will be implemented in 2016.
Crenshaw High School Wellness Center Coordinating Council	Crenshaw High School Wellness Center Coordinating Council is a partnership between LAUSD and key community stakeholders to support the successful implementation and utilization of Crenshaw High School Wellness Center.	The CB manager participated in Wellness Center Coordinating Council monthly meetings. KFH-West Los Angeles donated 23 examination tables and 13 waiting room chairs to the Crenshaw High School Wellness Center which opened in December 2014. The medical center also provided grants to support

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
		HIV-AIDS and STDs testing and education. In addition, through participating in the Council we have identified opportunities for supporting key initiatives with students, such as providing materials for presentations at student conferences or providing lab coats and giveaways to recognize student health leaders.

Access to health care, diagnostic and preventive services with emphasis on HIV-AIDS, chlamydia, and cancer
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
South Central Family Health Center	KFH - West LA Senior Learning Consultant conducted six workshops at South Central Family Health Center. The topics related to customer service practices, team building and personnel morale. Participants included all administrative and clinical staff during a period of two months in 2015. This consultant work can be valued at approximately $3,000 per workshop. It was provided entirely free of charge to this clinic to help them improve their capacity.
To Help Everyone Community Clinic (T.H.E).	KFH-West LA experts conducted 4 meetings with staff, assessed the clinic practice, developed and documented workflows, provided standard messaging (Smart Phrase) for appropriate message routing. Additionally they trained staff leaders on new practices. The purpose/goal of this collaboration is for T.H.E. Clinic to improve nurse phone triage and communications.
Saban Community Clinic	KFH-West LA participates in a pharmacy partnership program that focuses on enhancing the capacity of the clinic's pharmacy operations by assigning two residents to work at the Saban Free Clinic. Pharmacy residents go to the clinic once a month and see patients, providing cholesterol, high blood pressure, and chronic conditions medication support.
Uninsured service area residents	The KFH-West LA Community Access Day provides day surgeries and medical procedures at no cost to uninsured patients in order to increase access to needed specialty care and diagnostics services for uninsured low-income individuals in need of timely medical care. Procedures include gallbladder removal, hernia repair, cataract surgery, and diagnostic colonoscopies. Between 25 and 30 community clinic patients participate receive much needed procedures to restore their health every year. More than 60 physicians, medical personnel and support staff participate annually. Personnel donates approximately $7,000 to the clinic through a system of employee salary

Recipient	Description of Contribution and Purpose/Goals
	deduction established by labor agreement.
Service Area Community Clinics UMMA and T.H.E.	The SCPMG Physician Community Engagement Program facilitates SCPMG physician's use of one educational time (4-hour block) per month at a local community clinics to increase community clinic capacity to offer primary care consultation. KFH-West LA physicians in the fields of Family Practice, Internal Medicine, Pediatrics, OBGYN and Pulmonary have provided care to more than 200 patients. Additionally, physicians have provided updates and shared Kaiser Permanente protocols on HIV/AIDS treatments and Breast Cancer screening guidelines.
Impact of Regional Initiatives Addressing Access to health care, diagnostic and preventive services with emphasis on HIV-AIDS, chlamydia, and cancer	

In addition to the illustrated grants listed above, Kaiser Permanente designs Regional Health Initiatives that are implemented in one or more KFH service areas to address the priority health needs. These initiatives are multi-year investments that support policy, advocacy and/or system changes in communities, including support for clinic systems to enhance capacity, service provision and or coordination. Kaiser Permanente invests in external evaluation for Regional Health Initiatives, and where possible, the results to date will reflect the most recent evaluation findings.

Kaiser Permanente's Building Clinic Capacity for Quality (BCCQ) initiative aims to improve the quality of health care provided to Southern Californians by enhancing the capacity of community clinics to implement Quality Improvement (QI) strategies that are supported by health information technology (HIT). The overall goals of BCCQ are to increase the capacity of participating community clinics and to advance community clinics' implementation of HIT. In order to accomplish these goals, Kaiser Permanente funded a project office (Community Partners) to develop and implement a three series training program designed to reach clinics that were at different levels of QI experience and capacity. Additionally, the project office piloted the Proactive Office Encounter (POE) program to translate a promising practice from Kaiser Permanente to community clinics. POE is a model of planned care that uses clinical care guidelines, patient data, and team and practice organization to proactively ensure all patient needs are met. Clinics were recruited to participate in BCCQ in Los Angeles, Orange, and San Diego Counties. BCCQ also engaged with the Riverside County Health System by implementing a tailored program. To date, KPSC CB has invested a total of three (3) grants, amounting to $3,500,000 to support this initiative. (Note that this initiative continued to operate in 2014 and 2015, although no grant amounts were paid for these years).

Over 40 community clinics participated in this program and developed projects focused on improving areas such as cancer and LDL screening, patient wait times, diabetes self-management, no-show rates, scheduling and appointments, care team guidelines and protocols, and medication management (among others). To date, participating clinics have reported satisfactory progress against their stated project goals. Among clinics participating in POE, most are indicating improvements in areas such as clinic and operational outcomes, data, and ability to provide high quality pro-active care, including improved preventive health services.

Kaiser Permanente's Specialty Care Initiative aims to increase access to healthcare services for the underserved through the development and enhancement of specialty care access. In order to achieve this goal, Kaiser Permanente funded technical assistance through Community Partners to implement a

coalition approach, where various partners collaborated to develop and implement strategies tailored to their communities in Southern California. These strategies focused on instituting and enhancing referral processes, building and expanding specialty care networks, increasing primary care physicians' capacity, and utilizing care coordination in the safety net. This multi-year initiative was launched in 2007 and to date a total of over $4,953,000 were awarded and paid to community based agencies across Southern California to support specialty care access.

In Los Angeles County, participating coalition members improved care coordination, developed and implemented telemedicine, and enhanced capacity in and trained primary care physicians. For example, to improve care coordination, C-SNAP supported the implementation of 4PatientCare, an automated patient reminder system that notifies patients through text and phone messaging at two LA County Department of Health Services sites. The SPA 3 Specialty Care Planning Coalition was able to support telemedicine efforts by implementing teledermatology at six clinics. They supplied equipment to four clinics and provided training to PCPs on teledermatology consults and biopsy procedures and trained care coordinators on program guidelines, workflow, and capturing images.

ALL HEART - In 2006, Kaiser Permanente's Southern California Community Benefit (KPSC CB) began the translation of KP's evidence-based cardiovascular disease (CVD) risk-reduction program across the safety net organizations in Southern California through a program called *ALL* (*A*spirin, *L*isinopril, and *L*ipid lowering medications). As a result of receiving the James A. Vohs Award for Quality in 2011, Kaiser Permanente Southern California selected the Community Clinic Health Network (CCHN) to serve as a Project Office to further translate the ALL protocol across the Southern California Region. The program was renamed to *ALL HEART* (Heart Smart Diet, Exercise, Alcohol limits, Rx Medicine compliance, and Tobacco cessation) to include lifestyle measures that were also included in this program. CCHN continues to enroll community health centers across Southern California into the ALL HEART Program. To date, KPSC CB has invested a total of six (6) grants, amounting to $1,220,000 to support this initiative. This current two year grant began in 2015 and the focus will be on the diabetic and/or hypertension population. The ALL HEART program will also continue its pilot projects around behavioral health integration and clinic to community linkages.

CCHN has exceeded reach targets for ALL HEART, reaching over 35,000 patients served by 14 health centers and 75 clinic sites in Southern California. Based on the results of an evaluation of a cohort of 11 health centers in San Diego County, ALL HEART has built health center capacity to successfully implement and institutionalize the ALL medication protocol and most participating health centers improved blood pressure control among their patients, potentially reducing the risks associated with cardiovascular disease. Furthermore, Health Centers built their capacity to engage in population health management and to align with other national initiatives, such as Patient Centered Medical Home (PCMH) and Meaningful Use. Successful implementation of ALL HEART was driven by several HEAL Center characteristics, including data & IT systems, dedicated staffing, leadership buy-in, quality improvement infrastructure, and adequate time and space.

PRIORITY HEALTH NEED: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – WORKFORCE

KFH Workforce Development Highlights
Long Term Goal: • **To address health care workforce shortages and cultural and linguistic disparities in the health care workforce**
Intermediate Goal:

- **Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care**

Summary of Impact: During 2014-2015, a portion of money managed by a donor advised fund at California Community Foundation was used to pay two grants, totaling $150,000, that address this need. An illustrative sample of grants is provided below; DAF grants are denoted by asterisks (*). KFH-West Los Angeles also provided trainings and education for 65 residents in its Graduate Medical Education program, 16 nurse practitioner or other nursing beneficiaries, and 53 other health (non-MD) beneficiaries as well as internships for 71 high school and college students (Summer Youth, INROADS, etc.).

Grant Highlights

Grantee	Grant Amount	Project Description	Results to Date
California Institute for Nursing and Health Care (CINHC)	$100,000 DAF*	To provide expert technical assistance to registered nursing programs at California state universities (CSUs) and their identified California community college (CCC) partners in Southern California. It will also help schools implement an associate degree to a bachelor of science in nursing pathway, facilitating fast tracking and efficient implementation of the California Collaborative Model of Nursing Education (CCMNE).	CINHC will facilitate engagement and partnership to develop, implement, and sustain the CCMNE across all 10 CSU's and respective CCC's. CINHC will engage interested private universities and colleges within the region, including deans, directors, and faculty. Lastly, CINHC will conduct a curriculum review, mapping process, and development of integrated pathways based on prior success strategies that are consistent with evidence based models.
Campaign for College Opportunity (CCO)	$50,000*	This grant supports an in-depth research report to analyze trends in California science, technology, engineering, and math (STEM)/health workforce needs. The STEM/Health Workforce Report will focus on factors affecting demand and supply; public higher education funding policies; and programs to help meet workforce demands. This grant supports an in-depth research report to analyze trends in California science, technology, engineering, and math (STEM)/health workforce needs. The STEM/Health Workforce	The Campaign for College Opportunity will develop and disseminate the STEM/Health Workforce Report to increase awareness among the public and policymakers of the growing need for STEM health workers in California and the role California community colleges play in filing the demand. CCO has completed the report and the general release will occur in June 2016. The report's release will be accompanied by a media and communications strategy including a webinar, briefings with key stakeholders (in education, business, community and civic organizations) along

		Report will focus on factors affecting demand and supply; public higher education funding policies; and programs to help meet workforce demands.	with policymakers in Sacramento.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Individuals and organizations in the health care and medical workforce.	Kaiser Permanente Southern California Region's Department of Professional Education offered Advanced Practice and Allied Health Care Educational Programs for allied health care providers throughout Southern California. In 2015, across Kaiser Permanente Southern California Region, 644 community-based nurses, nurse practitioners, physician assistants, imaging professionals, clinical laboratory scientists, community audiologists and speech pathologists, and other health care professionals participated in symposia at no cost.
Service Area High School Students	KP Youth Engaged for Success (KP YES!) is a multi-year work preparation, career development and volunteer program for High School students. The program collaborates with STEM Magnet offices at Crenshaw and Dorsey High Schools. The goal of the program is to gradually introduce students to healthcare careers and continue to support their career development and work preparation throughout their high school years. The program was launched in September 2015 and targets exceptionally dedicated students. Six students completed on-boarding process and are currently serving their volunteer hours. Additionally, KP YES! offers multiple workshops, including the all-day "7 Habits of Highly Effective Teens."
Service Area High School Youth	Every year about 40 students from 20 high schools participate in this program at KFH-West Los Angeles medical center, from June to August in various departments. In addition to hands-on-job training, student employees attend weekly workshops designed to support their career goals. Topics include workplace safety, interviewing skills, and cultural diversity, among others. The purpose and goal is to offer summer jobs to high school students and give students from underserved communities the opportunity to access employment while getting exposed to healthcare careers.
Service Area Middle School Youth	The Hippocrates Circle program is designed to provide youth from under-represented communities and diverse backgrounds with an awareness of career opportunities as a physician. Students participate in a series of all-day visits to the Medical Center where they are encouraged to pursue their goals towards becoming physicians. Every year about 50 students from approximately six middle schools participate in this program at KFH-West Los Angeles. Student activities included a tour of the Medical Center and a Health Career Day. The purpose/goal is to provide youth from underrepresented communities and diverse backgrounds with awareness of career opportunities as a physician.

PRIORITY HEALTH NEED V: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH

KFH Research Highlights			
Long Term Goal: • **To increase awareness of the changing health needs of diverse communities**			
Intermediate Goal: • **Increase access to, and the availability of, relevant public health and clinical care data and research**			
Summary of Impact: Kaiser Permanente conducts, publishes, and disseminates research to improve the health and medical care of members and the communities served. The Southern California Region Department of Research and Evaluation (DRE) conducted a total of 988 studies in 2014 and 1,404 studies in 2015 across all regional hospitals, totaling $16,385,832. Research focuses on clinical trials, building scientific expertise in health services and policy, and implementation science to bridge the gap between research and practice. In addition, a portion of money managed by a donor advised fund (DAF) at California Community Foundation was used to pay two grants, totaling $1,050,000 that address this need. All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.			
Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
UCLA Center for Health Policy Research	$500,000*	The California Health Interview Survey (CHIS) investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and management, the health of children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models.	At the end of the grant period, UCLA Center for Health Policy Research interviewed approximately 41,500 households and completed 78,127 screenings along with 40,125 adult, 2,255 adolescent and 5,514 child interviews. In addition, 12 AskCHIS online trainings were completed.
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		
Individuals and organizations in the health care and medical community.	Kaiser Permanente Southern California Region's Department of Research and Evaluation works closely with national and regional research institutions and universities to provide high-quality health research. In the KFH-West Los Angeles service area, 22 research projects were active in 2014 and 17 research projects were active as of year-end 2015.		
Individuals	Kaiser Permanente Southern California Region's Nursing Research Program		

and organizations in the health care and medical community.	provides administrative and technical support for nurses to conduct, publish and disseminate research studies and evidence based practice projects. In the KFH-West Los Angeles service area, six research projects were active as of year-end 2014 and seven research projects were active as of year-end 2015.

Appendix A: Secondary Data Sources and Dates

Quantitative Secondary Data Sources

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2. California Department of Education. 2013.
3. California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013–2014.
4. California Department of Public Health, CDPH—Birth Profiles by ZIP Code. 2011.
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6. California Department of Public Health, CDPH—Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010–2012.
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23. Centers for Medicare and Medicaid Services. 2012.
24. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011–2012.
25. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
26. Environmental Protection Agency, EPA Smart Location Database. 2011.
27. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010–2012.

28. Feeding America. 2012.
29. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
30. National Center for Education Statistics (NCES)—Common Core of Data. 2012–2013.
31. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
32. New America Foundation, Federal Education Budget Project. 2011.
33. Nielsen, Nielsen Site Reports. 2014.
34. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007–2011.
35. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
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37. University of Wisconsin Population Health Institute, County Health Rankings. 2012–2013.
38. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
39. U.S. Census Bureau, American Community Survey. 2009–2013.
40. U.S. Census Bureau, American Housing Survey. 2011, 2013.
41. U.S. Census Bureau, County Business Patterns. 2011.
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53. U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
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56. U.S. Department of Housing and Urban Development. 2013.
57. U.S. Department of Labor, Bureau of Labor Statistics. June 2015.
58. U.S. Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011–2013.
59. U.S. Drought Monitor. 2012–2014

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us/community-benefit/community-building/documents/dignity-health-community-need-index-brochure. Accessed August 8, 2015.
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Appendix B:
Scorecard

DATA INDICATOR

Legend
*Data from the Kaiser Permanente CHNA data platform
†Data from secondary sources aggregated at the Service Planning Area (SPA)-level reflecting only zip codes represented in the KFH-WLA service area
^Data from secondary sources reflecting the entire Service Planning Area (SPA)
An *italicized indicator* denotes qualitative data collected in a focus group or interview
Comparison levels: CA - California LAC - LA County

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
HEALTH OUTCOMES										
Access to Care										
Percent of adults who could not afford to see a doctor for a health problem^	2011		LAC	16.0%	**17.7%**	12.2%	**18.7%**	14.0%		
Percent of adults who have never been to a dentist^	2014		CA	2.2%	**7.9%**	**2.2%**	0.3%	1.7%		
Percent of adults who have not visited a dentist in the past year*	2010		CA	30.5%	–	–	–	–		
Percent of adults who could not afford their medication^	2011		LAC	15.4%	15.3%	9.8%	**18.8%**	15.1%		
Percent who are currently uninsured^	2014		LAC	13.3%	**22.0%**	7.4%	**16.0%**	10.3%		
Percent of youth who are currently uninsured^	2011		LAC	5.0%	**6.6%**	3.0%	**8.6%**	2.9%		
Percent of adults who could not afford to see a dentist^	2011		LAC	30.3%	**37.6%**	19.4%	**35.0%**	27.4%		
Percent of adults with dental insurance^	2011		LAC	48.2%	**38.9%**	60.6%	**37.1%**	50.7%		
Percent of youth with dental insurance^	2011		LAC	78.2%	**75.7%**	**71.6%**	**75.8%**	81.5%		
Percent of youth who could not afford dental care^	2011		LAC	12.6%	11.3%	8.5%	**14.9%**	12.2%		
Percent of youth who have never been to a dentist^	2014		LAC	16.0%	11.3%	11.3%	12.7%	**20.7%**		
Percent who delayed or didn't get prescriptions^	2014	<=2.8%	LAC	7.9%	7.0%	4.4%	**8.8%**	7.7%		
Percent who delayed care due to cost or lack of insurance^	2014		LAC	44.8%	**69.9%**	**58.3%**	**55.5%**	37.5%		
Percent who delayed or didn't get medical care in the past 12 months^	2014		LAC	11.7%	**11.9%**	**14.4%**	10.7%	**13.7%**		
Percent who had a difficult time accessing services for their child^	2011		LAC	12.3%	12.1%	4.5%	**17.7%**	10.1%		
Percent who had a difficult time finding affordable health plan through Covered CA^	2014		LAC	57.3%	**91.3%**	42.3%	5.8%	**67.8%**		
Percent of adults who had a difficult time finding a primary care doctor^	2014		CA	4.6%	**5.8%**	**5.1%**	3.9%	4.0%		
Percent who had a difficult time finding a health plan with the needed coverage through Covered CA^	2014		LAC	57.6%	**92.6%**	54.6%	**63.1%**	41.3%		
Percent who had to forgo needed medical care^	2014		LAC	56.4%	**59.2%**	**63.7%**	**69.3%**	52.1%		
Percent of uninsured adults under 65 years eligible for Medi-Cal^	2014		LAC	5.8%	**7.8%**	0.0%	3.1%	0.0%		
Percent of uninsured adults under 65 years eligible for Healthy Families^	2014		LAC	3.9%	0.0%	**18.2%**	2.3%	0.0%		
Percent of adults whose insurance was not accepted by a general doctor in the past year^	2014		LAC	4.2%	4.0%	**4.6%**	**4.3%**	3.9%		
Percent of adults whose insurance was not accepted by a medical specialist in the past year^	2014		LAC	7.7%	5.8%	**11.9%**	0.8%	**9.0%**		
Percent living in a Health Professional Shortage Area*	2015		LAC	31.4%	–	–	–	–		
Percent without a regular doctor^	2012		LAC	15.2%	**23.1%**	8.9%	13.5%	11.5%		
Percent who needed to see a medical specialist in the past year^	2014		LAC	33.9%	24.4%	**47.0%**	31.8%	**38.7%**		
Percent of adults who could not afford mental health care^	2011		LAC	6.1%	6.0%	**6.5%**	**6.8%**	4.2%		
Percent of youth who could not afford mental health care^	2011		LAC	2.6%	1.1%	1.5%	**3.7%**	1.4%		

DATA INDICATOR **Legend** *Data from the Kaiser Permanente CHNA data platform †Data from secondary sources aggregated at the Service Planning Area (SPA)-level reflecting only zip codes represented in the KFH-WLA service area ^Data from secondary sources reflecting the entire Service Planning Area (SPA) An *italicized indicator* denotes qualitative data collected in a focus group or interview Comparison levels: CA - California LAC - LA County	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Percent who had a difficult time finding specialty care*	2014		LAC	11.1%	**15.9%**	5.5%	3.2%	9.7%		
Rate of mental health care provider per 100,000 pop.*	2014		CA	157.0	–	–	–	–		
Rate of primary care provider per 100,000 pop.*	2012		CA	77.2	–	–	–	–		
Cost of preventative health care									0	2
Difficulty navigating health care system									0	2
Lack of access to health care									18	0
Lack of access to specialty care									1	0
Lack of health education									3	0
Lack of health insurance									0	1
Medi-Care insurance not accepted by provider									1	0
Provider shortage									0	1
Unable to or difficult to use exisiting coverage									0	1
Alcohol Abuse/Substance Abuse/Tobacco Use										
Percent of adults who binge drank (5 or more) in the past month^	2011		LAC	15.4%	**19.2%**	**16.5%**	**16.9%**	**16.3%**		
Percent of adults who currently smoke^	2014		LAC	10.0%	**10.5%**	7.0%	**10.9%**	**10.3%**		
Percent of adults who drank alcohol in the past month^	2011		LAC	51.9%	50.6%	**68.7%**	42.6%	**55.4%**		
Percent of adults who drank heavily in the past month^	2011		LAC	3.5%	**4.6%**	3.4%	2.5%	**4.6%**		
Percent of adults who have ever smoked e-cigarette's^	2014		LAC	11.3%	4.7%	4.4%	3.2%	**33.6%**		
Percent of adults who needed or wanted treatment for an alcohol or drug problem in the past 5 years^	2011		LAC	2.5%	**3.3%**	1.4%	2.3%	**2.5%**		
Percent of expenditures for alcoholic beverages purchased at home*	2014		CA	12.9%	–	–	–	–		
Percent of teens who used marijuana in the past year^	2012		LAC	9.4%	**17.2%**	**14.3%**	3.5%	**21.6%**		
Percent who ever tried marijuana, cocaine, sniffed glue, or other drugs^	2012		LAC	14.7%	**18.2%**	14.3%	**31.9%**	**23.4%**		
Rate of alcohol/drug induced mental disease hospitalization per 100,000 pop.†	2012		LAC	125.8	**171.8**	**206.7**	109.9	92.6		
Rate of beer, wine and liquor access per 100,000 pop.*	2012		CA	10.0	–	–	–	–		
Alcohol and substance abuse									1	1
Medication misuse									1	1
Substance abuse (marijuana, crack, heroine, sniffing, inhaling)									9	2
Underage drinking									0	1
Alzheimer's Disease										
Rate of Alzheimer's mortality age-adjusted per 10,000 pop.†	2012		CA	3.1	2.8	**4.1**	2.0	1.4		
Alzheimer's disease									2	0
Dementia									1	0

DATA INDICATOR

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An *italicized indicator* denotes qualitative data collected in a focus group or interview
Comparison levels: CA - California LAC - LA County

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Asthma										
Percent of adults diagnosed with asthma*	2014		LAC	11.4%	**11.7%**	7.0%	6.8%	10.7%		
Rate of adult asthma hospitalizations per 100,000 pop.^	2012		CA	84.5	**98.4**	54.9	**207.2**	**162.4**		
Rate of asthma hospitalizations per 10,000 admissions*	2011		LAC	10.0	–	–	–	–		
Rate of youth asthma hospitalizations per 100,000 pop.^	2012		CA	114.4	88.1	77.8	**209.7**	**157.2**		
Asthma									4	2
Cancer, in General										
Rate of cancer mortality per 10,000 pop.†	2012		CA	15.1	**16.9**	**17.6**	**16.8**	14.1		
Rate of cancer mortality per 100,000 pop.*	2012		LAC	153.0	–	–	–	–		
Rate of cervical cancer incidence per 100,000 pop.*	2011	<=7.1	CA	7.8	–	–	–	–		
Rate of cervical cancer mortality age-adjusted per 100,000 pop.*	2011	<=38.7	CA	41.5	–	–	–	–		
Breast cancer									0	2
Cancer, general									4	1
Colorectal cancer									0	1
Prostate cancer									0	1
Cardiovascular Disease										
Percent diagnosed with heart disease^	2014		LAC	5.7%	2.4%	4.8%	**8.6%**	**5.7%**		
Percent who have a heart disease management plan from a health professional^	2014		LAC	55.5%	61.5%	89.8%	**51.8%**	59.2%		
Rate of coronary health disease mortality per 100,000 pop.*	2012	<=100.8	LAC	172.6	–	–	–	–		
Rate of heart disease mortality per 10,000 pop.†	2012		CA	15.5	**16.9**	**17.6**	**16.8**	14.1		
Rate of heart disease hospitalization per 100,000 pop.†	2012		LAC	366.6	**370.1**	334.0	**567.5**	**452.3**		
Heart disease									6	2
Cholesterol										
Percent of adults diagnosed with high cholesterol^	2014		LAC	25.6%	24.1%	24.8%	22.9%	**26.5%**		
Cholesterol									2	1
Communicable Diseases										
Rate of Hepatitis A prevalence per 100,000 pop.^	2013		LAC	0.6	**0.7**	**1.4**	0.2	0.5		
Rate of Hepatitis B (acute) prevalence per 100,000 pop.^	2013		LAC	0.6	**0.8**	**1.1**	**1.0**	0.2		
Rate of Hepatitis C (acute) prevalence per 100,000 pop.^	2013		LAC	0.1	0.0	**0.2**	0.0	**0.1**		
Hepatitis B									2	0
Diabetes										
Percent of diabetes prevalence*	2012		CA	8.1%	–	–	–	–		
Rate of adult diabetes hospitalizations per 10,000 pop.*	2011		LAC	11.1	–	–	–	–		

Legend
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†Data from secondary sources aggregated at the Service Planning Area (SPA)-level reflecting only zip codes represented in the KFH-WLA service area
^Data from secondary sources reflecting the entire Service Planning Area (SPA)
An *italicized indicator* denotes qualitative data collected in a focus group or interview
Comparison levels: CA - California LAC - LA County

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Rate of adult diabetes hospitalizations per 100,000 pop.†	2012		CA	142.6	135.2	89.0	**317.2**	**258.2**		
Rate of diabetes mortality per 10,000 pop.†	2012		CA	2.1	**2.3**	1.7	**3.2**	**2.2**		
Rate of hospitalizations for uncontrolled diabetes per 100,000 pop.†	2012		CA	2.8	2.2	**11.8**	**9.1**	**7.2**		
Rate of youth diabetes hospitalizations per 100,000 pop.†	2012		LAC	27.7	12.7	26.0	**32.0**	**31.5**		
Diabetes									**14**	**5**
Kidney failure related to diabetes									**0**	**1**
HIV/AIDS										
Rate of HIV hospitalizations per 10,000 pop.*	2011		CA	2.0	–	–	–	–		
Rate of HIV incidence per 100,000 pop.^	2013	<=13.0	LAC	13.0	**39.0**	8.0	**16.0**	**13.0**		
Rate of HIV prevalence per 100,000 pop.*	2010		CA	363.0	–	–	–	–		
Rate of HIV prevalence per 100,000 pop.†	2010		CA	11.0	**60.5**	8.6	**42.0**	**17.9**		
HIV									**2**	**3**
Hypertension										
Percent diagnosed with Hypertension^	2014	<=26.9%	LAC	27.3%	**28.6%**	26.8%	**35.7%**	**34.0%**		
Percent taking high blood pressure medication^	2014	>=69.5%	LAC	67.2%	**66.2%**	**60.6%**	**55.5%**	79.5%		
High blood pressure/hypertension									**9**	**2**
Kidney failure related to hypertension									**0**	**1**
Maternal and Infant Health										
Percent of infants with low birth weight (under 2500 grams)*	2011		LAC	7.3%	–	–	–	–		
Rate of birth to women under the age of 20 per 1,000 females*	2011		CA	8.5	–	–	–	–		
Prenatal care, lack of									**1**	**0**
Teen pregnancy									**1**	**4**
Unplanned pregnancies									**0**	**1**
Mental Health										
Average number of mentally unhealthy days in the last 30 days*	2012		CA	3.6	–	–	–	–		
Percent of adults at risk for depression^	2011		LAC	10.4%	**11.6%**	5.8%	**13.3%**	9.3%		
Percent of adults diagnosed with anxiety^	2011		LAC	11.3%	**12.0%**	**13.7%**	10.1%	10.2%		
Percent of adults diagnosed with depression^	2011		LAC	12.2%	**13.4%**	**13.4%**	10.8%	10.7%		
Percent of Medicare population with depression*	2012		CA	13.4%	–	–	–	–		
Percent of teens at risk for depression^	2014		LAC	23.1%	22.0%	**30.1%**	**30.4%**	18.8%		
Percent of teens who received psychological or emotional counseling in the past year^	2014		LAC	14.5%	6.2%	**15.1%**	10.4%	**36.6%**		
Percent who ever seriously thought about committing suicide^	2014		LAC	7.2%	**9.7%**	6.9%	5.2%	**9.2%**		

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^Data from secondary sources reflecting the entire Service Planning Area (SPA)
An *italicized indicator* denotes qualitative data collected in a focus group or interview
Comparison levels: CA - California LAC - LA County

