2016 Community Health Needs Assessment

Kaiser Foundation Hospital – Downey

License #930000078

Approved by KFH Board of Directors

September 21, 2016

To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

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Kaiser Permanente Southern California Region
Community Benefit
CHNA Report for KFH – Downey

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I. EXECUTIVE SUMMARY

Kaiser Foundation Hospital (KFH) – Downey has undertaken a Community Health Needs Assessment (CHNA) as required by state and federal law. The Community Health Needs Assessment is a primary tool used by KFH – Downey to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the hospital service area.

KFH – Downey is located at 9333 Imperial Highway, Downey, California 90242. The hospital serves the communities of: Artesia, Bell, Bellflower, Bell Gardens, Cerritos, Commerce, Compton, Cudahy, Downey, Hawaiian Gardens, Huntington Park, Lakewood, North Long Beach, Lynwood, Maywood, Norwalk, Paramount, Pico Rivera, Santa Fe Springs, South East Los Angeles, South Gate, Vernon and Whittier. The service area consists of portions of Service Planning Areas (SPAs) 6 and 7 in Los Angeles County.

The 2016 Community Health Needs Assessment indicates there are 1,492,097 persons in the KFH – Downey service area. Among the service area population, 29% are children and 8.9% are seniors. This is a higher percentage of children and a lower percentage of seniors than found in the county or the state. The majority of the population is Hispanic/Latino (72.8%); 10.7% of residents are White; 7.8% are African American; and 7.1% are Asian. Given the large percentage of Latinos, it is no surprise that 62.1% of the population speaks Spanish in the home. English only is spoken among 30.4% of the population in their homes, and Asian languages are spoken in the home among 5.6% of the population.

The demographic profile of the KFH – Downey service area paints a picture of a community at risk for health disparities. This is demonstrated by a number of educational and economic indicators. Over one-third (34.9%) of the adult population over age 25 have no high school diploma. While unemployment rates have decreased among cities in the area, poverty rates are higher than found in the county and the state. Among the residents in the KFH – Downey service area, 19.7% are at or below 100% of the federal poverty level (FPL) and 46.9% are at 200% or below FPL. Given the high percentage of children in the area, it is of concern that 28.3% of children, ages 0-17, live in households with income below the Federal Poverty Level (FPL). When examined by race/ethnicity, over one-third (34.7%) of Black/African American children and 30.8% of Hispanic/Latino children in the service area are living in poverty.

A. Community Health Needs Assessment Background

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was 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 must 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

KFH – Downey hosted a community forum on January 13, 2016 in Downey, California to prioritize the identified health needs. The forum engaged 40 community leaders who have current data or other information relevant to the health needs of the community served by the hospital facility. A review of the Community Health Needs Assessment process and the identified significant health needs were presented at the community forum. The attendees engaged in a process to prioritize the health needs using the Relative Worth method. The Relative Worth method is a ranking strategy where each participant received a fixed number of points. The points were assigned to health needs based on the size of the problem (relative portion of population afflicted by the problem); or seriousness of the problem (impact at individual, family, and community levels). As a result of the process, the significant health needs were ranked in the following priority order:

1. Overweight and obesity
2. Mental health
3. Access to health care
4. Diabetes
5. Community safety
6. Substance abuse
7. Preventive practices
8. HIV/AIDS/STD
9. Oral health
10. Teen pregnancy
11. Cardiovascular disease
12. Asthma

C. Summary of Needs Assessment Methodology and Process

The Community Health Needs Assessment incorporates primary and secondary data that focus on the health and social needs of the hospital service area. 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.

KFH – Downey used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. Additional data were collected to supplement the CHNA Data Platform. The secondary data were obtained from August – September 2015. When applicable, the data sets are presented in the context of county data and state data, framing the scope of an issue as it relates to the broader community. Health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). The secondary data collection and preliminary analysis were completed prior to primary data collection in order to assess the needs of the community served and identify a preliminary set of health needs.

Primary data collection was then used to validate secondary data findings, identify additional community issues, and to solicit information on disparities among subpopulations. Community input was provided by a broad range of community members through the use of key informant interviews and focus groups. These individuals included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, individuals with expertise of local health needs were consulted. The interviews and focus groups took place September – October, 2015. KFH – Downey worked collaboratively with PIH Health Hospital - Downey and PIH Health Hospital - Whittier on primary data collection. These hospitals share a large part of their service areas and collaboration eliminated redundancy in collecting data from the community stakeholders. Thirty-one (31) phone interviews were conducted among community stakeholders. Nine (9) focus groups were conducted and engaged 79 community stakeholders. Four (4) of the focus groups were conducted in Spanish with a bilingual facilitator. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, and ascertain community assets to address needs. Significant health needs were identified through this mixed-method analysis.

The following Community Health Needs Assessment provides a detailed demographic profile of the hospital community service area, a description of the significant community health needs, community stakeholder input on the health needs, community assets and resources available to respond to the significant health needs, and an evaluation of the impact the hospital has had on community needs. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change, and it allows us to deepen the relationships we have with other organizations that are working to improve community health.

D. Implementation Strategy Evaluation of Impact

In the 2013 Implementation Strategy (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. KFH – Downey 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 – Downey tracks outcomes, including behavior and health outcomes, as appropriate and where available. As of the documentation of this CHNA Report in March 2016, KFH – Downey had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH – Downey will continue to monitor impact for strategies implemented in 2016.

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:

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

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), 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 issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues 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, sustainable 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 Community Health Needs Assessment (CHNA) Report

i. To advance community health

Community Health Needs Assessments (CHNA) have been integral to learning about the health of the communities Kaiser Permanente serves. We are committed to building on the CHNA and relationships in the community to deepen our knowledge of the community specific needs and the resources and leaders in the community. This deeper knowledge will enable us to develop a new approach by engaging differently and activating in a way that addresses specific community needs and 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 – economic, relationships, and expertise – to positively impact 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 in order to maintain their tax exempt status. The provision was 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 must 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 kp.org/chna.

D. Kaiser Permanente Approach to CHNA

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing 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, the 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 impacted 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 their community. Once all of 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 – Downey 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.

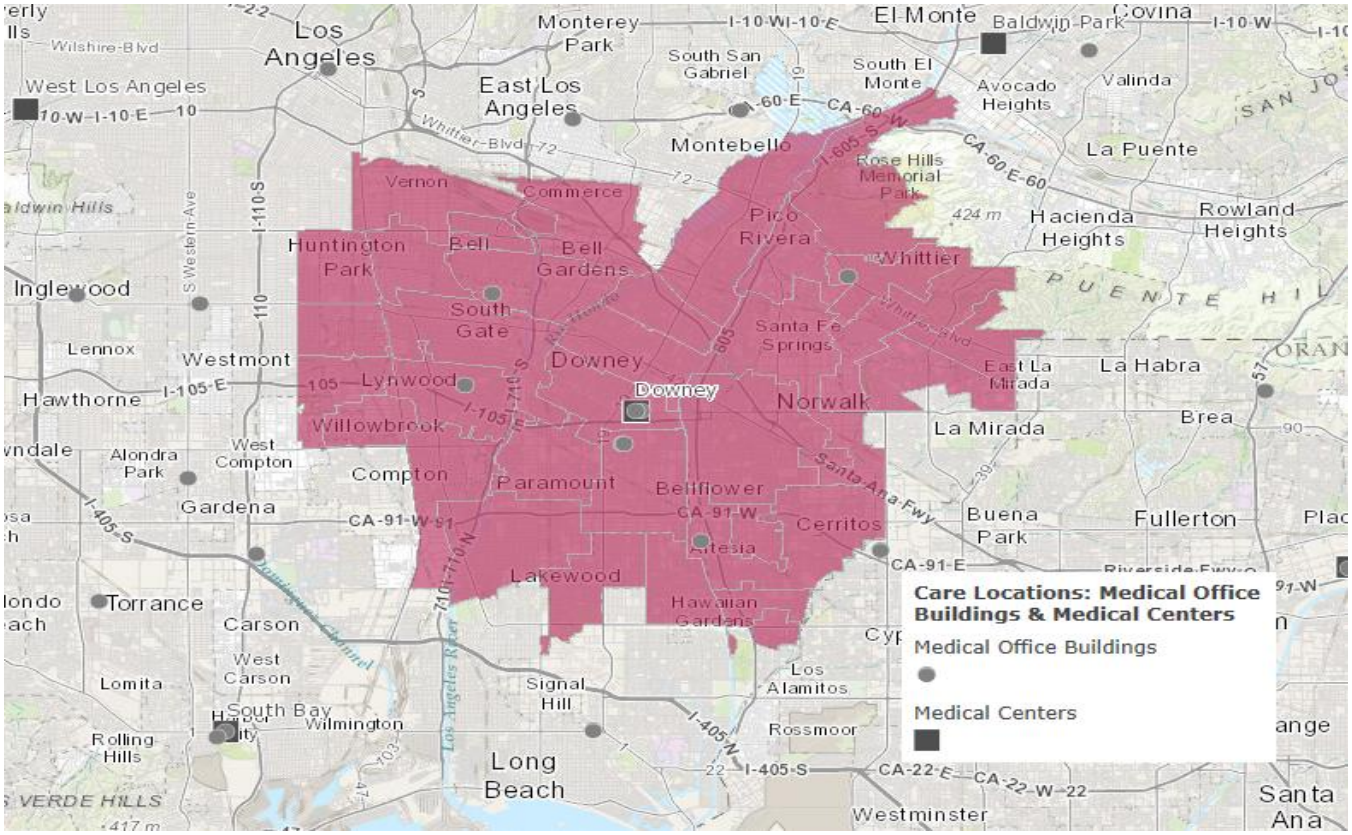
III. Community Served

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. Map and Description of Community Served

i. Map



ii. Geographic description of community served

Kaiser Foundation Hospital (KFH) – Downey is located at 9333 Imperial Highway, Downey, California 90242. The hospital service area is presented below by community, zip code and Service Planning Area (SPA). Given the available data sources, KFH – Downey information were presented as representing the entirety of the service area; the individual cities/places that make up the service area; or Service Planning Areas 6 and 7, portions of which are served by KFH - Downey. These cities/SPAs are located in Los Angeles County.

KFH – Downey Service Area

City	Zip Code	SPA
Artesia	90701	SPA 7
Bell	90201	SPA 7
Bellflower	90706	SPA 7
Bell Gardens	90201	SPA 7
Cerritos	90703	SPA 7
Commerce	90040	SPA 7
Compton	90221,90222	SPA 6
Cudahy	90201	SPA 7
Downey	90240,90241,90242	SPA 7
Hawaiian Gardens	90716	SPA 7
Huntington Park	90255	SPA 7
Lakewood	90712,90713,90715	SPA 7
North Long Beach	90805	SPA 8
Lynwood	90262	SPA 6
Maywood	90270	SPA 7
Norwalk	90650	SPA 7
Paramount	90723	SPA 6
Pico Rivera	90660	SPA 7
Santa Fe Springs	90670	SPA 7
South East Los Angeles	90001,90002, 90059	SPA 6
South Gate	90280	SPA 7
Vernon	90058	SPA 7
Whittier	90601,90602,90603,90604, 90605, 90606	SPA 7

iii. Demographic profile of community served

The 2016 Community Health Needs Assessment indicates there are 1,492,097 persons in the KFH – Downey service area. Among the service area population, 29% are children and 8.9% are seniors. This is a higher percentage of children and a lower percentage of seniors than found in the county or the state. The majority of the population is Hispanic/Latino (72.8%); 10.7% of residents are White; 7.8% are African American; and 7.1% are Asian. Given the large percentage of Latinos, it is no surprise that 62.1% of the population speaks Spanish in the home. English only is spoken among 30.4% of the population in their homes, and Asian languages are spoken in the home among 5.6% of the population.

The demographic profile of the KFH – Downey service area paints a picture of a community at risk for health disparities. This is demonstrated by a number of educational and economic indicators. Over one-third (34.9%) of the adult population over age 25 have no high school diploma. While unemployment rates have decreased among cities in the area, poverty rates are higher than found in the county and the state. Among the residents in the KFH – Downey service area, 19.7% are at or below 100% of the federal poverty level (FPL) and 46.9% are at 200% or below FPL. Given the high percentage of children in the area, it is of concern that 28.3% of children, ages 0-17, live in households with income below the Federal Poverty Level (FPL). When examined by race/ethnicity, over one-third (34.7%) of Black/African American children and 30.8% of Hispanic/Latino children in the service area are living in poverty.

Population

The population of the KFH – Downey service area is 1,492,097. The service area is 159 square miles and has a high population density of 9,336.6 persons per square mile.

Total Population

	Service Area	California
Total population	1,492,097	37,659,180
Total land area (square miles)	159	155,738.0
Population density (per square mile)	9366.6	241.8

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

From 2000 to 2010, the population in the service area decreased by 1.4%. During this same period the state experienced a 10% increase in population growth.

Change in Total Population 2000-2010

	Service Area	California
Total population 2000	1,464,428	33,871,648
Total population 2010	1,485,030	37,253,956
Change in population 2000-2010	-1.4%	10.0%

Source: U.S. Census Bureau, 2000 + 2010 Census of Population and Housing.
http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Of the area population, 49.2% are male and 50.8% are female.

Population by Gender

	Service Area	California
Male	49.2%	49.7%
Female	50.8%	50.3%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Children/youth, ages 0-17, make up 29% of the population; 62.1% are adults, and 8.9% of the population are seniors, ages 65 and over. The service area has a higher percentage of children/youth and a lower percentage of seniors than the county or the state.

Population by Age

	Service Area	Los Angeles County	California
0-4	7.7%	6.5%	6.7%
5-17	21.3%	17.4%	17.9%
18-24	11.7%	10.8%	10.5%
25-34	14.4%	15.2%	14.4%
35-44	14.1%	14.4%	13.7%
45-54	12.6%	13.9%	13.9%
55-64	9.3%	10.6%	11.1%
65 and older	8.9%	11.2%	11.8%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

When the service area is examined by community, South East Los Angeles has the largest percentage of youth, ages 0-17. Cerritos has the highest percentage of residents 65 and older (17.8%). Median age ranges from 25.8 years old in Cudahy and South East Los Angeles to 43.4 years old in Cerritos.

Population by Youth, Ages 0-17, Seniors, Ages 65+, and Median Age

	Youth (Ages 0-17)	Seniors (Ages 65+)	Median Age
Artesia	20.9%	11.4%	37.7
Bell	30.4%	7.3%	30.5
Bellflower	28.8%	9.2%	32.0
Bell Gardens	34.9%	5.4%	27.3
Cerritos	20.8%	17.8%	43.4
Commerce	28.0%	10.5%	32.4
Compton	33.0%	3.3%	27.6
Cudahy	35.0%	4.7%	25.8
Downey	26.1%	10.3%	34.0
Hawaiian Gardens	27.2%	9.1%	31.0
Huntington Park	31.0%	7.1%	29.2
Lakewood	24.5%	11.3%	37.7
Long Beach - 90805	30.1%	6.8%	30.2
Lynwood	32.8%	6.3%	27.9
Maywood	33.3%	5.6%	26.8
Norwalk	26.4%	10.7%	33.6
Paramount	31.8%	6.4%	29.4

	Youth (Ages 0-17)	Seniors (Ages 65+)	Median Age
Pico Rivera	25.1%	12.7%	35.0
Santa Fe Springs	24.9%	13.6%	35.9
South East/LA - 90001	33.6%	6.1%	27.0
South East/LA - 90002	35.6%	5.9%	25.8
South East/LA - 90059	35.6%	5.5%	25.8
South Gate	28.9%	7.9%	30.3
Vernon	15.0%	13.3%	32.8
Whittier	25.2%	12.1%	34.9
Service Area	**29.0%**	**8.9%**	**No Data**
California	**24.5%**	**11.8%**	**35.4**

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Race/Ethnicity

In the KFH – Downey service area, the majority of the population is Hispanic/Latino (72.8%); 10.7% of the residents are White; 7.8% are African American; 7.1% are Asian; and 1.6% of the population are multiple races, Native Hawaiian/Pacific Islander, Native American/Alaska Native and other races.

Race/Ethnicity

	Service Area		Los Angeles County	California
	Number	Percent	Percent	Percent
Hispanic/Latino	1,086,114	72.8%	47.9%	37.9%
White	159,467	10.7%	27.5%	39.7%
Black/African American	116,056	7.8%	13.7%	5.7%
Asian	105,989	7.1%	8.1%	13.1%
Multiple Races	14,428	0.9%	2.2%	2.6%
Native Hawaiian/Pacific Islander	4,036	0.3%	0.2%	0.4%
Some other Race	3,457	0.2%	0.2%	0.2%
Native American/Alaska Native	2,550	0.2%	0.2%	0.4%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Language

Spanish is spoken in the service area among 62.1% of the population. English only is spoken among 30.4% of the population. Asian languages are spoken among 5.6% of the population, and Indo-European languages are spoken among 1.4% of the population. In Lakewood over half the population (65.4%) speaks English only in the home. Over 90% of the population speaks Spanish in the home in Bell/Bell Gardens, Cudahy, Huntington Park and Maywood. Cerritos and Artesia have high rates of Asian language speakers. Artesia has the highest rates of the Indo-European speaking population.

Language Spoken at Home for the Population 5 Years and Over

	English Only	Spanish	Asian	Indo-European
Artesia	32.6%	23.9%	24.4%	19.0%
Bellflower	44.5%	43.3%	9.2%	1.4%

	English Only	Spanish	Asian	Indo-European
Bell/Bell Gardens	7.9%	90.6%	0.4%	0.3%
Cerritos	39.6%	8.4%	41.6%	8.1%
Commerce	21.4%	77.1%	0.3%	1.2%
Compton	29.8%	69.7%	0.3%	0.1%
Cudahy	7.9%	90.6%	0.4%	0.3%
Downey	29.9%	60.9%	6.0%	1.9%
Hawaiian Gardens	24.3%	61.0%	13.6%	0.7%
Huntington Park	5.8%	93.5%	0.5%	0.2%
Lakewood	65.4%	19.2%	12.6%	2.3%
Long Beach - 90805	42.7%	45.3%	10.9%	0.8%
Lynwood	15.8%	83.4%	0.6%	0.2%
Maywood	8.7%	91.0%	0.1%	0.2%
Norwalk	32.2%	55.5%	9.9%	2.3%
Paramount	22.8%	73.3%	2.7%	0.4%
Pico Rivera	26.1%	70.4%	2.2%	1.1%
Santa Fe Springs	42.8%	52.0%	4.3%	0.5%
South East/LA - 90001	13.4%	86.3%	0.2%	0.1%
South East/LA - 90002	29.3%	70.0%	0.3%	0.3%
South East/LA - 90059	39.1%	60.1%	0.3%	0.3%
South Gate	10.6%	88.2%	0.8%	0.4%
Vernon	14.1%	81.6%	4.3%	<0.1%
Whittier	47.7%	47.5%	2.8%	1.6%
Service Area	**30.4%**	**62.1%**	**5.6%**	**1.4%**
California	**55.9%**	**28.9%**	**9.7%**	**4.5%**

Source: Think Health LA, 2015. www.thinkhealthla.org

English proficiency reports the percentage of the population ages 5 and older who speak a language other than English at home and speak English less than "very well." In the KFH – Downey service area, 31.2% of the population has limited English proficiency. This is higher than the county rate of 26.2% and the state rate of 19.4%.

Limited English Proficiency, Population 5 Years and Older

	Service Area	Los Angeles County	California
Limited English proficient	31.2%	26.2%	19.4%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. *http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml*

Educational Attainment

Among adults, ages 25 and older, in the KFH – Downey service area, over one-third of the population (34.9%) have no high school diploma.

Educational Attainment

	Service Area	Los Angeles County	California
Population age 25 and over	886,593	6,456,772	24,455,010

	Service Area	Los Angeles County	California
Less than 9th grade	20.4%	13.7%	10.2%
9th to 12th grade, no diploma	14.5%	9.7%	8.5%
High school graduate	25.1%	20.5%	20.7%
Some college, no degree	19.8%	19.6%	22.1%
Associate degree	6.3%	6.9%	7.8%
Bachelor's degree	9.9%	19.4%	19.4%
Graduate or professional degree	4.0%	10.2%	11.2%

Source: U.S. Bureau of the Census, American Community Survey, 2009-2013; DP02. http://factfinder.census.gov

Unemployment

From 2011 to 2014 the unemployment rates in service area cities show a decrease. Commerce (12%) and Compton (12.7%) have the highest rates of unemployment in the service area. Artesia (5.1%), Cerritos (6.1%) and Vernon (2.8%) have the lowest rates of unemployment.

Unemployment Rates, 2011 + 2014 Comparison

	2011	2014
Artesia	8.9%	5.1%
Bell	16.1%	11.1%
Bellflower	12.4%	7.8%
Bell Gardens	19.3%	9.5%
Cerritos	6.7%	6.1%
Commerce	22.7%	12.0%
Compton	20.6%	12.7%
Cudahy	17.0%	10.3%
Downey	9.9%	7.3%
Hawaiian Gardens	13.8%	7.3%
Huntington Park	18.1%	10.8%
Lakewood	8.0%	6.4%
Lynwood	19.2%	10.2%
Maywood	17.7%	8.6%
Norwalk	13.0%	8.4%
Paramount	17.7%	9.6%
Pico Rivera	11.4%	7.6%
Santa Fe Springs	10.3%	9.8%
South Gate	15.6%	10.7%
Vernon	0%	2.8%
South Whittier	10.8%	6.9%
Whittier	8.8%	6.5%
Los Angeles County	**12.3%**	**8.7%**
California	**11.7%**	**7.5%**

Source: California Employment Development Department, Labor Market Information, April 2015.
www.labormarketinfo.edd.ca.gov/cgi/dataanalysis/AreaSelection.asp?tableName=labforce
** Data available by city, therefore, zip code only areas in the KFH – Downey service area are not listed.*

Poverty

Poverty thresholds are used for calculating all official poverty population statistics. They are updated each year by the Census Bureau. For 2013, the federal poverty level for one person was $11,490 and for a family of four $23,550. Among the residents in the KFH – Downey service area, 19.7% are at or below 100% of the federal poverty level (FPL) and 46.9% are at 200% or below FPL. These rates of poverty are higher than found in the county and the state.

Poverty Levels, All Residents

	Service Area		Los Angeles County	California
	Number	Percent		
<100% FPL	291,237	19.7%	17.8%	15.9%
<200% FPL	693,343	46.9%	40.3%	35.9%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

The percentage of children, ages 0-17, living in households with income below the Federal Poverty Level (FPL) is 28.3%, and this is higher than the county rate of 25.3% and the state rate of 22.2% of children living in poverty. When examined by race/ethnicity, over one-third (34.7%) of Black/African American children in the service area are living in poverty. White (13.7%) and Asian (10.5%) children have the lowest levels of poverty in the service area.

Children in Poverty, Ages 0-17

	Service Area	Los Angeles County	California
Children living below the Federal Poverty Level	28.3%	25.3%	22.2%
Black or African American	34.7%	35.0%	33.2%
Native American/Alaska Native	32.2%	35.8%	32.1%
Hispanic or Latino	30.8%	31.8%	30.1%
Some other Race	29.7%	31.2%	33.4%
Multiple Race	19.4%	16.8%	15.6%
Native Hawaiian/Pacific Islander	18.8%	12.2%	20.8%
White	13.7%	15.1%	10.3%
Asian	10.5%	9.0%	12.5%

Source: U.S. Census Bureau, American Community Survey , 2009-2013.
http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Uninsured Rates

In the service area, over one-quarter of the population (25.9%) are uninsured, which translates to 74.1% with health insurance. This is less than the Healthy People 2020 objective of 100% health insurance coverage. These data were obtained from the American Community Survey, 2009-2013. This was before the full implementation of the Affordable Care Act and the insurance coverage expansion. Therefore, the percent of residents who are currently uninsured may be lower as a result of Medi-Cal expansion and the availability of health care coverage.

Uninsured

	Service Area	Los Angeles County	California
Uninsured	25.9%	22.2%	17.8%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of Hospitals that Collaborated on the Assessment

KFH – Downey worked collaboratively on primary data collection with PIH Health Hospital - Downey and PIH Health Hospital - Whittier.

B. Other Partner Organizations that Collaborated on the Assessment

A number of organizations contributed time and resources to assist with the conduct of this needs assessment. These organizations hosted focus groups and assisted in recruiting focus group participants:

- Cerritos College Health Clinic
- Ernie Pyle Elementary School, Bellflower
- Interfaith Food Center, Santa Fe Springs
- Kaiser Permanente Watts Counseling and Learning Center
- My Friend's House
- Partnership for Healthier Communities Collaborative
- Plaza de la Raza
- TLC Collaborative, Downey Unified School District

The Center for Nonprofit assisted with planning, hosting and facilitating the community convening to prioritize the significant health needs.

C. Identity and Qualification of Consultants Used to Conduct the Assessment

Biel Consulting, Inc. conducted the Community Health Needs Assessment. Biel Consulting, Inc. is an independent consulting firm that works with hospitals, clinics and community-based nonprofit organizations. Dr. Melissa Biel conducted the KFH – Downey Community Health Needs Assessment. She was joined by Janice Frates, PhD, MSW, LCSW, Deborah Silver, MA, Sevanne Sarkis, JD, MHA, MEd, and Denise Flanagan, BA. Biel Consulting, Inc. has extensive experience conducting hospital Community Health Needs Assessments and working with hospitals on developing, implementing, and evaluating community benefit programs. www.bielconsulting.com

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Secondary Data

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

KFH – Downey used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. The secondary data were obtained from August – September 2015. Additional data were collected to supplement the CHNA Data Platform. These data were selected from recent data or local sources that were not offered on the CHNA Data Platform, such as previous CHNAs, the LA County Department of Public Health Community Health Assessment, and data available by the Los Angeles Service planning Area (SPA 6 and SPA 7) were also consulted. The additional data sets were accessed electronically. For details on specific sources and dates of data used, please see Appendix A.

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

The Kaiser Permanente common indicators data, available on the CHNA Data Platform, are calculated to obtain unique service area rates. In most cases, the service area values represent the aggregate of all data for geographies (zip codes, counties, tracts, etc.), which fall within the service area boundary. When one or more geographic boundaries were not entirely encompassed by a service area, the measure was aggregated proportionally. The options for weighting "small area estimations" were based upon total area, total population, and demographic-group population. The specific methodology for how service area rates were calculated for each indicator can be found on the CHNA.org/kp website.

These data values were organized by the Mobilizing Action Toward Community Health (MATCH) model, 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 drives that impact that status: access to health care, behaviors, socio-economic factors, and the physical environment. The KFH – Downey data indicators were organized within the morbidity/mortality (health outcome) and health driver categories to enable a broad understanding of the health needs in the community.

Health needs were identified from the secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of the problem, the secondary data were measured against benchmark data, specifically county rates, state rates and/or Healthy People 2020 objectives. Indicators related to the health needs that performed poorly against one or more benchmarks met this criterion to be considered a health need. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. Analysis of secondary data also included an examination and reporting of health disparities for some health indicators.

The secondary data for the KFH – Downey service area were collected and documented in data tables with narrative explanation. The tables present the data indicator, the geographic area represented, the data measurement (e.g. rate, number, percent), county and state comparisons (when available), the data source, data year and an electronic link to the data source. When applicable, the data sets are presented in the context of county data and state data, framing the scope of an issue as it relates to the broader community.

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 and focus groups. Focus groups and interviews were selected to obtain community input as they provided opportunities to engage a variety of stakeholders in a format that was convenient and accessible. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, individuals with expertise of local health needs were consulted.

The interviews and focus groups took place September – October, 2015. KFH – Downey worked collaboratively with PIH Health Hospital - Downey and PIH Health Hospital - Whittier on primary data collection. These hospitals share a large part of their service areas and collaboration eliminated redundancy in collecting data from the community stakeholders. Thirty-one (31) phone interviews were conducted among community stakeholders. Nine (9) focus groups were conducted and engaged 79 community stakeholders. Four (4) of the focus groups were conducted in Spanish with a bilingual facilitator. For a complete list of individuals who provided input, see Appendix B.

