



Glendale Adventist Medical Center 2019 COMMUNITY HEALTH NEEDS ASSESSMENT

September 12, 2019



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I. Acknowledgements and Authors

Acknowledgements

The 2019 Community Health Needs Assessment Adventist Health Glendale (AHGL) was conducted in partnership with Glendale Memorial Hospital and Health Center and in collaboration with the Glendale Healthier Community Coalition with the assistance of the Center for Nonprofit Management.

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Consultants

Established in 1979 by the corporate and foundation community as a professional development and management resource for the burgeoning nonprofit sector, the Center for Nonprofit Management (CNM) is the premier Southern California source for management education, training, and consulting throughout the region. Our mission is to foster thriving communities by ensuring that nonprofit leaders and organizations have the knowledge, skills and resources to fulfill their mission. Our training and consulting team offers decades of combined experience, providing support and expertise to a range of sizes and types of nonprofit organizations in developing stronger organizations, tracking and measuring outcomes, and telling their stories of success. CNM supports individuals and teams in being adaptable, effective leaders and assists organizations in building stronger structures, processes and programs to best support the achievement of mission and attain intended outcomes. All our activities and services are informed by academic and business theories and principles and are grounded in available local data.

The CNM team has extensive CHNA experience in assisting hospitals, nonprofits and community-based organizations on a wide range of assessment and capacity building efforts from conducting needs assessments to the development and implementation of strategic plans to the evaluation of programs and strategic initiatives. Team members have been involved in conducting more than 36 CHNAs for hospitals throughout Los Angeles County and San Diego County.

I. Executive Summary

Nonprofit hospitals conduct a community health needs assessment or CHNA every three years in order to maintain tax exempt status as required under California State Senate Bill 697 (SB 697) originally enacted in 1994. The requirement was expanded to the federal level thereafter and further solidified in 2010 under the Patient Protection and Affordable Care Act (ACA).

As in previous years, Glendale hospitals – Adventist Health Glendale and Glendale Memorial Hospital and Health Center– have partnered to conduct the 2019 CHNA in collaboration with the Center for Nonprofit Management consulting team. As part of the CHNA, the hospitals have jointly collected and analyzed primary data from individuals in the community through focus groups with public health experts, representatives of government and civic organizations, social service providers, community residents, leaders, and other relevant individuals. Appendix B presents the data collection tools, and Appendix C lists the stakeholders involved.

Concurrently, extensive 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 by ZIP code, when available, to allow for more in-depth analysis and identification of health issues. In addition, previous CHNA reports were reviewed to identify trends and ensure that previously identified needs were not overlooked. Primary and secondary data were compiled into a scorecard (Appendix A) presenting health needs with highlighted comparisons to the available data benchmarks. The scorecard was designed to allow for a comprehensive analysis across all data sources (Appendix D) and for use during the second, prioritization phase of the CHNA process.

The 2019 CHNA process included a prioritization process involving a facilitated group session that engaged key community stakeholders in a discussion of secondary and primary data (compiled and presented in the scorecards and accompanying health need narratives). At the session, participants were provided with a brief overview of the CHNA process and a list of community indicators in a scorecard format. In smaller groups, participants considered the data while discussing and identifying key issues or considerations that were then shared with the larger group. As a follow-up to this discussion, participants and other members of the hospitals’ network—including the Glendale Healthier Community Coalition—completed a questionnaire (hard copy and online) about health needs and resources, and ranked each health need according to several criteria including severity, change over time, resources available to address the need and community readiness to support action on behalf of any health need. The survey results were used to compare and prioritize the health needs identified at the session. This list of health needs will inform the hospital’s community benefit program focus and strategies for the period covering 2019 to 2022. The following full Community Health Needs Assessment provides extensive data and supportive information regarding the assessment process as well as relevant data and analysis of the identified community needs and health determinants.