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Percent who had serious psychological distress in the past year^	2014		LAC	9.6%	9.4%	9.0%	8.2%	**11.8%**		
Percent who received sufficient social and emotional support^	2011		LAC	64.0%	74.8%	83.8%	**53.9%**	68.8%		
Percent with poor mental health*	2014		CA	15.9%	–	–	–	–		
Rate of adult mental health hospitalizations per 100,000 pop.†	2012		CA	540.9	**707.0**	**552.8**	**1,071.7**	**542.8**		
Rate of suicide per 10,000 pop.†	2012	<=1.0	CA	1.0	**1.3**	**1.3**	0.4	**1.0**		
Rate of youth (under 18) hospitalizations per 100,000 pop.†	2012		CA	294.8	**316.7**	**405.6**	**449.0**	294.1		
Grief management									0	1
Mental health (general)									15	4
Lack of social support									1	0
Neurological issues									1	0
Obesity/Overweight										
Percent of adults who are obese^	2014	<=30.5%	CA	27.0%	**29.1%**	14.5%	**38.6%**	**30.2%**		
Percent of adults who are overweight *	2012		CA	35.8%	–	–	–	–		
Percent of adults who are overweight^	2014		CA	35.5%	**37.0%**	**38.8%**	**35.9%**	34.1%		
Percent of teens who are overweight^	2014		LAC	14.4%	10.7%	**24.0%**	2.0%	**37.2%**		
Percent of youth who are obese*	2014		CA	19.0%	–	–	–	–		
Percent of youth who are overweight*	2014		CA	19.3%	–	–	–	–		
Percent of youth who are overweight^	2014		CA	13.6%	**21.6%**	11.5%	7.3%	7.4%		
Obesity/Overweight									9	4
Oral Health										
Percent with poor dental health*	2010		CA	15.7%	–	–	–	–		
Oral health									2	1
Respiratory Disease										
Rate of COPD/emphysema mortality per 100,000 pop.^	2012		LAC	27.0	21.0	18.0	**29.0**	**30.0**		
Chronic obstructive pulmonary disease (COPD)									1	0
Pulmonary disease									1	0
Respiratory disease									0	1
Sexually Transmitted Diseases										
Rate of chlamydia incidence per 100,000 pop.*	2012		CA	444.9	–	–	–	–		
Rate of chlamydia incidence per 100,000 pop.^	2012		LAC	521.3	**628.8**	316.5	**968.0**	490.0		
Rate of gonorrhea incidence rate per 100,000 pop.^	2012		LAC	122.9	**271.8**	90.6	**233.0**	116.7		
Rate of syphilis incidence (primary and secondary) per 100,000 pop.^	2012		LAC	9.4	**30**	7.7	**12.0**	5.7		
Herpes									0	1

DATA INDICATOR

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Comparison levels: CA - California LAC - LA County

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Sexually transmitted diseases									2	3
Violence and Injury Prevention										
Percent of teens who feared being attacked at school in the past year^	2012		LAC	17.1%	**18.7%**	14.3%	**22.8%**	**19.6%**		
Percent of teens who perceive their neighborhood park or playground as unsafe^	2014		LAC	11.7%	7.0%	3.1%	**22.1%**	**25.6%**		
Percent of teens who received threats of violence or physical harm by peers in the past year^	2012		LAC	14.7%	**21.5%**	8.8%	11.7%	**27.6%**		
Rate of homicide per 100,000 pop.*	2012	<=5.5	LAC	6.0	–	–	–	–		
Rate of non-fatal assaults per 100,000 pop.*	2012		CA	290.3	–	–	–	–		
Rate of non-fatal firearm hospitalizations per 100,000 youth†	2012		LAC	5.4	**6.7**	**8.0**	**12.9**	**17.5**		
Rate of pedestrian motor vehicle mortality per 100,000 pop.*	2012	<=1.3	LAC	2.3	–	–	–	–		
Rate of robberies per 100,000 pop.*	2012		CA	149.5	–	–	–	–		
Rate of violent crime per 100,000 pop.*	2012		CA	425.0	–	–	–	–		
Community safety									6	2
Domestic violence									1	1
Gang activity									0	1
Gun violence									0	1
Sex trafficking									1	0
Trauma									2	1
DRIVERS OF HEALTH										
Access to Care										
Please see above										
Access to Healthy Foods										
Percent unable to afford enough food (food insecurity)^	2014		LAC	39.5%	**51.9%**	6.4%	**46.1%**	36.6%		
Percent who reported the availability of affordable fresh fruits and vegetables in their neighborhood^	2014		LAC	75.2%	**69.4%**	82.7%	**67.4%**	**74.5%**		
Rate of fast food restaurants per 100,000 pop.*	2011		CA	74.5	–	–	–	–		
Access to healthy food options									5	1
Food desert									2	0
Food equity									0	1
Food manufacturer regulations									0	1
Poor nutrition									5	3
Alcohol Abuse/Substance Abuse/Tobacco Use										
Please see above	2012		CA	10.0	–	–	–	–		

DATA INDICATOR

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Comparison levels: CA - California LAC - LA County

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Violence and Injury Prevention										
Please see above										
Cultural and Linguistic Barriers										
Percent who had a difficult time understanding their doctor^	2014		LAC	3.2%	**3.7%**	0.3%	**4.1%**	1.2%		
Percent who live in homes in which English is not spoken (linguistically isolated)*	2013		CA	9.9%	–	–	–	–		
Percent who speak a language other than English*	2013		CA	19.4%	–	–	–	–		
Cultural practices									0	2
Culturally competent providers									0	1
Fear									1	0
Language barriers									3	0
Legal status, undocumented									3	0
Perception and attitudes, cultural									0	1
Stigma									4	1
Dental Care Access										
Percent of adults who could not afford to see a dentist^	2011		LAC	30.3%	**37.6%**	19.4%	**35.0%**	27.4%		
Percent of adults who have never been to a dentist^	2014		CA	2.2%	**7.9%**	**2.2%**	0.3%	1.7%		
Percent of adults who have not visited a dentist in the past year*	2010		CA	30.5%	–	–	–	–		
Percent of adults with dental insurance^	2011		LAC	48.2%	38.9%	**60.6%**	37.1%	**50.7%**		
Percent of youth who could not afford dental care^	2011		LAC	12.6%	11.3%	8.5%	**14.9%**	12.2%		
Percent of youth who have never been to a dentist^	2014		LAC	16.0%	11.3%	11.3%	12.7%	**20.7%**		
Percent of youth with dental insurance^	2011		LAC	78.2%	75.7%	71.6%	75.8%	**81.5%**		
Dental care access									3	0
Disease Management										
Percent of Medicare enrollees who took an annual diabetes exam (hA1c)*	2012		CA	81.5%	–	–	–	–		
Percent taking high blood pressure medication^	2014	>=69.5%	LAC	67.2%	**66.2%**	**60.6%**	**55.5%**	79.5%		
Stress management, inability									0	2
Economic Security										
Percent living in households with income below 100% Federal Poverty Level*	2013		LAC	17.8%	–	–	–	–		
Percent living in households with income below 200% Federal Poverty Level*	2013		CA	35.9%	–	–	–	–		
Percent of burdened households (housing costs 30% of total household income)*	2013		LAC	50.3%	–	–	–	–		
Percent of Medicaid recipients*	2013		CA	23.4%	–	–	–	–		
Percent of youth eligible for free/reduced price lunch*	2014		LAC	66.9%	–	–	–	–		
Percent of youth in grade 4 reading below proficiency*	2013	<=36.3%	LAC	36.0%	–	–	–	–		

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Comparison levels: CA - California LAC - LA County

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Percent of youth living in households with income below 100% Federal Poverty Level*	2013		LAC	25.3%	–	–	–	–		
Percent on WIC with children 6 years and younger^	2014		CA	44.6%	36.9%	0.0%	**67.1%**	10.6%		
Percent receiving food stamps^	2014		LAC	18.7%	17.4%	3.0%	**26.6%**	6.8%		
Percent receiving Supplemental Nutrition Assistance Program (SNAP) benefits*	2011		CA	10.6%	–	–	–	–		
Percent receiving TANF or CalWORKS^	2014		CA	8.4%	5.6%	2.3%	**16.0%**	4.7%		
Percent who graduated high school*	2013	>=82.4%	LAC	77.1%	–	–	–	–		
Rate of Head Start program facilities per 10,000 children under age 5*	2014		LAC	7.2	–	–	–	–		
Rate of unemployment*	2015		CA	0.7	–	–	–	–		
Economic insecurity									5	0
High poverty									9	2
Incarceration									1	0
Joblessness and unemployment									4	2
Underemployment									0	1
Healthy Behaviors										
Percent 18 years and older who received an influenza vaccination^	2011		LAC	33.7%	**32.6%**	37.7%	**25.9%**	**33.3%**		
Percent 65 years and older who received a pneumonia vaccination^	2011		LAC	61.3%	**61.0%**	64.1%	**53.9%**	62.9%		
Percent 65 years and older who received an influenza vaccination^	2011		LAC	64.2%	**60.4%**	70.1%	**51.7%**	**63.9%**		
Percent of adults who are physically active (aerobic and strengthening)^	2011		LAC	29.7%	31.3%	37.4%	**28.1%**	31.7%		
Percent of adults who ate 5 or more fruit or vegetables a day^	2012		LAC	16.2%	16.9%	22.1%	**11.4%**	17.2%		
Percent of adults who consumed at least one soda or sweetened drink a day^	2014		LAC	38.8%	35.3%	35.2%	**56.8%**	35.6%		
Percent of youth who are active daily^	2014		LAC	26.4%	**24.0%**	n/a	28.9%	**18.8%**		
Percent of youth who consumed at least one soda or sweetened drink a day^	2011		LAC	38.3%	32.7%	21.9%	**53.3%**	**40.4%**		
Percent who ate fast food 3 or more times in the past week^	2014		LAC	21.6%	17.8%	17.6%	**25.2%**	**27.5%**		
Bad habits (poor eating, inactivity)									0	1
Health literacy									0	1
Personal hygiene									0	2
Physical activity, lack of									0	1
Preventative care									0	1
Unaware of available health services									0	2
Homelessness and Housing										
Percent of occupied housing with one or more substandard conditions*	2013		LAC	54.4%	–	–	–	–		
Total number of homeless individuals^	2015		LAC	44,359	11,681	4,276	7,513	3,006		
Total number of homeless that are mentally ill^	2015		LAC	12,253	3,408	1,748	1,894	825		

DATA INDICATOR **Legend** *Data from the Kaiser Permanente CHNA data platform †Data from secondary sources aggregated at the Service Planning Area (SPA)-level reflecting only zip codes represented in the KFH-WLA service area ^Data from secondary sources reflecting the entire Service Planning Area (SPA) An *italicized indicator* denotes qualitative data collected in a focus group or interview Comparison levels: CA - California LAC - LA County	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	Service Planning Area 4	Service Planning Area 5	Service Planning Area 6	Service Planning Area 8	Interviews (n=29)	Focus Groups (n=5)
Total number of homeless with a physical disability^	2015		LAC	8,148	2,035	1,077	1,349	569		
Total number of homeless with a substance abuse problem^	2015		LAC	10,388	2,843	1,147	1,284	1,084		
Total number of veterans who are homeless^	2015		LAC	4,016	1,237	888	472	575		
Affordable housing									0	1
Gentrification									4	2
Homelessness									0	3
Homelessness and housing									14	0

FOOTNOTES
N/A= no data available

Zip code assignment by Service Planning Area (SPA):
SPA 4: 90019, 90036, 90048, 90069
SPA 5: 90024, 90025, 90034, 90035, 90045, 90049, 90056, 90064, 90066, 90067, 90077, 90094, 90210, 90211, 90212, 90230, 90232, 90272, 90291, 90292, 90293, 90401, 90402, 90403, 90404, 90405
SPA 6: 90003, 90008, 90016, 90018, 90037, 90043, 90047, 90062
SPA 8: 90044, 90245, 90301, 90302, 90303, 90304, 90305, 90311

Appendix C: Community Input Tracking Form

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
1	Focus Group	Community Coalition Youth Leadership Group (identification and prioritization of health needs)	9	Low-income, medically underserved minority community members	Community members	10/1/2015	
2	Focus Group	Social Services and Health Services Providers (identification and prioritization of health needs)	8	Individuals and/or organizations serving or representing the interests of such populations	Community representatives Community members	10/7/2015	
3	Focus Group	Health Community Workers/Promotoras (identification and prioritization of health needs)	8	Individuals and/or organizations serving or representing the interests of such populations	Community representatives Community members	10/8/2015	

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
4	Focus Group	Faith-based Organizations (identification and prioritization of health needs)	6	Low-income, medically underserved minority community members. Individuals and/or organizations serving or representing the interests of such populations	Community leaders Community representatives Community members	10/9/2015	
5	Focus Group	Non-traditional Group (identification and prioritization of health needs)	14	Individuals and/or organizations serving or representing the interests of such populations	Community leaders Community representatives Community members	10/21/2015	
6	Key Stakeholder Interview	Executive Director, Venice Family Clinic (identification and prioritization of health needs)		Community Health Clinic Representative	Community Leader	10/20/2015	
7	Key Stakeholder Interview	Executive Director, Southside Coalition of Community Health Centers (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader	10/22/2015	

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
8	Key Stakeholder Interview	Executive Director, Westside Family Health Center (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader	10/8/2015	
9	Key Stakeholder Interview	Program Officer, California Community Foundation (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader	10/15/2015	
10	Key Stakeholder Interview	SVP Operations, Didi Hirsch Community Mental Health Center (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader	10/20/2015	
11	Key Stakeholder Interview	Health Deputy, LA County Supervisor, Third District (identification and prioritization of health needs)	1	Local government public health representative	Community Leader	11/6/2015	
12	Key Stakeholder Interview	Director of Community Outcomes and Impact, Para Los Niño (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader	10/20/2015	

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
13	Key Stakeholder Interview	Director, Concerned Citizens Community Involvement (identification and prioritization of health needs)	1	Member of the community served by the hospital facility and individuals representing the interest of such population	Community Leader Community Member	10/12/2015	
14	Key Stakeholder Interview	Police Officer, Los Angeles Police Department (identification and prioritization of health needs)	1	Local police officer	Community Leader	10/26/2015	
15	Key Stakeholder Interview	Health Deputy, Office of Supervisor Mark Ridley-Thomas (identification and prioritization of health needs)	1	Local government public health representative	Community Leader	10/28/2015	
16	Key Stakeholder Interview	CEO, Meals on Wheels (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader	10/28/2015	
17	Key Stakeholder Interview	CEO, OPCC – Ocean Park Community Center (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community representative		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
18	Key Stakeholder Interview	CEO, Step Up on Second (identification and prioritization of health needs)	1	organizations serving or representing the interests of such populations	Community Leader Community representative		
19	Key Stakeholder Interview	Trustee at Santa Monica Lifelong Learning Community, Santa Monica College (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		
20	Key Stakeholder Interview	Director, Mar Vista Family Center (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		
21	Key Stakeholder Interview	Pastor, Santa Monica Catholic Church (identification and prioritization of health needs)	1	Member of the community served by the hospital facility and individuals representing the interest of such population	Community Leader Community Member		
22	Key Stakeholder Interview	Director Safety Net Initiatives, LA Care Health Plan (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
23	Key Stakeholder Interview	Director of Program Development and Community Relations, Wise and Healthy Aging (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		
24	Key Stakeholder Interview	Public Health Officer, SPA 5 Public Health Officer (identification and prioritization of health needs)	1	Public health department representative	Community Leader		
25	Key Stakeholder Interview	Director, LA County Planning Department (identification and prioritization of health needs)	1	Local government representative	Community Leader		
26	Key Stakeholder Interview	Supervising Regional Planning, LA County Planning Department (identification and prioritization of health needs)	1	Local government representative	Community Leader		
27	Key Stakeholder Interview	Deputy Neighborhood Officer, Los Angeles Urban League (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
28	Key Stakeholder Interview	Executive Director, LA Trust for Children's Health (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		
29	Key Stakeholder Interview	Executive Director, Team Heal (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		
30	Key Stakeholder Interview	Director of Health and Mental Health Services, Los Angeles LGBT Center (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		
31	Key Stakeholder Interview	Manager Social Services, City of West Hollywood (identification and prioritization of health needs)	1	Local government representative	Community Leader Community Representative		
32	Key Stakeholder Interview	President and CEO, Charles R. Drew University of Medicine and Science (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
33	Key Stakeholder Interview	Executive Director, HOPICS – Homeless Outreach Program Integrated Care System (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		
34	Key Stakeholder Interview	Area Health Officer SPA 4, LA County Department of Public Health (identification and prioritization of health needs)	1	Health Department Representative	Community Leader		
35	Key Stakeholder Interview	Executive Director, Saban Clinic (identification and prioritization of health needs)	1	Community Health Clinic Representative	Community Leader		
36	Key Stakeholder Interview	Director of Quality Management and Program Development, Jewish Family Services of Los Angeles (identification and prioritization of health needs)	1	Community Health Clinic Representative	Community Leader		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
37	Key Stakeholder Interview	Executive Director, Korean American Family Services (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		
38	Key Stakeholder Interview	CEO, Martin Luther King Hospital (identification and prioritization of health needs)	1	Local hospital representative serving the community	Community Leader Community Representative		
39	Key Stakeholder Interview	Interim Chief of Staff, Department of Public Health (identification and prioritization of health needs)	1	Health Department Representative	Community Leader		
40	Key Stakeholder Interview	Outreach Manager, PHFE WIC Program (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		
41	Key Stakeholder Interview	Program Director, Mexican Consulate (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
42	Key Stakeholder Interview	Medical Director, LAUSD (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		
43	Key Stakeholder Interview	Student Services, Nurse Coordinator, Santa Monica, Malibu Unified School District (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Representatives		
44	Key Stakeholder Interview	Department of Medicine, Chair, UCLA (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		
45	Key Stakeholder Interview	Assistant Director, UCLA KP Center for Health Equity (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader		
46	Key Stakeholder Interview	Deputy Director, Substance Abuse Prevention and Control, LA County Department of Public Health (identification and prioritization of health needs)	1	Health Department Representative	Community Leader		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
47	Key Stakeholder Interview	Supervisor, LA County Department of Mental Health (identification and prioritization of health needs)	1	Health Department Representative	Community Leader		
48	Key Stakeholder Interview	District Chief, LA County Department of Mental Health (identification and prioritization of health needs)	1	Health Department Representative	Community Leader		
49	Key Stakeholder Interview	Executive Director, U.S. Veteran Initiative (identification and prioritization of health needs)	1	Organizations serving or representing the interests of such populations	Community Leader Community Representative		

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
50	Community Forum	Stakeholders of the KP - West Los Angeles, Kaiser Foundation Hospital - West Los Angeles Prioritization Meeting (identification and prioritization of health needs)	46	Health Services providers, Social Services providers, community members, city representatives, school district representatives, faith-based organization representatives, public health department representatives, community business leaders	Community leader Community members Community representatives	12/9/2015	

#	Data Collection Method Employed	Who Participated / Title of Event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
51	Community Forum	Stakeholders of the KP - West Los Angeles, Kaiser Foundation Hospital - West Los Angeles Prioritization Meeting (identification and prioritization of health needs)	22	Health Services providers, Social Services providers, community members, city representatives, school district representatives, faith-based organization representatives, public health department representatives, community business leaders	Community leaders Community members Community representatives	1/12/2016	

Appendix D: Health Need Profiles

This appendix's endnotes appear at the end of the full document.

Access to Health Care in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 4

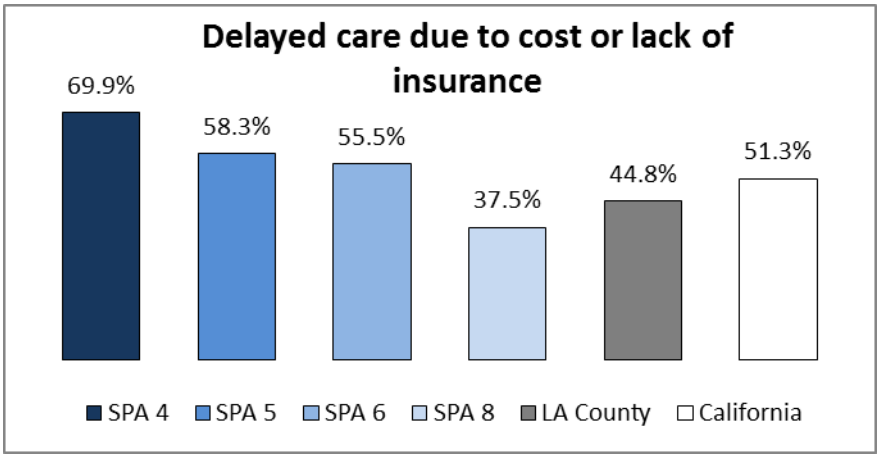
Access to comprehensive, high-quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.

Access to health care means the timely use of personal health services to support the achievement of the best health outcomes. Access to health care affects people's overall physical, social, and mental health status; the prevention of disease and disability; the detection and treatment of health conditions; quality of life; preventable death; and life expectancy. The lack of access to health care can lead to unmet health needs, delays in receiving appropriate care, an inability to benefit from preventive services, and preventable hospitalizations.[vi]

Health Outcome Statistics

The KFH-West Los Angeles service area is experiencing significant issues relating to affordability and access to health care. Stakeholders noted that community clinic services have expanded; however, this has increased wait times since more people are seeking services.

Access. Within the KFH-West Los Angeles service area residents in SPA 4 (69.9%), SPA 5 (58.3%) and SPA 6 (55.5%) reported delayed care due to cost of lack of insurance, which exceed the rate Los Angeles County (44.8%) and California (51.3%).
Similarly, a greater percentage of the population in the KFH-West Los Angeles service area (60.4%) reported having a difficult time finding affordable health care through Covered California when compared to Los Angeles County (57.3%) and California (54.7%).



Source: Percent of the population who delayed care because of cost or lack of insurance, California Health Interview Survey, 2014, SPA.

Health Disparities

Disparities were observed among Hispanic/Latino populations: a third (33.9%) did not have insurance and 20.7% lacked a consistent source of care. These percentages are higher than those reported for the KFH-West Los Angeles service area (19.3% and 18.0%, respectively). Health disparities were also observed among those residing in the southeast part of the KFH-West Los Angeles service area (see map below). Per 100,000 residents in South L.A., there are 39 licensed physicians and seven dentists, while in western portion of the service area, per the same population, there are 1,116 physicians and 225 dentists.

Stakeholders mentioned that women, undocumented populations (who have to access to care through ACA), and South L.A. residents are most affected.

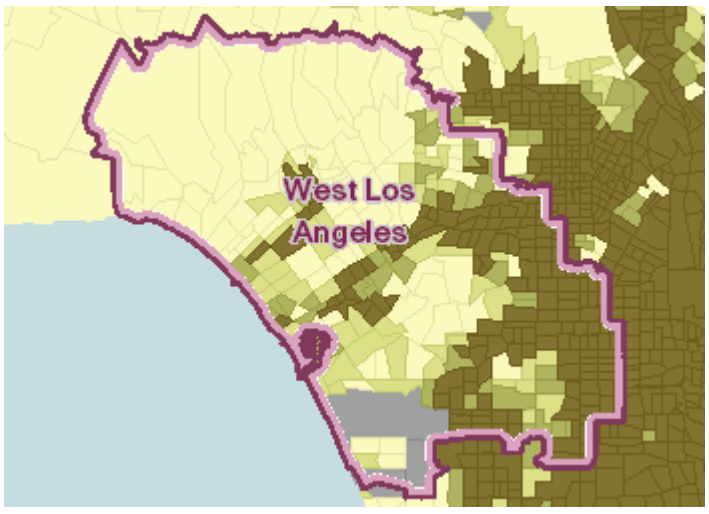
Communities Most Affected (Uninsured Populations and Those Located In A Primary Care Health Professional Shortage Area):

- Inglewood
- Lennox
- Westmont
- West Athens
- West Los Angeles (southeast section)

Community Perspective

"Hispanics and low-income families can't afford co-payments when they are already paying for ACA."

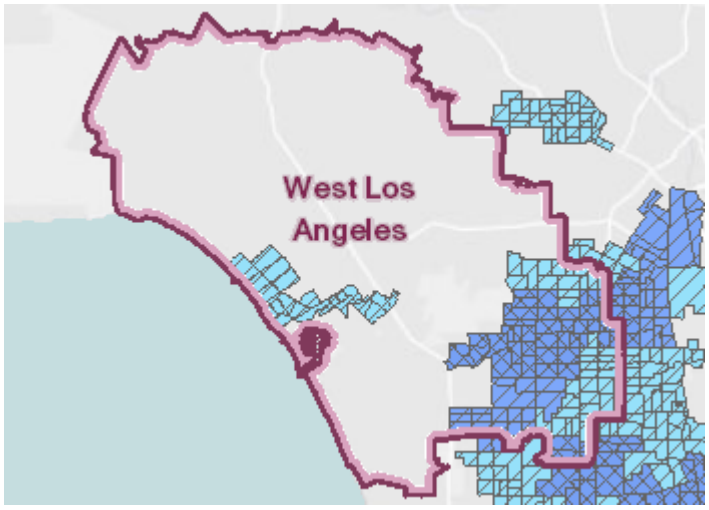
—Health Center CEO



Uninsured Population, Percent by Tract, ACS 2009-13

- Over 20.0%
- 15.1–20.0%
- 10.1–15.0%
- Under 10.1%
- No Data or Data Suppressed
- Report Area

Source: Percent of population who are uninsured, U.S. Census Bureau, American Community Survey, 2013, Tract.



Primary Care Health Provider Shortage Area (HPSA) Components, Type and Degree of Shortage by Tract/County, HRSA HPSA Database March 2015

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1–20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1–20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Report Area

Source: Percent of the population living in a HPSA, U.S. Department of Health and Human Services, Health Resources and Services Administration, 2015, HPSA.

A stakeholder expressed that there are a disproportionately low number of primary care specialists and dentists (citing data from the 2015 L.A. Healthy Aging Report). Stakeholders also remarked that barriers exist to accessing care for mental health as well as dental and vision care, because of a lack of providers and a lack of affordability. For low-income patients, specialty care is difficult to access—specifically, gastrointestinal health, cardiology, and dermatology.

Key Health Drivers/Factors

The inability to access affordable necessary health care services that provides sufficient coverage is detrimental to overall well-being. Access to high-quality health care is essential to achieving health equity and an increased quality of life.[vii] Stakeholders noted a variety of drivers for lack of access to care: some people don't know they qualify for care (under ACA) or that they can go to community clinics. Stakeholders also mentioned that existing clinics and hospitals in the area are overcrowded. Those without insurance do not know how to access resources and often resort to self-medicating. The current health care system is complicated to navigate, and there is a need for outreach workers and care coordinators that are culturally competent and speak the languages of those in the community.

Social & Economic

Transportation. Having access to a car or other form of transportation is often necessary to obtaining health care. In the KFH-West Los Angeles service area a greater percentage of households (11.1%) reported not having a car when compared to households in Los Angeles County (9.7%) and California (7.8%).

Households Without a Car

KFH-West Los Angeles Service Area	L.A. County	California
11.1%	9.7%	7.8%

Source: Percent of households with no motor vehicle, U.S. Census Bureau, American Community Survey, 2009-13, Tract.

Assets & Opportunities

A small number of health care facilities—including Federally Qualified Health Centers (FQHCs), hospitals, and general medical care facilities (n=60)—were identified within the KFH-West Los Angeles service area. The following is an abbreviated list of community-based health care assets in the KFH-West Los Angeles service area; it is not intended to be a comprehensive list of resources in the community, additional resources can be found at www.211.org.

Programs: Stakeholders mentioned programs in the area that were designed to address community health needs.

- **Care Harbor Clinic Events**
  Free-clinic events at the L.A. Sports Arena provide medical, dental, and vision care to uninsured, underinsured, and at-risk populations. They also provide follow-up care and prevention resources.
  http://www.careharbor.org/care-harbor-los-angeles/
- **CVS Minute Clinics**
  MinuteClinic® walk-in medical clinics are staffed by nurse-practitioners and physician assistants who specialize in family health care, offering care for children and adults every day with no appointment needed. There is one location in the West L.A. area, and its partner in Los Angeles is UCLA Health.
  https://www.cvs.com/minuteclinic/
- **Jules Stein Eye Institute**
  The Institute's UCLA Mobile Eye Clinic delivers basic eye-care services to the underprivileged in Los Angeles and outlying areas.
  http://www.jsei.org/About/about_comm.htm
- **L.A. Trust Wellness Centers**
  The Trust is collaborating with the LAUSD Student Health and Human Services Division and the Joint Use Development Program to increase student access to vital health and mental health services, wellness promotion, and health career options.
  http://thelatrust.org/wellness-centers/
- **School-Based Health Centers (SBHCs)**
  SBHCs are usually located directly on a school campus and provide primary care like any health clinic. Staff vary in size and typically includes nurse-practitioners, nurses, and mental health providers, as well as part-time physicians and medical students. Services are provided at no or low cost. There are approximately over 50 SBHCs in Los Angeles.
  http://www.schoolhealthcenters.org/

- **UCLA International Medical Graduate (IMG) Program**
  This program increases the Spanish-speaking medical doctor workforce and allows opportunities for international professionals to apply their expertise. The goal of the UCLA IMG program is to provide bilingual (English/Spanish) family physicians for the state's underserved rural and urban communities that include large Hispanic and other vulnerable populations, while providing opportunities for medical doctors from Latin America or other Spanish-speaking countries interested in obtaining residency training in family medicine and a medical license to practice in California.
  http://fm.mednet.ucla.edu/IMG/img_program.asp

Community Clinics: Few community clinics and health centers are located in the South Los Angeles area of Los Angeles County, where the need is the highest.

