2013
Community Health Needs Assessment
Report

Elevating health care. Together.

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CITRUS VALLEY
HEALTH PARTNERS

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I. Executive Summary

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included the requirement, under Section 501(r), that nonprofit hospital organizations must conduct a Community Health Needs Assessment (CHNA) at least once every three years to maintain tax-exempt status under section 501(c)(3) of the Internal Revenue Service Code. As part of the CHNA, each hospital is required to collect input from designated individuals in the community, including public health experts as well as members, representatives or leaders of low-income, minority, and medically underserved populations and individuals with chronic conditions. Though the CHNA process is a new national mandate within the ACA, nonprofit hospitals in California have been required to conduct a CHNA every three years following passage of California Senate Bill 697 (SB697) in 1994.

Citrus Valley Health Partners has conducted CHNAs for many years to identify needs and resources in its communities and to guide the development of Community Benefit plans. The adoption of ACA legislation has provided an opportunity to revisit the needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2013 and described in this report was conducted in compliance with these new federal requirements.

The new legislation guiding the CHNA for nonprofit hospitals requires a greater emphasis on structured and standardized methodologies in terms of how community needs are identified and prioritized. The assessment had to balance a strict focus on methodology with the individual needs of local hospitals and the desire to have an inclusive process, engaging a range of stakeholders and consideration of the diverse needs of the communities served.

For the 2013 CHNA, three Kaiser Foundation Hospitals and one non-Kaiser Foundation Hospital, Citrus Valley Health Partners, in Los Angeles, West Los Angeles and the San Gabriel Valley formed a collaborative to work with the Center for Nonprofit Management evaluation consulting team in conducting the CHNA. This CHNA report was produced for and in collaboration with Citrus Valley Health Partners and Kaiser Foundation Hospital-Baldwin Park.

During the initial phase of the CHNA process, community input was collected in the San Gabriel Valley during five focus groups and 19 interviews with key stakeholders selected with the assistance of the Citrus Valley Health Partners and KFH-BP Community Benefit Managers and recommendations from other key informants, and included health care professionals, government officials, social service providers, community residents, leaders and other relevant community representatives with knowledge of the Citrus Valley Health Partners service area. The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each; the conversations were confidential and interviewers adhered to standard ethical research guidelines. Focus group sessions were 60 to 90 minutes each. As with the interviews, the focus group topics also were designed to collect representative information about health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic

disease management and other community issues. Concurrently, secondary data were collected and compared to relevant benchmarks including Healthy People 2020, Los Angeles County or California when possible. The data were also collected at smaller geographies, when possible, to allow for more in-depth analysis and identification of community health issues. In addition, previous CHNAs were reviewed to identify trends and ensure that previously identified needs were not overlooked. Primary and secondary data were compiled into a scorecard presenting health needs and health drivers with highlighted comparisons to the available data benchmarks. The scorecard was designed to allow for a comprehensive analysis across all data sources and for use during the prioritization phase of the CHNA process.

After primary and secondary data were analyzed, a process was created with the assistance of the collaborative partners, which the identified needs, based on the amount of data indicating a need. The first step involved designing a method for sorting the extensive list of health issues and drivers identified through the primary and secondary sources described above. The method developed by the team sorted the identified needs into three levels or tiers, based on the amount of data indicating a need. The first and most inclusive tier included any need or driver identified as performing poorly against a set benchmark in secondary data or mentioned at least once in primary data collection. The second tier included those issues identified as poorly performing against a set benchmark or mentioned multiple times in primary data collection. The third and most exclusive tier included those issues identified as poorly performing against a set benchmark that also received multiple mentions in primary data collection.

After application of the rating method, tier two was deemed as the most appropriate identifier of a potential prioritized health need (and/or driver) as these criteria provided a stringent yet inclusive approach that would allow for a comprehensive list of 22 health needs to be brought forth for community input in the prioritization process. A summary of the data related to these identified health needs is included in Appendix B: Citrus Valley Health Partners Health Needs Profiles.

A modified Simplex Method was used to implement the prioritization process, consisting of two facilitated group sessions engaging participants in the first phase of community input and new participants in a discussion of the data (as presented in the scorecards and accompanying health need narratives) and the prioritization process. At the sessions, participants were provided with a brief overview of the CHNA process, a list of identified needs in the scorecard format and the brief narrative summary descriptions of the identified health needs described above. Then, in smaller break-out groups, participants considered the scorecards and health needs summaries in completing a prioritization grid exercise which was then shared with the larger group. (These prioritization grids will also serve as supplemental information for the Implementation Strategy Phase.) Following this series of discussions, participants completed a brief questionnaire about health needs, drivers and resources and ranked each health need according to several criteria including severity, change over time, resources available to address the need or driver and community readiness to support action on behalf of any health need or driver. After completing

the questionnaires, participants were each given ten (10) sticker dots and invited to place five dots on any health needs and five dots on any health drivers that were listed in alphabetical order on large flip chart paper posted around the meeting space. Participants could place the five dots in each section (health needs and health drivers) in any manner they wished, and each dot counted as one vote. Data gathered through the survey were analyzed and given an overall score, ranging from 1 for least need to 12 for highest need. Health needs were also ranked by the criteria including severity, change over time and available resources to address the need.

a. Health needs

The following list of 22 prioritized needs resulted from the above described process. Further details are included in Appendix B: CVHP Health Needs Profiles. See Appendix C for data source reference information.

1. **Mental Health**

   Among adults, mental disorders are common, with approximately one quarter of adults being diagnosable for one or more disorders. Research shows that more than 90 percent of those who die by suicide suffer from depression or other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders). Not only are mental disorders associated with suicide, but also with chronic diseases, family history of mental illness, age, substance abuse, and life event stresses. In the CVHP service area, the mental health hospitalization rate of 375.4 per 100,000 for youth under 18 years of age is higher than the statewide rate of 256.4 per 100,000. The mental health hospitalization rate for adults in the CVHP service area is also higher at 657.0 per 100,000 in contrast to the statewide rate of 551.7. The rate for individuals who needed help for mental, emotional, alcohol or drug issues but did not receive treatment in the CVHP service area was 51.4% compared to a slightly lower rate of 47.3% in Los Angeles County. Community stakeholders highlighted mental health as impacting youth, teens, adults ages 35 and older, the homeless and the uninsured. The highest mental health-related hospitalization rates for adults per 100,000 persons were in Covina (1,156.6) and Glendora (1,061.0) and for youth per 100,000 persons were in San Dimas (1,398.0) and La Verne (1,074.0). Suicide rates per 100,000 persons were highest in Glendora (2.4) and Hacienda Heights (1.5). More African-Americans (19.3%), Whites (17.8%) and Hispanics/Latinos (13.0%) suffer from poor mental health. Mental health is associated with other health factors including poverty, low birth rate, heavy alcohol consumption and unemployment. Mental health issues were identified by community stakeholders in four out of 19 interviews and three out of five focus groups. Mental health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

2. **Obesity/Overweight**

   Obesity, a condition in which a person has an abnormally high and unhealthy proportion of body fat, has risen to epidemic levels in the United States. Nationally, 68 percent of U.S. adults age 20

years and older are overweight or obese. Obesity is defined as the percentage of adults ages 18 and older who self-report a Body Mass Index (BMI) greater than 30.0. In the CVHP service area, youth obesity is at 30.6%, higher than the statewide rate of 29.8% and the percentage of overweight youth is at 15.1%, higher that the statewide rate of 14.3%. There is a slightly higher percent of obese males (21.5%) than females (21.3%). More Hispanic youth are obese (35.2%) and overweight (15.9%). The cities where the largest percent of students are obese are South El Monte (44.6 to 45.3%), and Baldwin Park (40.7%), and the cities where the largest percent of students are overweight are La Puente (19.3%), and Hacienda Heights (19.3%). Obesity reduces life expectancy and increases the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. Obesity also increases the risks of cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types. A number of factors likely contribute to obesity, including genetics, physical inactivity, unhealthy diet and eating habits, lack of sleep, certain medications, age, social and economic issues, and medical problems. Obesity was identified in four of five focus groups and nine of 19 interviews and was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

3. Diabetes

Diabetes affects an estimated 23.6 million people in the United States and is the seventh leading cause of death. Diabetes also lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness. The rate of diabetes is higher in the CVHP service area (18.5%) than in Los Angeles County (10.5%). The diabetes hospitalization rate in the CVHP service area for adults is 147.4 adults per 100,000, modestly above the statewide rate of 145.6 per 100,000. The CVHP communities of Azusa, Baldwin Park, Covina, El Monte, La Puente and South El Monte are particularly affected by diabetes. Hospitalization rates for uncontrolled diabetes are also significant, with an average in the CVHP service area of 12.7 per 100,000 persons compared to a statewide average of 9.5. Nearly all communities had hospitalization rates higher than the state average with El Monte (26.2) and South El Monte (26.8) reflecting the highest contrasts. Those between the ages of 45 and 64 (1.5%) and those over the age of 65 (1.0%) experienced the most hospital incidents resulting from diabetes compared to other age groups. Drivers associated with diabetes include being overweight, high blood pressure, high cholesterol, high blood sugar (or glucose), physical inactivity, smoking, unhealthy eating, and age, race, gender, and having a family history of diabetes. Diabetes was identified as a major health issue in four out of 19 interviews and four out of five focus groups. Diabetes was also identified as a health need in the 2010 CVHP Community Health Needs Assessment.

4. Oral Health

Oral health is essential to overall health and is relevant because engaging in preventative behaviors decreases the likelihood of developing future health problems. In addition, oral

diseases like cavities and oral cancer, cause pain and disability for many Americans. Oral health indicators include the percentage of adults ages 18 and older who self-report that six or more of their permanent teeth have been removed due to decay, gum disease or infection, an indication of lack of access to dental care and/or social barriers to utilization of dental services. Los Angeles County and the CVHP service area have the same rate of 11.6% adults with poor dental health, which is slightly higher than the statewide rate of 11.3%. The rate of children who have never seen a dentist in the CVHP service area is 11.9%, higher than the Los Angeles County rate of 10.5%. The portion of adults without dental insurance in the past year ranges between 37.1% and 70.0% throughout the CVHP service area and the largest portion are Hispanic/Latino (43.7%) and Asian/Pacific Islander (40.6%). Health behaviors that may lead to poor oral health include tobacco use, excessive alcohol use, and poor dietary choices. Social factors associated with poor dental health include lower levels or lack of academic education, poverty rates, having a disability and other health conditions such as diabetes. Oral health and dental care was identified by community stakeholders in all five focus groups and eleven out of 19 interviews, and highlighted new immigrants, adults and the aging as particularly impacted. Oral health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

5. Hypertension

Hypertension, defined as a blood pressure reading of 140/90 or higher, affects 1 in 3 adults in the United States. The condition has been called a silent killer as it has no symptoms or warning signs and can cause serious damage to the body. High blood pressure, if untreated, can lead to heart failure, blood vessel aneurysms, kidney failure, heart attack, stroke, and vision changes or blindness. The rate of adults diagnosed with high blood pressure was higher in the CVHP service area (30.2%) compared to Los Angeles County (25.5%). More (1.3) died of hypertension and hypertensive renal failure when compared to California (1.0). In particular, the cities of La Verne (3.0), San Dimas (2.7), Diamond Bar (1.5), Azusa (1.5), Covina (1.4), West Covina (1.4), Glendora (1.2), and La Puente (1.1). Associated drivers include smoking, obesity, eating salt and fat regularly, drinking excessively, and physical inactivity are risk factors for hypertension. As well, those who are at higher risk of developing hypertension are people who have had a stroke previously, have a high level of cholesterol, or have heart or kidney disease. Hypertension, indicated by high blood pressure, was identified as a health issue in three out of 19 interviews and one out of five focus groups. Hypertension was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

6. Cardiovascular Disease

Cardiovascular disease – also called heart disease and coronary heart disease – includes several problems related to plaque buildup in the walls of the arteries, or atherosclerosis. As the plaque builds up, the arteries narrow, restricting blood flow and creating a risk for a heart attack. Currently more than one in three adults (81.1 million) lives with one or more types of cardiovascular disease. The rates of heart disease in Los Angeles County and the CVHP service

area are the same at 5.8%, and very close to the statewide rate of 5.9%. Those most often diagnosed with heart disease in this service area include White (8.2%) and Hispanic/Latino (5.1%) populations. Coronary heart disease is a leading cause of death in the United States, associated with high blood pressure, high cholesterol and heart attacks and also linked to other negative health outcomes including obesity, heavy alcohol consumption and diabetes. The heart disease hospitalization rate of 382.6 people per 100,000 is notable and particularly impacts populations in the communities of Covina, El Monte, Glendora, Hacienda Heights, La Puente, San Dimas, and South El Monte. The community of San Dimas is the most significantly impacted, with a hospitalization rate of 507.3 per 100,000. The cardiovascular disease mortality rate is highest in the southernmost part of Glendora, particularly in ZIP code 91740 (195.8). Stakeholders identified the homeless, aging, uninsured, and adults over the age 35 as the most severely impacted. Heart disease/coronary disease was identified as a major health issue in five of 19 interviews and one of five focus groups. Stroke was also raised as a concern in one of 19 interviews. Cardiovascular disease was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

7. Cancer, in General

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year. The rate of death due to cancer in the CVHP service area is 154.3 per 100,000 persons, which is slightly lower than the Los Angeles County rate of 156.5 per 100,000. Cancer mortality rates per 10,000 persons were highest in the cities of La Verne (23.2), San Dimas (21.7), Hacienda Heights (19.6), Glendora (18.4), Covina (16.9), and West Covina (16.5). The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight, certain chemicals, some viruses and bacteria, family history of cancer, poor diet, and lack of physical activity. Stakeholders identified adults over the age of 35 as the most severely impacted subgroup and identified the San Gabriel Valley as the most severely impacted area. Cancer was identified as a major health issue by community stakeholders in two out of 19 interviews and in one out of five focus groups. Though a leading cause of death in the United States, cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

8. Vision

People with diabetes are at an increased risk of vision problems as diabetes can damage the blood vessels of the eye, potentially leading to blindness. Diabetics are 40% more likely to suffer from glaucoma and 60% more likely to develop cataracts compared to people without diabetes. The percent of diabetic adults who had their vision checked within the last year was higher in the CVHP service area (65.7%) compared to Los Angeles County (63.3%). Vision care providers should expect to see more of these complications among a younger population as more young children and adolescents are being diagnosed with diabetes. Stakeholders agreed that vision was an issue and attributed it to the lack of available services. They added that vision is not isolated

to any group but instead that it is widespread. There is a need for vision screenings, especially for children who experience difficulty in school because they cannot see well. Vision was identified as a major health issue in one out of 19 interviews and three out of five focus groups. Vision was not identified as a need in the 2010 CVHP Community Health Needs Assessment.

9. Colorectal Cancer

Colorectal cancer, defined as cancer that starts in the colon or the rectum, is the second leading cause of cancer-related deaths in the United States and is expected to cause about 50,830 deaths during 2013. The annual incidence rate of colon and rectum cancer in the CVHP service area is 45.2 individuals per 100,000, equivalent to the Los Angeles County rate. Both rates are above the statewide rate of 43.7 per 100,000 and the national rate of 40.2 per 100,000. The colon cancer mortality rate of 7.7 per 100,000 in the CVHP service area is below the Los Angeles County average of 11.2, however the community of Glendora (18.9) is notably higher than both the Los Angeles County (11.2) and CVHP service area (7.7) averages. African-Americans (59.9) have the highest colorectal cancer incidence rate compared to the other racial groups. The major factors that can increase the risk of colorectal cancer are aging and family history of colorectal cancer. Other less significant factors include a personal history of inflammatory bowel disease, inherited risk, heavy alcohol use, cigarette smoking, obesity, diabetes prevalence, and colon cancer screening. Colon/rectum cancer was identified as a major health issue in one out of 19 interviews and one of five focus groups. This condition was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

10. Disability

Disability is an umbrella term for impairments, activity limitations, and participation restrictions. Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports). Disability statistics are based on the percentage of the total civilian non-institutionalized population with a disability. Disability rates in Los Angeles County and the CVHP service area are the same at 9.4%. Disabilities are associated with poor general health, education level and poverty. Stakeholders identified children as the most severely impacted and noted the increase in children diagnosed with autism and developmental delays including speech impediments. People with disabilities typically have less access to health care services and often do not have their health care needs met. In addition, they are likely not to engage in physical activity, and more likely to smoke, be overweight or obese, have high blood pressure, experience psychological distress, receive less social-emotional support, and have high unemployment rates. Disability, defined as developmental delays and/or as behavior issues, were identified in two out of 19 interviews and one of five focus groups with stakeholders highlighting youth with IEPs (Individualized Education Plans) as a particularly impacted population. Disabilities were not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

11. Intentional Injury (Homicide)

Intentional injuries and violence are widespread in society and are among the top 15 killers for Americans of all ages. Intentional injury is defined as homicide or suicide; homicide is a measure of community safety and a leading cause of premature death. The homicide rate for the CVHP service area is 6.1 per 100,000 persons; lower than the Los Angeles County rate of 8.4 per 100,000. Both rates are above the statewide rate of 5.2. Rates are notably higher in the communities of West Covina (17.8), Covina (15.7), and La Puente (10.1). Intentional injuries are associated with several health factors and high-risk behaviors including alcohol use, risk-taking, social and physical environments that are unsafe and violent, as well as economic factors such as poverty and unemployment. Stakeholders identified teens as being the most impacted. Stakeholders identified homicide as a health need in one of 19 interviews and one of five focus groups. Intentional injury was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

12. Alcohol & Substance Abuse

The effects of substance abuse significantly contribute to costly social, physical, mental, and public health problems including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle crashes (unintentional injuries), physical fights, crime, homicide, and suicide. Alcohol and Substance Abuse is defined as adults (age 18 and older) who self-report heavy alcohol consumption. The alcohol/drug-induced hospitalization rate of 91.4 per 100,000 persons in the CVHP service area is lower than the state average of 109.1 per 100,000. However, the alcohol/drug-induced hospitalization rate is higher in Covina (159.5), Glendora (129.2), La Verne (123.3), San Dimas (120.8), and La Puente (109.8). Alcohol and substance is linked to poor mental health, HIV/AIDS, and poor physical health. Stakeholders indicated that the homeless and adults over the age of 35 are most impacted. Alcoholism was identified as a major concern in four out of 19 interviews and in one out of five focus groups. Alcohol and substance abuse was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

13. Cervical Cancer

Cervical cancer is a disease in which cells in the cervix - the lower, narrow end of the uterus connected to the vagina (the birth canal) to the upper part of the uterus - grow out of control. All women are at risk for cervical cancer and it occurs most often in women over the age of 30. The human papillomavirus (HPV), a common virus that is passed from one person to another during sex, is the main cause of cervical cancer. The annual rate of cervical cancer is the same in Los Angeles County and in the CVHP service area, at 9.9 individuals per 100,000 people, higher than the statewide rate of 8.30 per 100,000 and the national rate of 8 per 100,000. Over one-third of the communities in the CVHP service area have cervical cancer mortality rates above Los Angeles County (3.0) and the CVHP service area (2.2) average, including Diamond Bar (8.0),

West Covina (5.2), La Puente (4.3), Rowland Heights (3.9), and Walnut (3.6). Within the CVHP service area, cervical cancer related hospital discharge rates are higher among the Hispanic/Latino population (13.2). Cervical cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

14. Chlamydia

Chlamydia is the most frequently reported bacterial sexually transmitted infection in the United States. Chlamydial infections can lead to serious health problems. In women, untreated infection can cause pelvic inflammatory disease (PID), permanently damage a woman's reproductive tract and lead to long-term pelvic pain, inability to get pregnant and potentially deadly ectopic pregnancy. In men, infection sometimes spreads to the tube that carries sperm from the testis, causing pain, fever, and, rarely, preventing a man from being able to father children. Untreated Chlamydia may increase a person's chances of acquiring or transmitting HIV. The CVHP service area rate (476.3) of Chlamydia per 100,000 people is comparable to the Los Angeles County average according to 2009 data. Chlamydia is a measure of poor health status and associated with numerous other health factors including poverty, heavy alcohol consumption, unsafe sex practices and age (young people are at a higher risk of acquiring Chlamydia). Chlamydia was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

15. Asthma

Asthma is a disease that affects the lungs and is one of the most common long-term diseases of children. Adults also may suffer from asthma and the condition is considered hereditary. Asthma symptoms include wheezing, breathlessness, chest tightness, and coughing. The prevalence of asthma for adults in Los Angeles County and in the CVHP service area is the same at 11.1%. While the average adult asthma hospitalization rate per 100,000 persons in the CVHP service area (89.2) is lower than the statewide average (94.3), it is very high in South El Monte (198.2) and El Monte (171.7) and is also high in Baldwin Park, La Puente, West Covina and Rowland Heights. The asthma hospitalization rate for youth in the CVHP service area is higher with 20.8 youth per 1000 compared to a statewide average of 19.2 youth per 1000. Some asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroach allergens, pet dander, mold, and certain infections known to cause asthma such as the flu, colds, and respiratory related viruses. Other contributing factors include exercising, certain medication, bad weather, high humidity, cold/dry air, certain foods and fragrances. Within the CVHP service area, individuals between the ages of 1 and 19 (4.6%) experienced the most asthma related hospital discharges. Stakeholders indicated that asthma and respiratory illness were on the rise and attributed the prevalence to the inability of people to control their respiratory conditions. Asthma was mentioned as a major health issue in one out of five focus groups and five out of 19 interviews. Community stakeholders highlighted youth and individuals over the age of 35 as particularly affected populations. Asthma was not identified as a key health need in the 2010 CVHP Community Health Needs Assessment.

16. Alzheimer's Disease

An estimated 5.4 million Americans have Alzheimer's disease and it is the sixth-leading cause of death in the U.S. Alzheimer's, an irreversible and progressive brain disease, is the most common cause of dementia among older people. The rate of mortality due to Alzheimer's disease is slightly higher for the CVHP (17.9) service area compared to Los Angeles County (17.6). The average rate of Alzheimer's mortality per 10,000 persons is also lower in the CVHP service area (2.6) compared to the statewide average (2.9) but higher in La Verne (6.6), San Dimas (5.7), Glendora (5.5), and Covina (3.6). The greatest risk factor for Alzheimer's disease is advancing age. Other risk factors include a family history of Alzheimer's, genetic mutations, cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury. Stakeholders felt that those most impacted are people over the age of 85 years of age who are uninsured, low-income, Latinos, and Asians. Alzheimer's disease was identified as a major health need in three out of 19 interviews and was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

17. Unintentional Injury (Pedestrian/Motor Vehicle)

Unintentional injuries include those resulting from motor vehicle crashes resulting in death and pedestrians being killed in crashes. Motor vehicle crashes are one of the leading causes of death in the U.S. with more than 2.3 million adult drivers and passengers being treated in 2009. Pedestrians are 1.5 times more likely than passenger vehicle occupants to be killed in a car crash on each trip. The rate of mortality by a motor vehicle accident in the CVHP service area is 7.7 per 100,000, above the Los Angeles County rate of 7.1, though lower than the statewide rate of 8.2. Pedestrian motor vehicle accident mortality rates per 100,000 persons in CVHP service area are highest in West Covina (3.6), and South El Monte (3.1). Health factors associated with unintentional injury include poverty, education and heavy alcohol consumption. Populations most at risk are older adults, children, and drivers and pedestrians who are under the influence of alcohol and drugs. Unintentional injury was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

18. Arthritis

Arthritis affects one in five adults and continues to be the most common cause of physical disability. Risk factors associated with arthritis include being overweight or obese, lack of education around self-management strategies and techniques, and limited or no physical activity. Arthritis was identified as a major health concern in three out of 19 interviews and was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

19. Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) is the occurrence of chronic bronchitis or emphysema, commonly co-existing diseases of the lungs in which the airways narrow over time. COPD may also be referred to as chronic respiratory pulmonary disease and is most often associated with tobacco smoking; approximately 20% of chronic smokers develop COPD. Average rates of chronic lower respiratory disease per 10,000 persons are lower in the CVHP service area (3.1) compared to the statewide average (3.5) but remain higher in San Dimas (6.3), Glendora (5.7), La Verne (4.5), and Covina (4.0). Risk factors that can lead to the development of COPD are a genetic susceptibility to the disease, inhaling other irritants (e.g., cigar smoke, secondhand smoke, air pollution), people with asthma who are smokers, occupational exposure to dusts and chemicals, and age. COPD was identified as a health issue in two of 19 interviews and was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

20. HIV/AIDS

More than 1.1 million people in the United States are living with HIV and almost 1 in 5 (18.1%) are unaware of their infection. HIV infection weakens the immune system, making those living with HIV highly susceptible to a variety of illnesses and cancers, including tuberculosis (TB), cytomegalovirus (CMV), cryptococcal meningitis, lymphomas, kidney disease, and cardiovascular disease. Without treatment, almost all people infected with HIV will develop AIDS. The HIV/AIDS prevalence rate, defined as HIV diagnosis per 100,000 people, is 480.3 in the CVHP service area, close to the Los Angeles County rate of 480.4, though notably higher than the statewide rate of 345.5 and the national rate of 334.0 per 100,000. HIV is a life-threatening communicable disease that disproportionally affects minority communities and may indicate a prevalence of unsafe sex practices. The HIV/AIDS hospitalization rate per 100,000 in the CVHP service area is 6.6, lower than the statewide average of 11.0, however, the communities of Covina (14.0), El Monte (13.3), Glendora and (11.8) have higher rates than both the CVHP service area and state averages. HIV/AIDS is associated with numerous health factors including poverty, heavy alcohol consumption, lack of timely HIV screenings and liquor store access. HIV/AIDS was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

21. Allergies

Allergies are an overreaction of the immune system to substances that usually cause no reaction in most individuals. These substances can trigger sneezing, wheezing, coughing and itching. Risk factors associated with allergic reactions include pollen, dust, food, insect stings, animal dander, mold, medications, and latex. Other social and economic factors that can cause or trigger allergic reactions include poor housing conditions (living with cockroaches, mites, asbestos, mold etc.) and living in an environment or home with smokers. More teens in the CHVP service area had allergies (36.8%) when compared to Los Angeles County (24.9%).Allergies were

identified as a major health concern in three out of 19 interviews. Allergies were not indicated among major needs in the 2010 CVHP Community Health Needs Assessment.

22. Infant Mortality

Infant mortality remains a concern in the United States as each year approximately 25,000 infants die before their first birthday. The leading causes of infant death include congenital abnormalities, pre-term/low birth weight, Sudden Infant Death Syndrome (SIDS), problems related to complications of pregnancy, and respiratory distress syndrome. Infant mortality is the rate of infant death at less than one year of age per 1000 births. Los Angeles County and the CVHP service area have the same rate at 5.1 per 1000 births, below the national rate of 6.7. Infant mortality is associated with rates of low birth weight. A higher percentage of infants are born with very low birth weight (less than 1,500 grams) than the Los Angeles County average of 1.1% in the CVHP service area communities of Baldwin Park (1.7%), El Monte (1.4%), La Verne (1.7%), San Dimas (1.8%), and South El Monte (1.5%). Very low birth weight can indicate broader issues such as access to health care, maternal and child health, poverty, education rate, teen births, and lack of insurance and of prenatal care. Infant mortality was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

b. Health drivers

Drivers such as poverty and behaviors are very much linked and are often the root or cause of many health problems. For this reason, drivers were put through the same rigorous process of identification and prioritization as health needs. The following list includes the prioritized list of drivers:

1. Employment
2. Income
3. Homelessness
4. Health Insurance
5. Health Care Access
6. Awareness
7. Dental Care Access
8. Nutritional Access
9. Education
10. Healthy Eating
11. Physical Activity

12. Family and Social Support
13. Preventive Care Services
14. Language Barrier
15. Transportation
16. Cancer Screenings
17. Natural Environment
18. Safety

II. Introduction/Background

a. Purpose of the community health needs assessment report

Citrus Valley Health Partners is dedicated to enhancing the health of the communities it serves. The findings from this CHNA report will serve as a foundation for understanding the health needs found in the community and will inform the Implementation Strategy as part of their Community Benefit planning. This report complies with federal tax law requirements set forth in Internal Revenue Service Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years. The required written plan of Implementation Strategy is set forth in a separate written document. At the time that CVHP conducted their CHNA, Notice 2011-52 from the Internal Revenue Service provided the most recent guidance on how to conduct a CHNA. This written plan is intended to satisfy each of the applicable requirements set forth in IRS Notice 2011-52 regarding conducting the CHNA for the hospital facility.

b. About Citrus Valley Health Partners

As the largest, nonprofit health care provider for the residents of the East San Gabriel Valley, CVHP serves the community through the work of its four facilities: Citrus Valley Medical Center – Inter-Community Campus in Covina, Citrus Valley Medical Center – Queen of the Valley Campus in West Covina, Foothill Presbyterian Hospital in Glendora, Citrus Valley Hospice and Citrus Valley Home Health in West Covina.

Nearly one million residents in the East San Gabriel Valley rely on CVHP for their health care needs. They are known regionally for their primary stroke center, robotic surgery program, outpatient and inpatient rehabilitation services, diabetes treatment and education, maternal and child health services, the technologically advanced Citrus Valley Heart Center and an innovative palliative care program. Its family of 3,000 employees and 1,000 physicians work together as a team to elevate the health of their community.

While CVHP is focused on healing the sick, we are also dedicated to reaching out to improve the health of our community. Our community outreach efforts allows us to reach beyond our hospital walls to help educate our community members, to help manage their health and to give them options in resources and health screenings. We offer a variety of health programs, services and support groups and partner with a variety of community organizations, cities and school districts with the common goal of improving health and well-being.

c. About Citrus Valley Health Partners Community Benefit

CVHP is an organization recognized for its outstanding community outreach efforts and accomplishments. An organization dedicated to creating innovative partnerships among the numerous health and social service organizations in our valley, with close to 100 participating

agencies in diverse collaborative relationship devoted to promoting community health and well-being.

Some highlights include CVHP's Partnership Nursing Program, which is based on the concept that through working partnerships between faith communities, community organizations and medical professionals, health and wellness issues can be significantly improved. Get Enrollment Moving program, also known as GEM, volunteers and CVHP staff members work together to recruit eligible families and enroll them in Medi-Cal, Healthy Kids, Healthy Way LA, and other health access programs. GEM also calls enrolled individuals three separate times to ensure that confirm enrollment, ensure utilization of services and trouble shoot, and to provide assistance at renewal time. GEM is a project of CVHP and it is supported by funding from the L.A. County of Public Health Department and First 5 LA. GEM Promotoras de Salud/Health Promoters is a peer outreach and education neiborhood-based initiative with the purpose of teaching and connect community residents with health insurance options. As leaders in their community, they visit homes door-to-door to identify needs for information and services. CVHP'S Diabetes Program provides free diabetic foot screenings for patients and residents every month. Free diabetes test strips are provided free of charge to patients through a partnership with a local community clinic; this practice had already shown positive results in residents better managing their diabetes. Free support groups are offered at Foothill Education Center in Glendora and CVHP Resource Center in Covina to help residents with their concerns, achievements and challenges in managing their diabetes. The Latino community have access to Spanish language groups led by a Registered Nurse and Certified Diabetes Educator. CVHP's vision is to be an integral partner in elevating communities' health through partnerships. CVHP has formed a Diabetes Prevention and Management Multidisciplinary Group made up of 18 public and private agencies who join minds to respond to the needs of the diabetic population and decrease the devastating effects that come with it. CVHP's Best Babies Collaborative program which offers free home visitation services for high risk teens and women in partnership with six community partners. This program is made possible through funding and partnership with First 5 LA. CVHP has been proactive in offering outreach and education throughout the community in the Affordable Care Act/MediCal Expansion and Market Place. Since conception, Every Child's Healthy Option (ECHO) is a collaborative effort involving CVHP, coordinated and lead by local school districts. The ECHO program has in place a cadre of volunteer health providers who offer free urgent care services in various specialties; it ensures that every child, regardless of income level, has access to urgent quality health care and provides enrollment for the child in health insurance. Other important programs that receive support from CVHP are the San Gabriel Valley Coalition on Homelessness and the San Gabriel Valley Disabilities Collaborative.

d. Citrus Valley Health Partner's approach to the community health needs assessment

About the new federal requirements

Federal requirements included in the ACA, which was enacted March 23, 2010, stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations, one of which is conducting a CHNA every three years. With regard to the CHNA, the ACA specifically requires nonprofit hospitals to: collect and take into account input from public health experts as well as community leaders and representatives of high need populations—this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions; identify and prioritize community health needs; document a separate CHNA for each individual hospital; and make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an Implementation Strategy to address the identified community health needs and submit a copy of the Implementation Strategy along with the organization's annual Form 990.

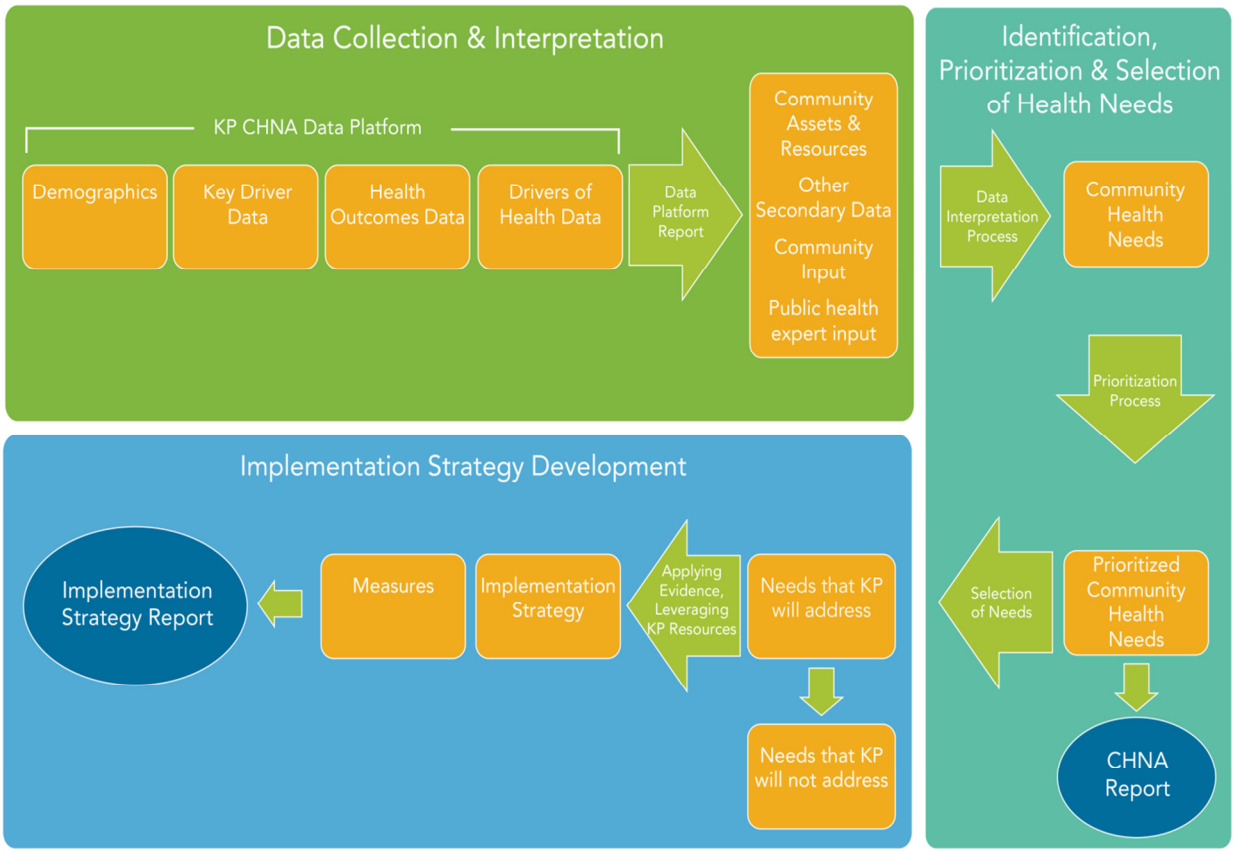
SB 697 and California's history with past assessments

For many years, CVHP has conducted needs assessments to guide our allocation of Community Benefit resources. In 1994, California legislators passed Senate Bill 697 (SB 697), which requires all private nonprofit hospitals in the state to conduct a CHNA every three years. As part of SB 697 hospitals are also required to annually submit a summary of their Community Benefit contributions, particularly those activities undertaken to address the community needs that arose during the CHNA. Kaiser Permanente has designed a process, which Citrus Valley Health Partners adopted, that will continue to comply with SB 697 and that also meets the new federal CHNA requirements.

Kaiser Permanente's CHNA framework and process

Kaiser Permanente Community Benefit staff at the national, regional, and hospital levels worked together to establish an approach for implementing the new federally legislated CHNA. 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 COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS MAP



Kaiser Permanente, in partnership with the Institute for People, Place and Possibility (IP3) and the Center for Applied Research and Environmental Studies (CARES), developed a web-based CHNA data platform to facilitate implementation of the CHNA process. More information about the CHNA platform can be found at http://www.CHNA.org/kp/. Because data collection, review, and interpretation are the foundation of the CHNA process, each CHNA includes a review of secondary and primary data.

To ensure a minimum level of consistency across the organization, Kaiser Permanente included a list of roughly 100 indicators in the data platform that, when looked at together, help illustrate the health of a community. California data sources were used whenever possible. When California data sources weren't available, national data sources were used. Once a user explores the data available, the data platform has the ability to generate a report that can be used to guide primary data collection and inform the identification and prioritization of health needs.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each Kaiser Permanente hospital collected primary data through key informant interviews, focus groups, and surveys. They asked local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. They also inventoried existing community assets and resources.

Each hospital/collaborative used 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 a second set of criteria. This process resulted in a complete list of prioritized community health. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, Citrus Valley Health Partners will examine the list of prioritized health needs and develop an implementation strategy for those health needs it will address. These strategies will build on Citrus Valley Health Partners 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.

III. Community Served

a. Definition of community served by hospital facility

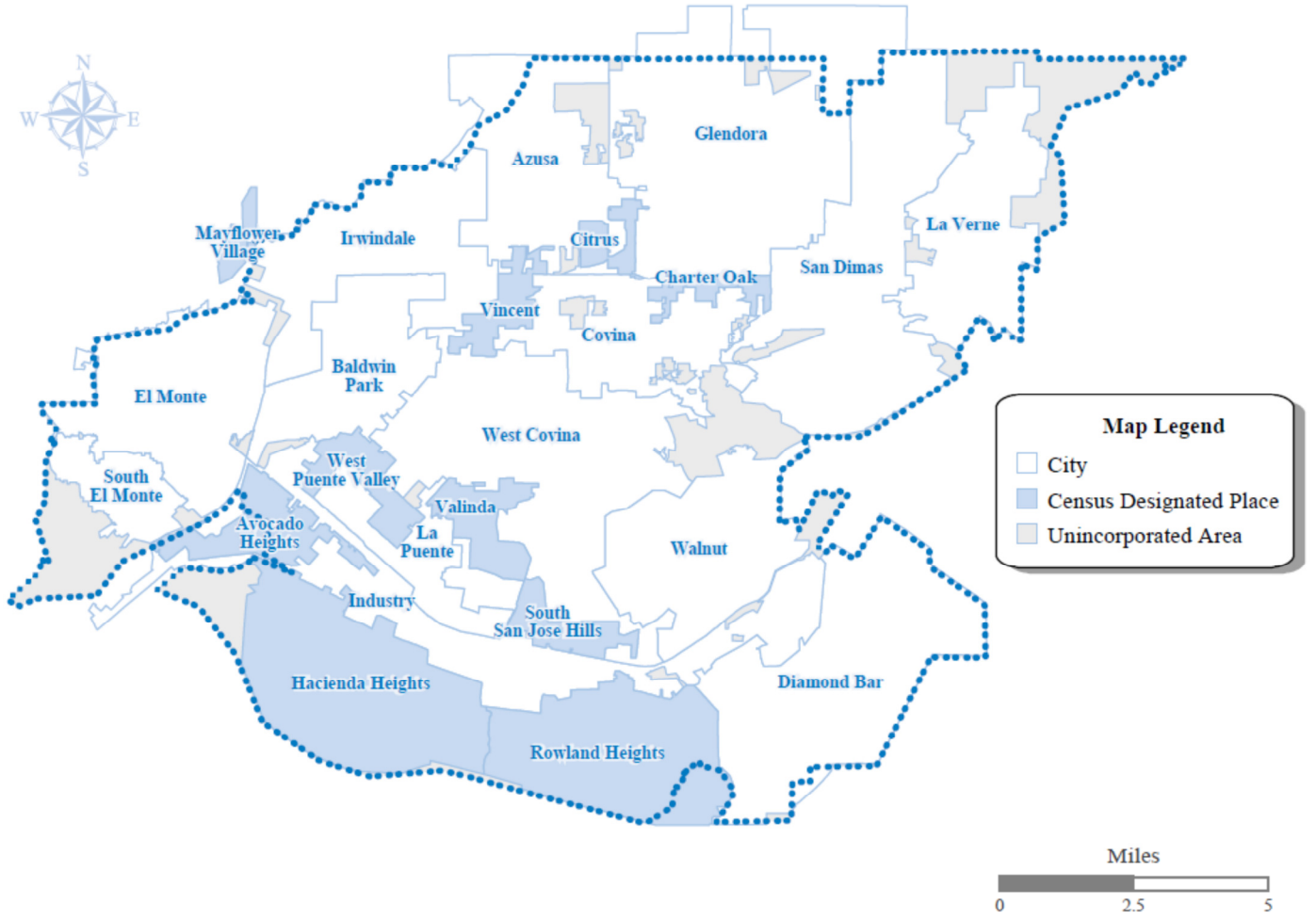
The community served by a hospital is defined as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

b. Description and map of community served by hospital facility

The Citrus Valley Health Partners (CVHP) service area includes the following zip codes, cities, and Service Planning Area (SPA):

Zip Codes		Cities	Service Planning Areas
91702	91747	Azusa	SPA 3 – San Gabriel and Pomona Valleys
91706	91748	Baldwin Park	
91722	91749	(including Irwindale)	
91723	91750	Covina	
91724	91765	Diamond Bar	
91731	91773	El Monte	
91732	91788	Glendora	
91733	91789	Hacienda Heights	
91734	91790	La Puente	
91735	91791	La Verne	
91740	91792	Rowland Heights	
91741	91793	San Dimas	
91744	91795	South El Monte	
91745		Walnut	
91746		West Covina	

Citrus Valley Health Partners
SERVICE AREA



November 2001

A description of the community served by CVHP is provided in the following data tables and narrative. Depending upon the available data sources for each variable, CVHP information are presented as representing the entirety of the city/community when possible. Data are organized in the following sections: Demographic Profile, Access to Health Care and Chronic Disease Prevalence and Incidence.

Demographic profile

Population

In 2010, the total population within CVHP service was 880,220, making up 7.1% of the population in Los Angeles County (U.S. Census, 2010) (U.S. Census Bureau Decennial Census, 2010). The largest portion of the population in the CVHP service area lives in La Puente (13.1%), West Covina (12.3%), and El Monte (10.3%).

Total Population, 2010

	Number	Percent
Azusa	59,705	6.8%
Baldwin Park	76,571	8.7%
Covina	78,868	9.0%
Diamond Bar	46,457	5.3%
El Monte	90,977	10.3%
Glendora	51,180	5.7%
Hacienda Heights	54,013	6.1%
La Puente	115,525	13.1%
La Verne	33,249	3.8%
Rowland Heights	45,406	5.2%
San Dimas	33,119	3.8%
South El Monte	43,896	5.0%
Walnut	43,079	4.9%
West Covina	108,175	12.3%
CVHP Service Area	880,220	7.1%
Los Angeles County	9,818,605	100.0%

Source: U.S. Census Bureau Decennial Census, 2010
Source Geography: Zip Code (each city is aggregated to include only those zip codes in the service area)

In the CVHP service area, there are slightly more females (50.1%) than males (49.9%). In Los Angeles County, the same is true – 50.3% are females and 49.7% are males (U.S. Census Bureau Decennial Census, 2010).

Gender, 2010

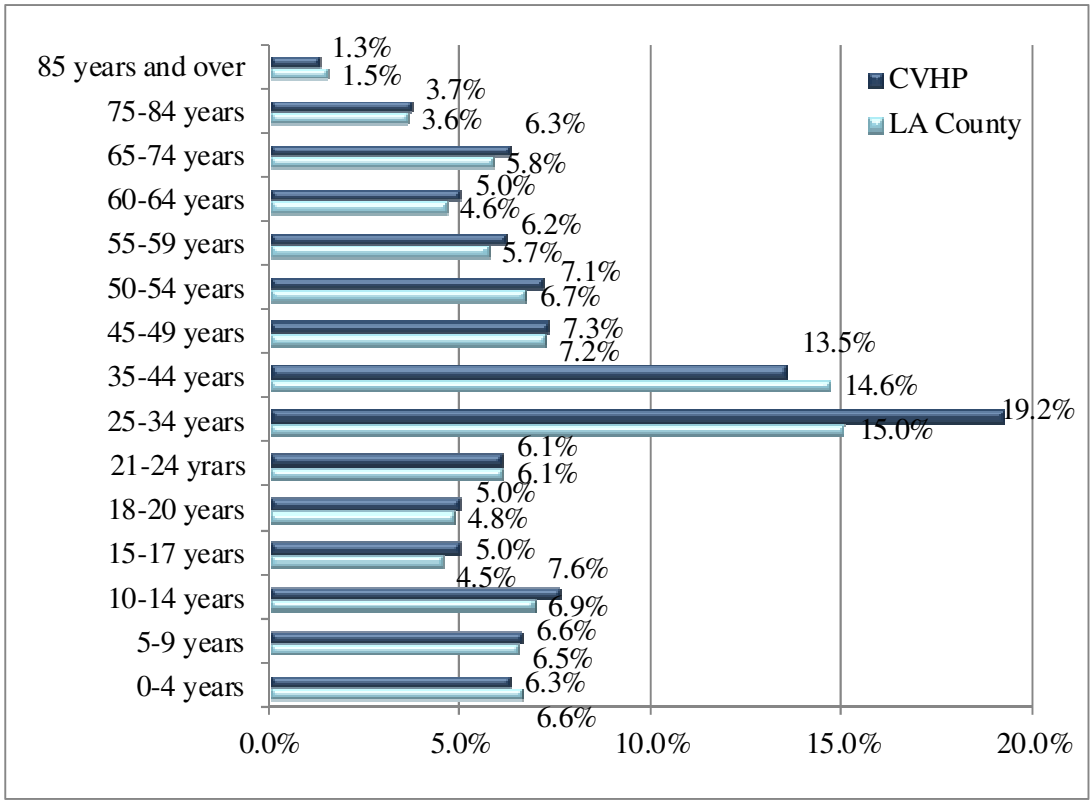
	Male		Female	
	#	%	#	%
Azusa	27,857	50.0%	27,811	50.0%
Baldwin Park	37,670	49.6%	38,258	50.4%
Covina	39,935	48.8%	42,540	51.2%
Diamond Bar	22,424	50.3%	23,480	49.7%
El Monte	47,191	47.7%	46,685	52.3%
Glendora	23,238	48.8%	25,512	51.2%
Hacienda Heights	27,116	54.5%	28,489	45.5%
La Puente	55,898	41.1%	46,685	58.9%
La Verne	15,727	52.0%	25,512	48.0%
Rowland Heights	23,234	50.0%	33,317	50.0%
San Dimas	16,639	49.6%	15,379	50.4%
South El Monte	20,371	48.8%	23,980	51.2%
Walnut	18,030	50.3%	18,189	49.7%
West Covina	52,373	47.7%	19,371	52.3%
CVHP Service Area	427,703	49.9%	415,208	50.1%
Los Angeles County	4,839,654	49.7%	18,736,126	50.3%

Source: U.S. Census Bureau Decennial Census, 2010
Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

Age

By age, over a third (32.7%) are between the ages of 25 and 44 years in the CVHP service area compared to 29.6% in Los Angeles County (U.S. Census Bureau Decennial Census, 2010). Another quarter (25.5%) in the CVHP service area is between the ages of 0 and 17 years slightly less than Los Angeles County (24.5%) (U.S. Census Bureau Decennial Census, 2010).