Rank	Health Needs
1	Homelessness/Poverty
2	Mental Health/ Substance Abuse
3	Access to Care
4	Cardiovascular Disease
5	Preventative Wellness
6	Dental Health
7	Obesity
8	Geriatric Care
9	Diabetes

II. BACKGROUND & METHODOLOGY

Purpose and Key Partners

In 1994, the California Legislature enacted Senate Bill 697 (SB 697) which required nonprofit hospitals to complete CHNAs 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.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new stipulations for hospital organizations to maintain their 501(c)(3) status. With regard to the CHNA, the ACA specifically requires nonprofit hospitals to collect and consider input from public health experts as well as community leaders and representatives of high-need populations (including 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 990.¹

Glendale Hospital Collaborative

Adventist Health Glendale (AHGL)

The Glendale Sanitarium opened in 1905, a year before Glendale was founded as a city. By the 1920s, it expanded its medical, surgical, and maternity services, and offered the most advanced medical equipment of the day. Given its growth, a 30-acre hillside was selected for a new hospital location. Overlooking Wilson Avenue, the new and expanded facility opened in the mid-1920s. The current hospital remains on this location today.

In the 1970s, the hospital's name changed to Glendale Adventist Medical Center (GAMC) and in the early 2000s, GAMC began a \$220-million renovation and building project, which included the West Tower, the Emergency Department and the Lee Hughes Medical Building. In 2017, the hospital's name was changed to Adventist Health Glendale (AHGL).

The Glendale hospital employs 800 physicians, 2,600 associates and 1,100 volunteers²
Currently, AHGL is also recognized as:

AHGL Awards and Recognitions

- High performing medical center by *U.S. News & World Report* in five types of care, including COPD, geriatrics, heart failure, neurology and orthopedics in 2017-18
- 'A' Rating from The Leapfrog Group for Fall 2017 for Hospital Safety
- "Top Docs" by Pasadena Magazine 2017
- Guidelines®-Gold Plus and the Target Stroke Honor Roll Elite award from the American Stroke Association
- First medical center in California to receive Comprehensive Stroke Center accreditation from DNV-GL Healthcare USA, Inc.
- Designated STEMI (ST-Elevation Myocardial Infarction) Receiving Center
- Designated Pink Ribbon Facility by Hologic & accredited by ACS Commission on Cancer as a Community Hospital Comprehensive Cancer Program

¹ For more information please see: <https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>

² <https://www.adventisthealth.org/glendale/a-legacy-of-healing/>

- A Community Hospital Comprehensive Cancer Program Joint Commission's Gold Seal of Approval for its joint replacement program (knee and hip) by the American College of Surgeons' Commission on Cancer.
- A hospital specially equipped and staffed for the rapid, quality care of heart attack patients by Los Angeles County's Emergency Medical Services

Glendale Memorial Hospital & Health Center (GMHHC)

Glendale Memorial Hospital & Health Center (GMHHC) works in close collaboration with other hospitals serving the Glendale community including Glendale Adventist Medical Center and USC Verdugo Hills Hospital. These hospitals joined together to conduct one data gathering process and one stakeholder engagement effort in order to better utilize resources and reduce the burden of calling upon community members for input.

Founded in 1926 as Physicians and Surgeons Hospital by six Glendale community members with a vision to expand health care services to the residents of south Glendale, GMHHC has grown from the original 47 beds to a 334-bed acute care community hospital offering primary service lines in heart, cancer, orthopedics, women's health, colorectal disease, emergency medicine, and diagnostic imaging services.

GMHHC is a part of Dignity Healthcare, a system with 39 hospitals located in California, Nevada, and Arizona. The hospital employs over 1,050 people with medical staff of 525 physicians.³

Glendale Memorial Hospital's service area includes the communities of Glendale, Burbank, La Crescenta, Montrose, Atwater Village, Eagle Rock, Echo Park, Glassell Park, Highland Park, Hollywood, North Hollywood, Los Feliz, and Silver Lake.