Interviews

KFH – Downey, in partnership with PIH Health, developed a list of key influencers in the community who have knowledge of the identified preliminary health needs. They were selected to cover a wide range of communities within the service area, represent different age groups, and racial/ethnic populations. In addition, non-traditional partners were identified. KFH – Downey intentionally included non-traditional stakeholders in this CHNA to give voice to a wide range of community members who represent a variety of sectors. For the purpose of this CHNA, non-traditional stakeholders were community members who represented organizations or groups beyond the required CHNA stakeholder groups. They could include representatives of anchor institutions, significant employers, other business stakeholders, financial institutions, banks, faith-based organizations, grocers and food producers, real estate developers, technology innovators, Chamber of Commerce leaders, urban planners, economic development experts, workforce development, uniformed public servants, sustainability leaders, and local civic leaders or their staff. The identified stakeholders were invited by phone and email to participate in a one hour phone interview. Appointments for the interviews were made on dates

and times convenient to the stakeholders. At the beginning of each interview, the purpose of the interview in the context of the assessment was explained, the stakeholders were assured their responses would not be attributed to them, and consent to proceed was given.

Interview participants were asked to share their perspectives on a number of topics related to the identified preliminary health needs in the KFH – Downey service area. Questions focused on the following topics:

- Biggest issues and health concerns facing the community.
- Issues, challenges, barriers faced by community members as they relate to the identified health needs (preliminary list from secondary data analysis).
- Services, programs, community efforts available to address each of the health needs.
- Special populations or groups that are affected by a health need.
- Socioeconomic, health behaviors, environmental or clinical factors that contribute to poor health in a community (MATCH Health Factors).
- What is being done to or can be done to address the social and economic determinants of health.
- Other comments or concerns.

Focus Groups

KFH – Downey, in partnership with PIH Health, developed a list of focus groups that included members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of these populations. In addition, non-traditional partners were identified. Focus group participants were also selected because of their perspectives on the identified preliminary health needs. Some of the focus groups were conducted with intact groups who agreed to participate in the focus groups as part of their regular meetings. In all cases, the focus group meetings were hosted by trusted community organizations. An agency contact was available to answer any questions at each focus group. Light refreshments were offered and a gift card was provided to participants.

At the beginning of each focus group, the purpose of the focus group and the community assessment were explained, the participants were assured their responses would not be attributed to them as responses would be aggregated. The focus group discussions were voice recorded for ease of documenting the discussion. Before beginning the discussion the facilitator asked for oral consent from each of the participants that they wished to participate in the focus group and agreed to be voice recorded. The focus group participants were asked to share their perspectives related to topics within the following areas:

- Biggest issues and health concerns facing the community.
- Issues, challenges, barriers faced by community members specific to the identified health needs.
- Services, programs, community efforts available to address each of the health needs.
- Special populations or groups that are affected by a health need.
- How the hospitals can help address the community needs.
- Other comments or concerns.

ii. Methodology for interpretation and analysis of primary data

The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, and ascertain community assets to address needs.

Analysis of the primary data occurred through a process that compared and combined responses to identify themes. Identification of additional health needs, beyond the preliminary list of health needs identified through the secondary data analysis, was determined by documenting if a need was discussed by stakeholders. When possible, the primary data responses were also organized into the MATCH Framework categories for ease in data analysis and comparison with secondary data. All responses to each question were examined together and concepts and themes were summarized to reflect the respondents' experiences and opinions.

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. This website will continue to allow for written community input on the most recently conducted CHNA Report. As of the time of this CHNA report development, KFH – Downey 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, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender were not available for all data indicators, which limited the ability to examine disparities of health within the community. Multiple year data were not consistently available to present trends. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

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 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.

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

Data analysis was an iterative process that commenced with secondary data collection and analysis to identify a preliminary list of health needs. Health needs were identified based on the following criteria:

- Met the Kaiser Permanente definition of a health need.
- Confirmed by more than one indicator or data source.
- Indicator(s) performed poorly against one or more benchmarks. (Benchmarks were used to determine the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels)).

Health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels), based on the methodology described above. The secondary data collection and preliminary analysis were completed prior to primary data collection in order to assess the needs of the community served and identify a preliminary set of health needs. The primary data collection was then used to validate secondary data findings, identify additional community issues, and to solicit information on disparities among subpopulations. Primary data collection corroborated and augmented the significant health needs identified through secondary data collection. The primary data collection was also used to solicit information from stakeholders to learn more about the specific health needs identified through the secondary data analysis.

The significant health needs identified through this mixed-method analysis in the KFH – Downey service area included:

- Access to Health Care
- Asthma
- Cardiovascular Disease
- Community Safety
- Diabetes
- HIV/AIDS/STD

- Mental Health
- Oral Health
- Overweight and Obesity
- Preventive Practices
- Substance Abuse
- Teen Pregnancy

B. Process and Criteria Used for Prioritization of the Health Needs

KFH – Downey hosted a community forum on January 13, 2016 in Downey to prioritize the significant health needs. The forum engaged 40 community leaders from public health, government agencies, schools, and nonprofit organizations that serve the medically underserved, low-income, and minority populations in the community. These individuals have current data or other information relevant to the health needs of the community served by the hospital facility. A review of the Community Health Needs Assessment process and the identified significant health needs were presented at the community forum.

Priority Setting Process

The forum attendees engaged in a process to prioritize the health needs using the Relative Worth method. The Relative Worth method is a ranking strategy where each participant received a fixed number of points; in this case 100 points (5 dots equaled 100 points, where each dot was worth 20 points). Instructions were given, and the criteria for assigning points were explained. The points were assigned to health needs based on the size of the problem (relative portion of population afflicted by the problem); or seriousness of the problem (impact at individual, family, and community levels). The points could be distributed among the health needs to be prioritized in a number of ways:

- Give all points to a single, very important item
- Distribute points evenly among all items (if none is larger or more serious than another)
- Distribute some points to some items, no points to other items

In the tabulation, items were ranked in priority order according to the total points the group assigned.

Participants engaged in a group discussion about the priority areas. Participants were asked to discuss the following questions for the high priority areas:

1. For priority issues, what is going well? What works in the community to address this issue? What groups/organizations are already focused on this issue?
2. What/who is missing? Where are the gaps? What are the barriers?
3. Identify collaborative opportunities to address the issues.

The participants were also asked to explain their thinking behind the lower rankings for some of the health needs. They indicated that many of the health needs were interrelated and impacted

on each other. So by addressing a particular health need, for example overweight and obesity, this would also serve to influence cardiovascular disease and diabetes. Therefore, more points were given to overweight and obesity as a health need because of the impact this need had on a number of other health needs. The information gathered from the community forum will be used for decision making in creation of the Implementation Strategy.

C. Description of Identified Community Health Needs

i. Community health landscape and trends

This section describes the health outcomes and important determinants (drivers) of health in the community. The list of significant health outcomes and drivers listed in this section is determined by the secondary and primary data collection and analysis (as described in Section V). This section provides information on morbidity and mortality as well as key drivers found in the community based on the analysis of secondary and primary data.

a. Significant Morbidity and Mortality (Health Outcomes)

A health outcome is a snapshot of a disease in a community that can be described in terms of both morbidity (incidence) and mortality (deaths).

Asthma

Asthma is a chronic disease that with treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives. Asthma episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath *(Healthy People 2020)*. Higher rates of asthma are found among lower income communities and communities of color in the service area. The communities located along area freeways are also prone to higher rates of asthma. Community members noted problems with obtaining timely diagnoses and a lack of education for proper asthma management. These factors may lead to higher hospitalization and ER usage.

In SPA 6, 6.8% of the population has been diagnosed with asthma, with 39.8% of those with asthma take medication to control asthma. Typically, higher percentages of persons with asthma taking medications can indicate better control of the disease; therefore, high rates of medication usage may be seen as a positive indicator. 9.5% of SPA 6 youth have been diagnosed with asthma, 3.8% of these youth take asthma medication. In SPA 7, 8.1% of the population has been diagnosed with asthma, with 18.8% taking medication to control their symptoms. Among youth, 5.3% have been diagnosed with asthma and 32.2% of these youth take asthma medication.

Asthma

	SPA 6	SPA 7	Los Angeles County	California
Diagnosed with asthma, total population	6.8%	8.1%	11.4%	14.0%
Diagnosed with asthma, 0-17 years old	9.5%	5.3%	10.5%	14.5%
ER visit in past year due to asthma, total population	3.4%	20.4%	4.7%	9.6%
ER visit in past year due to asthma, 0-17 years old	NA	10.5%	2.4%	13.9%
Takes daily medication to control asthma, total population	39.8%	18.8%	41.0%	44.2%
Takes daily medication to control asthma, 0-17 years old	3.8%	32.2%	27.7%	39.0%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Compton has the highest rate of youth diagnosed with asthma (16.5%) and Huntington Park has the lowest percentage of youth diagnosed with asthma (12.2%) for those cities with data available. Lakewood has the highest rate of adults diagnosed with asthma (16.4%), and Lynwood has the lowest rate of adults diagnosed with asthma (9.3%).

Diagnosed with Asthma, Youth, Ages 1-17, and Adults, 18 +

	Youth, Ages 1-17	Adults, Ages 18+
Bell	No Data	10.9%
Bell Gardens	No Data	10.6%
Bellflower	15.4%	13.8%
Cerritos	No Data	14.6%
Compton	16.5%	11.3%
Cudahy	No Data	10.3%
Downey	14.7%	12.8%
Huntington Park	12.2%	10.9%
Lakewood	15.5%	16.4%
Long Beach	14.8%	12.4%
Lynwood	14.5%	9.3%
Maywood	No Data	10.5%
Norwalk	14.2%	12.2%
Paramount	15.7%	10.3%
Pico Rivera	14.1%	11.3%
South East Los Angeles (Florence-Graham)	13.2%	9.5%
South Gate	13.6%	10.3%
South Whittier	No Data	12.5%
Whittier	14.1%	14.1%
West Whittier – Los Nietos	No Data	11.7%
Los Angeles County	**15.0%**	**12.2%**
California	**15.4%**	**13.7%**

Source: California Health Interview Survey, Neighborhood Edition, 2011-2012. http://askchisne.ucla.edu
No data available for Artesia, Commerce, Hawaiian Gardens, Santa Fe Springs, Vernon.

Asthma is a condition that when managed can prevent ER visits or hospitalizations. The overall hospitalization rate for asthma in the KFH – Downey service area is 14.3 per 10,000 persons. South East Los Angeles (90059) has the highest rate of ER visits for asthma per 10,000

persons (74.2), and South Los Angeles (90001) has the highest hospitalization rate (26.1) for asthma. Downey (90240) has the lowest asthma ER rate (26.3), and Cerritos has the lowest asthma hospitalization rate (6.3).

Asthma Age-Adjusted ER and Hospitalization Rate, per 10,000 Population, 2011-2013

	ER Rate	Hospitalization Rate
90001 - South East Los Angeles	52.0	26.1
90002 - South East Los Angeles	61.8	18.9
90040 - Commerce	45.9	10.0
90059 - South East Los Angeles	74.2	20.3
90201 - Bell/Bell Gardens	30.8	13.0
90221 - Compton	61.3	16.9
90222 - Compton	72.6	19.8
90240 - Downey	26.3	6.4
90241 - Downey	41.6	8.7
90242 - Downey	39.4	11.1
90255 - Huntington Park	39.4	16.3
90262 - Lynwood	42.1	11.0
90270 - Maywood	29.8	12.1
90280 - South Gate	31.7	10.0
90601 - Whittier	50.1	9.3
90602 - Whittier	54.4	11.0
90603 - Whittier	40.2	6.4
90604 - Whittier	53.3	9.9
90605 - Whittier	51.3	10.0
90606 - Whittier	49.3	10.5
90650 - Norwalk	42.8	11.6
90660 - Pico Rivera	45.4	9.6
90670 - Santa Fe Springs	44.3	8.5
90701 - Artesia	35.8	No Data
90703 - Cerritos	34.7	6.3
90706 - Bellflower	54.9	13.8
90712 - Lakewood	39.5	8.5
90713 - Lakewood	30.3	8.4
90715 - Lakewood	59.6	9.6
90716 - Hawaiian Gardens	48.8	No Data
90723 - Paramount	45.1	8.0
90805 - Long Beach	64.3	13.1
Los Angeles County	**42.7**	**10.0**

Source: California Office of Statewide Health Planning and Development, 2011-2013. www.thinkhealthla.org

Community Input – Asthma

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to asthma:

- The area is impacted by environmental factors such as freeways and increased emissions. We live next to freeways so there is poor air quality.
- I was over-medicating my son for a year, but the doctor hadn't explained the potential side-effects and we figured 'more is better'. There is a lack of understanding among parents about environmental factors that contribute to asthma in the household. Sometimes we are only given medications but not educated on how to prevent and control asthma (e.g., pets, smoking in the house, etc.).
- A diagnosis of asthma for my daughter took forever; the doctor just kept saying 'No, she just has a cold'. Until a mobile clinic for asthma came to her school and identified asthma, she'd been sick for years.
- There is a lack of education among parents and kids with asthma.
- We have a high percentage of kids in our school district with asthma and many go undiagnosed.

Cancer

Cancer remains the second leading cause of death in the United States. Many cancers are preventable by reducing risk factors such as: use of tobacco products, physical inactivity and poor nutrition, obesity, and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated, and screening is effective in identifying some types of cancers *(Healthy People 2020)*. Feedback from community members indicates that barriers accessing care may contribute to individuals not obtaining needed screenings to detect cancer or receiving timely cancer treatment. Environmental factors are perceived by community members to contribute to cancer in the service area, which is close to freeways and manufacturing.

Cancer incidence rates are available at the County level. In Los Angeles County, cervical cancer (8.9 per 100,000 persons) and colorectal cancer rates (41.3 per 100,000 persons) exceed state rates. Breast cancer (116.9), prostate cancer (122), lung cancer (41.6) and skin cancer (13.5) occur at rates less than the state rates for these types of cancer.

Age-Adjusted Cancer Incidence, per 100,000 Persons, 2008-2012

	Los Angeles County	California
Breast Cancer (Female)	116.9	122.1
Cervix	8.9	7.7
Colon and Rectum Cancer	41.3	40.0
Melanoma (Skin)	13.5	20.9
Prostate Cancer	122.0	126.9
Lung and Bronchus Cancer	41.6	48.0

Source: California Cancer Registry. Age-Adjusted Invasive Cancer Incidence Rates by County in California, 2008 - 2012. Based on November 2014 Extract (Released November 21, 2014). Cancer-Rates.info. http://cancer-rates.info/ca/

Cancer is the second highest cause of death after heart disease in the service area. The rate of age-adjusted death due cancer is 161.6 per 100,000 persons in the service area. This is higher

than the Healthy People 2020 objective of cancer death of 160.6 per 100,000 persons.

Cancer Mortality Rate, Age-Adjusted, Rate per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Cancer death rate	16,122	161.6	153.0	157.1

Source: University of Missouri, 2010-2012. Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data by zip code.

Community Input – Cancer

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to cancer:

- There are long waits at County for specialty care; by the time people are seen, their cancer has spread and become more serious.
- People, particularly the uninsured, don't get screenings or care until there are symptoms.
- Doctors give a diagnosis without offering any suggestions for next steps; people are stuck doing their own research about a health issue. There is a lack of knowledge about available resources, and a lack of programs to educate people with cancer to help them understand what is happening.
- Those with testicular cancer are not gaining access to care and not talking about it in school education.
- Education is needed in schools to normalize cancer so that children don't feel ostracized or get teased if a parent or other family member has cancer.
- There are community concerns regarding high rates of cancer deaths among people living near some manufacturing plants (e.g. battery recycling facility).
- There is fear around a cancer diagnosis. It is very devastating, very expensive. People don't know where to go to get treatment. They give up when they hear the diagnosis; they don't even investigate treatments or options.

Cardiovascular Disease

Cardiovascular disease includes conditions that impact the heart and vascular system. Conditions may include heart disease, stroke, high blood cholesterol and high blood pressure. A number of factors influence the development and management of cardiovascular disease: overweight, physical inactivity, and diets high in sugar and fat. The KFH – Downey service area shows high rates of heart disease and stroke. Interestingly, the higher socioeconomic neighborhoods in the service area tend to have higher rates of heart disease (i.e. Cerritos and Lakewood). Community members identified the need for more education and preventive screenings. They also connected healthy eating and increased physical activity to preventing heart disease and stroke.

Heart Disease

Heart disease is the leading cause of death in the service area. The rate of death, age-adjusted for coronary heart disease is 186.6 per 100,000 persons. This exceeds the county rate (172.6), state rate (163.2), and the Healthy People 2020 objective (100.8 per 100,000 persons).

Coronary Heart Disease Mortality Rate, Age-Adjusted, Rate per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Heart disease death rate	17,731	186.6	172.6	163.2

Source: University of Missouri, 2010-2012. Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, by zip code.

8.6% of adults in SPA 6 and 5.2% of adults in SPA 7 have been diagnosed with heart disease. 62.4% in SPA 6 and 40.4% of those with heart disease in SPA 7 are very confident they can manage their condition.

Adult Heart Disease

	SPA 6	SPA 7	Los Angeles County	California
Diagnosed with heart disease	8.6%	5.2%	5.7%	6.1%
Very confident to control condition	62.4%	40.4%	53.5%	53.6%
Somewhat confident to control condition	33.3%	28.4%	36.0%	34.9%
Not confident to control condition	4.2%	31.2%	10.4%	11.5%
Has a management care plan	55.4%	62.1%	55.5%	67.1%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Cerritos has the highest percentage of adults with heart disease (7.4%). Lynwood and South Los Angeles have the lowest rates of heart disease among adults (4.5%) in the service area.

Diagnosed with Heart Disease, Adults

	Percent
Bell	5.2%
Bell Gardens	4.8%
Bellflower	5.2%
Cerritos	7.4%
Compton	4.9%
Cudahy	4.6%
Downey	6.5%
Huntington Park	5.3%
Lakewood	6.7%
Long Beach	5.9%
Lynwood	4.5%
Maywood	4.9%
Norwalk	6.1%
Paramount	4.9%
Pico Rivera	6.4%
South Los Angeles (Florence-Graham)	4.5%
South Gate	5.2%
South Whittier	6.1%
Whittier	6.4%
West Whittier – Los Nietos	6.3%
Los Angeles County	**5.9%**
California	**6.3%**

Source: California Health Interview Survey, Neighborhood Edition, 2011-2012. http://askchisne.ucla.edu
No data available for Artesia, Commerce, Hawaiian Gardens, Santa Fe Springs, Vernon.

Among men 45 years and older and women 55 years and older in SPA 6, 30.9% reported taking aspirin daily or every other date for their heart. In SPA 7, 32.8% of adults reported taking aspirin. These rates are lower than the County rate of 33.8%.

Adults Who Reported Taking Aspirin Daily or Every Other Day for Their Heart

	SPA 6	SPA 7	Los Angeles County
Men 45+ years old and women 55+ years old	30.9%	32.8%	33.8%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011.
www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

High Blood Pressure

High blood pressure (hypertension) is a contributing cause to stroke, diabetes and heart disease. In SPA 6, 35.7% of adults have been diagnosed with high blood pressure and 55.5% are on medication to control the high blood pressure. In SPA 7, 20.8% of adults have been diagnosed with high blood pressure. Of these, 60.2% are on medication. The Healthy People 2020 objective is to reduce the proportion of adults with high blood pressure to 26.9%. Adults in SPA 6 exceed this rate.

High Blood Pressure

	SPA 6	SPA 7	Los Angeles County	California
Diagnosed with high blood pressure	35.7%	20.8%	27.3%	28.5%
Takes medication for high blood pressure	55.5%	60.2%	67.2%	68.5%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

High Cholesterol

High cholesterol contributes to heart disease. Among adults in SPA 6, 22.9% have been diagnosed with high cholesterol. 25.4% of adults in SPA 7 have high cholesterol. These rates are lower than the County rate of 25.6% of adults with high cholesterol. The Healthy People 2020 objective is to reduce the proportion of adults with high blood cholesterol levels to 13.5%. Adults in SPA 6 and SPA 7 exceed this rate.

Adults Diagnosed with High Cholesterol

	SPA 6	SPA 7	Los Angeles County
Diagnosed with high blood cholesterol	22.9%	25.4%	25.6%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011.
www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

Stroke

The rate of death, age-adjusted for cerebrovascular disease (stroke) is 44.0 per 100,000 persons. This exceeds the state rate (37.4), and the Healthy People 2020 objective, which is a mortality rate due to stroke of 34.8 per 100,000 persons.

Stroke Heart Disease Mortality Rate, Age-Adjusted, Rate per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Stroke disease death rate	4,091	44.0	36.2	37.4

Source: University of Missouri, 2010-2012. Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data by zip code.

Community Input – Cardiovascular Disease

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to cardiovascular disease:

- There is higher risk for heart disease among African-Americans, it is important for them to be aware of hypertension and the need to reduce sodium.
- There is a lack of training, education, and resources for information and CPR.
- Carotid artery screening is not promoted enough and many people are unaware of it.
- We have a lack of information about symptoms of stroke or symptoms of a heart attack. More communication is needed for stroke patients and their families.
- Heart disease is closely linked to diabetes and obesity. Affordability of healthy foods is a challenge for low-income people.
- For Hispanics cardiovascular disease is a major concern. We need access to more educational information.
- We experience a sedentary lifestyle, and there is a lack of public awareness of the risk factors and strategies for prevention.

Diabetes

Diabetes is the fifth leading cause of death in Los Angeles County. Living with uncontrolled diabetes can lead to severe health consequences that include heart disease, stroke and kidney failure. Diabetes is a costly chronic condition that can lead to disability, loss of productivity and premature death *(LA County Department of Public Health).* Higher rates of diabetes are found among lower income communities and communities of color in the service area. The residents in these communities also tend to have higher rates of hospitalization and ER visits as a result of diabetes. Community stakeholders from interviews and focus groups identified the difficulty of changing lifestyles to increase activity and make healthy food choices to address prevention and treatment of diabetes. Low-income communities tend to have less access to healthy food options and there is a perceived lack of safe places for exercise.

In the service area, South East Los Angeles has the highest percentage of adults diagnosed with diabetes (12.6%) and Lakewood has the lowest percentage of adults with diabetes (7%).

Ever Diagnosed with Diabetes, Adults

	Percent
Bell	11.3%
Bell Gardens	11.5%
Bellflower	8.6%
Cerritos	8.7%
Compton	11.1%

	Percent
Cudahy	12.3%
Downey	10.1%
Huntington Park	11.0%
Lakewood	7.0%
Long Beach	8.9%
Lynwood	11.7%
Maywood	11.9%
Norwalk	9.7%
Paramount	10.0%
Pico Rivera	10.9%
South East Los Angeles (Florence-Graham)	12.6%
South Gate	10.5%
South Whittier	9.7%
Whittier	8.0%
West Whittier – Los Nietos	11.2%
Los Angeles County	**8.8%**
California	**8.4%**

Source: California Health Interview Survey, Neighborhood Edition, 2011-2012. http://askchisne.ucla.edu
No data available for Artesia, Commerce, Hawaiian Gardens, Santa Fe Springs, Vernon.

In SPA 6, 14.7% of adults have been diagnosed with diabetes and 77.7% are very confident they can control their diabetes. In SPA 7, 12.4% of adults have been diagnosed with diabetes. For these adults, 52.6 are very confident they can control the disease.

Adult Diabetes

	SPA 6	SPA 7	Los Angeles County	California
Diagnosed pre/borderline diabetic	12.0%	12.9%	8.8%	10.5%
Diagnosed with diabetes	14.7%	12.4%	10.0%	8.9%
Very confident to control diabetes	77.7%	52.6%	56.9%	56.5%
Somewhat confident	19.0%	45.4%	33.7%	34.7%
Not confident	3.3%	2.0%	9.3%	8.8%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Diabetes is a condition that when managed can prevent ER visits or hospitalizations. When the rate of ER visits and hospitalizations for diabetes are examined by place in the service area, Compton (90221) has the highest ER rate for diabetes (65.9) and Compton has the highest hospitalization rate for diabetes (52.9). Cerritos has the lowest ER rate (14.6), and Lakewood (90713) has the lowest hospitalization rate (13.8) for diabetes among adults.

Adult Diabetes, Age-Adjusted ER & Hospitalization Rate, per 10,000 Persons, 2011-2013

	ER Rate	Hospitalization Rate
90001 - South Los Angeles	46.8	47.6
90002 - South East Los Angeles	57.1	52.8
90040 - Commerce	31.2	28.8
90059 - South East Los Angeles	57.9	45.7
90201 – Bell/Bell Gardens	33.4	24.7
90221 - Compton	65.9	52.9

	ER Rate	Hospitalization Rate
90222 - Compton	48.7	42.6
90240 - Downey	17.5	18.4
90241 - Downey	27.7	27.2
90242 - Downey	21.7	20.5
90255 - Huntington Park	38.3	34.3
90262 - Lynwood	49.8	35.1
90270 - Maywood	37.0	24.7
90280 - South Gate	38.6	30.0
90601 - Whittier	22.9	19.2
90602 - Whittier	36.6	23.9
90603 - Whittier	31.7	20.0
90604 - Whittier	21.4	17.6
90605 - Whittier	27.2	18.9
90606 - Whittier	38.7	31.6
90650 - Norwalk	36.6	30.3
90660 - Pico Rivera	36.5	30.6
90670 - Santa Fe Springs	33.6	22.0
90701 - Artesia	28.2	27.0
90703 - Cerritos	14.6	16.9
90706 - Bellflower	37.0	24.0
90712 - Lakewood	19.9	15.2
90713 - Lakewood	18.8	13.8
90715 - Lakewood	31.4	22.3
90716 - Hawaiian Gardens	42.5	50.5
90723 - Paramount	48.6	33.2
90805 - Long Beach	41.0	38.7
Los Angeles County	**24.5**	**20.5**

Source: California Office of Statewide Health Planning and Development, 2011-2013. www.thinkhealthla.org

Community Input – Diabetes

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to diabetes:

- The big challenge is the behavior and lifestyle changes needed to address diabetes.
- Diabetes is a major health issue. People are aware it is an issue but they don't know how to make the best choices; there are language barriers and a belief that pills will solve the problem.
- It is a huge problem but there is low community awareness; people are noncompliant or resistant, neglectful.
- There are a large number of people needing care, and they need to make big changes to their lifestyles. It is expensive to eat right; it requires care and education.
- We need to educate people at a younger age and emphasize prevention.
- Seniors have difficulty affording glucose test strips, though meters are provided. People

try to stretch their test strips, so they don't test their blood as frequently as recommended.

- We don't walk anywhere; we drive everywhere. We have no habit of exercise. Mandated physical education (PE) minutes in schools are not enforced due to the lack of qualified teachers to teach PE. In many local areas it's not safe for children to go outside to play.

HIV/AIDS/STD

STDs and HIV/AIDS continue to be major public health problems. 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. HIV is a preventable disease. Effective HIV prevention interventions have been proven to reduce HIV transmission *(Healthy People 2020)*. While HIV/AIDS rates are decreasing, the service area is experiencing very high rates of sexually transmitted infections. Young women of color experience the highest rates of STDs. Community stakeholders indicate the stigma associated with STDs, HIV/AIDS. This stigma may result in inadequate education and communication about this health outcome.

The rate of HIV diagnoses has decreased over the past three years. In SPA 6, the rate of HIV is 16 per 100,000 persons, in SPA 7 the rate is 8.

HIV Diagnoses and Rates per 100,000 Population, 2011 – 2013

	2011		2012		2013	
	Number	Rate	Number	Rate	Number	Rate
SPA 6	268	27	223	22	159	16
SPA 7	173	13	154	12	104	8
Los Angeles County	**1,930**	**19**	**1,911**	**19**	**1,268**	**13**

Source: County of Los Angeles, Public Health, 2013 Annual HIV Surveillance Report.
http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2013AnnualSurveillanceReport.pdf

The rate of persons living with AIDS per 100,000 population in SPA 6 is 285 and in SPA 7 the rate is 143. The rate of AIDS in SPA 6 is higher than the county rate (276).

Persons Living with AIDS and Rates per 100,000 Population, 2013

	SPA 6		SPA 7		Los Angeles County	
	Number	Rate	Number	Rate	Number	Rate
Persons living with AIDS	2,904	285	1,860	143	27,314	276

Source: County of Los Angeles, Public Health, 2013 Annual HIV Surveillance Report.
http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2013AnnualSurveillanceReport.pdf

All STD rates in SPA 6 are higher than the county while rates in SPA 7 rates are lower than county rates. The highest rates can be found for Chlamydia – 968.0 per 100,000 persons in SPA 6 and in SPA 7, 498.7 per 100,000 persons. Teens and young adults, age 15-29, and Blacks/African Americans, have the highest rates of sexually transmitted infections.