- **Curtis R. Tucker Health Center (SPA 8) (DPH)**
  The center offers public health clinical services such as immunizations and testing and treatment for tuberculosis and sexually transmitted diseases.
  http://publichealth.lacounty.gov/chs/Docs/SPA%208_%20Curtis%20Tucker_122613.pdf
- **Hubert H. Humphrey Comprehensive Health Center (DHS)**
  Adult/family medicine services, pediatrics services, urgent care services
  https://dhs.lacounty.gov/wps/portal/dhs/humphrey
- **Martin Luther King, Jr. Center for Public Health (SPA 6) (DPH)**
  Facility in South L.A. that offers public health clinical services such as immunizations and testing and treatment for tuberculosis and sexually transmitted diseases. Also provides case management and health promotion programming.
  http://publichealth.lacounty.gov/chs/Docs/SPA%206_MLK_122613.pdf
- **Planned Parenthood**
  Provides a wide range of safe, reliable health care and the majority is preventive, primary care, which helps prevent unintended pregnancies through contraception, reduce the spread of sexually transmitted infections through testing and treatment, and screen for cervical and other cancers.
  https://www.plannedparenthood.org/health-center/california/los-angeles/90016/planned-parenthood-basics,-baldwin-hills-crenshaw-3939-90070
- **Ruth Temple Health Center (SPA 6) (DPH)**
  The Dr. Ruth Temple Health Center offers free and low-cost STD testing and treatment, and immunization services.
  http://publichealth.lacounty.gov/chs/Docs/SPA%206_RuthTemple_122613.pdf
- **Saban Community Clinic**
  Provides low cost, integrated health care – primary medical care, dental care, pediatrics and prenatal care, and behavioral health care.
  http://www.sabancommunityclinic.org/
- **Simms/Mann Center (SPA 5) (DPH)**
  Adult/family medicine services
  http://publichealth.lacounty.gov/CHS/SPA5/index.htm
- **South Central Family Health Center**

Provides a range of services: primary care, behavioral health, health education and classes, pediatrics, women's health, and dental.
http://www.scfhc.org/

- **St. John's Well Child & Family Center Community Clinic**
  Nonprofit community health center serving through a network of Federally Qualified Health Centers and school-based clinics that span the breadth of Central and South Los Angeles and Compton. Provides primary care services as well as outreach, health education, child development and literacy education, case management, insurance enrollment, and mental health assessments.
  http://www.wellchild.org/
- **T.H.E. (To Help Everyone) Health and Wellness Centers**
  Serves men, women, seniors, and children of all ages from the vastly diverse, low-income population within Service Planning Area 6 (SPA 6) in Los Angeles County.
  http://tohelpeveryone.org
- **University Muslim Medical Association Community Clinic—Fremont Wellness Center**
  Provides health care for free or on a sliding scale to low-income residents in the South Los Angeles area. Services are provided in multiple languages including Spanish, Arabic, and Urdu.
  http://www.fremontwccg.org
- **Venice Family Clinic**
  Services include diagnosis, treatment, medications, follow-up care, and laboratory tests. Particular emphasis is placed on the needs of women, children, the homeless, and those with chronic diseases.
  www.venicefamilyclinic.org/
- **Watts Healthcare Corp**
  Offers a full range of services including clinical, preventive, specialty, and ancillary services.
  http://www.wattshealth.org/
- **Westside Family Health Center**
  Provides comprehensive, high quality, cost effective care.
  http://www.wfhcenter.org/

Hospitals: While several hospitals exist in and adjacent to the service area, only one is located in the southeast area where the need is the highest and a lack of hospitals is particularly apparent in the South Los Angeles area of Los Angeles County.

- **Brotman Medical Center/Southern California Hospital at Culver City**
  http://www.brotmanmedicalcenter.com/
- **California Hospital Medical Center**
  http://www.dignityhealth.org/californiahospital/
- **Cedars-Sinai Medical Center**
  Nonprofit academic medical center. Clinical programs range from primary care for preventing, diagnosing, and treating common conditions to specialized treatments for rare, complex, and advanced illnesses.
  http://cedars-sinai.edu/

- **Centinela Hospital Medical Center**
  Provides health services, hospital services, and safe haven services for people of all ages in Los Angeles County. There are no geographic restrictions.
  http://www.centinelamed.com
- **Charles R. Drew University of Medicine and Science**
  Private, nonprofit, nonsectarian medical and health sciences institution located in the Watts-Willowbrook area of South Los Angeles. Charles R. Drew University/OASIS Clinic provides free rapid HIV testing services for Los Angeles County.
  http://www.cdrewu.edu/
- **Harbor-UCLA Medical Center (DHS)**
  Harbor-UCLA Medical Center is one of only five level-one trauma centers in Los Angeles County. It offers a variety of services: adult/family medicine services, emergency services, HIV/AIDS services, inpatient services, pediatrics services, urgent care services, women's health services.
  http://dhs.lacounty.gov/wps/portal/dhs/harbor
- **Keck Medicine of USC**
  Keck Medical Center of USC includes two acute care hospitals: the 401-licensed bed Keck Hospital of USC and the 60-licensed bed USC Norris Cancer Hospital; it also owns USC Verdugo Hills Hospital, a 158-licensed bed community hospital.
  http://www.keckmedicine.org/
- **LAC + USC Medical Center (DHS)**
  One of the largest public hospitals in the country, offering a variety of services: adult/family medicine services, emergency services, HIV/AIDS services, inpatient services, pediatrics services, urgent care services, women's health services.
  https://dhs.lacounty.gov/wps/portal/dhs/lacusc
- **Marina Del Rey Hospital**
  https://www.marinahospital.com/
- **Martin Luther King, Jr. Outpatient Center (DHS)**
  The Martin Luther King, Jr. Outpatient Center offers over 70 primary care and specialty care services to serve the health care needs of surrounding communities. The Outpatient Center is the centerpiece of a new medical campus that will offer integrated inpatient and outpatient services on one site. Offers adult/family medicine services, HIV/AIDS services, pediatrics services, and urgent care services.
  https://dhs.lacounty.gov/wps/portal/dhs/mlk
- **UCLA Hospitals and Medical Centers**
  https://www.uclahealth.org/Pages/locations/ucla-hospitals.aspx

Other Related Assets

- **Church programs**
  Churches partner to organize health fairs and health-related events.
- **Health fairs**
  Community members trust the care received at local health fairs.
- **Mobile vans**

Provide general screening services.

- **School-based clinics**
- **Wellness centers**
  Hospital-based wellness centers provide access to early treatment, preventive care and pro-active wellness programs.

County Hotline Numbers and Referral Services

- **Domestic Violence Crisis Lines Free Spirit**
  (800) 548-2722
- **Elder Abuse Hotline**
  (800) 992-1660
- **Family Planning/ Birth Control Referrals**
  (800) 942-1054
- **Jenesse Center, Inc**
  (800) 479-7328
- **L.A. County Domestic Violence Hotline**
  (800) 978-3600
- **Los Angeles County Info Line**
  2-1-1
- **Mental Health Services and Referrals for L.A. County Referral line for free or low-cost services**
  (800) 854-7771
- **National Domestic Violence Hotline**
  (800) 799-7233
- **Teen Dating Abuse Helpline**
  (866) 331-9474
- **Suicide Prevention Hotline**
  (800) 273-TALK (8255)

Access to Healthy Foods in the KFH- West Los Angeles Service Area

Description & Significance

Ranked No. 10

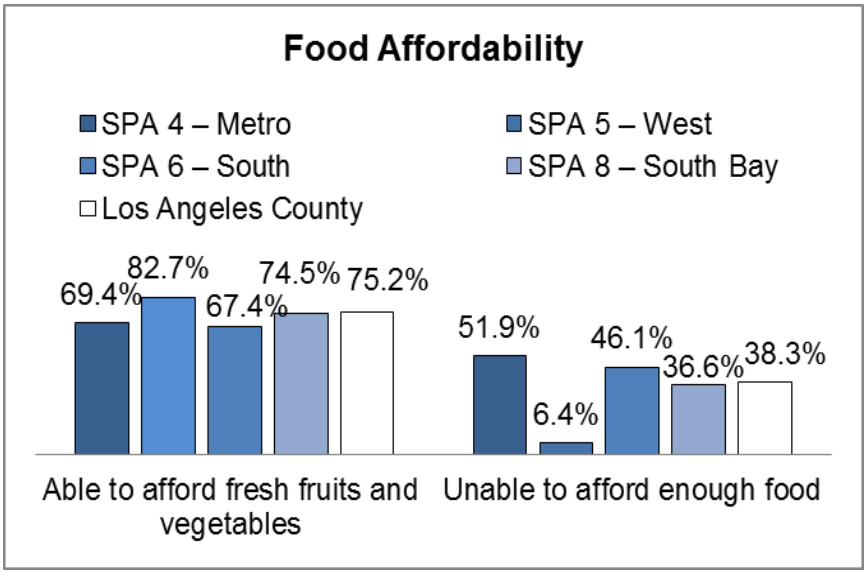
Good nutrition is essential to good health, disease prevention and the healthy growth and development of youth.

A combination of a healthy diet and physical activity is known to help reduce and prevent the development of heart disease, cancer, diabetes, and other diseases that lead to premature death and disability.[viii] However, it may be difficult for some to eat healthy meals because they lack access to healthy food options. Studies have shown that those who are more likely to suffer from such inequities in accessing healthy food options are those who are low-income and live in underserved communities.

Health Outcome Statistics

SPAs in the KFH-West Los Angeles service area suffer from a lack of access to affordable healthy food options, including fresh fruits and vegetables.

Affordability. In the KFH-West Los Angeles service area, a smaller portion of those living in SPA 4 (69.4%) and SPA 6 (67.4%) were able to afford fresh fruits and vegetables than in Los Angeles County (75.2%). A larger percentage of those in SPA 4 (51.9%) and SPA 6 (46.1%) were also unable to afford enough food when compared to Los Angeles County (38.3%).



Source: Able to afford fresh fruits and vegetables, California Health Interview Survey, 2014, SPA. Unable to afford enough food, California Health Interview Survey, 2014, SPA.

Health Disparities

Stakeholders indicated that the elderly, the working poor, the homeless, and those who lived in low-income communities were most likely to experience food insecurity/a lack of access to healthy food.

Stakeholders also added that communities that were most affected by the Los Angeles Riots in 1992 experienced a lot of grocery store and other food outlet closures, and these have not been reopened. This has contributed to community members' lack of access to healthy foods.

Community Perspective

"Fast food is often cheaper than healthy food options, and families often prefer fast food because it is more affordable."

—Community Outreach Worker/*Promotora*

Key Health Drivers/Factors

The inability to access fresh, affordable healthy food options is detrimental to health. Living in poverty and not being employed can limit or prevent an individual from obtaining the necessary nutrition to living a healthy life.

Social & Economic

Poverty. Financial instability creates barriers to insurance coverage, health services, healthy food, and other necessities[ix]. In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) than in California (8.3).In addition, the percentage of the population in the KFH-West Los Angeles service area living 200% below the Federal Poverty Level (FPL) was higher (40.0%) than in California (35.9%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Population Living Below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Assets & Opportunities

Stakeholders did not share any resources associated with access to healthy food. This list is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

Farmers Market

- **Century City Certified Farmers Market**
  10100 Santa Monica Blvd.
  https://www.facebook.com/CenturyCityFM/
- **Crenshaw-Baldwin Hills Farmers Market**
  3650 W. Martin Luther King Jr. Blvd., Baldwin Hills/Crenshaw
  http://www.seela.org/crenshaw-farmers-market/
- **Culver City Farmers Market**
  Main Street, Culver City
  http://www.culvercity.org/live/get-involved/farmers-market
- **Inglewood Certified Farmers Market Collaborative**
  https://www.facebook.com/inglewoodcertifiedfarmersmarket/info/
- **La Cienega Farmers Market**
  1801 S. La Cienega Blvd., Los Angeles, CA 90035
  http://www.lacienegafarmersmarket.com/
- **Mar Vista Famers Market**
  Grand View at Venice Boulevard
  http://www.marvistafarmersmarket.org/
- **Marina del Rey Farmers Market**
  Via Marina at Panay Way, Marina del Rey
- **Santa Monica Downtown Farmers Market**
  Arizona Avenue and 2nd Street, Santa Monica
  http://www.smgov.net/portals/farmersmarket/
- **Santa Monica Pico Farmers Market**
  2200 Virginia Ave., Santa Monica
  http://www.smgov.net/portals/farmersmarket/
- **Wellington Square**
  4394 Washington Blvd., Los Angeles, CA 90016
  http://www.wellingtonsquarefarmersmarket.com/

Grocery Stores

- **99 Cents Store**
  http://99only.com/
- **Food 4 Less**
  https://www.food4less.com/
- **Northgate Gonzalez Markets**
  http://www.northgatemarkets.com/
- **Ralph's**
  https://www.ralphs.com/
- **Smart & Final**
  https://www.smartandfinal.com/
- **Sprouts Farmers Market**
  https://www.sprouts.com/

- **Trader Joe's**
  http://www.traderjoes.com/
- **Vons**
  http://www.vons.com/ShopStores/Home.page
- **Whole Foods Market**
  http://www.wholefoodsmarket.com/

Community Gardens

- **Los Angeles Community Garden Council**
  The Los Angeles Community Garden Council (LACGC) partners with 40 community gardens in L.A. County. The Los Angeles Community Garden Council's mission is to strengthen communities by building new and supporting existing community gardens where every person in Los Angeles County can grow healthy food in their neighborhoods.
  http://lagardencouncil.org/
- **University of California Cooperative Extension**
  UC Cooperative Extension provides support for Los Angeles County community gardens through its Master Gardener Program. Master Gardeners volunteer at many area community gardens to train participants in sustainable gardening practices.
  http://celosangeles.ucanr.edu/UC_Master_Gardener_Program/Community_Gardens/
- **Community Services Unlimited—Growing Healthy**
  The Growing Healthy program engages youth in urban farming and food-based learning as a tool to help them adopt healthier lifestyles and develop an awareness of and political consciousness about the food access and environmental justice issues affecting their communities.
  http://csuinc.org/programs/growing-healthy/

Programs

- **Food Banks**
  Sources and distributes food and other products to those in need with the help of partnering agencies and Food Bank programs.
  https://www.lafoodbank.org/
- **Groceryships**
  Improves long-term health and wellness in low-income communities by creating a network of educational support groups and enhancing access to healthy, unprocessed foods.
  http://www.groceryships.org/
- **Meals on Wheels of West Los Angeles**
  Provides nutritious meals and friendships to individuals who are unable to plan, shop, or prepare meals for themselves due to illness, disability, or advanced age.
  http://www.mealsonwheelswla.org/
- **Project Angel Food**
  Cooks and delivers nutritious meals free of charge to the homes of men, women, and children affected by life-threatening illnesses.
  http://www.angelfood.org/
- **Project Chicken Soup**

Prepares and delivers free, nutritious, kosher meals to people in the greater Los Angeles area living with HIV/AIDS, cancer and other serious illness.
http://www.projectchickensoup.org/

- **Public Health Foundation WIC Program**
  The PHFE WIC Program provides WIC services in Los Angeles, Orange, and San Bernardino counties, employing nutritionists and paraprofessionals to provide culturally appropriate services to eligible families.
  https://www.phfewic.org/
- **WIC Programs**
  The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.
  http://www.fns.usda.gov/wic/women-infants-and-children-wic

Alcohol, Substance Abuse, and Tobacco Use in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 12

Alcohol and substance abuse has a major impact on individuals, families, and communities.

The effects of alcohol abuse contribute significantly to costly social, physical, mental, and public health problems, including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), violence, crime, homicide, and suicide.[x]

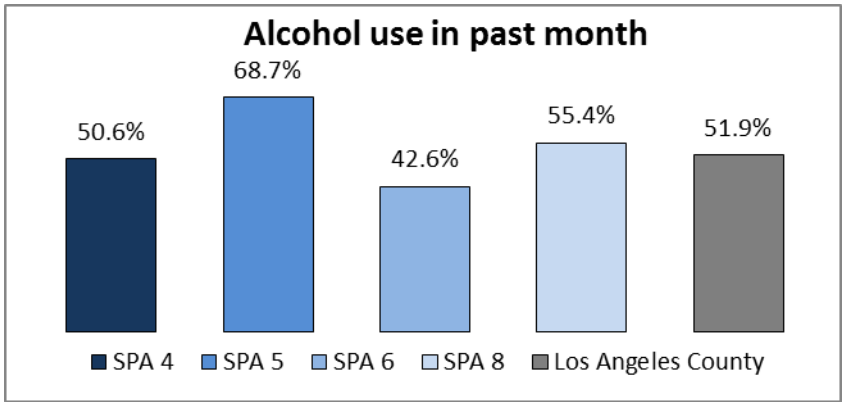
Tobacco use is the most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more suffer with at least one serious tobacco-related illness.[xi] Tobacco use is known to cause cancer, heart disease, lung disease (such as emphysema, bronchitis, and chronic airway obstruction), premature birth, low birthweight, stillbirth, and infant death.[xii]

Additionally, secondhand smoke has been known to cause heart disease and lung cancer in adults and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS) in infants and children. Smokeless tobacco use such as chewing tobacco can also cause a variety of oral health problems, like cancer of the mouth and gums, tooth loss, and periodontitis.[xiii]

Health Outcome Statistics

The KFH-West Los Angeles service area is experiencing an increase in people using smokeless tobacco, including electronic cigarettes. Stakeholders also noted an increase in substance abuse particularly cocaine, heroin, and methamphetamine.

Alcohol Use. Within the KFH-West Los Angeles service area, over half the population in SPA 5–West Los Angeles (68.7%), SPA 8–South Bay (55.4%), and SPA 4–Metro (50.6%) reported alcoholic beverage consumption in the past month—higher than in Los Angeles County (51.9%). In addition, high percentages reported binge-drinking (five or more drinks in two hours for men and four or more drinks for



Source: Alcohol use in the past month. California Health Interview Survey, 2014, SPA.

women) in SPA 4–Metro (19.2%) and SPA 6–South (16.9%), relative to Los Angeles County (15.4%).[xiv]

Substance Abuse. A large percentage of teens in SPA 8–South Bay (21.6%) and SPA 4–Metro (17.2%) reported using marijuana in the past year when compared to Los Angeles County (9.4%) and California (8.6%). Almost a third of adults in SPA 6–South (31.9%) reported ever using marijuana, cocaine, sniffing glue or another type of drug when compared to Los Angeles County (14.7%) and California (12.4%).

Hospitalizations. In the KFH-West Los Angeles service area, 10.0% of the population reported themselves as smokers, similar to Los Angeles County (10.0%) though less than for California overall (10.8%). Additionally, 15.3% in the service area have smoked electronic cigarettes in the past, a greater percentage than Los Angeles County (11.3%) and California (10.3%). A much larger percentage reported ever smoking electronic cigarettes in SPA 8 – South Bay (33.6%).

Health Disparities

The incidence rate (cases per 100,000 population per year) of lung cancer among Black/African-American populations (57.8) is highest of all ethnic groups, and exceeds that reported for the KFH-West Los Angeles service area (41.6).

Health disparities were noted by stakeholders among middle- to low-income communities, the homeless, teens in middle school, Latinos/Hispanic, and those who are less likely to have access to treatment for alcohol and substance abuse.

Key Health Drivers/Factors

Alcohol, substance abuse, and tobacco use are associated with a variety of health issues and social and economic factors.

Health Outcome(s)

Mental Health. The abuse of alcohol can often lead to poor mental health. In the KFH-West Los Angeles service area, the population experienced an average of 3.7 mentally unhealthy days per month, similar to that reports in Los Angeles County (3.7 days/month).

Average Number of Poor Mental Health Days

KFH-West Los Angeles Service Area	L.A. County	California
3.7	3.7	3.6

Source: Average number of poor mental health days in the past 30 days, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12, County.

Clinical Care

Affordable Care. The ability to access affordable health care is essential to getting timely treatment for an injury and avoiding premature death or a long-term disability. In the KFH-West Los Angeles service area 20.5% of the population did not have health insurance—higher when compared to California (17.8%) but lower than in Los Angeles County (22.2%). In addition, 44.8% residents Los Angeles County received delayed care because it was too expensive, a higher percentage than in California (17.8%).

Uninsured Population

KFH-West Los Angeles Service Area	L.A. County	California
20.5%	22.2%	17.8%

Source: Percent who are uninsured, U.S. Census Bureau, American Community Survey, 2009-13, Tract.

Delayed Health Care Because of Cost

L.A. County	California
44.8%	51.3%

Source: Percent who delayed health care due to cost or lack of health insurance, Los Angeles County Health Interview Survey, 2014, County.

Social & Economic

Poverty. Financial instability creates barriers to insurance coverage, health services, healthy food, and other necessities[xv]. In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) than in California (8.3). In addition, the percentage of the population in the KFH-West Los Angeles Service Area living at 200% below the Federal Poverty Level (FPL) was higher (40.0%) when compared to California (35.9%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Population Below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Assets & Opportunities

Stakeholders shared a few resources associated with alcohol and substance abuse. The following list provides assets that were identified through phone interviews and focus groups, and/or the KFH-West Los Angeles grant program. It is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

- **Alcoholics Anonymous—Central Office of Los Angeles**
  http://lacoaa.org/

- **Asian American Drug Abuse Program (AADAP)**
  The AADAP is a 501(c)3 nonprofit organization dedicated to serving Asian/Pacific Islanders and other underserved communities with substance abuse services throughout Los Angeles County. Programs and services are offered to all individuals regardless of race or ethnicity.
  http://www.aadapinc.org/
- **CLARE Foundation**
  CLARE Foundation is a nonprofit organization and trusted community resource, providing effective and affordable substance abuse treatment and prevention services for nearly 50 years. Experienced, compassionate, and specially trained staff help women and men find an end to the pain and suffering that is at the heart of addiction and discover hope in recovery. CLARE provides 24-hour residential treatment as well as a variety of outpatient programs designed to meet each person's needs and circumstances.
  http://clarefoundation.org/the-experience/
- **County of L.A. Department of Public Health – Substance Abuse Prevention and Control**
  http://publichealth.lacounty.gov/sapc/
- **Free-N-One Program**
  Free-N-One is a faith-based approach to treatment with cognitive behavioral interventions and therapy.
  http://www.free-n-one.org/content/
- **House of Uhuru – Substance Abuse Program**
  The House of Uhuru strives to enhance the well-being of communities impacted by chemical dependency by providing comprehensive culturally-sensitive prevention and education with a continuum of quality care for positive social change.
  http://www.wattshealth.org/services/substance-abuse-treatment-services/
- **Pacific Clinics**
  Provides leading-edge behavioral healthcare services across the life-span to diverse populations in Los Angeles, Orange, Riverside, San Bernardino and Ventura counties.
  http://www.pacificclinics.org/
- **The Promises Foundation**
  The Promises Foundation's vision is to support substance abuse prevention and provide behavioral health services to low-income women and their families. It strives to create innovative programs that provide a unique approach to substance abuse amidst underserved communities.
  http://promisesfoundation.org/

Cancer in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 17

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year.[xvi]

In 2009, cancer incidence rates (per 100,000 persons) indicated that the three most common cancers among men in the United States are prostate cancer (137.7), lung cancer (64.3), and colorectal cancer (42.5). Among women, the leading causes of cancer deaths are breast cancer (123.1), lung cancer (54.1), and colorectal cancer (37.1).[xvii]

Health Outcome Statistics

The KFH-West Los Angeles service area is experiencing higher rates of cervical and colorectal cancer diagnoses and mortality than Los Angeles County and California.

Incidence. In the KFH-West Los Angeles service area, 8.8 of every 100,000 women reported having cervical cancer. This is higher when compared to California (7.7) and the Healthy People 2020 goal of <=7.1 per 100,000 women.[xviii] A slightly higher rate of the population in the KFH-West Los Angeles service area (41.3 per 100,000 population) reported having colorectal cancer when compared to California (40.0) and the Healthy People 2020 goal of <=38.7.[xix]

Mortality. The cancer mortality rate in the KFH-West Los Angeles service area was higher (164.8 per 100,000 population.) when compared to Los Angeles County (153.0), California (157.1), and the Healthy People 2020 goal of <=160.6.[xx]

Community Perspective

"There is a need for having access to people that have been through the process . . . someone to support you during that time."

—Faith-based community member

Health Disparities

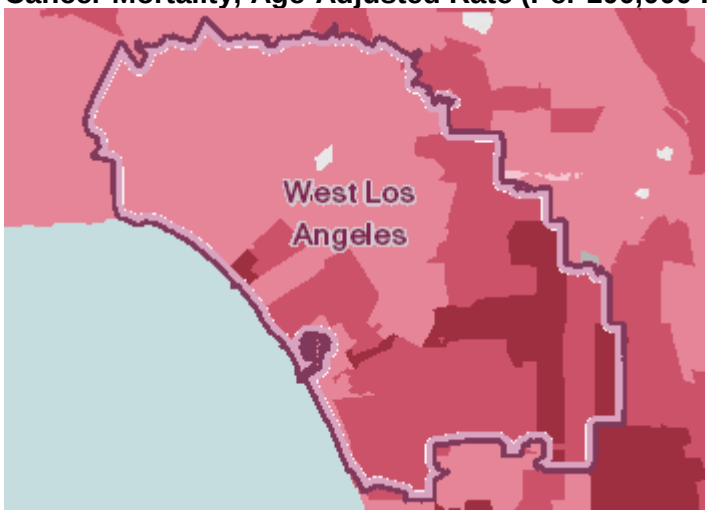
Black/African American populations are the most affected by cancer in the KFH-West Los Angeles service area. Cancer incidence rates per 100,000 persons for prostate cancer (189.7), breast cancer (127.1), lung cancer (57.8), and colon and rectum cancer (54.4) are the highest for Black/African Americans above all other races and ethnicities. These exceed rates reported for the KFH-West Los Angeles service area: prostate cancer (122.0), breast cancer (116.9), lung cancer (41.6), and colon and rectum cancer (41.3).

Stakeholders added that health disparities were observed among Hispanic/Latinos, Black/African-Americans, Whites, Native Hawaiian/Pacific Islanders, the low-income population, and those living close to freeways and industrial areas. Additionally, the southeast portion of the KFH-West Los Angeles service area was the most affected by cancer (communities listed below).

Communities Most Affected (Cancer Mortality):

- Crenshaw
- Culver City
- Hyde Park
- Jefferson Park
- Ladera Heights
- Leimert Park
- South Los Angeles
- West Athens

Cancer Mortality, Age-Adjusted Rate (Per 100,000 Population) by ZCTA, CDPH 2010-12



Source: Cancer Mortality Rate per 100,000 population, California Department of Public Health (CDPH) Death Public Use Data, 2010-12, ZIP Code.

Stakeholders agree that Blacks/African Americans, Hispanic/Latinos, Asians, low-income populations, smokers, and those close to freeways and industrial sites are most affected by cancer.

Key Health Drivers/Factors

Cancer is associated with being overweight or obese and unhealthy behaviors including physical inactivity, an unhealthy diet, tobacco use, and alcohol abuse. In addition, certain chemicals, and some viruses and bacteria have also been known to cause cancer.[xxi]

Health Behaviors

Physical Activity. A lack of physical activity may be a contributing factor to developing health issues including cancer. In the KFH-West Los Angeles service area, a larger percentage (43.1%) of youth is physically inactive when compared to Los Angeles County (40.0%) and California (35.9%).

Youth Who Are Physically Inactive

KFH-West Los Angeles Service Area	L.A. County	California
43.1%	40.0%	35.9%

Source: Percent of youth who are physically inactive, California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14, School District.

Tobacco Use. Smoking may cause many health issues including cancer. Electronic cigarettes have become a popular alternative to cigarettes and contain nicotine and a variety of other carcino-genic chemicals.[xxii] In Los Angeles County a larger percentage of adults reported smoking e-cigarettes (11.3%) than in California (10.3%).

Adults Who Smoked E-cigarettes

L.A. County	California
11.3%	10.3%

Source: Percent of adults who smoke electronic cigarettes, California Health Interview Survey, 2014, SPA.

Alcohol Abuse. Drinking a large amount of alcohol consistently may contribute to the development of a variety of health issues, including cancer. Within then the KFH-West Los Angeles service area, In addition, high percentages reported binge-drinking (five or more drinks in two hours for men and four or more drinks for women) in SPA 4–Metro (19.2%) and SPA 6–South (16.9%), relative to Los Angeles County (15.4%).[xxiii]

Assets & Opportunities

Research has shown that early detection through regular cancer screenings can help reduce the number of new cancer cases and, ultimately, deaths.[xxiv] Research has also shown that cancer is associated with certain diseases and behaviors including obesity, tobacco, alcohol, certain chemicals, some viruses and bacteria, a family history of cancer, poor diet, and lack of physical activity.[xxv]

Stakeholders identified a variety of assets in the community related to cancer. The following list provides assets that were identified through phone interviews and focus groups, and/or through the KFH-West Los Angeles grant program. It is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

Cancer-Specific Assets

- **American Cancer Society**
  Provides free programs and services towards treatment and recovery, as well as emotional support. http://www.cancer.org/
- **Camp Kesem**
  Nationwide community that supports children through and beyond their parents' cancer.
  http://campkesem.org
- **Cancer Support Community—Benjamin Center**
  Serves people living in West Los Angeles and the broader Los Angeles community with free-of-charge programs overseen by licensed therapists. These include support groups, mind/body classes, educational and nutritional workshops, social activities, and individual counseling sessions.
  http://www.cancersupportcommunitybenjamincenter.org/
- **Cedars-Sinai Medical Center**
  http://cedars-sinai.edu
- **Community Clinic Association of Los Angeles County**
  http://ccalac.org
- **Los Angeles Urban League—Fit4 Live C3**
  www.laul.org
- **Mobile vans**
  Provide general screening services
- **Navigating Cancer Survivorship**
  https://www.navigatingcancer.com
- **PADRES Contra El Cancer**
  http://www.iamhope.org
- **Ronald Reagan UCLA Medical Center**
  https://www.uclahealth.org/reagan
- **Saban Community Clinic**
  Provides services for prevention, screening, and care.
  http://www.sabancommunityclinic.org/
- **Team Survivor Los Angeles**
  http://www.teamsurvivor.org
- **The Achievable Foundation—The Achievable Health Center**
  http://www.achievable.org/
- **Venice Family Clinic**
  Venice Family Clinic's breast cancer screening and detection program
  www.venicefamilyclinic.org
- **Women of Color Breast Cancer Survivors Support Project—Wellness Warriors Project**
  http://woc4me.org/
- **YWCA Santa Monica/Westside—The Encore Program**
  http://www.smywca.org

Cardiovascular Disease
in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 9

Cardiovascular disease consists of several health conditions related to cholesterol, heart disease, and hypertension.