GMHHC Awards and Recognitions

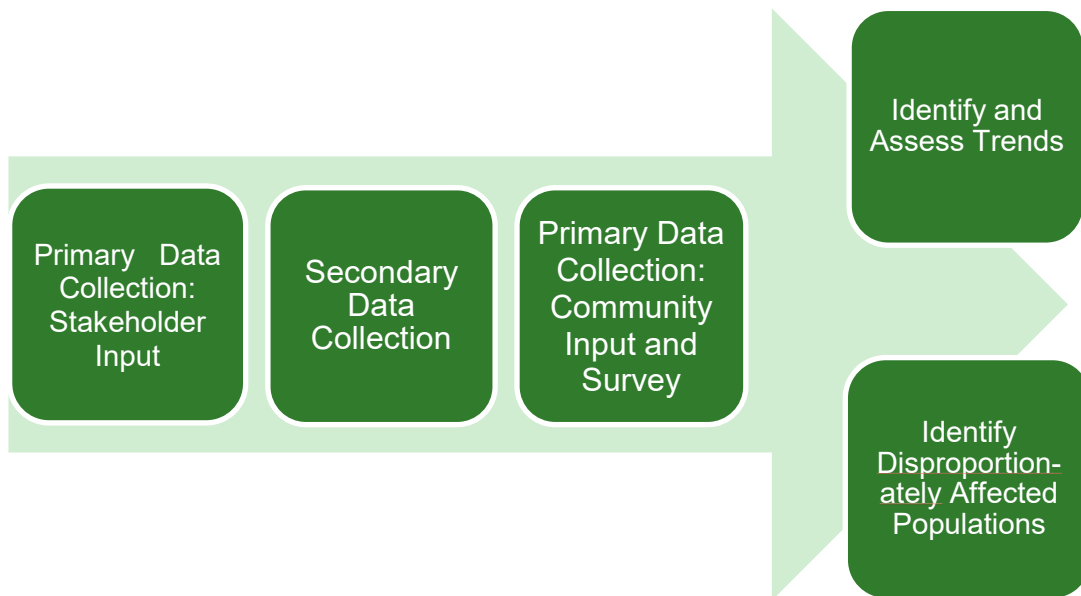
- 2019 Health Grades 5-Star Awards for Gallbladder Surgery, Total Knee Replacement, Valve Surgery
- 2019 Best Regional Hospital for high ratings in Congestive Heart Failure, Colon Cancer Surgery, Chronic Obstructive Pulmonary Disease.
- Marcia Ray Breast Center designated Breast Imaging Center of Excellence by American College of Radiology
- Chest Pain Center accredited by the Society of Chest Pain Centers
- American Heart Association/ American Stroke Association Stroke Elite Honor Roll.

³ Community Benefit 2018 Report and 2019 Plan, Dignity Health Glendale Memorial Hospital.

Needs Assessment Methodology and Process

The CHNA process is designed (1) to develop a deeper understanding of community healthcare needs, (2) to inform each hospital's community benefit plan for outreach and services that complement and extend clinical services, and (3) to improve disease prevention and overall health status.

The CHNA process unfolds in a three-step process outlined below. This CHNA report is the culmination of the Glendale Hospitals' efforts to complete Phase 1 and will inform Phase 2 and 3 for each hospital. As part of Phase 1, both primary data via community input and secondary data were collected to inform community health priorities and needs, as well as assets and gaps in resources. The chart below highlights the process:



STEP 1: Primary Data Collection and Analysis (Part 1): Community Stakeholder Input