Age, 2010



Source: U.S. Census Bureau Decennial Census, 2010
Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

Race and Ethnicity

In the CVHP service area over half (55.7%) of the population is Hispanic or Latino compared to 47.7% in Los Angeles County (U.S. Census Bureau Decennial Census, 2010). The second largest ethnic group is Asian/Pacific Islander making up over a quarter (22.5%) of the population in the CVHP service area compared to 13.7% in Los Angeles County (U.S. Census Bureau Decennial Census, 2010). The third largest ethnic group is Caucasian with 18.0% of the population in the CVHP service area, smaller when compared to 27.8% in Los Angeles County (U.S. Census Bureau Decennial Census, 2010).

Race and Ethnicity, 2010

	CVHP service area	Los Angeles County
Hispanic/ Latino	(490,117) 55.7%	(4,687,889) 47.7%
Caucasian	(158,751) 18.0%	(2,728,321) 27.8%
African American	(18,554) 2.1%	(815,086) 8.3%
American Indian/ Alaskan Native	(1,546) 0.2%	(18,886) 0.2%
Asian/ Pacific Islander	(198,341) 22.5%	(1,348,135) 13.7%
Other	(1,307) 0.1%	(25,367)0.3%
Two or More Races	(11,604) 1.3%	(194,921) 2.0%

Source: U.S. Census Bureau Decennial Census, 2010
Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

Language Spoken at Home

A larger portion of the population in CVHP service area speaks Spanish (41.3%) at home when compared to Los Angeles County (39.7%). Another third speak English only (37.2%) at home, a smaller portion when compared to Los Angeles County (39.7%). A larger portion of the population speaks an Asian/Pacific Island (18.9%) at home when compared to Los Angeles County (10.9%).

Language Spoken At Home, 2013

	CVHP service area		Los Angeles County	
Language	**#**	**%**	**#**	**%**
English Only	308,885	37.2%	3,998,524	42.9%
Asian/Pacific Island	156,742	18.9%	1,016,304	10.9%
Indo-European	15,741	1.9%	494,736	5.3%
Spanish	342,477	41.3%	3,699,298	39.7%
Other	6,141	0.7%	102,818	1.1%
Total	**829,986**	**100.0%**	**9,311,680**	**100.0%**

Data source: Nielson Claritas, 2013
Source geography: ZIP Code

Education Attainment

Over a quarter (26.9%) of the population in the CVHP service area has less than a 9th grade education, the same as Los Angeles County (26.9%) (U.S. Census Bureau Decennial Census, 2010). Another 20.1% in the CVHP service have a high school diploma, slightly higher when compared to Los Angeles County (16.9%) (U.S. Census Bureau Decennial Census, 2010). The service area has lower rates of four year college and graduate degrees than the County.

Education Attainment, 2010

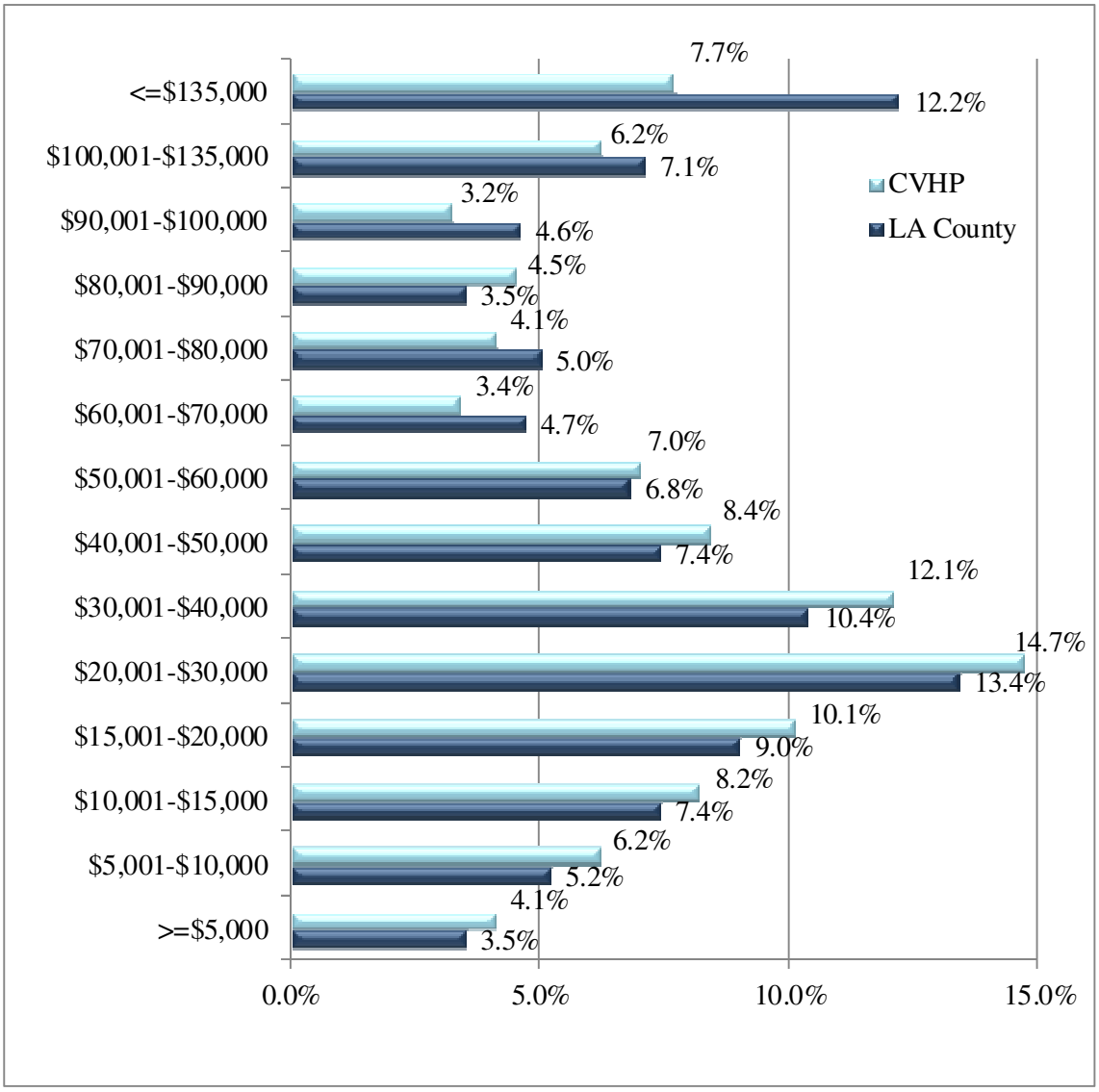
	Less than 9th Grade	9th to 12th Grade (no diploma)	High School Graduate (includes Equivalency)	Some College (no degree)	Associate's Degree	Bachelor's Degree	Graduate or Professional Degree
Azusa	No data	No data	No data	No data	No data	No data	No data
Baldwin Park	31.6%	14.5%	23.0%	15.8%	4.1%	9.3%	1.7%
Covina	No data	No data	No data	No data	No data	No data	No data
Diamond Bar	No data	No data	No data	No data	No data	No data	No data
El Monte	37.0%	16.7%	21.8%	14.2%	2.3%	6.2%	1.9%
Glendora	No data	No data	No data	No data	No data	No data	No data
Hacienda Heights	23.2%	13.7%	17.4%	21.7%	6.2%	12.2%	5.6%
La Puente	36.2%	18.2%	23.0%	13.0%	3.3%	4.9%	1.5%
La Verne	17.7%	9.1%	18.3%	24.1%	7.0%	14.8%	9.0%
Rowland Heights	No data	No data	No data	No data	No data	No data	No data
San Dimas	No data	No data	No data	No data	No data	No data	No data
South El Monte	No data	No data	No data	No data	No data	No data	No data
Walnut	18.6%	9.9%	19.0%	15.9%	7.1%	20.6%	9.0%
West Covina	24.0%	11.8%	18.4%	22.6%	5.6%	11.9%	5.9%
CVHP Service Area	26.9%	13.4%	20.1%	18.2%	5.1%	11.4%	4.9%
Los Angeles County	26.9%	12.7%	16.9%	18.0%	5.0%	13.6%	7.0%

Source: U.S. Census Bureau Public Use Microdata Statistics (PUMS), 2010
Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

Household Income

In 2009, over a quarter (26.8%) has an annual household income between $20,001 and $40,000 in the CVHP service area, a slightly smaller portion in Los Angeles County report the same (23.8%) (California Health Interview Survey, 2009). Over a quarter (28.6%) of the CVHP service area have an annual household income of $20,000 or below, which is slightly less when compared to Los Angeles County (25.1%) (California Health Interview Survey, 2009).

Annual Household Income, 2009



Source: California Health Interview Survey, 2009
Source Geography: SPA (data not available at the zip code level)

Poverty

Poverty level in the CVHP service area, for the most part, is higher when compared to Los Angeles County. The population in the CVHP service area living below 100% of the Federal Poverty Level (FPL) is smaller (12.0%) when compared to Los Angeles County (15.7%). Similarly, a slightly smaller portion of the population in the CVHP service area is living below 200% of the FPL (33.7%) than in Los Angeles County (37.6%). More children in the CVHP service area (16.6%) live below 100% of the FPL when compared to Los Angeles County (22.4%).

Poverty Level, 2010

	CVHP service area	Los Angeles County
Population living below 100% of the Federal Poverty Level	12.0%	15.7%
Population living below 200% of the Federal Poverty Level	33.7%	37.6%
Children (0-17 years) living below 100% of the Federal Poverty Level	16.6%	22.4%

Data source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Source geography: Tract

In the past 12 months, a smaller portion (8.3%) of families is living in poverty in the CVHP service area when compared to Los Angeles County (12.6%). Larger portions of families are living in poverty in the cities of El Monte (18.3%), Baldwin Park (14.0%), and South El Monte (12.6%) when compared to Los Angeles County (12.6%). Of the population living in poverty in the last 12 months within the CVHP service area (10.5%), the largest portions lived in the cities of El Monte (20.7%), Azusa (17.4%), and Baldwin Park (15.9%) when compared to Los Angeles County (15.7%).

Poverty Level, 2010

	Families living in poverty in the past 12 months	Population living in poverty in the past 12 months
Azusa	12.0%	17.4%
Baldwin Park	14.0%	15.9%
Covina	8.0%	10.7%
Diamond Bar	3.0%	4.6%
El Monte	18.3%	20.7%
Glendora	3.5%	6.5%
Hacienda Heights	5.9%	7.7%
La Puente	10.3%	12.0%
La Verne	5.3%	6.8%
Rowland Heights	9.1%	10.5%
San Dimas	3.5%	5.4%
South El Monte	12.6%	15.6%
Walnut	4.1%	4.9%
West Covina	6.1%	8.7%
CVHP Service Area	8.3%	10.5%
Los Angeles County	12.6%	15.7%

Data source: American Community Survey 5-Year Estimates, 2010
Source geography: City

Homeless Persons

Of the homeless population in Los Angeles (n=45,422) County, 8.6% reside in the CVHP service area.

Homeless Persons, 2011

	#	%
CVHP service area	3,918	8.6%
Los Angeles County	45,422	100.0%

Data source: Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011
Source geography: SPA

Homeless Persons by Age

More than half of the homeless population in the CVHP service area is between the ages of 25 and 54 (60.6%), higher than Los Angeles County (57.4%). Another 12.1% are 62 years old and older in the CVHP service area and another 9.8% are between the ages of 55 and 61, followed by those under the age of 18 (9.3%). Finally, 8.2% of the population in the CVHP service area is between the ages of 18 and 24.

Homeless Persons by Age, 2011

Age group	CVHP service area	Los Angeles County
Under 18	9.3%	13.4%
18-24	8.2%	7.9%
25-54	60.6%	57.4%
55-61	9.8%	14.1%
62 and Older	12.1%	7.2%

Data source: Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011
Source geography: SPA

Employment Status

In 2012, the U.S. Bureau of Labor Statistics reported an unemployment rate of 10.2 in the CVHP service, slightly higher when compared to Los Angeles County (9.7) In 2010, the percent of the population who are unemployed (5.0%) in the CVHP service area slightly lower when compared to Los Angeles County (American Community Survey 5-Year Estimates, 2010).

Over a third of the population (36.4%) in the CVHP service area are not in the labor force, which is slightly higher when compared to Los Angeles County (34.8%) (American Community Survey 5-Year Estimates, 2010). However, over half (56.6%) of the population in the CVHP service area are employed.

Employment Status, 2010

	Employed	Unemployed	Armed Forces	Not in Labor Force
CVHP Service Area	56.6%	5.0%	0.0%	36.4%
Los Angeles County	59.5%	5.7%	0.1%	34.8%
California	58.5%	5.8%	0.5%	35.3%

Source: American Community Survey 5-Year Estimates, 2006-2010
Source Geography: SPA (data not available at the zip code level)

Medical Insurance

In CVHP service area 16.2% of the population doesn't have medical insurance compared to 17.0% of the population in Los Angeles County (California Health Interview Survey, 2009). The largest portion of the population living in CVHP service area including La Puente (22.8%), Baldwin Park (22.2%), and South El Monte (22.1%) doesn't have medical insurance. In addition 209,450 individuals in CVHP service area are eligible and enrolled in Medi-Cal, with the largest portions living in La Puente (39,965) and El Monte (38,460).

Insurance Status, 2009 and 2011

	Percent of population (0 to 64 years) without insurance[1]	Number of individuals who are eligible and enrolled Medi-Cal[2]
Azusa	21.1%	16,141
Baldwin Park	22.2%	26,130
Covina	15.9%	14,111
Diamond Bar	11.3%	3,508
El Monte	21.0%	38,460
Glendora	13.3%	5,674
Hacienda Heights	13.7%	8,049
La Puente	22.8%	39,965
La Verne	11.4%	3,252
Rowland Heights	12.0%	8,041
San Dimas	11.4%	3,310
South El Monte	22.1%	19,314
Walnut	11.6%	3,609
West Covina	17.5%	19,886
CVHP Service Area	16.2%	209,450
Los Angeles County	17.0%	2,444,850
California	14.5%	7,790,828

Source: California Health Interview Survey (CHIS), 2009[1], California Department of Health Care Services (DHCS), 2011[2]
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

Population without a Usual Source of Care

The portion of the population in the CVHP who do not have a usual source of care is smaller (15.0%) when compared to Los Angeles County (16.2%).

Population without a Usual Source of Care, 2009

	Percent
CVHP Service Area	15.0%
Los Angeles County	16.2%
California	14.2%

Source: California Health Interview Survey (CHIS), 2009
Source Geography: SPA (data not available at the zip code level)

Health Professional Shortage Areas

Only 4.4% (n=6) of facilities in Los Angeles County (n=137) that are designated as health professional shortage areas (HPSAs) are within the CVHP service area. Despite only 4.4% of HPSAs being within the CVHP service area, nearly half (48.9%) of the population live in a HPSA. Please refer to Section VII of the Community Health Needs Assessment report for a comprehensive list of community assets including facilities designated as health professional shortage areas.

Health Professional Shortage Areas, 2012

	CVHP service area	Los Angeles County
Facilities designated as health professional shortage areas	6	137
Population living in a health professional shortage area	48.9%	53.2%

Data source: U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012
Source geographic: HPSA

Federally Qualified Health Center (FQHC)

Only 2.9% (n=3) of Federally Qualified Health Centers in Los Angeles County (n=101) are located in the CVHP service area. Please refer to Section VII of the Community Health Needs Assessment report for a comprehensive list of community assets including federally qualified health centers.

Federally Qualified Health Center (FQHC), 2011

	CVHP service area	Los Angeles County
Number of federally qualified health centers	3	101

Data source: U.S. Health Resources and Services Administration, Centers for Medicare & Medicaid Services, Provider of Service File, 2011
Source geographic: Address

Chronic diseases in the CVHP service area

Diabetes Prevalence and Hospitalizations

Diabetes is a very common disease in the general population. In 2009, 19.2% of the population 45 years old and above in the CVHP service area were diagnosed with diabetes, compared to only 10.5% in Los Angeles County. The cities of La Puente (26.0%), South El Monte (24.8), and Baldwin Park (24.5%) a quarter of the population 45 years and over were diagnosed with diabetes. In addition, the rate of hospitalizations resulting from uncontrolled diabetes per 100,000 population in the CVHP service area was 12.7, higher when compared to the state (9.5). The cities of South El Monte (26.8), El Monte (26.2), and La Puente (23.1) had the highest rates of hospitalizations due to uncontrolled diabetes.

Diabetes Prevalence, 2009 and 2010

	Percent Diagnosed with Diabetes (Adults age 45 and over)[1]	Number of Hospitalizations for Uncontrolled Diabetes[2]	Rate of Hospitalizations for Uncontrolled Diabetes (per 100,000 pop.)[2]
Azusa	22.5%	7	11.3
Baldwin Park	24.5%	12	14.9
Covina	17.6%	1	3.7
Diamond Bar	15.6%	4	8.0
El Monte	23.5%	27	26.2
Glendora	15.3%	5	9.6
Hacienda Heights	17.4%	4	7.0
La Puente	26.0%	24	23.1
La Verne	14.0%	5	14.0
Rowland Heights	16.8%	3	6.1
San Dimas	14.1%	4	11.4
South El Monte	24.8%	13	26.8
Walnut	16.1%	1	2.0
West Covina	20.0%	15	13.5
CVHP Service Area	19.2%	125	12.7
Los Angeles County	10.5%	No data	No data
California	8.5%	3,581	9.5

Source: California Health Interview Survey (CHIS), 2009[1], Office of Statewide Health and Planning and Development (OSHPD), 2010[2]
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)[2]

Adults in the CVHP service area experience more diabetes-related hospitalizations per 100,000 population (147.4) compared to youth (26.8). Specifically, in South El Monte where the rate of adults experience nearly double the rate (289.3) of California (145.6) and the CVHP service area (147.4) of diabetes-related hospitalizations. El Monte (211.8) and La Puente (194.7) also experienced some of the highest rates of diabetes-related hospitalizations by adults. As far as youth, Glendora (66.5) has twice the rate of diabetes-related hospitalizations when to the CVHP

service area (26.8) and California (34.9). The cities of Azusa (49.0), El Monte (42.3), Hacienda Heights (42.2), and La Puente (40.0) also experienced higher rates of diabetes-related hospitalizations of youth.

Diabetes Hospitalizations, 2010

	Number of Hospitalizations (adults)	Number of Hospitalizations (Youth-under 18)	Hospitalization Rate for Adults (per 100,000 pop.)	Hospitalization Rate for Youth (per 100,000 pop.)
Azusa	108	8	180.9	49.0
Baldwin Park	139	3	181.5	13.1
Covina	65	3	147.3	26.6
Diamond Bar	26	0	56.0	0.0
El Monte	203	10	211.8	42.3
Glendora	56	4	109.7	66.5
Hacienda Heights	68	5	125.9	42.2
La Puente	239	10	194.7	40.0
La Verne	42	0	126.3	0.0
Rowland Heights	40	3	88.1	32.1
San Dimas	46	1	138.9	14.4
South El Monte	127	4	289.3	30.2
Walnut	33	0	76.6	0.0
West Covina	153	5	137.0	19.3
CVHP Service Area	1,345	56	147.4	26.8
Los Angeles County	No data	No data	No data	No data
California	54,244	3,247	145.6	34.9

Source: Office of Statewide Health Planning and Development (OSHPD), 2010
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

Cardiovascular Disease Prevalence

The prevalence of cardiovascular disease (also referred to as heart disease) in the CVHP service area is comparable to Los Angeles County (5.8%).

Cardiovascular Disease Prevalence, 2009

	Percent Diagnosed with Heart Disease	Health Professional Provided Heart Disease Management Plan
CVHP Area	5.8%	75.1%
Los Angeles County	5.8%	65.5%
California	5.9%	70.9%

Source: California Health Interview Survey (CHIS), 2009
Source Geography: SPA data not available at the zip code level)

The rate of heart disease-related hospitalizations per 100,000 population is higher in the CVHP service area (367.9) when compared to California (367.1). Specifically, San Dimas (507.3) had the highest rates of heart disease-related hospitalizations. Also, three quarters (75.1%) of the population had a heart disease management plan, higher than Los Angeles County (65.5%). The heart disease mortality rate in the CVHP service area (14.4) is lower when compared to California (15.6). However, a large number of cities within the CVHP service area had higher

mortality rates than California (15.6) including San Dimas (22.7), La Verne (21.7), and Glendora (20.7).

Cardiovascular Disease Prevalence, 2009 and 2010

	Hospitalization Rate (per 100,000 pop.)	Death Rate for Heart Disease (per 10,000 pop.)
Azusa	323.3	10.4
Baldwin Park	342.2	10.5
Covina	419.2	18.4
Diamond Bar	318.6	13.4
El Monte	379.4	13.9
Glendora	408.4	20.7
Hacienda Heights	405.5	13.7
La Puente	402.5	11.0
La Verne	357.9	21.7
Rowland Heights	303.9	10.8
San Dimas	507.3	22.7
South El Monte	382.0	8.0
Walnut	257.7	10.2
West Covina	343.0	15.9
CVHP Service Area	367.9	14.4
California	367.1	15.6

Source: Office of Statewide Health and Planning and Development (OSHPD), 2010
Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

Cervical Cancer

The portion of women who received a pap smear in the last 3 years and resided in the CVHP service area (84.9%) did not meet the Healthy People 2020 benchmark of >=93% but was slightly higher when compared to Los Angeles County (84.4%).

Cervical Cancer , 2007

	Received Pap smear in the last 3 years
CVHP Service Area	84.9%
Los Angeles County	84.4%
Healthy People 2020	>=93%

Source: Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2007[2]
Source Geography: SPA (data not available at the zip code level)

The morality rate for cervical cancer per 100,000 population was slightly lower (2.2) in the CVHP service area when compared to Los Angeles County and meet Healthy People 2020 benchmark of <=2.2. In the CVHP service area, Diamond Bar had nearly three times the rate (8.0) than Los Angeles County (3.0) and the overall CVHP service area rate (2.2).

Cervical Cancer, 2008

	Death Rate (age-adjusted per 100,000 pop.)

Azusa	0.0
Baldwin Park	2.3
Covina	0.0
Diamond Bar	8.0
El Monte	3.0
Glendora	0.0
Hacienda Heights	0.0
La Puente	4.3
La Verne	0.0
Rowland Heights	3.9
San Dimas	0.0
South El Monte	0.0
Walnut	3.6
West Covina	5.2
CVHP Service Area	2.2
Los Angeles County	3.0
California	2.3
HP 2020	<=2.2

Source: California Department of Public Health, Death Statistical Master File, 2008
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)
** if <20 deaths a reliable rate cannot be calculated

Colorectal Cancer

The portion of men over the age of 50 who had a sigmoidoscopy or colonoscopy was on average much lower (28.3%) in the CVHP service area when compared to Los Angeles County (75.7%) and the Healthy People 2020 benchmark of >=70.5%. Men over the age of 50 who had the same tests done in the last five years was higher (51.5%) in CVHP service area when compared to Los Angeles County (65.5%) but did not meet the Healthy People 2020 benchmark >=70.5%.

Colorectal Cancer Incidence, 2009

	Percent of Adults ages 50 or older ever having a sigmoidoscopy, colonoscopy or FOBT	Percent of Adults ages 50 or older who had a sigmoidoscopy or colonoscopy in the last 5 years
CVHP Service Area	28.3%	61.5%
Los Angeles County	75.7%	65.5%
California	78.0%	68.1%
HP 2020	>=70.5%	>=70.5%

Source: California Health Interview Surveys, 2009
Source Geography: SPA data not available at the zip code level)

The mortality rate of colorectal cancer per 100,000 population is on average lower in the CVHP service area (7.7) when compared to Los Angeles County (11.2). It is nearly double the Los Angeles County rate (11.2) and the CVHP service area rate (7.7) in Glendora (18.9).

Colorectal Cancer Incidence, 2008

	Death Rate (age-adjusted per 100,000 pop.)
Azusa	11.2
Baldwin Park	4.7
Covina	7.9
Diamond Bar	8.2
El Monte	5.2
Glendora	18.9
Hacienda Heights	7.0
La Puente	0.0
La Verne	9.0
Rowland Heights	9.9
San Dimas	5.8
South El Monte	0.0
Walnut	9.2
West Covina	10.3
CVHP Service Area	7.7
Los Angeles County	11.2
California	11.1

Source: California Department of Public Health, Death Statistical Master File, 2008
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

Mental Health

Mental health-related hospitalization rates for per 100,000 adults in the CVHP service area is higher (657.0) than that of California (551.7). The rate of mental health-related hospitalizations per 100.000 youth under the age of 18 is higher for the CVHP service area (375.4) when compared to California (256.4).

Mental Health, 2010

	Hospitalizations (adult)	Hospitalizations (youth under 18)	Hospitalization Rate (adult)	Hospitalization Rate (youth under 18)
CVHP Service Area	3,312	388	657.0	375.4
California	205,526	28,836	551.7	256.4

Source: Office of Statewide Health Planning and Development (OSHPD), 2010
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

In addition, the rate of alcohol or drug induced mental disease hospitalizations is higher in the CVHP service area (115.9) when compared to California (109.1). Alcohol and drug induced hospitalization rate per 100,000 persons are nearly double that of California (109.1) in the community of Covina (197.0).

Mental Health, 2010

	Alcohol/Drug Induced Mental Disease Hospitalization Rate
CVHP Service Area	91.4

California	109.1

Source: Office of Statewide Health Planning and Development (OSHPD), 2010
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

The portion of the population in the CVHP service area who had a serious psychological distress event was higher (8.8%) when compared to Los Angeles count (7.3%). In addition, over half (51.4%) of the population in the CVHP service area has needed help for mental, emotional, or alcohol-drug issues and have received it, higher when compared to those in Los Angeles County (47.3%).

Mental Health, 2009

	Likely had serious psychological distress in past year		Needed help for mental/emotional/alcohol-drug issues but did not receive treatment	
	#	%	#	%
CVHP Service Area	85,000	8.8%	88,000	51.4%
Los Angeles County	541,000	7.3%	495,000	47.3%
California	1,785,000	6.5%	1,741,000	44.5%

Source: California Health Interview Surveys, 2009
Source Geography: SPA (data not available at the zip code level)

Obesity/Overweight

Nearly a third (28.8%) of the population in the CVHP service area is overweight with a BMI or Body Mass Index between 26 and 29. Another 20.0% are considered obese with a BMI of 30 and above. The largest portion of the population in the CVHP service area who are overweight live in La Verne (30.5%), and San Dimas (30.3%). La Puente (26.0%), Baldwin Park (24.9%), and Azusa (24.5%) have a quarter or more of their population who are obese.

Obesity/Overweight, 2009

	Percent Overweight (BMI 26-29)	Percent Obese (BMI <=30)
Azusa	28.5%	24.5%
Baldwin Park	28.8%	24.9%
Covina	29.5%	21.8%
Diamond Bar	28.1%	14.5%
El Monte	27.8%	22.3%
Glendora	28.8%	20.6%
Hacienda Heights	29.2%	16.8%
La Puente	29.4%	26.0%
La Verne	30.5%	19.5%
Rowland Heights	27.4%	13.2%
San Dimas	30.3%	19.2%
South El Monte	28.5%	23.7%
Walnut	27.5%	13.3%
West Covina	28.3%	20.4%
CVHP Service Area	28.8%	20.0%
Los Angeles County	29.7%	21.2%
California	31.5%	21.1%

Source: California Health Interview Survey (CHIS), 2009
Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

In the CVHP service area nearly a quarter (21.4%) of adults are obese, and another third (36.4%) are overweight. In addition, a third (30.6%) of youth is obese and another 15.1% are overweight.

Obesity/Overweight, 2009

	Percent of adults who are obese	Percent of youth who are obese	Percent of adults who are overweight	Percent of youth who are overweight
CVHP Service Area	21.4%	30.6%	36.4%	15.1%
Los Angeles County	21.4%	29.8%	26.4%	14.3%

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Source Geography: County

IV. Who Was Involved In The Assessment

a. The Center for Nonprofit Management Team

The Center for Nonprofit Management (CNM) Evaluation Consulting team conducted the 2013 Community Health Needs Assessment for Citrus Valley Medical Center and three Kaiser Foundation Hospitals, also known as the East Metro West Collaborative. CNM is the leading management assistance organization in Southern California, providing training, technical assistance, capacity-building resources and services, and customized counsel to the nonprofit sector since 1979.

The principal members of the CNM evaluation team—Dr. Maura Harrington and Ms. Jessica Vallejo—have extensive experience with SB 697 community health needs assessments and public health data. The team was involved in conducting the 2004, 2007, and 2010 CHNAs for the Metro Hospital Collaborative (California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital Los Angeles, QueensCare, and St. Vincent Medical Center) and has participated in other CHNAs in the region. Dr. Harrington has worked on projects with the Pasadena Public Health Department and California Wellness Foundation and many other health-related projects. The CNM team has extensive experience with a broad range of evaluation projects involving qualitative and quantitative data collection and analysis and the preparation of reports and documentation appropriate for diverse audiences and constituencies.

b. East Metro West Collaborative

The Collaborative includes the following partners:

Citrus Valley Health Partners (non-Kaiser Permanente)
Maria Peacock, Community Benefit Department

Kaiser Foundation Hospital–Baldwin Park (KFH-BP)
Gloria R. Bañuelos, Community Benefit Manager

Kaiser Foundation Hospital–Los Angeles (KFH-LA)
Mario P. Ceballos, Community Benefit Manager

Kaiser Foundation Hospital–West Los Angeles (KFH-WLA)
Celia A. Brugman, Community Benefit Manager

East

Citrus Valley Health Partners

Citrus Valley Health Partners, through its three hospital campuses (Citrus Valley Medical Center—Inter-Community Campus in Covina; Citrus Valley Medical Center—Queen of the Valley Campus in West Covina; and Foothill Presbyterian Hospital in Glendora) and hospice (Citrus

Valley Hospice in West Covina), serves a community of nearly one million people in the San Gabriel Valley. Its mission is lived through the work of its 3,000+ staff members and nearly 1,000 physicians. Each hospital campus offers different areas of specialty, including cardiac care, family-centered maternity services, a Level IIIB Newborn Intensive Care Unit (NICU), the Geleris Family Cancer Center, a Robotic Surgery Program, a full range of rehabilitation services, and an Outpatient Diabetes Education Program. Citrus Valley Hospice has an extensive home care program as well as a 10-bed inpatient hospice facility. Associated with Hospice, Citrus Valley Home Health provides physician-supervised nursing and rehabilitation care to individuals recovering at home from accidents, surgery, or illness.

Kaiser Foundation Hospital–Baldwin Park

Kaiser Foundation Hospital–Baldwin Park (KFH-BP) is a 272 licensed-bed hospital offering comprehensive services including primary care and specialty services. KFH-BP serves 246,000 members in the San Gabriel Valley through a network of more than 3,300 employees and 498 physicians at its medical center campus, four outlying medical office buildings, a behavioral and addiction medicine facility, and three retail Vision Essentials offices.

KFH-BP's service area includes the Southern California communities of Azusa, Baldwin Park, Covina, Diamond Bar, El Monte, Glendora, Hacienda Heights, Irwindale, Industry, La Puente, Montebello, Rosemead, Rowland Heights, San Dimas, San Gabriel, South El Monte, Valinda, Walnut, and West Covina.

Metro

Kaiser Foundation Hospital–Los Angeles

The Kaiser Foundation Hospital–Los Angeles (KFH-LA) is Kaiser Permanente's tertiary center of excellence in Southern California. KFH-LA offers a wide range of specialty care services, featuring 39 Centers of Excellence—including complex neurosurgery, pediatrics, comprehensive cancer care—and has the largest cardiac surgery program in the western United States. KFH-LA is also a medical learning institution where highly trained doctors mentor and teach new generations of physicians and caregivers. KFH-LA is home to The Center for Medical Education (CME) which includes an extensive graduate medical education program with more than 250 interns, residents, and fellows in 22 different specialties and subspecialties. KFH-LA currently hosts approximately 300 active medical research projects across a range of disciplines. More than 750,000 patients visit KFH-LA a year. For more information, visit www.kp.org/losangeles.

The KFH-Los Angeles service area includes the communities of Alhambra, Altadena, Arcadia, Burbank, Glendale, La Cãnada Flintridge, La Crescenta, Los Angeles (primarily SPA 4), Monrovia, Monterey Park, Montrose, Pasadena, San Gabriel, San Marino, Sierra Madre, South Pasadena, and West Hollywood (East). City of Los Angeles neighborhoods include Atwater Village, Boyle Heights, Chinatown, City Terrace, Downtown Los Angeles, Eagle Rock, East Los Angeles, Echo Park, El Sereno, Glassell Park, Hancock Park, Highland Park, Hollywood, Hollywood Hills, Laurel Canyon, Los Feliz, Montecito Heights, and Silverlake.

West

Kaiser Foundation Hospital–West Los Angeles

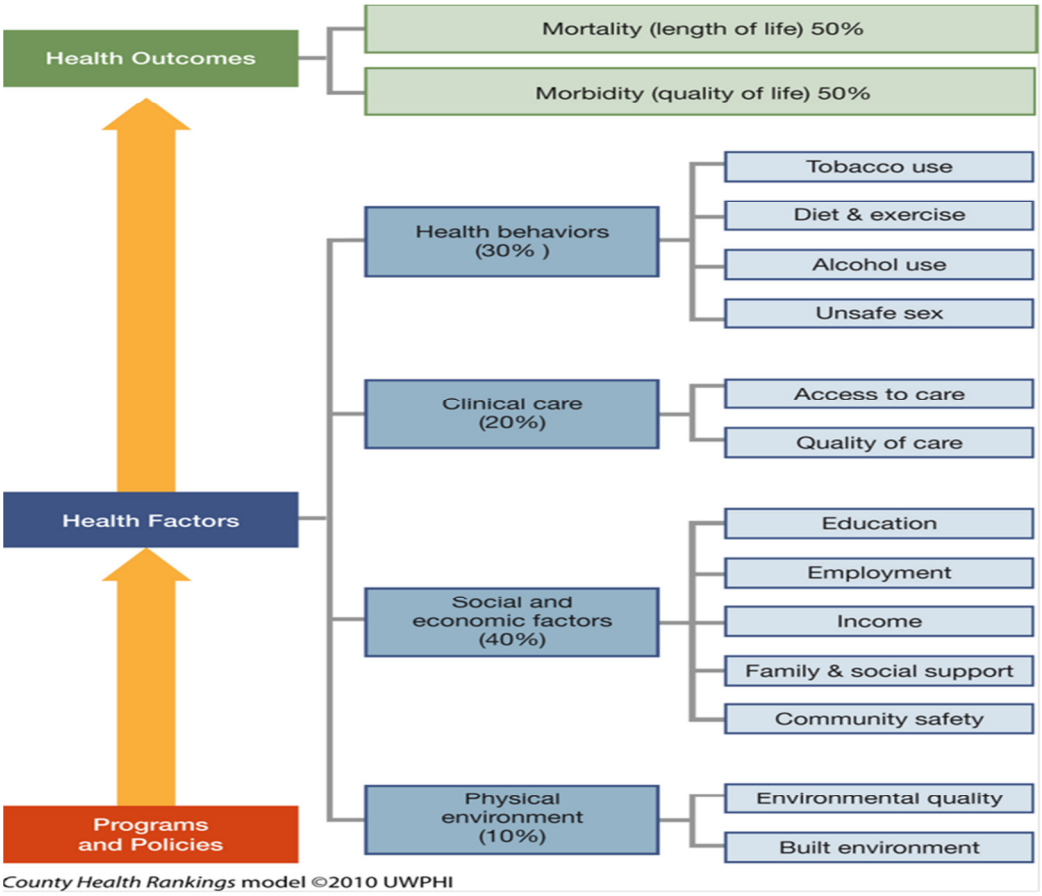
Kaiser Foundation Hospital–West Los Angeles (KFH-WLA) is a 305 licensed-bed hospital offering comprehensive services including primary care and specialty services. KFH-WLA serves 189,013 members and has a staff of 2,916 employees and 517 physicians. Four outlying medical offices, two retail Vision Service offices, and a Health Education Center expand KFH-WLA services throughout the West Los Angeles service area—in Playa Vista, Culver Marina, Inglewood, and South Los Angeles. KFH-WLA is home to six award-wining centers of expertise that provide innovative treatments and surgical procedures.

The WLA Service Area includes the cities of Beverly Hills, Culver City, El Segundo, Inglewood, Malibu, Santa Monica, West Hollywood, and the City of Los Angeles, including the communities of Baldwin Hills, Cheviot Hills, Crenshaw, Hyde Park, Jefferson Park, La Tijera, Leimert Park, Mar Vista, Mid City, Miracle Mile, Ocean Park, Pacific Palisades, Palms, Playa Del Rey, Rancho Park, Rimpau, University Park, Venice, Vermont Knolls, West Adams, Westchester, Westwood, Wilshire, and unincorporated areas such as Ladera Heights, Lennox, Marina del Rey, View Park, Westmont, and Windsor Hills, among others.

V. Process and Methods Used to Conduct the CHNA

a. Secondary data

Secondary data were collected from a wide range of local, county and state sources to present demographics, mortality, morbidity, health behaviors, clinical care, social and economic factors and physical environment. These categories are based on the Mobilizing Action Toward Community Health (MATCH) framework which illustrates the inter-relationships among the elements of health, and their relationship to each other: social and economic factors, health behaviors, clinical care, physical environmental, and health outcomes.



To promote consistency across the organization, Kaiser Permanente identified a minimum set of required indicators for each of the data categories to be used by all Kaiser Permanente Regions for the Community Health Needs Assessments. Kaiser Permanente partnered with the Center for Applied Research and Environmental Systems (CARES) at the University of Missouri to develop a web-based data platform to provide the common indicators across service areas. The secondary data for this report was obtained from the Kaiser Permanente CHNA data platform

from October 2012 through February 2013. The data platform is undergoing continual enhancements and certain data indicators may have been updated since the data were obtained for this report. As such, the most updated data may not be reflected in the tables, graphs, and/or maps provided in this report. For the most recent data and/or additional health data indicators, please visit CHNA.org/kp.

The Kaiser Permanente common indicator data were 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 are not entirely encompassed by a service area, the measure is aggregated proportionally. The options for weighting "small area estimations" are based upon total area, total population, and demographic-group population. The specific methodology for how service area rates are calculated for each indicator can be found on the CHNA.org/kp website.

Additional data sets were accessed to supplement the minimum required data sets. These data were selected from local sources that were not offered on the common indicators database. The data sets were accessed electronically and the data for the KFH – BP service area collected and documented in data tables. The tables present the data indicator, the geographical area the data represented, the data measurement (e.g. rate, number, percent), and the data source and year. When data from supplemental sources were available by ZIP code, the data from the ZIP codes of the service area were compiled for a medical service area indicator. For geographic comparisons across cities within the medical service area, if the source provided data by ZIP codes, then ZIP codes were aggregated to calculate medical service area rates in respective cities; when the data were not available by ZIP code, then the data for the entire city was utilized.

Secondary data for CVHP were downloaded from the Kaiser Permanente CHNA data platform as well as from the supplementary resources, and were input into tables to be included in the analysis. Data are presented based on the data source and geographic level of available data. When possible, these data are presented in the context of larger geographies such as county or state for comparison.

To allow for a comprehensive analysis across data sources, and to assist with the identification of a health need, a matrix (Appendix D: CVHP Scorecard) was created listing all identified secondary indicators and primary issues in one location. The matrix included medical center–level secondary data (averaged), primary data counts (number of times an issue was mentioned) for both interviews and focus groups and sub-populations noted as most severely impacted. The matrix also included benchmark data in the form of Healthy People 2020 (HP2020) benchmarks which are nationally recognized when the indicator matched the data on hand. If, however, an appropriate HP2020 indicator was not available, then the most recent county or state data source was used as a comparison.

Each data indicator for the medical service area was first compared to the HP2020 benchmark if available and then to the geographic level for benchmark data to assess whether the medical center area performance was better or worse than the benchmark. When more than one source (from the primary or secondary data) identified an issue, the issue was designated as a health need or driver.

Two additional steps of analysis were conducted. The first reviewed data in smaller relevant geographies, repeating the process described above to identify areas in which needs were more acute. In the second step, the previous Community Health Needs Assessment was reviewed to identify trends and ensure that a previously identified need had not been overlooked.

b. Community input

Information and opinions were gathered directly from persons who represent the broad interests of the community served by CVHP. Between September and December 2012, the consultants conducted nineteen interviews and convened five focus groups with a broad range of community stakeholders, including area residents. The purpose for the primary data collection component of the Community Health Needs Assessment was to identify broad health needs and key drivers, as well as assets and gaps in resources, through the perceptions and knowledge of varied and multiple stakeholders.

Interview and focus group candidates were selected with the assistance of the CVHP Community Benefit Manager and recommendations from other key informants, and included representation from a range of health and social service providers and other community based organizations and agencies as well as community residents.

The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each; the conversations were confidential and interviewers adhered to standard ethical research guidelines. The interview protocol was designed to collect reliable and representative information about health and other needs and challenges faced by the community, access and utilization of health care services, and other relevant topics.

Focus groups took place in a range of locations throughout the service area, with translation and interpretation services provided when appropriate. Focus group sessions were 60 to 90 minutes each. As with the interviews, the focus group topics also were designed to collect representative information about health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic disease management and other community issues. Participants included groups that the hospital identified as prioritized stakeholders for the needs assessment including residents from major ethnic groups, geographic areas and service providers in the service area. Ethnic groups represented included residents from the Latino community. Interpretation services were provided in Spanish. Two focus groups of individuals representing the geography of San Gabriel Valley were engaged as were three focus groups that included representatives of community agencies and service providers who interact with residents on issues related to health care.

The stakeholders engaged through the five focus groups and nineteen interviews represent a broad range of individuals from the community, including health care professionals, government officials, social service providers, local residents, leaders, and other relevant community representatives, as per the IRS requirement. The charts below demonstrate this broad diversity, highlighting the expertise/perspective, key categories and geographies represented by the participants in interviews and focus groups. Please see Appendix E for a summary of the interview responses and Appendix F for a summary of the stakeholder focus group responses. (See Appendix G for data collection tools and instruments used in primary data collection.)