STD Cases, Rate per 100,000 Persons, 2012

	SPA 6	SPA 7	Los Angeles County	California*
Chlamydia	968.0	498.7	521.3	448.4
Gonorrhea	233.0	76.3	122.9	89.2
Primary & Secondary Syphilis	12.0	4.3	9.4	7.8
Early Latent Syphilis	17.2	7.2	13.7	6.7

Source: County of Los Angeles, Public Health, Sexually Transmitted Disease Morbidity Report, 2012.
http://publichealth.lacounty.gov/dhsp/Reports/STD/STDMorbidityReport2012.pdf
**California Department of Public Health, STD Local Health Jurisdiction, 2012.*
http://www.cdph.ca.gov/data/statistics/Pages/STDLHJData.aspx

Females have the highest rates of Chlamydia. Rates of Chlamydia among females in SPA 6 and SPA 7 exceed the county rates. Black women experience Chlamydia in the highest rates.

Chlamydia Rates, per 100,000 Persons, Females, 2012

	SPA 6	SPA 7	Los Angeles County
White	1189.5	322.4	243.9
Black	2081.1	1396.3	1805.7
Latino	913.1	725.4	752.5
Asian Pacific Islander	491.0	201.3	207.6
Total	1307.9	672.0	665.4

Source: County of Los Angeles, Public Health, Sexually Transmitted Disease Morbidity Report, 2012.
http://publichealth.lacounty.gov/dhsp/Reports/STD/STDMorbidityReport2012.pdf

Among teens in SPA 6, 56.8% had not had sex. Of those who had sex, 4.6% had been tested for an STD. In SPA 7, 82.9% of teens indicated they had never had sex.

Teen Sexual History

	SPA 6	SPA 7	Los Angeles County	California
Never had sex	56.8%	82.9%	78.4%	82.9%
First encounter under 15 years old	29.4%	No Data	10.7%	7.6%
First encounter over 15 years old	13.9%	17.1%	10.9%	9.5%
If had sex, tested for STD in past year	4.6%	23.4%	36.7%	31.7%

Source: California Health Interview Survey, 2012. http://ask.chis.ucla.edu

Community Input – HIV/AIDS/STD

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to HIV/AIDS/STD:

- There is limited education in community and schools. There is a cultural reticence in the Hispanic community.
- This is a big issue but there are few resources. There is a cultural stigma about discussing it with a provider and getting tested.
- There needs to be continuing education about prevention and risks with youth.
- Kids think they are invincible. Parents need to be trained how to talk with their kids.

- I cannot tell you how many patients we see that say they didn't even know they had an STD. And then they just get it over and over again in a few months.
- Even if it's curable, people are afraid that it's something that's incurable, so they don't get tested.
- People still think they can get AIDS from a hug.
- We need to start the education sooner and school is a great place. By high school it is too late, but teachers say elementary school is too young to talk about it. We need more sexual education in schools, even middle schools, but definitely in high school.
- Significant improvement countywide, mostly because of an aggressive prevention campaign and making sites available for testing and counseling.

Mental Health

Mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression and outcome of chronic diseases *(Healthy People 2020)*. In the service area the rates of suicide and considering suicide are lower than county and state rates. However, 15% to 21.9% of adults and 17.5% to 18.9% of teens in the service are needed help for mental health or emotional issues.

In SPA 6, 8.2% of adults and 9.2% of adults in SPA 7 experienced serious psychological distress in the past year. In SPA 6, 15% of adults needed help for an emotional/mental health or alcohol/drug related issue. In SPA 7 21.9% needed help for a mental health or alcohol/drug issue.

Mental Health, Adults

	SPA 6	SPA 7	Los Angeles County	California
Adults who has likely had serious psychological distress during past year	8.2%	9.2%	9.6%	7.7%
Adults who needed help for emotional/mental and/or alcohol-drug issues in past year	15.0%	21.9%	18.0%	15.9%
Adults who took prescription medicine for emotional/mental health issue in past year	8.0%	8.5%	9.2%	10.1%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

In SPA 6, 17.5% of teens needed help for an emotional or mental health problem. In SPA 7, 18.9% of teens needed help for an emotional or mental health problem.

Mental Health, Teens

	SPA 6	SPA 7	Los Angeles County	California
Teens who needed help for emotional / mental health problems in past year	17.5%	18.9%	22.4%	23.2%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Adults with serious psychological distress was determined using the Kessler 6 series for adults (ages 18 years and older) who reported serious psychological distress in the past 12 months

(K6 score ≥ 13). The K6 is a tool used for screening mental health issues in a general adult population. Among service area cities, Compton has the highest percentage of adults with serious psychological distress (9.1%) and Cerritos has the lowest percent of psychological distress among adults (6.1%).

Adults with Serious Psychological Distress

	Percent
Bell	7.4%
Bell Gardens	6.9%
Bellflower	6.8%
Cerritos	6.1%
Compton	9.1%
Cudahy	6.8%
Downey	7.1%
Huntington Park	7.0%
Lakewood	7.5%
Long Beach	6.9%
Lynwood	8.4%
Maywood	7.2%
Norwalk	6.4%
Paramount	8.6%
Pico Rivera	6.8%
South East Los Angeles (Florence-Graham)	8.0%
South Gate	7.8%
South Whittier	6.8%
Whittier	7.1%
West Whittier – Los Nietos	6.5%
Los Angeles County	**8.0%**
California	**7.9%**

Source: California Health Interview Survey, Neighborhood Edition, 2011-2012. http://askchisne.ucla.edu
No data available for Artesia, Commerce, Hawaiian Gardens, Santa Fe Springs, Vernon.

In SPA 6, 5.2% of adults had seriously considered suicide. In SPA 7, 4.7% of adults had seriously considered suicide. This is less than the county and state rates.

Thought about Committing Suicide

	SPA 6	SPA 7	Los Angeles County	California
Adults who ever seriously thought about committing suicide	5.2%	4.7%	7.2%	7.8%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

In the hospital service area, the age-adjusted rate of suicide is 5.1 per 100,000 persons. This is less than the state rate of 9.8 and the Healthy People 2020 objective of 10.2 per 100,000 persons.

Suicide Mortality Rate, Age-Adjusted, Rate per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Suicide death rate	647	5.1	7.4	9.8

Source: University of Missouri, 2010-2012. Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data by zip code.

Overweight and Obesity

Being overweight or obese affects a wide range of health issues and are major risk factors for diabetes, cardiovascular disease, and other chronic diseases. There are high rates of overweight and obesity among adults and teens in the service area. This may have an impact on the high rates of chronic diseases identified in the service area. In the KFH – Downey service area, Blacks/African Americans and Latinos/Hispanics tend to have higher rates of overweight and obesity, while Asians have lower rates.

Over one-third of the adult population is overweight in SPA 6 (35.9%). In SPA 7, 29.1% of adults are overweight. In SPA 6, 2% of teens and 7.3% of children are overweight. In SPA 7, 11.5% of teens and 10.2% of children are overweight.

Overweight

	SPA 6	SPA 7	Los Angeles County	California
Adult (ages 18+)	35.9%	29.1%	36.2%	35.5%
Teen (ages 12-17)	2.0%	11.5%	14.4%	16.3%
Child (ages 2-11)	7.3%	10.2%	13.1%	13.6%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu
An adult is overweight if 25.0 ≤ Body Mass Index (BMI) ≤ 30.0. Teen overweight is a BMI at or above the 85th percentile and lower than the 95th percentile for the same age and sex. Child overweight is by age, and does not factor in height (CDC.gov, 2013)

Youth overweight reports the percentage of children in grades 5, 7, and 9 ranking within the "Needs Improvement" category (Overweight) for body composition on the Fitnessgram physical fitness test. Body composition is determined by skinfold measurements or bioelectrical impedance analysis for the calculation of percent body fat and/or Body Mass Index (BMI) calculation. In the service area, 20.5% of 5th, 7th and 9th graders are considered overweight.

Youth Overweight

	Service Area	Los Angeles County	California
Children in grades 5, 7, and 9 within the needs improvement* category for body composition	20.5%	20.0%	19.3%

*Source: California Department of Education, 2013-2014, FITNESSGRAM® Physical Fitness Testing. The CDC's BMI-for-age growth charts define an individual as overweight when his or her weight is between the "85th to less than the 95th percentile" *The percent body fat "needs improvement" threshold is 18.9%-22.3% for boys and 20.9%-31.4% for girls, depending on age. The BMI "Health Risk" threshold is 16.8-25.2 for boys and girls, depending on age.*

Multiple race youth (21.6%) and Hispanic or Latino youth (21.3%) have the highest rates of overweight among kids in the school districts served by KFH – Downey.

Youth Overweight by Race/Ethnicity

	Service Area	Los Angeles County	California
Multiple Races	21.6%	21.7%	18.3%
Hispanic or Latino	21.3%	20.1%	21.6%
Black or African American	19.8%	16.1%	20.3%
White	17.4%	14.7%	15.9%
Asian	14.3%	18.6%	15.1%

*Source: California Department of Education, 2013-2014, FITNESSGRAM® Physical Fitness Testing. The CDC's BMI-for-age growth charts define an individual as overweight when his or her weight is between the "85th to less than the 95th percentile" *The percent body fat "needs improvement" threshold is 18.9%-22.3% for boys and 20.9%-31.4% for girls, depending on age. The BMI "Health Risk" threshold is 16.8-25.2 for boys and girls, depending on age.*

From 2005 to 2011, there was an increase of 9% in adult obesity in SPA 6 and 10.3% in SPA 7. In 2011, 32.7% of SPA 6 adults were obese. 30.1% of the adult population in SPA 7 was obese. These rates are higher than the county rate of 23.6% obese adults.

Adult Obesity

	2005	2007	2011	Change 2005-2011
SPA 6	30.0%	35.4%	32.7%	9.0%
SPA 7	27.3%	26.6%	30.1%	10.3%
Los Angeles County	**20.9%**	**22.2%**	**23.6%**	**12.9%**

Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Trends in Obesity: Adult Obesity Continues to Rise, September 2012. http://publichealth.lacounty.gov/wwwfiles/ph/hae/ha/Obesity_2012_sFinal.pdf
An adult is considered obese if BMI ≥ 30kg/m^2.

In SPA 6, 38.6% of adults are obese and in SPA 7, 39.3% of adults are obese. These rates are higher than county (27.2%) and state (27%) rates of obesity. And they exceed the Healthy People 2020 objective of 30.5% of adult obesity.

Adult Obesity

	SPA 6	SPA 7	Los Angeles County	California
Adults with BMI 30 or higher	38.6%	39.3%	27.2%	27.0%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu An adult is considered obese if BMI ≥ 30kg/m^2.

African Americans and Latinos in SPA 6 have higher rates of obesity. African Americans and Whites in SPA 7 have higher rates of overweight and obesity. The Asian rate of overweight and obesity in SPA 6 exceeds county and state rates.

Adult Overweight and Obesity by Race/Ethnicity

	SPA 6	SPA 7	Los Angeles County	California
Black or African American	84.8%	99.1%	80.8%	71.2%
Asian	59.6%	30.8%	40.4%	43.7%
Hispanic or Latino	73.6%	70.5%	71.4%	73.2%
White	41.2%	76.5%	58.7%	58.9%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu. An adult is considered obese if BMI ≥ 30kg/m^2.

Youth obesity reports the percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category (Obese) for body composition on the Fitnessgram physical fitness test. Body

composition is determined by skinfold measurements or bioelectrical impedance analysis for the calculation of percent body fat and/or Body Mass Index (BMI) calculation.

Youth Obese

	Service Area	Los Angeles County	California
Children in grades 5, 7, and 9 within the high risk* category for body composition	23.6%	21.5%	19.0%

*Source: California Department of Education, 2013-2014, FITNESSGRAM® Physical Fitness Testing. The CDC's BMI-for-age growth charts define an individual as overweight when his or her weight is "greater than the 95th percentile" * The percent body fat "high risk" threshold is 27.0%-35.1% for boys and 28.4%-38.6% for girls, depending on age. The BMI "high risk" threshold is 17.5-25.2 for boys and 17.3-27.2 for girls, depending on age.*

Community Input – Overweight and Obesity

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to overweight and obesity:

- We are seeing a lot more awareness of the issue and community effort.
- This is a community focus for Hawaiian Gardens where about 25% of the kids are overweight or obese.
- This is a significant health need especially among the Latino population.
- Overweight and obesity contributes to diabetes and cardiovascular disease.

Violence and Injury Prevention

Death rates as a result of violence and injury are higher in the service area than in the state. The homicide death rate is 8.8 per 100,000 persons, which exceeds the Healthy People 2020 objective of 5.5 deaths per 100,000 as a result of homicide. The death rate as a result of motor vehicle accidents in the service area is 6.7 per 100,000. This rate of death is less than the Healthy People 2020 objective of 12.4 deaths per 100,000 as a result of motor vehicle accidents. The rate of pedestrians being killed by motor vehicles is 2.7 per 100,000 persons. This rate of death is higher than the Healthy People 2020 objective of 1.2 pedestrian deaths per 100,000 persons.

Violence and Injury Mortality Rates, Age-Adjusted, Rate per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate	Rate	Rate
Homicide death rate	1,232	8.8	6.0	5.2
Motor vehicle accident death rate	843	6.7	5.4	5.2
Pedestrian motor vehicle death rate	305	2.7	2.3	2.0

Source: University of Missouri, 2010-2012. Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data by zip code.

Crime

Violent crimes include homicide, rape, robbery (of an individual or individuals, not a home or business) and aggravated assault. Property crimes include burglary, larceny-theft, and motor vehicle theft. In the service area Commerce (7,748.4) has the highest rate of property crime reported and Compton (1,242.1) has the highest rates of violent crime reported per 100,000

persons. Maywood (1,026.9) has the lowest property crime rate and Cerritos (240.7) has the lowest violent crime rate per 100,000 persons.

Violent Crime Rates and Property Crime Rates per 100,000 Persons, 2012

	Property Crime Rates	Violent Crime Rates
Artesia	1,560.2	357.3
Bell	1,835.7	623.9
Bell Gardens	1,702.2	292.3
Bellflower	2,313.6	390.3
Cerritos	3,750.8	240.7
Commerce	7,748.4	859.2
Compton	2,446.5	1,242.1
Cudahy	1,433.8	623.9
Downey	3,112.8	335.3
Hawaiian Gardens	1,331.7	476.1
Huntington Park	3,244.8	631.4
Lakewood	2,533.7	278.9
Long Beach	3,007.3	575.7
Los Angeles	2,269.1	481.1
Lynwood	1,936.3	763.0
Maywood	1,026.9	628.4
Norwalk	2,431.6	403.6
Paramount	2,792.9	443.7
Pico Rivera	2,781.8	407.9
Santa Fe Springs	7,712.8	600.3
South Gate	2,652.0	576.2
Whittier	2,884.5	284.8
California	**2,758.7**	**423.1**

Source: U.S. Department of Justice, FBI, Uniform Crime Reporting Statistics, 2012. www.bjs.gov/ucrdata/index.cfm
No data for Vernon.

Compton and Downey have the highest number of domestic violence calls in the service area. In Downey, 94% of the domestic violence calls did not involve a weapon. In Compton, 91% of the domestic violence calls involved a weapon.

Domestic Violence Calls, 2014

	Total	Without Weapon	With Weapon
Artesia	32	7	25
Bell	120	46	74
Bellflower	364	77	287
Bell Gardens	97	91	6
Cerritos	52	7	45
Commerce	44	1	43
Compton	484	42	442
Cudahy	56	4	52
Downey	408	383	25
Hawaiian Gardens	39	4	35
Huntington Park	193	179	14
Lakewood	245	78	167
Lynwood	168	5	163
Maywood	48	3	45

Domestic Violence Calls, 2014

	Total	Without Weapon	With Weapon
Norwalk	306	35	271
Paramount	176	44	132
Pico Rivera	260	65	195
Santa Fe Springs	43	11	32
South Gate	275	188	87
Vernon	10	0	10
Whittier	257	10	247
California	**166,361**	**100,496**	**65,865**

Source: California Department of Justice, Office of the Attorney General, 2014. https://oag.ca.gov/crime/cjsc/stats/domestic-violence
Data available by city, therefore, zip code only areas in the KFH – Downey service area are not listed.

11.7% of teens in SPA 6 and 22.9% in SPA 7 received threats of violence or physical harm from their peers in the past year. 22.8% of teens in SPA 6 and 4.3% of teens in SPA 7 feared being attacked at school in the past year.

Teens Threat and Fear of Violence

	SPA 6	SPA 7	Los Angeles County	California
Teens received threats of violence or physical harm by peers in past year	11.7%	22.9%	14.7%	16.2%
Teens feared being attacked at school in past year	22.8%	4.3%	17.1%	14.3%

Source: California Health Interview Survey, 2012. http://ask.chis.ucla.edu

Community Input – Community Safety

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to community safety:

- Community violence is still a problem. Its roots are in poverty, alienation, and displaced anger. It is hard to deal with if it happens to someone in your family.
- The police are busy with the wrong things (i.e. giving tickets to people for collecting bottles from the trash), rather than dealing with violence and other important crimes.
- Domestic violence is a significant problem in the immigrant population. People are very fearful of reporting crimes or seeking help.
- Crime is probably under-reported. Community safety has decreased with early prisoner releases.
- More women are becoming aware of their rights, but reporting crime is still a taboo subject for many Hispanics. Victims are reluctant to speak out, don't know where to seek help or how to manage if their abuser is forced to leave the home.
- Both community violence and domestic violence are definitely present in Whittier; there is more community awareness now. Whittier is so diverse but this is a universal concern.
- Violent crime has gone down in unincorporated areas but there are some pockets where crime has always been a problem. Law enforcement blames early release programs.
- Until this year we had been in a great downward spiral reducing crime but it spiked up again this year. Some think it's due to early release of many prisoners. There is more

gang activity and a recent increase in drive-by shootings.

- There is more criminal activity on riverbeds throughout SPA 7 during the past year. Youth in our community are more exposed to gangs in communities around Downey.
- There are lots of panhandlers at banks, supermarkets, which can be scary especially for seniors. The homeless population seems to be increasing.
- We need to teach about healthy relationships, life skills, self-esteem issues. There is a lack of education for males about the cycle of violence and how to stop the cycle.
- There has been an increase in older teen girls who are abused by their boyfriends.

b. Significant Health Drivers

Health drivers are behavioral, environmental, social, economic and clinical care factors that positively or negatively impact health.

i. Access to care

With passage of the Affordable Care Act (ACA) in 2010, health insurance coverage was made more available. The secondary data sources for insurance coverage at this time do not fully capture the influence of the Affordable Care Act on access to care. Community input on access to care from interviews and focus groups indicate the availability of insurance coverage is improving access to care. However, a number of barriers remain, including affordability, transportation, navigating the system, and accessibility to appointments in a timely manner. Access to care remains limited for non-resident immigrants who are not covered by the ACA. Community stakeholders also identified barriers to accessing care experienced by the homeless, students and seniors.

In addition to health care access, there are identified barriers to accessing dental care and mental health care. There are limited health insurance options for dental care and not enough resources. The lack of resources is also a concern for those attempting to access services for mental health care. Obtaining dental health and mental health care are often not prioritized as necessary given limited resources. As a result, many residents in the service area forgo dental care and mental health care services.

Health Insurance Coverage

In the KFH – Downey service area, 35.7% of the population has Medi-Cal coverage. Over one-quarter of the population (25.9%) are uninsured, which translates to 74.1% with health insurance. This is less than the Healthy People 2020 objective of 100% health insurance coverage.

Medi-Cal and Uninsured

	Service Area	Los Angeles County	California
Medi-Cal coverage	35.7%	27.2%	23.4%
Uninsured	25.9%	22.2%	17.8%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov

A look at insurance coverage by SPA shows that in SPA 6, 19% have employment-based insurance and 48.5% are covered by Medi-Cal. In SPA 7 40.5% of residents have employment-based insurance and 30.7% are covered by Medi-Cal.

Insurance Coverage

	SPA 6	SPA 7	Los Angeles County	California
Medi-Cal	48.5%	30.7%	24.4%	22.5%
Medicare only	0.4%	0.4%	1.4%	1.4%
Medicare/Medi-Cal	5.9%	1.2%	3.7%	3.0%
Medicare and others	4.2%	6.3%	7.4%	9.0%
Other public	0.2%	1.9%	0.8%	1.0%
Employment based	19.0%	40.5%	41.5%	44.8%
Private purchase	5.9%	4.3%	7.4%	6.4%
No insurance	16.0%	14.6%	13.3%	11.9%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

When insurance coverage by SPA is examined by age groups, adults, ages 18-64, have the highest rate of uninsured. Coverage for children and adults is primarily through Medi-Cal and employment-based insurance. Seniors have low rates of uninsured and high rates of Medicare & Other coverage. The Healthy People 2020 objective for insurance coverage for children and adults is 100% health insurance coverage.

Insurance Coverage by Age Group

	Ages 0-17		Ages 18-64		Ages 65+	
	SPA 6	SPA 7	SPA 6	SPA 7	SPA 6	SPA 7
Medi-Cal	76.8%	53.6%	41.0%	25.4%	1.3%	N/A
Medicare only	N/A	N/A	N/A	N/A	4.6%	4.8%
Medicare/Medi-Cal	N/A	N/A	3.2%	0.6%	45.4%	9.5%
Medicare and others	N/A	N/A	N/A	N/A	48.3%	76.8%
Other public	N/A	0.4%	0.3%	2.0%	N/A	6.3%
Employment based	18.3%	38.3%	22.0%	46.3%	N/A	2.2%
Private purchase	3.7%	2.2%	7.8%	5.7%	N/A	N/A
No insurance	1.2%	5.5%	25.5%	20.1%	N/A	N/A

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Sources of Care

Residents who have a medical home and access to a primary care provider improve continuity of care and decrease unnecessary ER visits. Among the youth in SPA 6, 85.6% have a usual source of care. In SPA 7, 96.7% of children and youth have a usual source of care. Among adults, in SPA 6, 86% have a usual source of care, and 80.9% of adults in SPA 7 have a source of care. 93.4% of seniors in SPA 6 have a usual source of care and 95.6% of seniors in SPA 7 have a source of care.

Usual Source of Care

	Ages 0-17		Ages 18-64		Ages 65+	
	SPA 6	SPA 7	SPA 6	SPA 7	SPA 6	SPA 7
Usual source of care	85.6%	96.7%	86.0%	80.9%	93.4%	95.6%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

The source of care for 38.9% of SPA 6 and 59.2% of SPA 7 is a doctor's office, HMO, or Kaiser. Clinics and community hospitals are the source of care for 41.5% of those in SPA 6 and 25.5% in SPA 7.

Sources of Care

	SPA 6	SPA 7	Los Angeles County	California
Dr. Office/HMO/Kaiser	38.9%	59.2%	57.6%	60.7%
Community or Government clinic/ Community hospital	41.5%	25.5%	23.6%	23.0%
ER/Urgent Care	6.2%	N/A	1.7%	1.4%
Other	N/A	1.6%	0.9%	0.7%
No source of care	13.5%	13.7%	16.2%	14.2%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

24.3% of residents in SPA 6 and 15.4% of residents in SPA 7 visited an ER over the period of a year. Adults in SPA 6 and youth in SPA 7 visit the ER at the highest rates. In SPA 6 and SPA 7 poverty level and low-income residents visit the ER at higher rates than found in the county.

Use of Emergency Room

	SPA 6	SPA 7	Los Angeles County	California
Visited ER in last 12 months	24.3%	15.4%	16.6%	17.4%
0-17 years old	16.8%	27.6%	19.7%	19.3%
18-64 years old	28.5%	11.3%	15.7%	16.5%
65 and older	20.5%	9.1%	15.5%	18.4%
<100% of poverty level	20.5%	31.4%	17.6%	20.6%
<200% of poverty level	22.0%	21.3%	16.7%	19.0%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

A "Health Professional Shortage Area" (HPSA) is defined as a geographic area designated as having a shortage of primary medical care, dental or mental health professionals. Over half (56.7%) of the population in the KFH – Downey service area is living in a HPSA for primary care. 1.6% of the population is living in a designated HPSA for dental care.

Health Professional Shortage Areas

	Service Area	Los Angeles County	California
Percentage of population living in a primary care HPSA	56.7%	31.4%	25.2%
Percentage of population living in a dental care HPSA	1.6%	2.0%	4.9%

Source: U.S .Department of Health & Human Services, Health Resources and Services Administration, March 2015.
http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

Barriers to Care

Adults in SPAs 6 and 7 experience barriers accessing health care, dental care, mental health care and prescription medications. A greater percentage of SPA 6 adults have identified barriers to care, except for accessing mental health. 8.1% of SPA 7 adults have trouble accessing mental health care or counseling compared to 6.8% of SPA 6 adults.

Barriers to Accessing Health Care

	SPA 6	SPA 7	Los Angeles County
Adults unable to obtain dental care in the past year because they could not afford it	35.0%	33.9 %	30.3%
Adults unable to see a doctor for a health problem when needed in the past year because they could not afford it	18.7%	17.8%	16.0%
Adults unable to receive mental health care or counseling in the past year because they could not afford it	6.8%	8.1%	6.1%
Adults who reported they did not get prescription medication when needed in the past year because they could not afford it	18.8%	15.3%	15.4%
Adults who reported obtaining medical care when needed is somewhat or very difficult	44.6%	34.6%	31.7%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011.
www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

Delayed Care

Among residents of SPA 6, 10.7% delayed or did not get medical care and 8.8% delayed or did not obtain prescription medications when needed. 55.5% delayed care due to the cost of care or lack of insurance. In SPA 7, 11.4% of residents delayed care and 8.8% delayed obtaining prescription medications. 35.6% delayed care due to the cost of care or lack of insurance.

Delayed Care

	SPA 6	SPA 7	Los Angeles County	California
Delayed or didn't get medical care in past 12 months	10.7%	11.4%	11.7%	11.3%
Delayed care due to cost or lack of insurance	55.5%	35.6%	44.8%	51.3%
Delayed or didn't get prescription medicine in past 12 months	8.8%	8.8%	7.9%	8.7%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Community Input – Access to Care

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to access to care:

- To access care, you have to take time off work, this impacts your income. Low-income families have access to emergency Medi-Cal, but the working poor fall through the cracks because they don't qualify for Medi-Cal and they cannot afford health care premiums, deductibles and co-pays, even under Covered California.
- Affordability is still a problem, as is access for the undocumented.
- ACA has helped a lot; however, health insurance is still unaffordable for many community residents. Transportation is a barrier for many; long wait times for some doctors; limited provider networks are also barriers.
- Hispanic low-income people are especially affected by barriers to care. Transportation is a major barrier, especially for single mothers.
- The homeless have trouble accessing care. There has been some improvement as there are now health services popping up.
- There is a lack of patient advocacy within managed health plans. You have to tell the doctors what you want them to do and request your own referrals. You have to advocate for yourself, they won't investigate anything on their own.
- Young people are falling through the gaps, especially college students not working or working part time. They are not purchasing health insurance or taking advantage of resources to get health insurance.
- People don't understand open enrollment; they don't understand that Medi-Cal has year round enrollment.
- The senior population tends not to ask questions or keep up with changes to their medical plans. They have a hard time filling out forms. Transportation, language, timing are all barriers to accessing care for seniors.
- Lack of insurance keeps many people from accessing care and many people are still uninsured. Some may be afraid, or think it's unaffordable. For those without access to the Internet and non-English speakers it is difficult to find information. They don't understand the new laws.
- Doctors don't take the time to explain medications, or explain the difference between medications. They don't look at you or touch you at all, they just write out a prescription to cover the symptoms and hand it to you.
- Free clinics are not as accessible as needed. Hours of operation are not accessible. It makes it difficult for children to get needed immunizations.

Oral Health

Lack of access to dental health care can contribute to poor health status. In SPA 6, 86.9% of children and 98.4% of teens had been to the dentist in the past two years. In SPA 7, 81.3% of children and 86% of teens had been to the dentist in the past two years. 12.7% of children in SPA 6 and 18.5% in SPA7 had never been to a dentist.