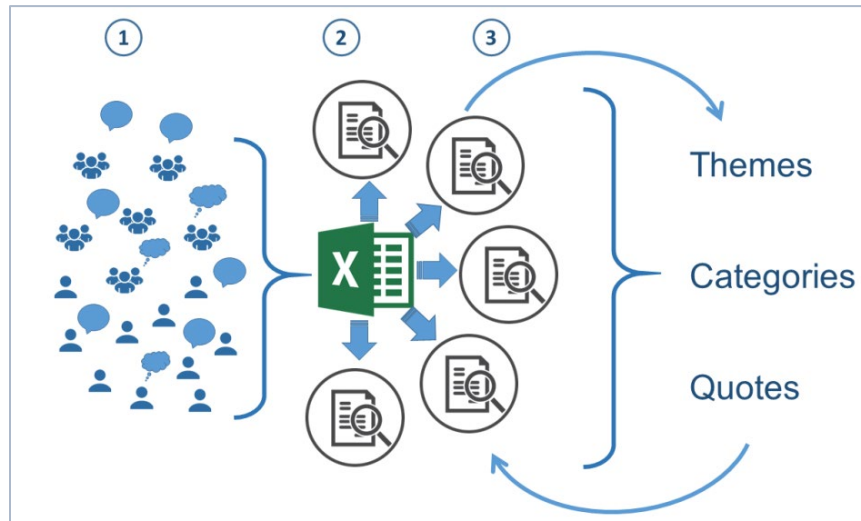
The goal of this component of the CHNA was to identify broad health outcomes and drivers (which, combined are health needs), as well as assets and gaps in resources, through the perceptions and knowledge of varied and multiple stakeholders.

Leveraging its extensive network of community partners, the hospitals, in collaboration with the Glendale Healthier Community Coalition, held a community summit on October 25, 2018, with 95 stakeholders. In compliance with the ACA, participants represented a broad range of geographic, public health, and population interest including health care professionals, social service providers, city and public health officials, members from the local police department, and other community leaders (Appendix C—Stakeholders). For more information on the focus group process, see Appendix B—Primary Data Gathering Tools.

To begin to gain a sense of the perceived severity of each health need in the community, each participant was given ten sticker dots and asked to vote for the most severe health needs on a grid created during the focus group. For the purpose of the voting activity, severity was defined as the level to which a health need or health driver affected the health and lives of those in the community.

The CNM consultant team used a modified content analysis to identify the main themes that emerged from community input through the facilitated groups. CNM used a three-step process for analyzing and interpreting primary data (community input): 1) all information gathered during focus groups were entered into Microsoft Excel, 2) spreadsheet data were reviewed multiple times using content analysis to begin sorting and coding the data, and 3) through the coding process, themes, categories and quotes were identified.

Analysis to Identify Main Themes Emerged Via Community Input



In the coding process, two requirements needed to be met: 1) a health need had to be mentioned in the primary data collection more than once and 2) a secondary data indicator associated with the need had to perform poorly against a designated benchmark (county averages, state averages, or Healthy People 2020 goals). Once a theme met both requirements, it was designated as an identified health need/indicator. The graphic below outlines the identified health indicators, in *alphabetical order*.



STEP 2: Secondary Data Collection

The CHNA included the collection of over 300 data indicators that helped illustrate the health states of the community. Secondary data were collected from a wide range of local, county, state and national sources to present demographics, mortality, morbidity, health behaviors, clinical care, social and economic factors, and physical environment.

Secondary Data Sources

Local, County, State and National data for **300+** health indicators and drivers



Wherever available, data at the ZIP Code level were compiled for the hospital's service area. When not available by ZIP Code, then the data for the appropriate representative portion of the Service Planning Area (SPA) was utilized.

A comprehensive data matrix, known as the "Scorecard", was created listing all identified secondary indicators. The Scorecard included three benchmark datapoints: (1) State of California, (2) Los Angeles County, and (3) nationally recognized Healthy People 2020 (HP2020) goals. Please see Appendix A.

STEP 3: Primary Data Collection and Analysis (Part 2): Community Input and Survey

In October 2018, a daylong Health Summit was held that included discussions throughout the day that were facilitated with the 91 community participants regarding the health of the Glendale community. In addition, a total of 66 community stakeholders (See Appendix C-Stakeholders) was convened April 4, 2019 for a Prioritization Forum with the goal of ranking the identified health needs. Many of the Forum participants had also attended the first focus group. Participants received the Scorecard and hospital data and allowed time to review and discuss in small groups. CNM consultants were available to answer data questions. After a large group discussion, participants were given the opportunity to provide input via voting and a survey. For details, please see Appendix B – Primary Data Gathering Tools.