Individuals with special knowledge of or expertise in public health

	Name	Title	Affiliation	Description of health knowledge/expertise	Date of Consult	Type of Consult
1.	Prentice, Cheryl	CEO	La Casa de San Gabriel Community Center	Early childhood development and education and serving low-income families	10/12/12	Interview
2.	Brehm, Connie	President, Board of Directors	East San Gabriel Valley Coalition for the Homeless	Community health, nursing, homeless population	9/26/12	Interview
3.	Munoz, Randy	Vice Chair	Latino Diabetes Association	Diabetes, preventative medicine, low-income, undocumented and un/underinsured	10/22/12	Interview
4.	Ballesteros, Al	CEO	JWCH Institute (John Wesley Community Health)	FQHC, primary care, mental health care for homeless and dual diagnosis, HIV services	10/19/12	Interview
5.	Marin, Maribel	Los Angeles Executive Director	211 LA County	Information and referral service agency for LA County	10/15/12	Interview
6.	Cox, Debra	Senior Director Foundation Relations	American Heart Association	Health equity, research and funding	10/5/12	Interview
7.	Donovan, Kevin	Staff Analyst	LA County Dept. of Public Health, Maternal,	Maternal, child and adolescent health	10/2/12	Interview

Individuals with special knowledge of or expertise in public health

	Name	Title	Affiliation	Description of health knowledge/expertise	Date of Consult	Type of Consult
			Child and Adolescent Health Programs			
8.	Blakeney, Karen	Executive Director	Chinatown Service Center	Serving Asian Pacific Immigrant and Latino communities (family resource center, clinics, workforce development)	10/22/12	Interview
9.	Martinez, Margie	CEO	Community Health Alliance of Pasadena	Public health	10/22/12	Interview
11.	Kurtz, Cynthia	President and CEO	San Gabriel Valley Economic Partnership	City administration, economic development and urban planning	10/3/12	Interview
12.	Hernandez, Ed	Senator	California State Senate	Health Care Access, optometrist	10/18/12	Interview
13.	Inman, Fran	Senior Vice President, Corporate Development	Majestic Realty Corp	Marketing, public relations	10/1/12	Interview
14.	Wolf-Morran, Helen	CEO	Foothill Family Service	Human services leadership and administration	9/28/12	Interview
15.	Allen, Walt	Mayor Pro-Tem	City of Covina	Public Administration, Law enforcement	9/27/12	Interview
16.	Mardini, Alicia	CEO	East Valley Community Health Center	Leads three clinics and health services for low income and uninsured populations	10/1/12	Interview

Individuals with special knowledge of or expertise in public health

	Name	Title	Affiliation	Description of health knowledge/expertise	Date of Consult	Type of Consult
17.	Chen, Sally	Community Liaison	Rowland Heights Unified School District	Finding resources for families when they need help in food, shelter, information anything to sustain the child in the school	10/2/12	Interview
18.	Marcussen, Cliff	CEO	Options	Child development, early headstart, preschool and after school care, resources and referral	10/2/12	Interview

Individuals consulted from Federal, tribal, regional, State or local health departments or other departments or agencies with current data or other relevant information

	Name	Title	Affiliation	Type of Department	Date of Consult	Type of Consult
1.	Donovan , Kevin	Staff Analyst	LA County Dept. of Public Health, Maternal, Child and Adolescent Health Programs	Local Health Department	10/2/12	Interview
3.	Allen, Walt	Mayor Pro-Tem	City of Covina	Public Administration, Law enforcement	9/27/12	Interview
4.	Chen, Sally	Community Liaison	Rowland Heights Unified School District	Finding resources for families when they need help in food, shelter, information anything to sustain the child in the school	10/2/12	Interview
5.	Hernandez, Ed	Senator	California State Senate	Health Care Access, Optometrist	10/18/12	Interview

Leaders, representatives, or members of medically underserved person, low income persons, minority populations and populations with chronic disease needs

	Group Size	Description of Leadership, Representative, or Member Role	What Group(s) Do They Represent?	Date of Consult	Type of consult
1.	11 participants	Health Care Providers	Health access, children, youth and families, minority populations	10/2/12	Focus group
2.	12 participants	Social Service Providers	Social service providers serving low-income, minority, chronic disease populations, undocumented individuals, youth	10/2/12	Focus Group
3.	13 participants	Promotoras and Community Leaders	Minority populations, underserved, outreach	10/2/12	Focus Group
4.	7 participants	Education and Economic leaders	Education, management consulting, business associations, vocational programs, students, underserved adults, low-income	10/11/12	Focus Group
5.	6 participants	Residents and Clients	Latino, minority, and underserved populations	10/18/12	Focus Group

c. Data limitations and information gaps

The Kaiser Permanente common data set includes a robust set of nearly 100 secondary data indicators that, when taken together, enable an examination of the broad health needs within a community. However, there are some limitations with regard to this data, as is true with any secondary data. Some data were available only at a county level, making an assessment of health needs at a neighborhood level challenging. Moreover, disaggregated data for age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health issues within the community. At time, when stakeholders identified a health issue it may not have been reflected by the secondary data indictors. In addition, data are not always collected on an annual basis, meaning that some data are several years old. Lastly, the project timeframe did not allow for additional data collection or data requests to other sources.

The goal of primary data collection is to gather information from a broad, relevant selection of stakeholders, from government officials to health care professionals and service providers to community members. Given busy schedules, stakeholders were offered several different ways in which to participate. Again, given the project timeframe, focus groups and interviews were organized with relatively short lead time. In each medical center, the local community benefit manager actively participated in outreach through personalized invitations and reminders.

VI. Identification and Prioritization of Community's Health Needs

a. Identifying community health needs

For the purposes of the CHNA, Kaiser Permanente defines a health need as a poor health outcome and associated health driver(s) *or* a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need. Health needs arise from the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data. Please refer to Appendix A for additional definitions.

Primary data were analyzed, by service area, by inputting all interviews and focus groups into Microsoft Excel. The data were then reviewed using content analysis to identify themes and determine a comprehensive list of codes; the data were coded and the number of times an issue was identified was tallied. In addition, sub-populations mentioned as being most affected by a specific issue were noted.

Secondary data were input into tables to be included in the analysis. When possible, benchmark data were included (Healthy People 2020, Los Angeles County, or California). Each medical center agreed to use county levels as the benchmark, when available. However, if the data source was not available at the county level, state-level data was used.

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

After primary and secondary data were analyzed, a process was created in collaboration with the local medical center's Community Benefit Manager and the Kaiser Permanente Regional Office to analyze the identified needs into three levels or tiers, based on the amount of data indicating a need.

The identification of a community health need was conducted through a multi-tiered process, using results from primary and secondary data analysis. This tiered system serves to document the process of analyzing health issues identified by both primary and secondary data. The following criteria were used for the tiers:

- **Tier 1**: Health issues that were identified in secondary data as poorly performing against a benchmark (HP 2020, California state rates, or Los Angeles County rates) *or* mentioned once in either primary data source (focus group or interview).
- **Tier 2**: Health issues that were identified in secondary data as performing poorly against a benchmark (HP 2020, California state rates, or Los Angeles County rates) *or* received repeated mentions in either primary data source (focus group or interview).
- **Tier 3**: Health issues that were identified in secondary data as performing poorly against a benchmark (HP 2020, California state rates, or Los Angeles County rates) *and* received repeated mentions in primary data sources (focus group or interview).

Tier	Secondary Data: Poorly Performing Indicators	Or/And	Primary Data: Mentions
1	Single	Or	Single
2	Single	Or	Multiple
3	Single	And	Multiple

Upon application of the tiers, a number of observations were made by the CNM team. First, use of the most inclusive criteria (tier one) resulted in a very long list. Furthermore, the use of the most stringent criteria, requiring identification by both a quantitative indicator as well as a qualitative indicator, yielded what was regarded as too few needs and drivers—in one case, five needs and eight drivers. Thus, the decision was made to use tier two, identification by a quantitative indicator and/or qualitative indicator, for the list of needs used in the prioritization process.

After application of this process, the tier-two designation was determined as most appropriate, providing a stringent yet inclusive approach that would allow for a comprehensive list of 22 health needs and 18 drivers to be brought forth in the second phase or prioritization process for the CVHP service area. The results of the application of this tiered approach can be found in Appendix H.

Health Needs and Drivers Carried Into Prioritization Phase

Health Need	Health Driver
Alcohol and Substance Abuse	Awareness
Allergies	Cancer Screenings
Alzheimer's Disease	Dental Care Access
Arthritis	Education
Asthma	Employment
Cancer, in General	Family & Social Support
Cardiovascular Disease	Health Care Access
Cervical Cancer	Health Insurance
Chlamydia	Healthy Eating
Chronic Obstructive Pulmonary Disease	Homelessness

Health Need	Health Driver
Colorectal Cancer	Income
Diabetes	Language Barrier
Disability	Natural Environment
HIV/AIDS	Nutritional Access
Hypertension	Physical Activity
Infant Mortality	Preventive Care Services
Intentional Injury	Safety
Mental Health	Transportation
Obesity/Overweight	
Oral Health	
Unintentional Injury	
Vision	

Note: Presented in alphabetical order

A matrix (or scorecard) was created listing Tier 2 health needs and drivers (listed above) to be carried into the prioritization phase which included secondary and primary data related to the 22 health needs and 18 drivers. (See Appendix D) To allow for a comprehensive analysis, and to assist with the prioritization of health needs identified in Tier 2, the matrix lists health issues correlated with secondary data indicators and primary data results. For example, the secondary indicators for adult hospitalizations due to mental health and reported serious psychological distress as well as primary data results that identified specific mental health-related issues found in the community are grouped under 'mental health'.

This matrix included benchmark data from Healthy People 2020 (HP2020) benchmarks when the indicator matched the data on hand. If an appropriate HP2020 indicator was not available, the most recent county or state rate was used. The matrix also included medical center–level secondary data (averaged), primary data counts (number of times an issue was mentioned) for interviews and focus groups, and sub-populations noted as most severely impacted. Each data indicator for the medical center was first compared to the HP2020 benchmark, if available, and then to the geographic level for benchmark data to assess whether the medical center performance was better or worse than the benchmark. When the process identified an issue from more than one source (from primary or secondary data), the issue was designated as a health need or driver.

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

After a series of discussions about possible approaches, all medical centers in the collaborative agreed to use the same method for prioritization and selected the Simplex Method as a guide. A Simplex Method is the process in which input is gathered through a close-ended survey where respondents rate each health need and driver using a set of criterion. After surveys are completed, the surveys are scored for each health need and driver. The health needs and drivers are then ranked in order of highest priority. Preferences for the approach included:

- To be inclusive of stakeholders

- That the method involve a moderate amount of rigor but not with so much math/statistics as to be difficult to use and to communicate
- That the rigor be balanced by a relatively easy-to-use methodology

Community Forums

1. **Facilitated Group Discussion**. Community forums were designed to provide the opportunity for a range of stakeholders to engage in a discussion of the data and participate in the prioritization process. In order to provide stakeholders an opportunity to participate, two community forums were held in each medical center area. Community representatives (stakeholders) were invited to participate in one of the two forums, according to their availability. A maximum of two representatives from an organization were invited to participate, drawing a total of 66 participants. In addition, all individuals who were invited to take part in the primary data collection (Phase I: focus groups and interviews, irrespective of whether or not they actually participated in that phase) were invited to attend a community forum.

   Each forum included a brief presentation that provided an overview of the CHNA data collection and prioritization processes, and a review of the documents to be used in the facilitated discussion. Participants were provided with a list of identified health needs and drivers in the scorecard format, developed from the matrix described previously in this report, and a narrative document of brief summary descriptions of the identified health needs using data from secondary data sources noted in Appendix C. Participants then engaged in a facilitated group discussion about the findings as presented in the scorecard and the narrative document, and a prioritization of the identified health needs and drivers. Participants completed a group prioritization grid exercise to share back with the larger group and to be used as supplemental information for the implementation strategy phase.

   The following questions were addressed in the grid exercise:

   - Which health needs/drivers most severely impact the community (communities) you serve?
   - For which health needs/drivers are there the most community assets/gaps in resources?
   - What are the drivers that can be addressed?

   At the end of each forum participants were asked to complete a questionnaire and to rank each health need and drivers according to several criteria, as described below.

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

provides a description of the scale used for each criterion to rank each health issue and driver.

3. **Secondary ranking of health needs and drivers.** After completing the questionnaires, participants were given 10 sticker dots and asked to place five dots on the health needs and five dots on the health drivers—listed in alphabetical order on flipchart paper—placed in a designated area in the meeting space. Each sticker dot counted as one vote; participants were able to place the dots in any manner they wished. For example, a participant could place all five of their health-need dots on diabetes. These counts served as a way to validate questionnaire findings and to serve as additional information that may be carried into the implementation strategy phase.

Analysis of Survey Scores

After the community forums, the 59 completed questionnaires (the net completed questionnaires received from the 66 participants) were entered and analyzed using Microsoft Excel. Each participant's scores for each health need and driver by each criterion (severity, change over time, resources, and community's readiness to support) were totaled. Scores were then averaged using the criterion severity, change over time and shortage of resources, for a final overall score (or rating) for each health need and driver. (The "community readiness to support" criterion was not used in the calculation because this would better serve as supplementary information for the implementation strategy phase.) Health needs and drivers were sorted by each criterion, including overall average (or rating), and placed in a grid to allow each medical center to weigh the information by criterion or overall. Please see the tables on page 55-56 for more information.

The overall average was calculated by adding the total across severity (total possible score equals 4), change over time (total possible equals 4), and resources (total possible equals 4) for each survey (with a total possible score of 12). The total scores were divided by the total number of surveys for which data was provided, resulting in an overall average per health need.

Overall Averages by Health Need and Criteria Resulting from Prioritization Process, n=59

Health Need	Severe impact on the community	Gotten worse over time	Shortage of resources in the community	Community unable to address/support	Overall rating
1. Mental Health	3.67	3.53	3.29	2.56	**10.36**
2. Obesity/Overweight	3.75	3.53	3.02	2.84	**10.12**
3. Diabetes	3.64	3.52	2.73	2.91	**9.72**
4. Oral Health	3.42	3.15	3.16	2.73	**9.22**
5. Hypertension	3.33	3.24	2.57	2.67	**8.87**
6. Cardiovascular Disease	3.33	3.14	2.61	2.73	**8.74**
7. Cancer, in General	3.51	2.85	2.70	2.96	**8.71**
8. Vision	3.08	2.97	2.86	2.61	**8.42**
9. Colorectal Cancer	3.18	2.94	2.76	2.67	**8.38**
10. Disability	2.98	2.85	2.69	2.39	**8.22**
11. Intentional Injury	3.00	2.61	2.77	2.64	**8.15**
12. Alcohol and Substance Abuse	3.11	2.86	2.76	2.60	**8.02**
13. Cervical Cancer	3.23	2.94	2.72	2.60	**7.95**
14. Chlamydia	2.77	2.97	2.70	2.34	**7.76**
15. Asthma	2.77	2.81	2.60	2.73	**7.56**
16. Alzheimer's Disease	2.83	3.03	2.89	2.79	**7.55**
17. Unintentional Injury	2.68	2.68	2.56	2.86	**7.23**
18. Arthritis	2.58	2.74	2.66	2.72	**7.10**
19. Chronic Obstructive Pulmonary Disease (COPD)	2.66	3.04	2.57	2.38	**7.00**
20. HIV/AIDS	2.53	2.30	2.34	2.28	**6.73**
21. Allergies	2.33	2.77	2.56	2.44	**6.67**
22. Infant Mortality	2.24	2.12	2.26	2.62	**6.07**

Note: Health needs are in prioritized order. The overall rating was calculated by averaging the variables "severe impact on the community," "gotten worse over time," and "shortage of resources in the community."

Overall Averages by Driver and Criteria Resulting from Prioritization Process, n=59

Health Driver	Severe impact on the community	Gotten worse over time	Shortage of resources in the community	Community unable to address/support	Overall rating
1. Employment	3.78	3.41	3.22	2.91	**10.29**
2. Income	3.71	3.43	3.12	2.76	**10.00**
3. Homelessness	3.48	3.49	3.27	2.43	**9.58**
4. Health Insurance	3.64	3.19	2.94	2.85	**9.50**
5. Health Care Access	3.64	2.96	3.00	2.85	**9.39**
6. Awareness	3.53	3.04	2.96	2.80	**9.36**
7. Dental Care Access	3.42	3.17	2.94	2.71	**9.34**
8. Nutritional Access	3.43	3.00	3.00	2.73	**9.21**
9. Education	3.42	2.96	2.82	2.98	**9.16**
10. Healthy Eating	3.62	2.96	2.80	2.86	**9.09**
11. Physical Activity	3.37	2.93	2.81	2.72	**9.06**
12. Family and Social Support	3.36	3.02	2.94	2.74	**9.04**
13. Preventive Care Services	3.38	2.88	2.87	2.74	**8.85**
14. Language Barrier	3.24	2.85	2.76	2.57	**8.75**
15. Transportation	3.21	2.98	2.74	2.78	**8.56**
16. Cancer Screenings	3.16	2.68	2.70	2.80	**8.38**
17. Natural Environment	3.07	2.86	2.78	2.69	**8.22**
18. Safety	3.00	2.58	2.64	2.88	**7.84**

Note: Health drivers are in prioritized order. The overall rating was calculated by averaging the variables "severe impact on the community," "gotten worse over time," and "shortage of resources in the community."

c. Description of prioritized community health needs

The following list of 22 prioritized needs resulted from the above described process. Further details are included in Appendix B: CVHP Health Needs Profiles. See Appendix C for data source reference information.

1. Mental Health

Among adults, mental disorders are common, with approximately one quarter of adults being diagnosable for one or more disorders. Research shows that more than 90 percent of those who die by suicide suffer from depression or other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders). Not only are mental disorders associated with suicide, but also with chronic diseases, family history of mental illness, age, substance abuse, and life event stresses. In the CVHP service area, the mental health hospitalization rate of 375.4 per 100,000 for youth under 18 years of age is higher than the statewide rate of 256.4 per 100,000. The mental health hospitalization rate for adults in the CVHP service area is also higher

at 657.0 per 100,000 in contrast to the statewide rate of 551.7. The rate for individuals who needed help for mental, emotional, alcohol or drug issues but did not receive treatment in the CVHP service area was 51.4% compared to a slightly lower rate of 47.3% in Los Angeles County. Community stakeholders highlighted mental health as impacting youth, teens, adults ages 35 and older, the homeless and the uninsured. The highest mental health-related hospitalization rates for adults per 100,000 persons were in Covina (1,156.6) and Glendora (1,061.0) and for youth per 100,000 persons were in San Dimas (1,398.0) and La Verne (1,074.0). Suicide rates per 100,000 persons were highest in Glendora (2.4) and Hacienda Heights (1.5). More African-Americans (19.3%), Whites (17.8%) and Hispanics/Latinos (13.0%) suffer from poor mental health. Mental health is associated with other health factors including poverty, low birth rate, heavy alcohol consumption and unemployment. Mental health issues were identified by community stakeholders in four out of 19 interviews and three out of five focus groups. Mental health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

2. Obesity/Overweight

Obesity, a condition in which a person has an abnormally high and unhealthy proportion of body fat, has risen to epidemic levels in the United States. Nationally, 68 percent of U.S. adults age 20 years and older are overweight or obese. Obesity is defined as the percentage of adults ages 18 and older who self-report a Body Mass Index (BMI) greater than 30.0. In the CVHP service area, youth obesity is at 30.6%, higher than the statewide rate of 29.8% and the percentage of overweight youth is at 15.1%, higher that the statewide rate of 14.3%. There is a slightly higher percent of obese males (21.5%) than females (21.3%). More Hispanic youth are obese (35.2%) and overweight (15.9%). The cities where the largest percent of students are obese are South El Monte (44.6 to 45.3%), and Baldwin Park (40.7%), and the cities where the largest percent of students are overweight are La Puente (19.3%), and Hacienda Heights (19.3%). Obesity reduces life expectancy and increases the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. Obesity also increases the risks of cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types. A number of factors likely contribute to obesity, including genetics, physical inactivity, unhealthy diet and eating habits, lack of sleep, certain medications, age, social and economic issues, and medical problems. Obesity was identified in four of five focus groups and nine of 19 interviews and was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

3. Diabetes

Diabetes affects an estimated 23.6 million people in the United States and is the seventh leading cause of death. Diabetes also lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness. The rate of diabetes is higher in the CVHP service area (18.5%) than in Los Angeles County (10.5%). The diabetes hospitalization rate in the CVHP service area for adults is 147.4 adults per 100,000, modestly above the statewide rate of 145.6 per 100,000. The CVHP communities of Azusa, Baldwin Park, Covina, El Monte, La Puente and South El Monte are particularly affected by diabetes. Hospitalization rates for uncontrolled diabetes are also significant, with an average in the CVHP service area of 12.7 per 100,000 persons compared to a statewide average of 9.5. Nearly all communities had hospitalization rates higher than the state average with El Monte (26.2) and South El Monte (26.8) reflecting the highest contrasts. Those between the ages of 45 and 64 (1.5%) and those over the age of 65 (1.0%) experienced the most hospital incidents resulting from diabetes compared to other age groups. Drivers associated with diabetes include being overweight, high blood pressure, high cholesterol, high blood sugar (or glucose), physical inactivity, smoking, unhealthy eating, and age, race, gender, and having a family history of diabetes. Diabetes was identified as a major health issue in four out of 19 interviews and four out of five focus groups. Diabetes was also identified as a health need in the 2010 CVHP Community Health Needs Assessment.

4. Oral Health

Oral health is essential to overall health and is relevant because engaging in preventative behaviors decreases the likelihood of developing future health problems. In addition, oral diseases like cavities and oral cancer, cause pain and disability for many Americans. Oral health indicators include the percentage of adults ages 18 and older who self-report that six or more of their permanent teeth have been removed due to decay, gum disease or infection, an indication of lack of access to dental care and/or social barriers to utilization of dental services. Los Angeles County and the CVHP service area have the same rate of 11.6% adults with poor dental health, which is slightly higher than the statewide rate of 11.3%. The rate of children who have never seen a dentist in the CVHP service area is 11.9%, higher than the Los Angeles County rate of 10.5%. The portion of adults without dental insurance in the past year ranges between 37.1% and 70.0% throughout the CVHP service area and the largest portion are Hispanic/Latino (43.7%) and Asian/Pacific Islander (40.6%). Health behaviors that may lead to poor oral health include tobacco use, excessive alcohol use, and poor dietary choices. Social factors associated with poor dental health include lower levels or lack of academic education, poverty rates, having a disability and other health conditions such as diabetes. Oral health and dental care was identified by community stakeholders in all five focus groups and eleven out of 19 interviews, and highlighted new immigrants, adults and the aging as particularly impacted. Oral health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

5. Hypertension

Hypertension, defined as a blood pressure reading of 140/90 or higher, affects 1 in 3 adults in the United States. The condition has been called a silent killer as it has no symptoms or warning signs and can cause serious damage to the body. High blood pressure, if untreated, can lead to heart failure, blood vessel aneurysms, kidney failure, heart attack, stroke, and vision changes or blindness. The rate of adults diagnosed with high blood pressure was higher in the CVHP service area (30.2%) compared to Los Angeles County (25.5%). More (1.3) died of hypertension and hypertensive renal failure when compared to California (1.0). In particular, the cities of La Verne (3.0), San Dimas (2.7), Diamond Bar (1.5), Azusa (1.5), Covina (1.4), West Covina (1.4), Glendora (1.2), and La Puente (1.1). Associated drivers include smoking, obesity, eating salt and fat regularly, drinking excessively, and physical inactivity are risk factors for hypertension. As well, those who are at higher risk of developing hypertension are people who have had a stroke previously, have a high level of cholesterol, or have heart or kidney disease. Hypertension, indicated by high blood pressure, was identified as a health issue in three out of 19 interviews and one out of five focus groups. Hypertension was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

6. Cardiovascular Disease

Cardiovascular disease – also called heart disease and coronary heart disease – includes several problems related to plaque buildup in the walls of the arteries, or atherosclerosis. As the plaque builds up, the arteries narrow, restricting blood flow and creating a risk for a heart attack. Currently more than one in three adults (81.1 million) lives with one or more types of cardiovascular disease. The rates of heart disease in Los Angeles County and the CVHP service area are the same at 5.8%, and very close to the statewide rate of 5.9%. Those most often diagnosed with heart disease in this service area include White (8.2%) and Hispanic/Latino (5.1%) populations. Coronary heart disease is a leading cause of death in the United States, associated with high blood pressure, high cholesterol and heart attacks and also linked to other negative health outcomes including obesity, heavy alcohol consumption and diabetes. The heart disease hospitalization rate of 382.6 people per 100,000 is notable and particularly impacts populations in the communities of Covina, El Monte, Glendora, Hacienda Heights, La Puente, San Dimas, and South El Monte. The community of San Dimas is the most significantly impacted, with a hospitalization rate of 507.3 per 100,000. The cardiovascular disease mortality rate is highest in the southernmost part of Glendora, particularly in ZIP code 91740 (195.8). Stakeholders identified the homeless, aging, uninsured, and adults over the age 35 as the most severely impacted. Heart disease/coronary disease was identified as a major health issue in five of 19 interviews and one of five focus groups. Stroke was also raised as a concern in one of 19 interviews. Cardiovascular disease was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

7. Cancer, in General

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year. The rate of death due to cancer in the CVHP service area is 154.3 per 100,000 persons, which is slightly lower than the Los Angeles County rate of 156.5 per 100,000. Cancer mortality rates per 10,000 persons were highest in the cities of La Verne (23.2), San Dimas (21.7), Hacienda Heights (19.6), Glendora (18.4), Covina (16.9), and West Covina (16.5). The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight, certain chemicals, some viruses and bacteria, family history of cancer, poor diet, and lack of physical activity. Stakeholders identified adults over the age of 35 as the most severely impacted subgroup and identified the San Gabriel Valley as the most severely impacted area. Cancer was identified as a major health issue by community stakeholders in two out of 19 interviews and in one out of five focus groups. Though a leading cause of death in the United States, cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

8. Vision

People with diabetes are at an increased risk of vision problems as diabetes can damage the blood vessels of the eye, potentially leading to blindness. Diabetics are 40% more likely to suffer from glaucoma and 60% more likely to develop cataracts compared to people without diabetes. The percent of diabetic adults who had their vision checked within the last year was higher in the CVHP service area (65.7%) compared to Los Angeles County (63.3%). Vision care providers should expect to see more of these complications among a younger population as more young children and adolescents are being diagnosed with diabetes. Stakeholders agreed that vision was an issue and attributed it to the lack of available services. They added that vision is not isolated to any group but instead that it is widespread. There is a need for vision screenings, especially for children who experience difficulty in school because they cannot see well. Vision was identified as a major health issue in one out of 19 interviews and three out of five focus groups. Vision was not identified as a need in the 2010 CVHP Community Health Needs Assessment.

9. Colorectal Cancer

Colorectal cancer, defined as cancer that starts in the colon or the rectum, is the second leading cause of cancer-related deaths in the United States and is expected to cause about 50,830 deaths during 2013. The annual incidence rate of colon and rectum cancer in the CVHP service area is 45.2 individuals per 100,000, equivalent to the Los Angeles County rate. Both rates are above the statewide rate of 43.7 per 100,000 and the national rate of 40.2 per 100,000. The colon cancer mortality rate of 7.7 per 100,000 in the CVHP service area is below the Los Angeles County average of 11.2, however the community of Glendora (18.9) is notably higher than both the Los Angeles County (11.2) and CVHP service area (7.7) averages. African-Americans (59.9) have the highest colorectal cancer incidence rate compared to the other racial groups. The major factors that can increase the risk of colorectal cancer are aging and family history of colorectal cancer. Other less significant factors include a personal history of inflammatory bowel disease, inherited risk, heavy alcohol use, cigarette smoking, obesity, diabetes prevalence, and colon

cancer screening. Colon/rectum cancer was identified as a major health issue in one out of 19 interviews and one of five focus groups. This condition was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

10. Disability

Disability is an umbrella term for impairments, activity limitations, and participation restrictions. Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports). Disability statistics are based on the percentage of the total civilian non-institutionalized population with a disability. Disability rates in Los Angeles County and the CVHP service area are the same at 9.4%. Disabilities are associated with poor general health, education level and poverty. Stakeholders identified children as the most severely impacted and noted the increase in children diagnosed with autism and developmental delays including speech impediments. People with disabilities typically have less access to health care services and often do not have their health care needs met. In addition, they are likely not to engage in physical activity, and more likely to smoke, be overweight or obese, have high blood pressure, experience psychological distress, receive less social-emotional support, and have high unemployment rates. Disability, defined as developmental delays and/or as behavior issues, were identified in two out of 19 interviews and one of five focus groups with stakeholders highlighting youth with IEPs (Individualized Education Plans) as a particularly impacted population. Disabilities were not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

11. Intentional Injury (Homicide)

Intentional injuries and violence are widespread in society and are among the top 15 killers for Americans of all ages. Intentional injury is defined as homicide or suicide; homicide is a measure of community safety and a leading cause of premature death. The homicide rate for the CVHP service area is 6.1 per 100,000 persons; lower than the Los Angeles County rate of 8.4 per 100,000. Both rates are above the statewide rate of 5.2. Rates are notably higher in the communities of West Covina (17.8), Covina (15.7), and La Puente (10.1). Intentional injuries are associated with several health factors and high-risk behaviors including alcohol use, risk-taking, social and physical environments that are unsafe and violent, as well as economic factors such as poverty and unemployment. Stakeholders identified teens as being the most impacted. Stakeholders identified homicide as a health need in one of 19 interviews and one of five focus groups. Intentional injury was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

12. Alcohol & Substance Abuse

The effects of substance abuse significantly contribute to costly social, physical, mental, and public health problems including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle crashes (unintentional injuries), physical fights, crime, homicide, and

suicide. Alcohol and Substance Abuse is defined as adults (age 18 and older) who self-report heavy alcohol consumption. The alcohol/drug-induced hospitalization rate of 91.4 per 100,000 persons in the CVHP service area is lower than the state average of 109.1 per 100,000. However, the alcohol/drug-induced hospitalization rate is higher in Covina (159.5), Glendora (129.2), La Verne (123.3), San Dimas (120.8), and La Puente (109.8). Alcohol and substance is linked to poor mental health, HIV/AIDS, and poor physical health. Stakeholders indicated that the homeless and adults over the age of 35 are most impacted. Alcoholism was identified as a major concern in four out of 19 interviews and in one out of five focus groups. Alcohol and substance abuse was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

13. Cervical Cancer

Cervical cancer is a disease in which cells in the cervix - the lower, narrow end of the uterus connected to the vagina (the birth canal) to the upper part of the uterus - grow out of control. All women are at risk for cervical cancer and it occurs most often in women over the age of 30. The human papillomavirus (HPV), a common virus that is passed from one person to another during sex, is the main cause of cervical cancer. The annual rate of cervical cancer is the same in Los Angeles County and in the CVHP service area, at 9.9 individuals per 100,000 people, higher than the statewide rate of 8.30 per 100,000 and the national rate of 8 per 100,000. Over one-third of the communities in the CVHP service area have cervical cancer mortality rates above Los Angeles County (3.0) and the CVHP service area (2.2) average, including Diamond Bar (8.0), West Covina (5.2), La Puente (4.3), Rowland Heights (3.9), and Walnut (3.6). Within the CVHP service area, cervical cancer related hospital discharge rates are higher among the Hispanic/Latino population (13.2). Cervical cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

14. Chlamydia

Chlamydia is the most frequently reported bacterial sexually transmitted infection in the United States. Chlamydial infections can lead to serious health problems. In women, untreated infection can cause pelvic inflammatory disease (PID), permanently damage a woman's reproductive tract and lead to long-term pelvic pain, inability to get pregnant and potentially deadly ectopic pregnancy. In men, infection sometimes spreads to the tube that carries sperm from the testis, causing pain, fever, and, rarely, preventing a man from being able to father children. Untreated Chlamydia may increase a person's chances of acquiring or transmitting HIV. The CVHP service area rate (476.3) of Chlamydia per 100,000 people is comparable to the Los Angeles County average according to 2009 data. Chlamydia is a measure of poor health status and associated with numerous other health factors including poverty, heavy alcohol consumption, unsafe sex practices and age (young people are at a higher risk of acquiring Chlamydia). Chlamydia was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

15. Asthma

Asthma is a disease that affects the lungs and is one of the most common long-term diseases of children. Adults also may suffer from asthma and the condition is considered hereditary. Asthma symptoms include wheezing, breathlessness, chest tightness, and coughing. The prevalence of asthma for adults in Los Angeles County and in the CVHP service area is the same at 11.1%. While the average adult asthma hospitalization rate per 100,000 persons in the CVHP service area (89.2) is lower than the statewide average (94.3), it is very high in South El Monte (198.2) and El Monte (171.7) and is also high in Baldwin Park, La Puente, West Covina and Rowland Heights. The asthma hospitalization rate for youth in the CVHP service area is higher with 20.8 youth per 1000 compared to a statewide average of 19.2 youth per 1000. Some asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroach allergens, pet dander, mold, and certain infections known to cause asthma such as the flu, colds, and respiratory related viruses. Other contributing factors include exercising, certain medication, bad weather, high humidity, cold/dry air, certain foods and fragrances. Within the CVHP service area, individuals between the ages of 1 and 19 (4.6%) experienced the most asthma related hospital discharges. Stakeholders indicated that asthma and respiratory illness were on the rise and attributed the prevalence to the inability of people to control their respiratory conditions. Asthma was mentioned as a major health issue in one out of five focus groups and five out of 19 interviews. Community stakeholders highlighted youth and individuals over the age of 35 as particularly affected populations. Asthma was not identified as a key health need in the 2010 CVHP Community Health Needs Assessment.

16. Alzheimer's Disease

An estimated 5.4 million Americans have Alzheimer's disease and it is the sixth-leading cause of death in the U.S. Alzheimer's, an irreversible and progressive brain disease, is the most common cause of dementia among older people. The rate of mortality due to Alzheimer's disease is slightly higher for the CVHP (17.9) service area compared to Los Angeles County (17.6). The average rate of Alzheimer's mortality per 10,000 persons is also lower in the CVHP service area (2.6) compared to the statewide average (2.9) but higher in La Verne (6.6), San Dimas (5.7), Glendora (5.5), and Covina (3.6). The greatest risk factor for Alzheimer's disease is advancing age. Other risk factors include a family history of Alzheimer's, genetic mutations, cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury. Stakeholders felt that those most impacted are people over the age of 85 years of age who are uninsured, low-income, Latinos, and Asians. Alzheimer's disease was identified as a major health need in three out of 19 interviews and was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

17. Unintentional Injury (Pedestrian/Motor Vehicle)

Unintentional injuries include those resulting from motor vehicle crashes resulting in death and pedestrians being killed in crashes. Motor vehicle crashes are one of the leading causes of death in the U.S. with more than 2.3 million adult drivers and passengers being treated in 2009.

Pedestrians are 1.5 times more likely than passenger vehicle occupants to be killed in a car crash on each trip. The rate of mortality by a motor vehicle accident in the CVHP service area is 7.7 per 100,000, above the Los Angeles County rate of 7.1, though lower than the statewide rate of 8.2. Pedestrian motor vehicle accident mortality rates per 100,000 persons in CVHP service area are highest in West Covina (3.6), and South El Monte (3.1). Health factors associated with unintentional injury include poverty, education and heavy alcohol consumption. Populations most at risk are older adults, children, and drivers and pedestrians who are under the influence of alcohol and drugs. Unintentional injury was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

18. Arthritis

Arthritis affects one in five adults and continues to be the most common cause of physical disability. Risk factors associated with arthritis include being overweight or obese, lack of education around self-management strategies and techniques, and limited or no physical activity. Arthritis was identified as a major health concern in three out of 19 interviews and was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

19. Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease is the occurrence of chronic bronchitis or emphysema, commonly co-existing diseases of the lungs in which the airways narrow over time. COPD may also be referred to as chronic respiratory pulmonary disease and is most often associated with tobacco smoking. COPD was identified as a health issue in two of 20 interviews and was not identified as a health need in the 2010 CVHP Community Health Needs Assessments.

20. HIV/AIDS

More than 1.1 million people in the United States are living with HIV and almost 1 in 5 (18.1%) are unaware of their infection. HIV infection weakens the immune system, making those living with HIV highly susceptible to a variety of illnesses and cancers, including tuberculosis (TB), cytomegalovirus (CMV), cryptococcal meningitis, lymphomas, kidney disease, and cardiovascular disease. Without treatment, almost all people infected with HIV will develop AIDS. The HIV/AIDS prevalence rate, defined as HIV diagnosis per 100,000 people, is 480.3 in the CVHP service area, close to the Los Angeles County rate of 480.4, though notably higher than the statewide rate of 345.5 and the national rate of 334.0 per 100,000. HIV is a life-threatening communicable disease that disproportionally affects minority communities and may indicate a prevalence of unsafe sex practices. The HIV/AIDS hospitalization rate per 100,000 in the CVHP service area is 6.6, lower than the statewide average of 11.0, however, the communities of Covina (14.0), El Monte (13.3), Glendora and (11.8) have higher rates than both the CVHP service area and state averages. HIV/AIDS is associated with numerous health factors including poverty, heavy alcohol consumption, lack of timely HIV screenings and liquor store access. HIV/AIDS was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

21. Allergies

Allergies are an overreaction of the immune system to substances that usually cause no reaction in most individuals. These substances can trigger sneezing, wheezing, coughing and itching. Risk factors associated with allergic reactions include pollen, dust, food, insect stings, animal dander, mold, medications, and latex. Other social and economic factors that can cause or trigger allergic reactions include poor housing conditions (living with cockroaches, mites, asbestos, mold etc.) and living in an environment or home with smokers. More teens in the CHVP service area had allergies (36.8%) when compared to Los Angeles County (24.9%).Allergies were identified as a major health concern in three out of 19 interviews. Allergies were not indicated among major needs in the 2010 CVHP Community Health Needs Assessment.

22. Infant Mortality

Infant mortality remains a concern in the United States as each year approximately 25,000 infants die before their first birthday. The leading causes of infant death include congenital abnormalities, pre-term/low birth weight, Sudden Infant Death Syndrome (SIDS), problems related to complications of pregnancy, and respiratory distress syndrome. Infant mortality is the rate of infant death at less than one year of age per 1000 births. Los Angeles County and the CVHP service area have the same rate at 5.1 per 1000 births, below the national rate of 6.7. Infant mortality is associated with rates of low birth weight. A higher percentage of infants are born with very low birth weight (less than 1,500 grams) than the Los Angeles County average of 1.1% in the CVHP service area communities of Baldwin Park (1.7%), El Monte (1.4%), La Verne (1.7%), San Dimas (1.8%), and South El Monte (1.5%). Very low birth weight can indicate broader issues such as access to health care, maternal and child health, poverty, education rate, teen births, and lack of insurance and of prenatal care. Infant mortality was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

VII. Community Assets and Resources Available to Response to the Identified Health Needs of the Community

Numerous community assets and resources are available to respond to the health needs of the CVHP community. These include health care facilities as well as community organizations and public agencies that provide health services, health promotion activities, social services, and referrals. A sampling of these programs and CVHP community partners is below. Community assets identified that address specific health needs are included in this list and noted in the individual CVHP Health Needs Profiles in Appendix B.

a. Health Care Facilities

Hospitals

- Aurora Charter Oak Hospital
- Beverly Hospital
- BHC Alhambra Hospital
- Citrus Valley Medical Center – Intercommunity Campus
- Citrus Valley Medical Center – Queen of the Valley Campus
- Citrus Valley Medical Center – Foothill Presbyterian Hospital
- Doctors Hospital of West Covina, Inc.
- East Valley Hospital Medical Center
- Garfield Medical Center
- Greater El Monte Community Hospital
- Kaiser Permanente Baldwin Park Medical Center
- Kindred Hospital - Baldwin Park
- San Dimas Community Hospital
- San Gabriel Valley Medical Center
- Silver Lake Medical Center - Ingleside Campus

Community Clinics

- AltaMed Medical and Dental Group - El Monte
- Asian Pacific Health Care Venture - El Monte Rosemead Health Center
- Buddhist Tzu Chi Free Clinic
- Chinatown Service Center - Alhambra
- East Valley Community Health Center, Inc. – Pomona
- East Valley Community Health Center, Inc. – West Covina
- El Proyecto Del Barrio, Inc – Azusa Health Center
- Herald Christian Health Center
- Los Angeles County La Puente Health Center

- Los Angeles County Comprehensive Health Center - El Monte
- Our Saviour Center - Cleaver Family Wellness Clinic

Dental Care

- AltaMed Health Services Corporation - El Monte, Montebello, West Covina
- Buddhist Tzu Chi Free Clinic
- Children's Dental and Outreach Project LA
- East Valley Community Health Center - West Covina
- El Proyecto del Barrio Family Health Care Clinic
- Herald Christian Health Center
- Our Saviour Center/Cleaver Family Wellness Center
- Special Service for Groups
- San Gabriel Valley Foundation for Dental Health

Mental Health

- Aurora Charter Oak Hospital
- Azusa Pacific University - Community Counseling Center
- Bridges - Casitas Tranquilas
- Citrus Valley Medical Center - Intercommunity Campus
- East Valley Community Health Center - West Covina
- El Proyecto del Barrio - San Gabriel Valley Health Care Clinic Azusa
- ENKI - Youth & Family Services and Administration - El Monte
- Kaiser Permanente - West Covina Behavioral Health Offices
- Pacific Clinics
- Options
- San Gabriel Children's Center
- River Community Covina

b. Other Community Resources

A partial list of community resources available to address identified community health needs is below. Additional resources can be found at:

www.211LA.org
www.HealthyCity.org
http://www.chna.org/KP/

School Districts

- Azusa Unified School District
- Baldwin Park Unified School District

- Bassett Unified School District
- Bonita Unified School District
- Charter Oak Unified School District
- Covina-Valley Unified School District
- El Monte City School District
- El Monte Union High School District
- Garvey School District
- Glendora Unified School District
- Hacienda La Puente Unified School District
- Montebello Unified School District
- Mountain View School District
- Rosemead School District
- Rowland Unified School District
- San Gabriel Unified School District
- Valle Lindo School District
- Walnut Valley Unified School District
- West Covina Unified School District

Community Organizations and Public Agencies

- AIDS Project Los Angeles
- Alliance for Housing and Healing
- AltaMed Health Services Corporation - El Monte, Montebello, West Covina
- Alzheimer's Association, California Southland Chapter
- American Cancer Society
- American Diabetes Association - Los Angeles Office
- American Heart Association
- American Lung Association
- American Red Cross
- APWCLA (Asian Pacific Women's Center)
- Asian Pacific Community Fund
- Asian Pacific Health Care Venture
- Asian Pacific Women’s Center
- Asian Youth Center
- Asthma & Allergy Foundation of America - California Chapter
- Asthma Coalition of Los Angeles County (ACLAC)
- Aurora Charter Oak Hospital
- Azusa Pacific University
- Bienvenidos Children’s Center

- Bike San Gabriel Valley
- Boys & Girls Club – of the Foothills; San Gabriel; West San Gabriel Valley
- Braille Institute
- Breath Savers
- BREATHE California of Los Angeles County
- Cal Poly Pomona, Department of Agriculture
- California Center for Public Health Advocacy
- California Certified Farmers Markets
- California Children's Medical Services
- California State Senate, 24th Senate District
- Children's Dental and Outreach Project LA
- Chinatown Service Center - Alhambra
- Churches/Congregations: General
- Citrus Valley Health Foundation/ECHO
- City of Azusa
- City of Baldwin Park
- City of Covina
- City of Diamond Bar
- City of El Monte
- City of Glendora
- City of Hacienda Heights
- City of Industry
- City of Irwindale
- City of La Puente
- City of La Verne
- City of Montebello
- City of Pasadena Public Health Department
- City of Rosemead
- City of San Dimas
- City of San Gabriel
- City of South El Monte
- City of Walnut
- City of West Covina
- Community Clinic Association of Los Angeles County
- Community Gardens: General
- Community Health Alliance of Pasadena
- Community Resource Centers: General
- Crohn's & Colitis Foundation of America - Greater Los Angeles Chapter

- Disability Rights Center California
- Early Identification and Intervention Collaborative for Los Angeles County
- East San Gabriel Valley Coalition for the Homeless
- East San Gabriel Valley Regional Occupational Program and Technical Center
- El Monte/South El Monte Emergency Resources Association
- Ettie Lee Youth and Family Services
- Family Resource Center Network of Los Angeles County
- Farmers markets: General
- Foothill Family Service
- Foothill Unity Center
- GEM (Get Enrollment Moving) Program at Citrus Valley Medical Center – Queen of the Valley Campus
- Girl Scouts of Greater Los Angeles
- Greater La Puente Valley Meals on Wheels
- Greater West Covina Business Association
- Head Start Programs: General
- Health Fairs: General
- Health Net
- Healthy Families
- Healthy Way LA
- JWCH Institute (John Wesley Community Health Institute)
- LA Best Babies Network
- LA Care
- La Casa de San Gabriel Community Center
- La Puente Community Center
- Latino Diabetes Association
- Lincoln Training Center
- Los Angeles Community Garden Council
- Los Angeles County Area Agency on Aging
- Los Angeles County Bicycle Coalition
- Los Angeles County Department of Mental Health Los Angeles County Department of Public Health - Substance Abuse Prevention & Control
- Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs
- Los Angeles County Department of Social Services
- Los Angeles County Emergency Medical Services
- Los Angeles Walks
- Majestic Realty Corporation
- March of Dimes - California Programs

- MediCal
- Montebello-Commerce YMCA
- Neighborhood Homework House
- New Horizons Caregivers Group
- Options
- PeaceBuilders
- Planned Parenthood Los Angeles
- Planned Parenthood Pasadena and San Gabriel Valley
- Pueblo que Camina
- Rails to Trails Conservancy
- Regional food banks: General
- San Gabriel Children's Center
- San Gabriel Valley Conservation Corps
- San Gabriel Valley Consortium on Homelessness
- San Gabriel Valley Council of Governments (SGVCOG)
- San Gabriel Valley Economic Partnership
- San Gabriel Valley Foundation for Dental Health
- San Gabriel Valley YMCA
- San Gabriel/Pomona Regional Center
- Schools: General/School Office; PTA
- Senior Centers: General
- Services Center for Independent Living
- SPA 3 Area Health Planning Group
- Special Service for Groups
- SPIRITT Family Services
- Stepping Stones for Women
- Susan B. Komen for the Cure - Los Angeles County Affiliate
- THINK Together
- Violence Prevention Coalition (VPC) of Los Angeles County
- West Covina Police Department
- Western University for Health Sciences
- Women, Infants and Children (WIC)
- YWCA San Gabriel Valley

Appendix A: Glossary

This glossary has been developed to provide definitions for key terms and terminology used throughout the East Metro West Kaiser Foundation Hospitals 2013 Community Health Needs Assessments (CHNA). The terms with footnotes have been adapted from the Kaiser CHNA Toolkit, developed "in order to standardize the [CHNA] process across the region and to ensure compliance with the Affordable Care Act (ACA) regulations," as well as to create a shared understanding of the terms within the CHNA consultants and Kaiser Foundation Hospitals Community Benefit Managers.

Age-adjusted rate

The incidence or mortality rate of a disease can depend on age distribution within 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 for some diseases than another community with a higher percentage of population of younger people. An age-adjusted incidence or mortality rate allows for taking the proportion of persons in corresponding age groups into consideration when reviewing statistics, which allows for more meaningful comparisons between communities with different age distributions.

Benchmark[1]

A benchmark is a measurement that serves as a standard by which other measurements and/or statistics may be measured or judged. In the case of the CHNA reports, the term "benchmark" indicates a standard by which a community can determine how well or not well the community is performing in comparison to the standard for specific health outcomes. For the purpose of the Kaiser Foundation Hospitals CHNA reports, one of three benchmarks has been used to make comparisons with the medical center area. These include statistics published by Healthy People 2020, Los Angeles County and California.

Community assets

Those people, places, and relationships that provide resources, individually or in the aggregate, to bring about the maximal functioning of a community. *(Example: Federally Qualified Health Care Centers, primary care physicians, hospitals and medical clinics, community-based organizations, social service and other public agencies, parks, community gardens, etc.)*

Community Health Needs Assessment2

Abbreviated as CHNA, a systematic process involving the review of public data and input from a broad cross-section of community resources and participants to identify and analyze community health needs and assets.