Time Since Last Dental Visit, Children and Teens

	SPA 6	SPA 7	Los Angeles County	California
Children been to dentist less than 6 months to 2 years	86.9%	81.3%	83.9%	83.8%
Children been to dentist more than 2 years to more than 5 years	0.4%	None	0.1%	0.9%
Children Never Been to Dentist	12.7%	18.5%	16.0%	15.3%
Teens been to dentist less than 6 months to 2 years	98.4%	86.0%	96.0%	94.7%
Teens been to dentist more than 2 years to more than 5 years	1.6%	3.0%	1.9%	3.5%
Teens never been to the dentist	None	11.0%	2.1%	1.8%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Among adults in SPA 6, 37.1% have dental insurance and 44.5% of adults have been to a dentist within the last year. In SPA 7, 47% of adults have dental insurance coverage and 48.9% had been to a dentist in the past year. However, due to the cost of obtaining dental care, 35% of adults in SPA 6 and 33.9% of adults in SPA 7 did not obtain dental care.

Dental Care, Adult

	SPA 6	SPA 7	Los Angeles County
Adults who have dental insurance that pays for some or all of their routine dental care	37.1%	47.0%	48.2%
Adults who reported their last visit to a dentist was less than 12 months ago	44.5%	48.9%	55.8%
Adults unable to obtain dental care because they could not afford it	35.0%	33.9%	30.3%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011.
www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

Children have increased access to dental care when compared to adults, as 75.8% of children in SPA 6 and 79.2% of children in SPA 7 have dental insurance. Nevertheless, 14.9% of children in SPA 6 and 16.6% in SPA 7 did not obtain dental care due to cost.

Dental Care, Children

	SPA 6	SPA 7	Los Angeles County
Children who have dental insurance	75.8%	79.2%	78.2%
Children unable to obtain dental care because they could not afford it	14.9%	16.6%	12.6%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011.
www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

Community Input – Oral Health

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to oral health care:

- Dental care is a big problem for a lot of people; dental care is expensive, Medi-Cal covers only a few services and it is hard to find providers.

- I see really young kids in the schools with severe dental issues and if someone had been able to work with their parents or the kids had seen a dentist before that happened, it would make a huge difference.
- I see kids with all silver teeth. And then you see a mom giving her baby Kool-Aid in the bottle. There are not enough programs to help people obtain routine dental services, and to keep them out of the emergency room when they are in pain
- Insurance does not cover much. Some people will have teeth removed rather than be in pain. Poor nutrition leads to poor dental health.
- The undocumented don't know where to go for dental care. They are fearful about accessing services (due to immigration status) and experience much stress.
- Denti-Cal coverage is horrible. Illegal dentists can be an option, though it's risky, or people go to Tijuana for dental care.
- Dental care is a huge need for seniors, but they don't see it as a main concern. People will go to Tijuana for cheaper care. Many don't realize the importance of oral health.
- Huge need, few resources. There is some expanded Medi-Cal services for kids but a huge need remains for adults, especially for specialized or more complex problems like gum disease. There is a shortage of providers doing this type of service. The undocumented have very little access, even though LA County has a health plan for undocumented residents.
- Some schools send information with resources for free dental work and braces home with children.

Mental Health

In SPA 6, 10.9% of adults saw a health care provider for emotional, mental health, alcohol or drug issues, and 45.6% of those who sought or needed help did not receive treatment. In SPA 7, 12.2% of adults saw a health care provider for emotional, mental health, alcohol or drug issues, and 47.9% of those who sought or needed help did not receive treatment. The Healthy People 2020 objective is for 64.6% of adults with a mental disorder to receive treatment (35.4% who do not receive treatment).

Mental Health, Adults

	SPA 6	SPA 7	Los Angeles County	California
Adults who saw a health care provider for emotional/mental health and/or alcohol/drug issues in past year	10.9%	12.2%	13.0%	12.0%
Adults who sought/needed help but did not receive treatment	45.6%	47.9%	43.2%	43.4%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

In SPA 6, 10.4% of teens received counseling for an emotional or mental health problem. In SPA 7, only 2.1% of teens received counseling for an emotional or mental health problem.

Mental Health, Teens

	SPA 6	SPA 7	Los Angeles County	California
Teens who received psychological/ emotional counseling in past year	10.4%	2.1%	14.5%	11.6%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Community Input – Mental Health Care

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to mental health care:

- Stigma prevents people from seeking or accessing services. Mental health affects children's achievement; it is important to identify and intervene early.
- Funding and sustainability for mental health services is an ongoing challenge for nonprofits.
- Mental health is a concern, especially with the homeless population, which is increasing in Whittier. Stress is a huge epidemic with both kids and college students.
- There is insufficient funding and no resources for the undocumented for mental health. Even for people with Medi-Cal coverage it is hard to find Psychiatrists or Psychologists.
- Primary care is not equipped to handle mental health issues. Instead if you say you are depressed, they will give you a pill. Some doctors would rather just medicate.
- There is stigma associated with mental health problems, especially in the Latino community; affordability is a barrier.
- Mental health services are highly utilized among college students. There is a higher demand for mental health services than for physical health.
- We have seen significant improvement in mental health access in the past 5 years, mainly due to MHSA funding, which requires public and stakeholder input. SPA 7 has enjoyed more expanded services, and developed new initiatives such as a pilot in Hawaiian Gardens targeting special needs youth, foster kids, gang members and at-risk youth.
- It is difficult to obtain mental health services for those who are homeless as the services are far away. It becomes too hard to access services when a person has children and family demands.
- People don't want to go to therapy; they don't think therapy can help.

ii. Health behaviors

Health behaviors are activities undertaken to promote or protect health. Health behaviors impact health status. The role of healthy eating and physical activity in reducing the burden of chronic diseases, morbidity and mortality due to overweight and obesity is well-documented and widely known. Despite the increase in public awareness, residents in the KFH – Downey service area do not consume enough nutritional foods and are not meeting recommended guidelines for physical activity. Some factors that contribute to this are resource access, financial constraints, food marketing and convenience, and cultural considerations.

Substance abuse is a negative health behavior that is increasing in scope in the service area. Community residents identified the linkages between substance abuse and mental health. Adult alcohol consumption and cigarette smoking are contributors to chronic diseases and increased death rates.

Preventive screenings are undertaken to identify cancer and other chronic diseases in the early stages. Community stakeholders from interviews and focus groups identified that many people put off prevention until it is too late. Sometimes the health system does not make it easy or convenient to access preventive services.

Healthy Eating

Among adults, 11.4% in SPA 6 and 12.4% in SPA 7 eat five or more servings of fruit and vegetables daily. This is less than adults in the county (16.2%).

Eat Five or More Servings of Fruits/Vegetables Daily, Adults

	SPA 6	SPA 7	Los Angeles County
Adults, 18+ years old	11.4%	12.4%	16.2%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011.
www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

In SPA 6, 76.3% of children consume two or more servings of fruit in a day. In SPA 7, 61.6% of children consume two or more servings of fruit in a day. Fruit consumption decreases considerably among teens. Only 38.2% of teens in SPA 6 and 35.7% of SPA 7 teens consume two or more servings of fruit a day.

Eat Two or More Servings of Fruit Daily, Children and Teens

	SPA 6	SPA 7	Los Angeles County	California
Children	76.3%	61.6%	63.4%	68.8%
Teens	38.2%	35.7%	43.6%	51.4%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

In Service Planning Area 7, 23.1% of children and teens consume two or more glasses of soda or sugary drinks a day. This is higher than SPA 6 (18%), county (17.3%) and state (14.2%) rates.

Soda or Other Sugary Drinks, Two or More Glasses, Consumed Yesterday

	SPA 6	SPA 7	Los Angeles County	California
Teens and children	18.0%	23.1%	17.3%	14.2%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

25.2% of SPA 6 residents eat fast food three or more times a week. In SPA 7, 29.9% of the residents eat fast food three or more times a week. Adults, age 18-64, consume fast food at a higher rate than youth or seniors.

Fast Food Consumption, Three or More Times a Week

	SPA 6	SPA 7	Los Angeles County	California
Total population	25.2%	29.9%	21.6%	20.6%
Ages 0-17	19.3%	17.5%	15.1%	14.6%
Ages 18-64	28.6%	36.7%	25.5%	24.9%
Ages 65+	19.7%	9.8%	11.5%	9.6%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Active Living

In SPA 6, 86.2% of children engaged in at least one hour of physical activity three or more days in the previous week; 47.6% of teens did the same in 'a typical week'. In SPA 7, 60.8% of children engaged in at least one hour of physical activity three or more days in the previous week; 90.2% of teens did the same in 'a typical week'. 77.7% of youth in SPA 6 and 90.6% of youth in SPA 7 visited a park, playground or open space in the last month. In SPA 6, 0.6% of children and 22.9% of teens were sedentary during the previous week. 8.9% of children in SPA 7 were sedentary and 2.8% of teens were sedentary.

Physical Activity, Children and Teens

	SPA 6	SPA 7	Los Angeles County	California
Engaged in at least one hour of physical activity 3-7 days of the previous week – child	86.2%	60.8%	72.2%	76.3%
Engaged in at least one hour of physical activity 3-7 days of a typical week - teen	47.6%	90.2%	60.6%	68.5%
No physical activity/week – child	0.6%	8.9%	6.1%	6.2%
No physical activity/week – teen	22.9%	2.8%	11.9%	8.6%
Youth visited park, playground or open space in the last month	77.7%	90.6%	83.3%	83.9%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

The California Department of Education's physical fitness test (PFT) measures the aerobic capacity of school children using run and walk tests. Children who meet established standards for aerobic capacity are categorized in the Healthy Fitness Zone. Youth physical inactivity is the percent of children in grades 5, 7, and 9 ranking within the "High Risk" or "Needs Improvement" zones for aerobic capacity on the *Fitnessgram* physical fitness test. Among the school districts in the service area, 42.3% of 5th, 7th and 9th graders rank in the high risk or needs improvement zones for aerobic capacity; this is higher than the county rate and the state rate.

Youth Physical Inactivity

	Service Area	Los Angeles County	California
Children in grades 5, 7, and 9 ranking within the "High Risk" or “Needs Improvement” zones for aerobic capacity	42.3%	40.0%	35.9%

Source: California Department of Education, 2013-2014, FITNESSGRAM® Physical Fitness Testing.

For adults to meet the government Physical Activity Guidelines at least one of the following criteria must be fulfilled: 1) Vigorous activity for at least 75 minutes a week, 2) Moderate activity for at least 150 minutes a week, or 3) A combination of vigorous and moderate activity for at least 150 minutes a week) AND muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders, and arms). In SPA 6, 28.1% of adults and 29.9% of adults in SPA 7 meet these guidelines.

Adults Who Meet the Recommended Weekly Aerobic & Muscle Strengthening Activity

	SPA 6	SPA 7	Los Angeles County
Adults, 18+ years old	28.1%	29.9%	29.7%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011.
www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

Community Input – Healthy Eating and Active Living

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to healthy eating and active living:

- We have unhealthy school meals and lack of parental education around healthy eating.
- Changing habits is difficult and it can be hard to start eating healthfully for people who have not eaten that way before. We need to educate parents and children to be aware of healthy food.
- It is difficult to change eating habits and to start engaging in physical activity. Healthy food is unaffordable and people are not engaging in much physical activity due to lack of time and safety concerns.
- People who experience income inequality and institutionalized racism, including primarily lower-income individuals and families living in low-income neighborhoods, lack access to affordable healthy foods (food deserts) coupled with an overabundance of fast food outlets, corner markets and liquor stores.
- Culture plays a big role in the way we eat. Food is comforting. In some cultures a chubby kid is a healthy kid.
- The free or reduced cost breakfasts and lunches are not healthy meals.
- I am too tired to exercise after work. I have to check homework and give baths. I am tired in the evenings. We are eating out too much because there's no time to cook.
- Parents are working long hours and not supervising the food their kids eat or how children are spending their after-school time.

Substance Abuse

Alcohol and Drug Use

Binge drinking is defined as consuming a certain amount of alcohol in a set period of time. For males, it is five or more drinks per occasion. For females, it is four or more drinks per occasion. In SPA 6, 31.9% of adults engaged in binge drinking; 17.8% of teens indicated they had tried an alcoholic drink. In SPA 7, 37.9% of adults engaged in binge drinking; no teens indicated they had tried an alcoholic drink.

Alcohol Consumption and Binge Drinking

	SPA 6	SPA 7	Los Angeles County	California
Adult binge drinking past year	31.9%	37.9%	31.5%	32.6%
Teen ever had an alcoholic drink	17.8%	None	19.1%	22.5%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

2.3% of SPA 6 adults and 1.8% of SPA 7 adults reported they needed or wanted treatment for an alcohol or drug problem in the past five years. In the county, 2.5% of adults reported a need for alcohol or drug treatment.

Adults Reported Needed/Wanted Treatment for Alcohol/Drug Problem in Past 5 Years

	SPA 6	SPA 7	Los Angeles County
Adults, 18+ years old	2.3%	1.8%	2.5%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011. www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

In SPA 6, 31.9% of teens have tried drugs and 3.5% have used marijuana in the past year. In SPA 7, 2.6% of teens have tried illegal drugs and 1.7% has used marijuana in the past year. These rates of marijuana use are lower than the county and state rates. SPA 6 teen use of drug experience is higher than among teens in the county and state.

Teen Illegal Drug Use

	SPA 6	SPA 7	Los Angeles County	California
Ever tried marijuana, cocaine, sniffing glue, other drugs	31.9%	2.6%	14.7%	12.4%
Marijuana use in past year	3.5%	1.7%	9.4%	8.6%

Source: California Health Interview Survey, 2012. http://ask.chis.ucla.edu

Cigarette Smoking

Smoking is a contributing cause to disease and death. It increases the risk of developing heart disease, stroke and cancer. Cerritos (11.2%) has the lowest rate of smoking and Compton (17.9%) has the highest rate of smoking in the service area. All cities in the service area, except Cerritos, have smoking rates higher than the Healthy People 2020 objective of 12%.

Cigarette Smoking, Adults

	Percent
Bell	12.2%
Bell Gardens	12.2%
Bellflower	15.5%
Cerritos	11.2%
Compton	17.9%
Cudahy	12.3%
Downey	13.6%
Huntington Park	12.5%
Lakewood	14.3%
Long Beach	14.2%
Lynwood	14.5%
Maywood	12.2%
Norwalk	13.2%
Paramount	14.7%
Pico Rivera	12.1%
South East Los Angeles (Florence-Graham)	14.3%
South Gate	12.7%
South Whittier	12.9%
Whittier	12.8%
West Whittier – Los Nietos	12.1%
Los Angeles County	**14.2%**
California	**13.8%**

Source: California Health Interview Survey, Neighborhood Edition, 2011-2012. http://askchisne.ucla.edu
No data available for Artesia, Commerce, Hawaiian Gardens, Santa Fe Springs, Vernon.

Community Input – Substance Abuse

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to substance abuse:

- The people who need help don't think that they need it. People think that addiction won't happen to them, that they are in control and can stop when they want to.
- Some doctors will give permits for marijuana to anyone.
- Parents are busy working and don't have time to supervise their children.
- Sometimes people are self-medicating for mental health issues.
- People with substance abuse problems who try to access services are told to keep calling back so the program can be sure that the person is serious about wanting help. This can result in missed opportunities to help people when they are ready
- People feel discouraged by the bad economy, so they turn to alcohol. It can be a way people try to deal with depression.

Preventive Practices

Colorectal Cancer Screening

The Healthy People 2020 objective rate for colorectal screening is 70.5% of adults 50 years and older. In SPA 6, 67.1% received colorectal screening and in SPA 7, 71.1% received colorectal cancer screening. Of adults advised to obtain screening, 57.9% in SPA 6 and 59.2% in SPA 7 complied at the time of recommendation.

Colorectal Cancer Screening, Adults 50+

	SPA 6	SPA 7	Los Angeles County	California
Screening Sigmoidoscopy, colonoscopy or fecal occult blood test	67.1%	71.1%	75.7%	78.0%
Compliant with screening at time of recommendation	57.9%	59.2%	66.5%	68.1%

Source: California Health Interview Survey, 2009. http://ask.chis.ucla.edu

Mammograms and Pap Smears

The Healthy People 2020 objective is for 81.1% of women age 50 to 74 to have a mammogram in the past two years. In SPA 6, 82.8% of women had a mammogram, which is better than the Healthy People 2020 objective. In SPA 7, 81.1% of women age 50 and over had a mammogram in the previous two years, matching the Healthy People 2020 objective.

The Healthy People 2020 objective is for 93% of women age 21 to 65 to have a Pap smear in the past three years. In SPA 6, 87.4% of women had a Pap smear. In SPA 7, 83.3% of women 18 to 65 had a Pap smear in the past three years. These rates do not meet the Healthy People 2020 objective.

Women Mammograms and Pap Smears

	SPA 6	SPA 7	Los Angeles County
Women 50-74 years, had a mammogram in past two years	82.8%	81.1%	79.8%
Women 18-65 had a Pap smear in past three years	87.4%	83.3%	82.8%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey, 2011. www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

Community Input – Preventive Practices

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to preventive practices:

- There is difficulty navigating the phone system to get information. And it is difficult to get an authorization from managed care plans for a mammogram and ultrasound at the same time following the detection of a lump.
- People (particularly the uninsured) don't get cancer screenings or care until there are symptoms.
- Families are unaware of where to go for free or low-cost school immunizations.
- The process of getting a colonoscopy is arduous and uncomfortable and many people prefer to avoid it.
- Good information is available for parents about vaccinations. But there is still a small group of non-vaccinating parents.
- Screenings need to be more widely available and publicized, especially within the Latino community, at times/places that are convenient for working people, and available for the

undocumented.

- This is not a big problem, as there are a lot of available resources.
- The resources are there, the issue is how to get people motivated. There is a perceived lack of access to care in some segments of the community.

iii. Physical environment

The physical environment of a community has an impact on its residents. Community residents identified the need for healthier food choices and more opportunities for physical activity to help reduce obesity and chronic diseases. The KFH – Downey service area has lower grocery store per population than found in the county and state, however, the service area also has fewer fast food restaurants per 100,000 persons. A majority of area adults feel it is easy to access fresh fruits and vegetables. The area has good access to parks but limited access to recreation and fitness facilities. Area air quality is better than the county as a whole, yet water quality is considered unsafe in some areas.

Access to Food and Physical Activity

In the KFH – Downey area there are 294 grocery stores, for a rate of 19.8 stores per 100,000 persons. This is less than the county rate of 20.9 and the state rate of 21.5.

Grocery Store Access, per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate		
Grocery store access	294	19.8	20.9	21.5

Source: U.S. Census Bureau, County Business Patterns, 2011. Additional data analysis by CARES

In the KFH – Downey area there are 1,062 fast food restaurants, for a rate of 71.5 fast food establishments per 100,000 persons. This is less than the county rate of 77.8 and the state rate of 74.5.

Fast Food Restaurant Access, per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate		
Fast food restaurant access	1,062	71.5	77.8	74.5

Source: US Census Bureau, County Business Patterns, 2011. Additional data analysis by CARES.

A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery store. Only 3% of the population in the service area lives in a designated food desert.

Food Desert

	Service Area		Los Angeles County	California
	Number	Percent		
Population with low food access	45,144	3.0%	6.9%	14.3%

Source: U.S. Department of Agriculture, Economic Research Service, 2010. USDA - Food Access Research Atlas.

Among adults, 18 years and older, 77.9% in SPA 6 and 89.4% in SPA 7 indicated that accessing fresh produce (fruits and vegetables) was somewhat or very easy. These rates are lower than the county rate of 89.7%.

Adults who Reported Accessing Fresh Produce was Very or Somewhat Easy

	SPA 6	SPA 7	Los Angeles County
Adults, 18+ years old	77.9%	89.4%	89.7%

Source: Los Angeles County Department of Public Health, Los Angeles County Health Survey 2011. www.publichealth.lacounty.gov/ha/LACHSDataTopics2011.htm

In the KFH- Downey service area, 2.8% of adults commute to work by either walking or riding a bicycle. This is lower than the county rate of 3.7% and the state rate of 3.8%.

Commute to Work, Adults, Walking or Biking

	Service Area	Los Angeles County	California
Adults who walk or bike to work	2.8%	3.7%	3.8%

Source: U.S. Census Bureau, American Community Survey, 2009-2013. http://factfinder.census.gov

70.2% of the population in the KFH – Downey service area lives within one-half mile of a park. This exceeds the county rate of 63.1% and the state rate of 58.6%.

Park Access

	Service Area	Los Angeles County	California
Population living within 1/2 mile of park	70.2%	63.1%	58.6%

Source: U.S. Census Bureau, 2010. Decennial Census. ESRI Map Gallery

In the KFH – Downey service area there are 2.8 recreation facilities per 100,000 persons. While park access is greater in the service area than the state, the rate of access to recreation facilities is less than the state rate of 8.7 facilities per 100,000 persons.

Recreation and Fitness Facility Access, per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate		
Recreation and fitness facilities	41	2.8	7.6	8.7

Source: U.S. Census Bureau, County Business Patterns, 2012. Additional data analysis by CARES.

Community Input – Access to Food and Physical Activity

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to access to food and physical activity:

- There is a high rate of overweight in the community and the area is a food desert with few outdoor recreation areas.
- We need more community education on the benefits of exercise and good nutrition. There is not enough exercise promotion as a lifestyle choice for adults and teens.
- There are barriers to drinking more water and eating better. Because of cost and convenience issues, people need to plan ahead.
- We have seen increased efforts to start addressing the problem through more walkable communities.
- In many local areas, it is not safe for children to go outside to play.

Liquor Store Access

There are 148 beer, wine, and liquor stores in the KFH – Downey service area, which equates to 10.0 liquor stores per 100,000 persons. This is less than the county rate (11.4).

Liquor Store Access, per 100,000 Persons

	Service Area		Los Angeles County	California
	Number	Rate		
Alcohol retail licenses	148	10.0	11.4	10.0

Source: U.S. Census Bureau, County Business Patterns, 2012. Additional data analysis by CARES.

Air, Water and Climate

The South Coast Air Quality Management District monitors air quality across Southern California. The Central Los Angeles location of the South Coast Air Basin is situated in the KFH – Downey service area. Rates of PM10 and carbon monoxide are lower in Central Los Angeles than in the South Coast Air Basin.

Air Quality, 2014

	Central Los Angeles	South Coast Air Basin
Suspended particulates PM10, average annual	30.6	44.1
Carbon monoxide maximum concentration in ppm 8 hours	2.0	3.8

Source: South Coast Air Quality Management District, 2014 Air Quality. http://www.aqmd.gov/docs/default-source/air-quality/historical-data-by-year/aq14card-gases.pdf?sfvrsn=6

In Los Angeles County, 3.0% of the population may be getting drinking water from public water systems with at least one health-based violation. This is higher than the population exposed to unsafe water in the state (2.7%).

Unsafe Drinking Water

	Los Angeles County	California
Population exposed to unsafe drinking water	3.0%	2.7%

Source: University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013. County Health Rankings

In the hospital service area, the percentage of weeks in drought from January 1, 2012 – December 31, 2014 was 97.3%, which is higher than found in California (92.8%).

Drought Severity

	Service Area	California
Percentage of weeks in drought	97.3%	92.8%

Source: U.S. Drought Monitor, 2012-2014. US Drought Monitor

iv. Socioeconomic factors

In the KFH – Downey service area there are a number of indicators that outline the socioeconomic status of area residents. These factors identify disparities among community residents and can impact health by limiting access to resources and influencing access to care and preventive services. Education is a social determinant of health and in the service area over one-third of the population (34.9%) has no high school diploma. The high school graduation rate from among schools in the KFH – Downey service area is 82.4%. Black/African Americans in the service area have the lowest graduation rate (77.7%). Other socioeconomic indicators indicate that area residents have high levels of food insecurity and enrollment of school children in the Free or Reduced Price Meal program. Community members engaged in interviews and focus groups commented on the importance of education and poverty impacting the community.

Educational Attainment

Among adults, ages 25 and older, in the KFH – Downey service area, over one-third of the population (34.9%) have no high school diploma. 25.1% of the population has a high school education. The service area has a lower percentage of college educated residents than found in the county and the state.

Educational Attainment

	Service Area	Los Angeles County	California
Population age 25 and over	886,593	6,456,772	24,455,010
Less than 9th grade	20.4%	13.7%	10.2%
9th to 12th grade, no diploma	14.5%	9.7%	8.5%
High school graduate	25.1%	20.5%	20.7%
Some college, no degree	19.8%	19.6%	22.1%
Associate degree	6.3%	6.9%	7.8%
Bachelor's degree	9.9%	19.4%	19.4%
Graduate or professional degree	4.0%	10.2%	11.2%

Source: U.S. Bureau of the Census, American Community Survey, 2009-2013; DP02. http://factfinder.census.gov

The high school graduation rate from among schools in the KFH – Downey service area is 82.4%. This meets the Healthy People 2020 objective, which is a high school graduation rate of 82.4%.

High School Graduation Rate

	Service Area	Los Angeles County	California
Enrollment cohort	36,772	128,324	495,316
Total graduates	30,283	98,973	398,442
On-time graduation rate	82.4%	77.1%	80.4%

Source: California Department of Education, 2013. http://www.cde.ca.gov/

When high school graduation rates are examined by race/ethnicity, Asians have the highest graduation rates (93.7%). Black/African Americans in the service area have the lowest graduation rate (77.7%).

High School Graduation Rate by Race/Ethnicity

	Service Area	Los Angeles County	California
Asian	93.7%	93.4%	91.6%
Other Race	90.2%	87.4%	85.7%
White	87.6%	86.4%	87.7%
Hispanic or Latino	81.0%	73.6%	75.7%
Black or African American	77.7%	68.1%	68.1%

Source: California Department of Education, 2013. http://www.cde.ca.gov/

Reading below Proficiency

Fourth grade students in schools in the KFH – Downey service area were tested through the standardized STAR test. Results of the English Language component of the test, 39% of the students tested below the "proficient" level. The Healthy People 2020 objective is that 36.3% or fewer students are not proficient in reading. The service area has a higher rate of not proficient students on the English Language standardized test.

4th Grade Reading Below Proficiency

	Service Area	Los Angeles County	California
Children in grade 4 whose reading skills tested below the "proficient" level for the English Language Arts portion of the California STAR test	39%	36%	36%

Source: California Department of Education, 2012-2013. http://www.cde.ca.gov/

The percentage of students eligible for the free or reduced price meal program is one indicator of socioeconomic status. In the KFH – Downey service area, 78.9% of the student population are eligible for the free or reduced price meal program, indicating a high level of low-income families. This rate is higher than the county (66.9%) or state rate (58.1%).

Free or Reduced Price Lunch Eligibility

	Service Area		Los Angeles County	California
	Number	Percent		
Public school students eligible for free or reduced price lunches	225,027	78.9%	66.9%	58.1%

Source: National Center for Education Statistics, 2013-2014. NCES - Common Core of Data

In Service Planning Area 6 (SPA 6), 46.1% of residents are not able to afford food and 26.6% utilize food stamps. This is higher than the county and state rates. In Service Planning Area 7 (SPA 7), 38.2% of residents are not able to afford food and 26.3% utilize food stamps. In SPA 6, 8.2% of adults are currently receiving Supplemental Security Income (SSI) and 3.4% of SPA 7 adults receive SSI. Among qualified children in SPA 6, 67.1% access WIC and in SPA 7,

62.3% access WIC. Among residents, 16% in SPA 6 and 23.6% in SPA 7 are Temporary Assistance for Needy Families (TANF)/CalWorks recipients.

Public Program Participation

	SPA 6	SPA 7	Los Angeles County	California
Not able to afford food (<200% FPL)	46.1%	38.2%	39.5%	38.4%
Food Stamp recipients	26.6%	26.3%	18.7%	18.1%
Currently receiving Supplemental Security Income (SSI)	8.2%	3.4%	7.0%	6.1%
WIC usage among qualified children (ages 6 and under)	67.1%	62.3%	50.8%	44.6%
TANF/CalWorks recipients	16.0%	23.6%	10.6%	8.4%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu

Food Insecurity

Food insecurity is a lack of access to sufficient amounts of safe and nutritious food for normal growth and development, and an active and healthy life. This indicator provides information on whether residents (adults ages 18+ with an income < 200% FPL) have a consistent ability to afford enough food. Higher percentages indicate increased food insecurity. Low-income adults in Bell Gardens and Cudahy have the highest percentage of food insecurity (21.9%).