Cholesterol. Cholesterol is a necessary waxy, fat-like substance in the body. However, too much cholesterol in the blood can build up on artery walls, leading to heart disease—one of the leading causes of death in the United States—and stroke.[xxvi] Approximately 73.5 million adults (31.7%) in the United States have high low-density lipoprotein (LDL), or "bad" cholesterol. Less than half (48.1%) of adults with high-LDL cholesterol receive treatment to improve their levels. People with high total cholesterol have approximately twice the risk for heart disease as people with ideal levels.[xxvii]

Heart Disease. As plaque builds up, the arteries narrow, restricting blood flow and creating the risk of heart attack. Currently, more than one in three adults (81.1 million) in the United States lives with one or more types of cardiovascular disease. Heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.[xxviii] The leading modifiable (controllable) risk factors for heart disease and stroke are high blood pressure, high cholesterol, cigarette smoking, diabetes, poor diet and physical inactivity, overweight, and obesity.

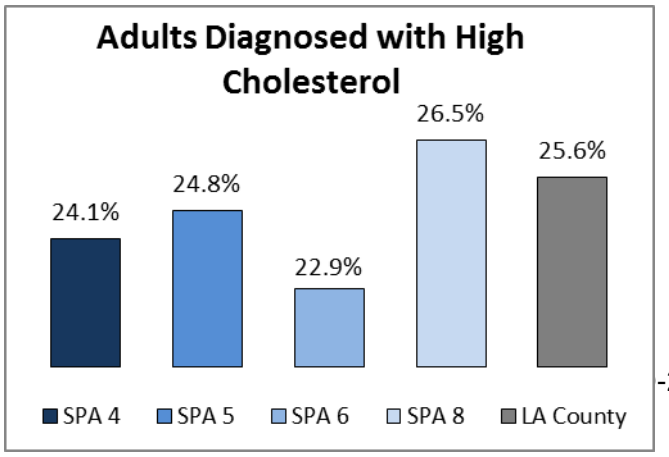
Hypertension. Hypertension, defined as a blood pressure reading of 140/90 mmHg or higher, affects one in three adults in the United States.[xxix] With no symptoms or warning signs and the ability to cause serious damage to the body, this condition has been called a silent killer. If untreated, high blood pressure can lead to blood-vessel aneurysms, chronic kidney disease (which may lead to kidney failure), cognitive changes (including memory loss, difficulty finding words, and losing focus during conversations), eye damage, heart attack, heart failure, peripheral arterial disease, and stroke.[xxx] High blood pressure can be controlled through medication and lifestyle changes; however, patients' lack of adherence to treatment regimens is a significant barrier to controlling the condition.[xxxi]

Stroke. Strokes are a leading risk factor for cardiovascular/heart disease and share many of the same risk factors.

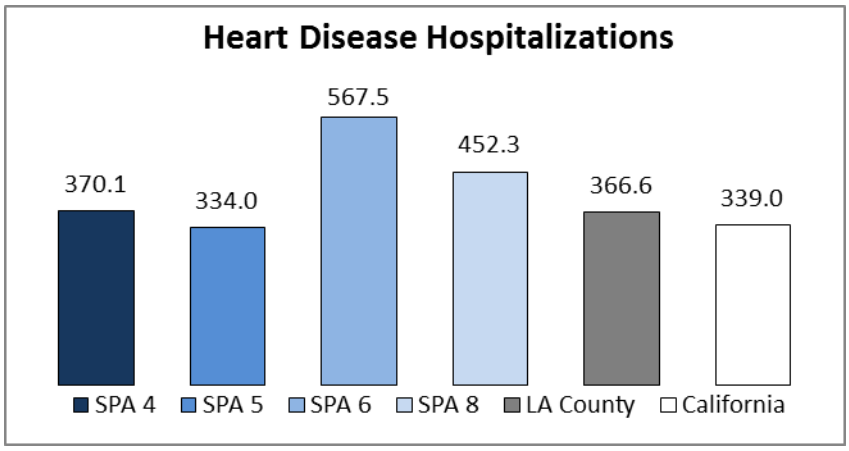
Health Outcome Statistics

Cholesterol

Within the KFH-West Los Angeles service area, over a quarter of the residents in SPA 8–South Bay (26.5%) was diagnosed with high cholesterol, which is above the percentage reported in Los Angeles County (25.6%).[xxxii]



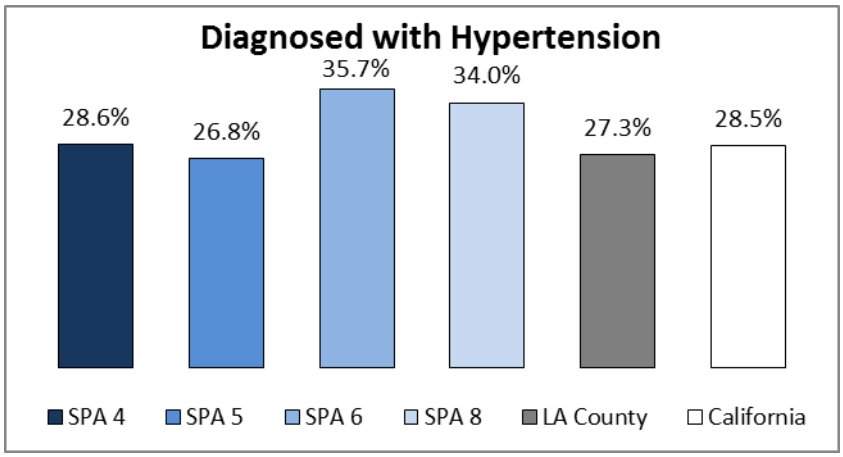
Heart Disease



The KFH-West Los Angeles service area is experiencing higher rates of heart disease hospitalizations and mortalities than in Los Angeles County and California.

Hospitalizations. Within the KFH-West Los Angeles service area, the rates of heart disease hospitalizations (adults per 100,000 population) were higher in SPA 6–South (567.5), SPA 8–South Bay (452.3) and SPA 4–Metro (370.1) when compared to Los Angeles County (366.6) and California (339.0).[xxxiii]

Hypertension



In the KFH-West Los Angeles service area, many people are diagnosed with hypertension, but management of the condition is not sufficient.

Prevalence. Over a third residents in SPA 6–South (35.7%) and SPA 8–South Bay (34.0%) were diagnosed with hypertension. These percentages are higher when compared to Los Angeles County (27.3%) and California (28.5%).

Stroke

The rate of stroke mortality per 10,000 population was lower in the KFH-West Los Angeles service area (3.4) relative to California.

Stroke Mortality Rate per 10,000 Population, 2012

KFH-West Los Angeles service area	California
3.4	3.5

Source: California Department of Public Health, Death Statistical Master File, 2012, ZIP Code.

Health Disparities

Cholesterol

Stakeholders observed disparities among Hispanic/Latinos, Black/African-Americans, Asians, smokers, and low-income residents are also at risk.

Community Perspective

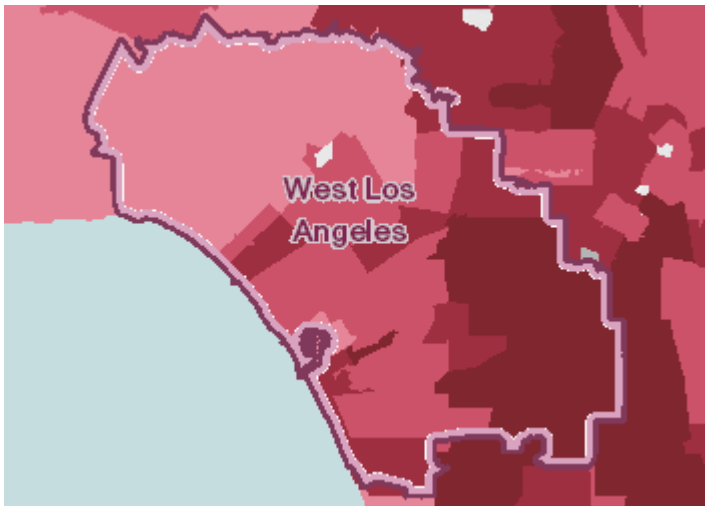
"Cholesterol is a health issue that impacts African-American and Latinos, and other populations in poverty."

—Community youth member

Heart Disease

The highest rates of death due to coronary heart disease per 100,000 population for the KFH-West Los Angeles service area was observed in Native Pacific Islanders (292.9), Black/African-Americans (264.8), and Non-Hispanic Whites (195.1). This rate exceeds observed in the KFH-West Los Angeles service area (184.67). Stakeholders noted that heart disease was an issue of concern among Black/African-Americans, Hispanic/Latinos, and those in their 20s and 30s.

Health disparities were also observed in the southeast portion of the KFH-West Los Angeles service area in the following communities: Hyde Park, Inglewood, Jefferson Park, South Los Angeles, West Adams, West Athens and Westmont among others.



Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 population) by ZCTA, CDPH 2010-12

- Over 200.0
- 160.1–200.0
- 120.1–160.0
- 80.1–120.0
- Under 80.1
- No Data or Data Suppressed
- Report Area

Source: California Department of Public Health (CDPH)*Death Public Use Data. 2010-12. Source geography: ZIP Code*

Hypertension

Stakeholders noted health disparities among Hispanic/Latinos, Black/African-Americans, women and low-income communities including South Los Angeles.

Key Health Drivers/Factors

Cholesterol

High cholesterol is associated with health issues such as diabetes and overweight/obesity. In addition, certain unhealthy behaviors contribute to the development of high cholesterol including physical inactivity, an unhealthy diet, tobacco use, and alcohol abuse.[xxxiv] A stakeholder observed that cholesterol is kept under control through education and access to health care.

Heart Disease

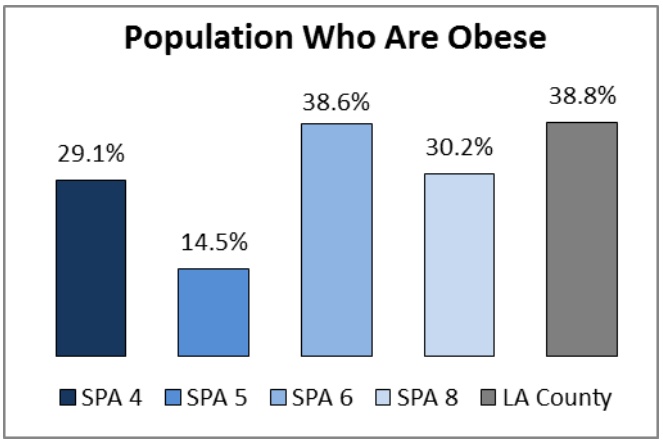
Heart disease is associated with health issues including high blood pressure, high cholesterol, diabetes and obesity as are certain unhealthy behaviors such as physical inactivity, an unhealthy diet, tobacco use, and alcohol abuse[xxxv]. Stakeholders expressed that heart disease and diabetes are getting worse due to an uptick in overweight/obesity. They mentioned that heart disease is connected to oral health, an issue often overlooked.

Hypertension

Hypertension is common among those who are diabetic and obese. Poor health behaviors such as unhealthy eating, physical inactivity, smoking, and alcohol abuse may also contribute to the development of hypertension.[xxxvi]

Health Outcome(s)

Obesity. Being overweight or obese can contribute to an individual's likelihood of developing high cholesterol and being susceptible to hypertension. Within the KFH-West Los Angeles service area, the population in SPA 6–South (38.6%) had the highest percentage of the population that was obese. This percentage is lower than in Los Angeles County (38.8%).



Health Behaviors

Physical Activity. A lack of physical activity is a contributing factor to developing health issues including heart disease, high cholesterol. and hypertension. In the KFH-West Los Angeles service area, a larger percentage (43.1%) of youth was physically inactive when compared to Los Angeles County (40.0%) and California (35.9%).

Youth Who Are Physically Inactive

KFH-West Los Angeles Service Area	L.A. County	California
43.1%	40.0%	35.9%

Source: Percent of youth who are physically inactive, California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14, School District.

Alcohol Abuse. Drinking a large amount of alcohol consistently may contribute to the development of a variety of health issues, including cancer. Within then the KFH-West Los Angeles service area, In addition, high percentages reported binge-drinking (five or more drinks in two hours for men and four or more drinks for women) in SPA 4–Metro (19.2%) and SPA 6–South (16.9%), relative to Los Angeles County (15.4%).[xxxvii]

Tobacco Use. Smoking may cause many health issues including cancer. Electronic cigarettes have become a popular alternative to cigarettes and contain nicotine and a variety of other carcinogenic chemicals.[xxxviii] In Los Angeles County a larger percentage of adults reported smoking e-cigarettes (11.3%) than in California (10.3%).

Adults Who Smoked E-cigarettes

L.A. County	California
11.3%	10.3%

Source: Percent of adults who smoke electronic cigarettes, California Health Interview Survey, 2014, SPA.

Assets & Opportunities

Stakeholders identified one hypertension-specific asset in the community, and a variety of related assets. Stakeholders did not identify assets in the community that specifically addressed cholesterol and heart disease. However, these health needs may be addressed indirectly through services for related conditions such as diabetes and overweight/obesity, as well as programs that promote proper nutrition, physical activity, and preventive health care.

The following list provides assets that were identified through the KFH-West Los Angeles grant program. This list is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

- **American Heart Association—EMPOWERED: Shape Up Your Heart!**
  www.heart.org
- **Black Women for Wellness**
  Project: Sisters in Motion

www.bwwla.com

- **California Certified Farmers Markets**
  www.cafarmersmarkets.com
- **City of Inglewood Parks, Recreation and Community Services Department—BE WELL**
  www.cityofinglewood.org
- **Community Clinic Association of Los Angeles County (CCALAC)**
  www.ccalac.org
- **Community Services Unlimited Inc.**
  www.csuinc.org
- **Crenshaw Family YMCA—PLAY (Physical Learning Activities for Youth)**
  www.ymcala.org/crenshaw
- **First African Methodist Episcopal Church (FAME)**
  FAME conducts screenings for high blood pressure and diabetes once a month on Sundays when church attendance is high. Individuals tend to use that Sunday to attend services and get checked.
  http://www.famechurch.org/
- **Heal One World—Fit Right In, Making Health Choices A Habit**
  www.healoneworld.com
- **Junior Blind of America**
  After-school enrichment program for low-income, blind, visually impaired, and sighted children and youth
  https://www.juniorblind.org
- **L.A.'s Promise—Health Happens Here Summer Enrichment Program**
  www.laspromise.org
- **LetsMove! West L.A.**
  http://letsmovewestla.ning.com
- **Lula Washington Dance Theatre—Community Dance Wellness Program**
  www.lulawashington.org
- **Mar Vista Family Center—Health and Wellness Program**
  www.marvistafc.org
- **Model Neighborhood Program/La Cienega Farmer's Market**
  www.lacienegafarmersmarket.com
- **Niswa Association Incorporated—Health Living Education (HLE) Series**
  www.niswainc.org
- **Project Angel Food**
  Medically tailored meal delivery for individuals disabled by chronic illness
  www.angelfood.org
- **REACH Partners in Health, by Community Health Councils (CHC)**
  The project collaborates with CHC, the Los Angeles County Department of Public Health, the Los Angeles Unified School District, and University of Southern California researchers. It is designed to reduce disparities in obesity rates and hypertension for African-American and Hispanic/Latino residents in the West Adams, Baldwin Hills, and South Los Angeles Community Plan Area of South Los Angeles. The goals are to improve the quality of nutrition and physical

activity in schools, adopt and implement the medical home model in FQHCs, and update individual community plans.
http://chc-inc.org/reach-2013

- **Ronald Reagan UCLA Medical Center**
  https://www.uclahealth.org/reagan
- **Saban Community Clinic—Chronic Disease Management Program**
  www.sabancommunityclinic.org
- **Social and Environmental Entrepreneurs**
  Comprehensive nutrition, education, and emotional support program for low-income families in South L.A.
  www.saveourplanet.org
- **Social Justice Learning Institute**
  www.sjli.org
- **Inglewood Certified Farmers Market Collaborative and Demonstration Project**
  https://www.facebook.com/inglewoodcertifiedfarmersmarket/info/
- **Socrates Opportunity Scholarship Foundation (SOS Mentor)— Imagine HEALTH**
  www.sosmentor.org
- **Special Olympics Greater Los Angeles**
  Sports, health, and fitness programs for persons with intellectual disabilities in West L.A.
  https://www.sosc.org
- **St. John's Well Child and Family Center—Kids N Fitness**
  www.wellchild.org
- **Students Run L.A.**
  Training for a marathon . . . training for life
  https://srla.org
- **The South Central Foundation for Fitness, Dance and Arts**
  Partnering with South Los Angeles community clinics to build healthier communities; promoting self-healing behavioral changes
  (424)456-4770
- **University Muslim Medical Association Community Clinic—Triple Threat Impact Initiative**
  www.ummaclinic.org
- **Wellington Square Farmers Market**
  www.wellingtonsquarefarmersmarket.com
- **YMCA—Palisades-Malibu**
  Expanded healthy living opportunities for seniors
  www.ymcala.org
- **YWCA Santa Monica/Westside—The Encore Program**
  www.smywca.org

Diabetes in the KFH- West Los Angeles Service Area

Description & Significance

Ranked No. 2

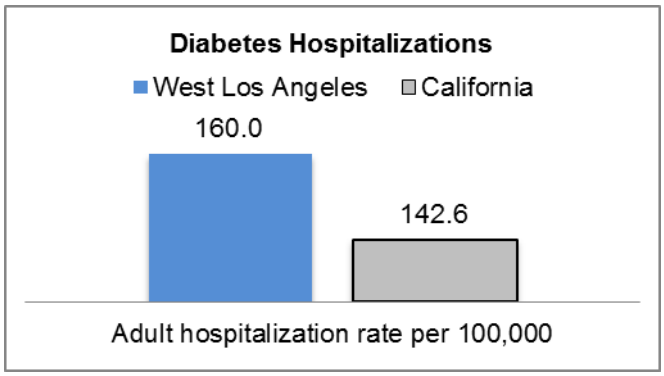
Diabetes affects an estimated 23.6 million people and is the seventh leading cause of death in the United States.

Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness.[xxxix] In addition to heart disease, diabetes has other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis.[xl] The different types of diabetes most commonly include Type 1, Type 2, and gestational diabetes. Gestational (developing diabetes during pregnancy) diabetes occurs more frequently among African-Americans, Hispanic/Latino Americans, American Indians, and women with a family history of diabetes. Women who have had gestational diabetes have a 35% to 60% chance of developing diabetes in the next 10 to 20 years. Other specific types of diabetes, which may account for 1% to 5% of all diagnosed cases, result from specific genetic syndromes, surgery, drugs, malnutrition, infections, and other illnesses.[xli]

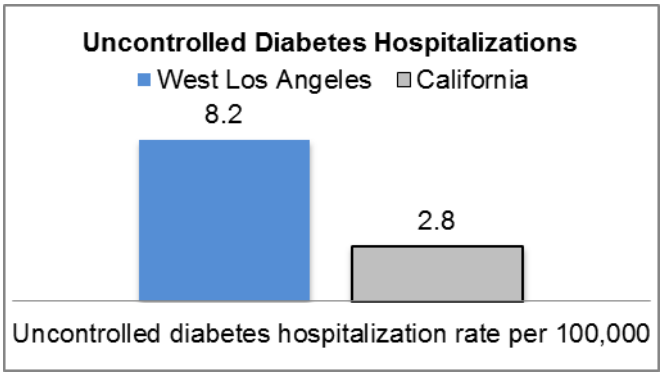
Health Outcome Statistics

The KFH-West Los Angeles service area is experiencing higher rates of diabetes-related hospitalizations than in California as a whole. Stakeholders added that diabetes has become more prevalent in the last few years, and that while services have expanded at community clinics, patients tend to experience very long wait periods before they receive care.

Hospitalizations. More adults in the KFH-West Los Angeles service area were hospitalized for diabetes (160.0 per 100,000 population) when compared to California (142.6). Nearly three times the rate of adults in the KFH-West Los Angeles service area were hospitalized for uncontrolled diabetes (8.2) when compared to California (2.8).



Source: Rate of adult diabetes-related hospitalizations per 100,000 population, Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code.



Source: Rate of uncontrolled diabetes-related hospitalizations per 100,000 population, Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code.

Health Disparities

Stakeholders reported that diabetes is growing rapidly among all racial and ethnic groups, and is most prevalent among Black/African American, Hispanics/Latino, and Asian Pacific Islander communities. They also identified other groups affected by diabetes, including people ages 1 to 19 and 45 to 64, women, substance abusers, low-income patients and those living in South Los Angeles and Compton.

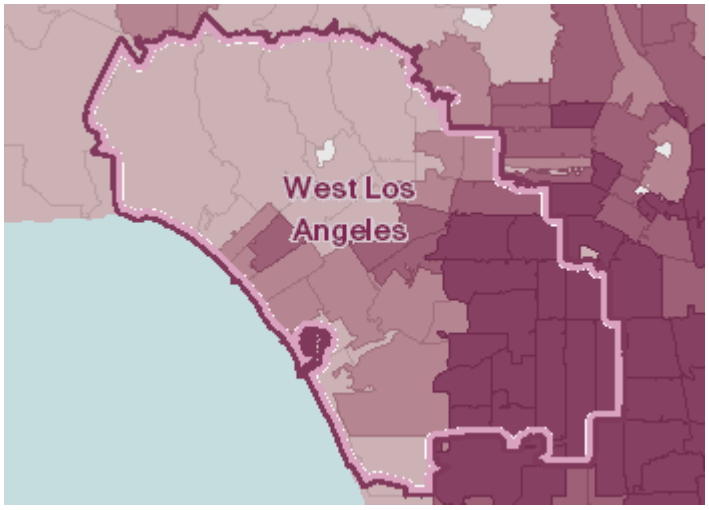
Communities Most Affected (diabetes-related hospitalizations):

- Baldwin Hills
- Compton
- Crenshaw
- Culver City
- Inglewood
- Jefferson Park
- Ladera Heights
- Leimert Park
- Lennox
- Mid City
- South Los Angeles
- West Adams
- West Athens

Community Perspective

"Rent is too expensive, parents have to work long hours, kids live mostly by themselves, and there is no time for home-cooked meals. In unsafe communities, kids have to stay indoors and get no exercise."

—Community member



Diabetes Hospital Discharges, Rate (Per 10,000 Population) by ZCTA, OSHPD 2011

- Over 12.0
- 7.1–12.0
- 4.1–7.0
- Under 4.1
- No Data or Data Suppressed
- Report Area

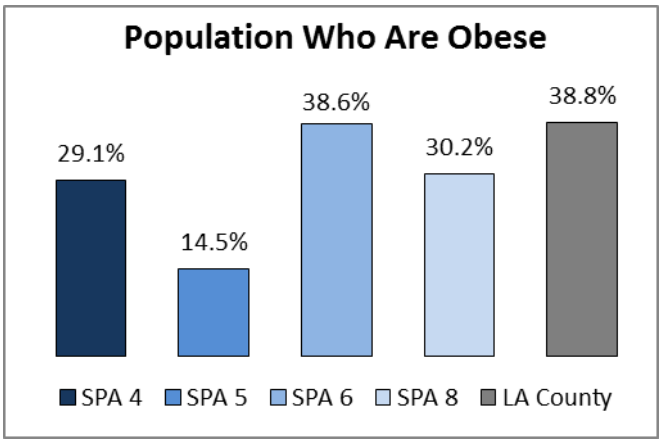
Source: Diabetes-related hospitalizations per 10,000 population., Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data, 2011, ZIP Code.

Key Health Drivers/Factors

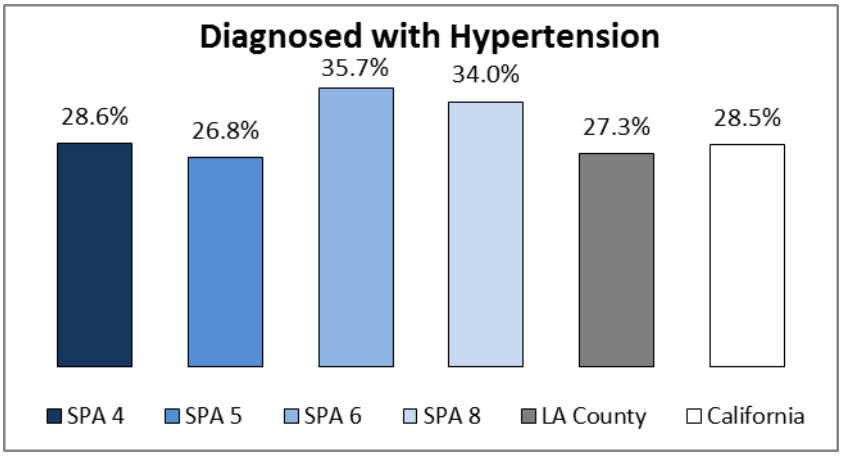
Diabetes is associated with being overweight and obesity, high blood pressure (i.e. hypertension), and high cholesterol. Diabetes is also highly correlated to poor health behaviors such as physical inactivity, smoking, and unhealthy eating.[xlii] Like obesity/overweight, stakeholders identified unhealthy eating habits as a large contributor to developing diabetes, citing a number of factors: a lack of time to cook healthy meals (most adults and parents work long hours), a lack of access to fresh foods in low-income neighborhoods, the perception that healthy and fresh groceries are expensive, the ease of access to and low cost of fast foods, and a lack of oversight on children's nutrition and physical activity habits resulting from parents' work outside the home. In particular, there is a lack of urgency to seek care when patients are told they are pre-diabetic, a stakeholder adds: "People think 'I may have diabetes but I am on the low end, so I don't have to worry as much.'"

Health Outcome(s)

Obesity. Being overweight or obese can contribute to an individual's likelihood of developing diabetes Within the KFH-West Los Angeles service area, the population in SPA 6–South (38.6%) had the highest percentage of the population that was obese. This percentage is lower than in Los Angeles County (38.8%).



Hypertension. About 60% of diabetics are very likely to develop heart disease at some point in their lives.[xliii] Over a third of residents in SPA 6–South (35.7%) and SPA 8–South Bay (34.0%) were diagnosed with hypertension. These percentages are higher when compared to Los Angeles County (27.3%) and California (28.5%).



Health Behaviors

Physical Activity. A lack of physical activity is a contributing factor to developing health issues, including diabetes. In the KFH-West Los Angeles service area, a larger percentage (43.1%) of youth was physically inactive than in Los Angeles County (40.0%) or California (35.9%).

Youth Who Are Physically Inactive

KFH-West Los Angeles Service Area	L.A. County	California
43.1%	40.0%	35.9%

Source: Percent of youth who are physically inactive, California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14, School District.

Healthy Eating. Consuming sugary drinks on a daily basis may contribute to the development of diabetes and other health issues. In Los Angeles County, 38.8% of adults consumed at least one soda per day.

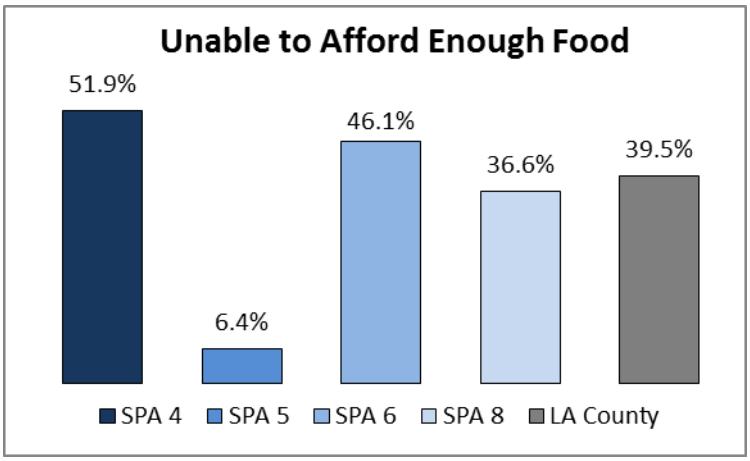
Adults Who Consumed One Soda a Day

L.A. County	California
38.8%	38.6%

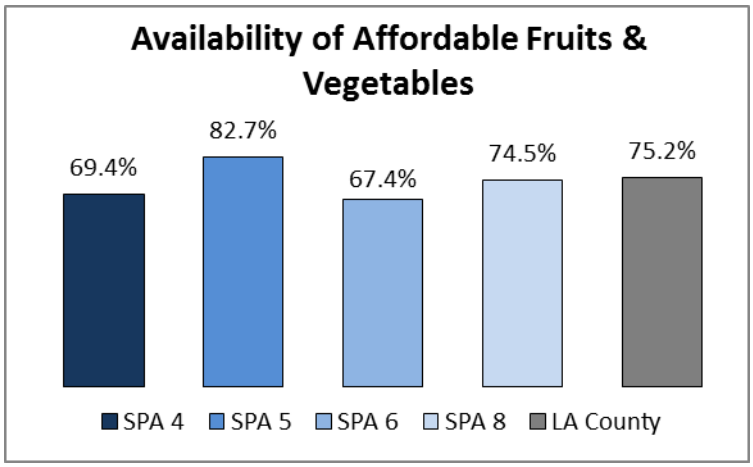
Source: Percent of adults who consumed one soda or sweetened drink a day, California Health Interview Survey, 2014, SPA.