Community served

Based on Affordable Care Act (ACA) regulations, the "community served" is to be determined by each individual hospital. The community served is generally defined by a geographical location such as a city, county, or metropolitan region. A community served may also take into consideration certain hospital focus areas (i.e., cancer, pediatrics) though is not defined so narrowly as to intentionally exclude high-need groups such as the elderly or low-income individuals.

Consultant

Individuals or firms with specific expertise in designing, conducting, and managing a process on behalf of the client.

Data set

A data set refers to a set or grouping of secondary, usually quantitative, data.

Data source

Data source refers to the original source (i.e., database, interview, focus group, etc.) from which quantitative or qualitative data were collected.

Disease burden

Disease burden refers to the impact of a health issue not only on the health of the individuals affected by the disease, but also on the financial cost of addressing the health issue, such as public expenditures. The burden of disease can also refer to the disproportionate impact of a disease on certain populations, which may negatively affect quality of life, socioeconomic status, and other factors.

Drivers of health

Drivers of health are risk factors that may positively or negatively impact a health outcome. For the purposes of the Kaiser Foundation Hospitals CHNA, drivers have been separated into four categories: social and economic factors, physical environment, health behaviors, and clinical care access and delivery.

FQHC[3]

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the federal Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC look-alikes (organizations that meet PHS Section 330 eligibility requirements but do not receive grant funding) also may receive special Medicare and Medicaid reimbursements.

Focus group

A gathering of people (also referred to as stakeholders) for the purpose of sharing and discussing a specific topic—in this case, community health.

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 health disparity research literature focuses on racial and ethnic differences—as to how these communities experience specific diseases—however, health disparity can also 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 (behavioral) 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[4]

A characteristic of an individual, population, or environment that 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. *(Example: Percent of children overweight in Los Angeles County, incidence of breast cancer in Los Angeles County)*

Health need

Kaiser Permanente uses the Mobilizing Action Toward Community Health (MATCH) framework to understand population health, and defines a health need as any of the following that arise from a comprehensive review and interpretation of a robust data set: a) a poor *health outcome* and its associated health driver and/or b) a *health drive/factor* associated with poor health outcome(s), where the outcome itself has not yet arisen as a need. *(Example: breast cancer, obesity and overweight, asthma, physical inactivity, access to healthcare)*

Health outcomes[5]

Snapshots of diseases in a community that can be described in terms of both morbidity and mortality. *(Example: breast cancer prevalence, lung cancer mortality, homicide rate)*

Healthy People 2020[6]

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions, and measure the impact of prevention activities.

Implementation strategy[7]

The nonprofit hospital's plan for addressing the health needs identified through the CHNA.

Incidence[8] **rate**

Incidence is a measure of the occurrence of new disease or health problem in a population of people at risk for the disease within a given time period. *(Example: 1,000 new cases of breast cancer in 2011)* Incidence rate is expressed either as a fraction (e.g., percentage) or a density rate (e.g., *x* number of cases per 10,000 people) to allow for comparison between different communities. Incidence rate should not be confused with *prevalence rate*, which measures the proportion of people found to have a specific disease or health problem (see *prevalence rate*).

Morbidity rate

Morbidity rate refers to the prevalence of a disease. Morbidity rate is usually expressed as a density rate (e.g. *x* number of cases per 10,000 people). Prevalence is often used to measure the level of morbidity in a population.[9]

Mortality rate

Mortality rate refers to the number of deaths in a population resulting from a disease. Mortality rate is usually expressed as a density rate (e.g., *x* number of cases per 10,000 people).

Percent

A percent is the portion of the total population that currently has a given disease or health problem. Percent is used to communicate prevalence, for example, and to give an idea of the severity (or lack thereof) of a disease or health problem.

Prevalence[10]

Prevalence is the proportion of total population that currently has a given disease. *(Example: 1,000 total cases of lung cancer in 2011)*

Prevalence rate

Prevalence rate is the proportion of total population that currently has a given disease or health problem. Prevalence rate is expressed either as a fraction (e.g., percentage) or a density rate (e.g., *x* number of cases per 10,000 people) to allow for comparison between different communities. Prevalence rate is distinct from incidence rate, which focuses 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 number of people suffering that disease (prevalence) because people are living longer as a result of 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 CHNA, primary data were collected through focus groups and interviews with key stakeholders. Primary data describes what is important to the people who provide the information and is useful in interpreting secondary data (see *qualitative data, quantitative data, secondary data*). *(Example: Focus groups, key informant interviews)*

Qualitative data[11]

These are typically descriptive in nature and not numerical; however, qualitative data can be coded into numeric categories for analysis. Qualitative data is considered to be more subjective than quantitative data, but they provide information about what is important to the people (see *stakeholder*) who provide the information. *(Example: focus group data)*

Quantitative data[12]

Data that has a numeric value. Quantitative data is considered to be more objective than qualitative data *(Example: State or National survey data)*

Risk factor[13]

Characteristics (genetic, behavioral, and environmental exposures and sociocultural living conditions) that increase the probability that an individual will experience a disease (morbidity) or specific cause of death (mortality). Some risk factors can be changed through behavioral or external changes or influences (e.g., smoking) while others cannot (e.g., family history).

Secondary data

Data that has already been collected and published by another party. Typically, secondary data collected for CHNAs is quantitative (numerical) in nature *(Example: California Health Interview Survey [CHIS], Behavioral Risk Factor Surveillance System [BRFSS])* Secondary data are useful in highlighting in an objective manner health outcomes that significantly impact a community.

Stakeholder

Stakeholders are people who represent and provide informed, interested perspectives regarding an issue or topic. In the case of CHNAs, stakeholders include health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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[9] New York State Department of Health. Basic Statistics: About Incidence, Prevalence, Morbidity, and Mortality—Statistical Teaching Tools. Retrieved from [http://www.health.ny.gov/diseases/chronic/basicstat.htm] Accessed on [May 1, 2013].

[10] Aschengrau, A. & Seage, G.R. (2008). *Essentials of Epidemiology in Public Health*. Sudbury, Massachusetts: Jones and Barlett Publishers.

[11] Catholic Health Association of the United States (March, 2011). Assessing & addressing community health needs: Discussion Draft. Retrieved from [http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx]

[12] Ibid.

[13] Adapted from: Green L. & Kreuter M. (2005). *Health program planning: An educational and ecological approach*. 4th edition. New York, NY: McGraw Hill.

Appendix B:
CVHP Health Needs Profiles

Health Need Profile: Mental Health

****Overall Ranking Resulting from Prioritization: 1 of 22**

About Mental Health—Why is it important?

Mental illness is a common cause of disability. Untreated disorders may leave individuals at-risk for substance abuse, self-destructive behavior, and suicide. Suicide is considered a major preventable public health problem. In 2010, suicide was the tenth leading cause of death among Americans of all ages, and the second leading cause of death among people between the ages of 25 to 34.[1] An estimated 11 attempted suicides occur per every suicide death.

Research shows that more than 90 percent of those who die by suicide suffer from depression or other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders).[2] Among adults, mental disorders are common, with approximately one-quarter of adults being diagnosable for one or more disorders.[3] Mental disorders are not only associated with suicide, but also with chronic diseases, a family history of mental illness, age, substance abuse, and life-event stresses.[4]

Interventions to prevent suicide include therapy, medication, and programs that focus both on suicide risk and mental or substance-abuse disorders. Another intervention is improving primary care providers' ability to recognize and treat suicide risk factors, given the research showing that older adults and women who die by suicide are likely to have seen a primary care provider in the year before death.[5]

Additionally, mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression and outcome of chronic diseases.[6]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- More adults (657.0) experienced mental health–related hospitalizations per 100,000 adults when compared to California (551.7).
- More youth (375.4) experienced mental health–related hospitalizations per 100,000 youth when compared to California (256.4).
- More people in the CVHP service area did not have needed mental health treatment (51.4%) when compared to Los Angeles County (47.3%).
- More people in the CVHP service area experienced serious psychological distress (8.8%) than in Los Angeles County (7.3%).
- High percentages of African-Americans (19.3%), Whites (17.8%), and Hispanics/Latinos (13.0%) in the CVHP service area suffer from poor mental health.
- Adults experiencing the highest mental health–related hospitalization rates per 100,000 persons live in the cities of Covina (1,156.6) and Glendora (1,061.0).
- Youth experiencing the highest mental health–related hospitalization rates per 100,000 persons live in the cities of San Dimas (1,398.0) and La Verne (1,074.0).
- Suicide rates per 100,000 persons were higher in the cities of Glendora (2.4) and Hacienda Heights (1.5).

- Stakeholders[7] identified youth, middle-aged adults, the homeless, and the uninsured as the most severely impacted.
- Stakeholders indicated that mental health was an issue that affects everyone. Mental health services are difficult to access and insurance criteria and requirements are difficult for many to meet. Even when a person qualifies for care, they must often wait a long time to receive services. Stakeholders attributed some of these barriers to a lack of funding for mental health services. Stakeholders also added that the responsibility for providing mental health services for youth is shifting to schools, leading to the need for schools to build school-based health providers' skills to address mental as well as physical health.
- Mental health issues were identified by stakeholders in four out of 19 interviews and three out of five focus groups.
- Mental health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is mental health measured? What is the prevalence/incidence rate of mental health in the community?

In the CVHP service area:

- In 2010, more adults (657.0) experienced mental health–related hospitalizations per 100,000 adults when compared to California (551.7).
- In 2010, more youth (375.4) experienced mental health–related hospitalizations per 100,000 youth when compared to California (256.4).
- In 2009, more people went without needed mental health treatment (51.4%) when compared to Los Angeles County (47.3%).
- In 2009, more people experienced serious psychological distress (8.8%) than in Los Angeles County (7.3%).

Mental Health Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Mental health treatment not received	2009	51.4%	LAC	47.3%
Mental health–related hospitalizations per 100,000 adults	2010	657.0	CA	551.7
Mental health–related hospitalizations per 100,000 youth	2010	375.4	CA	256.4
Poor mental health	2009	14.0%	LAC	14.0%
Serious psychological distress	2009	8.8%	LAC	7.3%
Suicides per 100,000 persons[1]	2010	6.3	LAC	8.0

LAC=Los Angeles County
CA=California
[1] Healthy People 2020 = <=10.2

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

- More African-Americans (19.3%), Whites (17.8%), and Hispanics/Latinos (13.0%) suffer from poor mental health.
- Stakeholders identified youth, middle-aged adults, the homeless, and the uninsured as the most severely impacted.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- More adults experienced mental health–related hospitalizations per 100,000 persons in the cities of Covina (1,156.6), Glendora (1,061.0), San Dimas (942.1), South El Monte (942.1), La Verne (932.4), Azusa (651.5), Baldwin Park[8] (650.4), and West Covina (620.4).
- More youth experienced mental health–related hospitalizations per 100,000 persons in the cities of San Dimas (1,398.0), La Verne (1,074.0), Covina (655.7), Glendora (608.2), Azusa (526.4), Baldwin Park (384.8), El Monte (327.7), Diamond Bar (311.5), La Puente (290.3), South El Monte (287.1), and West Covina (260.4).
- Suicide rates per 10,000 persons were higher in the cities of Glendora (2.4) and Hacienda Heights (1.5).

Stakeholders did not identify specific geographic disparities. Instead, stakeholders mentioned that the entire San Gabriel Valley was impacted.

Associated drivers and risk factors—What is driving the high rates of poor mental health in the community?

Mental health is associated with many other health factors, including poverty, heavy alcohol consumption, and unemployment. Suicide and chronic medical diseases, such as cardiovascular disease, diabetes, and obesity, are associated with mental disorders. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Cardiovascular Disease				
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons[1]	2010	132.7	LAC	147.1
Stroke mortality per 100,000 persons	2010	38.6	LAC	37.6
Diabetes				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
Obesity/Overweight				
Youth who are obese	2011	30.6%	CA	29.8%
Adults who are overweight	2010	36.4%	LAC	26.4%
Youth who are overweight	2011	15.1%	CA	14.3%
SOCIAL AND ECONOMIC				
Unemployment rate	2012	10.4	LAC	10.3
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

CA = California
[1]Healthy People 2020 = <=100.8

Community input—What do community stakeholders think about the issue of mental health?

Stakeholders indicated that mental health is an issue that affects everyone. There is lack of access to mental health services, and insurance criteria and requirements are difficult to meet for many. Even when a person qualifies to receive care, they must often wait a long time to receive the services. Stakeholders attributed some of these barriers to a lack of funding for mental health services. Stakeholders also added that the responsibility for providing mental health services for youth is shifting to schools, leading to the need for schools to build school-based health providers' skills to address mental as well as physical health.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of mental health–specific community assets:

- AltaMed Medical and Dental Group
- Azusa Pacific University - Community Counseling Center
- BHC Alhambra Hospital
- Bienvenidos
- Community Clinic Association of Los Angeles County
- East Valley Community Health Center
- El Proyecto del Barrio, Inc
- Pacific Clinics
- San Gabriel Children's Center
- Silver Lake Medical Center - Ingleside Campus

Stakeholders identified the following community resources available to address mental health:

- Aurora Charter Oak Hospital - Community resource for mental health care
- Citrus Valley Medical Center - Community resource for mental health care
- Options - Community resource for mental health care; provides services at school sites which decreases stigma of seeing behavioral health practitioner

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] Centers for Disease Control and Prevention. *10 Leading Causes of Death by Age Group, United States—2010*. Available at [http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf]. Accessed [March 12, 2013].

[2] National Institute of Mental Health. *Suicide in the U.S.: Statistics and Prevention*. Available at [http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml]. Accessed [March 12, 2013].

[3] National Institute of Mental Health. *Any Disorder Among Adults.* Available at [http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml]. Accessed [March 12, 2013].

[4] Public Health Agency of Canada. *Mental Illness*. Available at [http://www.phac-aspc.gc.ca/cd-mc/mi-mm/index-eng.php]. Accessed [March 12, 2013].

[5] National Institute of Mental Health. *Suicide in the U.S.: Statistics and Prevention*. Available at [http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml]. Accessed [March 12, 2013].

[6] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28]. Accessed [May14, 2013].

[7] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[8] Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

Health Need Profile: Obesity/Overweight

****Overall Ranking Resulting from Prioritization: 2 of 22**

About Obesity/Overweight—Why is it important?

Obesity, a condition in which a person has an abnormally high and unhealthy proportion of body fat, has risen to epidemic levels in the United States; 68 percent of adults age 20 years and older are overweight or obese.[1]

Obesity reduces life expectancy and causes devastating and costly health problems, increasing the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. Findings suggest that obesity also increases the risks for cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types.[2]

A number of factors contribute to obesity, including genetics, physical inactivity, unhealthy diet and eating habits, lack of sleep, certain medications, age, social and economic issues, and medical problems.[3]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- More youth (30.6%) were obese when compared to California (29.8%).
- More youth (15.1%) were overweight when compared to California (14.3%).
- More adults (36.4%) are overweight when compared to Los Angeles County (26.4%)
- More adult males (21.5%) were obese than females (21.3%).
- More Hispanic/Latino youth (35.2%) were obese.
- More Hispanic/Latinos youth (15.9%) were overweight.
- Baldwin Park (40.7%) and South El Monte (44.6 to 45.3%) had the largest portion of students who were obese. La Puente (19.3%) and Hacienda Heights (19.3%) had the largest portions of students who were overweight.
- Stakeholders[4] identified youth as being the most severely impacted.
- Stakeholders agree that obesity is an issue, and attribute its prevalence to a lack of education about nutrition, including healthy food options, cooking more healthily, and consuming large amounts of sugar, processed foods, fast food, soda and other sugary drinks, and fried foods. Stakeholders also mentioned the possibility of cultural preferences and how people prepare food. Stakeholders also attribute obesity to a lack of exercise and physical activity, particularly for youth who prefer to stay inside and spend time on the computer or watching television, versus spending time outdoors. The high cost of healthy food options is also an issue.
- Obesity was identified in four of five focus groups and nine of 19 interviews.
- Obesity was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is obesity/overweight measured? What is the prevalence/incidence rate of obesity/overweight in the community?

In the CVHP service area:

- In 2011, more youth (30.6%) were obese when compared to California (29.8%).
- In 2011, more youth (15.1%) were overweight when compared to California (14.3%).
- In 2010, more adults (36.4%) are overweight when compared to Los Angeles County (26.4%).

Obesity/Overweight Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Adults who are obese	2009	20.0%	LAC	21.2%
Adults who are overweight	2009	28.8%	LAC	29.7%
Adults who are overweight	2010	36.4%	LAC	26.4%
Youth who are obese	2011	30.6%	CA	29.8%
Youth who are overweight	2011	15.1%	CA	14.3%

LAC=Los Angeles County

Sub-populations experiencing greatest impact (disparities)

- Within the CVHP service area, the following sub-populations are the most severely impacted:
- More adult males (21.5%) were obese than females (21.3%).
- More Hispanic/Latino youth (35.2%) were obese.
- More Hispanic/Latino youth (15.9%) were overweight.

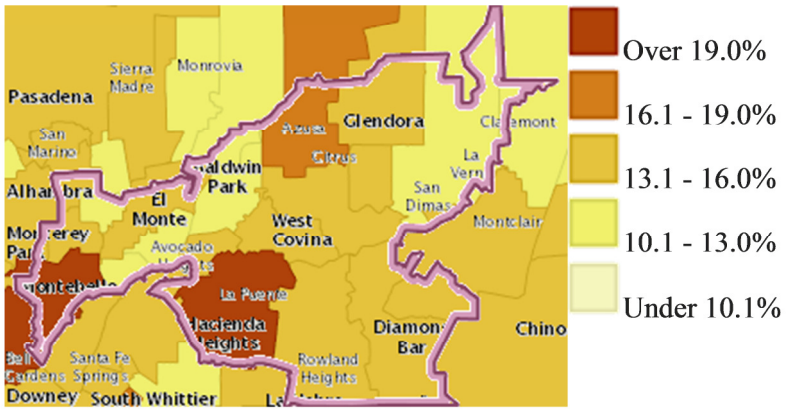
Stakeholders identified youth as being the most severely impacted.

Geographic areas of greatest impact (disparities)

Communities experiencing the highest disparities include (see maps):

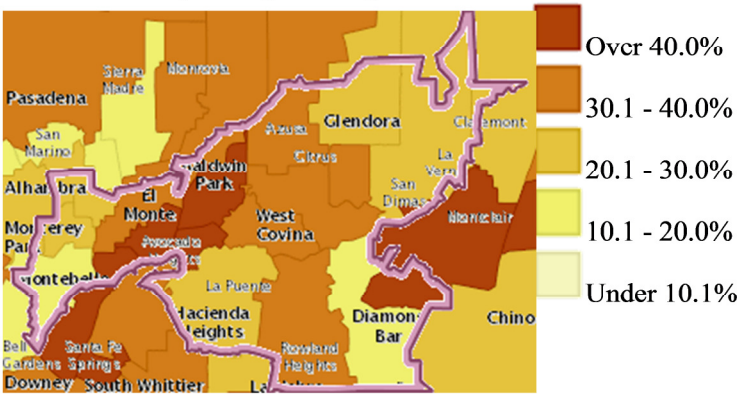
- Baldwin Park (40.7%) and South El Monte (44.6 to 45.3%) had the largest portion of students who were obese.
- La Puente (19.3%) and Hacienda Heights (19.3%) had the largest portions of students who were overweight.

Students In 'Needs Improvement' Body Composition Zone (Overweight), CA Dept. of Education, 2011



- Stakeholders identified Covina as being the most severely impacted and attributed this to the large number of fast food establishments in the area.

Percentage of Students In 'At High Risk' Body Composition Zone (Obese), CA Dept. of Education, 2011



Associated drivers and risk factors—What is driving the high rates of obesity/overweight in the community?

Obesity is associated with poverty, inadequate consumption of fruits and vegetables, physical inactivity, and access to grocery stores, parks, and open space. Obesity increases the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. Obesity also increases the risks of cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types.[5] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Cardiovascular Disease				
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons[1]	2010	132.7	LAC	147.1
Stroke mortality per 100,000 persons	2010	38.6	LAC	37.6
Colorectal Cancer				
Colorectal cancer incidence rate per 100,000 persons[2]	2009	45.2	LAC	45.2
Diabetes				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
Hypertension				
Adults ever diagnosed with high blood pressure	2009	30.2%	LAC	25.5%
Hypertension and hypertensive renal mortality per 10,000 persons	2010	1.3	CA	1.0
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

[1] Healthy People 2020 = <=100.8

[2] Healthy People 2020 = <=38.6

Community input—What do community stakeholders think about the issue of obesity/overweight?

Stakeholders agree that obesity is an issue, and attribute its prevalence to a lack of education about nutrition, including healthy food options, cooking more healthily, and consuming large amounts of sugar, processed foods, fast food, soda and other sugary drinks, and fried foods. Stakeholders also mentioned the possibility of cultural preferences and how people prepare food. Stakeholders also attribute obesity to a lack of exercise and physical activity, particularly for youth who prefer to stay inside and spend time on the computer or watching television, versus spending time outdoors. The high cost of healthy food options is also an issue. Stakeholders suggest hands-on approaches to teaching about healthy foods; for example, a cooking class in which parents could learn to prepare their favorite foods differently, in a healthier manner, with special consideration given to their culture.

> *"Every sector of the population gets bombarded with information, but there is no quality information about healthy food and nutrition." (education and business focus group participant)*

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Obesity/overweight-specific community assets:

- American Diabetes Association - Los Angeles Office
- American Heart Association
- Azusa Pacific University – Neighborhood Wellness Center
- Boys & Girls Club West San Gabriel Valley
- California Certified Farmers Markets
- City of Baldwin Park – Healthy BP Program
- Citrus Valley Medical Center – Foothill Presbyterian Hospital
- Los Angeles Community Garden Council

Stakeholders identified the following community resources available to address obesity/overweight issues:

- Community gardens
- Farmers markets: general - Makes healthy food available in the community on a regular basis; connects the wholesomeness of fresh food
- Head Start - Get Moving Program engages children in physical activity and healthy eating
- Options - Get Moving Program engages children in physical activity and healthy eating

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

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[1] National Cancer Institute. *Obesity and Cancer Risk*. Available at [http://www.cancer.gov/cancertopics/factsheet/Risk/obesity]. Accessed [March 10, 2013].

[2] Ibid.

[3] May Clinic. *Obesity Risk Factors*. Available at [http://www.mayoclinic.com/health/obesity/DS00314/DSECTION=risk-factors]. Accessed [March 10, 2013].

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[5] National Cancer Institute. *Obesity and Cancer Risk*. Available at [http://www.cancer.gov/cancertopics/factsheet/Risk/obesity]. Accessed [March 10, 2013].

Health Need Profile: Diabetes

****Overall Ranking Resulting from Prioritization: 3 of 22**

About Diabetes—Why is it important?

Diabetes affects an estimated 23.6 million people and is the seventh leading cause of death in the United States. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness.[1] A diabetes diagnosis can also indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity.

Given the steady rise in the number of people with diabetes, and earlier onset of Type 2 diabetes, there is growing concern about substantial increases in diabetes-related complications and their potential to impact and overwhelm the health care system. There is a clear need to take advantage of recent discoveries about the individual and societal benefits of improved diabetes management and prevention by bringing life-saving findings into wider practice, and complementing those strategies with efforts in primary prevention among those at risk for developing diabetes.[2]

In addition, evidence is emerging that diabetes is associated with other co-morbidities including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis.[3]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- More were diagnosed with diabetes in the CVHP service area (18.5%) than in Los Angeles County (10.5%).
- More adults (147.4) experienced diabetes-related hospitalizations per 100,000 adults when compared to Los Angeles County (145.6).
- More diabetes-related mortalities occurred per 10,000 persons (2.1) when compared to California (1.9).
- More uncontrolled diabetes-related hospitalizations occurred per 100,000 persons (12.7) when compared to Los Angeles County (9.5).
- Diabetes was more prevalent in males (8.5%) than to females (7.1%).
- More males (1.2%) were discharged from hospitals for diabetes-related incidents than females (0.7%).
- A slightly larger portion of those who classified themselves as multi-racial (1.1%) experienced hospital discharges resulting from diabetes than other groups. In addition, 1.1% of Hispanic/Latinos also were hospitalized as a result of diabetes.
- People between the ages of 45 and 64 (1.5%) and over the age of 65 (1.0%) experienced the most hospital incidents resulting from diabetes compared to other age groups.
- The diabetes discharge rate was particularly high in South El Monte (18.2), and the westernmost part of El Monte (15.1).
- Stakeholders[4] noted an increase in diabetes diagnoses, particularly for people with insulin dependence. Stakeholders also noted a lack of health education about diabetes and a need for re-education about diabetic maintenance, especially as technology (i.e., the glucometer) advances. Stakeholders also indicated that more people are being diagnosed with diabetes at a younger age, where previously the disease

appeared to be more prevalent among the middle-aged. Stakeholders also noted the connection between diabetes and other chronic diseases, including high blood pressure, heart disease, arthritis, and certain types of cancer. One stakeholder mentioned positive trends particularly in the Baldwin Park area where people are exercising more, eating less sugar, and making healthier choices overall.

- Stakeholders identified younger people as the most severely impacted.
- Diabetes was identified as a major health issue in four out of 19 interviews and four out of five focus groups.
- Diabetes was also identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is diabetes measured? What is the prevalence/incidence rate of diabetes in the community?

In the CVHP service area:

- In 2010, more adults (147.4) experienced diabetes-related hospitalizations per 100,000 adults when compared to Los Angeles County (145.6).
- In 2010, there were more diabetes-related mortalities per 10,000 persons (2.1) when compared to California (1.9).
- In 2010, more uncontrolled diabetes-related hospitalizations occurred per 10,000 persons (12.7) when compared to Los Angeles County (9.5).

Diabetes Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Diabetes hospitalizations per 10,000 adults	2010	10.5	LAC	9.7
Diabetes hospitalizations per 10,000 youth	2010	3.5	LAC	4.8
Diabetes hospitalizations per 100,000 adults	2010	147.4	LAC	145.6
Diabetes mortality per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Uncontrolled diabetes hospitalizations per 10,000 persons	2010	12.7	LAC	9.5

LAC=Los Angeles County

- In 2009, more were diagnosed with diabetes (18.5%) when compared to Los Angeles County (10.5%).

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

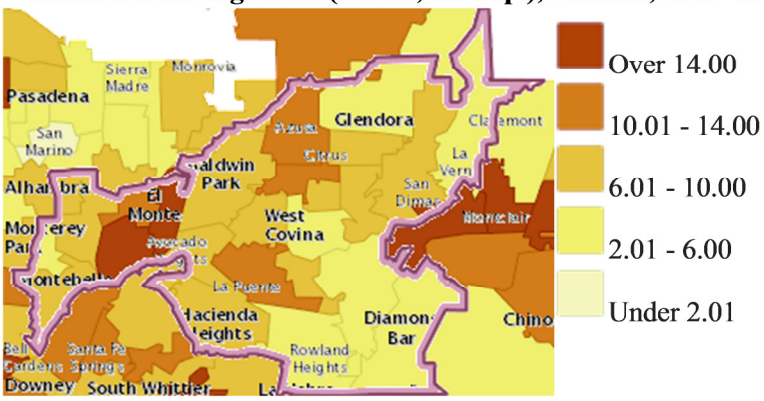
- Diabetes was more prevalent in males (8.5%) than females (7.1%).
- More males (1.2%) were discharged from hospitals for diabetes-related incidents than females (0.7%).
- A slightly larger portion of those who classified themselves as multi-racial (1.1%) and Hispanic/Latino (1.0%) experienced hospital discharges resulting from diabetes than other groups.
- People between the ages of 45 and 64 (1.5%) and over the age of 65 (1.0%) experienced the most hospital incidents resulting from diabetes compared to other age groups.
- Stakeholders identified younger people as the most severely impacted.

Geographic areas of greatest impact (disparities)

Communities experiencing the highest disparities include (see map):

- The diabetes discharge rate was particularly high in South El Monte (18.2), and the westernmost part of El Monte (15.1).

Diabetes Discharge Rate (Per 10,000 Pop.), OSHPD, 2010–11



By communities, the following disparities were found:

- More adults experienced diabetes-related hospitalizations per 100,000 adults in the cities of South El Monte (289.3), El Monte (211.8), La Puente (194.7), Baldwin Park (181.5), Azusa (180.9), and Covina (147.3).
- More uncontrolled diabetes-related hospitalizations occurred per 10,000 persons in the cities of South El Monte (26.8), El Monte (26.2), La Puente (23.1), Baldwin Park (14.9), La Verne (14.0), West Covina (13.5), San Dimas (11.4), Azusa (11.3), and Glendora (9.6).
- More people died of diabetes per 10,000 persons in the cities of Covina (3.1), La Puente (3.1), Azusa (2.9), La Verne (2.7), San Dimas (2.7), West Covina (2.7), Baldwin Park (2.2), and Glendora (2.2).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of diabetes in the community?

Factors associated with diabetes include being overweight; having high blood pressure, high cholesterol, high blood sugar (or glucose); physical inactivity, smoking, unhealthy eating, age, race, gender, and having a family history of diabetes.[5] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/ benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Cardiovascular Disease				
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons[1]	2010	132.7	LAC	147.1
Stroke mortality per 100,000 persons	2010	38.6	LAC	37.6
Obesity/Overweight				
Adults who are overweight	2010	36.4%	LAC	36.4%
Youth who are obese	2011	30.6%	CA	29.8%
Youth who are overweight	2011	15.1%	CA	14.3%
Hypertension				
Adults ever diagnosed with high blood pressure	2009	30.2%	LAC	25.5%
Hypertension and hypertensive renal mortality per 10,000 persons	2010	1.3	CA	1.0
BEHAVIORAL				

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

[1] Healthy People 2020 = <=100.8

[2] Healthy People 2020 = <=38.6

Community input—What do community stakeholders think about the issue of diabetes?

Stakeholders noted an increase in diabetes diagnoses, particularly for people with insulin dependence. Stakeholders also noted a lack of health education about diabetes and a need for re-education about diabetic maintenance especially as technology (i.e., the glucometer) advances. Stakeholders also noted that more people are being diagnosed with diabetes at a younger age, when previously the condition seemed more prevalent in the middle-aged population. Stakeholders also noted the connection of diabetes to other chronic diseases, including high blood pressure, heart disease, arthritis, and certain types of cancer. One stakeholder mentioned positive trends particularly in the Baldwin Park area where people are exercising more, eating less sugar, and making healthier choices overall.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Diabetes-specific community assets:

- American Diabetes Association - Los Angeles Office
- Azusa Pacific University – Neighborhood Wellness Center
- California Certified Farmers Markets
- Citrus Valley Medical Center – Foothill Presbyterian Hospital
- Community Clinic Association of Los Angeles County
- East Valley Community Health Center, Inc.
- Latino Diabetes Association
- Los Angeles Community Garden Council
- Our Saviour Center - Cleaver Family Wellness Clinic

Stakeholders did not identify specific community resources available to address diabetes.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32]. Accessed [February 26, 2013].

[2] Ibid.

[3] Ibid.

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

Health Need Profile: Oral Health

****Overall Ranking Resulting from Prioritization: 4 of 22**

About Oral Health—Why is it important?

Oral health is essential to overall health and is relevant because engaging in preventative behaviors decreases the likelihood of developing future oral health and related health problems. In addition, oral diseases such as cavities and oral cancer cause pain and disability for many Americans.[1] Poor oral health can be both a result of certain health conditions and a cause of poor health.[2]

> *"Parents resist taking children to the dentist because the cavities are in "baby teeth" that will fall out, so it's not a priority. Parents don't understand other troubling issues. Also, parents have had bad dental experiences and don't want to expose their kids to this pain." (executive director, community-based organization)*

Behaviors that may lead to poor oral health include tobacco use, excessive alcohol consumption, and poor dietary choices. Barriers that prevent or limit a person's use of preventative intervention and treatments for oral health include limited access to and availability of dental services, a lack of awareness of the need, cost, and fear of dental procedures. Low-income individuals, particularly children and minorities, are more likely to have poor oral health. Social factors associated with poor dental health include lower levels or lack of education, having a disability, and other health conditions such as diabetes.[3]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- The portion of adults without dental insurance in the past year ranges between 37.1% and 70.0% throughout the CVHP service area.
- The portion of children and teens unable to afford dental care ranges between 8.0% and 10.0% throughout the CVHP service area.
- Between 30.0% and 70.0% of the population has not had a dental exam in the past year throughout the CVHP service area.
- More Hispanics/Latinos (43.7%) and Asian/Pacific Islanders (40.6%) did not have dental insurance.
- Hispanic/Latino youth (or children) were the largest percentage (8.3%) among youth who are unable to afford dental care and had not had a dental exam (49.3%).
- Stakeholders[4] attributed poor oral health to the lack of access to affordable dental care specifically for adults and the aging (i.e., restorative and repair services), long wait times—sometimes up to a year—and/or the limited availability of dental care at free or low-cost dental clinics. Although services are available for children, there is a lack of education about dental care, specifically concerning regular checkups. Adults experienced a lack of access to restorative dental care.
- Stakeholders identified adults and the aging as the most severely impacted.
- Oral health and dental care was identified by community stakeholders in all five focus groups and eleven out of 19 interviews, including highlighting new immigrants as particularly impacted.
- Oral health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is oral health measured? What is the prevalence/incidence rate of oral health in the community?

In the CVHP service area:

- The portion of adults experiencing poor dental health was the same as that in Los Angeles County (11.6%).

Oral Health Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Poor dental health (adults)	2009	11.6%	LAC	11.6%

LAC=Los Angeles County

Sub-populations experiencing greatest impact (disparities)

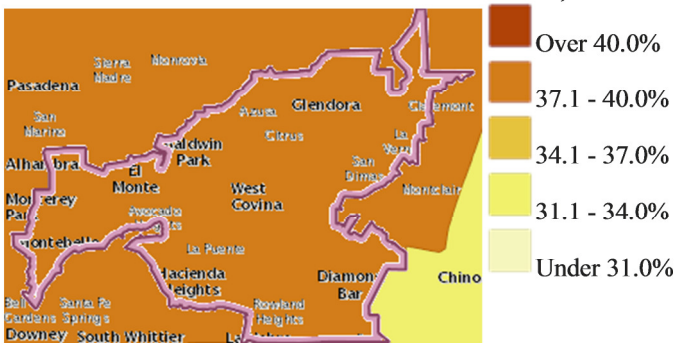
- Within the CVHP service area, the following sub-populations are the most severely impacted:
- More Hispanics/Latinos (43.7%) and Asian/Pacific Islanders (40.6%) did not have dental insurance.
- Hispanic/Latino youth (or children) were more likely (8.3%) among all youth to be unable to afford dental care and had not had a dental exam (49.3%).
- Stakeholders identified adults and the aging as the most severely impacted.

Geographic areas of greatest impact (disparities)

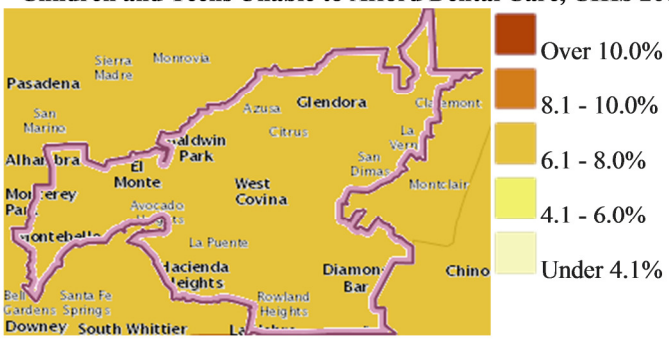
Communities are widely impacted by poor dental health (see maps):

- Over a third (37.4%) of adults throughout the CVHP service area was without dental insurance.
- Over 6% of children and teens were unable to afford dental care in the CVHP service area.

Adults Without Dental Insurance for Past 1 Year, CHIS 2007

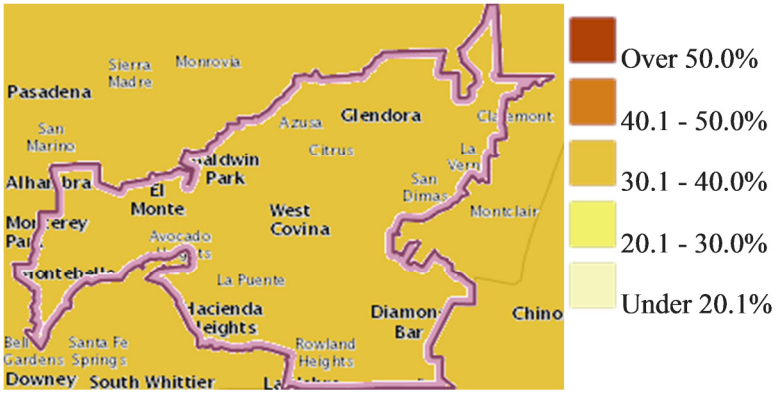


Children and Teens Unable to Afford Dental Care, CHIS 2007



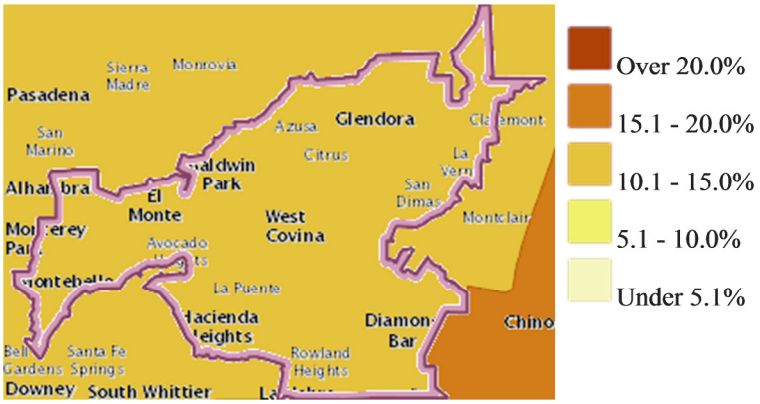
- The portion of the population who has not had a dental exam in the past year ranges between 30.0% and 70.0% throughout the CVHP service area.

Population (Age 18) without Dental Exam within Past 1 Year, CDC BRFSS 2006-2010



- The portion of teens that had not had a dental exam in the past year ranges between 15.0% and 20.0% throughout the CVHP service area.

Teens Without Dental Exam in Past 1 Year, CHIS 2007



Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of poor oral health in the community?

The following factors are associated with poor oral health in the community. Poor oral health can be prevented by decreasing sugar intake and eating well to prevent tooth decay and premature tooth loss, eating more fruits and vegetables to protect against oral cancer, cease smoking and decrease alcohol consumption to reduce the risk of oral cancers, periodontal disease, and tooth loss, use protective gear when playing sports, and living in a safe physical environment.[5] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Diabetes				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 10,000	2010	12.7	CA	9.5

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
persons				
BEHAVIORAL				
Soft drink expenditures	2010	0.49%	CA	0.46%
Youth drinking two or more glasses of soda yesterday	2009	18.8%	LAC	18.1%
CLINICAL CARE				
Children who have never seen a dentist	2009	11.9%	LAC	10.5%
Teens who can't afford dental care	2009	53.2%	LAC	23.8%
Youth who can't afford dental care	2007	6.3%	LAC	6.2%
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

Community input—What do community stakeholders think about the issue of oral health?

Stakeholders attributed poor oral health to the lack of access to affordable dental care specifically for adults and the aging (i.e. restorative and repair services), long wait times—sometimes up to a year—and/or the limited availability of dental care at free or low-cost dental clinics. Although services are available for children, there is a lack of education about dental care, specifically concerning regular checkups. Adults experience a lack of access to restorative dental care.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Oral health–specific community assets:

- AltaMed Program for All-Inclusive Care for the Elderly (PACE) – El Monte
- Buddhist Tzu Chi Free Clinic
- Children's Dental and Outreach Project LA
- Community Clinic Association of Los Angeles County
- El Proyecto del Barrio Family Health Care Clinic
- Herald Christian Health Center
- Our Saviour Center/Cleaver Family Wellness Center
- San Gabriel Valley Foundation for Dental Health
- Special Service for Groups

Stakeholders identified the following community resources available to address oral health:

- AltaMed - Community resource for dental care
- East Valley Community Health Center - Community resource for dental care
- La Casa de San Gabriel Community Center - Community resource for dental care; annual screenings for children
- Buddhist Tzu Chi Free Clinic - Community resource for dental care

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32]. Accessed [February 26, 2013].

[2] Ibid.

[3] Ibid.

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[5] World Health Organization, Oral health Fact sheet. Geneva, Switzerland. Available at [http://www.who.int/mediacentre/factsheets/fs318/en/index.html]. Accessed [February 26, 2013].

Health Need Profile: Hypertension

****Overall Ranking Resulting from Prioritization: 5 of 22**

About Hypertension—Why is it important?

Hypertension, defined as a blood pressure reading of 140/90 or higher, affects one in three adults in the United States.[1] With no symptoms or warning signs and the ability to cause serious damage to the body, the condition has been called a silent killer. High blood pressure, if untreated, can lead to heart failure, blood vessel aneurysms, kidney failure, heart attack, stroke, and vision changes or blindness.[2] High blood pressure can be controlled through medicines and lifestyle change; however, patient adherence to treatment regimens is a significant barrier to controlling high blood pressure.[3]

High blood pressure is associated with smoking, obesity, the regular consumption of salt and fat, excessive drinking, and physical inactivity. Those at higher risk of developing hypertension include people who have previously had a stroke and those who have high cholesterol or heart or kidney disease. African-Americans and people with a family history of hypertension are also at an increased risk of having hypertension.[4]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- A larger portion of the population in the CVHP service area (30.2%) was diagnosed with high blood pressure when compared to Los Angeles County (25.5%).
- More died of hypertension and hypertensive renal failure in the CVHP service area (1.3) when compared to California (1.0).
- More died of hypertension and hypertensive renal failure per 10,000 persons in the communities of La Verne (3.0), San Dimas (2.7), Diamond Bar (1.5), Azusa (1.5), Covina (1.4), West Covina (1.4), Glendora (1.2), and La Puente (1.1).
- Stakeholders[5] identified hypertension as an important issue and attributed its prevalence to a lack of access to specialty care (such as cardiologists), long wait times to receive care at county hospitals, and the high cost of care. Stakeholders also linked hypertension to high blood pressure, diabetes, heart disease, arthritis, and certain types of cancers.
- Hypertension, indicated by high blood pressure, was identified as a health issue in three out of 19 interviews and one out of five focus groups.
- Hypertension was identified as a health need in the 2010 CVHP Community Health Needs Assessments.

Statistical data—How is hypertension measured? What is the prevalence/incidence rate of hypertension in the community?

In the CVHP service area:

- In 2009, a larger portion of the population (30.2%) was diagnosed with hypertension when compared to Los Angeles County (25.5%).

Hypertension Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Hypertension incidence	2009	30.2%	LAC	25.5%
Hypertension and hypertensive renal failure mortality per 10,000 persons	2010	1.3	CA	1.0

LAC = Los Angeles County

- In 2010, more (1.3) died of hypertension and hypertensive renal failure when compared to California (1.0) per 10,000 persons.

Sub-populations experiencing greatest impact (disparities)

Secondary data did not identify disparities among sub-populations on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders did not identify disparities among sub-populations.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- More people died of hypertension and hypertensive renal failure per 10,000 persons in the cities of La Verne (3.0), San Dimas (2.7), Diamond Bar (1.5), Azusa (1.5), Covina (1.4), West Covina (1.4), Glendora (1.2), and La Puente (1.1).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of hypertension in the community?

Smoking, obesity, the regular consumption of salt and fat, excessive drinking, and physical inactivity are risk factors for hypertension. People who have previously had a stroke, have high cholesterol, or have heart or kidney disease are also at higher risk of developing hypertension. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/ benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Cardiovascular Disease				
Cerebrovascular disease hospitalizations per 100,000 persons	2009	233.6	CA	221.5
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality per 100,000 persons[1]	2010	132.7	LAC	147.1
Stroke mortality per 100,000 persons	2010	38.6	LAC	37.6
Obesity/Overweight				
Adults who are obese	2009	21.4%	LAC	21.4%
Adults who are overweight	2010	36.4%	LAC	36.4%
Youth who are obese	2011	30.6%	CA	29.8%
Youth who are overweight	2011	15.1%	CA	14.3%

Indicators	Year	CVHP Service Area	Comparison Level	Comparison Avg.
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.9	CA	9.5
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

[1] Healthy People 2020 = <=100.8

Community input—What do community stakeholders think about the issue of hypertension?

Stakeholders identified hypertension as an important issue and attributed its prevalence to a lack of access to specialty care (such as cardiologists), long wait times to receive care at county hospitals, and the high cost of care. Stakeholders also linked hypertension to high blood pressure, diabetes, heart disease, arthritis, and certain types of cancers.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Hypertension-specific community assets:

- Azusa Pacific University – Neighborhood Wellness Center
- California Certified Farmers Markets
- Citrus Valley Medical Center – Queen of the Valley Campus
- Community Clinic Association of Los Angeles County
- East Valley Community Health Center
- Garfield Medical Center
- Herald Christian Health Center
- Los Angeles Community Garden Council
- Our Saviour Center - Cleaver Family Wellness Clinic

Stakeholders did not identify specific community resources available to address hypertension.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] National Institutes of Health. *Hypertension (High Blood Pressure).* Available at [http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97]. Accessed [March 12, 2013].

[2] National Heart, Lung, and Blood Institute. *Blood Pressure: Signs & Symptoms.* Available at [http://www.nhlbi.nih.gov/health/health-topics/topics/hbp/signs.html]. Accessed [March 12, 2013].

[3] National Institutes of Health. *Hypertension (High Blood Pressure).* Available at [http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97]. Accessed [March 12, 2013].

[4] The Patient Education Institute. *Essential Hypertension*. Available at [http://www.nlm.nih.gov/medlineplus/tutorials/hypertension/hp039105.pdf]. Accessed [March 12, 2013].

[5] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

Health Need Profile: Cardiovascular Disease

****Overall Ranking Resulting from Prioritization: 6 of 22**

About Cardiovascular Disease—Why is it important?