Low-Income (<200 FPL) Adults with Food Insecurity

Geographic Area*	Percent
Bell	20.9%
Bell Gardens	21.9%
Bellflower	11.0%
Cerritos	3.5%
Compton	15.7%
Cudahy	21.9%
Downey	11.6%
Huntington Park	21.8%
Lakewood	5.0%
Long Beach	8.6%
Lynwood	18.3%
Maywood	21.7%
Norwalk	12.7%
Paramount	17.1%
Pico Rivera	15.3%
South East Los Angeles (Florence-Graham)	19.6%
South Gate	19.3%
South Whittier	13.1%
Whittier	8.7%
West Whittier-Los Nietos	13.7%
Los Angeles County	**9.9%**
California	**8.4%**

Source: California Health Interview Survey, Neighborhood Edition, 2011-2012. http://askchisne.ucla.edu
**No data available for Artesia, Commerce, Hawaiian Gardens, Santa Fe Springs, Vernon.*

Homelessness

The Los Angeles Homeless Services Authority (LAHSA) conducts the Greater Los Angeles Homeless Count every two years as a snapshot to determine how many individuals are homeless on a given day. SPA 6 has more than double the number of homeless than SPA 7. Data from this survey show an increase in homelessness from 2013 to 2015. In SPA 6 and SPA 7, approximately three quarters of the homeless are unsheltered. A comparison indicates an increase in unsheltered homeless from 2013 to 2105. SPA 6 and SPA 7 have a higher percentage of unsheltered homeless than LA County. Over one-fifth (20%) of the homeless in SPA 6 and SPA 7 are families, which are comprised of households with at least one adult and one child younger than age 18.

Homeless Population*, 2013 – 2015 Homeless Count Comparison

	SPA 6		SPA 7		Los Angeles County	
	2013	2015	2013	2015	2013	2015
Total homeless	7,045	7,513	2,429	3,571	35,524	41,174
Sheltered	33.9%	23.9%	36.9%	25.4%	36.4%	29.7%
Unsheltered	66.1%	76.1%	63.1%	74.6%	63.6%	70.3%
Adult individuals	77.4%	77.5%	78.2%	79.3%	78.9%	81.1%
Family members	21.5%	21.2%	20.5%	20.2%	18.8%	18.2%
Unaccompanied minors (<18)	1.1%	1.3%	1.3%	<1%	2.3%	<1%

*Source: Los Angeles Homeless Services Authority, 2013 & 2015 Greater Los Angeles Homeless Count Results. www.lahsa.org/homelesscount_results *These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

The percentage of chronically homeless has increased from 2013 to 2015. In SPA 6 increases were seen in homeless populations who experienced domestic violence and those with physical disabilities. In SPA 7, aside from persons with HIV/AIDS, all subpopulation categories of homelessness have seen an increase. Notable are the increases in the homeless population with substance abuse and a domestic violence experience.

Homelessness by Subpopulation*

	SPA 6		SPA 7		Los Angeles County	
	2013	2015	2013	2015	2013	2015
Chronically Homeless	25.9%	29.3%	24.5%	34.1%	24.5%	34.4%
Substance Abuse	30.6%	17.1%	31.1%	43.8%	31.2%	25.2%
Mentally Ill	26.9%	25.2%	28.2%	30.3%	28.0%	29.8%
Veterans	10.7%	6.3%	1.4%	8.0%	11.3%	9.8%
Persons with HIV/AIDS	0.9%	1.3%	1.0%	0.2%	0.6%	0.2%
Domestic Violence Experience	8.4%	16.6%	9.0%	25.8%	1.0%	21.4%
Physical Disability	16.8%	17.9%	17.9%	20.7%	8.9%	19.8%

*Source: Los Angeles Homeless Services Authority, 2013 & 2015 Greater Los Angeles Homeless Count Results. www.lahsa.org/homelesscount_results *These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Community Input – Social and Economic Factors

Stakeholder interviews and focus groups identified the most important socioeconomic, behavioral, environmental and clinical factors contributing to poor health in the community:

- Finance and education seem to go hand in hand; there is a lack of awareness of healthy lifestyles and a lack of funds for people when they do become aware of health.
- Poverty is the big challenge or barrier. Not having the means to pay for care, people wait until it's an emergency before they seek needed care.
- Education is the most important factor. Trust and respect are also important, especially for working people who have 2 or 3 jobs with inconsistent income; they experience lots of stress. This makes people nervous about signing up for health insurance, getting into a course of treatment.
- Environmental community surroundings dictate what you think your options are. If the community is not safe, people will have lower health outcomes and quality of life. We need affordable housing, programs to support kids and families as they try to get healthier, and programs that are culturally competent and sustainable.
- The biggest issues are unemployment, lack of education, limited job/educational opportunities, public assistance, and poor food choices.
- There are huge barriers with language; people are intimated about asking for help. Undocumented families are afraid to access health care and other community resources. There is a general stigma connected to accessing public health care within the Latino population.
- A lot is income-based. Poor people don't have access to available resources nor the time to find and secure these resources. Lots of families are working multiple jobs just to get by. They have to make very difficult choices. There are not a lot of resources in unincorporated Whittier, for example, especially for people using public transportation.
- There is a lack of education and knowledge. There is a huge difference between the types of foods available in affluent communities and those in low-income areas. Many people have a profound misunderstanding about how to eat well.

ii. Additional community health trends

Maternal and Infant Health

Maternal and infant health indicators provide important health trends that help to describe the health status of a potentially vulnerable population in the service area. These data provide information on healthy pregnancies and infants. The health behaviors of women during and after pregnancy will determine the health and well-being of their children. Overall, birth rates are decreasing in the service area. The birth indicators associated with accessing prenatal care and breastfeeding exceed comparison benchmarks. Nevertheless, the area has high rates of teen pregnancy, and infant mortality rates that are higher than state rates.

Births

In 2012, the number of live births in the service area was 22,595. This is a decrease from 23,913 births in 2011. The majority of the births were to mothers who are Hispanic/Latino (79.7%).

Prenatal Care

Pregnant women are recommended to enter prenatal care in the first trimester. Among pregnant women in the service area, 84.8% entered prenatal care in the first trimester. This is a higher rate than the state rate of 83.8%. The area rate of early entry into prenatal care exceeds the Healthy People 2020 objective of 77.9% of women entering prenatal care in the first trimester.

Prenatal Care Entry in the First Trimester

	Service Area			California
	Live Births*	Number	Percent	Percent
Prenatal care in the first trimester	21,735	18,432	84.8%	83.8%

Source: California Department of Public Health, 2012. www.cdph.ca.gov/data/statistics/Pages/BirthProfilesbyZIPCode.aspx
**Births in which the first month of prenatal care is unknown are not included in the tabulation.*

Low-Birth Weight

Low birth weight is a negative birth indicator. Babies born at a low birth weight (under 2500g at birth) are at higher risk for disease, disability and possibly death. For this measurement, a lower rate is a better indicator. The KFH – Downey service area rate of low birth weight babies is 7% (70.2 per 1,000 live births). This is higher than the state rate of 6.8%. The service area compares favorably to the Healthy People 2020 objective of 7.8% of births being low birth weight.

Low Birth Weight Births

	Service Area			California
	Live Births	Number	Percent	Percent
Low birth weight births under 2500g	22,595	1,586	7.0%	6.8%

Source: California Department of Public Health, 2012. www.cdph.ca.gov/data/statistics/Pages/BirthProfilesbyZIPCode.aspx

Teen Births

The percentage of births to teen mothers was 9.9%, which is higher than the state rate of 7%. There are a number of service area communities with high teen birth rates, most notably South East Los Angeles, Compton, Huntington Park and Vernon.

Teen Births

	Live Births	Births to Teen Mothers*	Percent
90001 - South East Los Angeles	1,146	138	12.0%
90002 - South East Los Angeles	1,059	166	15.7%
90040 - Commerce	171	16	9.4%
90058 - Vernon	69	18	26.1%
90059 - South East Los Angeles	848	124	14.6%
90201 - Bell/Bell Gardens	1,646	195	11.8%
90221 - Compton	1,098	157	14.3%
90222 - Compton	589	74	12.6%
90240 - Downey	286	18	6.3%
90241 - Downey	629	43	6.8%
90242 - Downey	603	55	9.1%
90255 - Huntington Park	1,229	157	12.8%
90262 - Lynwood	1,243	145	11.7%
90270 - Maywood	443	31	7.0%
90280 - South Gate	1,413	130	9.2%
90601 - Whittier	376	15	4.0%
90602 - Whittier	333	26	7.8%
90603 - Whittier	210	11	5.2%
90604 - Whittier	540	31	5.7%
90605 - Whittier	517	48	9.3%
90606 - Whittier	422	31	7.3%
90650 - Norwalk	1,465	130	8.9%
90660 - Pico Rivera	795	60	7.6%
90670 - Santa Fe Springs	155	12	7.7%
90701 - Artesia	165	19	11.5%
90703 - Cerritos	343	5	1.5%
90706 - Bellflower	1,100	70	6.4%
90712 - Lakewood	359	10	2.8%
90713 - Lakewood	305	7	2.3%
90715 - Lakewood	257	18	7.0%
90716 - Hawaiian Gardens	214	23	10.7%
90723 - Paramount	893	90	10.1%
90805 - Long Beach	1,674	160	9.6%
Service Area	**22,595**	**2,233**	**9.9%**
California	**503,757**	**35,281**	**7.0%**

Source: California Department of Public Health, 2012. www.cdph.ca.gov/data/statistics/Pages/BirthProfilesbyZIPCode.aspx
**When examining zip code areas with a small response, use caution when drawing conclusions as a small occurrence may result in a high rate.*

Community Input – Teen Pregnancy

Stakeholder interviews and focus groups identified the following issues, challenges and barriers related to teen pregnancy:

- Teen pregnancy is not as bad as before, but parents are often reluctant to allow the doctor to speak privately with their daughters who are patients.
- More parents are aware and asking for contraception for their daughters.
- This is a big problem, but schools are not receptive to working with a clinic on health promotion and pregnancy prevention.
- Greater access to care has helped with earlier interventions.
- There is pressure from parents for their children to either abort or give the newborn up for adoption. There is a lack of support from families.
- Teens get misinformation from other teens. Teens don't know how to get birth control. They need more available free protection.
- Hispanic families are reluctant to discuss sexuality, contraception, STDs. There are not enough agencies addressing the problem, giving education about prevention, or redirecting teens into positive pathways.

Infant Mortality

The infant (less than one year of age) mortality rate in the KFH – Downey service area was 4.9% (49.5 deaths per 1,000 live births). In comparison, the infant death rate in the state was 4.5%. The infant death rate compares favorably to the Healthy People 2020 objective of 60 deaths per 1,000 live births (6.0%).

Infant Mortality Rate

	Service Area			California
	Live Births	Number	Percent	Percent
Infant deaths	22,595	112	4.9%	4.5%

Source: California Department of Public Health, 2012. www.cdph.ca.gov/data/statistics/Pages/BirthProfilesbyZIPCode.aspx

Breast Feeding

Breastfeeding has been proven to have considerable benefits to baby and mother. The California Department of Public Health (CDPH) highly recommends babies be fed only breast milk for the first six months of life. Data on breastfeeding are collected by hospitals on the Newborn Screening Test Form. Breastfeeding rates at KFH – Downey indicate 95% of new mothers use some breastfeeding and 79.2% use breastfeeding exclusively. These rates are better than found among hospitals in LA County and the state. The hospital exceeds the Healthy People 2020 objective for 81.9% of women to breastfeed their infants.

In-Hospital Breastfeeding

	Any Breastfeeding		Exclusive Breastfeeding	
	Number	Percent	Number	Percent
KFH – Downey	3,082	95.0%	2,442	79.2%
Los Angeles County	**109,455**	**92.8%**	**62,955**	**53.3%**
California	**396,602**	**92.9%**	**275,706**	**64.6%**

Source: California Department of Public Health, In-Hospital Breastfeeding by Hospital of Occurrence, 2013. www.cdph.ca.gov/data/statistics/Pages/BreastfeedingStatistics.aspx

iii. Prioritized list of health needs

The health needs were ranked in the following order of priority:

Health Need	Points
Overweight and obesity	760
Mental health	720
Access to health care	420
Diabetes	360
Community safety	320
Substance abuse	220
Preventive practices	220
HIV/AIDS/STD	100
Oral health	80
Teen pregnancy	80
Cardiovascular disease	60
Asthma	40

D. Community Assets, Capacities and Resources to Respond to Identified Health Needs

For this needs assessment a community asset, capacity or resource is defined as an organization, coalition or collaborative, policy, program or service that has the potential to positively impact the identified significant health needs. KFH – Downey solicited community input through key stakeholder interviews, focus groups and a community convening to identify resources potentially available to address the significant health needs. Rather than list all of the identified resources, examples are provided of potential resources available to address these needs. Listing these resources does not assume KFH – Downey endorsement. For additional resources refer to Think Health LA at www.thinkhealthla.org and 211 LA County at https://www.211la.org/.

Access to Health Care

The Affordable Care Act has increased access to health insurance through the Covered California marketplace. In Los Angeles County, Healthy Way LA, is a no cost health program that provides health care coverage to low-income uninsured adult citizens and legal residents. Health centers and clinics are a significant resource for primary care access. The Community Clinic Association of Los Angeles County (www.ccalac.org) provides a searchable database of clinics in Los Angeles County. Two of the health centers that serve residents of the KFH – Downey service area are Family Health Care Centers of Greater Los Angeles (FHCCGLA) and AltaMed Health Care Services. FHCCGLA is a Federally Qualified Health Center (FQHC) that operates four clinics, the Bell Gardens Medical Center, Hawaiian Gardens Health Center, Maywood Medical Center, and the Downey Family Medical Center. FHCCGLA provides primary health care and assistance with insurance program enrollment. AltaMed is a Federally Qualified Community Health Center and designated as a Primary Care Medical Home. AltaMed provides assistance with health insurance enrollment. The clinics offer primary care prevention and treatment services for the entire family.

Asthma

Activate Whittier (http://activatewhittier.org) is a thriving community collaborative in Whittier that has a seven-year history of working together, with documented successes along the way. The mission of Activate Whittier is to build a healthy active Whittier through neighborhood and community engagement, collaborative partnerships, and policy/environmental change, with a focus on sustainable efforts to improve the health and wellness of those living, working, learning and playing in the community. As a result of the advocacy efforts of Activate Whittier's engage residents, Whittier's City Council adopted a policy change to ensure all 22 parks in Whittier are smoke-free. The County of Los Angeles Public Health Child and Adolescent Health Program and Policy unit coordinates the Asthma Coalition of Los Angeles County. This coalition is a broad-based group of stakeholders from community-based organizations, advocacy groups, universities, government entities, school districts, environmental groups, health plans, hospitals and clinics who work toward policy and systems change to prevent, minimize and manage the burden of asthma.

Cardiovascular Disease

Choose Health LA is a Los Angeles County Department of Public Health initiative to prevent and control chronic disease, which includes a program that teaches families how to shop through interactive grocery store tours. Another program focusing on the prevention of cardiovascular disease is through the Los Angeles County Office of Education, which offers nutrition education and obesity prevention programs funded by the USDA.

Community Safety

Helpline Youth Counseling provides strength-based counseling, education, prevention, and intervention services to assist youth and families to move toward realizing their life goals despite experiencing past or current life changes, trauma or abuse. They offer delinquency and gang intervention and prevention services. Elevate Your G.A.M.E. is another youth-focused program dedicated to promoting safety and reducing violence. They provide mentoring to lift urban students to higher levels in their Grades, Attendance, and Maturity to Empower them to be leaders who bring about positive change in their schools, communities, and the world.

Diabetes

The American Diabetes Association seeks to prevent and cure diabetes by educating the public about how to stop diabetes and provides support for those already diagnosed. Programs that address healthy eating and increased physical activity serve to prevent diabetes. A dedicated effort in the KFH – Downey service area focused on improved physical activity is the Coordinated Approach to Child Health (CATCH) program, a nationwide, evidence-based school health program designed to promote healthy eating and physical activity habits. It targets classroom curricula, physical education changes, school food service modifications, afterschool programs and family-based changes at home. School district policies adopting CATCH have been implemented in some schools and after-school programs. The Los Nietos School District has adopted the CATCH curriculum in its schools and all Whittier City School District (WCSD) elementary teachers were trained in the CATCH PE curriculum. This curriculum has also been implemented at the YMCA, Boys & Girls Club and other area afterschool physical activity

programs so that the same messages are delivered and reinforced in school and after-school among Whittier youth.

HIV/AIDS/STD

The County of Los Angeles Public Health provides STD clinics including the Los Angeles LGBT Center Sexual Health Program, which is dedicated to providing sexual health services to the gay, lesbian, bisexual and transgender community. Free testing and treatment for STDs and HIV are offered. Whittier Rio Hondo AIDS Project (WRHAP) provides support and understanding to individuals and families affected by HIV/AIDS. Services include health care, social services, case management, mental health care and policy advocacy. WRHAP educates youth and the community at large through programs aimed at the prevention of HIV/AIDS. The Family Health Care Centers of Greater Los Angeles operates four clinics that provide STD screening and treatment, and HIV testing and counseling.

Mental Health

There are various organizations that provide mental health services in the KFH – Downey service area. The Watts Counseling and Learning Center is a nonprofit Community Benefit program of Kaiser Permanente Southern California. Since 1967, the Center has provided counseling, outreach, and educational services to the residents of the Watts community. Kaiser Permanente Health Plan membership is not required to receive these services. SPIRITT Family Services provides crisis intervention, life skills and hope for a stable, nurturing and healthy family for high-need families in eastern Los Angeles County. Community Family Guidance Center provides mental health services. They support the success of children and families by reducing the impact of childhood trauma and abuse, supporting the development of positive social and emotional skills, and strengthening healthy family relationships.

Oral Health

In addition to community health centers that provide dental care services to area residents, there are a number of other organizations supporting oral health. The Assistance League provides emergency dental care to children who are uninsured and can't afford dental care. Dental treatment is provided by Whittier Area dentists who are members of the California Dental Association. Children are screened and referred to Assistance League by the schools. The Children's Dental Health Clinic is a safety-net resource and dental home for all-inclusive, multi-specialty dental services that can meet all of a child's treatment needs. Their services are available to children and young adults of low-income families, including children with special needs or complex medical considerations, and to those with access to care issues.

Overweight and Obesity

Healthy Los Nietos (HLN) is a comprehensive school-based wellness collaborative in unincorporated West Whittier. HLN has aligned district-wide health education, policy and environmental change initiatives to make the healthy choice the easy choice for students, families, and district employees. As a result of their efforts, students, parents, teachers and staff have changed their habits to increase healthy food choices and improve physical activity. The City of Downey is leading an effort to prepare a city-wide bicycle master plan. The Plan will

be a roadmap to improving the bicycling environment throughout the city, while taking into account the City's unique characteristics. A bike-able city is one where people ride bicycles because it is a convenient, fun, safe, and healthy choice.

Preventive Practices

There are many resources in the community focused on preventive practices that include health screening and vaccines and immunizations. Community clinics are key resources in the community to provide preventive services. For example, Wesley Health Centers are nonprofit community health centers that provide comprehensive medical care, physical exams, routine screenings and treatment of injuries and illnesses for men, women and children of Los Angeles County. Senior centers are another community resource dedicated to providing preventive services. The Whittier Senior Citizens Center provides health screenings and flu shots for adults, 55 years of age and older.

Substance Abuse

Whittier First Day provides a short-term emergency transitional housing with on-site supportive services to 45 individuals suffering from addiction. Services include: on-site health clinic, health screenings, mental health services, on-site meals, case management, clothing, transportation, 12 step meetings, education, training and employment assistance. The Los Angeles Centers for Alcohol and Drug Abuse (L.A. CADA) is a licensed and certified substance use and behavioral treatment provider by the State of California's Department of Health Care Services and the County of Los Angeles Department of Public Health – Substance Abuse Prevention and Control. They treat persons with addiction and behavioral problems by providing client-centered, trauma informed, recovery orientated services.

Teen Pregnancy

Planned Parenthood provides affordable, quality, confidential reproductive health care to women, men, and teens, regardless of personal circumstances or ability to pay. El Nido Family Centers is a provider of teen parent services. Through home visits, trained case managers reach out to teen parents who are isolated, overwhelmed and unprepared for the challenges of parenting.

VII. KFH – DOWNEY 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy Evaluation of Impact

KFH – Downey'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 – Downey'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-Downey.pdf . For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH – Downey in the 2013 Implementation Strategy report.

1. Access to Care
2. Overweight/Obesity
3. Preventive Care
4. Broader Health Care System Needs in Our Communities - Research and Workforce

KFH – Downey 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 – Downey tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, KFH – Downey had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH – Downey 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 – Downey had 62 active grant payments amounting to a total of $836,574 in service of 2013 health needs. Additionally, KFH – Downey 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 43 grant payments amounting to a total payment of $7,114,289 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 – Downey 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 – Downey 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 – Downey Priority Health Need: Access to Care

Long-Term Goal
- Increase access to health care for medically underserved.

Intermediate Goals
- Expand access to free and low cost services.
- Increase health care coverage among vulnerable populations.
- Improve timely access to needed medical care.
- Reduce workforce shortages.

Access to Care
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, $15,822,525 was spent on the Medicaid program and 27,659 Medi-Cal managed care members were served • In 2015, $29,255,910 was spent on the Medicaid program and 34,025 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, $8,200,465 was expended for 4,890 MFA recipients • In 2015, $4,058,961 was expended for 5,146 MFA recipients
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.	• In 2014, $1,755,159 was spent on the CHC program and 3,507 individuals received CHC • In 2015, $1,311,551 was spent on the CHC program and 3,282 individuals received CHC

Access to Care
Grant-Making Highlights

Grant-Making Snapshot: During 2014-2015, there were 16 active KFH grant payments, totaling $346,000 addressing the priority health need in the KFH – Downey service area. In addition, a portion of the money managed by a donor advised fund (DAF), The California Community Foundation, was used to pay 20 grant payments, totaling $4,037,500; 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
Insure the Uninsured Project	$75,000*	Insure the Uninsured Project (ITUP) received funding to focus on educating consumers and stakeholders on health reform as well as Outreach, Enrollment, Retention and Utilization (OERU) strategies for the uninsured.	ITUP will convene its statewide and regional workgroups to build consensus and engage local leaders to focus on region specific issues that will address the health outcomes of the newly insured and disseminate its non-partisan reports on statewide and local issues. Annually, ITUP will host at least 18 meetings—six statewide issue workgroups, ten regional workgroups, two Los Angeles Health Collaborative meetings, and legislative briefings—as well as produce twenty-five research reports on coverage efforts for the

Grantee	Grant Amount	Project Description	Results to Date
			uninsured, health reform implementation strategies, and findings from statewide and regional workgroups, annually.
Community Clinic Association of Los Angeles County	$150,000*	Community Clinic Association of Los Angeles County (CCALAC) received funding to strengthen their advocacy and external affairs, core operations and quality improvement efforts to maximize clinic and consortium viability post-health reform.	CCALAC has worked closely with clinics and the Los Angeles County Department of Health Services (LADHS) to close out its Healthy Way LA (HWLA) Matched program and was successful in obtaining a range of solutions to alleviate impact on clinics, including extensions for clinics to resubmit denied or cancelled claims. In addition, the professional expertise of member clinics' financial and operations staff was enhanced through the Chief Financial Officer (CFO) roundtable and the Chief Operating Officer (COO) Roundtable meetings. CCALAC's Clinical Services Division also communicated with clinic leadership to ensure continuity, and understanding of CCALAC's clinical quality improvement activities, broadening discussions that included the sharing of successes, challenges and best practices in chronic disease management and disease prevention.
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.
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	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

Grantee	Grant Amount	Project Description	Results to Date
		maternity services.	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.
Family Health Care Centers of Greater Los Angeles	$30,000	FHCCGLA will increase access to pediatric services for the residents of Downey by increasing clinical hours through the recruitment of a pediatric provider at the Downey Family Medical Center.	In 2015, 323 patients in need of mental health services were screened/access and referred to a licensed clinical social worker (LCSW) at the clinic for support. Access to culturally sensitive primary care was provided to 962 adult patients and 150 pediatric patients.
South Central Family Health Center	$25,000	To add an additional 250 uninsured and/or low income patients to our Huntington Park Family Health Center, whose unmet cost of care will be partially funded through this grant.	During the grant period, 272 new patients and 2,318 primary care visits were provided to clinic patients in the Huntington Park Family Health Center
St. Jeanne de Lestonnac Free Clinic	$25,000	Lestonnac's Bridge to Care Program provides low-income, uninsured patients with access to free medical and dental services via our multiple clinic locations, specifically our two Los Angeles based Clinics.	During the funding period, the clinic treated a total of 873 patients through 2,453 visits at the Artesia and Compton clinics. At the Compton clinic, 107 dental patients were treated through 185 visits and 339 medical patients were treated through 1,427 visits. At the Artesia clinic 348 medical patients were treated through 729 visits and 79 ER Follow-Up patients were treated through 112 visits.

Access to Care Collaboration/Partnership Highlights		
Organization/Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
Child Health Plan Partners	To increase enrollment in Child Health Plan Program	KFH – Downey hosted a community wide Child Health Plan enrollment training. Over 25 individuals representing 13 organizations participated in the training which was led by Kaiser Permanente Child Health Plan program leaders. This effort contributed to building the capacity of schools and nonprofits in SPA 7 to support health insurance outreach, education and enrollment efforts.

Access to Care
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
Bellflower and Downey Unified School Districts	Both school districts have school based clinics where KFH – Downey physicians donate their time to treat uninsured students. From January through December 2014, KFH – Downey physicians (Geraldine Chen, MD, Carol Ishimatsu, MD, Jeff Mallin, MD, Diane Truong, MD, Hugh Tsai, MD, Yvonne Tsai, MD, Victor Wong, MD, and Nicholas Chiou, MD) saw 33 students at Downey's Lewis clinic and 19 at Bellflower. This effort has increased the capacity for community and school based clinics to serve the medically underserved.
Montebello Unified School District	For more than ten years, KFH – Downey has collaborated with MUSD to provide mental health services to students, particularly those with attention deficit disorder and attention-deficit-hyperactivity-disorder (ADD/ADHD). Three KFH – Downey physicians volunteer twice a month at Suva Middle School in Bell Gardens treating uninsured students diagnosed with ADD/ADHD. They served 109 students in 2014.

Impact of Regional Initiatives Addressing Access to Care

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 Specialty Care Initiative aims to increase access to health care 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.

KFH – Downey Priority Health Need: Overweight/Obesity

Long-Term Goal
- Reduce incidence of overweight and obesity in the community.

Intermediate Goals
- Increase healthy eating among service area residents.
- Increase active living among residents of the service area

Overweight/Obesity
Grant-Making Highlights

Grant-Making Snapshot: During 2014-2015, there were 27 active KFH grant payments, totaling $241,574, addressing the priority health need in the KFH – Downey service area. In addition, a portion of the money managed by a donor advised fund (DAF)[1], The California Community Foundation, was used to pay 18 grant payments , totaling $1,851,789 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
California Food Policy Advocates	$212,500*	The Improving Nutrition Program Participation and Quality in Southern California project works to ensure that eligible people in need of nutritional support programs have access to CalFresh and Child Nutrition Programs such as federally subsidized school breakfast and lunch programs and child care nutrition.	To date, the California Food Policy Advocates has increased school breakfast participation, increased the number of public school students in Medi-Cal households who are enrolled in free school meal programs, and increased CalFresh enrollment. The grant has built awareness, evidence, and support for child care nutrition policies.