Social & Economic

Access to Healthy Foods. Access to healthy, affordable, high-quality food—including fruits and vegetables—is essential to an individual's overall well-being; the lack of such access and can contribute to the development of health issues such as diabetes. Within the KFH-West Los Angeles service area, a high percentage of the population in SPA 4–Metro (51.9%) and SPA 6–South (46.1%) were not able afford enough food—higher rates than in Los Angeles County (39.5%).[xliv]



Within the KFH-West Los Angeles service area, the residents in SPA 5–West (82.7%) had the most access to affordable fruits and vegetables at a higher rate than in Los Angeles County (75.2%).[xlv]



Physical Environment

Fast-Food Establishments. Environmental influences such as ready access to fast food rather than healthy food options is a critical factor that contributes to poor health outcomes such as diabetes. In the KFH-West Los Angeles service area, the rate of fast-food establishments per 100,000 population was higher (85.2) when compared to Los Angeles County (77.8) and California (74.5).

Fast-Food Establishments

KFH-West Los Angeles Service Area	L.A. County	California
85.2	77.8	74.5

Source: Fast food establishment rate per 100,000 population, U.S. Census Bureau, County Business Patterns, 2011, Tract.

Assets & Opportunities

Stakeholders identified two diabetes-specific assets. It is also likely that diabetes is addressed indirectly through programs and assets for overweight/obesity, and efforts to encourage proper nutrition and physical activity.

The following list provides assets that were identified through phone interviews and focus groups, and/or through the KFH-West Los Angeles grant program. it is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

Diabetes-Specific Assets

- **Black Women for Wellness—Sisters in Motion**
  www.bwwla.com
- **California Certified Farmers Markets**
  www.cafarmersmarkets.com
- **Centinela Hospital Medical Center**
  http://www.centinelamed.com
- **City of Inglewood Parks, Recreation and Community Services Department—BE WELL**
  www.cityofinglewood.org
- **Community Clinic Association of Los Angeles County**
  http://ccalac.org
- **Connections For Children**
  Building healthy nutrition and activity habits in child care settings to prevent childhood obesity
  www.connectionsforchildren.org
- **Crenshaw Family YMCA—PLAY (Physical Learning Activities for Youth)**
  www.ymcala.org/crenshaw
- **First African Methodist Episcopal Church (FAME)**
  FAME conducts screenings for diabetes and high blood pressure once a month on Sundays when church attendance is high . Individuals tend to use that Sunday to attend services and get

checked.
http://www.famechurch.org/

- **Heal One World—Fit Right In, Making Health Choices A Habit**
  www.healoneworld.com
- **"Healthy Environment, Active Living," Camp HEAL**
  Faith-based community initiative of the Diabetes and Obesity Program of Children's Hospital Los Angeles (CHLA) and New Mount Calvary Missionary Baptist Church. Camp HEAL is dedicated to developing physical, emotional, and spiritual health in a way that resonates with the young campers.
  http://www.chla.org/blog/community-programs/faith-based-summer-camp-promotes-%E2%80%9Chealthy-environment-active-living%E2%80%9D
- **Junior Blind of America**
  After-school enrichment program for low-income, blind, visually impaired, and sighted children and youth
  https://www.juniorblind.org
- **L.A.'s Promise—Health Happens Here Summer Enrichment Program**
  www.laspromise.org
- **LetsMove! West L.A.**
  http://letsmovewestla.ning.com
- **Los Angeles Brotherhood Crusade—Nutrition Education Obesity Prevention Program**
  www.brotherhoodcrusade.org
- **Lula Washington Dance Theatre—Community Dance Wellness Program**
  www.lulawashington.org
- **Mar Vista Family Center—Health and Wellness Program**
  www.marvistafc.org
- **Model Neighborhood Program/La Cienega Farmer's Market**
  www.lacienegafarmersmarket.com
- **Niswa Association Incorporated—Health Living Education (HLE) Series**
  www.niswainc.org
- **Project Angel Food**
  Medically tailored meal delivery for individuals disabled by chronic illness
  www.angelfood.org
- **Ronald Reagan UCLA Medical Center**
  https://www.uclahealth.org/reagan
- **RootDown L.A.—South L.A. Youth-Driven Diabetes Support Network**
  www.rootdownla.org
- **Saban Community Clinic—Chronic Disease Management Program**
  www.sabancommunityclinic.org
- **Social and Environmental Entrepreneurs**
  Comprehensive nutrition education and emotional support program for low-income families in South L.A.
  www.saveourplanet.org
- **Social Justice Learning Institute**

Inglewood certified farmers market collaborative and demonstration project
www.sjli.org

- **Socrates Opportunity Scholarship Foundation (SOS Mentor)—Imagine HEALTH**
  www.sosmentor.org
- **Special Olympics Greater Los Angeles**
  Sports, health, and fitness programs for persons with intellectual disabilities in West L.A.
  https://www.sosc.org
- **St. John's Well Child and Family Center—Kids N Fitness**
  www.wellchild.org
- **Students Run L.A.**
  Training for a marathon . . . training for life
  https://srla.org
- **The South Central Foundation for Fitness, Dance and Arts**
  Partnering with South Los Angeles community clinics to build healthier communities: promoting self-healing behavioral changes
  (424)456-4770
- **University Muslim Medical Association Community Clinic—Triple Threat Impact Initiative**
  www.ummaclinic.org
- **Weingart YMCA—Youth Fitness Initiative**
  www.ymcala.org
- **Wellington Square Farmers Market**
  www.wellingtonsquarefarmersmarket.com
- **Worksite Wellness L.A.—Project Health Lunch**
  www.worksitewellnessla.org
- **YMCA—Anderson Munger (Wilshire)—Diabetes Prevention Program (DPP)**
  www.ymcala.org

Economic Security
in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 7

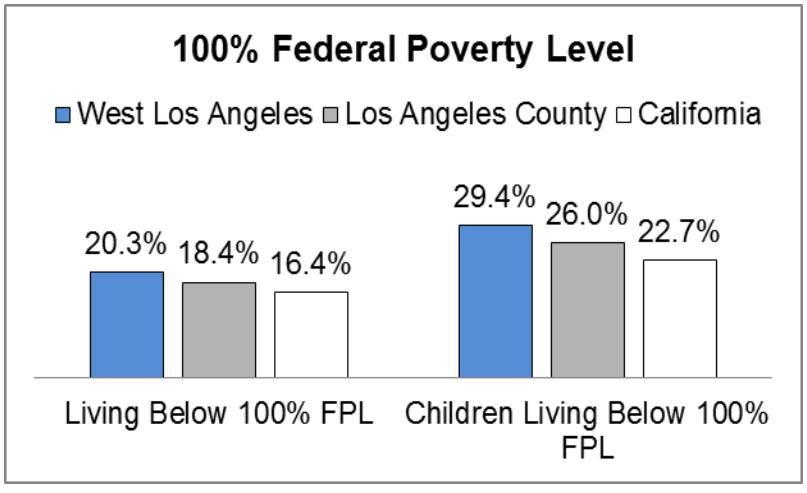
Economic security is integral to achieving health equity and for increasing the quality of a healthy life for everyone.

Economic security is critical to achieving health equity and leading a healthy life. Economic security encompasses socioeconomic factors such as poverty, employment, and level of education, which can have a significant influence on population health. It is important to understand the relationship between these factors and how people experience them.[xlvi] Living in poverty, being unemployed or underemployed, and having little to no education can contribute to poor health for a variety of reasons. Living in poverty may expose an individual to an unhealthy environment and conditions that contribute to the development of disease. Similarly, being unemployed or underemployed may limit the level of access an individual has to health care, healthy foods, and other basic necessities. Research has shown that education not only leads to better jobs and higher incomes but also affects the quality of life an individual leads.[xlvii]

Health Outcome Statistics

The KFH-West Los Angeles service area is characterized by high poverty, high unemployment rates, and low educational attainment. Certain communities are more affected by particular factors than others.

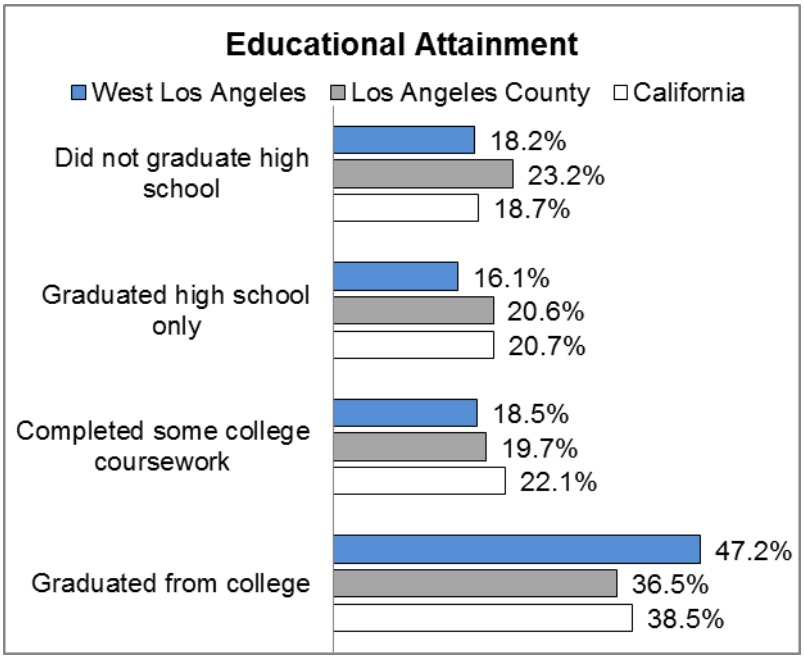
Poverty. In the KFH-West Los Angeles service area, 20.3% of the population was living at 100% of the Federal Poverty Level—a rate higher than in Los Angeles County (18.4%) or California (16.4%). In addition, almost a third (29.4%) of the children in the service area lived at 100% of the Federal Poverty Level. This was higher when compared to Los Angeles County (26.0%) and California (22.7%).



Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

Unemployment. The unemployment rate in the KFH-West Los Angeles service area was 8.6, the same as for Los Angeles County but higher than the rate in California of 8.3.

Education Level. A large portion (34.3%) of the population age 25 and older in the KFH-West Los Angeles service area either did not graduate high school (18.2%) or only had a high school education (16.1%). These percentages were lower when compared to Los Angeles County (23.2% and 20.6%, respectively) and California (18.7% and 20.67%, respectively).



Source: Nielsen Claritas Site Reports, 2015, ZIP Code

Health Disparities

Hispanic/Latino populations have the greatest percent (28.7%) of the population below 100% FPL, followed by Black/African-Americans (24.3%), and Native Americans (24.0%). Stakeholders stated that the working class, African-Americans, and residents of areas where there are high concentrations of immigrants are most affected.

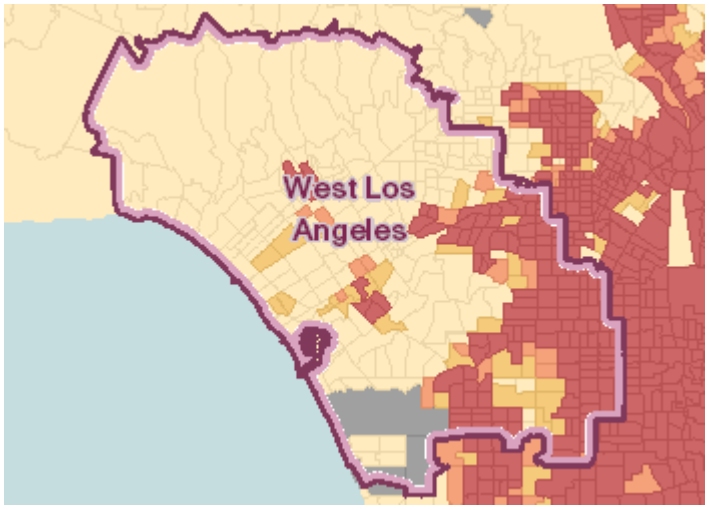
Communities Affected (No High School Diploma):

- Arlington Heights
- Jefferson Park
- Inglewood
- Lennox
- South Los Angeles
- West Adams
- West Athens
- Westmont

Community Perspective

"Many families ask themselves how they are going to pay rent, buy groceries, and pay their light bill?"

—Community Outreach Worker/*Promotora*



Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2010-14

- Over 21.0%
- 16.1–21.0%
- 11.1–16.0%
- Under 11.1%
- No Data or Data Suppressed
- Report Area

Source: U.S. Census Bureau, American Community Survey, 2010-14, Tract

Key Health Drivers/Factors

Economic security can affect an individual's ability to access healthy foods and other basic necessities. Not having the financial means to access transportation may limit one's ability to get to work, access the medical care they need, and live a high-quality life.

Social & Economic

Transportation. Having access to a car or other form of transportation is often necessary to obtaining health care. In the KFH-West Los Angeles service area, a greater percentage of households (11.1%) reported not having a car than in Los Angeles County (9.7%) or California (7.8%).

Households Without a Car

KFH-West Los Angeles Service Area	L.A. County	California
11.1%	9.7%	7.8%

Source: Percent of the of households with no motor vehicle, U.S. Census Bureau, American Community Survey, 2009-13, Tract.

Unemployment

In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) than in California (8.3). Within the KFH-Kaiser Permanente, 20.3% of the population lived in households with income below 100% the Federal Poverty Level (FPL). Hispanic/Latino populations have the greatest percent (28.7%) of the population below 100% FPL, followed by Black/African-Americans (24.31%), and Native Americans (24.0%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Assets & Opportunities

Stakeholders did not share any resources associated with economic security. This list is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

- **Chrysalis**
  At the core of Chrysalis' program are its job-readiness classes and services. In tandem with these classes, employment specialists assist clients throughout their self-directed job search by providing individualized support, counseling clients in goal setting, and providing referrals to a range of other services, including child care, housing, healthcare, legal services, and mental health support.
  http://www.changelives.org/
- **West Angeles Community Development Corporation**
  The Economic Development Department of West Angeles Community Development Corporation aims to reverse the trend of disinvestment in inner-city commercial districts by redeveloping state-of-the-art commercial properties as well as offering programs, education, and resources for individuals and families that will create momentum for ongoing improvements in the lives of people who live and work in the Crenshaw District and surrounding South Los Angeles communities.
  http://www.westangelescdc.org/index.html
- **Worksource Centers—**http://www.worksourcecalifornia.com/
  West Hollywood—Jewish Vocational Services—West Hollywood AJCC
  Tel: (310) 652-6378
  Compton—Community Career Development Compton AJCC
  Tel: (310) 762-1101
  Inglewood—South Bay One-Stop Business & Career Center Inglewood
  Tel: (310) 680-3700
  Southeast L.A.—Southeast L.A. Crenshaw WorkSource Center
  Tel: (323) 730-7900
  South Los Angeles—South Los Angeles WorkSource Center Community Centers Inc.
  Tel: (323) 752-2115
  West Adams—West Adams-Baldwin Hills Satellite WorkSource Center L.A. Urban League
  Tel: (323) 525-3740
  Culver City—Mar Vista Gardens Satellite
  Tel: (310) 915-0531
  Marina del Rey—Marina del Rey WorkSource Center operated by Jewish Vocational Services
  Tel: (310) 309-6000

Homelessness and Housing in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 5

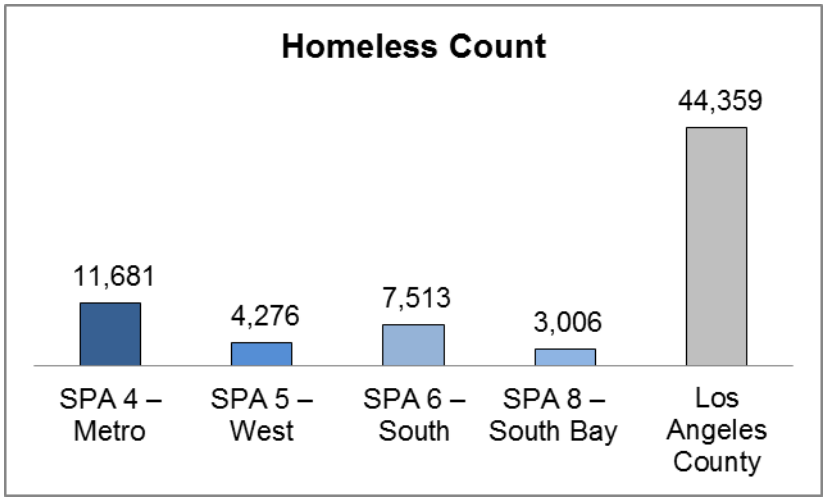
Homelessness and poor housing conditions affect individual health and can lead to chronic health issues.

Homelessness and poor housing conditions are intertwined with health in many ways. As a result of poor housing conditions, someone can be susceptible to the development or worsening of health conditions.[xlviii] Being homeless not only contributes to the development of health problems, but can also exacerbate existing problems as a result of not having stable housing or a safe and healthy place to recover from an illness.[xlix] Housing conditions including overcrowding, not having the appropriate plumbing or kitchen facilities, and unaffordable rents and mortgages, all of which can affect health and overall quality of life. [l]

Health Outcome Statistics

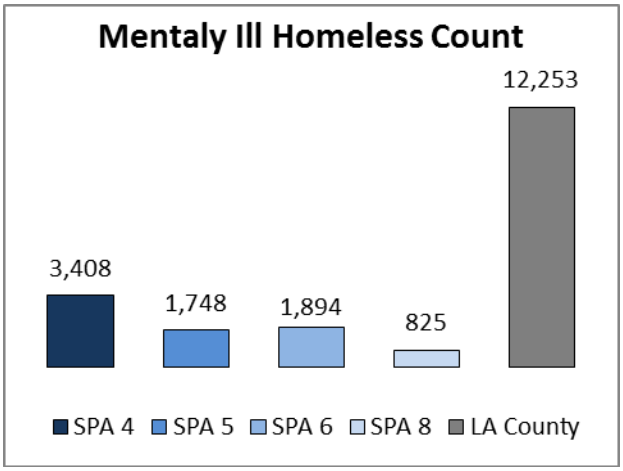
SPAs in the KFH-West Los Angeles service area have a large number of homeless individuals and families, as well as individuals and families living in poor housing conditions.

Homelessness. As of 2015, Los Angeles County had an estimated 44,359 homeless people. Most homeless in the service area are within SPA 4–Metro (44.1%) and SPA 8–South Bay (28.4%). The homeless counts represented in this section are for entire service planning areas, and do not provide accurate representations of homelessness in the KFH-West Los Angeles service area. Most of that service area falls in SPA 5–West and SPA 6–South, with only small portions being in SPA 4–Metro and SPA 8–South Bay.

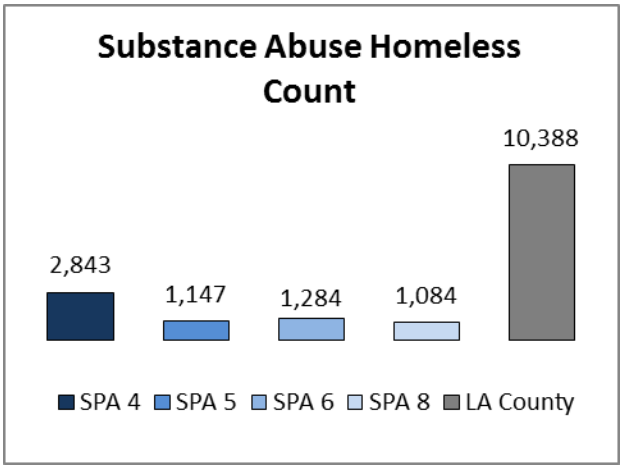


Source: Homeless Count, Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2015, SPA

Homeless count by special population. Of the estimated 4,276 homeless in SPA 5–West, 40.9% were mentally ill, and 26.8% had substance abuse issues, while in SPA 4–Metro were mentally ill. 29.7% were mentally ill and 24.3% were dealing with substance abuse issues.

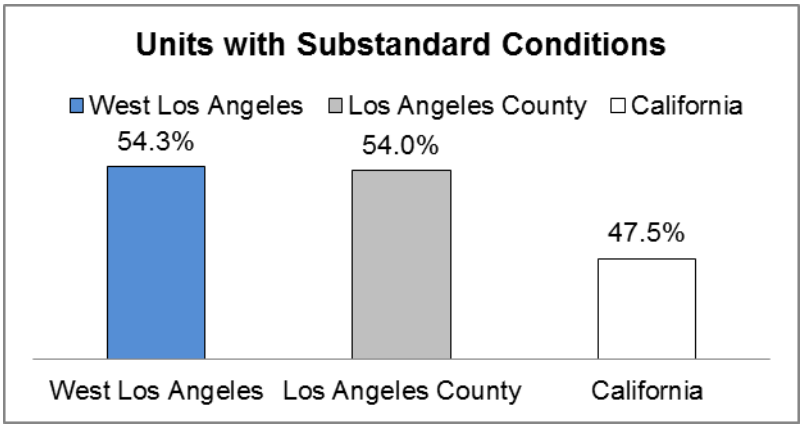


Source: Homeless County by Special Population, Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2015, SPA



Source: Homeless County by Special Population, Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2015, SPA

Housing. Substandard housing conditions include 1) a lack of complete plumbing facilities, 2) a lack of complete kitchen facilities, 3) having 1.01 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. In the KFH-West Los Angeles service area, over half (54.3%) the population lives in housing with one or more of these conditions, a similar percentage to that reported for Los Angeles County (54.0%) and higher than in California (47.5%).



Source: U.S. Census Bureau, American Community Survey, 2010–14, Tract

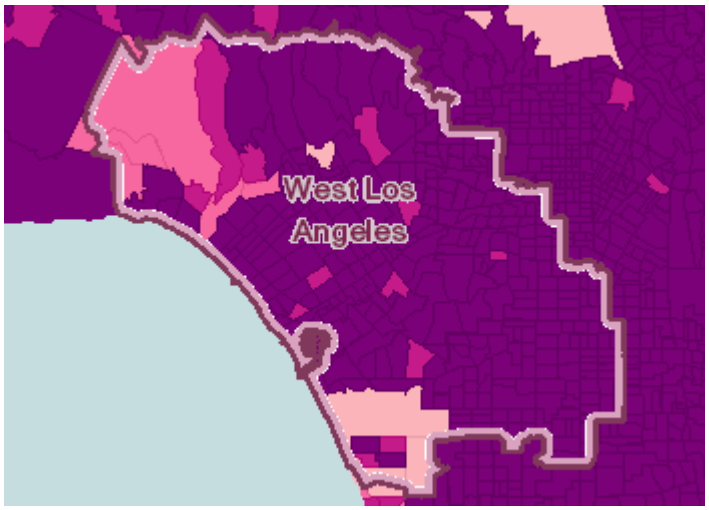
Health Disparities

Health disparities in most of the KFH-West Los Angeles service area with highest percentage of households with substandard conditions are located in the southeast portion of the service area. Stakeholders specified that the communities of Venice, Santa Monica, Van Nuys, Downtown Los Angeles, Watts-Willowbrook, and South East Los Angeles were most affected by homelessness and poor housing conditions. Stakeholders added that transitional youth, war veterans, and the mentally ill and chronically ill were most affected by homelessness.

Stakeholders also added that families and individuals often cannot find affordable, good-quality housing and end up living in poor housing conditions.

Communities Most Affected (Housing Units with Substandard Conditions):

- Arlington Heights
- Jefferson Park
- Inglewood
- Lennox
- South Los Angeles
- West Adams
- West Athens
- Westmont



Substandard Housing Units, Percent of Total by Tract, ACS 2010-14

Over 34.0%
28.1–34.0%
22.1–28.0%
Under 22.1%
No Data or Data Suppressed
Report Area

Source: U.S. Census Bureau, American Community Survey, 2010-14, Tract

Key Health Drivers/Factors

Economic security can affect an individual's ability to access healthy foods and other basic necessities, including good-quality housing. In addition, not having the financial means to access transportation may limit their ability to get to work, access the medical care they need, and live a high quality life.

Social & Economic

Poverty. Financial instability creates barriers to insurance coverage, health services, healthy food, and other necessities like good-quality housing.[li] In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) than in California (8.3). The percentage of the population in the KFH-West Los Angeles service area living 200% below the Federal Poverty Level (FPL) was also higher (40.0%) when compared to California (35.9%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Population below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Assets & Opportunities

The following list provides assets that were identified through phone interviews, focus groups, and through the KFH-West Los Angeles grant program. It is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

- **Abode Communities**
  Creates service-enhanced affordable housing and socially beneficial community facilities that promote the social, economic, and physical transformation of underserved communities.
  http://abodecommunities.org/site/
- **Children's Hospital Los Angeles**
  The Homeless Adolescent and Young Adult Wellness Center (HAWC) provides integrated services for runaway and homeless youth between the ages of 12 and 24. In 2013, Children's Hospital Los Angeles provided medical care to 1,964 homeless youth and more than 700 youth at high risk for homelessness. Free comprehensive care, counseling, and case management services are offered through the HAWC clinic at The Teen and Young Adult Clinic.
  http://www.chla.org/homeless-adolescent-and-young-adult-wellness-center
- **Chrysalis**
  At the core of Chrysalis' program are job-readiness classes and services. In tandem with these classes, employment specialists assist clients throughout their self-directed job search by providing individualized support, counseling clients in goal setting, and providing referrals to a range of other services, including: child care, housing, healthcare, legal services, and mental health support.
  http://www.changelives.org/
- **Covenant House**
  Covenant House was founded in 1972 with the simple, profound mission to help homeless kids escape the streets. Today it is the largest privately funded charity in the Americas providing

loving care and vital services to homeless, abandoned, abused, trafficked, and exploited youth.
https://www.covenanthouse.org/

- **Hollywood Homeless Youth Partnership (HHYP)**
  A partnership of youth-serving agencies that prevent and reduce homelessness among youth and young adults.
  http://hhyp.org/
- **Home for Good**
  http://homeforgoodla.org/
- **HOPICS**
  Assists individuals with rebuilding their support networks by way of addressing their immediate housing needs and developing a long-term plan for success.
  http://www.hopics.org/
- **Housing Authority of the City of Los Angeles**
  http://www.hacla.org/
- **Los Angeles Homeless Service Authority: LAHSA**
  Supports, creates and sustains solutions to homelessness in Los Angeles County by providing leadership, advocacy, planning, and management of program funding.
  https://www.lahsa.org/
- **Midtown Los Angeles Homeless Coalition**
  The Midtown Los Angeles Homeless Coalition is made up of local resident and business groups, government agencies, and social service organizations working together to address chronic homelessness in the midtown Los Angeles area.
  https://midtownlosangeleshomelesscoalition.wordpress.com/
- **My Friends Place**
  My Friends Place assists and inspires homeless youth to build self-sufficient lives.
  http://myfriendsplace.org/
- **Ocean Park Community Center (OPCC)**
  Links clients with permanent supportive housing and interim and emergency housing. Provides ongoing supportive services to ensure that the individual retains his or her housing.
  https://www.opcc.net/
- **Saint Joseph's Center**
  St. Joseph Center's mission is to provide working-poor families, as well as homeless men, women, and children of all ages, with the inner resources and tools to become productive, stable, and self-supporting members of the community.
  http://www.stjosephctr.org/
- **Sanctuary of Hope**
  The Sanctuary of Hope is a refuge for unwed mothers and orphaned children.
  http://www.sohcares.org/
- **U.S. Veterans Initiative**
  Offers temporary assistance to at-risk, low-income families in an effort to keep them from becoming homeless.
  http://www.usvetsinc.org/
- **Venice Community Housing**

The mission of Venice Community Housing is to reduce homelessness, maximize affordable housing, empower residents, provide social services, and advocate for public policy that protects and strengthens the economic, racial, and cultural diversity of Venice and other neighborhoods on the Westside of Los Angeles.
http://www.vchcorp.org/

- **West Angeles Community Development Corporation**
  Develops housing that is affordable for working families, educates first-time home buyers, and provides access to financing in South Los Angeles.
  http://www.westangelescdc.org/index.html
- **Westside Coalition**
  Westside Coalition is an alliance of over 40 organizations, public agencies and faith communities committed to ending hunger and homelessness through service coordination, public education and advocacy.
  http://www.westsideshelter.org/

Legal (Immigration) Status in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 15

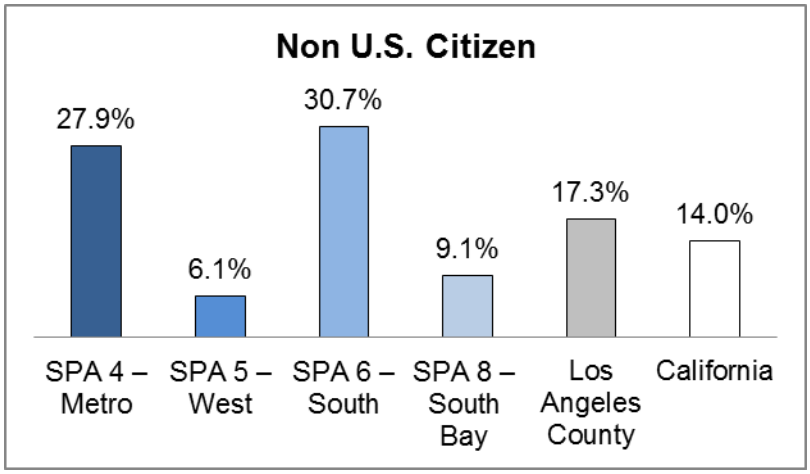
Legal or immigration status is a barrier for many immigrants, both documented and undocumented to the ability to live a healthy life.