Cardiovascular disease—also called heart disease and coronary heart disease—includes several problems related to the buildup of plaque in the walls of the arteries, or atherosclerosis. Coronary heart disease is a leading cause of death in the United States and is associated with high blood pressure, high cholesterol, and heart attacks as well as other health outcomes including obesity, heavy alcohol consumption, and diabetes. As the plaque builds up, the arteries narrow, restricting blood flow and creating a risk for a heart attack. Currently more than one in three adults (81.1 million) lives with one or more types of cardiovascular disease. In addition to being the first and third leading causes of death, heart disease result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.[1]

Cardiovascular disease encompasses and/or is closely linked to a number of health conditions that include arrhythmia, atrial fibrillation, cardiac arrest, cardiac rehab, cardiomyopathy, cardiovascular conditions of childhood, cholesterol, congenital heart effects, diabetes, heart attack, heart failure, high blood pressure, HIV, metabolic syndrome, pericarditis, peripheral artery disease (PAD), and stroke.[2]

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities based on gender, age, race/ethnicity, geographic area, and socioeconomic status with regard to prevalence of risk factors, access to treatment, appropriate and timely treatment, treatment outcomes, and mortality.[3]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- More adults were hospitalized for heart disease (374.4) when compared to Los Angeles County (367.1).
- Hospitalizations resulting from cerebrovascular disease were higher (233.6) when compared to California (221.5).
- Those most often diagnosed with heart disease included the White (8.2%) and Hispanic/Latino (5.1%) populations.
- The cardiovascular disease mortality rate was highest in the southernmost part of Glendora, particularly in ZIP Code 91740 (195.8).
- Heart disease hospitalization rates per 100,000 persons were highest in San Dimas (507.3), Covina (419.2), Glendora (408.4), Hacienda Heights (405.5), La Puente (402.5), South El Monte (382.0), and El Monte (379.4).
- Heart disease mortality rates per 10,000 persons were highest in San Dimas (22.7), La Verne (21.7), Glendora (20.7), Covina (18.4), and West Covina (15.9).
- Cerebrovascular disease hospitalizations per 100,000 persons were highest in Glendora (340.9), San Dimas (315.5), La Verne (272.5), Covina (253.3), and West Covina (238.8).
- The cerebrovascular disease mortality rates per 10,000 persons were highest in Glendora (5.3), San Dimas (5.1), Covina (4.5), West Covina (4.4), and Rowland Heights (3.7).
- Stakeholders[4] identified the homeless, the aging, the uninsured, and adults over the age 35 as the most severely impacted.

- Stakeholders attributed cardiovascular disease to a lack of access to specialty care (such as cardiologists). Stakeholders also linked cardiovascular disease to high blood pressure, diabetes, arthritis, and certain cancers.
- Cardiovascular disease was identified as a major health issue in five of 19 interviews and one of five focus groups. Stroke was also raised as a concern in one of 19 interviews.
- Cardiovascular disease was identified as a health need in the 2010 CVHP Community Health Needs Assessments.

Statistical data—How is cardiovascular disease measured? What is the prevalence/incidence rate of cardiovascular disease in the community?

In the CVHP service area:

- In 2010, more adults were hospitalized for heart disease (374.4) when compared to Los Angeles County (367.1).
- In 2009, hospitalizations resulting from cerebrovascular disease were higher (233.6) when compared to California (221.5).

Cardiovascular Disease Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Cardiovascular disease mortality rate per 10,000 adults	2010	14.4	LAC	15.6
Heart disease hospitalizations per 100,000 adults	2010	374.4	LAC	367.1
Heart disease mortality rate per 100,000 adults[1]	2010	132.7	LAC	147.1
Heart disease prevalence (adults)	2009	5.8%	LAC	5.8%
Cerebrovascular disease hospitalizations per 100,000 persons	2009	233.6	CA	221.5
Cerebrovascular disease mortality per 10,000 persons	2010	3.6	CA	3.6

LAC=Los Angeles County

[1] Healthy People 2020 = <=100.8

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

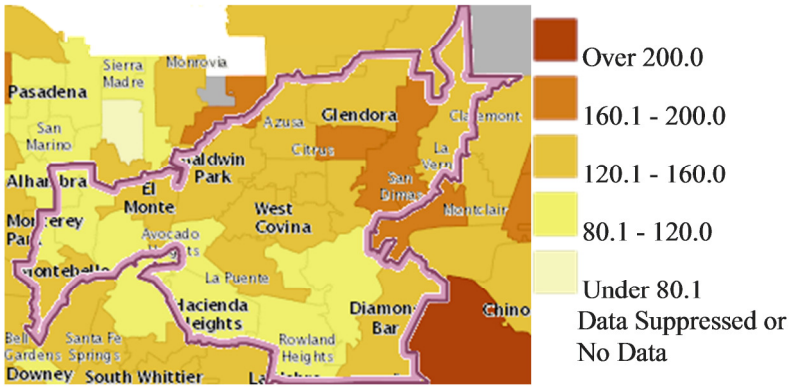
- Those most often diagnosed with heart disease included the White (8.2%) and Hispanic/Latino (5.1%) populations.
- Stakeholders identified the homeless, the aging, the uninsured, and adults over the age 35 as the most severely impacted.

Geographic areas of greatest impact (disparities)

Communities experiencing the highest disparities included (see map):

- The cardiovascular disease mortality rate was highest in the southernmost part of Glendora, particularly in ZIP Code 91740 (195.8).

Cardiovascular Disease Mortality, Rate (Per 100,000 Pop.), CDPH, 2008–10



By communities, the following disparities were found:

- Heart disease hospitalization rates per 100,000 persons were highest in San Dimas (507.3), Covina (419.2), Glendora (408.4), Hacienda Heights (405.5), La Puente (402.5), South El Monte (382.0), and El Monte (379.4).
- Heart disease mortality rates per 10,000 persons were highest in San Dimas (22.7), La Verne (21.7), Glendora (20.7), Covina (18.4), and West Covina (15.9).
- Cerebrovascular disease hospitalizations per 100,000 persons were highest in of Glendora (340.9), San Dimas (315.5), La Verne (272.5), Covina (253.3), and West Covina (238.8).
- Cerebrovascular disease mortality rates per 10,000 persons were highest in the cities of Glendora (5.3), San Dimas (5.1), Covina (4.5), West Covina (4.4), and Rowland Heights (3.7).
- Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of cardiovascular disease in the community?

The leading risk factors for heart disease are high blood pressure, high cholesterol, smoking, diabetes, poor diet, physical inactivity, and overweight and obesity. Cardiovascular disease is closely linked with and can often lead to stroke.[5] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Diabetes				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality rate per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
Obesity/Overweight				
Adults who are obese	2009	21.4%	LAC	21.4%

Indicators	Year	CVHP Service Area	Comparison Level	Comparison Avg.
Adults who are overweight	2010	36.4%	LAC	36.4%
Youth who are obese	2011	30.6%	CA	29.8%
Youth who are overweight	2011	15.1%	CA	14.3%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.9	CA	9.5
Hypertension				
Adults ever diagnosed with high blood pressure	2009	30.2%	LAC	25.5%
Hypertension and hypertensive renal mortality rate per 10,000 persons	2010	1.3	CA	1.0
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

Community input—What do community stakeholders think about the issue of cardiovascular disease?

Stakeholders attributed cardiovascular disease to a lack of access to specialty care (such as cardiologists). Stakeholders also linked cardiovascular disease to high blood pressure, diabetes, arthritis, and certain cancers.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Cardiovascular disease–specific community assets:

- American Heart Association
- Azusa Pacific University – Neighborhood Wellness Center
- California Certified Farmers Markets
- Citrus Valley Medical Center – Intercommunity Campus
- Community Clinic Association of Los Angeles County
- East Valley Community Health Center, Inc.
- Los Angeles Community Garden Council
- San Gabriel Valley Medical Center

Stakeholders did not identify community assets specific to cardiovascular disease.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21]. Accessed [February 28, 2013].

[2] Ibid.

[3] Ibid.

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[5] Ibid.

Health Need Profile: Cancer

****Overall Ranking Resulting from Prioritization: 7 of 22**

About Cancer—Why is it important?

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year.[1] In the United State, cancer incidence rates per 100,000 persons show that the three most common cancers among American men are prostate cancer (137.7), lung cancer (78.2), and colorectal cancer (49.2). Likewise, the leading causes of cancer death among men are lung cancer (62.0), prostate cancer (22.0), and colorectal cancer (19.1). Among women, the three most common cancers are breast cancer (123.1), lung cancer (54.1), and colorectal cancer (37.1). Lung (38.6), breast (22.2), and colorectal (13.1) cancers are also the leading causes of cancer-related deaths among women.[2]

Medical advances have allowed the number of new cancer cases to be reduced, and many cancer deaths can be prevented. Research indicates that screening for cervical and colorectal cancers, as recommended, helps to prevent these diseases by finding and treating precancerous lesions to prevent them from becoming cancerous. Screening for cervical, colorectal, and breast cancers also helps to find these diseases at an early, often highly treatable stage.[3] The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight, certain chemicals, some viruses and bacteria, a family history of cancer, poor diet, and lack of physical activity.[4] Cancer is associated with access to health care, obesity, heavy alcohol consumption, and specific cancers (breast, cervical, etc.).

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Cancer mortality rates per 10,000 persons were highest in La Verne (23.2), San Dimas (21.7), Hacienda Heights (19.6), Glendora (18.4), Covina (16.9), and West Covina (16.5).
- The lung cancer mortality rate per 100,000 persons was higher (30.2) when compared to Los Angeles County (29.0).
- Lung cancer mortality rates per 100,000 persons were highest in La Verne (63.0), Glendora (62.0), Hacienda Heights (33.2), Baldwin Park[5] (31.6), West Covina (29.8), Walnut (29.6), and San Dimas (29.5).
- The prostate cancer mortality rate per 100,000 men was higher (16.3) when compared to Los Angeles County (15.4).
- Prostate cancer mortality rates per 100,000 men were highest in San Dimas (30.3), Glendora (26.8), Covina (19.5), La Verne (18.6), Walnut (18.8), West Covina (17.9), and La Puente (17.4).
- The breast cancer mortality rates per 100,000 women were highest in La Verne (40.8), San Dimas (34.4), Azusa (28.7), Covina (23.5), and Walnut (21.8).
- Stakeholders[6] identified adults over the age of 35 as the most severely impacted.
- Stakeholders identified cancer as an issue and linked cancer to cardiovascular disease.
- Cancer was identified as a major health issue by community stakeholders in two out of 19 interviews and one out of five focus groups.
- Cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is cancer measured? What is the prevalence/incidence rate of cancer in the community?

In the CVHP service area:

- In 2008, the lung cancer mortality rate per 100,000 persons was higher (30.2) when compared to Los Angeles County (29.0).
- In 2008, the prostate cancer mortality rate per 100,000 men was higher (16.3) when compared to Los Angeles County (15.4).

Cancer Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Breast cancer mortality rate per 100,000 women	2008	18.7	LAC	21.2
Cancer mortality rate per 10,000 persons	2010	15.1	CA	15.1
Cancer mortality rate per 100,000 persons[1]	2010	154.3	LAC	156.5
Lung cancer mortality rate per 100,000 persons	2008	30.2	LAC	29.0
Prostate cancer mortality rate per 100,000 men	2008	16.3	LAC	15.4

LAC=Los Angeles County

[1] Healthy People 2020 = <=160.6

Sub-populations experiencing greatest impact (disparities)

- Secondary data did not identify disparities among sub-populations on the Kaiser Permanente CHNA data platform or other secondary sources.
- Stakeholders identified adults over the age of 35 as the most severely impacted.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- Cancer mortality rates per 10,000 persons were highest in La Verne (23.2), San Dimas (21.7), Hacienda Heights (19.6), Glendora (18.4), Covina (16.9), and West Covina (16.5).
- Breast cancer mortality rates per 100,000 women were highest in La Verne (40.8), San Dimas (34.4), Azusa (28.7), Covina (23.5), and Walnut (21.8).
- Lung cancer mortality rates per 100,000 persons were highest in La Verne (63.0), Glendora (62.0), Hacienda Heights (33.2), Baldwin Park[5] (31.6), West Covina (29.8), Walnut (29.6), and San Dimas (29.5).
- Prostate cancer mortality rates per 100,000 men were highest in San Dimas (30.3), Glendora (26.8), Covina (19.5), La Verne (18.6), Walnut (18.8), West Covina (17.9), and La Puente (17.4).
- Stakeholders did not identify specific geographic disparities. Instead, stakeholders mentioned that the entire San Gabriel Valley was impacted.

Associated drivers and risk factors—What is driving the high rates of cancer in the community?

A primary method of preventing cancer is screening for cervical, colorectal, and breast cancers.[7] The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight exposure, certain chemicals, some viruses and bacteria, a family history of cancer, poor diet, and lack of physical activity.[8] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing

worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison Level	Comparison Avg.
HEALTH OUTCOMES				
Obesity/Overweight				
Adults who are obese	2009	21.4%	LAC	21.4%
Adults who are overweight	2010	36.4%	LAC	36.4%
Youth who are obese	2011	30.6%	CA	29.8%
Youth who are overweight	2011	15.1%	CA	14.3%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
Unemployment	2012	10.4	LAC	10.3
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
Adults ages 50 and older who have had a sigmoidoscopy or colonoscopy in the last 5 years	2009	61.5%	LAC	65.5%
Adults ages 50 and older who received a sigmoidoscopy, colonoscopy, or fecal occult blood test	2009	28.3%	LAC	75.7%
Percent with cervical cancer screenings in last 3 years[1]	2010	67.6%	LAC	67.6%
Percent with cervical cancer screenings in last 3 years[2]	2007	84.9%	LAC	84.4%
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

[1] Healthy People 2020 = >=93%

[2] Healthy People 2020 = >=93%

Community input—What do community stakeholders think about the issue of cancer?

Stakeholders identified cancer as an issue. Stakeholders also linked cancer to cardiovascular disease.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Cancer-specific community assets:

- AltaMed Medical and Dental Group

- American Cancer Society
- Citrus Valley Medical Center – Queen of the Valley Campus
- City of Hope
- Community Clinic Association of Los Angeles County
- San Gabriel Valley Medical Center

Stakeholders did not identify community assets specific to cancer in general.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

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[1] Centers for Disease Control and Prevention. *Using Science to Reduce the Burden of Cancer.* Available at [http://www.cdc.gov/Features/CancerResearch/]. Accessed [March 7, 2013].

[2] Ibid.

[3] Centers for Disease Control and Prevention. *Cancer Prevention*. Available at [http://www.cdc.gov/cancer/dcpc/prevention/index.htm]. Accessed [March 7, 2013].

[4] National Cancer Institute. *Risk Factors*. Available at [http://www.cancer.gov/cancertopics/wyntk/cancer/page3]. Accessed [March 7, 2013].

[5] Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

[6] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[7] Centers for Disease Control and Prevention. *Cancer Prevention*. Available at [http://www.cdc.gov/cancer/dcpc/prevention/index.htm]. Accessed [March 7, 2013].

[8] National Cancer Institute. *Risk Factors*. Available at [http://www.cancer.gov/cancertopics/wyntk/cancer/page3]. Accessed [March 7, 2013].

Health Need Profile: Vision

****Overall Ranking Resulting from Prioritization: 8 of 22**

About Vision—Why is it important?

People with diabetes are at an increased risk of vision problems, as diabetes can damage the blood vessels of the eye, potentially leading to blindness. Diabetics are 40% more likely to suffer from glaucoma and 60% more likely to develop cataracts compared to people without diabetes. People who have had diabetes for a long time or whose blood glucose or blood pressure is not under control are also at risk of developing retinopathy.[1] These kinds of vision impairment cannot be corrected with glasses and typically require laser therapy or surgery.[2] Vision loss also makes it difficult for people to live independently.

As diabetes rates continue to rise among all age groups, vision complications tied to the disease are expected to increase as well. Vision care providers should expect to see more complications in the younger population as more children and adolescents are diagnosed with diabetes.[3]

Many eye problems are not evident until they are quite advanced, but early detection and treatment can be effective in saving vision. For example, screening for people with diabetes can almost completely eliminate diabetes-related blindness. However, only about half of diabetics in the United States currently get regular eye exams.[4]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Stakeholders[5] agreed that vision was an issue and attributed this to a lack of available services. They added that vision issues are not isolated to any group but instead are a widespread challenge. Vision screenings are much needed, especially for children who experience difficulty in school because they cannot see well.
- Vision was identified as a major health issue in one out of 19 interviews and three out of five focus groups.
- Vision was not identified as a need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is vision measured? What is the prevalence/incidence rate of vision issues in the community?

In the CVHP service area:

- In 2009, slightly more people (65.7%) had an eye exam in the past year when compared to Los Angeles County (63.3%).

Vision Indicator

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Had an eye exam in the past year	2009	65.7%	LAC	63.3%

LAC=Los Angeles County

Sub-populations experiencing greatest impact (disparities)

Secondary data for disparities among sub-populations were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders did not identify a specific population but instead added that everyone was severely impacted.

Geographic areas of greatest impact (disparities)

Secondary data for geographic disparities were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of vision problems in the community?

Diabetes-related vision problems are linked to the length of time one has had diabetes, high blood glucose, and high blood pressure. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Diabetes				
Diabetes hospitalizations rate per 10,000 adults	2010	10.5	LAC	9.7
Diabetes hospitalizations rate per 10,000 youth	2010	3.5	LAC	4.8
Diabetes hospitalizations rate per 100,000 adults	2010	147.4	LAC	145.6
Diabetes mortality per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	7.7%	LAC	7.7%
Uncontrolled diabetes hospitalizations per 10,000 persons	2010	12.7	LAC	9.5
Hypertension				
Adults ever diagnosed with high blood pressure	2009	30.2%	LAC	25.5%
Hypertension and hypertensive renal failure mortality rate per 10,000 persons	2010	1.3	CA	1.0
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

Community input—What do community stakeholders think about the issue of vision?

Stakeholders agreed that vision was an issue and attributed this to a lack of available services. They added that vision is not isolated to any group but instead is widespread. Vision screenings are much needed, especially for children who experience difficulty in school because they cannot see well.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Vision-specific community assets:

- Braille Institute
- Community Clinic Association of Los Angeles County
- Kaiser Foundation Hospital – Baldwin Park
- Lions Eye Foundation
- Los Angeles County Comprehensive Health Center - El Monte
- San Gabriel Valley Medical Center

Stakeholders identified the following community resources available to address vision issues:

- El Monte/South El Monte Emergency Resources Association - Community resource for vision care; provides free glasses to school children
- Western University for Health Sciences - Community resource for vision care; access to prescription lenses and glasses

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] American Diabetes Association. *Living with Diabetes.* Available at [http://www.diabetes.org/living-with-diabetes/complications/mens-health/serious-health-implications/blindness-or-vision-problems.html]. Accessed [March 5, 2013].

[2] Genevra Pittman, *Vision Loss Tied to Diabetes on the Rise*. Available at [http://www.reuters.com/article/2012/12/11/us-diabetes-vision-loss-idUSBRE8BA1AP20121211]. Accessed [March 5, 2013].

[3] Ibid.

[4] Ibid.

[5] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

Health Need Profile: Colorectal Cancer

****Overall Ranking Resulting from Prioritization: 9 of 22**

About Colorectal Cancer—why is it important?

Colorectal cancer, defined as cancer that starts in the colon or the rectum, is the second leading cause of cancer-related deaths in the United States and is expected to cause about 50,830 deaths during 2013. The lifetime risk of developing colorectal cancer is about one in 20 (5.1%), with the risk being slightly lower for women than in men.[1] In addition, colorectal cancer is associated with overall cancer mortality, heavy alcohol consumption, obesity, and diabetes prevalence.

The number of new colorectal cancer cases and the number of deaths from colorectal cancer are decreasing. The likely causes are regular screenings and improved treatment. Regular screenings can often detect colorectal cancer early on, when the disease is most likely to be curable. Screenings can also find polyps, which can be removed before turning into cancer.[2] As a result, there are now more than one million survivors of colorectal cancer in the United States.[3]

Given the success of colorectal cancer screening, public health organizations are working to increase awareness of these screenings among the general public and health care providers. Currently, only about half of Americans ages 50 or older have had any colorectal cancer screening.[4]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- The colorectal cancer incidence rate per 100,000 persons (45.2) did not meet the Healthy People 2020 rate of <=38.6.
- The colorectal mortality rate per 100,000 persons was highest in Glendora (18.9).
- African-Americans (59.9) had the highest colorectal cancer incidence rate compared to the other racial groups.
- Colorectal cancer was identified as a major health issue in one out of 19 interviews and one of five focus groups.
- Colorectal cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is colorectal cancer measured? What is the prevalence/incidence rate of colorectal cancer in the community?

In the CVHP service area:

- In 2009, the colorectal cancer incidence rate per 100,000 persons was the same (45.2) when compared to Los Angeles County.

Colorectal Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Colon cancer mortality rate per 100,000 persons (age-adjusted)	2008	7.7	LAC	11.2
Colorectal cancer incidence per 100,000 persons[1]	2009	45.2	LAC	45.2

LAC=Los Angeles County

[1] Healthy People 2020 = <=38.6

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

- African-Americans (59.9) had the highest colorectal cancer incidence rate compared to the other racial groups.

Stakeholders[5] did not identify disparities among sub-populations.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- The colorectal mortality rate per 100,000 persons was highest in Glendora (18.9).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of colorectal cancer in the community?

The major factors that can increase the risk of colorectal cancer are increasing age and a family history of colorectal cancer. Other less significant factors include a personal history of inflammatory bowel disease, inherited risk, heavy alcohol use, cigarette smoking, obesity, diabetes prevalence, and colon cancer screening.[6] Regular physical activity and diets high in vegetables, fruits, and whole grains have been linked with a decreased incidence of colorectal cancer.[7] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Diabetes				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality rate per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
Obesity/Overweight				
Adults who are obese	2009	21.4%	LAC	21.4%
Adults who are overweight	2010	36.4%	LAC	36.4%
Youth who are obese	2011	30.6%	CA	29.8%
Youth who are overweight	2011	15.1%	CA	14.3%
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
CLINICAL CARE				

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
Adults 50 years or older who had a sigmoidoscopy or colonoscopy in the last 5 years[1]	2009	61.5%	LAC	65.5%
Adults 50 years or older who had a sigmoidoscopy, colonoscopy, or fecal occult blood test	2009	28.3%	LAC	75.7%
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

[1] Healthy People 2020 = >=70.5%

Community input—What do community stakeholders think about the issue of colorectal cancer?

Stakeholders indicated that colon cancer was a prevalent issue in their communities.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Colorectal cancer–specific community assets:

- American Cancer Society
- Citrus Valley Medical Center – Intercommunity Campus
- City of Hope
- Community Clinic Association of Los Angeles County
- Crohn's and Colitis Foundation of America - Greater Los Angeles Chapter

Stakeholders did not identify community assets specific to colorectal cancer.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] American Cancer Society. *Colorectal Cancer*. Available at [http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics]. Accessed [March 4, 2013].

[2] American Cancer Society. *Colorectal Cancer*. Available at [http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-detection]. Accessed [March 4, 2013].

[3] American Cancer Society. *Colorectal Cancer*. Available at [http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics]. Accessed [March 4, 2013].

[4] Ibid.

[5] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[6] National Cancer Institute. *Colorectal Cancer Prevention.* Available at [http://www.cancer.gov/cancertopics/pdq/prevention/colorectal/Patient/page3#Keypoint4]. Accessed [March 4, 2013].

[7] American Cancer Society. *Colorectal Cancer*. Available at Available at [http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-risk-factors]. Accessed [March 4, 2013].

Health Need Profile: Disability

****Overall Ranking Resulting from Prioritization: 10 of 22**

About Disability– Why is it important?

An umbrella term for impairments, activity limitations, and participation restrictions, disability is the interaction between individuals with a health condition (e.g., cerebral palsy, Down syndrome, and depression) and personal and environmental factors (e.g., negative attitudes, inaccessible transportation and public buildings, and limited social supports).[1] Examples of disabilities include impairment of hearing, vision, movement, thinking, remembering, learning, communication, and/or mental health and social relationships. Disabilities can affect a person at any point in the life cycle.[2]

Over a billion people—corresponding to about 15% of the world population—are estimated to live with some form of disability. Between 110 million (2.2%) and 190 million (3.8%) people 15 years and older have significant difficulties functioning. In addition, rates of disability are increasing, in part as a result of aging populations and increases in chronic health conditions. People with disabilities typically have less access to health care services and often do not have their health care needs met.[3]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Stakeholders[4] mentioned the increase in children diagnosed with autism and developmental delays, including speech impediments. Stakeholders added that behavioral issues can lead to poor health.
- Stakeholders identified children as the most severely impacted.
- Disability, defined as developmental delays and/or as behavior issues, were identified in two out of 19 interviews and one of five focus groups, with stakeholders highlighting youth with IEPs (Individualized Education Plans) as a particularly impacted population.
- Disabilities were not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is disability measured? What is the prevalence/incidence rate of disability in the community?

In the CVHP service area:

- In 2010, the population with a disability (9.4%) was the same in Los Angeles County.

Disability Indicator

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Population with a disability	2010	9.4%	LAC	9.4%

LAC=Los Angeles County

Sub-populations experiencing greatest impact (disparities)

Secondary data for disparities among sub-populations were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders identified children as the most severely impacted.

Geographic areas of greatest impact (disparities)

Secondary data for geographic disparities were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders did not identify geographic disparities.

Associate drivers and risk factors—What is driving the high rates of disability in the community?

Disabilities may occur to anyone at any point in time; however, disability rates are increasing in part as a result of aging populations and increases in chronic health conditions. People with disabilities typically have less access to health care services and often do not have their health care needs met.[5] People with disabilities are more likely to experience difficulties or delays in getting the health care they need in a timely manner, including visiting a dentist and getting mammograms and Pap smear tests, among other important diagnostic and preventative resources. In addition, they are likely to not engage in physical activity, to smoke, to be overweight or obese, to have high blood pressure, to experience psychological distress, to receive less social/emotional support, and to have high unemployment rates.[6] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Diabetes				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality rate per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
Obesity/Overweight				
Adults who are obese	2009	21.4%	LAC	21.4%
Adults who are overweight	2010	36.4%	LAC	36.4%
Youth who are obese	2011	30.6%	CA	29.8%
Youth who are overweight	2011	15.1%	CA	14.3%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
Hypertension				
Adults ever diagnosed with high blood pressure	2009	30.2%	LAC	25.5%
Hypertension and hypertensive renal mortality rate per 10,000 persons	2010	1.3	CA	1.0
Mental Health				
Mental health treatment not received	2009	51.4%	LAC	47.3%
Mental health–related hospitalizations per 100,000 adults	2010	657.0	CA	551.7
Mental health–related hospitalizations per 100,000 youth	2010	375.4	CA	256.4
Serious psychological distress	2009	8.8%	LAC	7.3%
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
Unemployment	2012	10.4	LAC	10.3
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
Adults 50 and older who received a sigmoidoscopy, colonoscopy in the last 5 years2	2009	61.5%	LAC	65.5%
Adults 50 and older who received a sigmoidoscopy, colonoscopy, or fecal occult blood test	2009	28.3%	LAC	75.7%
Percent with cervical cancer screenings in last 3 years[2]	2010	67.6%	LAC	67.6%
Percent with cervical cancer screenings in last 3 years[3]	2007	84.9%	LAC	84.4%
Children who have never seen a dentist	2009	11.9%	LAC	10.5%
Teens who can't afford dental care	2009	53.2%	LAC	23.8%
Youth who can't afford dental care	2007	6.3%	LAC	6.2%
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

[1] Healthy People 2020 = >=70.5%

[2] Healthy People 2020 = >=93%

[3] Healthy People 2020 = >=93%

Community input—What do community stakeholders think about the issue of disability?

Stakeholders mentioned the increase in children diagnosed with autism and developmental delays, including speech impediments. Stakeholders added that behavioral issues can lead to poor health.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Disability-specific community assets:

- AltaMed Program for All-Inclusive Care for the Elderly (PACE) - El Monte
- California Children's Medical Services
- Citrus Valley Centers for Rehabilitation Services
- Community Clinic Association of Los Angeles County
- Family Resource Center Network of Los Angeles County
- Kindred Hospital - Baldwin Park
- Lincoln Training Center
- San Gabriel Pomona Parents Place
- San Gabriel/Pomona Regional Center
- Services Center for Independent Living

Stakeholders did not identify community assets specific to disability.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

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[1] World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at [http://www.who.int/mediacentre/factsheets/fs352/en/index.html]. Accessed [March 5, 2013].

[2] Center for Disease Control and Prevention. Atlanta, GA. Available at [http://www.cdc.gov/ncbddd/disabilityandhealth/types.html]. Accessed [March 5, 2013].

[3] World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at [http://www.who.int/mediacentre/factsheets/fs352/en/index.html]. Accessed [March 5, 2013].

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[5] World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at [http://www.who.int/mediacentre/factsheets/fs352/en/index.html]. Accessed [March 5, 2013].

[6] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=9 Accessed [March 5, 2013].

Health Need Profile: Intentional Injury

****Overall Ranking Resulting from Prioritization: 11 of 22**

About Intentional Injury—Why is it important?

Intentional injuries and violence are widespread in society and are among the top 15 causes of death of Americans of all ages. Injuries are the leading cause of death for Americans ages one to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from intentional injuries each year, and approximately one in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department. Beyond the immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to premature death, disability, poor mental health, high medical costs, and lost productivity.[1] In addition, violence erodes communities by reducing productivity, decreasing property values, and disrupting social services.[2]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- In 2010, the homicide rate per 100,000 persons was higher (5.9) than the Healthy People 2020 goal (<=5.5).
- Homicide rates per 100,000 persons were highest in West Covina (17.8), Covina (15.7), La Puente (10.1), Baldwin Park[3] (9.4), El Monte (7.5), and Glendora (7.3).
- Homicide by firearm rates per 100,000 persons was highest in La Puente (10.6).
- Non-fatal firearm hospitalizations per 100,000 persons were highest in Covina (9.9), Baldwin Park (9.1), and South El Monte (9.1).
- Stakeholders[4] identified teens as being the most impacted.
- Stakeholders identified homicide as a health need in one of 19 interviews and one of five focus groups.
- Intentional injury was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is intentional injury measured? What is the prevalence/incidence rate of intentional injuries in the community?

In the CVHP service area:

- In 2010, the homicide rate per 100,000 persons was higher (5.9) than the Healthy People 2020 goal (<=5.5).

Intentional Injury Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Homicide rate per 100,000 persons[1]	2010	5.9	LAC	7.0
Homicide by firearm rate per 100,000 persons	2009	2.2	CA	3.9
Non-fatal firearm hospitalizations per 100,000 persons	2010	4.5	CA	8.8

LAC=Los Angeles County

[1] Healthy People 2020: <=5.5

Sub-populations experiencing greatest impact (disparities)

Secondary data for disparities among sub-populations were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

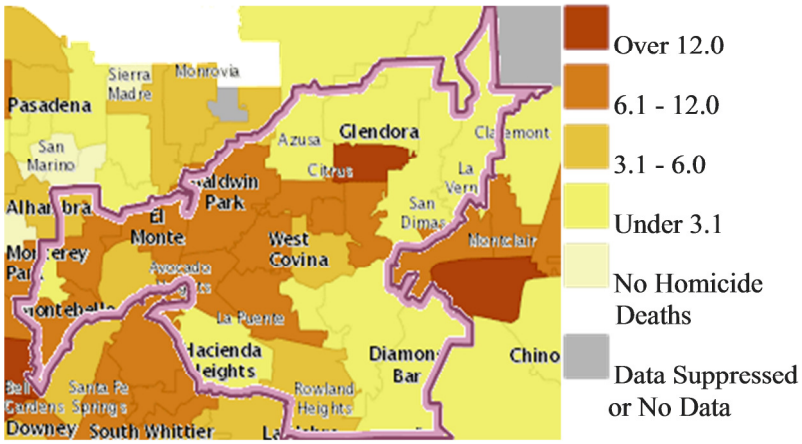
Stakeholders did not identify sub-populations.

Geographic areas of greatest impact (disparities)

Communities experiencing the highest disparities include (see map):

- Homicide rates were highest in the southernmost area of Glendora (12.2).

Homicide Mortality, Rate (Per 100,000 Pop.), CDPH, 2008–10



By communities, the following disparities were found:

- Homicide rates per 100,000 persons were highest in West Covina (17.8), Covina (15.7), La Puente (10.1), Baldwin Park (9.4), El Monte (7.5), and Glendora (7.3).
- Homicide by firearm rates per 100,000 persons was highest in La Puente (10.6).
- Non-fatal firearm hospitalizations per 100,000 persons were highest in Covina (9.9), Baldwin Park (9.1), and South El Monte (9.1).
- Stakeholders identified teens as being the most impacted.

Associated drivers and risk factors—What is driving the high rates of intentional injury in the community?

Factors associated with intentional injuries include high-risk behaviors such as alcohol use, risk-taking, socializing in unsafe and violent physical environments, as well as economic factors including poverty and unemployment.[5] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP

service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison Level	Comparison Avg.
HEALTH OUTCOMES				
Mental Health				
Mental health treatment not received	2009	51.4%	LAC	47.3%
Mental health–related hospitalizations per 100,000 adults	2010	657.0	CA	551.7
Mental health–related hospitalizations per 100,000 youth	2010	375.4	CA	256.4
Serious psychological distress	2009	8.8%	LAC	7.3%
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness facility establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
PHYSICAL ENVIRONMENT				
Fast food restaurants per 100,000 persons	2009	76.2	LAC	72.5
Grocery stores per 100,000 persons	2010	21.5	LAC	21.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

Community input—What do community stakeholders think about the issue of intentional injuries?

Stakeholders identified suicide as an issue, specifically among teens.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Intentional injury–specific community assets:

- Asian Pacific Women's Center
- Citrus Valley Medical Center – Foothill Presbyterian
- Community Clinic Association of Los Angeles County
- Kaiser Foundation Hospital – Baldwin Park
- PeaceBuilders
- Violence Prevention Coalition (VPC) of Los Angeles County

Stakeholders did not identify community assets specific to intentional injury.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=24]. Accessed [March 6, 2013].

[2] Centers for Disease Control and Prevention. Injury Center: *Violence Prevention*. Atlanta, GA. Available at [http://www.cdc.gov/ViolencePrevention/index.html]. Accessed [March 6, 2013].

[3] Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[5] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=24]. Accessed [March 6, 2013].

Health Need Profile: Alcohol and Substance Abuse

****Overall Ranking Resulting from Prioritization: 12 of 22**

About Alcohol and Substance Abuse—Why is it important?

Alcohol and substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse significantly contribute to costly social, physical, mental, and public health problems, including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide, and suicide. In addition to the considerable health implications, substance abuse has been a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.[1] Heavy alcohol consumption is an important determinant of future health needs, including cirrhosis, cancers, and untreated mental and behavioral health needs.

Alcohol and substance abuse is defined as adults (age 18 and older) who self-report heavy alcohol consumption.

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- The alcohol/drug-induced hospitalization rate of 91.4 per 100,000 in the CVHP service area was lower than the state average of 109.1 per 100,000.
- The alcohol/drug-induced mental disease hospitalization rate per 100,000 persons was higher in Covina (197.0), Glendora (129.2), La Verne (123.3), San Dimas (120.8) and La Puente (109.8) when compared to the overall CVHP service area (91.4).
- Alcoholic beverages expenditures were highest around the boundaries shared by Azusa and Glendora.
- Stakeholders[2] identified the homeless and adults over the age of 35 as most impacted.
- Stakeholders shared that there is a lack of information about or access to drug rehabilitation services, which is attributed to a cut in funding for these services. Stakeholders added that often services are not affordable.
- Stakeholders made the links between alcohol and substance abuse to poor mental health, HIV/AIDS, and poor physical health.
- Alcoholism was identified as a major concern by four out of 19 interviews and during one out of five focus groups.
- Alcohol and substance abuse was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is alcohol and substance abuse measured? What is the prevalence/incidence rate of alcohol and substance abuse in the community?

In the CVHP service area:

- The alcohol/drug-induced mental disease hospitalization rate in the CVHP service area was 91.4 per 100,000 adults, which is lower when compared to California (109.1).

Alcohol and Substance Abuse Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Alcohol- and drug-induced mental disease hospitalization per 100,000 adults	2010	91.4	LAC	109.1

LAC=Los Angeles County

Sub-populations experiencing greatest impact (disparities)

Secondary data for disparities among sub-populations were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

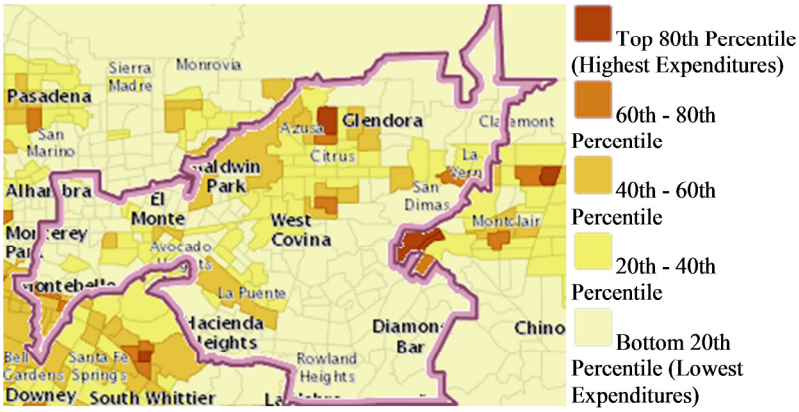
- Stakeholders identified the homeless and adults over the age of 35 as most impacted.

Geographic areas of greatest impact (disparities)

Communities experiencing the highest disparities include (see map):

- Alcoholic beverages expenditures were highest around the boundaries shared by Azusa and Glendora.

Ranked Alcoholic Beverage Expenditures (Pct. of Total Expenditures per Household), Nielsen Site Reports 2011



By communities, the following disparities were found:

- The alcohol/drug-induced mental disease hospitalization rates per 100,000 persons were higher in Covina (197.0), Glendora (129.2), La Verne (123.3), San Dimas (120.8), and La Puente (109.8) when compared to the overall CVHP service area (97.5).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of alcohol and substance abuse in the community?

Several biological, social, environmental, psychological, and genetic factors are associated with alcohol and substance abuse. These factors may include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community factors. Family, social networks, and peer pressure are key influencers of substance abuse among adolescents.[3] Teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide (intentional injuries), and suicide can be attributed to alcohol and

substance abuse.[4] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Intentional Injury				
Homicide rate per 100,000 persons[1]	2010	5.9	LAC	7.0
Homicide rate per 100,000 persons[1]	2008	6.1	LAC	8.4
Mental Health				
Needed but did not receive help for mental/emotional/alcohol-drug issues	2009	51.4%	LAC	47.3%
Suffered serious psychological distress in last year	2009	8.8%	LAC	7.3%
Mental health hospitalization rate per 100,000 adults	2010	657.0	CA	551.7
Mental health hospitalization rate per 100,000 youth	2010	375.4	CA	256.4
Unintentional Injury				
Motor vehicle mortality per 100,000 persons	2010	7.7	LAC	7.1
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Visited a park in the last month	2009	76.3%	LAC	79.3%
Recreation and fitness establishments per 100,000 persons	2009	5.7	LAC	7.5
SOCIAL AND ECONOMIC				
Unemployment rate	2012	10.4%	LAC	10.3%

LAC = Los Angeles County

CA = California

[1] Healthy People 2020 = <=5.5

Community input—What do community stakeholders think about the issue of alcohol and substance abuse?

Stakeholders shared that there is a lack of information about and access to drug rehabilitation services, which they attributed to a cut in funding for these services. Stakeholders also mentioned that services are often not affordable. Stakeholders linked alcohol and substance to poor mental health, HIV/AIDS, and poor physical health.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Alcohol/substance abuse–specific community assets:

- AltaMed Medical and Dental Group - El Monte
- Azusa Pacific University – Community Counseling Center
- BHC Alhambra Hospital
- Community Clinic Association of Los Angeles County
- Ettie Lee Youth and Family Services
- Kaiser Permanente – West Covina Behavioral Health Offices
- SPIRITT Family Services

Stakeholders did not identify community assets specific to alcohol and substance abuse.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32]. Accessed [February 26, 2013].

[2] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[3] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/lhi/substanceabuse.aspx?tab=determinants]. Accessed [February 27, 2013].

[4] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32]. Accessed [February 26, 2013].

Health Need Profile: Cervical Cancer

****Overall Ranking Resulting from Prioritization: 13 of 22**

About Cervical Cancer—*Why is it important?*

Cervical cancer is a disease in which cells in the cervix—the lower, narrow end of the uterus connecting the vagina (the birth canal) to the upper part of the uterus[1]—grow out of control. All women are at risk for cervical cancer, which occurs most often in women over the age of 30. Each year, approximately 12,000 women in the United States are diagnosed with cervical cancer. The human papillomavirus (HPV), a common virus that is passed from one person to another during sex, is the main cause of cervical cancer. At least half of sexually active people will have HPV at some point in their lives, but fortunately, fewer women will get cervical cancer.[2]

Most adults have been infected with HPV at some time in their lives, although most infections clear up on their own. An HPV infection that doesn't go away can cause cervical cancer in some women. Other risk factors, such as smoking, can increase the risk of cervical cancer among women infected with HPV. A woman's risk of cervical cancer can be reduced by having regular cervical cancer screening tests. Cervical cancer can be prevented, if abnormal cervical cell changes are found early on, by removing or destroying the cells before they become cancerous. Women can also reduce the risk of cervical cancer by getting an HPV vaccine before becoming sexually active (between the ages of 9 and 26). Even women who have had an HPV vaccine need regular cervical cancer screening tests.[3]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- The annual rate of cervical cancer was the same in Los Angeles County and in the CVHP service area, at 9.9 individuals per 100,000 persons, higher than the statewide rate of 8.3 per 100,000 and the national rate of 8 per 100,000 persons.
- The cervical cancer death rate in the CVHP service area was lower, at 2.2 individuals per 100,000 persons, than the Los Angeles County rate of 3 per 100,000 persons.
- Over one-third of the communities in the CVHP service area had cervical cancer mortality rates above Los Angeles County and the CVHP service area average including Diamond Bar (8.0), West Covina (5.2), La Puente (4.3), Rowland Heights (3.9), Walnut (3.6), and Baldwin Park (2.3).
- Cervical cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is cervical cancer measured? What is the prevalence/incidence rate of cervical cancer in the community?

In the CVHP service area:

- The incidence rate of cervical cancer was the same in Los Angeles County and in the CVHP service area, at 9.9 individuals per 100,000 adults, higher than the statewide rate of 8.3 per 100,000 and the national rate of 8 per 100,000 adults.
- The cervical cancer death rate in the CVHP service area was lower, at 2.2 individuals per 100,000 persons, than the Los Angeles County rate of 3 per 100,000 persons.

Cervical Cancer Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Cervical cancer incidence rate per 100,000 adults[1]	2009	9.9	LAC	9.9
Cervical cancer mortality rate per 100,000 adults[2]	2008	2.2	LAC	3.0

LAC=Los Angeles County

No data available for City of Industry and Irwindale.

[1] Healthy People 2020 = <=7.1

[2] Healthy People 2020 = <=2.2

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

- Those most often diagnosed with cervical cancer per 100,000 women include the Hispanic/Latina (13.2) and White (10.3) populations.

Stakeholders[4] did not identify geographic disparities.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- The cervical cancer mortality rates per 100,000 adults were higher in Diamond Bar (8.0), West Covina (5.2), La Puente (4.3), Rowland Heights (3.9), Walnut (3.6), and Baldwin Park (2.3) when compared to the overall CVHP service area (2.2).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of cervical cancer in the community?

Factors associated with cervical cancer include the common sexually transmitted human papillomavirus virus (HPV), smoking, having HIV or other conditions that cause the immune system to weaken, using birth control pills for an extended period of time (five or more years), and having given birth to three or more children.[5] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
SOCIAL AND ECONOMIC				
Unemployment	2012	10.4	LAC	10.3
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
Percent with cervical cancer screenings in last 3 years[1]	2010	67.6%	LAC	67.6%
Percent with cervical cancer screenings in last 3 years[1]	2007	84.9%	LAC	84.4%
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

[1] Healthy People 2020 = >=93%

Community input—What do community stakeholders think about the issue of cervical cancer?

Stakeholders did not comment on this issue.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Cervical cancer–specific community assets:

- American Cancer Society
- Asian Pacific Health Care Venture - El Monte Rosemead Health Center
- City of Hope
- Community Clinic Association of Los Angeles County
- East Valley Community Health Center, Inc.
- Kaiser Foundation Hospital – Baldwin Park
- Planned Parenthood Los Angeles
- Planned Parenthood Pasadena and San Gabriel Valley

Stakeholders did not identify community assets specific to cervical cancer.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Cervical Cancer Fact Sheet. Washington, DC. Available at [http://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf]. Accessed [March 4, 2013].

[2] Ibid.

[3] National Institutes of Health. National Cancer Institute. What you need to know about Cervical Cancer booklet. Bethesda, MD. Available at [http://www.cancer.gov/cancertopics/wyntk/cervix/page4]. Accessed [March 4, 2013].

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[5] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Cervical Cancer Fact Sheet. Washington, DC. Available at [http://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf]. Accessed [March 4, 2013].

Health Need Profile: Chlamydia

****Overall Ranking Resulting from Prioritization: 14 of 22**

About Chlamydia—Why is it important?

Chlamydia is the most frequently reported bacterial sexually transmitted infection in the United States. In 2011, 1,412,791 cases of chlamydia were reported to the Centers for Disease Control and Prevention (CDC) from 50 states and the District of Columbia, but an estimated 2.86 million infections occur annually. A large number of cases are not reported because most people with chlamydia do not have symptoms and do not seek testing.[1]

Chlamydial infections can lead to serious health problems. In women, untreated infection can cause pelvic inflammatory disease (PID), permanently damage a woman's reproductive tract, and lead to long-term pelvic pain, the inability to become pregnant, and potentially deadly ectopic pregnancies. In men, infection sometimes spreads to the tube that carries sperm from the testis, causing pain and fever and, rarely, affecting male fertility. Untreated chlamydia may also increase a person's chances of acquiring or transmitting HIV.[2]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Chlamydia rates were lower at 309.0 per 100,000 persons when compared to Los Angeles County (455.1).
- Chlamydia is a measure of poor health status and is associated with numerous other health factors, including poverty, heavy alcohol consumption, and unsafe sex practices.
- Chlamydia was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is chlamydia measured? What is the prevalence/incidence rate of chlamydia in the community?