All participants were given sticker dots (10 sticker dots each), presented with the list of identified health needs and asked to cast their sticker votes for the most severe health needs in the community, which were then tabulated.

Post-voting, participants were asked to complete a written survey that presented the identified health needs, and asked to score each health need based on the following criteria:

- severity of the health need in the community
- change over time (improved or gotten worse)
- availability of community resources
- community readiness to address the health need

Participants were given a companion document that further explained the four criteria and the scoring system. Absent participants could complete the survey online if they were not able to attend the Prioritization Forum. A total of 37 participants completed the survey. The survey and the companion document can be found in the Appendix B—Primary Data Gathering Tools.

Data Limitations and Gaps

The secondary data allows for an examination of the broad health needs within a community. However, these data have limitations, as is true with any secondary data:

- Data were not always available at the ZIP code level, so Los Angeles County level data as well as SPA level data were utilized.
- Disaggregated data for age, ethnicity, race, and gender are not available for all data indicators, which limited the examination of disparities of health issues within the community.
- At times, a stakeholder-identified a health issue may not have been reflected by the secondary data indicators.
- Data are not always collected on an annual basis, meaning that some data are several years old.

Prioritized Health Needs

Using the primary and secondary data collected, the following prioritized health needs were identified for Adventist Health Glendale and Glendale Memorial Hospital and Health Center.

Rank	Health Needs
1	Homelessness/Poverty
2	Mental Health/ Substance Abuse
3	Access to Care
4	Cardiovascular Disease
5	Preventative Wellness
6	Dental Health
7	Obesity
8	Geriatric Care
9	Diabetes

2016-2018 CHNA Three-Year Report

Identified Priority Areas and Responses

2016 to the present has been a time of goal-setting and achievement for Adventist Health Glendale (AHGL). AHGL's recent successes were recognized in Spring 2019, with the hospital's ninth consecutive 'A' from The Leapfrog Group's Leapfrog Hospital Safety Grade. The award recognizes AHGL for its efforts in protecting patients from harm and meeting the highest safety standards in the U.S. AHGL is among the top 4% of hospitals graded nationwide, and the only hospital in the Glendale/Burbank area to receive nine 'straight A's' from 2016 through 2019, four years in a row.

Priority Area 1: Cardiovascular Health - Integrate Patient Education into Cardiovascular Services

Increasing access to and/or number of impactful community educational events providing heart health education and related health screenings was the initial goal for this priority area. Short-term evaluation indicators included the number of sites created for community-based management of heart disease, and community members' ability to monitor their health and disease. In 2015, the Hospital added the goal of improving cardiovascular patients' ED experience through the implementation of a system to more accurately record patients' ED arrival times. Progress related to short-term evaluation indicators is demonstrated by the opening of the Heart and Vascular Institute, monitoring and education for heart failure patients by the Care Transitions Team to reduce readmissions, and the implementation of a green arm band door time process to ensure accurate patient arrival time.

Cardiovascular Health Response 1:

The need was identified to educate community residents regarding early signs of heart attack. "Did you know heart attacks have early signs? Do you know how to recognize them and get help? Take the early heart attack care (EHAC) education course and learn how to potentially save someone's life!" (Note: Course takes approximately 30 minutes to complete.) The Early Heart Attack Education (EHAC) course, provided to the community, reviews the signs and symptoms of a heart attack and the importance of calling 911. This information has also been made available on flyers, magnets, and on the hospital website. AHGL also collaborated with the L.A. County STEMI center to obtain two standing screens that display the signs and symptoms of acute coronary syndrome, the cardiovascular differences between men and women, and the importance of calling 911 when these symptoms are spotted. These screens are displayed at events in the community and on our hospital grounds for the community to see. AHGL also offers free blood pressure and BMI screenings at the Glendale Galleria shopping mall via a state-of-the-art blood pressure kiosk. A touch screen available in the kiosk offers information on cardiovascular risk and offers the community an opportunity to receive emails to help them learn more about risk reduction and response resources available at AHGL.