Legal or immigration status has often been found to be a barrier to receiving proper health care and living a healthy life. Although immigrants—both documented and undocumented—often arrive in the United States in relatively good health, it is the inability to access affordable and high-quality health care that contributes to their development of health issues. This is often exacerbated by both low socioeconomic status and a lack of English proficiency.[lii] Although not all immigrants are eligible, the Affordable Care Act has generally improved access to health care, including for those who are undocumented and the Dreamers (individuals who are lawfully present through the Deferred Action for Childhood Arrivals).[liii] A critical factor that contributes to poor health is the inability to communicate effectively. A health care professional can be limited by both language barriers as well as cultural sensitivity and understanding.

Health Outcome Statistics

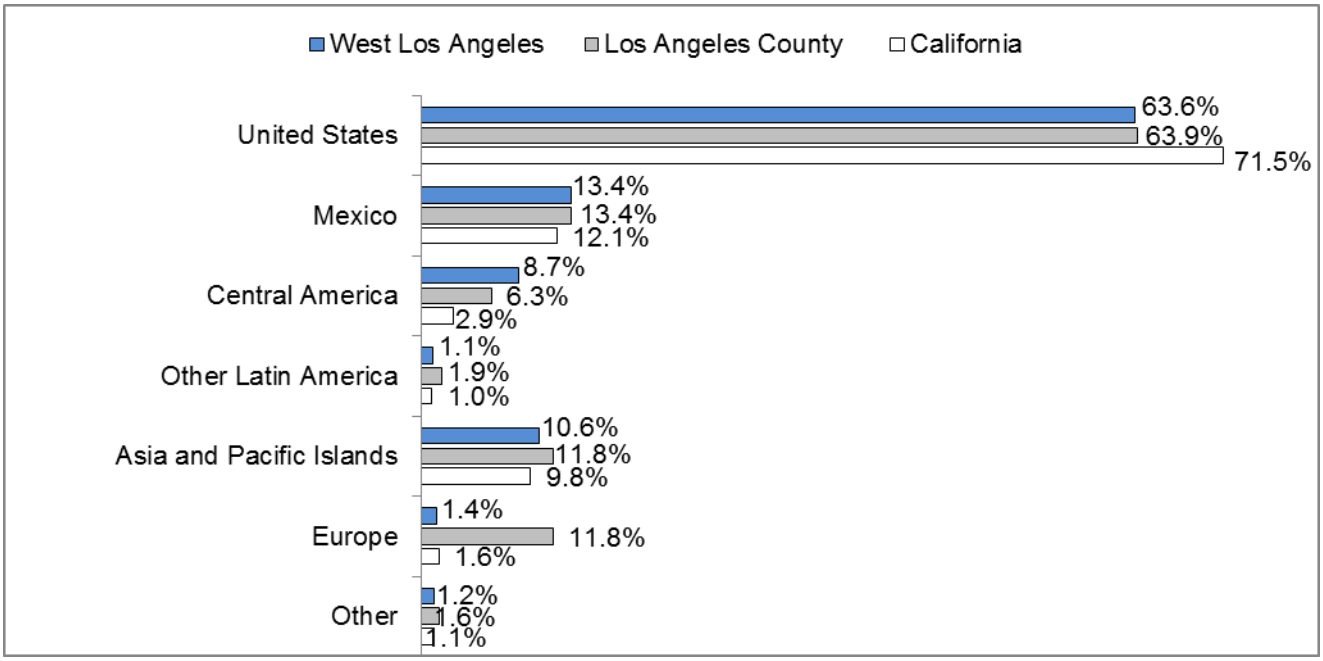
A large percentage of the population in the KFH-West Los Angeles service area is non–U.S. citizens originating mostly from Mexico or Asia and the Pacific Islands. Stakeholders reported many residents in the area who are undocumented are unable to receive health care.

Citizenship. In the KFH-West Los Angeles service area, a larger percentage (18.6%) of the population are not United States citizens than in either Los Angeles County (17.3%) or California (14.0%). Nearly a third (30.7%) of the those living in SPA 6–South and more than a quarter in SPA 4–Metro (27.9%) were not United States citizens.



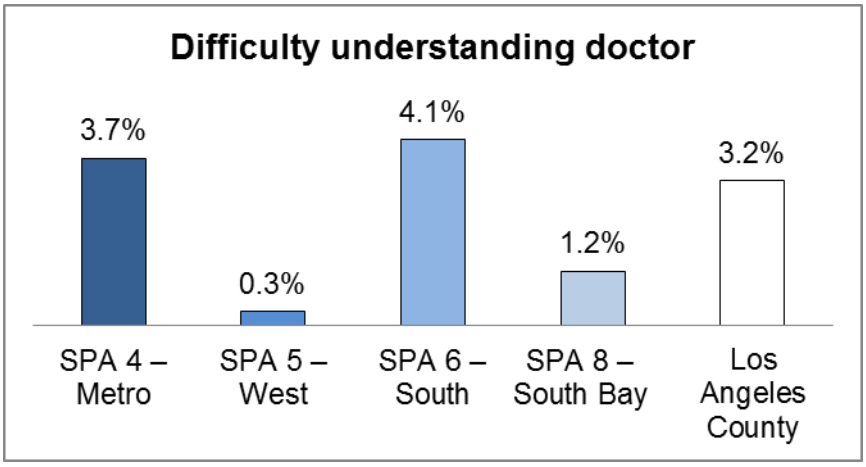
Source: Percentage who are not United States citizens, California Health Interview Survey, 2014, SPA.

Country of Origin. Most of the population in the KFH-West Los Angeles service area were born in the United States (63.6%)—slightly fewer than in Los Angeles County (63.9%) and fewer than in California (71.5%). Almost a quarter (23.2%) were born in a Latin American country, which is a higher percentage when compared to Los Angeles County (21.6%) and California (16.0%).



Source: Country of birth, California Health Interview Survey, 2014, SPA.

Language. In the service area, a larger percentage of those living in SPA 4–Metro (3.7%) and SPA 6–South (4.1%) reported having a difficult time understanding their doctor when compared to Los Angeles County (3.2%).



Source: Percentage who had a difficulty understanding a doctor, California Health Interview Survey, 2014, SPA

Health Disparities

Stakeholders mentioned that undocumented populations experience the most difficulty when trying to access health care services, and that these are compounded by the Affordable Care Act, which does provide coverage for them. The undocumented are also forced to use clinics that are often overburdened and have a complex process patients must go through to receive care.

Key Health Drivers/Factors

Citizenship status can have an impact on an individual's level of health care access and quality of medical service.

Social & Economic

Poverty. Financial instability creates barriers to insurance coverage, health services, healthy food, and other necessities like good-quality housing.[liv] In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) than in California (8.3). The percentage of the population in the KFH-West Los Angeles service area living 200% below the Federal Poverty Level (FPL) was also higher (40.0%) when compared to California (35.9%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Population below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Assets & Opportunities

Stakeholders did not share any resources associated with legal status. This following list is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

- **Adult Education**
  Adult education is a public education program for all adults. Adult schools offer free to low-cost classes for adults 18 years and older.
  http://www.cde.ca.gov/sp/ae/
- **CARECEN**
  The Central American Resource Center (CARECEN) is a nonprofit organization that offers low-cost immigration legal services, community education programs.

http://www.carecen-la.org/

- **CHIRLA**
  Promotes harmonious multi-ethnic and multi-racial human relations; and through coalition-building, advocacy, community education and organizing, empower immigrants and their allies to build a more just society.
  http://www.chirla.org/
- **MALDEF**
  MALDEF promotes social change through advocacy, communications, community education, and litigation in the areas of education, employment, immigration rights, and political access.
  http://www.maldef.org/

Mental Health in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 1

Mental illness is a major and complex health issue; if left untreated, it may leave individuals at-risk for substance abuse, self-destructive behavior, and suicide.

Mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression, and outcome of chronic diseases.[lv] Mental illnesses such as depression and anxiety affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.[lvi] New mental health issues have emerged among some special populations, such as veterans who have experienced physical and mental trauma; people in communities with psychological trauma caused by natural disasters and exposure to violence; and older adults, as the awareness, understanding and treatment of dementia and mood disorders continues to improve.[lvii] The stigma associated with mental health causes suffering, potentially leading a person to deny symptoms, delay treatment, and refrain from daily activities.

Health Outcome Statistics

The KFH-West Los Angeles service area is experiencing more or the same amount of mental health related issues than Los Angeles County and/or California. Particular issues include general mental health status, depression, anxiety, alcohol and drug related hospitalizations, access to mental health providers and services, mental health-related hospitalization, and suicide.

Prevalence. The KFH-West Los Angeles service area population experienced an average of four mentally unhealthy days per month, the same as to that reported in Los Angeles County. [lviii] [lix]

Higher percentages of adults were diagnosed with depression in SPA 4–Metro (13.4%) and SPA 5–West (13.4%) than in Los Angeles County (12.2%), and higher percentages were diagnosed with anxiety in SPA 5–West (13.7%) and SPA 4–Metro (12.0%) than in Los Angeles County (11.3%).

Mental Health Diagnoses, 2011

Report Area	Depression	Anxiety
SPA 4–Metro	13.4%	12.0%
SPA 5–West	13.4%	13.7%
SPA 6–South	10.8%	10.1%
SPA 8–South	10.7%	10.2%
Los Angeles County	12.2%	11.3%

Source: Los Angeles County Health Survey, 2011, SPA

A third of teens age 14 to 17 in SPA 5–West (30.1%) and SPA 6–South (30.4%)—representing larger areas of the service area—reported being at risk for depression. Percentages in these SPAs are well above the average for Los Angeles County (23.1%) and California (21.0%). Adults were also at risk for depression, though not as much as teens. However, a greater percentage of adults in SPA 6–South (13.3%) and SPA 4–Metro (11.6%) reported being at risk for depression than in Los Angeles County (10.4%).

At Risk for Depression, 2011, 2014

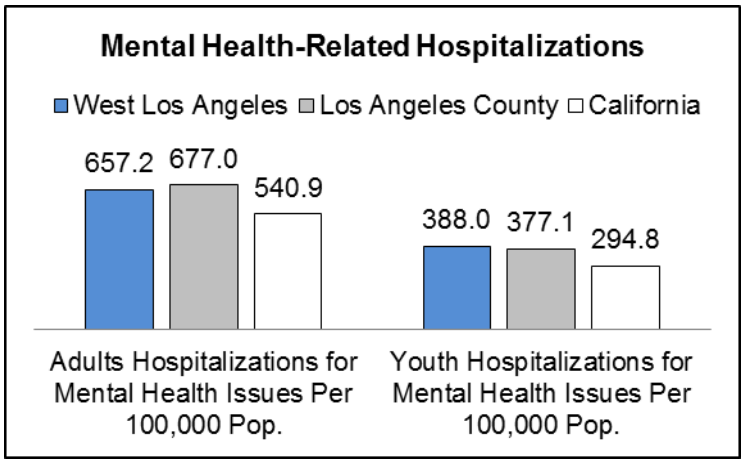
Report Area	Teens[1]	Adults[2]
SPA 4–Metro	22.0%	11.6%
SPA 5–West	30.1%	5.8%
SPA 6–South	30.4%	13.3%
SPA 8–South Bay	18.8%	9.3%
Los Angeles	23.1%	10.4%
California	21.0%	

Source: California Health Interview Survey, 2014, SPA[1]

Source: Los Angeles County Health Survey, 2011, SPA[2]

Access. The rate of mental health providers per 100,000 population in the KFH-West Los Angeles service area was lower (149.5) when compared to California (157.0).[lx] Accessibility to mental health providers is extremely limited, leading to various implications for the community.

Hospitalizations. In the KFH-West Los Angeles service area, mental health–related hospitalization rates were higher when compared to Los Angeles County and California. In the KFH-West Los Angeles service area the mental health hospitalization rate per 100,000 adults was much higher (657.2) when compared to California (540.9). While for youth, the mental health hospitalization rate per 100,000 was higher (388.0) when compared to Los Angeles County (377.1) and California (294.8).[lxi]



Rate of mental health hospitalizations per 100,000 adults, Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code

Mortality. The suicide rate in the KFH-West Los Angeles service area was slightly higher (1.1) than the Healthy People 2020 goal of <=1.0.[lxii]

Health Disparities

Of all races and ethnicities, Non-Hispanic White populations had the highest rate of death due to intentional self-harm (suicide) per 100,000 population (11.9) and the highest percentage of adults who self-report seeking mental health in the past 12 months (21.8%). This rate and percent are higher than that reported for the KFH-West Los Angeles service

area (7.3 and 18.0%, respectively). Stakeholders observed health disparities among Hispanic/Latinos, Non-Hispanic Whites, youth (18 years and younger). Geographic disparities were observed in communities mostly located in the eastern and central part of the KFH-West Los Angeles service area.

Communities Most Affected (Experienced Higher Hospitalization Rates Among Youth And Adults):

- Baldwin Hills
- Crenshaw
- Leimert Park
- Century City
- Culver City
- Downtown Santa Monica
- Hyde Park, View Park, Windsor Hills
- South Los Angeles
- West Adams
- West Fairfax
- West Hollywood

Stakeholders identified other groups at risk, including Hispanic/Latinos, Black/African-Americans, the LGBT community, homeless populations, pre-teens and teens, foster youth, single mothers (in general and post-partum), veterans, those experiencing grief, victims of domestic violence, substance abusers, and the mentally and physically-disabled. Stakeholders also further verified that school-age children do not receive the support they need at school.

Key Health Drivers/Factors

Mental health is associated with factors that include poverty, heavy alcohol consumption, and unemployment. Stakeholders mentioned the a lack of resources, funding. training, and education among health care professionals to properly address the needs of mental health patients.

Social & Economic

Poverty. Financial instability creates barriers to insurance coverage, health services, healthy food, and other necessities like good-quality housing.[lxiii] In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) than in California (8.3). The percentage of the population in the KFH-West Los Angeles service area living 200% below the Federal Poverty Level (FPL) was also higher (40.0%) when compared to California (35.9%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Population below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Health Behaviors

Alcohol. Alcohol use, including binge-drinking, is a behavior that may contribute to the development of mental health and behavioral issues.[lxiv] In the KFH-West Los Angeles service area, the percentage of household expenditures on alcohol was higher (13.1%) when compared to California (12.9%).

Alcohol Expenditures

KFH-West Los Angeles service area	California
13.1%	12.9%

Source: Alcohol Expenditures, Nielsen, Nielsen Site Reports. 2014, Tract

Assets & Opportunities

Numerous assets and resources are available to respond to the health needs within a given community, including health care facilities, community organizations, and public agencies. The following list provides assets that were identified through phone interviews and focus groups, and/or through the KFH-West Los Angeles grant program. It list is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org

Mental Health–Specific Providers: A limited number of mental health providers are located in and around the easternmost part of the KFH-West Los Angeles service area, where the need is highest.

- **AMAAD Institute**
  http://www.amaad.org/
- **Airport Marina Counseling Service**
  www.airportmarina.org
- **Alcott Center for Mental Health Services**
  www.alcottcenter.org
- **Brotman Medical Center**

www.brotmanmedicalcenter.com

- **CASA Los Angeles**
  http://casala.org/
- **Catholic Charities of Los Angeles, Inc.—My Club Drop in Center**
  Provides free individual and family counseling, crisis counseling, and case management for youth ages 10 to 17 in L.A. County.
  http://catholiccharitiesla.org/where-we-are/program-directory-by-city/
- **Centinela Youth Services**
  http://www.cys-la.org/
- **Child Guidance Clinic**
  http://www.lacgc.org/
- **Coalition of Mental Health Professionals, Inc.**
  Provides a variety of service including counseling and domestic violence, and sexual assault services to residents in South L.A. for a fixed fee or on a sliding scale.
  http://mentalhealthprofessionals.org/
- **Community Clinic Association of Los Angeles County (CCALAC)**
  www.ccalac.org
- **Community Coalition Kinship Program**
  http://cocosouthla.org/new-kinship-program-helps-relative-caregivers-find-support/
- **Didi Hirsch Mental Health Services**
  Provides affordable mental health services including counseling, case management, medication, and other related services.
  www.didihirsch.org
- **Grandparents as Parents**
  http://grandparentsasparents.org/
- **IDOM Industries Inc.—Crenshaw**
  Provides a variety of services including counseling and crisis intervention to youth and adults in L.A. County for free or on a sliding scale.
  http://www.idomindustries.org/
- **Jenesse Center**
  https://www.jenesse.org/
- **Kaiser Permanente Watts Counseling and Learning Center**
  http://community.kp.org/be-informed/program/watts-counseling-and-learning-center
- **Kedren Community Mental Health Center**
  www.kedren.org
- **Los Angeles County Department of Mental Health**
  www.dmh.lacouonty.gov
- **Midnight Mission**
  http://www.midnightmission.org/
- **NAMI—Westside; Urban Los Angeles**
  www.namila.org
- **Open Paths Counseling Center**
  http://openpaths.org/

- **Pacific Clinics**
  www.pacificclinics.org/
- **SHIELDS for Families**
  Provides a variety of mental health services including individual and family counseling, case management, and other relevant services for families in South L.A. for free or on a sliding scale.
  https://www.shieldsforfamilies.org/
- **Sanctuary of Hope**
  www.thesoh.org/
- **Southern California Counseling Center**
  https://sccc-la.org/
- **St. John's Well Child and Family Center**
  Provides free counseling for low-income L.A. County residents.
  www.wellchild.org/
- **Step Up on Second**
  www.stepuponsecond.org
- **The Laurel Foundation**
  www.laurel-foundation.org
- **The Promises Foundation**
  http://promisesfoundation.org/
- **UCLA Resnick Neuropsychiatric Hospital**
  https://www.uclahealth.org/resnick
- **Veterans Administration (VA) Greater Los Angeles Healthcare System**
  www.losangeles.va.gov
- **West Angeles Community Development Corporation Young in L.A. Program**
  www.westangelescdc.org/
- **WISE and Health Aging**
  http://www.wiseandhealthyaging.org/

Alcohol and Drug-Related Services: The New You Center Inc.
Provides alcoholism treatment and counseling for youth and adults on a sliding scale.
http://www.thenewyoucenter.org/

- **SHIELDS for Families**
  Provides alcohol and substance abuse education, prevention and treatment for families in South L.A. for free or on a sliding scale.
  https://www.**shieldsforfamilies**.org

Crisis Response and Hotlines: Many mental health providers have crisis hotlines that community members may access.

- **Didi Hirsch Mental Health Services**
  Suicide prevention hotline: 877-7CRISIS-Suicide
  www.**didihirsch**.org
- **The Trevor Lifeline**
  Suicide prevention for youth and adults in the LGBT community: (866) 488-7386
  www.**thetrevorproject**.org/

Overweight and Obesity in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 3

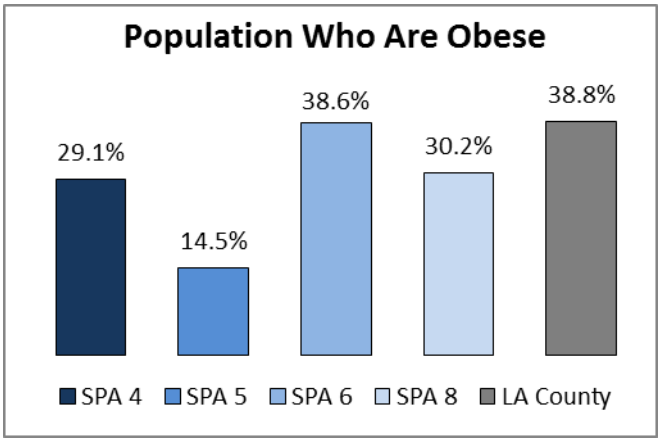
Obesity is defined as having a body mass index (BMI) of 30.0 or higher, and being overweight is defined by a BMI between 25.0 and 29.9.

Excess weight is a significant national problem and indicates an unhealthy lifestyle that influences further health issues. Obesity reduces life expectancy and causes devastating and costly health problems, increasing the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases.[lxv] Being overweight or obese results from a combination of causes and contributing factors, including individual factors such as behavior and genetics. Behaviors can include dietary patterns, physical activity or inactivity, medication use, and other exposures. Additional contributing factors in our society include the food and physical activity environment, education and skills, and food marketing and promotion. Some Americans have less access to stores and markets that provide healthy, affordable food such as fruits and vegetables, especially in rural, minority, and lower-income neighborhoods. Obesity in particular is a serious concern because it is associated with a reduced quality of life and many serious diseases and health conditions, including diabetes, heart disease, stroke, high blood pressure (hypertension), high cholesterol, and mental illnesses such as clinical depression and anxiety.[lxvi] Findings suggest that obesity also increases the risks for cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types.[lxvii]

Health Outcome Statistics

The KFH-West Los Angeles (KFH-West Los Angeles) service area has a larger portion of its population who are overweight and obese when compared to Los Angeles County and California. The issue has become more prevalent among youth over the years. Stakeholders agree that children as young as 12 years old have obesity/overweight issues.

Prevalence. Within the KFH-West Los Angeles service area, the population in SPA 6–South (38.6%) had the highest percentage of the population that was obese. This percentage is lower than in Los Angeles County (38.8%).

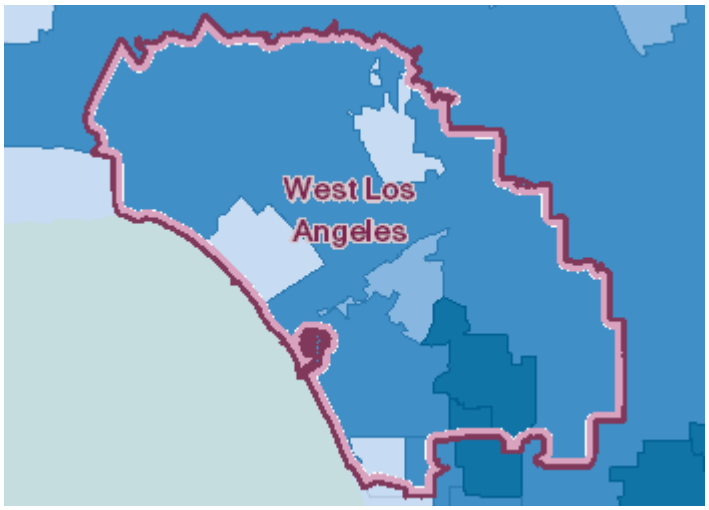


Health Disparities

The percentage of Hispanic/Latino children (in grades 5, 7, and 9) who were considered obese was much higher than for any other race or ethnicity (28.1%). This rate is higher than reported for the KFH-West Los Angeles service area (23.9%). Stakeholders noted health disparities were observed among Hispanic/Latinos, Black/African-Americans, and those between the ages of 12 and 17. Health disparities were observed in the southernmost part of the KFH-West Los Angeles service area.

Communities Most Affected (Teens Who Are Overweight/Obese):

- Inglewood
- Ladera Heights
- Lennox



Students Obese/in 'High Risk' Zone for Body Composition , Percent by School District (Elementary), FITNESSGRAM 2013-14

Over 26.0%
18.1–26.0%
10.1–18.0%
Under 10.1%
No Data or Data Suppressed
Report Area

Source: Percent of youth in grades 5, 7, and 9 who are obese, California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14, School District

As with diabetes, stakeholders identified unhealthy eating habits as a large contributor to developing overweight/obesity, citing a number of factors: a lack of time to cook healthy meals (most adults and parents work long hours), lack of access to fresh foods in low-income neighborhoods, the perception that healthy and fresh groceries are expensive, the ease of access to and low cost of fast foods, and a lack of oversight on children's nutrition resulting from parents' work outside the home. A lack of proper physical activity is also named as a contributing factor, and most stakeholders agree that parents need to push their children to pursue more physical activity. Some parents do not because they are not present to encourage these behaviors, or because neighborhoods are not safe enough for children to play outside.

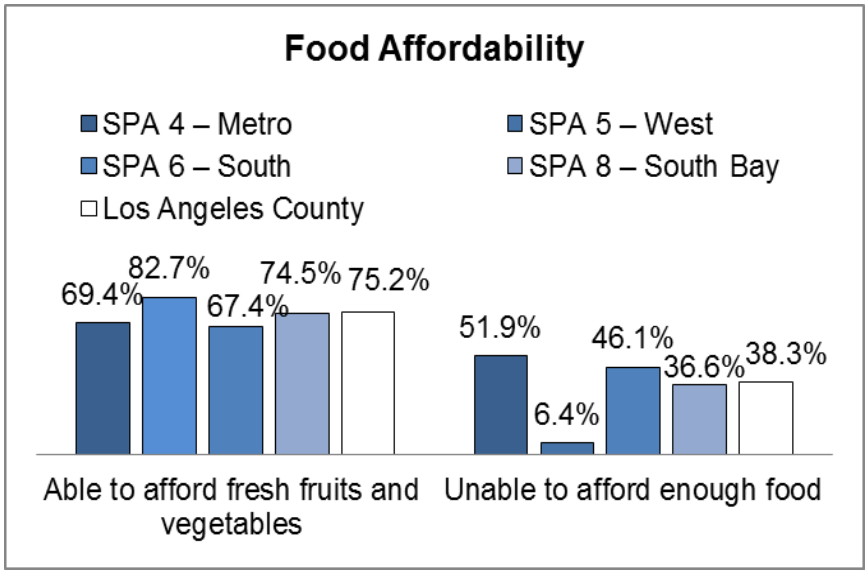
Key Health Drivers/Factors

Obesity is associated with increased risk of cardiovascular disease, stroke, high blood pressure, diabetes, and a number of other health issues.[lxviii] Obesity is also associated with the lack of physical

activity, access to healthy food option, access to safe green space like parks and other social and economic issues.

Social & Economic

Affordability. In the KFH-West Los Angeles service area, a smaller portion of those living in SPA 4–Metro (69.4%) SPA 6–South (67.4%) were able to afford fresh fruits and vegetables than in Los Angeles County (75.2%). However, addition, a larger percentage of those in SPA 4–Metro (51.9%) and SPA 6–South (46.1%) were able to afford enough food when compared to Los Angeles County (38.3%).



Source: Able to afford fresh fruits and vegetables, California Health Interview Survey, 2014, SPA. Unable to afford enough food, California Health Interview Survey, 2014, SPA.

Health Outcome(s)

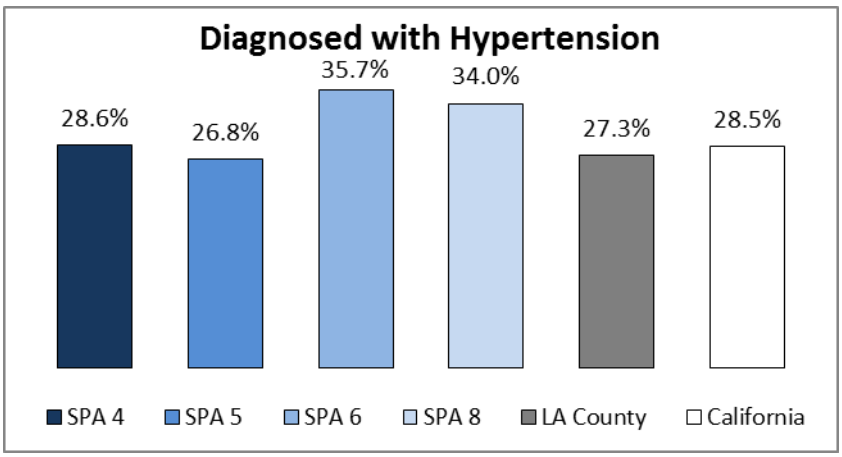
Cardiovascular Disease. Being overweight or obese often leads to health issues, including cardiovascular disease. In the KFH-West Los Angeles service area, a larger rate (397.1 per 100,000 population) were hospitalized for heart disease than in Los Angeles County (366.6) or California (339.0).

Heart Disease Hospitalization Rate Per 100,000 Population

West Los Angeles	L.A. County	HP2020
397.1	366.6	339.0

Source: Rate of heart disease-related hospitalizations per 100,000 population, Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code.

Hypertension. About 60% of diabetics are very likely to develop heart disease at some point in their lives.[lxix] Over a third of residents in SPA 6–South (35.7%) and SPA 8–South Bay (34.0%) were diagnosed with hypertension. These percentages are higher when compared to Los Angeles County (27.3%) and California (28.5%).



Physical Environment

Fast-Food Establishments. Environmental influences such as ready access to fast food rather than healthy food options is a critical factor that contributes to poor health outcomes such as obesity. In the KFH-West Los Angeles service area, the rate of fast-food establishments per 100,000 population was higher (85.2) when compared to Los Angeles County (77.8) and California (74.5).

Fast-Food Establishments

KFH-West Los Angeles Service Area	L.A. County	California
85.2	77.8	74.5

Source: Fast food establishment rate per 100,000 population, U.S. Census Bureau, County Business Patterns, 2011, Tract.