In the CVHP service area:

- The chlamydia rate was 309.0 per 100,000 persons, which is lower than the rate for Los Angeles County (455.1).

Chlamydia Indicators

Indicators	Year	CVHP Service Area	Comparison Level	Comparison Avg.
Chlamydia rate per 100,000 persons	2009	476.3	LAC	476.3
Chlamydia rate per 100,000 persons	2010	309.0	LAC	455.1

LAC=Los Angeles County

No data available for City of Industry and Irwindale.

Sub-populations experiencing greatest impact (disparities)

Secondary data did not identify disparities among sub-populations on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders[3] did not identify sub-populations.

Geographic areas of greatest impact (disparities)

Secondary data did not identify geographic disparities on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of chlamydia in the community?

Chlamydia is associated with other factors, including poverty, heavy alcohol consumption, sexual activity, and age (young people are at a higher risk of acquiring chlamydia). Untreated chlamydia may increase a person's chances of acquiring or transmitting HIV.[4] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
Unemployment	2012	10.4	LAC	10.3
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

Community input—What do community stakeholders think about the issue of chlamydia?

Stakeholders did not comment on the issue.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Chlamydia-specific community assets:

- Asian Pacific Health Care Venture - El Monte Rosemead Health Center
- Beverly Hospital
- Community Clinic Association of Los Angeles County
- Our Saviour Center - Cleaver Family Wellness Clinic
- Planned Parenthood Los Angeles
- Planned Parenthood Pasadena and San Gabriel Valley

Stakeholders did not identify community assets specific to chlamydia.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] Centers for Disease Control and Prevention. *Chlamydia Fact Sheet*. Available at [http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm]. Accessed [February 27, 2013].

[2] Ibid.

[3] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[4] Centers for Disease Control and Prevention. *Chlamydia Fact Sheet*. Available at [http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm]. Accessed [February 27, 2013].

Health Need Profile: Asthma

****Overall Ranking Resulting from Prioritization: 15 of 22**

About Asthma—Why is it important?

Asthma is a disease that affects the lungs and is one of the most common long-term diseases of children. Adults also may suffer from asthma, and the condition is considered hereditary. In most cases, the causes of asthma are not known, and no cure has been identified. Although asthma is always present in those with the condition, attacks occur only when the lungs are irritated. Asthma symptoms include wheezing, breathlessness, chest tightness, and coughing. Some asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroach allergen, pet dander, mold, smoke, other allergens, and certain infections known to cause asthma such as the flu, colds, and respiratory-related viruses. Other contributing factors include exercising, certain medication, bad weather, high humidity, cold/dry air, and certain foods and fragrances.[1]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Asthma prevalence among adults living in the CVHP service area was the same as that in Los Angeles County at 11.1%.
- The CVHP service area had a slightly lower asthma hospitalization rate per 100,000 adults (89.2) than the statewide rate (94.3).
- Among CVHP service area youth, the asthma hospitalization rate per 10,000 youth was slightly higher (20.8) than the statewide rate (19.2).
- Multi-racial individuals (1.4%) experienced more asthma-related hospital discharges than other ethnic groups, and individuals between the ages of one and 19 (4.6%) experienced the most asthma-related hospital discharges.
- The westernmost part of the CVHP service area experienced high rates of asthma-related hospital discharges, including areas in El Monte and South El Monte.
- The overall CVHP service area patient discharge rate per 10,000 persons for asthma was 8.6. In El Monte, ZIP Code 91732 experienced 19.8 discharges per 10,000 persons. In South El Monte, ZIP Code 91733 experienced 17.5 discharges per 10,000 persons.
- The adult asthma hospitalization rate per 100,000 persons was higher in South El Monte (198.2), El Monte (171.7), Baldwin Park[2] (120.1), El Puente (103.2), and West Covina (107.9) when compared to the overall CVHP service area (89.2).
- Stakeholders[3] identified the homeless as the most impacted sub-population.
- Asthma was mentioned as a major health issue in one out of five focus groups and five out of 19 interviews.
- Asthma was not identified as a key health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is asthma measured? What is the prevalence/incidence rate of asthma in the community?

In the CVHP service area:

- The asthma hospitalization rate per 100,000 adults (89.2) was slightly lower than the statewide rate (94.3).
- Among youth, the asthma hospitalization rate per 10,000 youth was slightly higher (20.8) than the statewide rate (19.2).

Asthma Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Asthma prevalence (adults)	2010	11.1%	LAC	11.1%
Asthma hospitalization rate per 10,000 adults	2010	7.7	CA	7.7
Asthma hospitalization rate per 100,000 adults	2010	89.2	CA	94.3
Asthma hospitalization rate per 10,000 youth	2010	20.8	CA	19.2
Asthma hospitalization rate per 100,000 youth	2010	99.1	CA	112.3

LAC=Los Angeles County
CA = California

Sub-populations experiencing greatest impact (disparities)

- Multi-racial individuals (1.4%) experienced more asthma-related hospital discharges than other ethnic groups, and individuals between the ages of one and 19 (4.6%) experienced the most asthma-related hospital discharges.

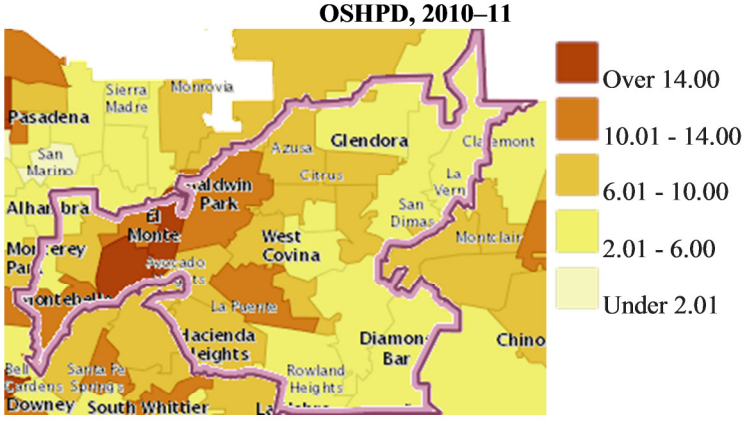
Stakeholders identified the homeless as the most impacted sub-population.

Geographic areas of greatest impact (disparities)

Communities experiencing the highest disparities include (see map):

- The westernmost part of the CVHP service area experienced high rates of asthma-related hospital discharges, including areas in El Monte and South El Monte.
- The overall CVHP service area patient discharge rate per 10,000 persons for asthma was 8.6. In El Monte, ZIP Code 91732 experienced 19.8 discharges per 10,000 persons. In South El Monte, ZIP Code 91733 experienced 17.5 discharges per 10,000 persons.

Asthma Discharge Rate (Per 10,000 Pop.), By ZCTA, OSHPD, 2010–11



By communities, the following disparities were found:

- The adult asthma hospitalization rate per 100,000 persons was higher in South El Monte (198.2), El Monte (171.7), Baldwin Park (120.1), West Covina (107.9), and El Puente (103.2) when compared to the overall CVHP service area (89.2).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of asthma in the community?

Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Allergic reactions are known to be caused by pollen, dust, food, insect stings, animal dander, mold, medications, and latex.[4] Other social and economic factors have been known to cause or trigger allergic reactions, including poverty, which leads to poor housing conditions (living with cockroaches, mites, asbestos, mold, etc.). Living in an environment or home with smokers has also been known exacerbate allergies and/or asthma. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Asthma				
Asthma hospitalizations per 10,000 youth	2010	20.8	CA	19.2
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
Unemployment	2012	10.4	LAC	10.3
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

Community input—What do community stakeholders think about the issue of asthma?

Stakeholders indicated that asthma and respiratory illness was on the rise. Stakeholders attributed the prevalence of asthma to the inability of people to control their respiratory conditions.

> *"Respiratory problems such as asthma, pneumonia, chronic respiratory disease, [and] pulmonary disease are not controlled well and can lead to death. If they [the homeless] were housed and out of the elements, they might not have died, as they need to leave the shelter in the daytime when it's still cold outside."*
> *(executive director, resource center)*

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Asthma-specific community assets:

- American Lung Association
- Asthma & Allergy Foundation of America - California Chapter
- Asthma Coalition of Los Angeles County (ACLAC)
- BREATHE California of Los Angeles County
- Community Clinic Association of Los Angeles County
- East Valley Community Health Center, Inc.
- San Dimas Community Hospital

Stakeholders did not identify community assets specific to asthma.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] Centers for Disease Control and Prevention (CDC). Asthma-Basic Information. Atlanta, GA. Available at [http://www.cdc.gov/asthma/faqs.htm]. Accessed [March 1, 2013].

[2] Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

[3] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[4] American Academy of Allergy Asthma and Immunology. Allergies. Landover, MD. Available at [http://www.aafa.org/display.cfm?id=9]. Accessed [March 1, 2013].

Health Need Profile: Alzheimer's Disease

****Overall Ranking Resulting from Prioritization: 16 of 22**

About Alzheimer's Disease—Why is it important?

An estimated 5.4 million Americans have Alzheimer's disease, which is the sixth leading cause of death in the U.S.[1] Alzheimer's, an irreversible and progressive brain disease, is the most common cause of dementia among older people. The disease is characterized by the loss of cognitive functioning and ranges in severity from the mildest stage of minor cognitive impairment to the most severe stage of complete dependence on others to carry out the simplest tasks of daily living. People with Alzheimer's disease and other dementias have more hospital stays, skilled nursing facility stays, and home health care visits than other older people.[2]

The likely causes of Alzheimer's disease include some combination of age-related changes in the brain, a family history of Alzheimer's, and genetic, environmental, and lifestyle factors. Some data suggest that cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury are associated with a higher risk of developing Alzheimer's disease.[3]

Currently, there is no cure for Alzheimer's disease, although treatment can help manage symptoms and slow the progression of the disease.[4] People with Alzheimer's can experience a significant improvement in quality of life with active medical management for the disease. Active management includes: "(1) appropriate use of available treatment options, (2) effective management of coexisting conditions, (3) coordination of care among physicians, other health care professionals and lay caregivers, (4) participation in activities and adult day care programs and (5) taking part in support groups and supportive services such as counseling (p. 12)."[5]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- The Alzheimer's disease mortality rate per 10,000 persons was higher in La Verne (6.6), San Dimas (5.7), Glendora (5.5), and Covina (3.6).
- Stakeholders[6] identified people over the age of 85 years of age who are uninsured, low-income, Latino, and Asian as most impacted.
- Stakeholders shared that, given the increase in the aging population, there is an increased need for services, including diagnosis.
- Alzheimer's disease was identified as a major health need in three out of 19 interviews, but was not indicated as a major need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is Alzheimer's disease measured? What is the prevalence/incidence rate of Alzheimer's disease in the community?

In the CVHP service area:

- The Alzheimer's disease mortality rate per 100,000 persons was slightly higher (17.9) when compared to Los Angeles County (17.6).
- The Alzheimer's disease mortality rate per 10,000 persons was lower (2.6) in the CVHP service area than statewide (2.9).

Alzheimer's Disease Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Alzheimer's disease mortality rate per 100,000 persons (age-adjusted)	2009	17.9	LAC	17.6
Alzheimer's disease mortality rate per 10,000 persons	2010	2.6	CA	2.9

LAC = Los Angeles County
CA = California
No data available for City of Industry and Irwindale.

Sub-populations experiencing greatest impact (disparities)

Secondary data for disparities among sub-populations were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

- Stakeholders identified people over the age of 85 years of age who are uninsured, low-income, Latino, and Asian as the most impacted.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- The Alzheimer's disease mortality rate per 10,000 persons was higher in La Verne (6.6), San Dimas (5.7), Glendora (5.5), and Covina (3.6).
- Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—what is driving the high rates of Alzheimer's disease in the community?

The greatest risk factor for Alzheimer's disease is advancing age. Other risk factors include a family history of Alzheimer's, genetic mutations, cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury.[7] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Cardiovascular Disease				
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons[1]	2010	132.7	LAC	147.1
Stroke mortality rate per 100,000 persons	2010	38.6	LAC	37.6
Cerebrovascular disease hospitalizations per 100,000 persons	2009	233.6	CA	221.5

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Diabetes				
Diabetes prevalence	2009	18.5%	LAC	10.5%
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
Diabetes mortality rate per 10,000 persons	2010	2.1	CA	1.9
Hypertension				
Adults ever diagnosed with high blood pressure	2009	30.2%	LAC	25.5%
Hypertension and hypertensive renal mortality rate per 10,000 persons	2010	1.3	CA	1.0

LAC = Los Angeles County

CA = California

[1] Healthy People 2020 = <=100.8

Community input—What do community stakeholders think about the issue of Alzheimer's disease?

Stakeholders shared that, given the increase in the aging population, there is an increased need for services, including diagnoses.

> *"There is an increasing need for services for older adults, especially with the anticipated increase in the number of people with Alzheimer's." (health professional)*

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Alzheimer's disease–specific community assets:

- AltaMed Program for All-Inclusive Care for the Elderly (PACE) - El Monte
- Alzheimer's Association, California Southland Chapter
- Chinatown Service Center - Alhambra
- Community Clinic Association of Los Angeles County
- Doctors Hospital of West Covina, Inc.
- Los Angeles County Area Agency on Aging
- San Gabriel Valley Medical Center

Stakeholders did not identify community assets specific to Alzheimer's disease.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] Alzheimer's Association. *2012 Alzheimer's Disease Facts and Figures.* Available at [http://www.alz.org/downloads/facts_figures_2012.pdf]. Accessed [March 6, 2013].

[2] National Institutes of Health. *About Alzheimer's Disease: Alzheimer's Basics*. Available at [http://www.nia.nih.gov/alzheimers/topics/alzheimers-basics]. Accessed [March 5, 2013].

[3] Alzheimer's Association. *2012 Alzheimer's Disease Facts and Figures.* Available at [http://www.alz.org/downloads/facts_figures_2012.pdf]. Accessed [March 6, 2013].

[4] National Institutes of Health. *About Alzheimer's Disease: Alzheimer's Basics*. Available at [http://www.nia.nih.gov/alzheimers/topics/alzheimers-basics]. Accessed [March 5, 2013].

[5] Alzheimer's Association. *2012 Alzheimer's Disease Facts and Figures.* Available at [http://www.alz.org/downloads/facts_figures_2012.pdf]. Accessed [March 6, 2013].

[6] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[7] Alzheimer's Association. *2012 Alzheimer's Disease Facts and Figures.* Available at [http://www.alz.org/downloads/facts_figures_2012.pdf]. Accessed [March 6, 2013].

Health Need Profile: Unintentional Injury

****Overall Ranking Resulting from Prioritization: 17 of 22**

About Unintentional Injury—Why is it important?

Unintentional injuries include deaths resulting from motor vehicle accidents and from pedestrians being killed in accidents. Motor vehicle accidents are one of the leading causes of death in the U.S., with more than 2.3 million adult drivers and passengers treated in emergency departments as a result of injuries motor vehicle crashes in 2009. The economic impact is also notable: the lifetime costs of accident-related deaths and injuries among drivers and passengers were $70 billion in 2005.[1] In 2007, 4,820 pedestrians were killed in traffic accidents in the United States, and another 118,278 pedestrians were injured. This averages one accident-related pedestrian death every two hours, and a pedestrian injury every four minutes. Pedestrians are one and a half times more likely than passenger vehicle occupants to be killed in a car accident on any given trip.[2] Populations most at risk are older adults, children, and drivers and pedestrians who are under the influence of alcohol and drugs.[3]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- The portion of pedestrians killed in motor vehicle accidents was lower (21.0%) in the CVHP service area than in Los Angeles County (25.7%).
- In the CVHP service area, the mortality rate for unintentional injuries per 10,000 persons was lower (1.6) compared with the statewide rate (2.7).
- The motor vehicle mortality rate in the CVHP service area was 7.7 per 100,000 persons, which is above the Los Angeles County rate of 7.1 and lower than the statewide rate of 8.2.
- Morality rates due to unintentional injuries per 10,000 persons were higher in San Dimas (2.7), South El Monte (2.3), Glendora (2.0), Rowland Heights (1.8), Hacienda Heights (1.7), and La Puente (1.7) when compared to the CVHP service area average rate of 1.6.
- Stakeholders[4] identified the homeless and adults over the age of 35 as most impacted.
- Health factors associated with unintentional injury include poverty, education, and heavy alcohol consumption.
- Unintentional injury was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is unintentional injury measured? What is the prevalence/incidence rate of unintentional injuries in the community?

In the CVHP service area:

- There was a slightly higher motor vehicle mortality rate per 100,000 persons (7.7) when compared to Los Angeles County (7.1).

Unintentional Injury Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Pedestrians killed	2008	21.0%	LAC	25.7%
Unintentional injuries mortality rate per 10,000 persons	2010	1.6	CA	2.7
Motor vehicle mortality rate per 100,000 persons	2010	7.7	LAC	7.1
Pedestrian motor vehicle mortality rate per 100,000 persons	2010	1.3	LAC	1.5

LAC=Los Angeles County
CA=California

Sub-populations experiencing greatest impact (disparities)

Secondary data on disparities among sub-populations were not available.

Stakeholders did not identify disparities among sub-populations.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- Morality rates due to unintentional injuries per 10,000 persons were higher in San Dimas (2.7), South El Monte (2.3), Glendora (2.0), Rowland Heights (1.8), Hacienda Heights (1.7), and La Puente (1.7) when compared to the CVHP service area average rate of 1.6.
- Stakeholders identified that the homeless and adults over the age of 35 are most impacted.

Associated drivers and risk factors—What is driving the high rates of intentional injury in the community?

Populations most at risk for unintentional injuries include older adults, children, and drivers and pedestrians who are under the influence of alcohol and drugs.[5] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Mental Health				
Mental health treatment not received	2009	51.4%	LAC	47.3%
Mental health–related hospitalizations per 100,000 adults	2010	657.0	CA	551.7
Mental health–related hospitalizations per 100,000 youth	2010	375.4	CA	256.4
Serious psychological distress	2009	8.8%	LAC	7.3%

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
SOCIAL AND ECONOMIC				
Unemployed	2012	10.4%	LAC	10.4%
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider rate per 100,000 persons	2011	80.6	LAC	80.7

LAC—Los Angeles County
CA—California

Community input—What do community stakeholders think about the issue of unintentional injuries?

Stakeholders did not comment on the issue.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Unintentional injury–specific community assets:

- Beverly Hospital
- Bike San Gabriel Valley
- Community Clinic Association of Los Angeles County
- Healthy Way LA
- Los Angeles County Bicycle Coalition
- Los Angeles County Comprehensive Health Center - El Monte
- Los Angeles Walks

Stakeholders did not identify community assets specific to unintentional injury.

*For information on other assets in the community, please refer to Section **Error! Reference source not found.** of the Community Health Needs Assessment report.*

[1] Centers for Disease Control and Prevention. Injury Center: Injury Prevention & Control: Motor Vehicle Safety. Atlanta, GA. Available at [http://www.cdc.gov/motorvehiclesafety/]. Accessed [March 7, 2013].

[2] Centers for Disease Control and Prevention. Injury Center: Injury Prevention & Control: Pedestrian Safety. Atlanta, GA. Available at [http://www.cdc.gov/Motorvehiclesafety/Pedestrian_safety/index.html]. Accessed [March 7, 2013].

[3] Centers for Disease Control and Prevention. Injury Center: Injury Prevention & Control: Pedestrian Safety Fact Sheet. Atlanta, GA. Available at [http://www.cdc.gov/Motorvehiclesafety/Pedestrian_Safety/factsheet.html]. Accessed [March 7, 2013].

[4] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[5] Centers for Disease Control and Prevention. Injury Center: Injury Prevention & Control: Pedestrian Safety Fact sheet. Atlanta, GA. Available at [http://www.cdc.gov/Motorvehiclesafety/Pedestrian_Safety/factsheet.html]. Accessed [March 7, 2013].

Health Need Profile: Arthritis

****Overall Ranking Resulting from Prioritization: 18 of 22**

About Arthritis—Why is it important?

Arthritis affects one in five adults in the United States and continues to be the most common causes of physical disability. Arthritis costs more than $128 billion per year currently in the United States, and is projected to increase over time as the population ages. Interventions such as increased physical activity, education about disease self-management, and weight loss among overweight/obese adults can reduce arthritis pain and functional limitations; however, these resources are underutilized.[1]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Arthritis was identified as a major health concern in three out of 19 interviews.
- Arthritis was not identified as a major need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is arthritis measured? What is the prevalence/incidence rate of arthritis in the community?

Secondary data for arthritis were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

Sub-populations experiencing greatest impact (disparities)

Secondary data for arthritis disparities among sub-populations were not available on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders[2] did not identify sub-populations.

Geographic areas of greatest impact (disparities)

Secondary data was not available for the geographic disparities on the Kaiser Permanente data platform or other secondary sources.

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of arthritis in the community?

Factors associated with arthritis include being overweight or obese, lack of education around self-management strategies and techniques, and limited or no physical activity.[3] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHPH Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Visited a park in the last month	2009	76.3%	LAC	79.3%
Recreation and fitness establishments per 100,000 persons	2009	5.7	LAC	7.5
Eat fast food 4 times a week or more	2009	15.5%	LAC	12.5%
Soft drink expenditures	2010	0.49%	CA	0.46%

LAC = Los Angeles County
CA = California

Community input—What do community stakeholders think about the issue of arthritis?

Stakeholders did not comment on the issue.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Arthritis-specific community assets:
Stakeholders did not identify community assets specific to unintentional injury.

- AltaMed Program for All-Inclusive Care for the Elderly (PACE) – El Monte
- Community Clinic Association of Los Angeles County
- Kindred Hospital - Baldwin Park
- Los Angeles County Area Agency on Aging
- San Dimas Community Hospital

Stakeholders did not identify community assets specific to arthritis.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=3]. Accessed [February 26, 2013].

[2] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[3] Ibid.

Health Need Profile: Chronic Obstructive Pulmonary Disease

****Overall Ranking Resulting from Prioritization: 19 of 22**

About Chronic Obstructive Pulmonary Disease—Why is it important?

Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases—including emphysema and chronic bronchitis—that block airflow and make breathing difficult. Although men (46.4 per 100,000 persons) in the United States had higher COPD death rates than women (34.2 per 100,000 persons) in 2006, the death rates for COPD declined significantly for men (from 57.0 per 100,000 persons) but did not for women (from 35.3 per 100,000 persons) between 1999 and 2006.[1]

The primary cause of COPD is long-term tobacco smoking; approximately 20% of chronic smokers develop COPD. Other risk factors that can lead to the development of COPD include a genetic susceptibility to the disease, inhaling other irritants (e.g., cigar smoke, secondhand smoke, air pollution), smoking if you have been diagnosed with asthma, occupational exposure to dusts and chemicals, and age.[2] COPD prevention efforts focus on smoking prevention or cessation. Lung damage from COPD is irreversible, though treatment can minimize further damage and help to control symptoms.[3]

In California, nearly 4%, or approximately 1.1 million people, have been diagnosed with COPD. Among those diagnosed, more than half (3.9% or 550,000) live in Southern California (Los Angeles, Orange, Ventura, San Bernardino, Riverside, San Diego, and Imperial counties). Nearly one-fifth of California adults with COPD—or approximately 197,000 people (3.1%)—are residents of Los Angeles County.[4]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- In Los Angeles County, more Whites (3.6%) had COPD. In addition, more females (3.7%) and more over the age of 65 years (7.1%) had COPD.
- The communities of San Dimas (6.3), Glendora (5.7), La Verne (4.5), and Covina (4.0) had higher rates of chronic lower respiratory disease per 10,000 persons when compared to California (3.5).
- COPD was identified as a health issue in two of 19 interviews.
- COPD was not identified as a health need in the 2010 CVHP Community Health Needs Assessments.

Statistical data—How is COPD measured? What is the prevalence/incidence rate of COPD in the community?

- In 2011, COPD was less prevalent (3.1%) in the CVHP service area when compared to California (4.0%).

COPD Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
COPD prevalence	2011	3.1%*	CA	4.0%
Chronic lower respiratory disease per 10,000 persons	2010	3.2	CA	3.5

LAC=Los Angeles County
CA=California
* Represents Los Angeles County

Sub-populations experiencing greatest impact (disparities)

- In Los Angeles County, more Whites (3.6%) have COPD. In addition, more females (3.7%) and more over the age of 65 years (7.1%) have COPD.

Stakeholders[5] did not identify sub-populations.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- San Dimas (6.3), Glendora (5.7), La Verne (4.5), and Covina (4.0) had higher rates of chronic lower respiratory disease per 10,000 persons when compared to California (3.5).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of COPD in the community?

Known drivers or risk factors include smoking, air pollution exposure, recurrent infection, diet, and genetic factors.[6] COPD is also the cause of disabilities and death.[7] The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Mental Health				
Mental health treatment not received	2009	51.4%	LAC	47.3%
Mental health–related hospitalizations per 100,000 adults	2010	657.0	CA	551.7
Mental health–related hospitalizations per 100,000 youth	2010	375.4	CA	256.4
Serious psychological distress	2009	8.8%	LAC	7.3%
BEHAVIORAL				
Not physically active (youth)	2010	38.4%	CA	37.5%
Recreation and fitness establishments per 100,000 persons	2009	5.7	LAC	7.5
Visited a park in the month	2009	76.3%	LAC	79.3%
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
Unemployment	2012	10.4	LAC	10.3
CLINICAL CARE				
Preventable hospital admissions (ACSC) per 1,000 admissions	2010	97.9	CA	88.5
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

Community input—What do community stakeholders think about the issue of COPD?

Stakeholders did not comment on this issue.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of COPD-specific community assets:

- American Lung Association
- Azusa Pacific University – Neighborhood Wellness Center
- Breath Savers
- Community Clinic Association of Los Angeles County
- Kaiser Foundation Hospital – Baldwin Park
- San Dimas Community Hospital

Stakeholders did not identify community assets specific to chronic obstructive pulmonary disease (COPD).

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] Centers for Disease Control and Prevention. *Chronic Obstructive Pulmonary Disease (COPD)*. Available at [http://www.cdc.gov/copd/data.htm]. Accessed [March 8, 2013].

[2] Mayo Clinic. *COPD Risk Factors.* Available at [http://www.mayoclinic.com/health/copd/DS00916/DSECTION=risk-factors]. Accessed [March 8, 2013].

[3] Mayo Clinic. *COPD.* Available at [http://www.mayoclinic.com/health/copd/DS00916]. Accessed [March 8, 2013].

[4] UCLA Center for Health Policy Research. *Chronic Obstructive Pulmonary Disease Burden in California and Southern California, 2011*. Available at http://healthpolicy.ucla.edu/publications/Documents/PDF/copdpnoct2012.pdf]. Accessed [April 29, 2012].

[5] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[6] Ibid.

[7] Ibid.

Health Need Profile: HIV/AIDS

****Overall Ranking Resulting from Prioritization: 20 of 22**

About HIV/AIDS—Why is it important?

More than 1.1 million people in the United States are living with HIV, and almost one in five (18.1%) are unaware of their infection.[1] HIV infection weakens the immune system, making those living with the infection highly susceptible to a variety of illnesses and cancers, including tuberculosis (TB), cytomegalovirus (CMV), cryptococcal meningitis, lymphomas, kidney disease, and cardiovascular disease.[2] Without treatment, almost all people infected with HIV will develop AIDS.[3] While HIV is a chronic medical condition that can be treated, it cannot yet be cured.

The risk of acquiring HIV is increased by engaging in unprotected sex, having another sexually transmitted infection, sharing intravenous drugs, having been diagnosed with hepatitis, tuberculosis, or malaria, exchanging sex for drugs or money, and having been exposed to the virus as a fetus or infant before or during birth, or through breastfeeding from a mother infected with HIV.[4] Racial disparities in HIV prevalence persist; African-Americans and Hispanics/Latinos are disproportionately affected by HIV and experience the most severe burdens compared with other races and ethnicities in the United States. Prevention efforts encompass many components, such as behavioral interventions, HIV testing, and linkage to treatment and care.[5]

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Within the CVHP service area, a larger proportion of African-Americans (0.3%) experienced hospital discharges resulting from HIV than Whites (0.1%) and multi-racial persons (0.1%).
- Those between the ages of 20 and 44 (0.1%) and 45 and 64 (0.2%) experienced the most hospitalizations resulting from HIV compared to other age groups.
- HIV hospitalizations per 100,000 persons was higher in Covina (14.0), El Monte (13.3), Glendora (11.8) , La Puente (9.4), Walnut (9.3), and South El Monte (6.8) when compared to the overall CVHP service area (6.6).
- The HIV mortality rate per 100,000 persons, were higher in West Covina (6.1), La Puente (4.7), Covina (3.9), El Monte (3.0), San Dimas (2.4), and Rowland Heights (2.0) than the overall CVHP service area (1.9).
- HIV/AIDS is associated with numerous health factors, including poverty, heavy alcohol consumption, lack of timely HIV screenings, and liquor store access.
- HIV/AIDS was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is HIV/AIDS measured? What is the prevalence/incidence rate of HIV/AIDS in the community?

In the CVHP service area:

- HIV prevalence per 100,000 persons was slightly lower (480.3) when compared to Los Angeles County (480.4).

HIV/AIDS Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HIV prevalence per 100,000 persons	2008	480.3	LAC	480.4
HIV hospitalizations per 10,000 persons	2011	0.9	LAC	2.2
HIV hospitalizations per 100,000 persons	2010	6.6	CA	11.0

LAC=Los Angeles County
CA=California

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

- A larger proportion of African-Americans (0.3%) experienced hospital discharges resulting from HIV than Whites (0.1%) and multi-racial people (0.1%).
- Those between the ages of 20 and 44 (0.1%) and 45 and 64 (0.2%) experienced the most hospitalizations resulting from HIV compared to other age groups.

Stakeholders did not identify disparities among sub-populations.

Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

- HIV hospitalizations per 100,000 persons was higher in Covina (14.0), El Monte (13.3), Glendora (11.8) , La Puente (9.4), Walnut (9.3), and South El Monte (6.8) when compared to the overall CVHP service area (6.6).
- The HIV mortality rate per 100,000 persons, were higher in West Covina (6.1), La Puente (4.7), Covina (3.9), El Monte (3.0), San Dimas (2.4), and Rowland Heights (2.0) than the overall CVHP service area (1.9).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of HIV/AIDS in the community?

The following factors are associated with HIV/AIDS: injection drug use, risky sexual behaviors,[6] poverty, heavy alcohol consumption, liquor store access, and HIV screenings. HIV prevalence is highest among gay, bisexual, and other men who have sex with men, and among African-Americans.[7]

Untreated HIV infection is associated with many diseases, including cardiovascular disease, kidney disease, liver disease, and cancer.[8] Persons with HIV infections are disproportionately affected by viral hepatitis, and those co-infected with HIV and viral hepatitis experience greater liver-related health problems than those who do not have the HIV infection.[9] The table below includes drivers that did not meet the indicated benchmark, indicating that the

CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Cancers				
Cervical cancer incidence rate per 100,000 persons[1]	2009	9.9	LAC	9.9
Cervical cancer mortality rate per 100,000 persons (age adjusted)[2]	2008	2.2	LAC	3.0
Colorectal cancer incidence rate per 100,000 persons[3]	2009	45.2	LAC	45.2
Lung cancer mortality rate per 100,000 persons	2008	30.2	LAC	29.0
Prostate cancer mortality rate per 100,000 males	2008	16.3	LAC	15.4
Cardiovascular Disease				
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons[4]	2010	132.7	LAC	147.1
Stroke mortality rate per 100,000 persons	2010	38.6	LAC	37.6
Cerebrovascular disease hospitalizations per 100,000 persons	2009	233.6	CA	221.5
ACCESS TO CARE				
Lack of a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC=Los Angeles County

CA=California

[1] Healthy People 2020 = <=7.1

[2] Healthy People 2020 = <=2.2

[3] Healthy People 2020 = <=38.6

[4] Healthy People 2020 = <=100.8

Community input—What do community stakeholders think about the issue of HIV/AIDS?

Stakeholders did not comment on the issue.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of HIV/AIDS-specific community assets:

- AIDS Project Los Angeles
- Alliance for Housing and Healing
- Asian Pacific Health Care Venture
- Community Clinic Association of Los Angeles County
- Foothill AIDS Project
- Los Angeles County Comprehensive Health Center - El Monte

Stakeholders did not identify community assets specific to HIV/AIDS.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

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[1] Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States.* Available at [http://www.cdc.gov/hiv/resources/factsheets/idu.htm]. Accessed [February 28, 2013].

[2] Mayo Clinic. *Complications*. Available at [http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=complications]. Accessed [March 1, 2013].

[3] National Institutes of Health, *HIV Infection.* Available at [http://www.nlm.nih.gov/medlineplus/ency/article/000602.htm]. Accessed [March 1, 2013].

[4] National Institute of Allergy and Infectious Diseases. *HIV Risk Factors.* Available at [http://www.niaid.nih.gov/topics/hivaids/understanding/pages/riskfactors.aspx]. Accessed [March 6, 2013].

[5] Centers for Disease Control and Prevention. *CDC's HIV Prevention Progress in the United States*. Available at [http://www.cdc.gov/hiv/resources/factsheets/cdcprev.htm]. Accessed [February 28, 2013].

[6] Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States.* Available at [http://www.cdc.gov/hiv/resources/factsheets/idu.htm]. Accessed [February 28, 2013].

[7] Centers for Disease Control and Prevention, *HIV in the United States: At A Glance.* Available at [http://www.cdc.gov/hiv/resources/factsheets/us.htm]. Accessed [February 28, 2013].

[8] Centers for Disease Control and Prevention. *Basic Information about HIV and AIDS.* Available at [http://www.cdc.gov/hiv/topics/basic/index.htm]. Accessed [March 1, 2013].

[9] Centers for Disease Control and Prevention. *HIV and Viral Hepatitis.* Available at [http://www.cdc.gov/hiv/resources/factsheets/hepatitis.htm]. Accessed [March 1, 2013].

Health Need Profile: Allergies

****Overall Ranking Resulting from Prioritization: 21 of 22**

About Allergies—Why is it important?

Allergies are an overreaction of the immune system to substances that usually cause no reaction in most individuals. These substances can trigger sneezing, wheezing, coughing, and itching. Allergies have been linked to a variety of common and serious chronic respiratory illnesses such as sinusitis and asthma. Factors such as a family history with allergies, the types and frequency of symptoms, seasonality, duration, and even location of symptoms (indoors or outdoors, for example) are all taken into consideration in allergy diagnoses. Allergic reactions can be severe and even fatal. With proper management and patient education, allergic diseases can be controlled and people with allergies can lead normal and productive lives.[1] Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Other social and economic factors have been known to cause or trigger allergic reactions, including poor housing conditions (living with cockroaches, mites, asbestos, mold, etc.). Living in an environment or home with smokers has also been known to exacerbate allergies and/or asthma.

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- Allergies among teens were higher in the CVHP service area (36.8%) compared to Los Angeles County (24.9%).
- Within the CVHP service area, male teens were more often diagnosed with allergies (23.3%) than females (23.0%).
- Stakeholders[2] linked allergies with asthma and other chronic respiratory conditions.
- Allergies were identified as a major health concern in three out of 19 interviews.
- Allergies were not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How are allergies measured? What is the prevalence/incidence rate of allergies in the community?

In the CVHP service area:

- The portion of teens that have allergies was higher (36.8%) when compared to Los Angeles County (24.9%).

Allergy Indicators

Indicators	Year	CVHP Service Area	Comparison Level	Comparison Avg.
Allergies prevalence (teens)	2007	36.8%	LAC	24.9%

LAC=Los Angeles County

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

- Male teens were more often diagnosed with allergies (23.3%) than females (23.0%).

Stakeholders did not identify sub-populations.

Geographic areas of greatest impact (disparities)

Secondary data did not identify geographic disparities on the Kaiser Permanente CHNA data platform or other secondary sources.

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of allergies in the community?

Allergic reactions are known to be caused by pollen, dust, food, insect stings, animal dander, mold, medications, and latex.[3] Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Social and economic factors have been known to cause or trigger allergic reactions, including poverty leading to poor housing conditions (living with cockroaches, mites, asbestos, mold, etc.) and living in an environment or home with smokers. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HEALTH OUTCOMES				
Asthma				
Asthma hospitalizations per 10,000 youth	2010	20.8	CA	19.2
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons[1]	2010	132.7	LAC	147.1
Stroke mortality per 100,000 persons	2010	38.6	LAC	37.6
SOCIAL AND ECONOMIC				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
ACCESS TO CARE				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC—Los Angeles County
CA—California
[1] Healthy People 2020 = <=100.8

Community input—What do community stakeholders think about the issue of allergies?

Stakeholders linked allergies with asthma and other chronic respiratory conditions.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Allergy-specific community assets

- American Lung Association

- Asthma & Allergy Foundation of America - California Chapter
- Asthma Coalition of Los Angeles County (ACLAC)
- BREATHE California of Los Angeles County
- Community Clinic Association of Los Angeles County
- Kaiser Foundation Hospital – Baldwin Park
- San Dimas Community Hospital

Stakeholders did not identify community assets specific to allergies.

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] Asthma and Allergy Foundation of America (AAFA). *Allergies*. Milwaukee, WI. Available at [http://www.aaaai.org/conditions-and-treatments/allergies.aspx]. Accessed [March 1, 2013].

[2] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[3] American Academy of Allergy Asthma and Immunology. *Allergies*. Landover, MD. Available at [http://www.aafa.org/display.cfm?id=9]. Accessed [March 1, 2013].

Health Need Profile: Infant Mortality

****Overall Ranking Resulting from Prioritization: 22 of 22**

About Infant Mortality—Why is it important?

Infant mortality remains a concern in the United States: each year, approximately 25,000 infants die before their first birthday.[1] The leading causes of infant death include congenital abnormalities, pre-term/low birth weight, Sudden Infant Death Syndrome (SIDS), problems related to complications of pregnancy, and respiratory distress syndrome.[2]

Infant mortality is associated with factors such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices. Significant disparities exist among racial and ethnic groups that impact the infant mortality rate. For example, African-Americans had an infant mortality rate of 14.1 deaths per 1,000 live births in the year 2000, which is more than twice the national average of 6.9 deaths per 1,000 live births.[3]

The Centers for Disease Control and Prevention have set the goal of eliminating disparities among racial and ethnic groups with infant mortality rates above the national average. The CDC's prevention strategy focuses on modifying behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness.

Major Findings in the Citrus Valley Health Partner's Service Area (CVHP)

- The infant mortality rate per 1,000 live births was much higher among African-Americans (11.5) than Hispanics/Latinos (4.8), Whites (4.5), and Asians (3.3).
- Infant mortality is associated with low birth weight. A higher percentage of infants were born with very low birth weight (less than 1,500 grams) in San Dimas (1.8%), Baldwin Park[4] (1.7%), La Verne (1.7%), South El Monte (1.5%), and El Monte (1.4%) when compared with Los Angeles County (1.3%).
- Very low birth weight can indicate broader issues such as access to health care, maternal and child health, poverty, education rate, teen births, and a lack of insurance and of prenatal care.
- Infant mortality was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

Statistical data—How is infant mortality measured? What is the prevalence/incidence rate of infant mortality in the community?

In the CVHP service area:

- The infant mortality rate per 1,000 live births (5.1) was the same as the rate for Los Angeles County.

Infant Mortality Indicators

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Infant mortality rate per 1,000 births[1]	2009	5.1	LAC	5.1
Low-birth-weight infants	2010	6.3%	CA	6.8%
Very-low-birth-weight infants	2010	1.1%	LAC	1.3%

LAC=Los Angeles County
CA = California
[1] Healthy People 2020 = <=6.0

Sub-populations experiencing greatest impact (disparities)

Within the CVHP service area, the following sub-populations are the most severely impacted:

- The infant mortality rate per 1,000 live births was much higher among African-Americans (11.5) than Hispanics/Latinos (4.8), Whites (4.5), and Asians (3.3).

Stakeholders[5] did not identify disparities among sub-populations.

Geographic areas of greatest impact (disparities)

By community, the following disparities were found:

- A higher percentage of infants were born with very low birth weight (less than 1,500 grams) in San Dimas (1.8%), Baldwin Park[6] (1.7%), La Verne (1.7%), South El Monte (1.5%), and El Monte (1.4%) when compared with Los Angeles County (1.3%).

Stakeholders did not identify geographic disparities.

Associated drivers and risk factors—What is driving the high rates of infant mortality in the community?

Factors that affect birth outcomes include smoking, substance abuse, poor nutrition, medical problems, and chronic illness. Additionally, infant mortality is associated with low birth weight. High rates of infant mortality can indicate broader issues such as access to health care, maternal and child health, poverty, education rate, lack of insurance, teen births, and lack of prenatal care. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
SOCIAL AND ECONOMIC				
Lack health insurance	2009	16.2%	CA	16.2%
Soft drink expenditures	2010	0.49%	CA	0.46%
Drink two or more glasses of soda in a day (youth)	2009	18.8%	LAC	18.1%
Frequent fast food restaurants 4 times a week or more	2009	15.5%	LAC	12.5%
ACCESS TO CARE				
Lack of consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC=Los Angeles County
CA=California

Community input—What do community stakeholders think about the issue of infant mortality?

Stakeholders did not comment on this issue.

Assets—What are some examples of community assets that can address the health need?

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have

been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Infant mortality–specific community assets:

- Asian Pacific Health Care Venture - El Monte Rosemead Health Center
- Beverly Hospital
- Community Clinic Association of Los Angeles County
- Early Identification and Intervention Collaborative for Los Angeles County
- East Valley Community Health Center, Inc.
- LA Best Babies Network
- Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs
- March of Dimes - California Programs

Stakeholders identified the following community resources available to address infant mortality:

- Women, Infants and Children (WIC) - Community resource for social services

For information on other assets in the community, please refer to Section ***Error! Reference source not found.*** *of the Community Health Needs Assessment report.*

[1] Centers for Disease Control and Prevention. *Infant Mortality.* Available at [http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm]. Accessed [March 5, 2013].

[2] Centers for Disease Control and Prevention. *Infant Health.* Available at [http://www.cdc.gov/nchs/fastats/infant_health.htm]. Accessed [March 5, 2013].

[3] Centers for Disease Control and Prevention. *Eliminate Disparities in Infant Mortality.* Available at [http://www.cdc.gov/omhd/amh/factsheets/infant.htm#2]. Accessed [March 5, 2013].