Grantee	Grant Amount	Project Description	Results to Date
Community Partners	$350,000*	Community Partners provides technical assistance and strategic support for coalition building, resident engagement, and leadership through peer-to-peer learnings, webinars, teleconferences for the HEAL Zone and HEAL Partnership grant communities.	Community Partners provided technical assistance and strategic support to ten HEAL grantees, their partners, and resident/youth leaders to apply the knowledge, skills, and competencies to successfully implement their HEAL Community Action Plan strategies in 2015.
YMCA of Greater Whittier	$100,000*	The HEAL Partnership Grant aims to a) revise the WCSD wellness policy, b) recruit and train parent advocates, c) increase access to healthy food and beverages in participating schools, and d) implement a Healthy Picks labeling program in food markets.	The following accomplishments were achieved to date: a) schools are piloting the removal of chocolate milk three days/week, b) the Food Services Directed has drafted new Wellness Policy revision and nine participating schools have implemented a healthy fundraiser in place of typical food fundraisers, c) training of a new cohort of parents on the “Change Starts with Me’ advocacy program and connecting them to work in the schools and community, and d) built partnership with three local food markets to implement a healthy picks labeling program and successfully implemented in one corner store. These efforts have the potential to reach approximately 9,000 individuals
ABC Unified School District	$44,263*	This Thriving Schools project aims to a) offer more PA opportunities for students during school hours b) revise and a school district wellness policy, and b) establish an employee wellness program.	The school district improved physical activity opportunities for students during the school day, such as Walk to School Days, walking/running clubs, active recess, and staff wellness activities. Additionally, the district implemented a three district wide two-day physical activity training

Grantee	Grant Amount	Project Description	Results to Date
			program (Playworks) targeting 144 employees. This project is being implemented in 11 Elementary Schools and potentially reaches 5,480 students.
Young Men's Christian Association of Metropolitan Los Angeles	$15,000	The Downey YMCA continued HIP Kids, a program that promotes healthier eating and increased exercise for overweight or obese children and their families.	The project aims to target 200 families referred by school nurses in Downey Unified School District. The HIP Kids curriculum, delivered by a registered dietician, focuses on nutrition education for adults and children as well as exposure to physical activity opportunities.
Community Agencies for Caring Connections	$10,000	To prevent and decrease the population of low income children ages 5-17 who are overweight or obese in our community by providing them access to physical activity and nutrition classes.	A total of 454 children have been enrolled into the parks and recreation physical activity classes during the two years of the program's existence. More than 100 parents have attended eight nutrition education workshops provided by Bellflower Unified School District's Nutrition Education Outreach Grant Program.
Bellflower Unified School District	$20,000	This grant supported the implementation of a nutrition education program within the Physical Education curriculum at all ten of the elementary schools within the district. The new program combines physical activity and nutrition education and incorporates all 6 National PE standards and 3 of the National Health Education standards.	This grant was provided in October 2015 and implementation is underway. Bellflower Unified School District is implementing a new nutrition education component within the elementary physical education curriculum at all ten schools. All elementary students will benefit from this curriculum change and by the end of June 2016.
City of Downey	$25,000	Healthy Downey is committed to reducing the obesity rate in the	With grant support, Healthy Downey continued the successful

Grantee	Grant Amount	Project Description	Results to Date
		City of Downey through education and events geared at encouraging healthy eating and physical activity.	implementation of its second year, which included the creation of a strategic, long-term plan for the initiative.

Overweight/Obesity Collaboration/Partnership Highlights		
Organization/Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**
Partnership for Healthy Communities	The goal of the collaborative is to bring evidence-based nutrition education programs to all cities involved.	This work was created out of the Center for Nonprofit Management and KFH – Downey's capacity building grant and partnership work with nonprofit organizations. KFH – Downey helped bring the partners together and provided a forum for the work to develop. To date 24 individuals from the communities of Cerritos, Artesia, Bellflower and Whittier have been trained by the LA County Department of Public Health in an evidence based nutrition program that will be implemented in 2016.
Healthy Downey	Create a Healthier Downey	KFH – Downey supported the 2014 International Walk to School Day in Downey Unified School District and 13 KFH – Downey employees volunteered at the October event. Two KFH – Downey technical advisors attended monthly meetings and provided individual consultations to city leaders to assist the collaborative in creating programs and initiatives that focus on health.
Activate Whittier	Address obesity issues in the City of Whittier	For the past five years, the KFH – Downey Community Benefit Manager has served on the board of directors

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
		for Activate Whittier, which has transformed the food served at Whittier elementary schools and urged all Whittier schools to implement an evidence-based physical activity curriculum.

Impact of Regional Initiatives Addressing Overweight/Obesity

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 – Downey and the results to date, please see the Thriving Schools listing above under ABC Unified School District.

Kaiser Permanente's HEAL (Healthy Eating, Active Living) Partnership grant initiative is awarded a place-based approach that aims to lower the prevalence of obesity and overweight by increasing access to fresh fruit, vegetables and healthy beverages, as well as increasing safe places to be play and be physically active. Participating school districts and schools implement policies, programs and environmental system changes to impact healthy eating and active living behavior among students, parents and/or school staff. To date, Kaiser Permanente has awarded over $7,000,000 to community based organizations across Southern California to support this initiative. For the specific project implemented in KFH – Downey and the results to date, please see the listing above for the HEAL Partnership grant project coordinated by the YMCA of Greater Whittier.

KFH – Downey Priority Health Need: Preventive Care

Long-Term Goal
- Improve community health and wellness through preventive practices.

Intermediate Goals
- Increase access to preventive care in the community.
- Improve access to preventive interventions for at-risk youth.

Preventive Care
Grant-Making Highlights

Grant-Making Snapshot: During 2014-2015, there were 19 active KFH grant payments, totaling $248,500, addressing the priority health need in the KFH – Downey service area. In addition, a portion of the money managed by a donor advised fund (DAF)[1], The California Community Foundation, was used to pay 1 grant, totaling $25,000; 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
Harbor Area Gang Alternatives	$20,000	My Gangfree Life is a 4th Grade curriculum approved by the State of California Principals of Learning and recognized by the Office of Juvenile Justice and Delinquency Prevention, as a "Best Practices" program, which is a nationwide comprehensive gang prevention strategy.	In 2015, the curriculum was provided to 650 4th grade students in Watts, Whittier, Hawaiian Gardens, Lynwood, and Compton who were given the opportunity to pledge to be gang free and graduate in a commencement ceremony at the culmination of the 8-week school based intervention program.
The California Conference for Equality and Justice	$10,000	CCEJ provided technical assistance and coaching to staff of Locke High School in Watts in order to further the work of school-wide implementation of Restorative Justice.	CCEJ supported the school leadership at Locke High School in Watts with 160 hours of technical assistance and coaching in implementing a restorative justice program. Implementation of Restorative Justice programs leads to reduced suspensions and improved school climate.
The California Conference for Equality and Justice	$16,000	CCEJ supported human relations training and Restorative Justice workshops at Cerritos and Hawaiian Gardens schools. Students received Talking in Class training, a three-day curriculum that promotes respect and builds positive human relations among youth.	CCEJ reached 75 students through Talking in Class, a three-day curriculum that promotes respect and builds positive human relations among youth. In addition, teachers from ABC Unified School District's Tracy High School and Fedde Middle School received Restorative Justice training. This training has been shown to change the culture of schools by helping students to be safe, successful, accountable, and to stay out of prison
Elevate Your	$10,000	Elevate Your Game's mentoring	During the 2014-2015 school year,

Grantee	Grant Amount	Project Description	Results to Date
G.A.M.E.		program utilizes adult and peer-mentors to mentor at-risk teenagers to motivate them to improve in their academics and character.	119 Compton youth received one-on-one mentoring as well as opportunities for job shadowing and summer youth employment programs.

PRIORITY HEALTH NEED V: 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 (*). All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded. KFH – Downey also provided trainings and education for 111 residents in its Graduate Medical Education program, 18 nurse practitioner or other nursing beneficiaries, and 36 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*	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	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

		of Nursing Education (CCMNE).	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 Report will focus on factors affecting demand and supply; public higher education funding policies; and programs to help meet workforce demands.	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 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.

PRIORITY HEALTH NEED VI: 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. An illustrative grant is provided below. 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 – Downey service area, 83 research projects were active as of year-end 2014 and 105 research projects were active as of year-end 2015.
Individuals and organizations in the health care and medical community.	Kaiser Permanente Southern California Region's Nursing Research Program provides administrative and technical support for nurses to conduct, publish and disseminate research studies and evidence based practice projects. In the KFH – Downey service area, six research projects were active as of year-end 2014 and eight research projects were active as of year-end 2015.

VIII. APPENDICES

A. Secondary Data Sources and Dates
B. Community Input Tracking Form
C. Health Need Profiles
D. Glossary of Terms

Appendix A: Secondary Data Sources and Dates

1. California Cancer Registry, Age-Adjusted Invasive Cancer Incidence Rates by County in California, 2008-2012. 2014.
2. California Department of Education. 2012-2013.
3. California Department of Education. 2013.
4. California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.
5. California Department of Justice, Office of the Attorney General, Crime Statistics. 2014.
6. California Department of Public Health, CDPH – Birth Profiles by ZIP Code. 2011.
7. California Department of Public Health, CDPH – Birth Profiles by ZIP Code. 2012.
8. California Department of Public Health, CDPH – Breastfeeding Statistics. 2012.
9. California Department of Public Health, CDPH – Breastfeeding Statistics. 2013.
10. California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
11. California Department of Public Health, CDPH – Tracking. 2005-2012.
12. California Employment Development Department, Labor Market Information. 2015.
13. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011-2013.
14. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
15. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
16. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
17. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
18. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
19. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
20. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
21. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
22. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
23. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
24. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
25. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
26. Centers for Disease Control and Prevention, National Vital Statistics System. University of

Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
27. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
28. Centers for Medicare and Medicaid Services. 2012.
29. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
30. County of Los Angeles, Department of Public Health, Annual HIV Surveillance Report. 2013.
31. County of Los Angeles, Department of Public Health, Sexually Transmitted Disease Morbidity Report. 2012.
32. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
33. Environmental Protection Agency, EPA Smart Location Database. 2011.
34. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
35. Feeding America. 2012.
36. Los Angeles County Department of Public Health, Los Angeles County Health Survey. 2011.
37. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Trends in Obesity: Adult Obesity Continues to Rise. 2012.
38. Los Angeles Homeless Services Authority, Greater Los Angeles Homeless Count Results. 2013.
39. Los Angeles Homeless Services Authority, Greater Los Angeles Homeless Count Results. 2015.
40. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
41. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
42. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
43. New America Foundation, Federal Education Budget Project. 2011.
44. Nielsen, Nielsen Site Reports. 2014.
45. South Coast Air Quality Management District, Air Quality. 2014.
46. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
47. Think Health LA. 2015.
48. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
49. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
50. University of California Center for Health Policy Research, California Health Interview Survey. 2014.
51. University of California Center for Health Policy Research, California Health Interview Survey. Neighborhood Edition. 2011-2012.
52. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
53. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
54. US Census Bureau, American Community Survey. 2009-2013.
55. US Census Bureau, American Housing Survey. 2011, 2013.
56. US Census Bureau, County Business Patterns. 2011.
57. US Census Bureau, County Business Patterns. 2012.
58. US Census Bureau, County Business Patterns. 2013.
59. US Census Bureau, Decennial Census. 2000-2010.
60. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
61. US Census Bureau, Small Area Income & Poverty Estimates. 2010.

62. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
63. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
64. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
65. US Department of Education, EDFacts. 2011-2012.
66. US Department of Health & Human Services, Administration for Children and Families. 2014.
67. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
68. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
69. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
70. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
71. US Department of Housing and Urban Development. 2013.
72. US Department of Justice, FBI, Uniform Crime Reporting Statistics. 2012.
73. US Department of Labor, Bureau of Labor Statistics. June 2015.
74. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
75. US Drought Monitor. 2012-2014

Appendix B: 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
e.g. community forum, focus group, interview, online or in-person survey, written correspondence, etc.	Community member's title/role, organization, event name, input during identification, prioritization (or both), etc.	Number of people who participated	List all that apply & describe: (a) health department rep; (b) medically underserved, (c) minority population; (d) low-income community	List all that apply: (a) community leader; (b) community representative; (c) community member	Date that community input was gathered	
Key Stakeholder Interview	RN, SPA 7 identification	1	Health department representative	Community representative	9/28/2015	
Key Stakeholder Interview	Facility Director, Community Resource Center, LA County CDC identification	1	Minority population; low-income community	Community representative	9/28/2015	
Key Stakeholder Interview	Field Representative, Assemblymember Cristina Garcia identification	1	Minority population; low-income community	Community leader	9/29/2015	
Focus Group	Residents of SE Los Angeles cities; Leaders in Action identification	10	Medically underserved; minority population, low-income community	Community members	9/29/2015	Spanish-language group
Key Stakeholder Interview, Community Forum	Executive Director, Elevate Your Game Identification and prioritization	1	Minority population; low-income community	Community leader, community representative	9/30/2015 1/13/2016	
Key Stakeholder Interview	COO, The Whole Child identification	1	Low-income, medically underserved minority community members	Community representative	9/30/2015	
Key Stakeholder Interview, Community Forum	Director, Caring Connections Identification and prioritization	1	Minority population; low-income community	Community representative	9/30/2015 1/13/2016	
Key Stakeholder Interview	Associate Dean, Student Health & Wellness, Cerritos College identification	1	Low-income, medically underserved minority community members	Community leader	9/30/2015	

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
Key Stakeholder Interview	Executive Director, Work Site Wellness LA identification	1	Low-income, medically underserved minority community members	Community representative	9/30/2015	
Focus Group	Agencies represented included: YMCA of Greater Whittier; Caring Connections; LA County Nutrition Education Obesity Prevention; LA County Department of Public Health; City of Bellflower Volunteer Center identification	6	Public Health; medically underserved; minority population, low-income community	Community leaders; community representatives	10/2/2015	English-language group
Key Stakeholder Interview	Director, Downey Parks & Recreation identification	1	Low-income, minority community members	Community representative	10/5/2015	
Key Stakeholder Interview	Promotora, Activate Whittier identification	1	Low-income, medically underserved minority community members	Community representative, Community member	10/5/2015	
Key Stakeholder Interview	Executive Director, Helpline Youth Counseling identification	1	Low-income, medically underserved minority community members	Community leader, community representative	10/5/2015	
Key Stakeholder Interview	Executive Director, Cerritos Chamber of Commerce identification	1	Low-income, minority populations	Community leader	10/5/2015	
Key Stakeholder Interview	Director, LA County DMH SPA 7 identification	1	Health department representative	Community representative	10/5/2015	
Key Stakeholder Interview, Community Forum	Program Director, Activate Whittier Identification and prioritization	1	Low-income, medically underserved minority community members	Community representative	10/5/2015 1/13/2016	

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
Key Stakeholder Interview	Councilmember, City of Downey identification	1	Minority population; low-income community	Community leader, community representative	10/6/2015	
Focus Group	Parents of children who attend Ernie Pyle elementary school, Bellflower identification	10	Medically underserved; minority population, low-income community	Community members	10/6/2015	Spanish-language group
Key Stakeholder Interview	Health Deputy, Supervisor Knabe identification	1	Low-income, medically underserved minority community members	Community leader	10/7/2015	
Key Stakeholder Interview	Executive Director, Kingdom Causes identification	1	Low-income, medically underserved minority community members	Community representative	10/7/2015	
Key Stakeholder Interview	Councilmember, City of Hawaiian Gardens identification	1	Low-income, medically underserved minority community members	Community leader, community representative	10/7/2015	
Key Stakeholder Interview	Psychologist, Rio Hondo College identification	1	Low-income, medically underserved minority community members	Community representative	10/9/2015	
Key Stakeholder Interview	Pastor, Faith Missionary Baptist Church, Compton identification	1	Low-income, medically underserved minority community members	Community leader, community representative	10/9/2015	
Key Stakeholder Interview, Community Forum	Executive Director, Downey Family YMCA Identification and prioritization	1	Minority population; low-income community	Community representative	10/9/2015 1/13/2016	
Key Stakeholder Interview	Lead Administrator, JWCH Clinic identification	1	Low-income, medically underserved minority community members	Community representative	10/9/2015	
Key Stakeholder	Deputy Director, Rep. Linda	1	Minority population; low-	Community leader	10/9/2015	

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
Interview	Sanchez identification		income community			
Key Stakeholder Interview	Promotora President, Healthy Los Nietos identification	1	Low-income, medically underserved minority community members	Community representative, Community member	10/12/2015	
Key Stakeholder Interview	COO, Whittier Boys & Girls Club identification	1	Low-income, medically underserved minority community members	Community representative	10/12/2015	
Key Stakeholder Interview	Teen Program Director, Whittier Boys & Girls Club identification	1	Low-income, medically underserved minority community members	Community representative	10/12/2015	
Key Stakeholder Interview	Recreation Coordinator, Pico Rivera Senior Center identification	1	Low-income, medically underserved minority community members	Community representative	10/12/2015	
Key Stakeholder Interview	Program Director, SPIRITT Family Services identification	1	Low-income, medically underserved minority community members	Community representative	10/12/2015	
Focus Group	Plaza de la Raza, parents of preschool aged children, Pico Rivera identification	5	Medically underserved; minority population, low-income community	Community members	10/14/2015	Spanish-language group
Focus Group	College-aged students; Cerritos College health clinic consumers identification	6	Medically underserved; minority population, low-income community	Community members	10/15/2015	English-language group
Key Stakeholder Interview	Program Director, SPIRITT Family Services, Bell Gardens identification	1	Low-income, medically underserved minority community members	Community representative	10/16/2015	

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
Focus Group	Agencies represented included: Los Angeles County Office of Education (LACOE); Downey Unified School District (DUSD) Health Services; TLC - DUSD; Exchange Club Family Support Center; Downey Adult School; Kaiser Permanente Watts Counseling Center; Living Help Center; Human Services Association; and Foundhelp identification	10	Medically underserved; minority population, low-income community	Community leaders; community representatives	10/16/2015	English-language group
Key Stakeholder Interview	Chief Mission Advancement Officer, YMCA Los Angeles identification	1	Low-income, medically underserved minority community members	Community representative	10/19/2015	
Focus Group	Food pantry clients, Interfaith Food Center, Santa Fe Springs identification	10	Medically underserved; minority population, low-income community	Community members	10/20/2015	Spanish-language group
Key Stakeholder Interview	Primary Care Provider, Bell Gardens identification	1	Low-income, medically underserved minority community members	Community representative	10/22/2015	
Focus Group	Faith-based group, including pastors, lay pastors and congregants, Whittier identification	12	Medically underserved; minority population, low-income community	Community leaders and members.	10/23/2015	English-language group
Focus Group	Clients of Kaiser Permanente Watts Counseling and Learning Center identification	10	Medically underserved; minority population, low-income community	Community members	10/27/2015	English-language group

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
Community Forum	Department Administrator, Kaiser Permanente prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Grant Writer, Bridge of Faith prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Executive Director, Interfaith Food Center prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	CFO, KFH- Downey prioritization	1	Medically underserved; minority population, low-income community	Community leader	1/13/2016	
Community Forum	District Wellness Promotion Specialist, ABC Unified School District prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Community Benefit Specialist, PIH Health prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	CEO, The Whole Child prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	School Nurse, ABC Unified School District prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Intern, Healthy Downey prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Development Director, Clinica Romero prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	

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
Community Forum	Medical Social Worker, Kaiser Permanente prioritization	2	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Program Administrator, Compton Junior Posse prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Director of Community Services, City of Hawaiian Gardens prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Director Community Benefit Development, PIH Health prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Chief Operating Officer, Wesley Health Centers prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Community Liaison Public Health Nurse, LA County Department of Public Health prioritization	1	Health department representative	Community representative	1/13/2016	
Community Forum	Associate Executive Director, CCEJ prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Director, The Compton Initiative prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Public Health Nurse, SPA 6 prioritization	1	Health department representative	Community representative	1/13/2016	
Community Forum	Executive Director, CCEJ prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Controller, SPIRITT Family Services	1	Medically underserved;	Community representative	1/13/2016	

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
	prioritization		minority population, low-income community			
Community Forum	TLC Coordinator, Downey Unified School District prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Physician, Kaiser Permanente prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Executive Director, Bridge of Faith prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Health Program Coordinator, Children's Defense Fund prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Program Manager, LA County Office of Education prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Executive Director, Community Family Guidance Center prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	President and CEO, YMCA of Greater Whittier prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Executive Director, Pathways prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Board Member, SPIRITT Family Services prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	
Community Forum	Recreation Coordinator, Bellflower Volunteer	1	Medically underserved; minority	Community representative	1/13/2016	

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
	Center prioritization		population, low-income community			
Community Forum	Executive Director, Olive Crest prioritization	1	Medically underserved; minority population, low-income community	Community representative	1/13/2016	

Appendix C: Health Need Profiles

Health Profile: Access to Health Care

Access to comprehensive, quality health care services is important for health equity and for increasing the quality of a healthy life. Health care access is a key requirement for early detection of illnesses, chronic disease management and reduction of Emergency Room usage *(Healthy People 2020)*.

SNAPSHOT

Insurance – Insurance coverage by SPA shows that in SPA 6, 19% have employment-based insurance and 48.5% are covered by Medi-Cal. In SPA 7 40.5% of residents have employment-based insurance and 30.7% are covered by Medi-Cal.

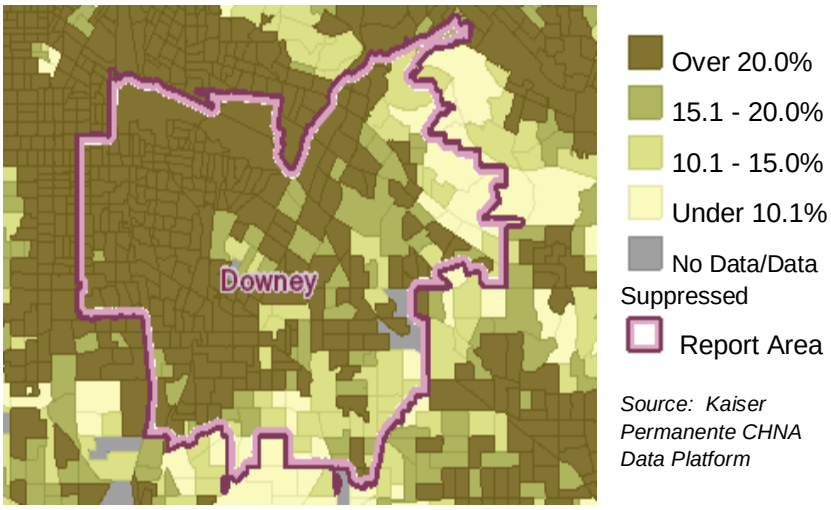
Adults, ages 18-64, have the highest rate of uninsured. Coverage for children and adults is primarily through Medi-Cal and employment-based insurance. Seniors have low rates of uninsured and high rates of Medicare and other coverage.

Sources of Care – The source of care for 38.9% of SPA 6 and 59.2% of SPA 7 residents is a doctor's office, HMO, or Kaiser. Clinics and community hospitals are the source of care for 41.5% of those in SPA 6 and 25.5% in SPA 7.

(CHIS, 2014)

Access to Health Care Statistics

Uninsured Population, Percent by Tract, ACS 2009-2013

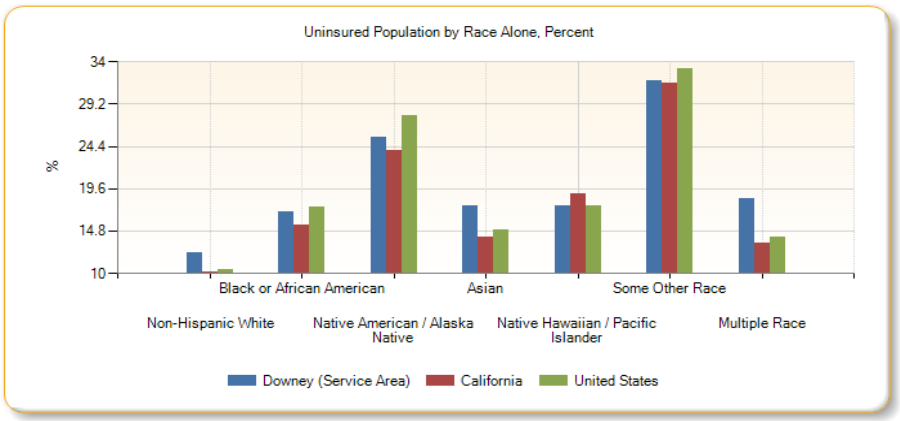


Source: Kaiser Permanente CHNA Data Platform

Over one-quarter of the population (25.9%) are uninsured, which translates to 74.1% with health insurance. This is less than the Healthy People 2020 objective of 100% health insurance coverage *(American Community Survey, 2009-2013)*.

Health Disparities

When examined by race, the service area has higher rates of uninsured than found in the state among all races except Hawaiian and Pacific Islanders.



Source: Kaiser Permanente CHNA Data Platform

Key Health Drivers

HPSA – A "Health Professional Shortage Area" (HPSA) is defined as a geographic area designated as having a shortage of primary medical care, dental or mental health professionals. Over half (56.7%) of the population in the KFH – Downey service area is living in a HPSA for primary care (*U.S .Department of Health & Human Services, Health Resources and Services Administration, March 2015).*

Usual Source of Care – Residents who have a medical home have access to a primary care provider. Among the youth in SPA 6, 85.6% have a usual source of care. In SPA 7, 96.7% of youth have a usual source of care. Among adults, in SPA 6, 86% have a usual source of care, and 80.9% of adults in SPA 7 have a source of care. 93.4% of seniors in SPA 6 have a usual source of care and 95.6% of seniors in SPA 7 have a source of care *(CHIS, 2014).*

Delayed Care – Among residents of SPA 6, 10.7% delayed or did not get medical care and 8.8% delayed or did not obtain prescription medications when needed. 55.5% delayed care due to the cost of care or lack of insurance. In SPA 7, 11.4% of residents delayed care and 8.8% delayed obtaining prescription medications. 35.6% delayed care due to the cost of care or lack of insurance *(CHIS, 2014)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Healthy Way LA – A no cost health program that provides health care coverage to low-income uninsured adult citizens and legal residents.

Family Health Care Centers of Greater Los Angeles – FHCCGLA is a Federally Qualified Health Center (FQHC) that operates four clinics, the Bell Gardens Medical Center, Hawaiian Gardens Health Center, Maywood Medical Center, and the Downey Family Medical Center. FHCCGLA provides primary health care and assistance with insurance program enrollment.

AltaMed Health Care Services – AltaMed is a Federally Qualified Community Health Center and designated as a Primary Care Medical Home. AltaMed provides assistance with health insurance enrollment. The clinics offer primary care prevention and treatment services for the entire family.

Community Input

“To access care, you have to take time off work, this impacts your income. Low-income families have access to emergency Medi-Cal, but the working poor fall through the cracks because they don’t qualify for Medi-Cal and they cannot afford health care premiums, deductibles and co-pays, even under Covered California.”

“Transportation is a barrier for many; long wait times for some doctors; limited provider networks are also barriers.”

Health Profile: Asthma

Asthma is a chronic disease that with preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives. Asthma episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath *(Healthy People 2020)*.

SNAPSHOT

Prevalence
In SPA 6, 6.8% of the population has been diagnosed with asthma; 9.5% of SPA 6 youth have been diagnosed with asthma. In SPA 7, 8.1% of the population has been diagnosed with asthma. Among youth in SPA 7, 5.3% have been diagnosed with asthma *(CHIS, 2014)*.

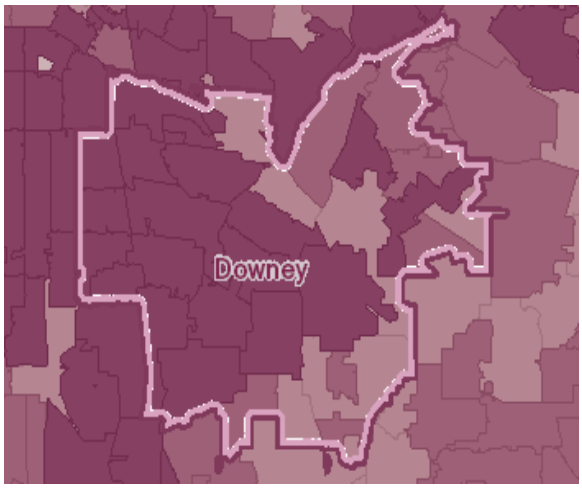
Compton has the highest rate of youth diagnosed with asthma (16.5%) and Huntington Park has the lowest percentage of youth diagnosed with asthma (12.2%) for those cities with data available.

Lakewood has the highest rate of adults diagnosed with asthma (16.4%), and Lynwood has the lowest rate of adults diagnosed with asthma (9.3%).