Health Behaviors

Physical Activity. A lack of physical activity is a contributing factor to developing health issues, including obesity. In the KFH-West Los Angeles service area, a larger percentage (43.1%) of youth was physically inactive than in Los Angeles County (40.0%) or California (35.9%).

Youth Who Are Physically Inactive

KFH-West Los Angeles Service Area	L.A. County	California
43.1%	40.0%	35.9%

Source: Percent of youth who are physically inactive, California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14, School District.

Assets & Opportunities

Stakeholders identified a variety of assets in the community related to obesity, including those that address obesity directly and indirectly though nutrition-related resources.

The following list provides assets that were identified through phone interviews and focus groups, and/or through the KFH-West Los Angeles grant program. It list is not intended to be a comprehensive list of resources in the community, additional resources can be found at www.211.org.

Also refer to the following health need profile for additional resources: Diabetes, Cardiovascular Health and Access to Healthy Food.

Obesity/Overweight–Specific Assets

- **Church Programs**
  Many churches have developed programs around health and nutrition.
- **Connections For Children**
  Building healthy nutrition and activity habits in child care settings to prevent childhood obesity
  www.connectionsforchildren.org
- **Crenshaw Family YMCA—PLAY (Physical Learning Activities for Youth)**
  www.ymcala.org/crenshaw
- **Heal One World—Fit Right In, Making Health Choices A Habit**
  www.healoneworld.com
- **"Healthy Environment, Active Living," Camp HEAL**
  A faith-based community initiative of the Obesity and Diabetes Program of Children's Hospital Los Angeles (CHLA) and New Mount Calvary Missionary Baptist Church. Camp HEAL is dedicated to developing physical, emotional, and spiritual health in a way that resonates with the young campers.
  http://www.chla.org/blog/community-programs/faith-based-summer-camp-promotes-%E2%80%9Chealthy-environment-active-living%E2%80%9D
- **LAUSD Nutrition Programs**
  The LAUSD Food Services Division has a variety of programs that serve health-conscious meals at reduced-prices during the school year and summer. They also provide nutrition education to children and parents at Early Education Centers.
  http://achieve.lausd.net/Page/462
- **Los Angeles Brotherhood Crusade—Nutrition Education Obesity Prevention Program**
  www.brotherhoodcrusade.org
- **Nutrition Classes**
  Specific programs were not named, but stakeholders described a need for more education programs. For example: show people how to make traditional meals (e.g., fried chicken and fries) in a healthier manner (e.g., baked chicken with baked potatoes); how to cook and serve appropriate food portions; teach people how to prepare and serve healthier foods they are not familiar with.

- **REACH Partners in Health, by Community Health Councils (CHC)**
  The project collaborates with CHC, the Los Angeles County Department of Public Health, the Los Angeles Unified School District, and University of Southern California researchers. It is designed to reduce disparities in obesity rates and hypertension for African Americans and Hispanic/Latino residents in the West Adams, Baldwin Hills, and South Los Angeles Community Plan Area of South Los Angeles. The goals are to improve the quality of nutrition and physical activity in schools, adopt and implement the medical home model in FQHCs, and update individual community plans.
  http://chc-inc.org/reach-2013
- **St. John's Well Child and Family Center, Inc.—Kids N Fitness**
  www.wellchild.org
- **The South Central Foundation for Fitness, Dance and Arts**
  Partnering with South Los Angeles community clinics to build healthier communities by promoting self-healing behavioral changes
  (424)456-4770
- **University Muslim Medical Association Community Clinic—Triple Threat Impact Initiative**
  www.ummaclinic.org
- **Weight management programs**
  Corporate weight management programs with exercise plans, eating plans, and supplements, such as Herbalife.

Nutrition-Related Services

- **Black Women for Wellness—Sisters in Motion**
  www.bwwla.com
- **Community Gardens**
  There are more than 125 community gardens in Los Angeles County. The L.A. Garden Council has a mapping tool to find a garden.
  http://lagardencouncil.org/find-a-garden/
- **Farmers markets**
- **Food banks**
  Community food banks and church-sponsored food banks. The Los Angeles Regional Food bank has a mapping tool to find local food banks and food pantries.
  https://www.lafoodbank.org/get-help/pantry-locator/
- **Mar Vista Family Center—Health and Wellness Program**
  www.marvistafc.org
- **Meals on Wheels**
  Nonprofit, volunteer community service organization that provides nutritious meals and friendship to individuals who are unable to plan, shop, or prepare meals for themselves because of illness, disability, or advanced age.
  http://www.mealsonwheelswla.org/
- **Seeds of Hope**
  A group of congregations and organizations in the L.A. area that coordinate food distribution services for families, seniors, and others in need**.**
  http://www.ladiocese.org/seedsofhope/home.html

- **Social and Environmental Entrepreneurs**
  Comprehensive nutrition education and emotional support program for low-income families in South L.A.
  www.saveourplanet.org
- **Worksite Wellness L.A.—Project Health Lunch**
  www.worksitewellnessla.org

Preventive Health Care in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 6

Preventive health care services are essential for early detection and treatment of health problems such as heart disease, cancer and diabetes.

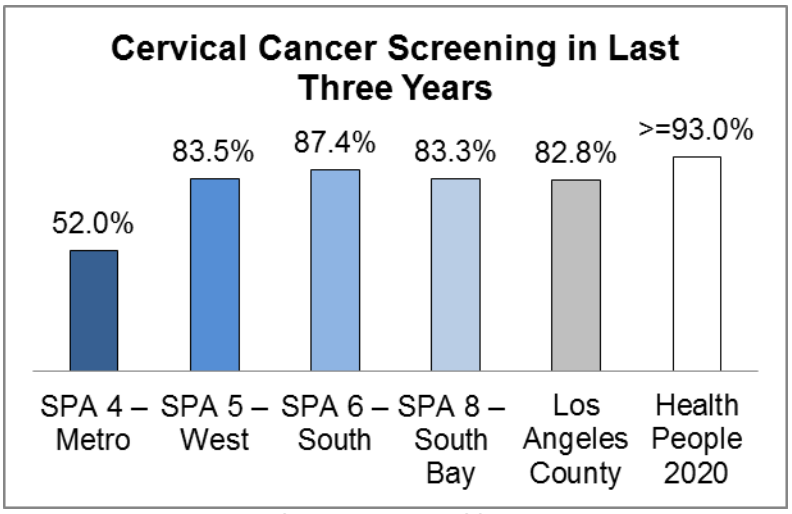
Accessing preventive health care services in a timely manner is essential to preventing the development of chronic diseases. Preventive health services include health screenings, doctor visits for regular checkups, and vaccinations.[lxx] Regular checkups can help detect health problems early in development, avoiding bigger problems in the future. A health provider can also lend education to their patients that may help them recognize changes in their body, leading to early detection and treatment for health problems.[lxxi] Opportunities for prevention affect everyone regardless of income level, age, or health status. Every year, potentially preventable health problems such as heart disease, cancer and diabetes are responsible for premature deaths. Although the Affordable Care Act has increased access for many by forcing health insurance providers to cover certain preventable health services at no additional cost, many are still not accessing these services. [lxxii]

Health Outcome Statistics

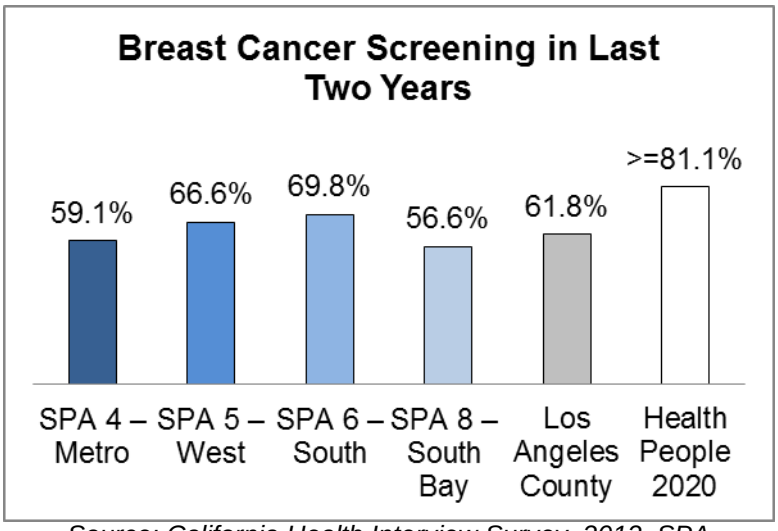
The KFH-West Los Angeles service area is experiencing high rates of preventable hospitalizations.

Health Screenings. In the KFH-West Los Angeles service area, the percentage of women receiving cervical cancer screenings in the past three years was higher (84.1%) than in Los Angeles County (82.8%) but did not meet the Healthy People 2020 goal of >=93.0%.

A similar percentage (61.7%) of women in the service area had a mammogram in the last two years when compared to women in Los Angeles County (61.8%), though the percentage was lower than for women in California (65.1%) and did not meet the Healthy People 2020 goal of >=81.1%. Mammogram rates were lower for women living in SPA 4–Metro (59.1%) and SPA 8–South Bay (56.6%).



Source: Los Angeles County Health Survey, 2011, SPA



Source: California Health Interview Survey, 2012, SPA

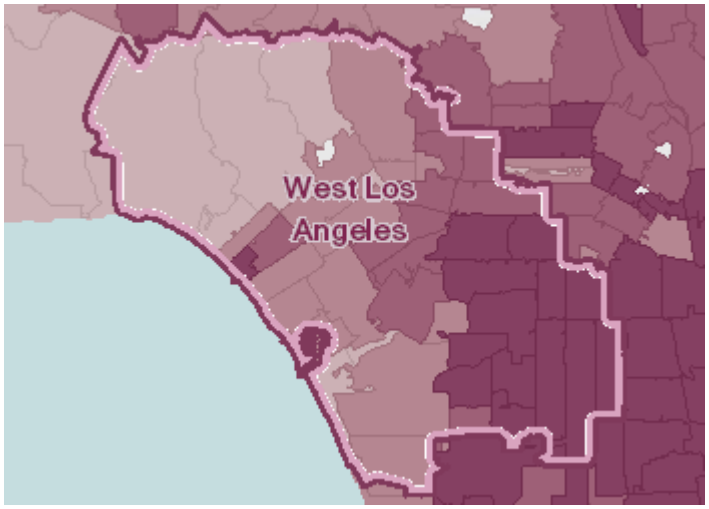
Hospitalizations. In the KFH-West Los Angeles service area, the hospital discharge rate for preventable hospital events was higher (119.9 per 10,000 population) when compared to Los Angeles County (92.2) and California (102.9).

Health Disparities

Health disparities were observed in the southeast portion of the KFH-West Los Angeles service area (see map below). Stakeholders expressed that access to preventive health care services were most difficult for immigrants who did not speak English proficiently.

Communities Most Affected (Preventable-Condition Hospital Discharges):

- Inglewood
- South Los Angeles
- Westmont
- West Athens



Preventable (ACS) Condition Hospital Discharges, Rate (Per 10,000 Population) by ZCTA, OSHPD 2011

- Over 120.0
- 80.1–120.0
- 50.1–80.0
- Under 50.1
- No Data or Data Suppressed
- Report Area

Source: California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data. Additional data analysis by CARES, 2011, ZIP Code

Key Health Drivers/Factors

As with access to health care, it is important to follow preventive practices such as having a regular source of care and timely physical and medical tests. Adequate, regular primary care can help maintain a positive health status and prevent the onset of health issues.

Social & Economic

Poverty. Financial instability creates barriers to insurance coverage, health services, healthy food, and other necessities like preventive health care.[lxxiii] In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) than in California (8.3). The percentage of the population in the KFH-West Los Angeles service area living 200% below the Federal Poverty Level (FPL) was also higher (40.0%) when compared to California (35.9%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Population below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Transportation. Having access to a car or other form of transportation is often necessary to obtaining health care. In the KFH-West Los Angeles service area, a greater percentage of households (11.1%) reported not having a car than in Los Angeles County (9.7%) or California (7.8%).

Households Without a Car

KFH-West Los Angeles Service Area	L.A. County	California
11.1%	9.7%	7.8%

Source: Percent of the of households with no motor vehicle, U.S. Census Bureau, American Community Survey, 2009-13, Tract.

Assets & Opportunities

A small number of health care facilities—including Federally Funded Health Centers (FQHCs), hospitals, and general medical care facilities (n=60)—were identified within the KFH-West Los Angeles service area.

Please refer to Access to Care health need profile for additional resources.

Sexually Transmitted Diseases in the KFH-West Los Angeles Service Area

Description & Significance

Ranked No. 22

Sexually transmitted diseases (STDs) refer to more than 25 infectious organisms that are transmitted primarily through sexual activity.

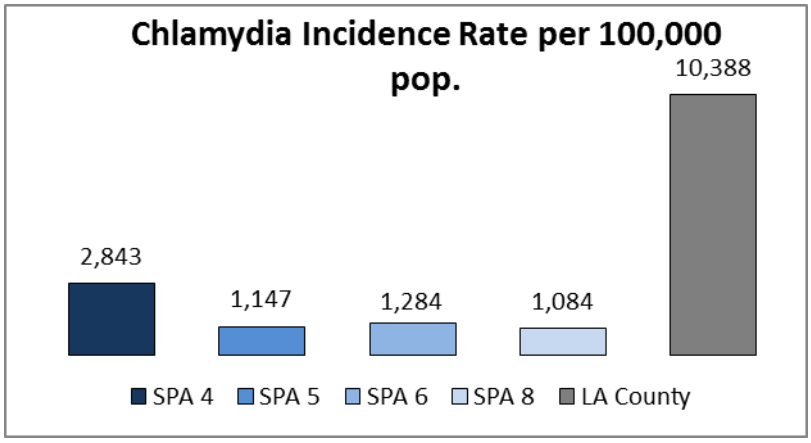
STD prevention is an essential primary care strategy for improving reproductive health.[lxxiv] Despite their burdens, costs, and complications—and the fact that they are largely preventable—STDs remain a significant public health problem in the United States, considered by some to be largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications with reproductive health, fetal and perinatal health problems and cancer, and the facilitated sexual transmission of HIV.[lxxv]

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

Health Outcome Statistics

The KFH-West Los Angeles service area is experiencing higher STD infections rates, particularly as related to chlamydia, gonorrhea, and syphilis.

Incidence. Within the KFH-West Los Angeles service area, SPA 4–Metro reported more (2,843) chlamydia infections (i.e., incidences) per 100,000 population when compared to Los Angeles County (10,388).



Health Disparities

Stakeholders mentioned health disparities were observed among teens and young adults, the homeless, drug users, sex workers, and the LGBT community.

Community Perspective

> **"STDs, including HIV and AIDS, are rapidly growing among the homeless, drug users, sex workers, the LGBT community, African Americans, teens, young adults, and the elderly."**
>
> **—Social Worker**

Adolescents ages 15 to 24 account for nearly half of the 20 million new cases of STDs each year. Today, four in 10 sexually active teen girls have had an STD that can cause infertility and even death. STDs often have no obvious signs or physical symptoms, so regular screenings are critical.[lxxviii] Certain racial and ethnic groups (mainly African-American, Hispanic/Latino, and American Indian/Alaska Native populations) have higher rates of STDs compared to Whites. However, differences in Department of Pulbic Health reporting may account for some of these disparities. Race and ethnicity in the United States are correlated with other determinants of health status, such as poverty, limited access to health care, fewer attempts to seek medical treatment, and living in communities with high rates of STDs.[lxxix]

Stakeholders agreed and emphasized that young adults between age 12 and 25 are at risk. They added that many Asian women working at karaoke rooms and parlor rooms were at risk for contracting STDs as well.

Key Health Drivers/Factors

Sexually transmitted diseases (STDs) are often associated with unprotected sex with an infected partner. Other factors that may contribute to contracting an STD include lack of transportation, lack of access to affordable STD prevention services, and the perceived stigma attached to STDs.[lxxx]

Clinical Care

Affordable Care. The ability to access to affordable health care is essential to getting timely treatment for an injury and avoiding premature death or a long-term disability. In the KFH-West Los Angeles service area. 20.5% of the population did not have health insurance—higher when compared to California (17.8%) but lower than in Los Angeles County (22.2%).

Uninsured Population

KFH-West Los Angeles Service Area	L.A. County	California
20.5%	22.2%	17.8%

Source: Percent who are uninsured, U.S. Census Bureau, American Community Survey, 2009-13, Tract.

Health Screenings. Receiving Pap smears every three years is essential to identifying an STD early enough to receive care, prevent future health issues, and reduce the likelihood of spreading the infection. A large percentage of women age 18 to 74 (82.8%) received Pap smears in the suggested timeframe in Los Angeles County—though not enough to meet the Healthy People 2020 goal of >=93.0%.

Received a Pap Smear in the Past 3 Years

L.A. County	HP2020
82.8%	>=93.0%

Source: Percent of women 18–74 years old who had a Pap smear in the past 3 years, Los Angeles County Health Interview Survey, 2011, SPA.

Social & Economic

Poverty. Poverty creates financial instability and limits access to insurance coverage, health services, healthy food, and other necessities.[lxxxi] In the KFH-West Los Angeles service area in 2015, the unemployment rate was higher (8.6) when compared to California (8.3). In addition, the percentage of the population in the KFH-West Los Angeles service area living at 200% below the Federal Poverty Level (FPL) was higher (40.0%) when compared to California (35.9%).

Unemployment Rate

KFH-West Los Angeles Service Area	L.A. County	California
8.6	8.6	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2016–March, County

Population Living Below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Transportation. Having access to a car or other form of transportation is often necessary to obtaining health care. In the KFH-West Los Angeles service area a greater percentage of households (11.1%) reported not having a car when compared to households in Los Angeles County (9.7%) and California (7.8%).

Households Without a Car

KFH-West Los Angeles Service Area	L.A. County	California
11.1%	9.7%	7.8%

Source: Percent of households with no motor vehicle, U.S. Census Bureau, American Community Survey, 2009-13, Tract.

Assets & Opportunities

Stakeholders provided a few assets that specifically address STDs. The following list provides assets that were identified through phone interviews and focus groups, and/or through the KFH-West Los Angeles grant program. It is not intended to be a comprehensive

list of resources in the community, additional resources can be found at www.211.org.

STD-Specific Assets

- **AIDS Drug Assistance Program (ADAP)**
  www.aahivm.org
- **AIDS Healthcare Foundation**
  Medical services for people living with HIV/AIDS, mobile testing and counseling for HIV and STDs, testing and counseling for HIV at Out of the Closet Thrift Stores, and hospice care.
  http://www.aidshealth.org/#/
- **AIDS Project Los Angeles (APLA) Health and Wellness Division**
  APLA Dental Services offers a full range of dental care for people living with HIV/AIDS via a mobile dental clinic.
  For more information call (213) 201-1388.
- **Alliance for Housing and Healing**
  Nurse case management team, HIV/AIDS group home
  www.alliancehh.org
- **APLA Health & Wellness**
  Pre-Exposure Prophylaxis (PrEP) education campaign for low-income LGBT Individuals in South Los Angeles
  www.apla.org
- **Asian American Drug Abuse Program—Survivor for Wellness**
  www.aadapinc.org
- **Being Alive**
  http://beingalivela.org
- **Cedars-Sinai Medical Center**
  http://cedars-sinai.edu
- **Common Ground—The Westside HIV Community Center**
  http://commongroundhiv.org/
- **Community Clinic Association of Los Angeles County**
  http://ccalac.org
- **In the Meantime Men's Group, Inc.**
  www.inthemeantime.org
- **Minority AIDS Project—G.L.A.M.O.R.**
  www.minorityaidsproject.org
- **Northeast Community Clinics—Foshay Clinic**
  www.northeastcommunity**clinics**.com
- **Planned Parenthood**
  Planned Parenthood delivers reproductive health care, sex education, and information.
  https://www.plannedparenthood.org/planned-parenthood-los-angeles
- **South Bay Family Healthcare Center**
  200 HIV tests and 600 STD tests to low-income residents of Kaiser West L.A.'s service area through its Inglewood clinic
  www.sbclinic.org

- **To Help Everyone Clinic—T.H.E. Wellness Center at Crenshaw High School**
  www.tohelpeveryone.org
- **Watts Healthcare Corporation**
  www.**watts**health.org

Violence and Injury Prevention in the KFH-West Los Angeles Service Area

Description & Significance

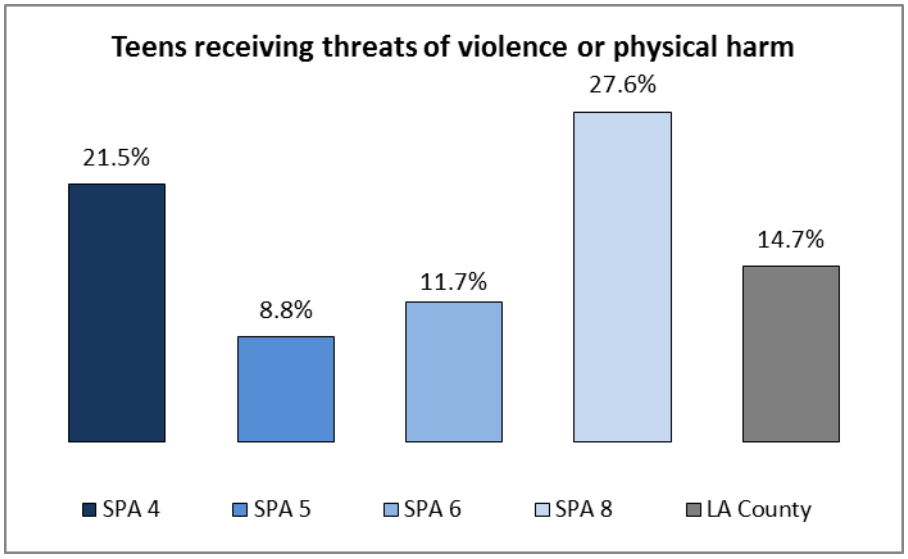
Ranked No. 8

Motor vehicle accidents, homicide, domestic and school violence, child abuse and neglect, suicide, and unintentional drug overdoses are important public health concerns in the United States and locally.

Both unintentional injuries and those caused by acts of violence are among the top 15 killers of Americans of all ages.[lxxxii] Injuries are the leading cause of death for Americans age 1 to 44, and a leading cause of disability for all ages, regardless of sex, race, ethnicity, or socioeconomic status. Many intentional and unintentional injuries are preventable. They can be caused by a number of events, such as motor vehicle accidents and physical assault, and can occur virtually anywhere. No matter the circumstances, injuries can have serious, painful, and debilitating physical and emotional health consequences, many long term or permanent, including: hospitalization, brain injury, poor mental health, disability, and premature death.[lxxxiii]

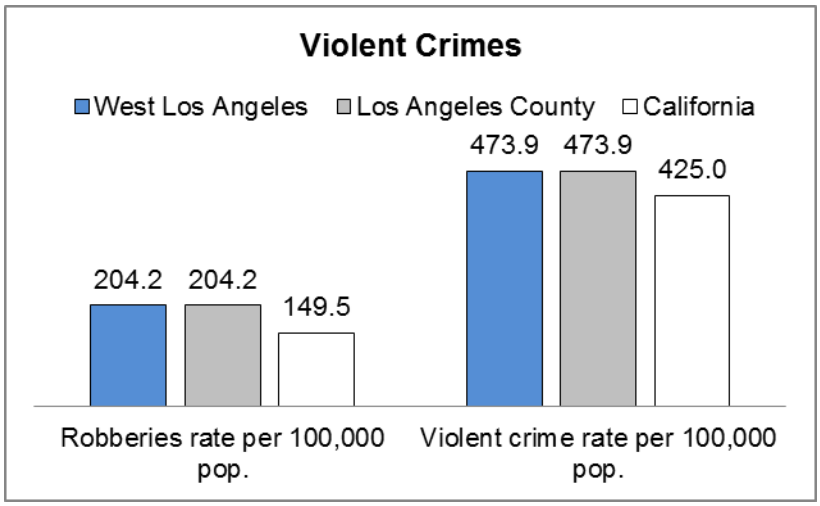
Health Outcome Statistics

The KFH-West Los Angeles service area is experiencing high rates of community violence that results in physical harm and often hospitalizations. Percentages of teens receiving threats of violence in SPA 8–South Bay (27.6%), and SPA 4–Metro (21.5%) are higher than the percentage reported for Los Angeles County (14.7%).



Hospitalizations. In the KFH-West Los Angeles service area, the hospitalization rate of those age 18 and younger for firearm-related injuries was higher (12.2 per 100,000 youth) than in Los Angeles County (5.4) and California (4.2).[lxxxiv]

Mortality. In the KFH-West Los Angeles service area, the homicide rate was also higher (9.2 per 100,000 population) than in Los Angeles County (6.0) or California (5.2), and did not meet the Healthy People 2020 goal of <=5.5.[lxxxv]



Source: Rates of robberies per 100,000 population Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research, 2010-12, County.

Rate of violent crimes per 100,000 population Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research, 2010-12, County.

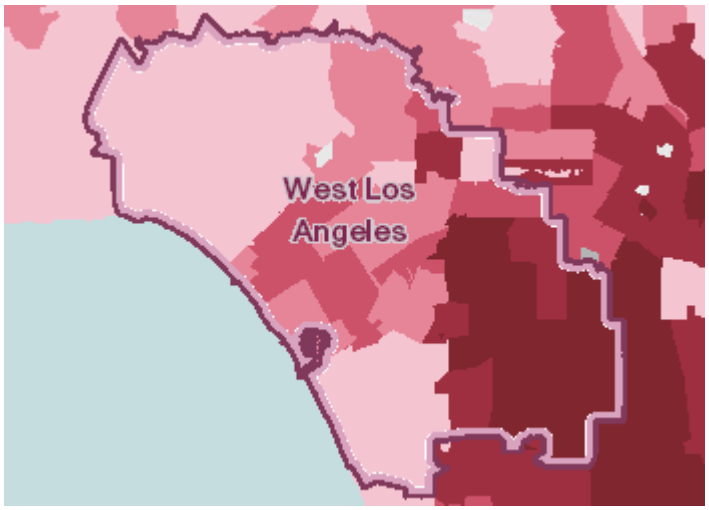
The rate of pedestrians killed by motor vehicle per 100,000 population was higher in the KFH-West Los Angeles service area (2.9) than in Los Angeles County (2.3) and California (2.0), and did not meet the Healthy People 2020 goal of <=1.3.[lxxxvi]

Health Disparities

Stakeholders observed disparities in Black/African-Americans, youth, young men, women, and in the southeast and in small pockets of the central east portions of the KFH-West Los Angeles service area.

Communities Most Affected (Non-Fatal Hospitalizations And Homicides):

- Arlington City
- Hyde Park
- Inglewood
- Jefferson Park
- Ladera Heights
- South Los Angeles
- Venice
- West Adams
- West Athens
- West Hollywood
- Westmont



Homicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by ZCTA, CDPH 2010-12

- Over 12.0
- 6.1–12.0
- 3.1–6.0
- Under 3.1
- No Homicide Deaths
- No Data or Data Suppressed
- Report Area

Source: Rate of homicides per 100,000 population, University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health (CDPH) Death Public Use Data, 2010–12, ZIP Code.

Stakeholders endorsed the health disparities observed, and added that violence occurs heavily among homeless populations. They further emphasized that victims of sex trafficking and abuse were also vulnerable to domestic and sexual violence. Stakeholders stated that domestic violence went hand-in-hand with sexual abuse and often took place in low-income neighborhoods. Geographically, they stated that pockets of gang activity and violence took place in poor areas of the Westside, including Hollywood and in housing projects in Culver City and Santa Monica. Reported areas of improvement were Mar Vista Gardens, Slauson, and Inglewood.

Key Health Drivers/Factors

Violence and injuries are associated with a number of factors, including individual behaviors, physical environment, access to health services, and social environment/community.[lxxxvii]

Clinical Care

Affordable Care. The ability to access to affordable health care is essential to getting timely treatment for an injury and avoiding premature death or a long-term disability. In the KFH-West Los Angeles service area. 20.5% of the population did not have health insurance—higher when compared to California (17.8%) but lower than in Los Angeles County (22.2%).

Uninsured Population

KFH-West Los Angeles Service Area	L.A. County	California
20.5%	22.2%	17.8%

Source: Percent who are uninsured, U.S. Census Bureau, American Community Survey, 2009-13, Tract.

Health Behaviors

Alcohol. Alcohol use, including binge-drinking, is a behavior that may contribute to the development of mental health and behavioral issues.[lxxxviii] In the KFH-West Los Angeles service area, the percentage of household expenditures on alcohol was higher (13.1%) when compared to California (12.9%).

Alcohol Expenditures

KFH-West Los Angeles service area	California
13.1%	12.9%

Source: Alcohol Expenditures, Nielsen, Nielsen Site Reports. 2014, Tract

Social & Economic

Poverty. Financial instability creates barriers to insurance coverage, health services, healthy food, and other necessities like preventive health care.[lxxxix] The percentage of the population in the KFH-West Los Angeles service area living 200% below the Federal Poverty Level (FPL) was also higher (40.0%) when compared to California (35.9%).

Population below 200% FPL

KFH-West Los Angeles Service Area	L.A. County	California
40.0%	40.3%	35.9%

Source: Population living below 200% Federal Poverty Level, U.S. Census Bureau, American Community Survey. 2009-13, Tract.

Assets & Opportunities

Stakeholders identified assets that address community safety as well as trauma, which are both factors associated with violence and injury. The following list provides assets that were identified through phone interviews and focus groups, and/or through the KFH-West Los Angeles grant program. It is not intended to be a comprehensive list of resources in the community; additional resources can be found at www.211.org.