[4] Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

[5] Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

[6] Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

Appendix C: Secondary Data Sources from Kaiser Permanente CHNA Data Platform and Other Sources

Secondary Data Sources from Kaiser Permanente CHNA Data Platform and Other Sources

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Absence of Dental Insurance Coverage	CA Only	California Health Interview Survey (CHIS), 2007	County (Grouping)	State Average	Yes
Clinical Care	Access to Primary Care	U.S.	U.S. Health Resources and Services Administration Area Resource File, 2011	County	State Average	No
Clinical Care	Adults ages 50 and older ever have a sigmoidoscopy, colonoscopy, or FOBT	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Adults ages 50 and older have a sigmoidoscopy, colonoscopy in the last 5 years	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Breast Cancer Screening (Mammogram)	U.S.	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2003-2007	County	State Average	No
Clinical Care	Cervical Cancer Screening in last 3 years	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Clinical Care	Cervical Cancer Screening in last 3 years	U.S.	Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Health Assessment Unit, Los Angeles County Health Survey, 2007	County	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Children who have never seen a dentist	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Colon Cancer Screening (Sigmoid/Colonoscopy)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Clinical Care	Delayed or didn't get medical care	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Delayed or didn't get prescriptions	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Dental Care Affordability (Youth)	CA Only	California Health Interview Survey (CHIS), 2007	County (Grouping)	State Average	Yes
Clinical Care	Dental Care Utilization (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Clinical Care	Dental Care Utilization (Youth)	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes
Clinical Care	Diabetes Management (Hemoglobin A1c Test)	U.S.	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2010	County	State Average	No
Clinical Care	Do Not Have a Usual Source of Care	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Facilities designated as health professional shortage areas	CA Only	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012	HPSA		No
Clinical Care	Federally Qualified Health Centers	U.S.	U.S. Health Resources and Services Administration, Centers for Medicare & Medicaid Services, Provider of Service File, 2011	Address		No
Clinical Care	Hard Time Understanding Doctor	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Heart Disease Management	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	High Blood Pressure Management	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Clinical Care	HIV Screenings	CA Only	California Health Interview Survey (CHIS), 2005	County (Grouping)	State Average	Yes
Clinical Care	Hospitalizations per 1,000 Pop.	CA Only	Office of Statewide Health Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Clinical Care	Lack of a Consistent Source of Primary Care	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Lack of Prenatal Care	CA Only	California Department of Public Health, Birth Profiles by ZIP Code, 2010	ZIP Code	State Average	No
Clinical Care	Needed help for mental/emotional/alcohol-drug issues but did not receive treatment	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Pneumonia Vaccinations (Age 65+)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Clinical Care	Population Living in a Health Professional Shortage Area	U.S.	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012	HPSA	State Average	No
Clinical Care	Preventable Hospital Events	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010-2010	ZIP Code	State Average	Yes
Clinical Care	Primary care provider per 100,000 Population	CA Only	U.S. Health Resources and Services Administration Area Resource File, 2011	County	County Average	No
Clinical Care	Received Pap smear in last 3 years	County	Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2007	SPA	Healthy People 2020	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Received Pap smear in last 3 years	County	Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2010	SPA	Healthy People 2020	No
Clinical Care	Teens who can't afford dental care	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	No
Demographics	Change in Total Population	U.S.	U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1	County		No
Demographics	Linguistically Isolated Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Demographics	Median Age	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Female Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Male Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Demographics	Total Population Age 0-4	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 18-24	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 25-34	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 35-44	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 45-54	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 5-17	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 55-64	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 65 or Older	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Health Behaviors	Adequate Fruit/Vegetable Consumption (Youth)	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Behaviors	Alcohol & Substance Use	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010.	County	County Average	No
Health Behaviors	Alcohol Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Breastfeeding (Any)	CA Only	California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011	County	State Average	Yes
Health Behaviors	Breastfeeding (Exclusive)	CA Only	California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011	County	State Average	Yes
Health Behaviors	Children drinking two or more glasses of soda	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Children eating less than 5 servings of Fruit/Vegetable a Day	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Frequent Fast Food Restaurants	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Fruit/Vegetable Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Heavy Alcohol Consumption	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Behaviors	Inadequate Fruit/Vegetable Consumption (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2003-2009	County	State Average	No
Health Behaviors	Physical Inactivity (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Health Behaviors	Physical Inactivity (Youth)	CA Only	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011	School District	State Average	Yes
Health Behaviors	Serious Psychological Distress in Last Year	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Soft Drink Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Tobacco Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Tobacco Usage (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Health Outcomes	Adults Taking Medicine to Lower Cholesterol	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	Allergies (teens)	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Alzheimer's mortality age-adjusted	CA Only	Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, 2006	SPA	County Average	Yes
Health Outcomes	Alzheimer's mortality age-adjusted	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	County Average	Yes
Health Outcomes	Arthritis Prevalence	CA Only	Los Angeles County Department of Public Health, Los Angeles County Health Survey, 2011	SPA	County Average	Yes
Health Outcomes	Asthma Hospitalization (Adults)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010.	ZIP Code	State Average	No
Health Outcomes	Asthma Hospitalization (Adults)	CA Only	Office of Statewide Health Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Asthma Hospitalizations (Youth)	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010	ZIP Code	State Average	Yes
Health Outcomes	Asthma Hospitalizations (Youth)	CA Only	Office of Statewide Health Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Asthma Prevalence	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Asthma Prevalence	CA Only	California Health Interview Survey (CHIS), 2009	ZIP Code	County Average	Yes
Health Outcomes	Breast Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	State Average	Yes
Health Outcomes	Breast Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes
Health Outcomes	Cancer Mortality per 10,000 Pop.					
Health Outcomes	Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Cardiovascular Disease Mortality	CA only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Cerebrovascular Disease Hospitalization per 100,000 Pop.	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Cerebrovascular Disease Mortality per 10,000 Pop.	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Cervical Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	Healthy People 2020	Yes
Health Outcomes	Cervical Cancer Mortality	CA only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Chlamydia Incidence	U.S.	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2009	County	State Average	No
Health Outcomes	Chronic Lower Respiratory Disease per 10,000 Pop.	CA Only	California Behavioral Risk Factor Surveillance System, CDC, 2011	ZIP Code	State Average	Yes
Health Outcomes	Colon Cancer Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	County Average	Yes
Health Outcomes	Colorectal Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	Healthy People 2020	Yes
Health Outcomes	COPD prevalence	CA Only	California Behavioral Risk Factor Surveillance System, CDC, 2011	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Diabetes Hospitalizations	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Hospitalizations (adult)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Hospitalizations (under 18)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Mortality per 10,000 Pop.	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Prevalence	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	Diabetes Prevalence	U.S.	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009	County	State Average	Yes
Health Outcomes	Diagnosed with Diabetes	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	Heart Disease Hospitalization	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Heart Disease Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Heart Disease Prevalence	CA Only	California Health Interview Survey (CHIS), 2009	County	State Average	Yes
Health Outcomes	Hepatitis C Prevalence	County	Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report, 2011	SPA	County Average	Yes
Health Outcomes	High Blood Pressure Prevalence	County	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	HIV Hospitalizations	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010	ZIP Code	State Average	Yes
Health Outcomes	HIV Hospitalizations	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	HIV Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	State Average	Yes
Health Outcomes	HIV Prevalence	U.S.	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	HIV Prevalence	U.S.	Los Angeles County Department of Public Health, Annual HIV Surveillance Report, 2011	County	County Average	Yes
Health Outcomes	Homicide	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Homicide	CA Only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Homicide by Firearms per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2010	ZIP Code	State Average	Yes
Health Outcomes	Hospitalizations for Uncontrolled Diabetes	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Hypertension and Hypertensive Renal Mortality per 10,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2010	ZIP Code	State Average	Yes
Health Outcomes	Infant Mortality	U.S.	Centers for Disease Control and Prevention, National Vital Statistics System, 2003-2009	County	Healthy People 2020	Yes
Health Outcomes	Low Birth Weight	CA Only	California Department of Public Health, Birth Profiles by ZIP Code, 2010	ZIP Code	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Lung Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	State Average	Yes
Health Outcomes	Lung Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes
Health Outcomes	Mental Health Hospitalizations (adults)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	County Average	Yes
Health Outcomes	Mental Health Hospitalizations (under 18)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	County Average	Yes
Health Outcomes	Motor Vehicle Crash Death	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Non-fatal Firearm Hospitalizations per 100,000 Pop.	CA Only	Office of Statewide Health Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Obesity (Adult)	LAC Only	California Health Interview Survey (CHIS), 2009	ZIP Code		Yes
Health Outcomes	Obesity (Adult)	U.S.	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009	County	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Obesity (Youth)	CA Only	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011	School District	State Average	Yes
Health Outcomes	Overweight (Adult)	LAC Only	California Health Interview Survey (CHIS), 2009	ZIP Code		Yes
Health Outcomes	Overweight (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Health Outcomes	Overweight (Youth)	CA Only	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011	School District	State Average	Yes
Health Outcomes	Pedestrian Motor Vehicle Death	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Pedestrians Killed	CA Only	California Highway Patrol Statewide Integrated Traffic Records System (CHP - SWITRS), 2008	SPA	County Average	Yes
Health Outcomes	Poor Dental Health	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Poor General Health	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Health Outcomes	Poor Mental Health	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes
Health Outcomes	Population with Any Disability	U.S.	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates	Tract	State Average	No
Health Outcomes	Prostate Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes
Health Outcomes	Premature Death	U.S.	Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (As Reported in the 2012 County Health Rankings)	County	State Average	No
Health Outcomes	Prostate Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	State Average	Yes
Health Outcomes	Stroke Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Suicide	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Suicide per 10,000 Pop.	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	State Average	Yes
Health Outcomes	Uncontrolled Diabetes Hospitalizations		Office of Statewide Health and Planning and Development (OSHPD), 2009	ZIP Code	State Average	Yes
Health Outcomes	Unintentional Injuries Mortality per 10,000 Pop.	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	State Average	Yes
Health Outcomes	Very Low Birthweight	CA Only	California Department of Public Health, 2010	ZIP Code	County Average	No
Physical Environment	Fast Food Restaurant Access	CA Only	U.S. Census Bureau, ZIP Code Business Patterns, 2009	ZIP Code	State Average	No
Physical Environment	Grocery Store Access	U.S.	U.S. Census Bureau, County Business Patterns, 2009	County	State Average	No
Physical Environment	Liquor Store Access	CA Only	California Department of Alcoholic Beverage Control, Active License File, April 2012	ZIP Code	State Average	No
Physical Environment	Park Access (Within 1/2 mile of park)	U.S.	U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1; Esri's USA Parks layer (compilation of Esri, National Park Service, and TomTom source data), 2012	Block Group	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Physical Environment	Poor Air Quality (Particulate Matter 2.5)	U.S.	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008	Tract	State Average	No
Physical Environment	Population Living in Food Deserts	U.S.	U.S. Department of Agriculture, Food Desert Locator, 2009	Tract (2000)	State Average	No
Physical Environment	Protected Open Space Areas in Acres per 1,000 People	CA Only	California Health Interview Survey (CHIS), 2009	ZIP Code	County Average	No
Physical Environment	Recreation and Fitness Facility Access	CA Only	U.S. Census Bureau, ZIP Code Business Patterns, 2009	ZIP Code	State Average	No
Physical Environment	Visited park in last month	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Physical Environment	Walkability	U.S.	WalkScore.Com (2012)	City		Yes
Physical Environment	WIC-Authorized Food Store Access	U.S.	U.S. Department of Agriculture, Food Environment Atlas, 2012	County	State Average	No
Social & Economic Factors	Adequate Social or Emotional Support	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Social & Economic Factors	Children Eligible for Free/Reduced Price Lunch	U.S.	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2010-2011	Address	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Social & Economic Factors	Children in Poverty	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Social & Economic Factors	Families in Poverty in The Past 12 Months	U.S.	American Community Survey 5-Year Estimates, 2007-2011	ZIP Code	County Average	Yes
Social & Economic Factors	High School Graduation Rate	U.S.	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Local Education Agency (School District) Universe Survey Dropout and Completion Data, 2008-2009	School District	HP 2020:On-Time Graduation Rate:>82.4	No
Social & Economic Factors	Homeless by Age	County	Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011	County	County Average	Yes
Social & Economic Factors	Homeless Count	County	Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011	County	County Average	Yes
Social & Economic Factors	Population Below 100% of Poverty Level	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	No
Social & Economic Factors	Population Below 200% of Poverty Level	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	No
Social & Economic Factors	Population in Poverty in The Past 12 Months	U.S.	American Community Survey 5-Year Estimates, 2007-2011	ZIP Code	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Social & Economic Factors	Population Receiving Medicaid	U.S.	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates	PUMA	State Average	Yes
Social & Economic Factors	Population with No High School Diploma	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Social & Economic Factors	Poverty Rate	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Social & Economic Factors	Student Reading Proficiency (4th Grade)	U.S.	States' Department of Education, Student Testing Reports, 2011	School District	Healthy People 2020	No
Social & Economic Factors	Supplemental Nutrition Assistance Program (SNAP) Recipients	U.S.	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009	County	State Average	No
Social & Economic Factors	Teen Births	CA Only	California Department of Public Health, Birth Profiles by ZIP Code, 2010	ZIP Code	State Average	Yes
Social & Economic Factors	Unable to Afford Enough Food (Food Insecurity) (Adults)	CA Only	California Health Interview Survey (CHIS), 2009	County	County Average	Yes
Social & Economic Factors	Unemployed (over 16 years of age)	U.S.	American Community Survey 5-Year Estimates, 2006-2010	City	County Average	Yes
Social & Economic Factors	Unemployment Rate	U.S.	U.S. Bureau of Labor Statistics, December, 2012 Local Area Unemployment Statistics	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Social & Economic Factors	Uninsured	CA Only	California Health Interview Survey (CHIS), 2009	ZIP Code	County Average	Yes
Social & Economic Factors	Uninsured Population	U.S.	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates	PUMA	State Average	Yes
Social & Economic Factors	Violent Crime	U.S.	U.S. Federal Bureau of Investigation, Uniform Crime Reports, 2010	Place, County	State Average	No

Appendix D:
CVHP Scorecard

Community Health Needs Assessment Health Needs and Health Drivers Data Summary
Kaiser Foundation Hospital – Baldwin Park

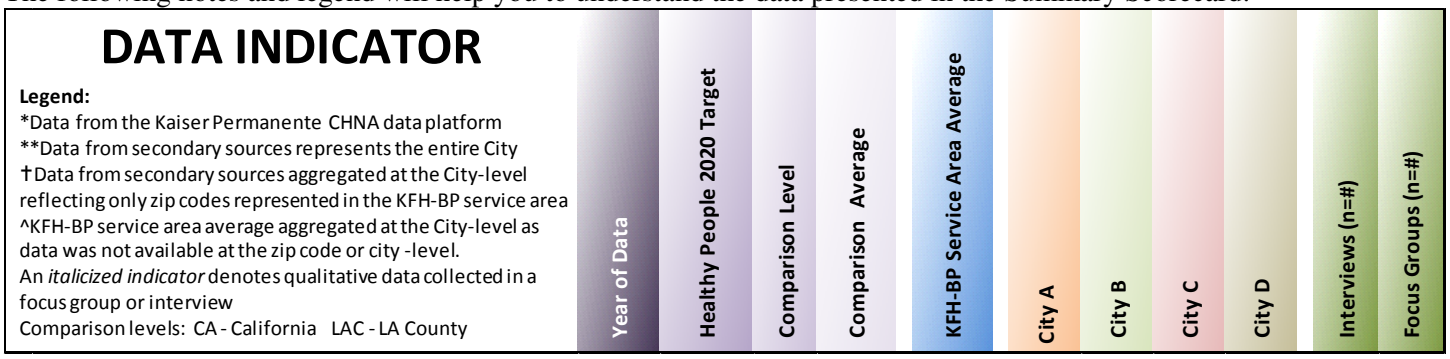
Identification of Health Needs and Health Drivers

In 2012, Citrus Valley Health Partners (CVHP) conducted Phase I of the 2013 Community Health Needs Assessment (CHNA). This included review of data from the Kaiser Permanente CHNA data platform and other secondary data sources. Additional information was gathered through five (5) focus groups with providers and residents from across the , Kaiser Foundation Baldwin Park service area and interviews with nineteen (19) key stakeholders including public health experts, community leaders, and public agency officials. In all, the CHNA process has engaged nearly 70 individuals in sharing their insight and expertise to identify key needs in the Baldwin Park service area.

This process highlighted numerous health needs and health drivers in the CVHP service area. The document that follows represents a subset of those needs based on set criteria, which included poor performance against California or Los Angeles County benchmarks or the Healthy People 2020 (HP2020) Target or repeated mentions in stakeholder interviews and focus groups. The identified health needs and drivers are summarized in the attached Health Needs and Drivers Summary Scorecard.

Reading the Health Needs & Drivers Data Summary Scorecard

The following notes and legend will help you to understand the data presented in the Summary Scorecard.



DATA INDICATORS

- Indicators, or standard measures of health, are highlighted in the first column
- Qualitative data collected in focus groups or interviews is indicated by an *italicized indicator*
- Indicators which did not meet a benchmark, including HP2020 Targets, are highlighted by a **black box**
- When health indicator definitions are consistent across comparison levels, and the HP2020 Target is not met, the HP2020 Target is noted
- The Health Needs and Drivers are listed in alphabetical order, NOT by order of importance

DATA INDICATORS LEGEND

*Data gathered from the Kaiser Permanente CHNA data platform
**Data from secondary sources represents the entire City
†Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the CVHP service area
^CVHP service area average aggregated at the City-level as data was not available at the zip code or city-level

COMPARISON LEVEL

- CVHP service area is compared against benchmarks at the State or County-level depending on data available
  - CA: State of California
  - LAC: Los Angeles County
- Where available, data is also presented for individual Service Planning Areas (SPAs) or cities in the CVHP service area

2013 KP CHNA - Citrus Valley Health Partners Health Needs and Drivers Summary Scorecard

Legend:
*Data from the Kaiser Permanente CHNA database reflecting the CVHP/KFH-BP service area.
†Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the MCA
^Service area average represents Service Planning Area 3 as data was not available at the zip code or city -level.
An *italicized indicator* denotes qualitative data collected in a focus group or interview

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Azusa	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)
HEALTH NEEDS																					
Alcohol & Substance Abuse																					
Rate of alcohol/drug induced mental disease hospitalization per 100,000 pop.†	2010		CA	109.1	91.4	77.0	70.5	**197.0**	84.0	77.4	**129.2**	72.2	**109.8**	**123.3**	41.8	**120.8**	59.2	30.2	87.4		
Alcoholism																				4	1
Substance abuse																				1	2
Allergies																					
Percent of teens with allergies^	2007		LAC	24.9%	**36.8%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Allergies																				3	0
Alzheimer's Disease																					
Rate of Alzheimer's mortality age-adjusted per 100,000 pop.^	2009		LAC	17.6	**17.9**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of Alzheimer's mortality per 10,000 pop.†	2010		CA	2.9	2.6	2.3	1.0	**3.6**	1.3	0.4	**5.5**	1.9	1.5	**6.6**	1.1	**5.7**	0.9	2.8	2.3		
Alzheimer's disease																				3	0
Arthritis																					
Arthritis																				3	0
Asthma																					
Percent of adults diagnosed with asthma*	2010		LAC	11.1%	11.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of adult asthma hospitalization per 10,000*	2010		CA	7.7	7.7	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of adult asthma hospitalization per 100,000†	2010		CA	94.3	89.2	87.1	**120.1**	72.1	25.8	**171.7**	61.0	55.5	**103.2**	87.2	46.2	54.3	**198.2**	58.0	**107.9**		
Rate of youth asthma hospitalization per 10,000*	2010		CA	19.2	**20.8**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Asthma																				5	1
Cancer																					
Rate of cancer mortality per 100,000 pop.*	2010	<=160.6	LAC	156.5	154.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Cancer																				2	1
Cardiovascular Disease																					
Percent of heart disease prevalence*	2009		LAC	5.8%	5.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of heart disease hospitalization per 100,000 pop.†	2010		CA	367.1	**374.4**	323.3	342.2	**419.2**	318.6	**379.4**	**408.4**	**405.5**	**402.5**	357.9	303.9	**507.3**	**382.0**	257.7	**434.0**		
Rate of heart disease mortality per 10,000 pop.†	2010		CA	15.6	14.4	10.4	10.5	**18.4**	13.4	13.9	**20.7**	13.7	11.0	**21.7**	10.8	**22.7**	8.0	10.2	**15.9**		
Rate of heart disease mortality per 100,000 pop.*	2010	<=100.8	LAC	147.1	**132.7**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of stroke mortality per 100,000 pop.*	2010		LAC	37.6	**38.6**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Coronary disease/heart disease																				5	1
Stroke																				1	0
Cervical Cancer																					
Rate of cervical cancer incidence per 100,000 pop.*	2009	<=7.1	LAC	9.9	**9.9**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of cervical cancer mortality per 100,000 pop.†	2008	<=2.2	LAC	3.0	2.2	0.0	**2.3**	0.0	**8.0**	**3.0**	0.0	0.0	**4.3**	0.0	**3.9**	0.0	0.0	**3.6**	**5.2**		
Chlamydia																					
Rate of chlamydia incidence per 100,000 pop.*	2009		LAC	476.3	476.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of chlamydia incidence per 100,000 pop.^	2010		LAC	455.1	309.0	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Chronic Obstructive Pulmonary Disease (COPD)																					
Percent of COPD prevalence**	2011		CA	4.0%	3.1%^^																
Rate of chronic lower respiratory disease per 10,000 pop.†	2010		CA	3.5	3.2	3.2	3.1	**4.0**	2.8	2.3	**5.7**	1.9	2.2	**4.5**	2.6	**6.3**	1.4	1.4	3.2		
Chronic Obstructive Pulmonary Disease (COPD)																				2	0
Colorectal Cancer																					
Rate of colorectal cancer mortality age-adjusted per 100,000 pop.†	2008		LAC	11.2	7.7	11.2	4.7	7.9	8.2	5.2	**18.9**	7.0	0.0	9.0	9.9	5.8	0.0	9.2	10.3		
Rate of colorectal cancer incidence per 100,000 pop.*	2009	<=38.6	LAC	45.2	**45.2**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		

2013 KP CHNA - Citrus Valley Health Partners Health Needs and Drivers Summary Scorecard

DATA INDICATOR **Legend:** *Data from the Kaiser Permanente CHNA database reflecting the CVHP/KFH-BP service area. †Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the MCA ^Service area average represents Service Planning Area 3 as data was not available at the zip code or city -level. An *italicized indicator* denotes qualitative data collected in a focus group or interview	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Azusa	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)
Colon/rectum cancer																				1	1
Diabetes																					
Percent diagnosed with diabetes†	2009		N/A	N/A	19.2%	22.5%	24.5%	17.6%	15.6%	23.5%	15.3%	17.4%	26.0%	14.0%	16.8%	14.1%	24.8%	16.1%	20.0%		
Percent of diabetes prevalence*	2009		LAC	10.5%	**18.5%**																
Percent of diabetes prevalence*	2009		LAC	7.7%	7.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of adult diabetes hospitalizations per 10,000 pop.*	2010		CA	9.7	**10.5**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of adult diabetes hospitalizations per 100,000 pop.†	2010		CA	145.6	**147.4**	**180.9**	**181.5**	**147.3**	56.0	**211.8**	109.7	125.9	**194.7**	126.3	88.1	138.9	**289.3**	76.6	137.0		
Rate of diabetes mortality per 10,000 pop.†	2010		CA	1.9	**2.1**	**2.9**	**2.2**	**3.1**	0.9	1.4	**2.2**	1.9	**3.1**	**2.7**	0.9	**2.7**	1.4	1.2	**2.7**		
Rate of hospitalizations for uncontrolled diabetes per 10,000 pop.†	2010		CA	9.5	**12.7**	**11.3**	**14.9**	3.7	8.0	**26.2**	**9.6**	7.0	**23.1**	**14.0**	6.1	**11.4**	**26.8**	2.0	**13.5**		
Rate of youth diabetes hospitalizations per 10,000 pop.*	2010		CA	4.8	3.5	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Diabetes (specifically type 1 and 2)																				4	4
Disability																					
Percent of population with a disability*	2010		LAC	9.4%	9.4%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Behavior issues																				2	0
Developmental delays																				0	1
HIV/AIDS																					
Rate of HIV hospitalizations per 10,000 pop.*	2011		LAC	2.2	0.9	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of HIV hospitalizations per 100,000 pop.†	2010		CA	11.0	6.6	5.0	6.5	**14.0**	2.2	**13.3**	**11.8**	1.9	9.4	3.0	6.6	0.0	6.8	9.3	2.7		
Rate of HIV prevalence per 100,000 pop.*	2008		LAC	480.4	480.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of HIV prevalence per 100,000 pop.^	2010		LAC	14.0	10.0	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of HIV mortality per 100,000 pop.†	2008		CA	2.5	1.9	1.6	1.2	**3.9**	0.0	**3.0**	0.0	1.7	**4.7**	0	2.0	2.4	0.0	0.0	**6.1**		
Hypertension																					
Percent of adults ever diagnosed with high blood pressure^	2009		LAC	25.5%	**30.2%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of hypertension & hypertensive renal mortality per 10,000	2010		CA	1.0	**1.3**	**1.5**	0.5	**1.4**	**1.5**	0.7	**1.2**	0.9	**1.1**	**3.0**	0.7	**2.7**	0.5	0.7	**1.4**		
Hypertension																				3	1
Infant Mortality																					
Percent of infants, low birth weight (1500-2499 grams)*	2010		CA	6.8%	6.3%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of infants, very low birth weight (<1500 grams)†	2010		LAC	1.3%	1.1%	0.9%	**1.7%**	0.6%	0.7%	**1.4%**	1.2%	0.5%	1.2%	**1.7%**	0.3%	**1.8%**	**1.5%**	0.6%	1.1%		
Rate of infant mortality per 1,000 births*	2009	<=6.0	LAC	5.1	5.1	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Intentional Injury																					
Rate of homicide by firearms per 100,000 pop.†	2009		CA	3.9	2.2	1.5	3.5	3.2	0.0	3.0	2.1	0.0	**10.6**	0.0	3.8	0.0	0.0	0.0	3.5		
Rate of homicide per 100,000 pop.*	2010	<=5.5	LAC	7.0	**5.9**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of homicide per 100,000 pop.†	2008	<=5.5	LAC	8.4	**6.1**	3.2	**9.4**	**15.7**	0.0	**7.5**	**7.3**	0.0	**10.1**	3.0	3.9	2.9	3.9	0.0	**17.8**		
Rate of non-fatal firearm hospitalizations per 100,000 pop.†	2010		CA	8.8	4.5	6.7	**9.1**	**9.9**	4.3	5.9	3.9	0.0	8.0	0.0	0.0	0.0	**9.1**	0.0	5.8		
Homicide																				1	1
Mental Health																					
Percent needing help for mental/emotional/alcohol-drug issues but did not receive treatment^	2009		LAC	47.3%	**51.4%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent who had serious psychological distress in the last year^	2009		LAC	7.3%	**8.8%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent with poor mental health*	2009		LAC	14.0%	14.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of adult hospitalizations per 100,000 pop.†	2010		CA	551.7	**657.0**	**651.5**	**650.4**	**1156.6**	346.6	548.1	**1061.0**	340.7	444.7	**932.4**	235.7	**942.1**	**942.1**	325.0	**620.4**		
Rate of suicide per 100,000 pop.*	2010	<=10.2	LAC	8.0	6.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of suicide per 10,000 pop.†	2010		CA	1.0	0.9	0.5	0.8	0.7	0.7	0.8	**2.4**	**1.5**	0.6	0.6	0.9	0.6	0.9	0.7	0.6		
Rate of youth (under 18) hospitalizations per 100,000 pop.†	2010		CA	256.4	**375.4**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
ADHD																				4	0

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DATA INDICATOR

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DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Azusa	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)
Aging																				1	0
Anxiety																				2	0
Autism																				2	1
Bipolar																				2	0
Depression																				0	2
Eating disorder																				1	0
Mental health, general																				3	2
Stress																				1	0
Suicide																				0	1
Obesity/Overweight																					
Percent of adults who are obese†	2009		LAC	21.2%	20.0%	**24.5%**	**24.9%**	**21.8%**	14.5%	**22.3%**	20.5%	16.8%	**26.0%**	19.5%	13.2%	19.2%	**23.7%**	13.3%	20.4%		
Percent of adults who are overweight†	2009		LAC	29.7%	28.8%	28.5%	28.8%	29.5%	28.1%	27.8%	28.8%	29.2%	29.4%	**30.5%**	27.4%	**30.3%**	28.5%	27.5%	28.3%		
Percent of adults who are obese*	2009		LAC	21.4%	21.4%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of adults who are overweight*	2010		LAC	26.4%	**36.4%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth who are obese*	2011		CA	29.8%	**30.6%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth who are overweight*	2011		CA	14.3%	**15.1%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Obesity																				7	4
Oral Health																					
Percent with poor dental health*	2010		LAC	11.6%	11.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Oral health																				6	4
Unintentional Injury																					
Percent of pedestrians killed^	2008		LAC	25.7%	21.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of motor vehicle mortality per 100,000 pop.*	2010	<=12.4	LAC	7.1	**7.7**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of pedestrian motor vehicle mortality per 100,000 pop.*	2010	<=1.3	LAC	1.5	1.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of unintentional injuries mortality per 10,000 pop.†	2010		CA	2.7	1.6	1.5	1.6	1.0	0.7	1.5	2.0	1.7	1.7	0.9	1.8	2.7	2.3	1.2	1.4		
Vision																					
Percent of diabetic adults who had an eye exam in the last year^	2009		LAC	63.3%	65.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Vision																				1	3
DRIVERS OF HEALTH																					
Awareness																					
Lack of general awareness/education																				9	3
Inability to navigate health system																				2	1
Women's health education																				1	1
Cancer Screenings																					
Percent of adult men (50+) screened for colon cancer*	2010		LAC	50.1%	50.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of adults ages 50 and older have a sigmoidoscopy, colonoscopy in the last 5 years^	2009	>=70.5%	LAC	65.5%	**61.5%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of adults ages 50 and older have a sigmoidoscopy, colonoscopy, or FOBT^	2009		LAC	75.7%	**28.3%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of breast cancer screenings*	2007		LAC	52.5%	53.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent with cervical cancer screenings in last 3 years*	2010	>=93%	LAC	67.6%	**67.6%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent with cervical cancer screenings in last 3 years^	2007	>=93%	LAC	84.4%	**84.9%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Dental Care Access																					
Percent of adults utilizing dental care*	2010		LAC	34.5%	34.5%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of children who have never seen a dentist^	2009		LAC	10.5%	**11.9%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		

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Percent of teens who can't afford dental care^	2009		LAC	23.8%	**53.2%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth (children and teens) can't afford dental care*	2007		LAC	6.2%	**6.3%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth (children and teens) utilizing dental care*	2009		LAC	12.2%	12.2%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent without dental insurance coverage*	2007		LAC	37.4%	37.4%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Education																					
Percent of 4th grade children reading below proficiency*	2011	<=36.3%	CA	35.6%	35.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of population with no high school diploma**	2010		LAC	24.1%	22.3%	**25.3%**	**43.3%**	15.9%	7.5%	**47.8%**	10.6%	15.3%	**44.0%**	8.1%	14.3%	7.1%	**48.3%**	7.8%	17.3%		
Rate of high school graduation*	2009	>82.4	CA	82.3	87.2	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Education level																				8	4
Employment																					
Rate of unemployment*	2012		LAC	10.3	**10.4**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent unemployed (over 16 years of age)**	2010		LAC	5.7%	4.9%	**5.9%**	**6.4%**	**7.4%**	3.4%	**5.9%**	4.8%	3.9%	5.0%	4.9%	3.7%	3.6%	4.7%	2.9%	**5.8%**		
Underemployment																				1	0
Unemployment																				8	4
Family & Social Support																					
Percent who have social/emotional support*	2010		LAC	71.1%	71.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Health Care Access																					
Lack of a consistent source of primary care	2009		LAC	16.2%	**18.2%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Number of facilities designated as health professional shortage areas*	2012		LAC	137[1]	6[2]	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Number of federally qualified health centers (FQHC)*	2011		LAC	101	3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of population living in a health professional shortage areas*	2012		CA	53.2%	48.9%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent who delayed or didn't get medical care^	2009		LAC	11.6%	9.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent who delayed or didn't get prescriptions^	2009		LAC	7.5%	7.2%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of primary care provider per 100,000 pop.*	2011		LAC	80.7	**80.6**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of hospitalizations per 1,000 pop.**	2010		CA	106.6	102.8	97.8	105.5	**112.9**	75.8	**113.1**	**118.4**	96.8	102.3	**108.4**	97.5	**126.0**	**115.0**	67.8	101.7		
Access to health services																				2	0
Adequate providers																				2	0
Coordinated healthcare																				3	2
Cost of care																				5	3
Health Insurance																					
Percent of population receiving Medicaid*	2010		LAC	19.9%	**19.9%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent who are uninsured*	2010		LAC	22.6%	20.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent who are uninsured†	2009		CA	16.2%	16.2%	**21.1%**	**22.2%**	15.9%	11.3%	**21.0%**	13.3%	13.7%	**22.8%**	11.4%	12.0%	11.4%	**22.1%**	11.6%	**17.5%**		
Medical insurance																				6	2
Healthy Eating																					
Percent of adults who consume inadequate amount of fruit/vegetables*	2010		LAC	72.3%	72.3%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of fruit/vegetable expenditures*	2011		CA	1.6%	1.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of soft drink expenditures*	2010		CA	0.46%	**0.49%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth drinking two or more glasses of soda yesterday^	2009		LAC	18.1%	**18.8%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth eating less than 5 servings of fruit/vegetables a day^	2009		LAC	50.8%	49.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		

2013 KP CHNA - Citrus Valley Health Partners Health Needs and Drivers Summary Scorecard

Legend:
*Data from the Kaiser Permanente CHNA database reflecting the CVHP/KFH-BP service area.
†Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the MCA
^Service area average represents Service Planning Area 3 as data was not available at the zip code or city -level.
An *italicized indicator* denotes qualitative data collected in a focus group or interview

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Azusa	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)
Percent of youth who consume adequate amount of fruit/vegetables*	2009		LAC	50.8%	50.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent who frequent fast food restaurants 4 times a week or more^	2009		LAC	12.5%	**15.5%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Poor nutrition																				3	1
Homelessness																					
Number of homeless persons^	2011		LAC	45,422	17,412	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Homelessness																				6	2
Affordability																				2	1
Overcrowding																				1	0
Poverty																					
Percent of adults unable to afford enough food (food insecurity)	2009		LAC	38.2%	36.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent eligible for free/reduced price school lunch*	2010		LAC	58.5%	**61.6%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of population living at 100% of Federal Poverty Level (FPL)*	2010		LAC	15.7%	12.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of population living at 200% of Federal Poverty Level (FPL)*	2010		LAC	37.6%	33.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of population receiving Supplemental Nutrition Assistance Program (SNAP) benefits*	2009		LAC	8.7%	8.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth in poverty*	2010		LAC	22.4%	16.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
High cost of living																				5	2
Poverty																				5	1
Language Barrier																					
Percent who have a hard time understanding doctor^	2009		LAC	4.7%	**6.6%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Language barrier																				5	2
Natural Environment																					
Percent of days with poor air quality (particulate matter 2.5)*	2008		LAC	2.6%	2.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Air quality																				2	2
Clean water																				1	1
Nutrition Access																					
Percent living in food deserts*	2009		LAC	1.5%	1.5%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of food insecurity^	2009		LAC	38.2%	36.3%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of fast food restaurants per 100,000 pop.*	2009		LAC	72.5	**76.2**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of grocery stores per 100,000 pop.*	2010		LAC	21.6	**21.5**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of WIC-authorized food stores per 100,000 pop. *	2012		LAC	17.0	17.0	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Lifestyle/access (healthy food, food desert, nutrition)																				3	3
Physical Activity																					
Percent in Walk Score Area (walkability)*	2012		CA	84.0%	93.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of adults who are not physically active*	2010		LAC	24.7%	24.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of youth who are not physically active*	2010		CA	37.5%	**38.4%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent who visited a park in the last month^	2009		LAC	79.3%	**76.3%**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent within ½ mile of a park*	2010		LAC	63.1%	64.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of protected open space areas in acres per 1,000 pop.†	2009		N/A	N/A	168.9	1091.8	16.8	2.29	11.2	2.2	193.5	19.7	4.4	34.51	8.7	942.1	23.3	9.2	4.8		
Rate of recreation and fitness facility establishment per 100,000 pop.*	2009		LAC	7.5	**5.7**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of families in poverty in the past 12 months**	2010		LAC	12.6%	8.3%	12.0%	**14.0%**	8.0%	3.0%	**18.3%**	3.5%	5.9%	10.3%	5.3%	9.1%	3.5%	12.6%	4.1%	6.1%		

2013 KP CHNA - Citrus Valley Health Partners Health Needs and Drivers Summary Scorecard

DATA INDICATOR **Legend:** *Data from the Kaiser Permanente CHNA database reflecting the CVHP/KFH-BP service area. †Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the MCA ^Service area average represents Service Planning Area 3 as data was not available at the zip code or city -level. An *italicized indicator* denotes qualitative data collected in a focus group or interview	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Azusa	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)
Percent of population in poverty in the past 12 months**	2010		LAC	15.7%	10.5%	**17.4%**	**15.9%**	10.7%	4.6%	**20.7%**	6.5%	7.7%	12.0%	6.8%	10.5%	5.4%	15.6%	4.9%	8.7%		
Access to green space																				6	3
Lack of exercise																				3	0
Preventative Care Services																					
Rate of preventable hospital admissions (ACSC) per 1,000 total admissions*	2010		CA	88.5	**97.9**	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Preventative healthcare																				0	1
Specialty care																				1	1
Safety																					
Domestic violence																				2	1
Safety																				3	0
Violence																				1	0
Transportation																					
Transportation																				11	4

FOOTNOTES
[1]Health Professional Shortage Area Facilities: Los Angeles County - 48 primary, 45 mental health, 44 dental
[2]Health Professional Shortage Area Facilities: Citrus Valley MCA - 2 primary, 2 mental health, 2 dental
N/A=no data available

Zip code assignments by City:

Azusa: 91702
Baldwin Park/Irwindale: 91706*
Covina: 91722, 91723,
Diamond Bar: 91765
El Monte: 91731, 91732, 91734, 91735
Glendora: 91740, 91741
La Puente: 91744, 91746, 91747, 91749,
La Verne: 91750
Rowland Heights: 91748
San Dimas: 91773
South El Monte: 91733
Walnut: 91788, 91789, 91795

Appendix E: Stakeholder Interviews Summary for CVHP

Health Trends and Drivers

CHNA interviews with stakeholders were conducted via telephone during September and October 2012. Nineteen interviews representing a broad range of community stakeholders, including health professionals and service providers, were conducted to gather information and opinions directly from persons who represent the broad interests of the community served by the Hospital. The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each. The interview protocol was designed to collect reliable and representative information about health and other needs and challenges faced by the community, access and utilization of health care services, and other relevant topics. A summary of key interview findings is noted below.

Interviewees identified several issues of primary concern that cut across all population groups in the CVHP service area including obesity, and drivers including poor eating habits and a lack of exercise. The most frequently mentioned broader, community-wide issues include:

Health Needs

- Asthma, pneumonia, chronic respiratory disease
- Cancer
- Cardiovascular disease
- Diabetes
- High cholesterol
- HIV/AIDS
- Hypertension
- Mental Health
    - Anxiety
    - Autism
    - Bipolar
    - Dementia
    - Depression
    - Post-Traumatic Stress Disorder
    - Schizophrenia
- Obesity
- STDs and women's health issues

Drivers of Health

- Community safety
- Cost of healthy food
- Economy / recession
- Education
- Family issues and violence
    - Lack of parental guidance / supervision
- Food deserts (no access to fresh fruits and vegetables)
- Lack of access to primary and specialty care
- Lack of follow-up care
- Lack of green space

    - Lack of open places to exercise
- Lack of knowledge or education
    - Lack of access to information and resources
- Language barriers
- Lifestyle, poor choices, people unmotivated to be active
- Poor air and water quality (pollution)
- Substance abuse
- Transportation
- Uninsured
    - Lack of insurance to get chronic diseases under control
- Unemployment
    - Loss of manufacturing jobs / Obesity

Participants provided further insight into these key issues. One interviewee noted that, "poor immigrants have culturally-based eating patterns that include too many carbs and deep fried foods" which often leads to obesity. In addition, people "don't exercise, and instead drive everywhere, even if it's just two blocks away". Another interviewee added that, "kids don't play and exercise or participate in athletics."

Health-Related Trends in the Community

Negative Trends

Recent health-related developments noted by interviewees include increases in chronic diseases including obesity and diabetes in children and poor oral health including greater numbers of tooth extractions and other restorative dental procedures, diagnoses of developmental delays in children between 0 and 5 years of age, increase in depression and suicide cases, dual diagnoses, in co- and tri-morbidity, drug-resistant bacterial infections, , people living in unhealthy conditions due to multiple families living in homes, and unemployment rates. There is also a need for access to preventative medical care including tests and screenings, shelters, affordable housing and employments services.

Other recent developments noted by interviewees include cuts to Head Start and other developmental programs for low-income children, Medi-Cal cuts to vision care services (limited prescription for lenses/glasses) and dental care for adults, reduced coverage for children, loss of community redevelopment funds, increasing financial burdens on community hospitals, and the continuing ripple effects of the recession.

It was noted that Citrus Community College closed the campus childcare center due to inadequate funding: "We've lost about 30% of the spaces for children in Head Start and early childhood development.

In addition, interviewees added that "prior to the recession, our community had about the same unemployment rate as the U.S. There are jobs available but they are not good quality jobs and they don't pay a living wage." Also, "manufacturing jobs have been reduced by almost half in the last 12 years. We used to produce mostly durable goods, but now it's mostly food-related products. The recession's ripple effect and loss of construction jobs has raised the unemployment rate in our area and has changed the materials used for new housing units."

Positive Trends

Interviewees also noted positive health-related trends including people being able to identify links between chronic diseases such as obesity, diabetes and hypertension and behaviors such as healthy eating. There is also an increased awareness about diseases such as HIV/AIDS, with more people accessing screenings and other preventative measures.

One interviewee said that while HIV/AIDS infections are still occurring, the infection rate is slowing down: "A few years ago we found 136 HIV-positive people in one year. Last year, this dropped to 68. I'm not sure if that's because we just got the motivated ones or there was actually a decrease."

Interviewees seemed concerned and anxious about the roll out of the Affordable Care Act (ACA), while many commented on the potential benefits expected, including:

- "The Healthy LA program has opened access to many people, and the county is expanding access to specialty care."
- "The whole health care system is shifting with Affordable Care. The Act indirectly addresses the undocumented issue by paying clinics to care for the uninsured, so we're moving toward being able to address some of these issues."

An interviewee commented about California's role in the changing healthcare landscape. Related observations include:

- California must take a leadership role and draw as many federal dollars as possible
- California needs to control healthcare costs and maintain stability in the system
- Covered California (ACA-mandated health exchange) will benefit all Californians
- With more people on Medi-Cal, the state will have to provide care with fewer resources
- Need to grow overall workforce; 25% of population is over age of 65
- Aging baby boomers will have different health needs to address

In addition to health-related trends, interviewees also noted a shift in the population, economy, and barriers. The following observations were made:

- "The San Gabriel Valley is a fairly strong working class community and has a long history of second and third generation immigrant groups."
- "People here are resource poor. They don't have enough food or affordable places to live. Multiple families live in one apartment."
- "Healthcare is the Valley's largest and strongest industry. The area has an unusually high number of quality hospitals that other providers (e.g., pharmacies, physical therapists) tend to cluster around."
- "Our aging population is growing; people stay in the region, others are retiring here."
- "Enrollment in elementary school and pre-school is declining. People are putting off having children. Sometimes there are small increases, but the numbers decrease again. This may turn around once the economy stabilizes, but the long term trend is fewer young children, even among Latinos, Blacks, and Asians."
- "On-going immigration will require a new approach to health."

- "The San Gabriel Valley is mostly Latino, and now 25% of the population is Asian. The number of Asian-owned businesses is growing."
- "Poverty is the source of chronic disease; it comes from multiple interacting issues, including the economy and family stresses."

Barriers to Access

Interviewees were asked to identify the kinds of problems or challenges that people face in obtaining health care and/or social services. The most frequently reported barriers specifically related to delivery of services.

- "There are resources but the public just doesn't have the knowledge."
- "The critical issue is the lack of access to specialty care physicians such as cardiologists and gastroenterologists. It can take month or over a year to be seen and is very expensive. Referral to specialty care is complicated. When we refer a patient to neurology, they say the patient needs a CT scan before they can be seen."
- "There's very little specialty care through public clinics. Clients usually get referred to the County where there is a long wait or don't have a way to get there (transportation)."

Additional barriers identified by interviewees include access to care, prevention, treatment, and management of chronic health conditions.

- Economic constraints
- Fear
- Homelessness
- Inadequate capacity (long waits, especially for specialty care)
- Lack of health insurance
- Lack of services on weekends and after working hours
- Lack of transportation
- Language issues and cultural differences
- Limited knowledge / education / understanding
- Noncompliance with advice and recommended treatments
- Preference for alternative, nonmedical treatment

Insurance /Accessing Available Services

- "Some have insurance but don't understand the co-pay. They have a fear of billing. They think they'll be presented with a huge bill at the end of the doctor visit."
- "We make a big effort to encourage parents to get medical and dental preventative treatment, but without our intervention, they just don't use preventative services. Many low-income families have government sponsored or job-based health coverage, but they don't use it. Most go to county health clinics, or wait until the situation is dire and then go to the ER."

Transportation

- "The bus system is designed to take people to work downtown, so it isn't easy to navigate. The working poor may have one car someone takes to work so the other person has to walk or take the bus."

- "The San Gabriel Valley is very spread out. Bus fare is expensive, about $75 a month. They get some bus tokens from LA Metro and Foothill Transit, but only for the main bus line. Lack of viable transportation is a barrier to getting to a job interview."
- "Children have access to health insurance through a variety of programs, but aren't using it. It may be a transportation issue because parents have to get them there, or it may be cultural."

Language, Education, and Cultural Barriers

- "Most of our clients won't go to San Gabriel Valley Medical Center due to discomfort around cultural differences (with the providers)."
- "The cultural issues are complex. Some are very wary around others wearing any kind of uniform; others are uncomfortable traveling through San Marino to get to a clinic in East Pasadena."
- "Many don't realize that there are translators available at some clinics."

Psychological Barriers

- "The homeless and some of the working poor have a hard time going to large institutions for care. They feel they don't look presentable; they aren't clean. They don't want to sit in a waiting room for hours. They worry they'll get stuck downtown at night, in a strange neighborhood."
- "Recent immigrants are afraid to access services, especially if they are undocumented."
- "The biggest resistance comes from thinking the problem will go away, or from fear of the doctor or dentist."
- "What has been the practice when you're ill? Go to the botanicas. They believe in an alternative non-medical system."
- "Really low-income people have all types of social issues from unemployment, or having a job but not enough to get by, the safety of the area where they live, not knowing where their next meal is coming from. These issues are more important than their health."

Autism

An interviewee noted that the "spike" in diagnosed cases of autism, which started twenty years ago, has resulted in a large population of adults, now 25 to 30 years old, who deal with continuing challenges related to autism. It was suggested that Kaiser Permanente take a leadership role in investigating the reason for the rise in autism diagnoses (environmental triggers, genetic issues). Additionally, hospitals can do the following to address autism early when intervention is most effective:

- Focus on early intervention and diagnose children correctly
- Conduct annual developmental screenings with a reliable, effective tool on every child
- Build performance standards into regular pediatric care/clinics to ensure that assessments for are being conducted
- Track assessments over time (up to 6 years old)
- Have parents fill out an assessment in the emergency waiting room and keep on file for future use

Suggestions were also offered to help hospitals deal with autism including:

- "Help families coordinate the non-medical pieces that also have implications for the wellbeing of children with autism."

- "Take the lead in helping families navigate not only the health care system, but other systems. There's a cost argument for coordination of complimentary services— they end up making people healthier."
- "If you can't figure out how to fill out paperwork for your child with a disability because you don't speak English, you can't get the child enrolled in early intervention. If the child is chronically absent from school and failing, a system navigator can walk parents through it otherwise they will flounder."

Oral Health

Participants discussed challenges faced by those seeking dental services including finding a dentist, getting parental compliance to serve children, and the lack of restorative care services:

- "It's almost impossible to get free dental care. I'd like to see the dental community come together to organize groups of dentists who will set aside a certain number of visits/services per week/month for low-income families. Dentists fear they will be overwhelmed by the number of requests from low-income clients."
- "Parents resist getting dental care when cavities are in the child's baby teeth because those will fall out so it's not a priority to them. Also parents who have had bad dental experiences don't want to expose their kids to the pain."
- "We can't do restorative work anymore, only extractions and fillings. We don't have money for dental lab services."

Mental Health

Participants described a large gap in the availability of mental health services and how difficult it is to get people with mental illness to come in for treatment:

- "Among the homeless, 50 percent have addiction and mental health issues."
- "Most don't seek mental health care. (Our organization) brings mental health providers to school sites because parents won't go to a counseling office. There's a big stigma attached to going to a therapist."
- "The vast majority wouldn't seek help; those who do, go to their churches or family members. Stigma is huge around mental health."

Most Severely Impacted Sub-Populations

Interviewees were asked to comment on issues of concern to specific sub-populations within the communities their agencies serve. The following sub-populations were identified as being the most severely impacted:

- Adult males
- Homeless individuals and families
- Least educated
- Mothers
- Newly immigrated
- Seniors
- Undocumented
- Veterans
- Young families

Homeless

Interviewees described a "huge need" for recuperative care, year-round shelters, and programs designed to address the issues unique to people without stable homes.