(CHIS, Neighborhood Edition, 2011-2012)

Health Outcome Statistics

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

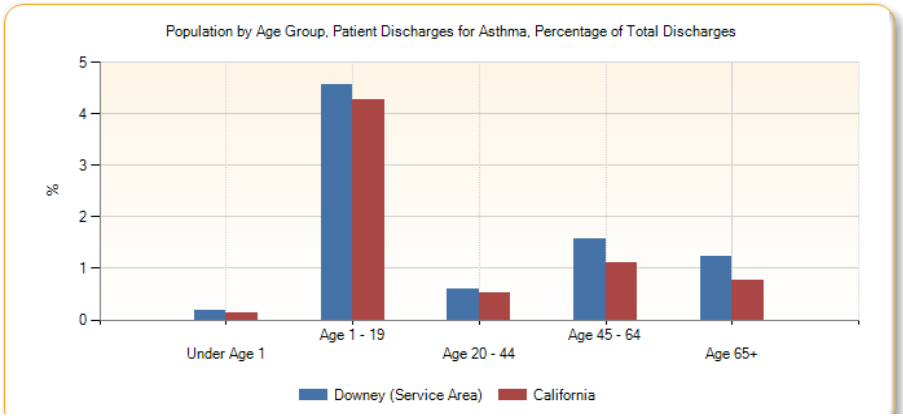


Source: Kaiser Permanente CHNA Data Platform

South East L.A. (90059) has the highest rate of ER visits for asthma per 10,000 persons (74.2), and South L.A. (90001) has the highest hospitalization rate (26.1) for asthma. Downey (90240) has the lowest asthma ER rate (26.3), and Cerritos has the lowest asthma hospitalization rate (6.3) *(OSHPD, 2011)*.

Health Disparities

All age groups in the service area have higher rates of hospitalization for asthma compared to those with asthma in the state.
Source: Kaiser Permanente CHNA Data Platform



Key Health Drivers

Smoking – Being a smoker, exposure to secondhand smoke or having a mother who smoked during pregnancy have been shown to increase the chances of developing asthma. A number of communities in the KFH – Downey service area have high rates of cigarette smoking. Bellflower (15.5%), Compton (17.9%), Lynwood (14.5%), and Paramount (14.7%) have the highest rates of smoking in the service area. These rates exceed the Healthy People 2020 objective for smoking of 12% *(CHIS, Neighborhood Edition, 2011-2012)*.

Overweight/Obesity – Over one-third of the adult population is overweight in SPA 6 (35.9%). In SPA 7, 29.1% of adults are overweight. In SPA 6, 2% of teens and 7.3% of children are overweight. In SPA 7, 11.5% of teens and 10.2% of children are overweight *(CHIS, 2014)*.

Air Quality – The South Coast Air Quality Management District monitors air quality across Southern California. The Central Los Angeles location of the South Coast Air Basin is situated in the KFH – Downey service area. While rates of PM10 (30.6) and carbon monoxide (2.0) are lower in Central Los Angeles than in the South Coast Air Basin (44.1 and 3.8), air quality continues to negatively impact those who suffer from asthma *(AQMD, 2014)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Activate Whittier – as a result of the advocacy efforts of residents and youth, Whittier's City Council adopted a policy change to ensure all 22 parks in Whittier are smoke-free.

Communities for a Better Environment – Communities for a Better Environment (CBE) is an environmental justice organization with a mission to build people's power in California's communities of color and low-income communities to achieve environmental health and justice by preventing and reducing pollution and building green, healthy and sustainable communities and environments.

County of Los Angeles Public Health – The Child and Adolescent Health Program and Policy unit coordinates the Asthma Coalition of Los Angeles County, a broad-based coalition of stakeholders from community-based organizations, advocacy groups, universities, government entities, school districts, environmental groups, health plans, hospitals and clinics in Los Angeles County.

Community Input

"The area is impacted by environmental factors such as freeways and increased emissions. We live next to freeways so there is poor air quality."

"I was over-medicating my son for a year, but the doctor hadn't explained the potential side-effects and we figured 'more is better'. There is a lack of understanding about environmental factors that contribute to asthma in the household."

Health Profile: Cardiovascular Disease

Cardiovascular disease includes conditions that impact the heart and vascular system. Conditions may include heart disease, stroke, high blood cholesterol and high blood pressure. A number of factors influence the development and management of cardiovascular disease: overweight, physical inactivity, and diets high in sugar and fat.

SNAPSHOT

Heart Disease – For adults in SPA 6, 8.6% have been diagnosed with heart disease; 5.2% of adults in SPA 7 have been diagnosed with heart disease.

High Blood Pressure – A co-morbidity factor for heart disease is hypertension (high blood pressure). In SPA 6, 35.7% of adults have been diagnosed with high blood pressure. Of these, 55.5% are on medication for their blood pressure. In SPA 7, 20.8% of adults have been diagnosed with high blood pressure and 60.2% are on medication.

High Cholesterol – High cholesterol contributes to cardiovascular disease. 22.9% of adults in SPA 6 and 25.4% of SPA 7 adults have been diagnosed with high cholesterol.

(CHIS, 2014)

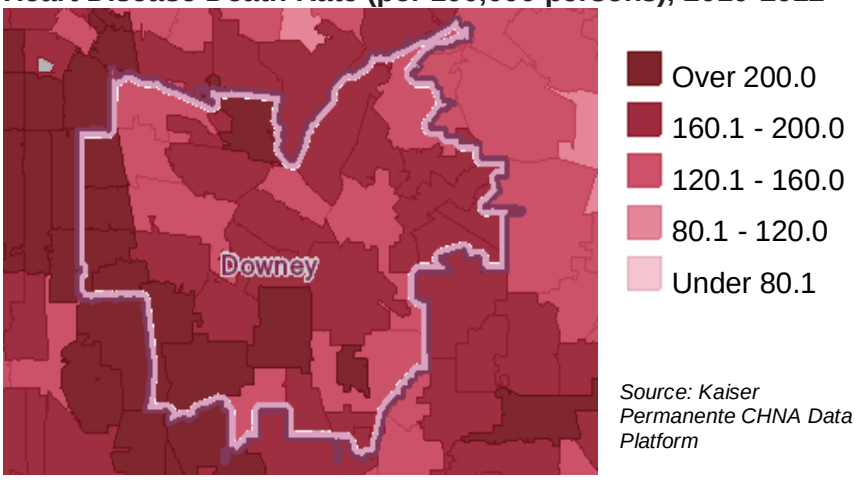
Health Outcome Statistics

Mortality Rates, per 100,000 persons, Age-Adjusted, 2010-2012

	Service Area	California	Healthy People 2020
Heart Disease	186.6	163.2	100.8
Stroke	44.0	37.4	34.8

Source: University of Missouri, 2010-2012. Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data.

Heart Disease Death Rate (per 100,000 persons), 2010-2012



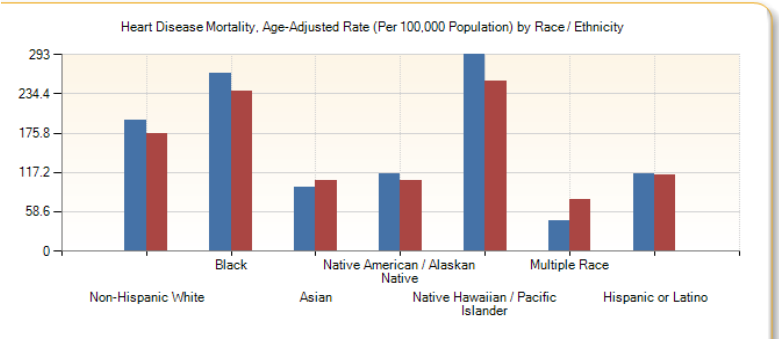
Source: Kaiser Permanente CHNA Data Platform

Heart disease is the leading cause of death in the service area. Rates of death for heart disease and stroke exceed the Healthy People 2020 objectives *(California Department of Public Health, 2010-2012).*

Health Disparities

Among all races, except Asian and multiples races, the rate of heart disease deaths is higher in the servcie area than the state.

Source: Kaiser Permanente CHNA Data Platform



Key Health Drivers

Smoking - Smoking is a contributing cause to cardiovascular disease. Cerritos (11.2%) has the lowest rate of smoking and Compton (17.9%) has the highest rate of smoking in the service area. All cities in the service area, except Cerritos, have smoking rates higher than the Healthy People 2020 objective of 12% *(CHIS, Neighborhood Edition, 2011-2012)*.

Overweight - Over one-third of the adult population is overweight in SPA 6 (35.9%). In SPA 7, 29.1% of adults are overweight. In SPA 6, 2% of teens and 7.3% of children are overweight. In SPA 7, 11.5% of teens and 10.2% of children are overweight *(CHIS, 2014).*

Physical Inactivity – In SPA 6, 0.6% of children and 22.9% of teens were sedentary during the previous week. 8.9% of children in SPA 7 were sedentary and 2.8% of teens were sedentary.

Access to Recreation Facilities – In the KFH – Downey service area there are 2.8 recreation facilities per 100,000 persons. The rate of access to recreation facilities is less than the state rate of 8.7 facilities per 100,000 persons *(CHIS, 2014).*

Diets High in Fat - 25.2% of SPA 6 residents eat fast food three or more times a week. In SPA 7, 29.9% of the residents eat fast food three or more times a week. Adults consume fast food at a higher rate than youth or seniors *(CHIS, 2014).*

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Activate Whittier – as a result of the advocacy efforts of residents and youth, Whittier's City Council adopted a policy change to ensure all 22 parks in Whittier are smoke-free.

Choose Health LA – LA County Department of Public Health initiative to prevent and control chronic disease, which includes a program that teaches families how to shop. Grocery store tours are provided.

LA County Office of Education – offers nutrition education and obesity prevention programs funded by the USDA.

Healthy Los Nietos – through a program with the Los Nietos School District, students, parents, teachers and staff have changed their habits to increase healthy food choices and improve physical activity.

Community Input

"Those most affected by cardiovascular disease are people who experience income inequality, including primarily lower-income individuals and families living in low-income neighborhoods where there is lack of access to affordable healthy foods (food deserts), coupled with an overabundance of fast food outlets, corner markets and liquor stores."

Health Profile: Community Safety

Community violence is pervasive, especially in inner-city urban areas. Socioeconomic status and crime interconnect and contribute to community violence. High rates of crime and violence impact on families' feelings of safety and tend to reduce community interaction and outside physical activities *(National Center for Children Exposed to Violence).*

SNAPSHOT

Homicide – In SPA 6, homicide is the leading cause of premature death and in SPA 7 it is the second highest cause of premature death *(LA County Department of Public Health, 2012).*

Fear of Violence - 22.8% of teens in SPA 6 and 4.3% of teens in SPA 7 feared being attacked at school in the past year *(California Health Interview Survey, 2012).*

Domestic Violence - Compton and Downey had the highest number of domestic violence calls in 2014 in the KFH - Downey service area *(California Department of Justice, 2014).*

Motor Vehicle Accident - In the KFH - Downey service area the rate of death from motor vehicle crash is 6.7 per 100,000 persons. In California the rate is 5.2. The Healthy People 2020 objective is 12.4 *(California Department of Public Health, 2010-2012).*

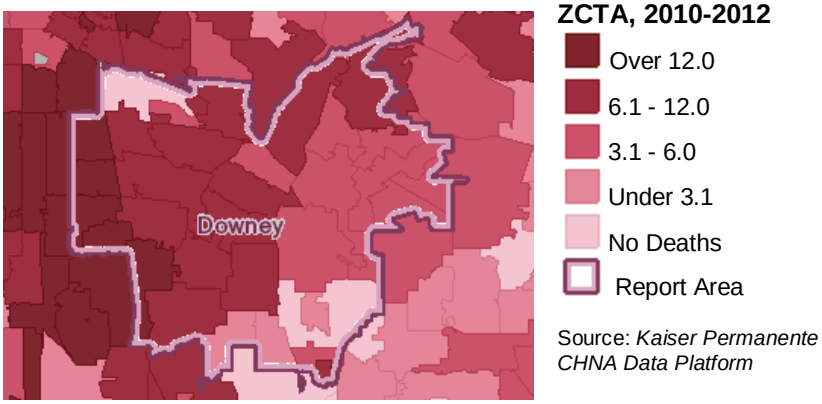
Health Outcome Statistics

Mortality Rates, per 100,000 persons, Age-Adjusted, 2010-2012

	Service Area	California	Healthy People 2020
Motor vehicle	6.7	5.2	12.4
Pedestrian	2.7	2.0	1.2

Source: University of Missouri, 2010-2012. Center for Applied Research and Environmental Systems. California Department of Public Health.

Homicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by ZCTA, 2010-2012



Source: *Kaiser Permanente CHNA Data Platform*

In the KFH - Downey service area the rate of homicide is 8.8 per 100,000 persons (age-adjusted, averaged over three years). This rate is higher than the California rate (5.2) and the Healthy eople 2020 objective (5.5) *(California Department of Public Health, 2010-2012).*

Health Disparities

The following cities in the service area have high rates of violent crime. These rates exceed the state rate for violent crimes.

Violent Crime Rates per 100,000 Persons, 2012

Geographic Area	Violent Crime Rates
Compton	1,242.1
Commerce	859.2
Lynwood	763.0
Huntington Park	631.4
Maywood	628.4
Bell	623.9
Santa Fe Springs	600.3
California	**423.1**

Source: U.S. Department of Justice, FBI, Uniform Crime Reporting Statistics, 2012.

Key Health Drivers

Educational Attainment – Lack of educational attainment is an associated risk factor for violence and crime in communities. Among adults, ages 25 and older, in the KFH – Downey service area, over one-third of the population (34.9%) have no high school diploma. This is compared to 18.7% of residents in California who do not have a high school diploma *(American Community Survey, 2009-2013)*.

Poverty – In 2013, the federal poverty level for one person was $11,490 and for a family of four $23,550. Among the residents in the service area, 19.7% are at or below 100% of the federal poverty level (FPL) and 46.9% are at 200% or below FPL. These rates of poverty are higher than found in the state (15.9% and 35.9%) *(American Community Survey, 2009-2013)*.

Children Living in Poverty – The percentage of children, ages 0-17, living in households with income below the Federal Poverty Level (FPL) is 28.3%, this is higher than the county rate of 25.3% and the state rate of 22.2% of children living in poverty. When examined by race/ethnicity, over one-third (34.7%) of Black/African American children in the service area are living in poverty *(American Community Survey, 2009-2013)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

East Los Angeles Women's Center – provides sexual assault services, domestic violence services, parenting programs and offers support to victims and survivors of human trafficking.

Helpline Youth Counseling – HYC provides strength-based counseling, education, prevention, and intervention services to assist youth and families to move toward realizing their life goals despite experiencing past or current life changes, trauma or abuse. They offer delinquency and gang intervention and prevention services.

Elevate Your G.A.M.E – Elevate Your G.A.M.E. provides mentoring to lift urban students to higher levels in their Grades, Attendance, and Maturity to Empower them to be leaders who bring about positive change in their schools, communities, and the world.

Community Input

"Community violence is still a problem. Its roots are in poverty, alienation, and displaced anger."

"Domestic violence is a significant problem in the immigrant population. People are very fearful of reporting or seeking help."

"Until this year we had been in a great downward spiral reducing crime but it spiked up again this year. Some think it's due to early release of many prisoners. There is more gang activity, and a recent increase in drive-by shootings."

Health Profile: Diabetes

Diabetes is the fifth leading cause of death in Los Angeles County. Living with uncontrolled diabetes can lead to severe health consequences that include heart disease, stroke and kidney failure. Diabetes is a costly chronic condition that can lead to disability, loss of productivity and premature death *(LA County Department of Public Health).*

SNAPSHOT

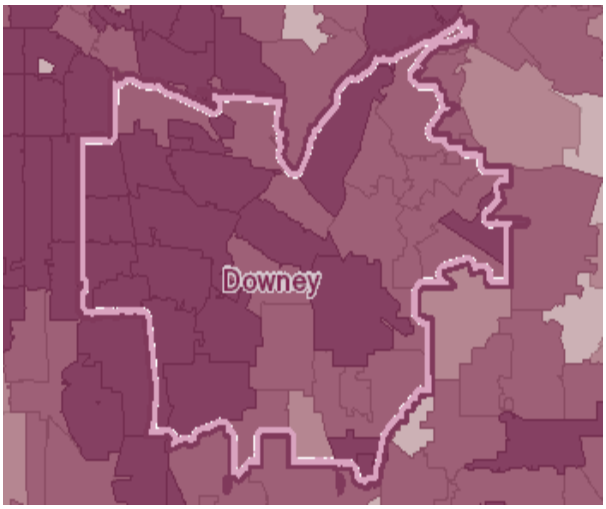
Prevalence – In SPA 6, 14.7% of adults have been diagnosed with diabetes and 77.7% are very confident they can control their diabetes. In SPA 7, 12.4% of adults have been diagnosed with diabetes. For these adults, 52.6% are very confident they can control the disease.
(CHIS, 2014)

In the service area, South East Los Angeles has the highest percentage of adults diagnosed with diabetes (12.6%) and Lakewood has the lowest percentage of adults with diabetes (7%). Other areas with high rates of diabetes are:
Cudahy – 12.3%
Maywood – 11.9%
Lynwood – 11.7%
Bell Gardens – 11.5%
Bell – 11.3%
Los Nietos – 11.2%
Compton – 11.1%

(CHIS Neighborhood Edition, 2011-2012)

Health Outcome Statistics

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

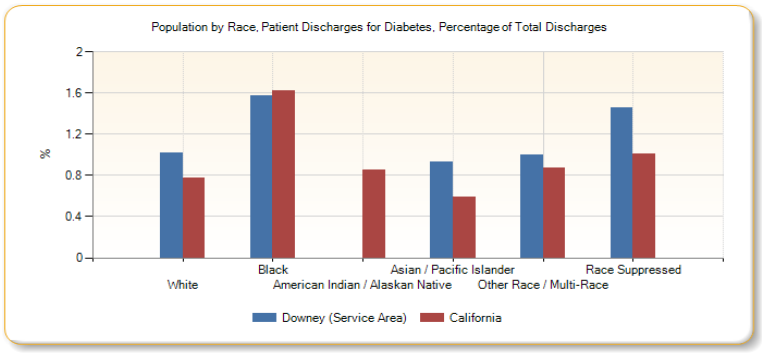


Source: Kaiser Permanente CHNA Data Platform

Diabetes is a condition that when managed can prevent ER visits or hospitalizations. When the rate of ER visits and hospitalizations for diabetes are examined by place in the service area, Compton (90221) has the highest ER rate for diabetes (65.9) and Compton has the highest hospitalization rate for diabetes (52.9). Cerritos has the lowest ER rate (14.6), and Lakewood (90713) has the lowest hospitalization rate (13.8) for diabetes among adults *(OSHPD, 2011-2013).*

Health Disparities

When examined by race, Blacks in the service area have lower diabetes hospitalization rates than found in the state. *Source: Kaiser Permanente CHNA Data Platform*



Key Health Drivers

High Blood Pressure – In SPA 6, 35.7% of adults have been diagnosed with high blood pressure and 55.5% are on medication to control the high blood pressure. In SPA 7, 20.8% of adults have been diagnosed with high blood pressure. Of these, 60.2% are on medication. The Healthy People 2020 objective is to reduce the proportion of adults with high blood pressure to 26.9%. Adults in SPA 6 exceed this rate *(CHIS, 2014)*.

Smoking – Smoking is a condition that contributes to diabetes. A number of communities in the KFH – Downey service area have high rates of cigarette smoking. Bellflower (15.5%), Compton (17.9%), Lynwood (14.5%), and Paramount (14.7%) have the highest rates of smoking in the service area. These rates exceed the Healthy People 2020 objective for smoking of 12% *(CHIS, Neighborhood Edition, 2011-2012)*.

Overweight/Obesity – Over one-third of the adult population is overweight in SPA 6 (35.9%). In SPA 7, 29.1% of adults are overweight. In SPA 6, 2% of teens and 7.3% of children are overweight. In SPA 7, 11.5% of teens and 10.2% of children are overweight *(CHIS, 2014)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Choose Health LA – LA County Department of Public Health initiative to prevent and control chronic disease, which includes a program that teaches families how to shop. Grocery store tours are provided.

LA County Office of Education – offers nutrition education and obesity prevention programs funded by the USDA.

Healthy Los Nietos – through a program with the Los Nietos School District, students, parents, teachers and staff have changed their habits to increase healthy food choices and improve physical activity.

Boys & Girls Club of Whittier – The Boys & Girls Club of Whittier ensures that every member receives 60 minutes a day of physical activity.

Community Input

“Diabetes is a major health issue. People are aware it’s an issue but they don't know how to make the best choices; there are language barriers and a belief that pills will solve the problem.”

“We don't walk anywhere; we drive everywhere. We have no habit of exercise. Mandated physical education (PE) minutes are not enforced due to lack of qualified teachers to teach PE. In many local areas it’s not safe for children to go outside to play.”

Health Profile: HIV/AIDS/STD

STDs and HIV/AIDS continue to be major public health problems. 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. HIV is a preventable disease. Effective HIV prevention interventions have been proven to reduce HIV transmission *(Healthy People 2020)*.

SNAPSHOT

Prevalence
The rate of HIV diagnoses has decreased over the past three years. In SPA 6, the rate of HIV is 16 per 100,000 persons, in SPA 7 the rate is 8.

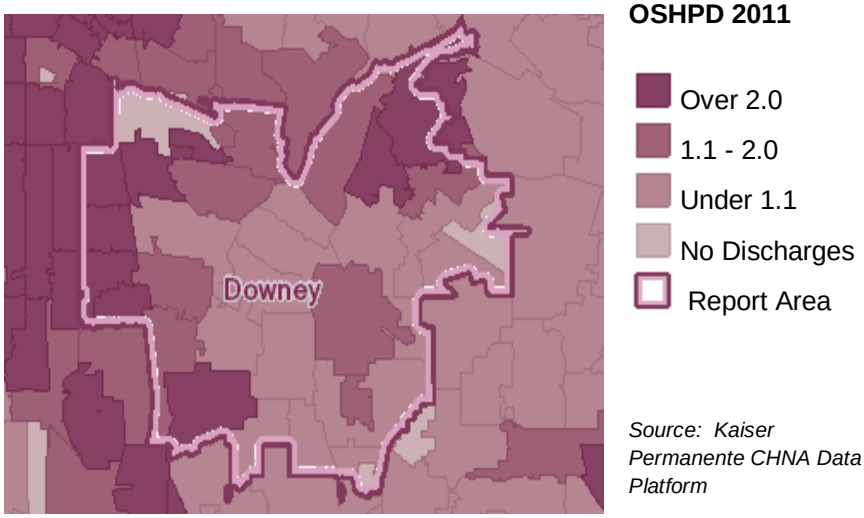
The rate of persons living with AIDS per 100,000 population in SPA 6 is 285 and in SPA 7 the rate is 143. The rate of AIDS in SPA 6 is higher than the county rate of 276.

The highest rates of STDs can be found for Chlamydia – 968.0 per 100,000 persons in SPA 6 and in SPA 7, 498.7 per 100,000 persons. Females have the highest rates of Chlamydia. Teens and young adults, age 15-29, and Blacks/African Americans, have the highest rates of sexually transmitted infections.

(County of Los Angeles Public Health, 2012 and 2013)

Health Outcome Statistics

HIV / AIDS Hospital Discharges, Rate (Per 10,000 Pop.) by ZCTA, OSHPD 2011



Source: Kaiser Permanente CHNA Data Platform

The hospital discharge rate indicates the number of persons (per 10,000 population) that are hospitalized for HIV/AIDS. A lower discharge rate indicates fewer persons are hospitalized. In the KFH – Downey service area, the patient discharge rate (per 10,000 total population) for HIV-related complications is 1.6, which is lower than found in LA County (2.8 per 100,000 persons) (*OSHPD, 2011).*

Health Disparities

Blacks have the highest rates of the STD chlamydia in SPA 6 and SPA 7.

Chlamydia Rates, per 100,000 Persons, Females, 2012

	SPA 6	SPA 7	Los Angeles County
White	1189.5	322.4	243.9
Black	2081.1	1396.3	1805.7
Latino	913.1	725.4	752.5
Asian Pacific Islander	491.0	201.3	207.6
Total	1307.9	672.0	665.4

Source: County of Los Angeles, Public Health, Sexually Transmitted Disease Morbidity Report, 2012.

Key Health Drivers

Economic Disparity – STDs are more likely to occur in low-income populations. In the KFH – Downey service area, 46.9% of the population is low-income (200% or below FPL). 35.9% of the state population is low-income *(American Community Survey, 2009-2013)*.

Alcohol Use – In SPA 6, 31.9% of adults engaged in binge drinking; 17.8% of teens indicated they had tried an alcoholic drink. In SPA 7, 37.9% of adults engaged in binge drinking; no teens indicated they had tried an alcoholic drink *(CHIS, 2014)*.

Drug Use – In SPA 6, 31.9% of teens have tried drugs and 3.5% have used marijuana in the past year. In SPA 7, 2.6% of teens have tried illegal drugs and 1.7% has used marijuana in the past year. These rates of marijuana use are lower than the county and state rates. SPA 6 teens' use of drugs is higher than among teens in the county (14.7%) and state (12.4%) *(CHIS, 2012)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Whittier Rio Hondo AIDS Project – WRHAP provides support and understanding to individuals and families affected by this disease. Services include health care, social services, case management, mental health care and policy advocacy. WRHAP educates youth and the community at large through programs aimed at the prevention of HIV/AIDS.

Family Health Care Centers of Greater Los Angeles – FHCCGLA is a Federally Qualified Health Center (FQHC) that operates four clinics, the Bell Gardens Medical Center, Hawaiian Gardens Health Center, Maywood Medical Center, and the Downey Family Medical Center. FHCCGLA provides STD screening and treatment, and HIV testing and counseling.

County of Los Angeles Public Health – Provides STD clinics including the Los Angeles LGBT Center Sexual Health Program, which is dedicated to providing sexual health services to the gay, lesbian, bisexual and transgender community (though everyone is welcome). Free testing and treatment for STDs and HIV are offered.

Community Assets

"This is a big issue but there are few resources. There is a cultural stigma about discussing with provider, getting tested."

"Kids think they are invincible. Parents need to be trained how to talk with kids."

"I cannot tell you how many patients we see that say they didn't even know they had an STD. And then they just get it over and over again."

Health Profile: Mental Health

Mental illness is a common cause of disability. Untreated disorders may leave individuals at-risk for substance abuse, self-destructive behavior, and suicide. Additionally, mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression and outcome of chronic diseases *(Healthy People 2020)*.

SNAPSHOT

Adults – In SPA 6, 8.2% of adults had serious psychological distress, and 9.2% of adults in SPA 7 had serious psychological distress compared to 9.6% of adults in California *(CHIS, 2014)*.

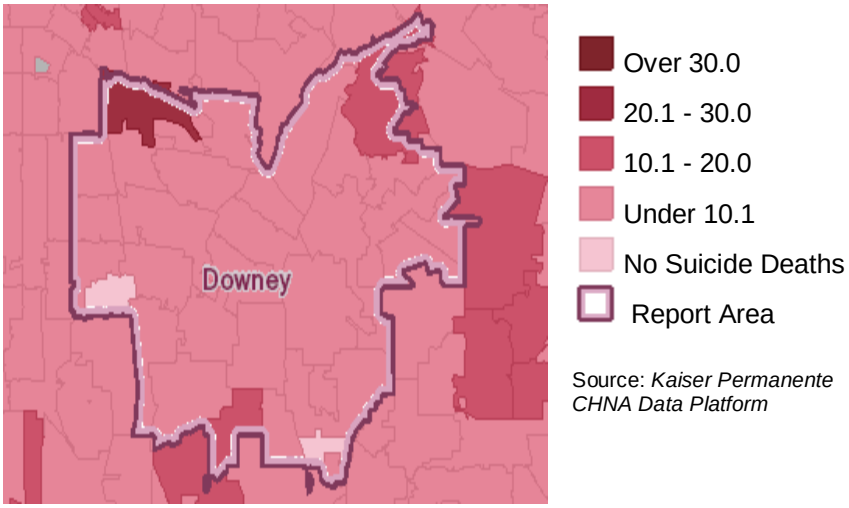
Teens – 17.5% of teens in SPA 6 and 18.9% of teens in SPA 7 needed help for emotional issues/substance abuse *(CHIS, 2014)*.

Accessibility – 6.8% of adults in SPA 6 and 8.1% of SPA 7 adults reported needing mental health care but did not receive care because they could not afford it. This is higher than found in LA County (6.1%) (*LA County Health Survey, 2011)*.