Cardiovascular Health Response 2:

The need was identified to educate community residents and medical providers on risk and symptoms for aortic stenosis. The TAVR team of interventional cardiologists and cardiothoracic surgeons at AHGL is paving the way to save lives with a new technology. TAVR enables patients with severe aortic stenosis to receive a new heart valve without undergoing open heart surgery. "It's revolutionary. It's minimally invasive. It's saving lives. It's TAVR." Aortic stenosis (AS) is a condition in which progressive obstruction of blood flow across the aortic valve results in pressure hypertrophy of the left ventricle and can present as classic symptoms of angina, heart failure and even sudden death. The echocardiogram is the standard

for identifying severe aortic stenosis. This procedure is fairly new and is FDA approved for people with symptomatic aortic stenosis who are considered an intermediate or high-risk patient for standard valve replacement surgery.

Cardiovascular Health Response 3:

Cardiology works alongside cardiac rehab to provide education for patients post open heart surgeries. Cardiac rehab open heart classes last for approximately an hour and are held every fourth Thursday of the month. Patients come in to speak with the open-heart nurse and ask questions about their current condition, what they went through, and the healing process. The class provides a community for those who feel isolated after their cardiac event and allows for unanswered questions to be answered. Patients consistently express their satisfaction with this class and how they appreciate the monthly meetings.

For improving access to cardiovascular services, AHGL has received the following Cardiovascular Health Awards:

- Adventist Health Glendale is designated a STEMI (ST-Elevation Myocardial Infarction) Receiving Center. This designation, given by L.A. County's Emergency Medical Services, recognizes hospitals that are specially equipped and staffed for the rapid, quality care of heart attack patients.
- Adventist Health Glendale is one of the few accredited chest pain centers in the region. The accreditation is awarded by the Society of Cardiovascular Patient Care to medical centers that combine evidence-based science, quality initiatives, guidelines and clinical best practices into effective care for patients with chest pain.
- For 2017-18, Adventist Health Glendale was rated a high performing medical center by U.S. News & World Report in five types of care, including COPD, geriatrics, heart failure, neurology and orthopedics. U.S. News created Best Hospitals for Common Care to help patients find better care for the kinds of common procedures and medical conditions that account for millions of hospitalizations each year.

Priority Need 1 - Cardiovascular Health - Improve Aortic Stenosis Education and Support - Partners

- American College of Cardiology
- American Heart Association
- American Red Cross
- National Cardiovascular Data Registry (NCDR) /TVT Registry
- Adventist Health Glendale Cardiac Rehabilitation Program
- Adventist Health Glendale Heart and Vascular Institute
- Hospital and community physicians
- Edwards Life Sciences
- Glendale YMCA
- La Cañada YMCA
- Los Angeles County Department of Health
- Society for Interventional Radiology
- Society of Chest Pain Centers
- Covidien

- Toshiba
- Verdugo Hills Hospital for cardiac rehab

Priority Area 2: Improve Stroke Education and Support

Improvement in cardiovascular health and quality of life through prevention, detection and treatment of risk factors for heart attack and stroke, early identification and treatment of heart attacks and strokes, and prevention of repeat cardiovascular events were the initial goals for this priority area. Short-term evaluation indicators included increasing the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high, the reach of stroke support groups, the Stroke Medication Management and Education Clinic, impact of stroke awareness and stroke risk assessment activities. Progress related to short-term evaluation indicators is demonstrated by the successful implementation of 57 blood pressure screenings in 2015, ongoing Stroke Support Group activities, and community and patient education by the Neuroscience Institute.

Stroke Education Response 1:

The need was identified to improve prevention, detection, and treatment for stroke among community residents. AHGL provided stroke education and awareness to the community in on and off-site settings to Live Well Senior Center participants and paramedics. Presentations were offered to increase knowledge of signs and symptoms of stroke, risk factors, and support services for stroke survivors. Blood pressure screening and pre- and post-program survey were also incorporated to assess program effectiveness. Each year, the Neuroscience Institute stroke program has served over 150 participants in the Glendale region.