- "The very ill and those discharged from ICU need to get off the streets. They can't go to the shelters; they need a place to be out of the cold, rest and get well. There are a few recuperative beds, but those are far from San Gabriel Valley. There was a guy who came out of ICU with a drain and dressing on an open gunshot wound. There's no in-between for people like him."
- "Respiratory problems can be lethal to the homeless. If they were housed and out-of-the elements, they might not have died, but they have to leave the shelter in the day, when it's still cold outside."
- "We have only one winter shelter and funding has been cut, but the number of homeless is increasing. I've been affiliated with this (homeless resource) organization since 1997, and I see the need get worse every year."
- "Services are set-up to meet the needs of low-income clients, not the homeless. Homeless clients don't know where to go, how to get there. They don't know they have to line up at 5am for services. This is only doable if there's some stability in their lives. If they have other appointments or are waiting in another line for food, then they miss the 5am."
- "The homeless have extra difficulty accessing services (don't have required documents e.g., ID, insurance cards, legal residency) for county eligibility. They have trouble getting prescriptions filled because they can't pay the co-pay."
- "The homeless don't have a choice about what they eat. They have no way to cook, no refrigeration. They eat food high in sodium, fat, and calories."
- "A lot of our clients are totally bewildered by their circumstances. They're dazed and just trying to survive."

Seniors

Interviewees also identified the senior population as the most severely impacted by the lack of available doctors and nurses, and follow-up care for chronic disease.

- "The boomer population is aging and living longer. They will have mobility issues. There are not enough doctors, nurses, caregivers to serve this population."
- "There's little follow-up to manage chronic disease. This is a burden on the patient and the caregivers, who often don't have the skills or wherewithal to care for a condition."

Undocumented

The undocumented were also identified as one of the most severely impacted populations unable to access health care.

- "The undocumented are locked out of access to health care even with the advent of health care reform – they have no way to even buy in to low cost insurance. Either we pay now or we pay later because this population will need care from the system at some point."

Veterans

Veterans were also identified as severely impacted by the lack of transportation..

- "Veterans qualify for services, but they have to get to West LA, Long Beach or Loma Linda, there's nothing in East San Gabriel Valley. The veterans housing/social services in El Monte, doesn't have medical care. There's no viable transportation for veterans."

Other Disparities

Concern was also expressed regarding adult women who "tend to put health concerns on the back burner in order to take care of their families" and for adult men who need assistance managing chronic conditions.

Expanding on the issues and challenges of these subgroups, interviewees offered the following:

- "We are seeing a younger population with these health issues compared to before. Now they are in their early 40s with diabetes, compared to being in their 50s in prior years."
- "One in three of our 3 to 4 year olds are overweight or obese! This will lead to a range of health and psychological problems as the kids go through school and life."

Health Care Utilization

Interviewees were asked to name places where people go to access services and information to help them deal with mental and physical health care issues, family challenges, and personal concerns. Community members access services, information, and education in varied settings and across many communication platforms. Community resources mentioned during the interviews are included in the compiled list of community assets in Section VII of the Community Health Needs Assessment report.

Interviewees noted that community members were more likely to hear about these resources through word-of-mouth, churches, radio and billboard campaigns, community events including health fairs and farmers markets, community clinics, county hospitals, and phone help lines.

Patient Advocacy

Several interviewees concurred that utilization of available services would increase and produce more effective outcomes if clients knew how to access and understand what is available to them. They recommended increased training and use of patient advocates and system navigators:

- "It seems more and more that you need an advocate when you go to the hospital or clinic. Someone to come with you, make sure you're getting what you need."
- "They need someone to accompany them on medical visits, so two people hear and learn the key points about the condition."
- "We need more social workers, advocates and discharge planners who can translate preventative care practices into people's real life needs and capabilities."
- "Train front line people to provide resources to patients, their caregivers and families."
- "Provide someone who can help people pursue resources, make calls, and help them figure out how they can do it."
- "A proactive person can ask for what they think should be monitored, but a less knowledgeable person is at the mercy of the system and the capacity of health care staff on any given day to pay attention and do the appropriate follow up."

Gaps in Services

Interviewees mentioned that the San Gabriel Valley service area had significant service gaps in the following areas:

- Emergency rooms, trauma centers, and urgent care facilities
- Follow-up care
- Nutrition and health education
- Preventative care
- Primary care center designed to address the unique needs of the homeless
    - Year-round shelters for the homeless
- Recuperative care
- Specialty care
- Viable transportation options

Ideas for Collaboration and Cooperation among Service Providers

Interviewees were asked to reflect on specific actions or initiatives that hospitals could take to help address identified needs. They were also asked to describe potential areas for collaboration and coordination among hospitals and CBOs to better meet the needs of the communities they serve.

- Be more patient-centric and customer service oriented
- Be more specific about referrals (where to go, who to see) after a patient is discharged from the ER
- Create a care coordinating entity to work with private providers
    - Streamline services
- Follow-up with primary care doctor after ER discharge
- Get physicians to provide referrals to social services, not just prescriptions for medications
- Help with recuperative care (pay for motel stays and nurse visits for homeless)
- Partner with family resource centers (e.g., Magnolia Place)
- Partner with farmers markets to promote healthy eating
- Provide practical, hands-on, culturally sensitive cooking and nutrition classes
- Subsidize specialists at community clinics
- Team with churches, YMCAs, schools, and community centers where people congregate

Interviewees also offered cost-based, economic reasons for expanding collaboration with hospitals:

- "Hospital-sponsored off-site recuperative care for the homeless frees up hospital beds."

- "Hospitals need to increase partnerships with urgent care providers to handle everyday issues, like the flu, for the uninsured. That would shorten ER wait times."
- "The healthcare sector is a vital part of the San Gabriel Valley economy, with good jobs that pay good wages. Hospitals should make a concerted effort to train and hire local people—train young people, starting in high school, to get them interested in healthcare career."

Examples of working collaborations among hospitals and community-based organizations include:

- Citrus Valley Hospital and Altamed are sharing information, coordinating Electronic Health Records, and trying to form an efficient system
- Model recuperative program in Orange County (possibly called Illuminate). Hospitals run it, pay for 6- to 10-day stays in motels and nurse visits for recuperating homeless patients
- Kaiser Permanente - Baldwin Park Medical Center provided low risk outpatient surgeries for uninsured patients who couldn't afford the procedures

Potential Areas of Collaboration among Service Providers

Interviewees suggested the following areas as fertile ground for productive collaboration:

- Conduct proactive educational outreach, class, and programs
- Organize more town hall forums, health fairs, farmers markets
- Partner with comprehensive family resource centers (e.g., Magnolia Place)

Interviewees also offered additional insight into the dynamics of and obstacles to collaboration:

- "Hospitals and health providers need to learn to work together better. The challenge is for health systems to learn to keep people healthy, not just treat them when they are ill."
- "We need to get more service providers around the table, including the local cities. Trying to get city government involved. Coordinate quite well through Consortium, meeting once a month. Also need to collaborate on a day-to-day basis. Has gotten better, know each other, names, call each other for help. No master plan for this and needs to continue to improve."
- "A lot of groups across our communities are doing good work, most are small and don't have many resources. Connect with these community services that want to collaborate, but don't come in with a grandiose idea and try to push it on people. Build on the strengths and services that already exist in the community."

Outreach Methods and Message Content

Interviewees were asked to share their thoughts about the most effective outreach methods for delivering information to their service populations including:

- Booklet or directory of resources (challenge to keep hard copy version updated)
- Cell phones, online platforms, and social media
- City websites
- Community forums and town hall meetings specific to communities

- Events at schools and libraries
- Faith-based organizations
- Locations where people congregate, local gathering places (e.g., Mexican Consulate)
- Mailings local residents (multilingual text)
- Mobile clinics
- Organizations that serve specific populations
- Promotoras
- Provide information in other languages
- Publications specific to communities (Spanish, and Chinese)
- Radio programs and public service announcements

Interviewees agreed that, to be effective, messaging should have the following attributes:

- Delivery through local service providers and organizations
- Family-centered messaging ("My Kitchen, My Rules" campaign is good)
- Relevant and up-to-date messaging in order to reach young people
- Tailor message according to disease issue and targeted audience

Further suggestions regarding messaging provided by the participants include:

- "Talk about outcomes, but scaring people is not a good idea."
- "Cost-effective, quality healthcare at a reasonable cost is the message."
- "Spanish-speaking people prefer visually oriented communication materials."
- "Approach this by focusing on kids, because many low-income families are child-focused; what little they have is directed to their kids."
- "Make educational resources available in waiting rooms that are appealing and user-friendly. A good example is, 'The People's Guide to Food and Hunger.'"
- "Kaiser Permanente's public service announcements about health are good."
- "Mass campaigns around healthy eating and diet really help. We can't afford to do that on our own, but in partnership we can."

Appendix F:
Focus Group Summary for CVHP

Health Needs and Drivers

Five focus groups representing a broad range of community stakeholders, including area residents, were convened to gather information and opinions directly from persons who represent the broad interests of the community served by the Hospital. Focus groups took place in a range of locations throughout the service area, with translation and interpretation services provided when appropriate. Focus group sessions were 60 to 90 minutes each. The focus group topics were designed to collect representative information about health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic disease management and other community issues. A summary of key focus group findings is noted below.

Health needs

- Alcoholism
- Asthma and other respiratory illnesses
- Birth defects
    - Autism
    - Developmental delays including speech impediments
- Cancer (breast, colon, prostate, pancreas, stomach)
- Coronary disease
- Dental disease
- Diabetes
- High blood pressure
- Homicide
- Mental health
    - Depression
- Obesity
- Teen suicide
- Vision problems

Drivers of health

- Cultural
    - Language barriers
- Environmental
    - Lack of clean and fluoride-free water, lack of clean and wholesome food
- Family violence
    - Domestic violence
- Lack of access to health care
    - Lack of insurance
    - Long waiting time for appointments – one participant shared how a young woman with breast cancer was afraid her cancer would become more advanced because she had to wait for such a long time to get an appointment with a doctor.

    - Lack of information
    - Lack of trust
- Lack of coordination of healthcare
    - Going from doctor to doctor with no communication between medical service providers
- Lack of dental care
    - Lack of preventative health due to a lack of knowledge
- Lack of green space
    - People feel unsafe going to the park, gym, or walking in the community
- Lack of transportation
    - Public transportation is inadequate, takes too much time (long waits, long lines)
    - Lack of access to bike trails
- Social and Economic
    - High concentration of foster youth and emancipated youth
    - Unemployment, underemployment
    - Immigrant/resident status, lack of legal identification
    - Gyms are not affordable
        - "There are many outdoor and indoor activities such as gyms but everything has a cost and there is not enough money to afford them."
    - High number of teenage moms with two or three children - need health education
    - Unemployment, lack of work causes stress (unable to pay bills, food and gas costs)
- Unhealthy behaviors and lifestyle
    - Lack of self-management for disease
    - Wait until an illness turns into an emergency
    - Poor nutrition, feeding sugar/sodas to children, no access to fresh vegetables, information gap about healthy foods
        - "People get bombarded with information about health and nutrition but there is no quality information that helps people understand what healthy food and nutrition really is."
    - Lack of exercise due to time spent watching television or using technology such as video games and computers

Health-Related Trends in the Community

Focus group participants were asked to discuss negative and positive health-related trends they have noticed in the last five years related to chronic illness, barriers to access, and other factors and issues.

Negative Trends

- Decrease in the quality of food
    - Product quality is bad and food goes bad faster than before
- Environmental

    - Air quality has improved, however there is not enough awareness about how to dispose of man-made materials and products composed of toxic materials
- Increase in chronic illnesses
    - Increase in diabetes, insulin dependence
    - Anemia – one person mentioned that their daughter had this condition and did not want to eat because she did not want to become fat
- Increase in unhealthy behaviors
    - Adults continue to consume too much sugar/salt, more obesity, no education about nutrition
- Lack of access
    - Lack of access to qualified specialists
    - Medical reimbursements rates decrease and specialists opt out of the system
    - Lack of information about how to navigate the health care system, which has become more complicated and less user-friendly
    - Reduction in funding for substance abuse treatment
    - Challenges with accessing mental health services, especially for adults
- Lack of access to specialty care
    - Lack of dental and vision especially in adults/seniors
- Poverty
    - Increase in food bank clients
    - Increase in people using donation boxes as a source for clothing for themselves and their children
    - No change in income in conjunction with higher costs for consumer products
    - Public transportation costs – more homeless and working people are now taking public transportation, however, drivers are less lenient if riders are unable to pay the complete fare
    - Increase in homelessness – increased in SPA 3 by 19% despite overall decrease in Los Angeles County – and lack of affordable/accessible housing
    - Cost of gas is "an extreme economic problem" because people use money from other budget areas to pay for gasoline and transportation
- Strict medical insurance guidelines
    - Less medical benefits due to reductions in coverage

Positive trends noted by focus group participants included an increase in a holistic perspective and better understanding of health issues and recognition of community-based needs, of connections between health drivers and health issues and the need to collaborate. Community members are also slowly starting to understand the

importance of fresh fruits and vegetables in the diet (i.e. the popularity of farmers markets). Schools have also implemented healthy lunch programs and have become more involved in sharing health care resources.

Healthcare providers talked about health behaviors in the community and stated the following changes occurring in the local communities:

- Changes in policies (and not behavior) were leading to improvement of the health environment
    - Healthier choices were available due to new policies
        - "The healthy choice is the easy choice."
- Change in attitude and behaviors
    - Decrease of BMI in Baldwin Park
    - More people walking and eating less sugar
- Greater cultural sensitivity towards immigrants
- Moratorium on fast food restaurants

Sub-Populations most affected by these general health needs

Focus group participants identified the most affected populations as the undocumented, the disabled, seniors, homeless, children and families living below the poverty level, parolees from the prison system, those with special needs, and youth transitioning out of foster care. Many participants felt that these health needs affected "everyone" and that children are impacted as well when they see their parents being affected.

Barriers to Access

Many participants shared that there is a sense of anxiety about using the health care system. Some immigrants in the community will not use county health services, food banks or churches due to lack of documentation. Others have only emergence insurance and fear that if they see a doctor they will be presented with a large bill. When they do have insurance, they visit the doctor. Otherwise, they self-medicate. When asked about services that were lacking and barriers to access, people's responses focused on basic needs such as food banks, jobs and affordable housing. The following lists include barriers and services lacking in the community.

Barriers

- Immigration status – unsure of consequences when seeking health care and not able to use certain county services
- Eligibility – only those with no income qualify; part-time and self-employed people no longer have access to health care services unless they are 65 years old. If they are under 65 and have assets/income, they cannot get insurance
- Financial barriers – cannot afford insurance co-payments or to take time away from work
- Increase of multiple families in a single residence – causes mental stress, depression, anxiety, lack of privacy, inability to sleep, and family violence

- Lack of motel vouchers for the homeless – Los Angeles County provides help only "one time in lifetime" and once used, the person no longer has access to assistance. One participant described a single mother with four children who could not afford to pay the weekly rate of $480 at a motel and had no other place to stay. Another participant spoke of a family from Europe that was very stressed because they could not afford any food
- Lack of transportation
- Lack of understanding of the health care system – especially among grandparents who are often taking care of grandchildren and need to be educated about changes in the health care system
- Language/literacy/culture barriers – different cultures have different ways of dealing with health issues; people might have insurance but do not understand co-pays/billing
- Many people have only emergency insurance and fear that if they do see a doctor they will be presented with a large bill
- Need organizations that will "fast-track" and serve as liaisons between people and medical services
- People are losing homes and jobs – if one of the main providers in the family gets laid off they must scramble to pay for other necessities such as gas, utilities and rent and go without food
- Small businesses are choosing not to expand because of the cost of insurance for new employees

Health services that are lacking or difficult to access

Participants identified a number of services that were missing the community including mental health resources, youth services, homeless services, recuperative care, computer literacy and access, public transportation, and referrals for the disabled. Health services that are lacking or difficult to access include:

- Affordable health care – a participant shared that her unemployed husband broke his hand and had to see a doctor; the visit was very expensive
    - Ambulance service – can cost almost $800 without insurance
- Affordable housing – homeless students and families are living in their cars and are not able to take online classes without Internet access
- Better public transportation
- Computer classes for parents – children need help with homework but parents are not able to help because of lack of knowledge
- Computer/Internet access – library use is limited to one hour
- Employment – jobs are being created for skilled workers; need more jobs in manufacturing and other employment opportunities for people with less skills
- Food support services– families needing supportive resources for food are embarrassed because they have not been in this situation before, do not know how to access information and are reluctant to ask for help
- Health education
    - Re-education for diabetic maintenance, due to changes in medical technology (glucometer)

    - Educational resources about nutrition, exercise
    - Information/referrals for the disabled or potentially disabled
- Homeless shelters – especially for families. Sometimes available shelters are far away from a family's local community.
- Mental health services – no access for those with insurance coverage, language barrier, lack of access for youth, psychologists provide screening but not care, and other difficulties finding mental health care
    - Not enough mental health resources for uninsured people. Difficult to meet eligibility requirements. Even after qualification, can take long time before start of service. More challenges for adults.
    - Depression treatment and care
- Nurses in clinics and at schools (Reduction in nurses within schools)
- Seamless transition from primary care to behavioral health services/treatment
- Specialty care
    - Neurologist, rheumatologist, pediatrician
    - Vision services – students with vision problems having difficulty seeing in the classroom, affecting academic performance
    - Dental care – can take up to a year to get an appointment. Need dental clinics and preventive dental care for students to reduce cavities and other dental issues. Even when dental screenings and basic services are available, restorative dental care is not available for all ages, including seniors
    - Recuperative centers
- Youth services

Healthy behaviors most difficult to promote

Participants attributed the inability to promote healthy behaviors in the community to a lack of education around healthy behaviors and access to preventative care. In addition, one participant noted that "it's easier to buy fast food than to cook for ourselves." Other behaviors that are among the most difficult to promote include:

- Counseling – cultural biases and stigmas attached to mental health
- Smoking cessation
- Engaging in self-medication and using other people's medications and prescriptions

One participant suggested that connecting with Parent Teacher Associations (PTA) as a means to develop creative ways to teach healthy alternatives for the usual candy and cookie fundraising campaigns. Hospitals can disassociate with fast food restaurants and instead back healthier alternatives.

Health care utilization

Preventive healthcare

Participants noted a 100% participation rate in preventative healthcare programs within the school district. They believed that people use these services because they are being delivered at a trusted site. However, they further note that preventative care is not a priority if basic needs are not being met. In such cases, people will seek medical care only in the case of an emergency. They also commented that adult men and homeless individuals tend not to seek medical care while Latinos seek a more holistic approach to healthcare. Participants also indicated that people do not obtain preventative healthcare due to fear, lack of time, lack of insurance, lack of money, indifference, and a feeling of discomfort or shame.

Insurance programs available and/or used by community members

While there are many different programs available in the community, participants reported that requirements keep changing, are inconsistent, and are difficult to understand. Also, many do not have insurance because this is not a priority.

- "Basic needs (paying the rent, bills) are more important than health needs."

Focus group participants reported using the following insurance programs to access care:

- Blue Cross
- Health Net
- Healthy Families (though this program keeps changing, is hard to understand)
- Healthy Way LA (though there is a lack of low cost clinics for services)
- LA Care (dual eligibility with MediCare/MediCal though overwhelmed with applications)
- MediCal
- MediCare
- PacifiCare

Community Resources

Participants were asked to share information about community resources available in their community. Participants noted that community members mostly went to community clinics to obtain health care, including:

- Cleaver Family Wellness Center
- East Valley Health Center – free clinic
- El Monte Clinic (where you wait all day)
- El Monte Comprehensive Center
- El Monte/South El Monte Resource Services – free glasses for school children
- El Proyecto del Barrio
- Pomona Health Center

In addition to community clinics, community members also go to the following places or resources for care and/or health information:

- Alternative medicine/herbalist
- Boys and Girls Clubs
- Churches
- Community resource centers – La Puente has notebooks full of health information for residents
- Community-based organizations such as Stepping Stones for Women
- Los Angeles County 211 hotline
- Emergency rooms
- Health fairs – organized by hospitals, community centers, veterans' groups
- Internet/Google/Facebook (some families lack Internet/phone access, but those that do have access use social media, such as Facebook, quite effectively)
- Local pharmacies
- School clinics
- Schools – PTA/School office
- Senior centers
- Social gatherings including job clubs, veteran networking clubs, student councils, booster groups, college career fairs
- Tijuana, Mexico and China (or other native countries)

How hospitals can address the health service needs of this community

Participants discussed the need for hospitals to build partnerships and relationships within the community. While some participants wanted to see additional preventative health services, others wanted more appropriate and accessible programs (e.g., in multiple languages, culturally relevant, located within the community). Specific suggestions included:

- Create marketing/policy/advocacy effort against fast food and bad nutrition
- Encourage doctors to volunteer in community clinics
- Engage in better discharge planning to improve the long term health of patients and prevent hospital re-admissions; make referrals to agencies for recuperative care; make sure people can afford prescription medications
- Form partnerships with corporations such as Macy's and offer free services/donations
- Hospitals as conveners – facility/staff can create and facilitate partnerships with community groups as well as connect with established community resources. Get to know community-based agencies and collaborate with them.

- Hospitals and motels could collaborate to provide temporary housing for the homeless
- Kaiser's new communication plan could provide quality information about where food comes from
- Make educational classes accessible to non-Kaiser members
- Make specialty services accessible to non-Kaiser members
- More health fairs and screenings within the community for local residents
- Partner with large corporations to contribute to the community. A participant shared a story about a large group of Vietnamese refugees/immigrants who received assistance and jobs. Another participant talked about how the store Sephora, where her daughter works, provides food and clothing donations to St. Vincent de Paul, a charity organization in Los Angeles.
- Promote available health services to the community through flyers/brochures
- Provide diabetes screenings and diabetes education in multiple languages for a broader audience
- Provide e-consultation with Kaiser specialists
- Provide free breast screenings and checkups
- Provide information about health, nutrition and obesity
- Provide nutritional education in Spanish to support the healthy lunch program
- Provide vision screenings and make vision services low-cost and affordable
- Provide vouchers for doctor visits to reduce costs
- Reduce medical service costs and/or educate patients about options for paying less than billed amount

Appendix G: Data Collection Tools and Instruments

KP CHNA 2012
Provider Focus Group Protocol

Introduction:
Thank you for participating in this focus group discussion. We are holding discussion groups as part of a community needs assessment for Kaiser Permanente and their medical centers to help them better understand community needs and identify the type of support Kaiser Permanente can provide to its diverse communities. Therefore, we would like get your ideas about the most important health issues facing your community. In addition, we will talk about what community members need to be healthier as well as the availability of services to meet those needs. Please share your honest opinions and experiences and allow other to express theirs freely. Your responses will not be associated with your name in the report and only to ensure your confidentiality and anonymity. Does anyone have any questions before we get started?

Note to facilitator: *Review health data for appropriate service area in order to effectively probe where appropriate.*

GENERAL NEEDS (INCLUDING HEALTH AND SOCIAL NEEDS)

1. What are some of the **major issues** that impact individuals in your service area?
    a. Why do you think they're the **most important**?
    b. What **populations are most affected** by these needs? Why?
    c. What are the **social issues** that contribute to the health problems? (Such as substance use, unemployment, etc.)

2. What **major trends in needs** (positive and negative) are you seeing in your service area?
    a. How are today's trends **different** from the major trends **5 years ago**? Are there any differences among **different communities/geographic areas**? What are the differences (if any)? Why?

3. Are there **social or environmental factors** that have contributed to these changes? **Other factors**?
4. What kind of **insurance programs** do community members have available to them?
    a. How does insurance **impact their ability** to get the health care they need? Is it different for their family members by age?
    b. If they are **uninsured**, why? *[barriers, etc.]*

BARRIERS TO ACCESS

5. What health services are **difficult to access** in your service area? [*For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.]*
    a. Does this affect certain **communities/geographic areas** more than others? Which? **What factors** contribute to this?

6. What health services are **lacking** in your service area? [*For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.]*
    a. Does this affect certain **communities/geographic areas** more than others? Which? **What factors** contribute to this?

7. What other **challenges** keep individuals from **seeking help**? [*For example, this could be a lack of awareness of available resources, language barriers, lack of bilingual healthcare providers, immigration status/issues, lack of transportation or childcare, cultural values/beliefs, unsafe neighborhood, working multiple jobs/lack of time, etc.]*

8. Which **healthy behavior is the most difficult to promote** in your service area?
    a. Why?
    b. Are there any healthy behaviors that are the hardest to promote for **a particular population**? Which? Why?

c. Based on your knowledge of this community, what are some **possibilities** for addressing this?

ASSETS (HEALTH AND SOCIAL)

Health services

9. What **health-related services are available** to you in the community?
    a. **Where** do community members go to receive or obtain information on health services?
    b. How do you prefer to **receive information** about important health issues or available services? [newspaper, radio, community clinic, flyers, billboards]
    c. Does **access differ** for certain populations or groups?

Social services

10. What **social services (non-medical) are available** to you in the community? *(For example, senior services, food/nutrition, family support, disability, employment, environmental, homeless, etc.]*
    a. **Where** do community members go to receive or obtain information on social services?
    b. Does **access differ** for certain populations or groups?
    c. Which social services are **needed** in your community?

11. What are the **strengths and resources** available that have had a positive impact health?
    a. What **populations are more able to access** these resources because of this?

HEALTH CARE UTILIZATION

12. Are individuals in your service area likely to use **preventative healthcare**?
    a. **If no**, why?
    b. **Had this changed** in the last 5 years?
    c. Do **culture or community norms** influence the health behaviors of community member? How?

13. If community members are not feeling well [not an emergency], where do they usually **go for care**? *[Prompt for other providers: alternative health care including curanderos, traditional healers, use of herbs and natural medicines]*
    a. Where are they **located**? How do you **get there**?
    b. Do you feel that it's getting easier or harder to **obtain healthcare**? Why?

HOSPITALS ROLE

14. What **role could hospitals** play in addressing the service needs of your service area?

KP CHNA 2012
Resident Focus Group Protocol

Introduction:
Thank you for participating in this focus group discussion. We are holding discussion groups as part of a community needs assessment for Kaiser Permanente and their medical centers to help them better understand community needs and identify the type of support Kaiser Permanente can provide to its diverse communities. Therefore, we would like get your ideas about the most important health issues facing your community. In addition, we will talk about what community members need to be healthier as well as the availability of services to meet those needs. Please share your honest opinions and experiences and allow other to express theirs freely. Your responses will not be associated with your name in the report and only to ensure your confidentiality and anonymity. Does anyone have any questions before we get started?

Note to facilitator: *Review health data for appropriate service area in order to effectively probe where appropriate.*

GENERAL HEALTH NEEDS (i.e. CHRONIC DISEASE, COMMUNICABLE DISEASES, MENTAL HEALTH, ETC.)

1. What are some of the **major health issues** that affect individuals in your community overall?
    a. Why do you think they're the **most important**?
    b. What populations are **most affected** by these needs? Why?
    c. What are the **social/societal issues** that contribute to the health problems? (**DO NOT SAY ALOUD:** Such as substance use, unemployment, etc.)

2. What **major trends** in health needs (positive and negative) are you seeing in your **community**?
    d. How are health issues **different** from **5 years ago**? Are there any differences among **different communities/geographic areas**? What are the differences (if any)? Why?
    e. What **factors** have contributed to these changes?

3. Are there **social or environmental factors** that have contributed to health needs or trends? Which? **Other factors**?

4. Do **you or a family member** have a **chronic health condition** such as asthma, diabetes or heart disease?
    f. If yes, how do you keep your **condition under control**?
    g. How helpful is the support you receive from your **health care provider**?
    h. How helpful is the **information** that you receive?

5. What kind of **insurance programs** do you use for yourself? Your spouse? Your children?
    i. How does insurance **impact/effect your ability** to get the health care you need? Is it different for your other family members?
    j. What **other kinds** of insurance programs are you aware of?
    k. If you are **uninsured**, why?

BARRIERS TO ACCESS

6. What health **services are difficult to access** in this community? [**DO NOT SAY ALOUD:** *For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.]*
    l. Does this affect certain **communities/geographic areas** more than others? Which? What **factors** contribute to this?

7. What health **services are lacking** in this community? [**DO NOT SAY ALOUD:** *For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.]*
    m. Does this affect certain **communities/geographic areas** more than others? Which? What **factors** contribute to this?

8. What other **challenges** keep individuals from **seeking help/care**? [**DO NOT SAY ALOUD:** *For example, this could be a lack of awareness of available resources, language barriers, lack of bilingual healthcare providers, immigration status/issues, lack of transportation or childcare, cultural values/beliefs, unsafe neighborhood, working multiple jobs/lack of time, etc.]*

9. Which **healthy behavior is the most difficult to encourage** in this community? Why?
    n. Are there any healthy behaviors that are the hardest to promote for **certain communities/geographic areas**? Which? Why?
    o. Based on your knowledge of this community, what are some **possibilities** for addressing this?

COMMUNITY ASSETS (HEALTH AND SOCIAL)

Health services

10. What **health-related services are available** to you in the community?
    p. **Where** do community members go to receive or obtain information on health services?
    q. How do you prefer to **receive information** about important health issues or available services? [newspaper, radio, community clinic, flyers, billboards]
    r. Does **access differ** for certain populations or groups?

Social services

11. What **social services (non-medical) are available** to you in the community? *(***DO NOT SAY ALOUD:** *For example, senior services, food/nutrition, family support, disability, employment, environmental, homeless, etc.]*
    s. **Where** do community members go to receive or obtain information on social services?
    t. Does **access differ** for certain populations or groups?
    u. Which social services are **needed** in your community?

HEALTH CARE UTILIZATION

12. What does **preventative/preventive healthcare** mean to you?
    a. What do you do to stay healthy?
    b. Do culture or community norms influence the health behaviors of community member? How?

13. If you are not feeling well [not an emergency], where do you usually **go for care**? *[Prompt for other providers: alternative health care including curanderos, traditional healers, use of herbs and natural medicines]*
    a. Where are they **located**? How do you **get there**?
    b. Do you feel that it's getting easier or harder to **obtain healthcare**? Why?

HOSPITALS ROLE

14. What **role could hospitals** play in addressing the health service needs of this community?

KP CHNA 2012
Resident Focus Group Protocol

Introducción:
Gracias por participar en esta plática. Estamos hablando con varios grupos en el Condado de Los Ángeles como parte de un estudio sobre las necesidades de las comunidades en el condado para mejorar los servicios de Kaiser Permanente y sus centros médicos locales y para identificar los tipos de apoyo Kaiser Permanente puede proveer a las diversas comunidades. Por eso es importante que nos digan cuales son los problemas de salud más grandes en su comunidad para poder identificar arias de necesidad y los servicios disponibles para servir sus necesidades. Por favor sean honestos y respetosos de los demás. Esto será completamente confidencia. ¿Tienen preguntas antes de empezar?

Note to facilitator: *Review health data for appropriate service area in order to effectively probe where appropriate.*

NECESIDADES DE SALUD GENERALES (COMO ENFERMEDADES CRÓNICAS Y TRANSMISIBLES, SALUD MENTAL, ETC.)

1. ¿Cuáles son algunos de los **temas más grandes de salud afectando** la comunidad?
    a. ¿Porque piensan que estos temas son **más importantes**?
    b. ¿Quiénes son **los más afectados** por esto? ¿Por qué?
    c. ¿Hay **problemas sociales** que contribuyen a estos problemas? *[Pueden ser como abuso de la droga, desempleo, etc.]*

2. ¿Cuáles **tendencias de salud** (positive o negativa) ve en su comunidad?
    d. ¿Esas tendencias **han cambiado** a comparadas a 5 años atrás? ¿Cómo?
    e. ¿Que ha **contribuido** a estos cambios?

3. ¿Existen **factores sociales o ambientales** que han contribuido a las necesidades de salud o cambios? ¿Cuáles? ¿**Otros factores**?

4. ¿**Usted o alguien de su familia** tiene una **condición de salud crónica** como asma, diabetes, o problemas del corazón?
    f. ¿Si contesto si, **como mantiene su condición** bajo control
    g. ¿Qué tan útil es el **apoyo que recibe** de su proveedor medico?
    h. ¿Qué tan útil fue la **información que recibió**?

5. ¿Qué **tipo de seguro médico** utilizan para usted y su familia?
    i. ¿Ha podido **utilizar** el cuidado médico necesario con su seguro médico? ¿Sus familiares?
    j. ¿Cuáles **otros seguros médicos** conoce?
    k. **¿Si no tiene** seguro médico, porque?

LAS BARRERAS AL ACCESO

6. ¿Ahí **servicios que son difíciles de utilizar** en la comunidad? *[Por ejemplo, puede ser clínicas comunitarias, proveedores de salud para gente con bajos recursos o sin seguro médico, clases de salud, cuidado dental o de visión, servicios para el abuso de sustancias, servicios de salud mental, ferias de salud gratuitas, recursos para mujeres embarazadas]*
    a. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?

7. ¿Ahí **servicios que faltan** en la comunidad? *[Por ejemplo, puede ser clínicas comunitarias, proveedores de salud para gente con bajos recursos o sin seguro médico, clases de salud, cuidado dental o de visión, servicios para el abuso de sustancias, servicios de salud mental, ferias de salud gratuitas, recursos para mujeres embarazadas]*
    b. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?

8. ¿Hay otros problemas o **situaciones que impiden** a la gente buscar ayuda? *[Por ejemplo, falta de conocimiento de recursos disponibles, lenguaje, falta e proveedores bilingües, estate inmigratorio, falta de transportación cuidado de niño, valores o crianzas de cultura, falta de seguridad en la comunidad, falta de tiempo, etc.]*

9. ¿Cuál **comportamiento saludable** es más difícil de promover en la comunidad? ¿Por qué?
    c. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?
    d. ¿Cuáles son las mejores formas de tratar de cambiar esto?

SERVICIOS EXISTENTES (SALUD Y SOCIALES)

Servicios de Salud

10. ¿Cuáles **servicios de salid** están disponibles en su comunidad?
    e. ¿**A dónde van** residentes para obtener información sobre servicios de salud?
    f. ¿Cómo **prefiere recibir** este tipo de información?
    g. ¿Hay **diferencias** en acceso para diferentes grupos?

Servicios Sociales

11. ¿Cuáles **servicios sociales (no de salud)** están disponibles en su comunidad? *[Por ejemplo, servicios para personas mayores, comida/nutrición, apoyo familiar, deshabilite, empleo, ambiental, vivienda, etc.]*
    h. ¿**A dónde van** residentes para obtener información sobre servicios de salud?
    i. ¿Hay **diferencias** en acceso para diferentes grupos?
    j. ¿Cuáles servicios sociales **faltan** en su comunidad?

USO DE SERVICIOS DE SALUD

12. ¿Para usted **que es medicina preventivita**?
    k. ¿**Qué hace** para mantenerse saludable?
    l. ¿Hay **algo que afecta** los comportamientos saludables como cultura o costumbres? ¿Cómo?

13. ¿A dónde van cuando **no se sienten bien**? *[Por ejemplo: curanderos, naturalistas, etc.]*
    m. ¿En **dónde** están localizados? ¿**Cómo llega** a ese lugar?
    n. ¿Siente que se está **facilitando el uso** de servicios médicos? ¿Por qué?

PAPEL DE HOSPITALES

14. ¿**Qué pueden hacer los hospitales** para corresponder a las necesidades de salud en la comunidad?

Organization: _____

KP CHNA 2012
Provider Focus Group Survey

1. Primary service area: _____

2. Primary area of expertise: _____

3. Primary service population: _____

This survey is confidential, thank you!

Organization: _____

KP CHNA 2012
Resident Focus Group Survey

1. What ZIP code do you live in? _____
2. How many years have you lived in this ZIP code? _____
3. How many children do you have? _____
4. What year were you born? _____
5. Gender? ☐ Male ☐ Female
6. Ethnicity? ☐ African-American ☐ Hispanic/Latino ☐ Asian/Pacific Islander
   ☐ Caucasian/While ☐Other _____

This survey is confidential, thank you!

Organización: _____

KP CHNA 2012
Resident Focus Group Survey

1. ¿En cuál código postal vive? _____
2. ¿Cuántos años ha vivido en este código postal? _____
3. ¿Cuántos hijos tiene? _____
4. ¿En cuál año nació? _____
5. ¿Sexo? ☐ Masculino ☐ Femenino
6. ¿Etnicidad? ☐ Afro-Americano ☐ Hispano/Latino ☐ Asiático
   ☐ Blanco/Americano ☐Otro _____

¡Esta encuesta es confidencial, gracias!

Date:
Interviewer:
Interviewee:

KP CHNA 2012

Stakeholder Interview Protocol

Introduction:
The Center for Nonprofit Management is working with Kaiser Permanente to conduct their 2013 Community Health Needs Assessment. We are talking to health experts to obtain their perspective on the most important health issues facing the local community and to identify areas of need as well as the availability of services to meet those needs. All the information collected will help local medical centers improve and better target their services. The information you provide will not be associated with your name and will only be reported in an aggregated manner.

For the interviewer: *Review health data to help inform appropriate probing where appropriate.*

Area of expertise:

Primary service area:

Population served:

GENERAL ISSUES

1. What are the **primary issues or challenges** facing your service population? [e.g., health, socio-economic, legal]
    - Have there been any **recent events or developments** that have had an impact or are likely to have an impact on the welfare of the community members you serve? [negative or positive]

PRIMARY CONCERNS

2. What are the most **significant concerns** among your service population?
    - **Who** do they impact the most?
    - What are the key **drivers** behind the concerns?
    - What **services are available** to address these concerns?
    - Are there any significant **service gaps**?
    - Has there been a significant change in the **availability of services** over the last few years?

HEALTH CARE UTILIZATION

3. To what extent does your service population **utilize basic health care services** (including preventive care) and **where** do community members **access those services**? What other community **assets are available** to community members?

To what extent do they **utilize dental care** and where do they go?

4. When community members become sick **where do they go to receive care**? (Doctor's office, urgent care, ER, community clinic, etc.)

    - Where do they tend to **obtain information**?

5. Where do **community members go** if they have chronic health issues?
    - Where do they go if they **need specialized care**?
    - Where do they go if they **need mental health care**?

BARRIERS TO ACCESS

6. What kinds of **challenges** does your service population experience when trying to get the care they need? [e.g., transportation, language barriers, lack of information, no health insurance, economic constraints]
    - Who tends to have the **most difficulty**?
    - How might these **challenges be addressed**?

SERVICE PROVISION

7. Are there any **growing needs/trends** among your service population? Explain.
    - What **measures** have your organization taken to address this need?

8. What specifically could **hospitals** do to help address these needs?

9. Do you see any potential areas for **collaboration or coordination** among service providers to better meet the needs of your service population? Explain.

OUTREACH

10. What would be the most effective **way to provide information** to your service population about the availability of health and other services?
    - Is there a **particular message** that would appeal to community members?

11. Is there **anything else** you would like to add?

Community Health Needs Assessment
Prioritization Criteria Scale

SEVERITY

1 (Not Severe)	2 (Moderately Severe)	3 (Severe)	(V
The community is slightly impacted and the health need does not generally impact the lives of those affected by it.	The community is slightly impacted and the health need slightly impacts the lives of those affected by it.	The community is greatly impacted but the health need does not generally impact the lives of those affected by it.	The commun and the healt the lives of th

CHANGE OVER TIME

1 (Great Improvements)	2 (Moderate Improvements)	3 (No improvements)	(Ge
The health need has greatly improved and will likely continue to improve in the future.	The health need has remained the same will either stay the same or improve in the future.	The health need has remained the same but will likely get worse in the future.	The health ne and will likely

RESOURCES

1 (Vast Resources)	2 (Moderate Resources)	3 (Gaps in Resources)	(Serious Sh
There are extensive resources in the community that address this health need and community members are aware of them.	There are moderate resources in the community that address this health need but not many community members are aware of them.	There are few resources in the community to address this health need but there is a potential to leverage existing resources to create interventions.	There are litt available in t address this existing reso interventions

COMMUNITY'S READINESS TO SUPPORT

1 (Not Supportive)	2 (Somewhat Supportive)	3 (Supportive)	(Extre
Community is not ready to address the issue.	Community is interested in the issue, but unlikely to be able to support efforts.	Community is supportive, but has limited ability to effectively implement programs.	Community i implement p this need.

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

The Center for Nonprofit Management is conducting the 2013 Community Health Needs Assessment for the Kaiser Permanente Baldwin Park and Citrus Valley Health Partners Medical Center and we need your help.

In the fall of 2012, we spoke with more than 100 people from the community to obtain their input on important health issues. Through this process we gained valuable insights about the Baldwin Park-Citrus Valley Medical Center service area. After reviewing this input, in conjunction with a wide range of health indicators from public and private data sources, we developed the following list of prominent health needs. The health needs listed below are in alphabetical order, and NOT by order of importance.

We now need your input to help prioritize these identified health needs and determine which represent areas of greatest need. The following confidential survey should take about 15 minutes to complete. When considering your responses, please keep your specific service area and community in mind. If you believe some pertinent issues in your community are not included in the survey, please let us know about these in the final section of the survey.

Please refer to the Community Health Needs Assessment Prioritization Criteria Scale when completing this survey. (In the interest of space, this scale was not included on each page of the survey.)

The results from this survey will inform Kaiser Permanente Baldwin Park-Citrus Valley Medical Center in developing strategies for the next Community Benefits Plan in summer 2013.

Thank you very much for your time and assistance!

Please contact Maura Harrington at mharrington@cnmsocal.org with any questions about this survey.

1. Please tell us about yourself (for analysis purposes).

Name

Organization

Email

2. Please define your service area by selecting from the list below.

- [ ] Azusa
- [ ] Baldwin Park
- [ ] Covina
- [ ] Diamond Bar
- [ ] El Monte
- [ ] Glendora
- [ ] Hacienda Heights
- [ ] La Puente
- [ ] La Verne
- [ ] Montebello
- [ ] Rosemead
- [ ] Rowland Heights
- [ ] San Dimas
- [ ] San Gabriel
- [ ] South El Monte
- [ ] Walnut
- [ ] West Covina
- [ ] Monterey Park
- [ ] Los Angeles County

Identified Health Needs

Page 1

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

Please refer to the Prioritization Criteria Scale when selecting your responses.

3. Alcohol and Substance Abuse

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

4. Allergies

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

5. Alzheimer's Disease

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

6. Arthritis

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

7. Asthma

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

8. Cancer

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

9. Cancer - Cervical Cancer

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

10. Cancer - Colon and Rectum Cancer

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

11. Cardiovascular Disease

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

12. Chlamydia

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

13. Chronic Obstructive Pulmonary Disease (COPD)

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

14. Diabetes

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

15. Disability (i.e. developmental delays, behavioral issues)

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

16. HIV/AIDS

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

17. Hypertension

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

18. Infant Mortality (i.e. low birth weight)

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

19. Injury - Intentional Injury (i.e. homicide)

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

20. Injury - Unintentional Injury (i.e. pedestrians killed by motor vehicles)

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

21. Mental Health

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

22. Obesity/Overweight

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

23. Oral Health

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

24. Vision

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

Drivers of Health

Please refer to the Prioritization Criteria Scale when selecting your responses.

25. Awareness

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

26. Cancer Screenings

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

27. Dental Care Access

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

28. Education

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

29. Employment

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

30. Family and Social Support

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

31. Health Care Access

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

32. Health Insurance

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

33. Healthy Eating

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

34. Homelessness

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

35. Income

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

36. Language Barrier

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

37. Natural Environment (i.e., air and water quality)

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

38. Nutrition Access

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

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39. Physical Activity

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

40. Preventative Care Services

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

41. Safety

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

42. Transportation

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	◯	◯	◯	◯	◯
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	◯	◯	◯	◯	◯
RESOURCES - The availability of community resources and assets to address this health need.	◯	◯	◯	◯	◯
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	◯	◯	◯	◯	◯

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43. Are there any health needs or drivers you feel have been overlooked that need to be represented?
(Please remark on the severity, change over time, resources, and community readiness to support as it relates to this need or driver.)

Health Need or Driver:

Health Need or Driver:

Thank you for your participation in the 2013 Community Health Needs Assessment.
(If completing this survey online, please click "Done" to submit your responses.)

Appendix H:
Tier Results

The following tables include the list of all identified health needs and drivers. Each health need and driver is presented according to the tier that they fell into during the identification phase, from Tier 1 which was all inclusive to Tier 3 which was the most exclusive. After much discussion between the consultant and the Collaborative, the list in Tier 2 was taken into the prioritization phase. Please note that both tables are presented in alphabetical order and not in any ranking order.

CVHP Identified Health Issues 2013, by Tier

	Tier 1	Tier 2	Tier 3
Alcohol and Substance Abuse	X	X	
Allergies	X	X	
Alzheimer's Disease	X	X	
Arthritis	X	X	
Asthma	X	X	X
Brain Cancer	X		
Breast Cancer	X		
Cancer, in General	X	X	
Cardiovascular Disease	X	X	X
Cervical Cancer	X	X	
Cholesterol	X		
Chronic Disease	X		
Chronic Obstructive Pulmonary Disease (COPD)	X	X	
Chronic Pain	X		
Colon Cancer	X	X	
Diabetes	X	X	X
Disability	X	X	
Hepatitis C	X		
Hypertension	X	X	
Infant Mortality	X	X	
Intentional Injury	X	X	
Lung Cancer	X		
Mental Health	X	X	X
Mortality, in General	X		
Obesity/Overweight	X	X	X
Oral Health	X	X	
Overall Health	X		
Pancreatic Cancer	X		
Pneumonia	X		
Prostate Cancer	X		
Respiratory	X		
Sexually Transmitted Diseases	X	X	
Stomach Cancer	X		
Unintentional Injury	X	X	
Vision	X	X	
Allergies	X	X	

CVHP Identified Drivers 2013, by Tier

	Tier 1	Tier 2	Tier 3
1. Access - Healthcare	X	X	X
2. Access to Dental Care	X	X	
3. Alcohol and Substance Abuse	X	X	
4. Awareness	X	X	
5. Breastfeeding	X		
6. Cancer Screenings	X	X	
7. Diabetes Management	X		
8. Education	X	X	X
9. Employment	X	X	X
10. Family and Social Support	X	X	
11. Health Insurance	X	X	X
12. Healthy Eating	X	X	
13. HIV Screenings	X		
14. Housing	X	X	
15. Income	X	X	X
16. Language Barrier	X	X	X
17. Natural Environment	X	X	
18. Nutrition Access	X	X	X
19. Physical Activity	X	X	X
20. Pneumonia vaccinations	X		
21. Prenatal Care	X		
22. Preventive Services	X	X	
23. Safety	X	X	
24. Teen Births	X		
25. Transportation	X	X	