Community Safety

- **City of Los Angeles Department of Recreation and Parks**
  Social service providers in the L.A. region offer an array of recreational programs to serve youth, adults, and seniors. The department maintains and operates athletic fields, playgrounds, recreation centers, and senior centers, and supports summer youth camps and the Summer Night Lights gang-reduction and community intervention program.
  http://www.laparks.org/
- **Boys & Girls Clubs**
  Community nonprofit organization that provides education, career, arts, and sports after-school

and weekend programs for children.
http://www.bgca.org/

- **YMCA**
  YMCA of Metropolitan Los Angeles is a nonprofit organization dedicated to strengthening the foundations of community through youth development, healthy living, and social responsibility. Los Angeles youth participate in Y programs ranging from preschool to wellness physical activities; for many low-income youth, the Y may be their only access to such activities.
  http://www.ymcala.org/
- **Santa Monica Police Activities League (PAL)**
  Public/private partnership operated by the City of Santa Monica; PAL is an after-school program that provides educational, cultural, fitness and recreational programs for youth ages 6 to 17.
  http://www.smpal.org/
- **L.A. Police Department Community Policing**
  http://www.lapdonline.org/support_lapd/content_basic_view/731
- **Los Angeles Police Department**
  www.lapdonline.org/
- **Santa Monica Police Department**
  https://santamonicapd.org/

Trauma

- **Domestic Violence Shelters**
  The domestic violence program's shelter-based operations provide emergency or transitional housing and services exclusively dedicated to survivors of domestic violence 24-hours a day, 365 days a year.
  http://dpss.lacounty.gov/dpss/sss/shelters.cfm
- **Emergency rooms**
- **Jenesse Center**
  https://www.jenesse.org/
- **L.A. County Department of Mental Health Referrals**
  http://dmh.lacounty.gov/wps/portal/dmh
- **Midnight Mission—Inglewood**
  http://www.midnightmission.org/
- **National Alliance on Mental Illness (NAMI)**
  Offers recovery education classes and support groups to aid mental illness and promote mental wellbeing.
  https://www.nami.org/
- **Urgent Care**
- **UCLA Hospitals and Medical Centers**
  https://www.uclahealth.org/Pages/locations/ucla-hospitals.aspx

Intentional-Injury Community Assets:

- **Centinela Youth Services**
  www.cys-la.org

- **Children's Institute, Inc.**
  www.childrensinstitute.org
- **City Lites**
  http://www.citylitesnetworkinc.org/
- **Healthy African American Families**
  www.haafii.org
- **Homies Unidos, Inc.**
  http://homiesunidos.org
- **Open Paths and Open PATHS Counseling Center**
  http://openpaths.org
- **Peace First Los Angeles**
  www.peacefirst.org
- **Ronald Reagan UCLA Medical Center**
  https://www.uclahealth.org/reagan
- **The Trevor Project**
  www.thetrevorproject.org

Appendix E: Glossary of Terms

The following terms are used throughout the Community Health Needs Assessment report. They represent concepts that are important to understanding the findings and analysis in this report.

Age-adjusted rate. The incidence or mortality rate of a disease can depend on the age distribution of a community. Because chronic diseases and some cancers affect older adults disproportionately, a community with a higher number of older adults might have a higher mortality or incidence rate of some diseases than another community that may have a higher number of younger people. An incidence or mortality rate that is **age-adjusted** takes into the consideration of the proportions of persons in corresponding age groups, which allows for more meaningful comparison between communities with different age distributions.

Benchmarks. A benchmark serves as a standard by which a community can determine how well or not well it is doing in comparison for specific health outcomes. For the purpose of this report, one of two benchmarks is used to make comparison with the medical center area. They are Healthy People 2020 objectives and state (California) averages.

Death rate. See ***Mortality rate***.

Disease burden. Disease burden refers to the impact of a health need not only on the health of the individuals affected by it, but also the financial cost in addressing this health need, such as public expenditures in addressing a health need. The burden of disease can also refer to the disproportionate impact of a disease on certain populations, which may negatively affect their quality of life and socioeconomic status.

Health condition. A health condition is a disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

Health disparity. Diseases and health problems do not affect all populations in the same way. Health disparity refers to the disproportionate impact of a disease or a health problem on specific populations. Much of research literature on health disparity focuses on racial and ethnic differences in how these communities experience the diseases, but health disparity can be correlated with gender, age, and other factors, such as veteran, disability, and housing status.

Health driver. Health drivers are behavioral, environmental, social, economic and clinical care factors that positively or negatively affect health. For example, smoking (behavior) is a health driver for lung cancer, and access to safe parks (environmental) is a health driver for obesity/overweight. Some health drivers, such as poverty or lack of insurance, affect multiple health needs.

Health indicator. A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.

Health outcome. A health outcome is a snapshot of a disease in a community that can be described in terms of both morbidity and mortality (e.g. breast cancer prevalence, lung cancer mortality, homicide rate, etc.).

Health need. A health need is a poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

Hospitalization rate. Hospitalization rate refers to the number of patients being admitted to a hospital and discharged for a disease, as a proportion of total population.

Incidence rate. Incidence rate is the number of *new* cases for a specific disease or health problem within a given time period. It is expressed either as a fraction (e.g. percentage) or a density rate (e.g., *x* number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with *prevalence rate*, which measures the proportion of people found to have a specific disease or health problem.

Morbidity rate. Morbidity rate refers to the frequency with which a disease appears within a population. It is often expressed as a *prevalence rate* or *incidence rate.*

Mortality rate. Mortality rate refers to the number of deaths in a population due to a disease. It is usually expressed as a density rate (e.g. *x* number of cases per 10,000 people). It is also referred to as “death rate.”

Prevalence rate. Prevalence rate is the proportion of total population that currently has a given disease or health problem. It is expressed either as a fraction (e.g., percentage) or a density rate (e.g., *x* number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with incidence rate, which focuses only on *new* cases. For instance, a community may experience a decrease in new cases of a certain disease (incidence) but an increase in the total of number suffering that disease (prevalence) because people are living longer due to better screening or treatment for that disease.

Primary data. Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this community health needs assessment, primary data were collected through focus groups and interviews with key stakeholders. These primary data describe what is important to the people who provide the information and are useful in interpreting secondary data.

Secondary data. Secondary data are data that have been collected and published by another entity. They are typically quantitative (numerical) in nature. Secondary data are useful in highlighting in an objective manner health outcomes that significantly affect a community.

Appendix F: Data Collection Protocols

CHNA 2016
Interview Protocol -

Introduction:
The Center for Nonprofit Management is working with Kaiser Permanente West Los Angeles Medical Center to conduct their 2016 Community Health Needs Assessment. We are talking to health experts to obtain their perspective on the most important health needs facing the local community and to identify areas of need as well as the availability of services to meet those needs. All the information collected will help Kaiser Permanente West Los Angeles Medical Center better serve their community. The information you provide is confidential and will not be associated with your name and will only be reported in an aggregated manner.

Familiarity with Medical Center:

Area of Expertise:

Primary Service Area:

Primary Population Served:

COMMUNITY HEALTH NEEDS AND ASSOCIATED DRIVERS

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

2. As a result of our review of community data, we have identified some significant health needs.

Health Needs	**Issues/Challenges/Barriers** Are there specific sub-populations (seniors, youth, others) and areas in the community that are most affected by this need? Has the health need gotten better or worse over the past 2-3 years?	**Resources: Services, Programs and/or Community Efforts** Where do community residents go to receive help or obtain information for this health need? In your experience, what are the most effective program /service delivery models for addressing this need?
Access to care: primary care, specialty care, medications, health insurance (Prompt: How has the Affordable Care Act (ACA) impacted community members' ability to access care and other services?)		

Cancer		
Chronic disease (asthma, diabetes, heart disease, HIV/AIDS, others)		
Community safety		
Dental care Vision care		
Homelessness / Housing		
Mental health		
Overweight/Obesity		
Preventive practices and services		

Substance abuse		
Other needs identified in question #1		

ACCESS TO CARE

3. What health or social services are **most difficult to access or are missing** in the community? *[DO NOT SAY ALOUD: This could include access to medical care that is affordable or free, health education workshops, dental care, vision care, substance abuse services, mental health care, etc.]*

    a. Are there socio-economic, behavioral, environmental or clinical factors that contribute to this?

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

COLLABORATION

4. What are the potential areas for **collaboration or coordination** among hospitals, community organizations, and/or businesses (i.e., health or social providers, local government, etc.) to address community health needs or specific socio-economic, behavioral, environmental or clinical factors?

COMMUNICATION

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

RANKING OF HEALTH NEEDS AND FACTORS/DRIVERS OF HEALTH

6. I would like to ask you to **rank the identified community health needs** on a scale of 1 to 5 according to severity where 1 is least severe and 5 is most severe.

   Note to facilitator: severity is defined as the level a health need or health factor/driver that affects the health and lives of those in the community.

7. Thinking of these health needs, I would like to ask you to prioritize each by indicating the level of importance that **the hospital** should place on addressing them; on a scale of 1 to 5, where 1 is not important to address and 5 is very important to address.

Health Needs	Severity 1-5	Importance 1-5
Access to care		
Asthma		
Cancer		
Community safety		
Dental care		
Diabetes		
Heart Disease		
HIV/AIDS		
Homelessness / Housing		
Mental health		
Overweight /Obesity		
Preventive practices and services		
Substance abuse		
Other needs identified in question #1		

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

9. Before we end the interview, is there anything else you would like to add?

Your responses have been very helpful.
Thank you for your time.

Kaiser Foundation Hospital KFH-BP CHNA 2016

Focus Group Protocol

Introduction:
The Center for Nonprofit Management is working with Kaiser Permanente West Los Angeles Medical Center to conduct their 2016 Community Health Needs Assessment. We are talking to health experts and providers to obtain their perspective on the most important health needs facing the local community and to identify areas of need as well as the availability of services to meet those needs. All the information collected will help Kaiser Permanente West Los Angeles Medical Center better serve their community. The information you provide is confidential and will not be associated with your name and will only be reported in an aggregated manner.

Note to Facilitator: *Review health data for the medical center and hospital to effectively probe where appropriate.*

****Go around the room and ask participants to briefly introduce themselves (1 minute).**

****Assure that all participants fill out the short Provider Survey.**

COMMUNITY HEALTH NEEDS AND ASSOCIATED DRIVERS

Note to Facilitator: (Create 2 grids, one for health needs and one for drivers, on flip chart paper to help organize sub-populations, community areas and assets by health needs/driver)

10. What are some of the **major health needs** affecting individuals in the community?
    a. ***Ask by issue:***
        i. What **sub-populations** are most affected by these needs?
        ii. Are there specific **areas in the community** that are most affected?
        iii. Where do community members go to treat their illness?
    b. Have they gotten **better or worse** over time (past 2-3 years)?

11. What are the most important factors **(socio-economic, behavioral, environmental or clinical factors)** contributing to poor health in the community?
    a. ***Ask by issue:***
        i. What **sub-populations** are most affected by these needs?
        ii. Are there specific **areas in the community** that are most affected?
        iii. Where do community members go to receive or obtain information on related services?

ACCESS TO CARE

12. What health or social services are **most difficult to access or are missing** in the community? **[DO NOT SAY ALOUD:** *This could include access to medical care that is*

affordable or free, health education workshops, dental care, vision care, substance abuse services, mental health care, etc.]

c. Are there specific **factors (socio-economic, behavioral, environmental or clinical factors)** contribute to this?
d. Does this affect certain **sub-populations** more than others? Which?

13. In your experience, what are the most **effective program/service delivery models** for addressing:
    a. Health needs? ***(refer to the issues identified in question 1)***
    b. Socio-economic factors (i.e., transportation, language barriers, poverty, etc.)? ***(refer to the issues identified in question 2)***

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

COLLABORATION

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

16. What are the potential areas for **collaboration or coordination** among hospitals, community organizations, and/or businesses (i.e., health or social providers, local government, etc.) to address community health needs or specific socio-economic, behavioral, environmental or clinical factors?

COMMUNICATION

17. What would be the most efficient **ways to provide information** to community members about the availability of health and other services?
    a. Is there a **particular message** that would appeal to community members?

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

RANKING OF HEALTH NEEDS AND FACTORS/DRIVERS OF HEALTH

19. Of the health needs and contributing factors you mentioned, how would you **rank each health need and factor** according to severity? ***(Create a grid on flip chart paper, give each participant 10 (5 for health needs and 5 for factors/driver) dot stickers and ask them to vote.)***

Note to Facilitator: Severity is defined as the level a health need or health factor/driver affects the health and lives of those in the community.

Appendix G: Primary Data Summaries

Interview Summary

About the Participants

To assess and identify current health needs and health drivers facing the West Los Angeles community, 29 local health experts were interviewed during the months of October and November 2015.

The majority of the interviewees were relatively to very familiar with the KFH-West Los Angeles medical center. Many cited experience in working or collaborating with KFH-West Los Angeles on pilot projects, community programs, and grants. For others, familiarity stemmed from attending trainings held by KFH-West Los Angeles or from having mutual contacts and networks. Interviewees with a low level of familiarity with KFH-West Los Angeles medical center were aware of its location and services. They added that the KFH-West Los Angeles medical center had a "well-known standard" and was "one of the premier hospitals" with a "tremendous reputation."

The broad range of interviewees included representatives from health philanthropy, health education, health policy, administration, social justice, and community safety as well as providers of primary, public, mental, behavioral, substance, health and mental health for children, youth, parents, families, the homeless, veterans, the unemployed and immigrant sub-populations. In terms of service area, the health experts' programs serve the local West Los Angeles service area as well as Los Angeles County as a whole and, for some, as far as Orange and Ventura counties.

Community Health Outcomes and Associated Drivers

When asked directly about major health needs affecting individuals in the West Los Angeles communities (KFH-West Los Angeles service area), the interviewed health experts reported 42 health outcomes and health drivers. The health outcomes most often mentioned included:

- Alzheimer's disease
- Cancer
- Community violence and injury
- Diabetes
- Heart disease
- Hypertension and high blood pressure
- Overweight and obesity
- Poor mental health, specifically stress and anxiety
- Poor oral care
- Respiratory Issues including asthma and COPD
- Sexually transmitted diseases
- Substance and alcohol abuse
- The lack of access to primary and specialty care, and affordable health care and medication

The health drivers most often mentioned included:

- Cultural and linguistic barriers
- Economic insecurity, including poverty and unemployment
- Homelessness and housing
- Lack of education, including health education
- Lack of green space and a healthy environment
- Lack of healthy and affordable food options
- Lack of healthy behaviors, including poor eating and exercising habits
- Lack of preventive health practices

In terms of disparities, the vulnerable sub-populations most often mentioned included the low-income/poor, immigrant, Latino/Hispanic, African-American, homeless, veterans, underinsured, uninsured, undocumented, underserved, mentally ill, victims of domestic violence, and Los Angeles Unified School District students and families.

Most Mentioned Health Outcomes and Drivers

Mental health services and counseling, specialty care, dental care, and substance abuse prevention care, counseling, and treatment were the most frequently mentioned difficult-to-access or missing health and social services .

Consequently, the socio-economic, behavioral, environmental, or clinical factors contributing to these barriers are perceived to be most attributed to socio-economic status and access issues. For instance, some local health leaders identified a negative stigma associated with 'access' to health care services in which a lack of access is viewed as the person's own fault. Access issues may additionally arise from the mental health of an individual and/or their family. Public health insurance (e.g., Medi-Cal) does not take the patient far enough in care, often because contractors (providers) are spread out and there is a general disconnect to access in the Medi-Cal infrastructure. Uninsured or underinsured individuals face even deeper and wider access issues.

> *"Hospitals play a pivotal role in capturing patients at their sickest, and it's also an opportunity to access care and change. It's important for hospitals to collaborate with health plans to help coordinate transitions."*
>
> *– Director*

Interviewees perceived the poor (from children to seniors), the medically uninsured, and Latino/Hispanics as the sub-populations most affected by socio-economic and access issues in the West Los Angeles community.

Collaborating with Others

To collaboratively address community health outcomes or specific socio-economic, behavioral, environmental, or clinical factors, the interviewed health leaders most frequently indicated that leveraging funding from hospitals and businesses would help sustain, support, and create health programs (e.g., homeless bed shortage, veterans' services, residential treatment programs).

Other leaders would like to see hospitals and community-based organizations working together to create a universal health information exchange where patient data would be shared among providers and thus limit duplicate paperwork and time.

Additionally, two people recommended that community-based providers, clinics, and social service organizations could provide health services, information, and education at their sites to mitigate emergency room overcrowding. Others suggested school-based health clinics to be accessed by students and their families, possibly coordinating the integration of health education into the classroom setting.

> *"Mental health patients die on average 25 years younger than other types of patients. Much of that is a stigma as they are not taking care of themselves."*
>
> *– Senior Vice President of Operations*

Current collaborative efforts taking shape include UCLA and Cedars-Sinai working together on a suicide prevention program that involves the Didi Hirsch Community Mental Health Center providing follow-up and service links for those clients who do not meet the 'hold' criteria. Following on the heels of the Los Angeles County Department of Mental Health, another health leader is working with volunteers and nonprofit organizations in the community to build physical and substance abuse networks using the 'health neighborhood' model.

Ways of Sharing the CHNA Findings

In regards to the best way to share findings from the KFH-West Los Angeles Community Health Needs Assessment, interviewees would like the information presented online on a website or in a webinar or short YouTube video made available in various languages. Others would prefer to receive findings via email or listserv. To bring information-sharing to a larger audience, health leaders agreed that the CHNA findings should be presented to community partners, community members, board members, stakeholders, and local and elected government officials. For community members, information should be presented at town hall meetings with handouts, PowerPoint slides, food, and translators and/or translation headsets. Most important, messages to the community should be clear, transparent, and intentional, containing "real suggestions to improve their lives."

> *"We are trying to move towards more integrated care as part of a federal mandate to do vitals, and "checks" within our own agency— they are not doing primary care at sites but educate their clients to follow up more."*
>
> *– Senior Vice President of Operations*

Interviewees also suggested disseminating health and health services information via social media, traditional media outlets (e.g., newspaper, radio and TV ads, and billboards), and the Internet/webpages in multiple translations as the most efficient means to provide information to West Los Angeles residents/community members. Other suggestions included using email chains, blasts, or listservs; conducting presentations at key community or coalition meetings; or utilizing faith-based centers.

Level of Severity and Importance by Health Outcomes and Health Drivers

Interviewees were specifically asked to rank a pre-identified list of community health outcomes and health drivers, or factors, on a scale from 1 to 5. The first ranking was a measure of severity, where 1 is least severe and 5 is most severe, with severity defined as the degree to which a health outcome or health driver affects the health and lives of individuals in the community.

The second ranking involved prioritizing each health outcome or health driver by level of importance for the hospital to address, with 1 representing not important and 5 as very important to address.

The following health need were ranked as the most severe:

- Chronic diseases
- Cost of medication
- Food insecurity, including food deserts
- Lack of healthy and affordable food options
- Poor eating habits
- Poverty
- Specialty care
- Stigma associated with disease
- Trauma

> *"We tell our community to eat healthy knowing they can't afford healthy foods."*
>
> *– CEO*

All in all, interviewees were open, thoughtful, and forthcoming with their deep knowledge of the local and surrounding communities. Moreover, they are looking forward to utilizing and sharing the KFH-West Los Angeles 2016 Community Health Needs Assessment results to improve care and coordination throughout the area.

Focus Groups Summary

About the Participants

Focus group were conducted in October 2015 that included over 100 community representatives, health experts, local government representatives, local business owners, and social and health service providers.

> *"Within the black community— "you're crazy if you do seek a mental health professional" but in reality . . . in reality, you're crazy if you don't"*
>
> *– Social Services Focus Group Participant*

Community Health Needs

Focus group participants identified 20 major health outcomes, from obesity, nutrition, cancer, and sexually transmitted diseases (STDs) to substance, domestic, and sexual abuse.

Promotoras and faith-based focus group participants, reported seeing an increase in poverty, the effects of overcrowded clinics and hospitals, and an increase in STD's in the lesbian, gay, bisexual and transgender (LGBT) community, teens, females, and African-Americans.

Faith-based focus group participants also reported dealing with many major health outcomes; local churches are overwhelmed with grief management cases and are actively referring community members to mental health programs.

Participants in the youth focus group reported a number of health outcomes including diabetes, high blood pressure/cholesterol, and STDs.

> *"If they go to the hospital and are diagnosed with diabetes . . . they are referred to different places . . . and will not go." "I think the problem is not having a linkage, a facilitator, or a wrap-around service that follows up to see if the patient actually went."*
>
> *– Faith-Based Focus Group Participant*

Associated Health Drivers

In addition to discussing major health outcomes affecting individuals in the community, focus group participants were also asked to describe the most important socio-economic, behavioral, and environmental or clinical factors that contribute to poor health in the community. Participant identified a variety of factors from the lack of health insurance, awareness, resources, providers, linkages, and prevention to poverty, obesity, and social injustices.

Participants from the faith-based, youth, and *promotoras* focus groups agreed that generally the community had low levels of health literacy and were not familiar with the health system, health insurance, or health resources in their neighborhoods. Participants from the faith-based focus group, on the other hand, reported that their constituency had a high level of awareness and that churches had become important assets in the community. For example, some churches have Wellness Sundays in which they promote health and wellness practices and that conclude with a farmer's market or health screening mobile unit.

> *"Near our church we have 40 fast food restaurants, in a two-mile radius, and there is a dialysis center in the area as well." "You won't see Sprouts in South LA, but you will see a Food 4 Less."*
>
> *– Faith-Based Focus Group Participant*

The specific areas in the community most affected by poor health are Service Planning Area 6 and low-income, high-density, and immigrant communities. - Participants from the health providers focus group noted many underlying health drivers stemming from poor mental health and substance abuse, associating these issues with a lack of community safety, awareness of available health resources, healthier food options, access to health care services, and opportunities to make a livable wage.

Participants specifically indicated that mental health services are the most difficult to access, and added that African-Americans and Hispanic/Latinos in South Los Angeles had the greatest need for mental health services.

The lack of access to mental health services was attributed to the large gap in response by the Department of Mental Health's (DMH) because of its lack in capacity. Participants indicated that a person could "get through the (DMH) door quickly"; however, one could wait three months for an appointment. Intake requirements leave little focus and resources to meet "real" patient needs.

Other missing services included general health maintenance and promotion, and supporting churches financially in providing social services. Participants cited many needed services along with the related need to have more consistent and sustained services and health practices to meet community health needs. Participants indicated a reliance on churches to meet the needs of the community, resulting in churches needing financial assistance as well as to build their knowledge and abilities in health education and healthy living. To encourage healthy behaviors, community focus group participants suggest targeted health lifestyle and money (financial) management education through media marketing (e.g., Univision) and social programs (MALDEF, the Mexican American Legal Defense and Educational Fund, offers large-scale health and nutrition classes and cooking demonstrations, for example).

> *"There is a need for having access to people that have been through the process." "There are not many supports for Hispanic women; someone to walk with you or support you during that time."*
> *-Faith-Based Focus Group Participant*

To address the aforementioned health needs, the community health and outreach model was the most frequently recommended service delivery model, with outreach involving faith-based centers and churches.

When directly asked about West Los Angeles community members' ability to access care and other services, participants from the health provider focus group "positively" and "tremendously" responded to the impact of the Affordable Health Care Act (ACA). The group agreed that health coverage has expanded as more community members enrolled. Although the ACA is perceived as a community asset, especially for South Los Angeles and older sub-populations, negative aspects include a low provider reimbursement rate that limits the number of providers accepting ACA plans, a lack of consistent health coverage maintenance as members fall in and out of income qualification requirements, and the exclusion of health coverage for undocumented community members.

Collaborating with Others

In the last few years, hospitals have realized that community members will not always come to them. Therefore, the majority of participants in the faith-based focus group reported collaborating with local health clinics. For example, Van Nuys Hospital conducts monthly mobile clinics at churches. Participants shared that they host monthly mobile mammography visits. Another center hosts a monthly food pantry. In fact, there is such a high demand for mobile health church visits that focus group members agreed amongst themselves to coordinate scheduling mobile visits months in advance to ensure everyone is served.

Participants from the social service providers focus group noted seeing a change in the way police address trauma and attributed this to the increased police force education. Additionally, participants have seen a growing problem with the scarcity of affordable housing and how this has become a driver for many other health outcomes.

Participants from the *promotoras* focus group have seen a change in the distribution of specialized health services because "not all community clinics can provide all types of health services or have the capacity to provide a specific service to a patient . . . like beds." They also have observed changes in

vaccination rates and discussed the importance of creating messaging around the importance of child and adult vaccines.

To collaboratively address community health outcomes or specific socio-economic, behavioral, environmental, or clinical factors, participants from the faith-based focus group discussed their growing civic engagement and involvement with other civically engaged faith-based organizations and community providers. Based on the collaborative efforts of over 30 churches between Central and Compton avenues and Vernon and Slauson avenues, a community resource guide was put together by USC's Center for Religion and Civic Culture through the John Randolph and Dora Haynes Foundation. Church groups are actively applying for additional grants to assist with more community collaborations and to develop a community health center.

Another example is from a group of Los Angeles' "first ladies" of faith-based organizations that developed the First Ladies Health Initiative to offer community-wide diabetes, cholesterol, blood pressure, vision, dental, mammogram, STD, mental health, Hepatitis C, and bone density health screenings. Other offerings included cooking demonstrations and information on Alzheimer's, CPR training, healthy eating, and other health needs affecting the community.

Overall, faith-based centers have found the most effective means of reaching their communities through trusting relationships with recreation centers, city council officials, community-based organizations, food pantries, and social media.

Participants from the non-traditional focus group expressed concerns about coordinating and collaborating to deal with the problem of unhealthy lifestyle choices. Participants would like to work with more than one media outlet (e.g., Univision's "Join the Challenge") and also hold more health events at parks to promote a healthier way of living for the entire family. They also reported that they have seen good participation from law enforcement.

On the other hand, representatives from the WorkSource Center admitted that they have multiple agency resources in one place but struggle with organizations not knowing what each agency does. Magnolia Family Center in South Los Angeles is an example of the successful co-location of services for low-income communities that work together to offer and coordinate free services for families, including mental health. One participant shared that his agency now operates under the hub design in which the client goes from desk to desk to receive tailored services to meet the client's mental health, substance abuse, housing, or welfare needs.

> *"We need resources that are comprehensible and we need more information to inform all the communities."*
> -Promotoras *Focus Group Participant*

Participants from the *promotoras* focus group did not feel that the coordination of access to services and care had improved. One participant commented that "big hospitals have the opportunity to collaborate with certain areas of the community, but why don't they partner with small clinics in their area to maximize the capacity of the services provided?" As a group, they agreed that they were unsure why hospitals and clinics do not collaborate, because "we all have a lack of resources, expertise in certain areas, and hospital can reach out and help improve upon those particular areas." Other potential areas for collaboration include bilingual informational ads and commercials through popular Latino communication outlets such as Univision. For example, participants agreed that the Kaiser Permanente television and radio commercials were good. More important, they added, "we need to integrate our services with Kaiser Permanente; we are the ones out in the community."

Participants from the social service provider focus group reported seeing changes in the way providers and other agencies collaborate. For example, specialty care hospitals in the area are now working to increase access to specialty care initiated by grant funding as a result of the influx of new ACA-covered members. Participants reported seeing "strongly encouraged" collaboration from federal funders; the

caveat is that funds are available only for group versus individual programs. Participants also perceive nonprofits as working together more "now that there is less money" compared to before, when there was more money and nonprofits operated far more in "silos."

Ways of Sharing the CHNA Findings and Other Information

Participants from the faith-based focus group suggested disseminating health and other service information via trusting relationships and partnerships with community recreation centers (especially on weekends), food pantries, and school and community-based organizations. Other large-scale suggestions include social media and utilizing a facts-and-statistics format.

Participants from the social service provider focus group highlighted that there is "no one way" to efficiently share information in the mental health field. Possible solutions included navigation/outreach services provided by training those who have been treated and having them engage with those just starting the process. A self-sustaining strategy could provide employment for specific populations to help others. Communication with the Department of Mental Health staff and their contract provider list was also suggested as a strategy.

Participants from the *promotoras* focus group agreed that commercial ads in Spanish would be the most efficient means of information-sharing, using messages similar to Kaiser Permanente's "Thrive" and "Tan Solo Trata" ("Just Try"). Non-traditional providers simply suggest "it's best to share with stakeholders and community members."

In regard to the best way to share findings from the 2016 KFH-West Los Angeles Community Health Needs Assessment, participants from the health provider focus group suggested presenting information to community members and stakeholders via media and social media. Participants from the non-traditional, faith-based, *promotoras* and youth focus groups suggested presenting the results from the health needs assessment through social media, including television, Twitter, Facebook, and community presentations.

Level of Severity and Importance by Health Outcomes and Health Drivers

Focus group participants were specifically asked to rank a pre-identified list of community health outcomes and health drivers, or factors, on a scale from 1 to 5. The first ranking was a measure of severity, where 1 is least severe and 5 is most severe, with severity defined as the degree to which a health need or health driver affects the health and lives of individuals in the community.

The second ranking involved prioritizing each health need or health driver by level of importance for the hospital to address, with 1 representing not important and 5 as very important to address.

The following health outcomes were ranked as the most severe:

- Obesity
- Mental health
- Diabetes
- Sexually transmitted disease, including HIV/AIDS
- Substance abuse

The following health drivers were ranked as the most severe:

- Community safety
- Substance abuse
- Food insecurity
- Lack of health awareness
- Lack of education

Endnotes for Appendix D

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