10.9% of adults in SPA 6 and 12.2% of SPA 7 adults did see a health care provider for emotional / mental health and/or alcohol / drug issues in the past year (*CHIS, 2014).*

Health Outcome Statistics

Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by ZCTA, CDPH, 2010-2012



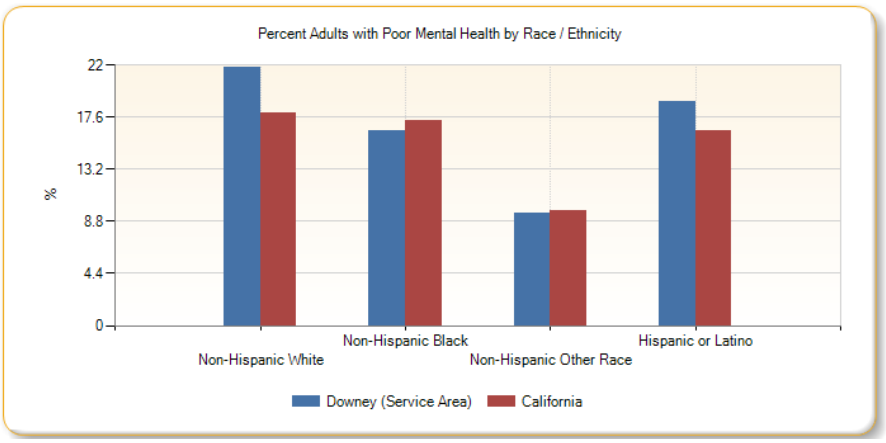
Source: *Kaiser Permanente CHNA Data Platform*

In the KFH – Downey service area, the age-adjusted rate of suicide is 5.1 per 100,000 persons. This is less than the state rate of 9.8 and the Healthy People 2020 objective of 10.2 per 100,000 persons *(California Department of Public Health, 2010-2012).*

Health Disparities

Higher percentages of Whites and Latinos have identified as having poor mental health, than compared to state rates.

Source: *Kaiser Permanente CHNA Data Platform*



Key Health Drivers

Health Insurance Coverage – Availability of health insurance can increase access to mental health services. In the KFH – Downey service area, 35.7% of the population has Medi-Cal coverage. Over one-quarter of the population (25.9%) are uninsured, which translates to 74.1% with health insurance. This is less than the Healthy People 2020 objective of 100% health insurance coverage *(American Community Survey, 2009-2013)*.

Homelessness – Mental health issues are prevalent among the homeless. In SPA 6, 25.2% of the homeless experience mental illness. In SPA 7, 30.3% of the homeless have mental health issues *(Los Angeles Homeless Services Authority, 2015*).

Excessive Alcohol Use – Binge drinking is defined as consuming a certain amount of alcohol within a set period of time. For males this is five or more drinks per occasion and for females it is four or more drinks per occasion. Among adults, 31.9% in SPA 6 and 37.9% in SPA 7 had engaged in binge drinking in the past year. This is lower than the county rate of 31.5% *(CHIS, 2014).*

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Watts Counseling Center – The Watts Counseling and Learning Center is a nonprofit Community Benefit program of Kaiser Permanente Southern California. Since 1967, the Center has provided counseling, outreach, and educational services to the residents of the Watts community. Kaiser Permanente Health Plan membership is not required to receive these services.

SPIRITT Family Services – Provides crisis intervention, life skills and hope for a stable, nurturing and healthy family for high-need families in eastern Los Angeles County.

Community Family Guidance Center – CFGC provides mental health services. They support the success of children and families by reducing the impact of childhood trauma and abuse, supporting the development of positive social and emotional skills, and strengthening healthy family relationships.

Community Input

“Stigma prevents people from seeking or accessing services. Mental health affects children's achievement; it is important to identify and intervene early.”

“Mental health is a concern, especially with the homeless population, which is increasing in Whittier.”

“Stress is a huge epidemic with both kids and college students.”

Health Profile: Oral Health

Low-income individuals, particularly children and minorities, are more likely to have poor oral health. Poor oral health can be both a result of certain health conditions and a cause of poor health *(Healthy People 2020)*.

SNAPSHOT

Adults – Among adults in SPA 6, 37.1% have dental insurance and 44.5% of adults have been to a dentist within the last year.

In SPA 7, 47% of adults have dental insurance coverage and 48.9% had been to a dentist in the past year.
(Los Angeles County Health Survey 2011)

Children – Children have increased access to dental care when compared to adults, as 75.8% of children in SPA 6 and 79.2% of children in SPA 7 have dental insurance.
(Los Angeles County Health Survey 2011)

12.7% of children in SPA 6 have never been to a dentist. 18.5% of children in SPA 7 have never been to a dentist. *(CHIS, 2014)*

Health Outcome Statistics

Dental Care

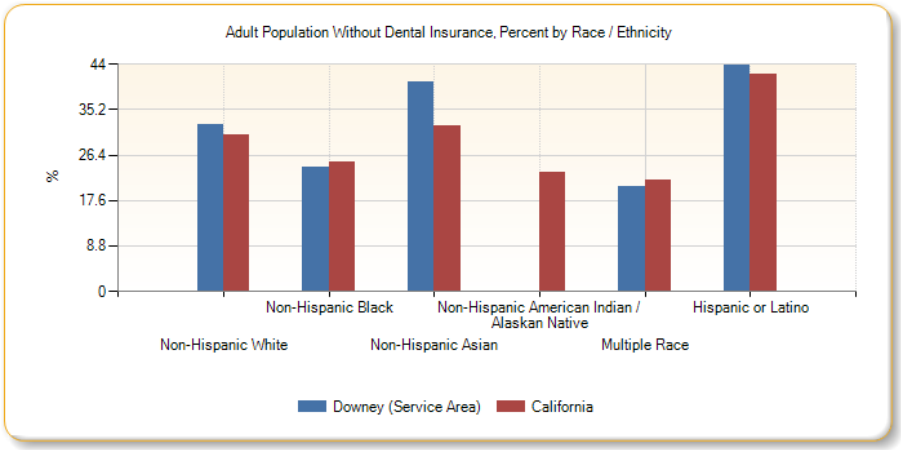
	SPA 6	SPA 7	LA County
Children been to dentist less than 6 months to 2 years	86.9%	81.3%	83.9%
Teens been to dentist less than 6 months to 2 years	98.4%	86.0%	96.0%

Source: CHIS, 2014

Lack of access to dental health care can contribute to poor health status. In SPA 6, 86.9% of children and 98.4% of teens had been to the dentist in the past two years. In SPA 7, 81.3% of children and 86% of teens had been to the dentist in the past two years.

Health Disparities

Lack of dental insurance is found in high rates among Whites, Asians and Latinos in the service area.



Source: Kaiser Permanente CHNA Data Platform

Key Health Drivers

Poverty – Lack of dental insurance is linked to poverty. In 2013, the federal poverty level for one person was $11,490 and for a family of four $23,550. Among the residents in the service area, 19.7% are at or below 100% of the federal poverty level (FPL) and 46.9% are at 200% or below FPL. These rates of poverty are higher than found in the state (15.9% and 35.9%) *(American Community Survey, 2009-2013)*.

Soda Consumption – Sugary drinks can lead to dental caries. In Service Planning Area 7, 23.1% of children and teens consume two or more glasses of soda or sugary drinks a day. This is higher than SPA 6 (18%), county (17.3%) and state (14.2%) rates *(CHIS, 2014)*.

Premature Birth / Low Birth Weight: Gum disease has been linked to premature birth and low birth weight babies. The KFH – Downey service area rate of low birth weight babies is 7%, which is slightly higher than the California rate of 6.8% *(CDPH, 2012)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Assistance League of Whittier – The Assistance League provides emergency dental care to children who are uninsured and can't afford dental care. Dental treatment is provided by Whittier Area dentists who are members of the California Dental Association. Children are screened and referred to Assistance League by the schools.

Children's Dental Health Clinic – CDHC is a safety-net resource and dental home for all-inclusive, multi-specialty dental services that can meet all of a child's treatment needs. Their services are available to children and young adults of low-income families, including children with special needs or complex medical considerations, and to those with access to care issues.

Downey Dental Academy – Local dentists serve the community of Downey by doing dental checks for all first third and fifth grade students in the Downey Unified School District.

Community Input

"This is a big problem for a lot of people; dental care is expensive, Medi-Cal covers only a few services and it is hard to find providers."

"I see young kids with severe dental issues and if someone had been able to work with their parents or seen a dentist before that happened, it would make a huge difference."

"Dental care is a huge need for seniors, but many don't realize the importance of oral health."

Health Profile: Overweight and Obesity

Being overweight or obese affects a wide range of health issues and are major risk factors for diabetes, cardiovascular disease, and other chronic diseases. Physical activity plays a key role in levels of overweight and obesity, and in the development and management of chronic diseases. Healthy eating and nutrition programs also promote a healthy body weight.

SNAPSHOT

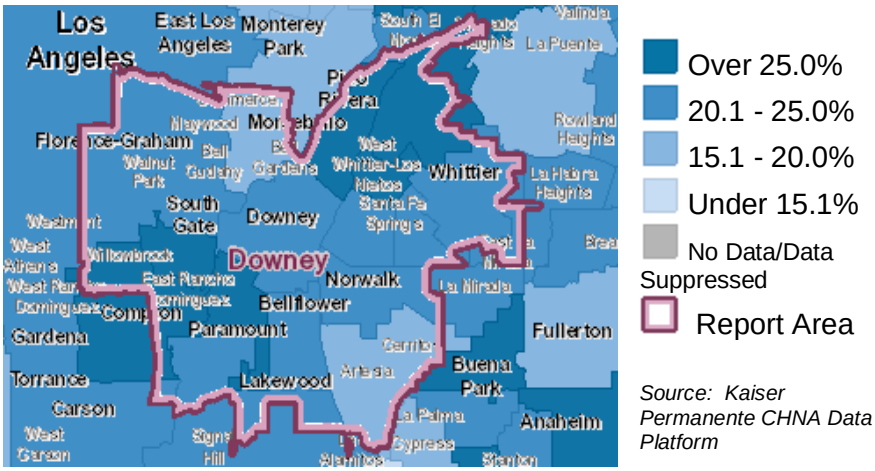
Overweight – Over one-third of the adult population is overweight in SPA 6 (35.9%). In SPA 7, 29.1% of adults are overweight. In SPA 6, 2% of teens and 7.3% of children are overweight. In SPA 7, 11.5% of teens and 10.2% of children are overweight *(CHIS, 2014)*.

Obesity – In SPA 6, 38.6% of adults are obese and in SPA 7, 39.3% of adults are obese. These rates are higher than county (27.2%) and state (27%) rates of obesity. And they exceed the Healthy People 2020 objective of 30.5% of adult obesity *(CHIS, 2014)*.

African Americans and Latinos in SPA 6 have higher rates of overweight and obesity. African Americans and Whites in SPA 7 have higher rates of overweight and obesity *(CHIS, 2014)*.

Health Outcome Statistics

Students Overweight / in 'Needs Improvement' Zone for Body Composition , Percent by School District (Elementary), 2013-2014



Source: Kaiser Permanente CHNA Data Platform

Youth overweight reports the percentage of children in grades 5, 7, and 9 ranking within the "Needs Improvement" category (Overweight) for body composition on the Fitnessgram physical fitness test. In the service area, 20.5% of 5th, 7th and 9th graders are considered overweight. *(Source: California Department of Education, 2013-2014).*

Health Disparities

A higher percentage of multiple race and Latino youth in the service area are overweight.

Youth Overweight by Race/Ethnicity

	Service Area	Los Angeles County	California
Multiple Races	21.6%	21.7%	18.3%
Hispanic or Latino	21.3%	20.1%	21.6%
Black or African American	19.8%	16.1%	20.3%
White	17.4%	14.7%	15.9%
Asian	14.3%	18.6%	15.1%

Source: California Department of Education, 2013-2014. Fitnessgram.

Key Health Drivers

Diets High in Fat – 25.2% of SPA 6 residents eat fast food three or more times a week. In SPA 7, 29.9% of the residents eat fast food three or more times a week. Adults, age 18-64, consume fast food at a higher rate than youth or seniors *(CHIS, 2014)*.

Soda Consumption – In Service Planning Area 7, 23.1% of children and teens consume two or more glasses of soda or sugary drinks a day. This is higher than SPA 6 (18%), county (17.3%) and state (14.2%) rates *(CHIS, 2014)*.

Fresh Fruits and Vegetables – Among adults, 11.4% in SPA 6 and 12.4% in SPA 7 eat five or more servings of fruit and vegetables daily. This is less than adults in the county (16.2%) *(LA County Health Survey, 2011)*.

Physical Inactivity – In SPA 6, 86.2% of children engaged in at least one hour of physical activity three or more days in the previous week; 47.6% of teens did the same in 'a typical week'. In SPA 7, 60.8% of children engaged in at least one hour of physical activity three or more days in the previous week; 90.2% of teens did the same in 'a typical week' *(CHIS, 2014)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Healthy Los Nietos – through a program with the Los Nietos School District, students, parents, teachers and staff have changed their habits to increase healthy food choices and improve physical activity.

Activate Whittier – Activate Whittier champions “A Healthy Active Whittier” through neighborhood & community engagement, collaborative partnerships, and policy/environmental change, with a focus on sustainable efforts to improve the health and wellness of those living, working, learning and playing in our community.

City of Downey Bicycle Master Plan – The City of Downey is leading an effort to prepare a city-wide bicycle master plan. The Plan will be a roadmap to improving the bicycling environment throughout the city, while taking into account the City’s unique characteristics. A bike-able city is one where people ride bicycles because it is a convenient, fun, safe, and healthy choice.

Community Input

“Changing habits is difficult and it can be hard to start eating healthfully for people who have not eaten that way before. We need to educate parents and children to be aware of healthy alternatives to unhealthy food.”

“Culture plays a big role in the way we eat. Food is comforting. In some cultures a chubby kid is a healthy kid.”

“We are seeing a lot more awareness of the issue and community effort.”

Health Profile: Preventive Practices

Health care preventive services include cancer and chronic disease screening and scheduled vaccines and immunizations. Preventive care reduces death and disability and improves health. These services prevent and detect illnesses and diseases—from flu to cancer—in earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs for individuals and the community *(Healthy People 2020)*.

SNAPSHOT

Mammograms – The Healthy People 2020 objective is 81.1% of women 50-74 years to have a mammogram in the past two years. In SPA 6, 82.8% of women, age 40+, have had a mammogram, and 81.1% of women in SPA 7 have had a mammogram *(LA County Department of Public Health, 2011)*.

Pap Smear – The Healthy People 2020 objective is 93% of women have a Pap smear in the past three years. In SPA 6, 87.4% of women have had a Pap smear in the past three years, and 83.3% of women in SPA 7 have had a Pap smear in that time period *(LA County Department of Public Health, 2011)*.

Colorectal Cancer Screening – In SPA 6, 67.1% of adults have had the recommended screening. In SPA 7, the rate of compliance is 71.1%, which exceeds the Healthy People 2020 objective for colorectal cancer screening of 70.5% *(CHIS, 2009)*.

Health Outcome Statistics

In Los Angeles County, 43% of people in 2011 died before they reached age 75; deaths prior to 75 years of age are determined to be premature deaths. In SPA 6, heart disease was the second leading cause of premature death. In SPA 7, coronary heart disease was the leading causes of premature death.

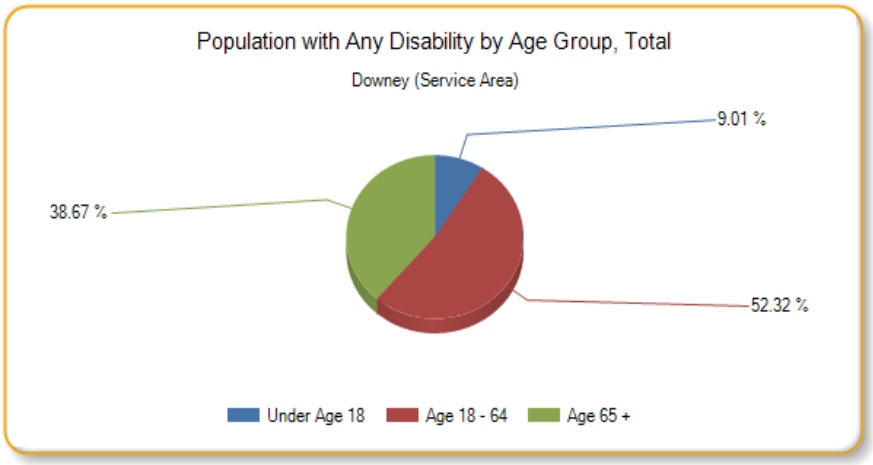
Leading Cause of Premature Death, SPAs 6 & 7, 2011

Leading Causes of Premature Death SPA 6	Leading Causes of Premature Death, SPA 7
1. Homicide	1. Coronary Heart Disease
2. Coronary Heart Disease	2. Homicide
3. Motor Vehicle Crash	3. Motor Vehicle Crash
4. Liver Disease	4. Liver Disease
5. Stroke	5. Suicide

Source: LA County Department of Public Health, Mortality in Los Angeles County, 2014.

Health Disparities

A person is considered to have a disability if they have specific physical (hearing, vision, ambulatory) and cognitive conditions, which, make living in the absence of accommodations difficult or impossible. In the service area, 9% of the disabled population are youth, 39% are seniors and 52% are adults.



Source: Kaiser Permanente CHNA Data Platform

Key Health Drivers

Educational Attainment – Lack of educational attainment is an associated risk factor for poor health, lack of insurance and decreased access to preventive health care. Among adults, ages 25 and older, in the KFH – Downey service area, over one-third of the population (34.9%) have no high school diploma. This is compared to 18.7% of residents in California who do not have a high school diploma *(American Community Survey, 2009-2013)*.

Poverty – Persons in poverty tend to lack health insurance and as a result, do not regularly access preventive health care services. In 2013, the federal poverty level for one person was $11,490 and for a family of four $23,550. Among the residents in the service area, 19.7% are at or below 100% of the federal poverty level (FPL) and 46.9% are at 200% or below FPL. These rates of poverty are higher than found in the state (15.9% and 35.9%) *(American Community Survey, 2009-2013)*.

Health Insurance Coverage – Availability of health insurance can increase access to preventive screenings and vaccines. In the KFH – Downey service area, 35.7% of the population has Medi-Cal coverage. Over one-quarter of the population (25.9%) are uninsured, which translates to 74.1% with health insurance. This is less than the Healthy People 2020 objective of 100% health insurance coverage *(American Community Survey, 2009-2013)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

Family Health Care Centers of Greater Los Angeles – FHCCGLA is a Federally Qualified Health Center (FQHC) that operates four clinics, the Bell Gardens Medical Center, Hawaiian Gardens Health Center, Maywood Medical Center, and the Downey Family Medical Center.

JWCH, Inc. – Wesley Health Centers are nonprofit community health centers. They provide comprehensive medical care, physical exams, routine screenings and treatment of injuries and illnesses for men, women and children of Los Angeles County.

Whittier Senior Citizens Center – the Senior Center provides health screenings and flu shots for adults, 55 years of age and older.

Community Input

“People (particularly the uninsured) don’t get cancer screenings or care until there are symptoms.”

“Families are unaware of where to go for free or low-cost school immunizations.”

“Screenings need to be more widely available and publicized especially within the Latino community that is convenient for working people, and available for the undocumented.”

Health Profile: Substance Abuse (Alcohol/Drugs/Tobacco)

Smoking is a contributing cause to disease and death. It increases the risk of developing heart disease, stroke and cancer. Alcohol and drug abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems *(Healthy People 2020).*

SNAPSHOT

Alcohol Use –In SPA 6, 31.9% of adults engaged in binge drinking; 17.8% of teens indicated they had tried an alcoholic drink.

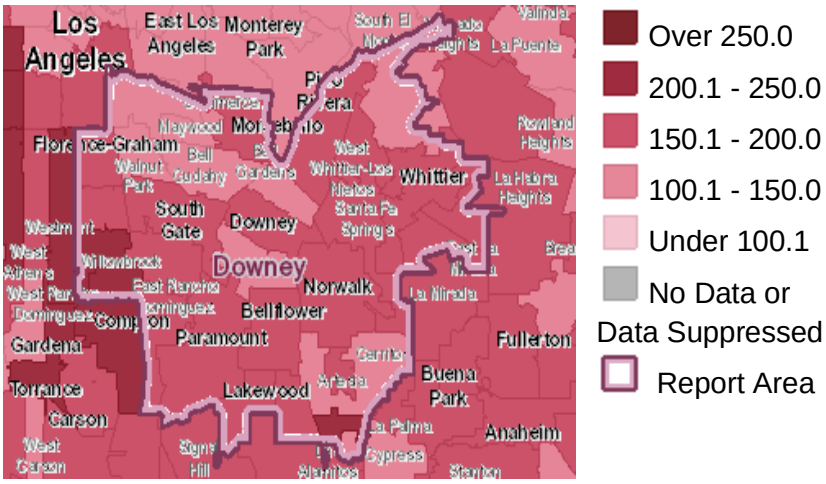
In SPA 7, 37.9% of adults engaged in binge drinking; no teens indicated they had tried an alcoholic drink. (CHIS, 2014)

Drug Use – In SPA 6, 31.9% of teens have tried drugs and 3.5% have used marijuana in the past year.

In SPA 7, 2.6% of teens have tried illegal drugs and 1.7% has used marijuana in the past year. These rates of marijuana use are lower than the county and state rates. SPA 6 teens' use of drugs is higher than among teens in the county (14.7%) and state (12.4%). (CHIS, 2012)

Health Outcome Statistics

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



Substance abuse is a contributing cause to disease and death. The age-adjusted cancer rate death rate in the service area is 161.3 per 100,000 population. This is higher than the LA County rate of 153.0 per 100,000 population.

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

Health Disparities

In SPA 6, Latinos have the highest percentage of binge drinking, and in SPA 7, binge drinking is highest among Whites.

Adults Binge Drinking in Past Year, by Race/Ethnicity

	SPA 6	SPA 7	California
Latino	35.2%	40.0%	38.2%
White	5.3%	47.0%	35.7%
Black	29.6%	No Data	20.7%
Asian	No Data	14.5%	20.3%

Source: California Health Interview Survey, 2014.

Key Health Drivers

Homelessness – Substance abuse issues are prevalent among the homeless. In SPA 6, 17.1% of the homeless are substance abusers. In SPA 7, 43.8% of the homeless have substance abuse problems *(Los Angeles Homeless Services Authority, 2015*).

Mental Health Issues – Substance abuse is often a behavior associated with mental health issues. In SPA 6, 8.2% of adults had serious psychological distress, and 9.2% of adults in SPA 7 had serious psychological distress compared to 9.6% of adults in California *(CHIS, 2014).*

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

SPIRITT Family Services – Provides crisis intervention, life skills and hope for a stable, nurturing and healthy family for high-need families in eastern Los Angeles County. They provide substance abuse education and counseling.

Whittier First Day – Provides a short-term emergency transitional housing with on-site supportive services to 45 individuals in the City of Whittier. Services include: on-site health clinic, health screenings, mental health services, on-site meals, case management, clothing, transportation, 12 step meetings, education, training and employment assistance.

L.A. CADA – The Los Angeles Centers for Alcohol and Drug Abuse (L.A. CADA) is a licensed and certified substance use and behavioral treatment provider by the State of California's Department of Health Care Services and the County of Los Angeles Department of Public Health – Substance Abuse Prevention and Control. They treat persons with addiction and behavioral problems by providing client centered, trauma informed, recovery orientated services.

Community Input

"Sometimes people are self-medicating for mental health issues."

"People feel discouraged by the bad economy, so they run to alcohol. It can be a way people try to deal with depression."

"The people who need help don't think that they need it. People think that addiction won't happen to them, that they are in control and can stop when they want to."

Health Profile: Teen Pregnancy

Teen parents have unique needs for social, economic, and health support services. Teenage pregnancies may pose risks for the teen mothers and result in poor health outcomes for their children.

SNAPSHOT

In 2012, the number of live births in the service area was 22,595. This is a decrease from 23,913 births in 2011. The majority of the births were to mothers who are Hispanic/Latino (79.7%).

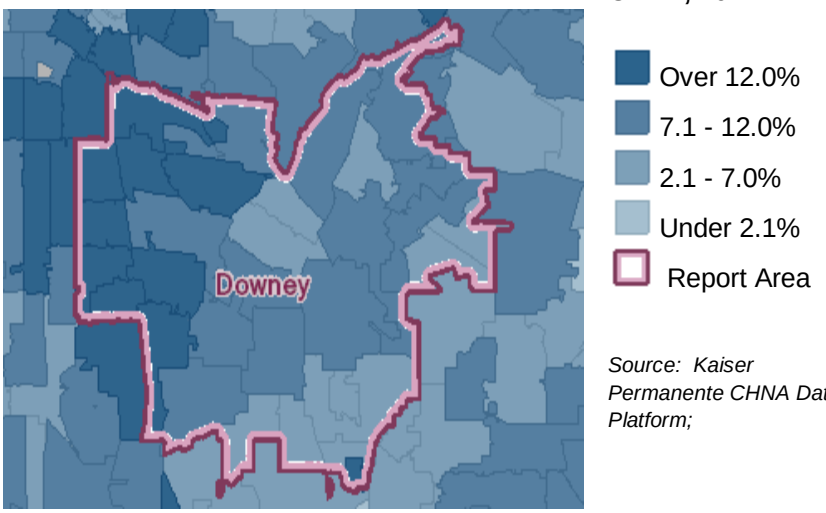
Prenatal Care – Among pregnant women in the service area, 84.8% entered prenatal care in the first trimester. This is a higher rate than the state rate of 83.8%. The area rate of early entry into prenatal care exceeds the Healthy People 2020 objective of 77.9% of women entering prenatal care in the first trimester.

Low-Birth Weight – The service area rate of low birth weight babies is 7% (70.2 per 1,000 live births). The service area compares favorably to the Healthy People 2020 objective of 7.8% of births being low birth weight.

(California Department of Public Health, 2012)

Health Outcome Statistics

Births to Females under Age 20, Rate (Per 1,000 Pop.) by ZCTA, CDPH, 2011



Source: Kaiser Permanente CHNA Data Platform;

The percentage of births to teen mothers was 9.9%, which is higher than the state rate of 7% *(California Department of Public Health, 2012).*

Health Disparities

There are a number of service area communities with high teen birth rates, most notably South East Los Angeles, Compton, and Huntington Park.

Geographic Area	Percent Teen Births
90001 - South East Los Angeles	12.0%
90002 - South East Los Angeles	15.7%
90059 - South East Los Angeles	14.6%
90221 - Compton	14.3%
90222 - Compton	12.6%
90255 - Huntington Park	12.8%

Source: California Department of Public Health, 2012.

Key Health Drivers

Educational Attainment – Lack of educational attainment is an associated risk factor for teen pregnancy. Among adults, ages 25 and older, in the KFH – Downey service area, over one-third of the population (34.9%) have no high school diploma. This is compared to 18.7% of residents in California who do not have a high school diploma *(American Community Survey, 2009-2013)*.

Children Living in Poverty – The percentage of children, ages 0-17, living in households with income below the Federal Poverty Level (FPL) is 28.3%, this is higher than the county rate of 25.3% and the state rate of 22.2% of children living in poverty. When examined by race/ethnicity, over one-third (34.7%) of Black/African American children in the service area are living in poverty *(American Community Survey, 2009-2013)*.

Community Assets & Opportunities

Community assets are resources within the community potentially available to meet the identified health need.

El Nido Family Centers – El Nido is a provider of teen parent services. Through home visits, trained case managers reach out to teen parents who are isolated, overwhelmed and unprepared for the challenges of parenting.

Planned Parenthood – Planned Parenthood provides affordable, quality, confidential reproductive health care to women, men, and teens, regardless of personal circumstances or ability to pay.

AltaMed Health Care Services – AltaMed's Adolescent Family Life Program (AFLP) enhances the health, educational achievement, economic, personal, and societal integration and independence of pregnant and parenting adolescents.

Community Input

"Teens get misinformation from other teens. Teens don't know how to get birth control. They need more available free protection."

"Hispanic families are reluctant to discuss sexuality, contraception, STDs. There are not enough agencies addressing the problem, giving education about prevention, and redirecting teens into positive pathways."

"More parents are aware and asking for contraception for their daughters."

Appendix D: 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 issue not only on the health of the individuals affected by it, but also the financial cost in addressing this health issue, such as public expenditures in addressing a health issue. 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 impact 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, impact multiple health issues.

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.

Relative worth method. The Relative Worth method is a ranking strategy where each participant receives a fixed number of points. The points are then assigned to health needs based on the size of the problem (relative portion of population afflicted by the problem); or seriousness of the problem (impact at individual, family, and community levels).

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 impact a community.