Stroke Education Response 2:

AHGL created a Community Mobility Program for people who have had a stroke and are experiencing neurological deficits that may impair driving ability. Because the loss of driving ability is one of the most difficult losses stroke patients face, AHGL offers this service to evaluate patients from a clinical and an on the road perspective to determine driving ability. Some are evaluated as being able to drive immediately; some as needing special training, and others as having lost the dexterity to drive again. AHGL's Community Mobility Program is operated in partnership with the Department of Motor Vehicles.

Stroke Education Response 3:

The AHGL Neuroscience Institute offers FREE Stroke Medication Management & Education Clinics – the first of its kind in the community. Stroke patients receive a consultation with AHGL pharmacist including answers to their medication/ prescription questions, discussing adjustments to medication dosage (if necessary) and receiving guidance regarding post-stroke rehabilitation. Armenian- and Spanish-speaking pharmacists are also available for patients upon request. In addition to continued marketing initiatives through the AHGL website and Health Quarterly, Pharmacy consults are built into our process to ensure patients receive a free consultation from the pharmacist prior to discharge. The signs and symptoms of a stroke are also available on our stroke education web page. Learn more about stroke on Healthline, AHGL's health education cable TV show hosted by Dr. Gregory Zarian.

For improving access to stroke education, detection, and treatment services, AHGL has received the following Stroke Care Awards:

- Adventist Health Glendale is the first medical center in California to receive Comprehensive Stroke Center accreditation from DNV-GL Healthcare USA, Inc. By earning this prestigious accreditation, Adventist Health Glendale has demonstrated that it exceeds patient safety standards set forth by the U.S. Centers for Medicare & Medicaid Services, the Brain Attack Coalition and the American Stroke Association.
- In 2017, Adventist Health Glendale received the Get With the Guidelines®-Gold Plus and the Target Stroke Honor Roll Elite award from the American Stroke Association for excellence in stroke care. Hospitals receiving the Stroke Gold Plus Award have reached an aggressive goal of treating patients with 85% or higher compliance to core standards.

Priority Need 2 - Improve Stroke Education and Support - Partners

- American Heart/ Stroke Association
- National Stroke Association
- Center for Neuro Skills
- Los Angeles Stroke Coordinator's Network (LASCN)
- Department of Motor Vehicles
- Genentech

Priority Area 3: Population Health for Chronic Disease

Reducing the illness, disability and number of deaths caused by chronic disease (principally diabetes) among low-income, at-risk and vulnerable populations in the AHGL service area was the initial goal for this priority area. An increase in the healthy behaviors of vulnerable populations, including a special focus on children 0-5 and their family members who may be at risk for chronic disease was selected as the short-term evaluation indicator for this priority area. Progress related to short-term evaluation indicators is demonstrated by program activities including the successful completion of various outreach efforts engaging over 5,000 community members by the AHGL chapter of Choose Health LA Kids.

Chronic Disease Response 1:

The need was identified to address the root causes of chronic disease among community residents. Champions for Change (C4C) is a population-health disease prevention campaign that aims to decrease statewide rates of obesity and chronic illnesses. Under C4C funding, AHGL reaches children between the ages of four and eight, and their families, in Glendale. AHGL programs under C4C funding to help families implement and sustain healthy practices include nutrition workshops, food demonstrations, gardening, Zumba, and Rethink Your Drink, an effort that focuses on reducing the consumption of high sugar beverages while promoting alternatives such as water. This three-year program followed on the heels of another three-year program called Choose Health L.A. Key efforts under Champions for Change include teaching fundamental skills such as cooking, reading food labels, shopping on a budget, growing fruits and vegetables, and introducing low-cost and fun ways to be physically active. Under \$300,000 in annual funding, Champions for Change has served over 700 participants each year in the Glendale region. Individual programs included:

- C4C added nutrition classes to a Glendale Unified School District after school sports program in which eight elementary schools participated in a range of sports. We also trained district coaches in healthy options, and as a group, the coaches pledged to drink only water and healthy drinks for the length of the program in order to set a good example for the children.

- C4C provided a nutrition and gardening program for the students of Thomas Edison Elementary school. Students learned about plant care, nutritional labels, and the health benefits of drinking water instead of sugary drinks. Using vegetables from the garden had children eating vegetables with enthusiasm—they were excited about recipes such as salsa made with the tomatoes and radishes they had grown and nurtured themselves. The kindergarten students made up their own names for the days the program was held: “Terrific Tuesdays” and “Wonderful Wednesdays.”
- In response to the popularity of garden-grown foods, C4C installed four school gardens at partner school sites under a grant from AHGL.
- C4C held 446 health promotion events through the course of the year, in the categories Community Gardens, Exercise/Sports, Health Education, and Nutrition Education. Direct education classes consist of AHGL staff conducting nutrition education classes to members of the community; Some topics include reading food labels, choosing foods from all the food groups, reducing sugar and sodium, and increasing water consumption; These classes were held at community centers, elementary schools, Head Start sites, and homeless shelters From February through August each year, C4C conducted 26 Zumba classes in Pacific Community Center and Park in Glendale, every Thursday, free of charge. Over three years, the class grew from 10 to 50 participants.
- C4C participated in annual community events, giving information about the Champions for Change program and its benefits at the Cesar Chavez Festival, Glendale Fire Pancake Breakfast, Glendale Cruise Night, Edison Elementary School Carnival, Edison Elementary Back to School Night, and After School Sports Championship Events at Thomas Edison Elementary School, Pacific Clinics-Head Start Lexington, and Pacific Clinics-Head Start Glendale.

C4C is funded by the California Department of Public Health Nutrition Education and Obesity Prevention Branch (NEOPB).

Chronic Disease Response 2:

Building infrastructure to address chronic disease has included establishing 10 FQHCs and conducting the annual *We Own The Health Of Our Community* health summit.

Chronic Disease Response 3:

Homeless care and mental health care emerged as intersecting priority needs in 2016-2018. Homeless care:

- Working with the City of Glendale, which invests \$2.3 mil/year into homeless care, AHGL was awarded HEAP funding to hire a homeless care coordinator who works in conjunction with Glendale Homeless Coalition and ACCESS center.
- Mental health care: AHGL is coaching 16 primary care practices to provide depression screening and referral.

Priority Need 3 – Population Health for Chronic Disease - Partners

- AHGL Senior Live Well Center
- AJ Nursery

- Ascencia Homeless Services
- California Department of Public Health, NEOP Division
- Cerritos Elementary School
- City of Glendale Parks and Recreation Department
- City of Glendale Community Services Department
- City of Glendale Fire Department
- Columbus Elementary School
- Crescenta Valley Alliance
- Eagle Rock Seventh Day Adventist Church
- Glendale Adult Recreation Center
- Glendale Chamber of Commerce
- Glendale City Manager Scott Ochoa
- Glendale Communitas Initiative
- Glendale Educational Foundation
- Glendale Healthier Community Coalition
- Glendale Kiwanis Club
- Glendale Kool Dayz Summer Camp
- Glendale Parks and Open Space Foundation
- Glendale Unified School District
- Glendale Unified School District, Nutrition Services Department
- Glendale YMCA
- Glendale YWCA Healthy Kids, Healthy Lives Parent Collaborative
- Horace Mann Elementary School
- Jefferson Elementary School
- John Marshall Elementary School
- John Muir Elementary School
- Los Angeles County of Public Health, Chronic Disease and Injury Prevention Department
- Maple Park and Community Center
- One Glendale After-School Sports Program
- Pacific Clinics-Head Start, Early Head Start
- Pacific Park and Community Center
- RD White Elementary School
- Thomas Edison Elementary School
- University of California Agriculture and Natural Resources Master Gardener Program

Priority Area 4: Wellness and Support for Patients Diagnosed with Cancer

Increasing access to colorectal cancer screenings with GAMC's primary service area was the initial goal of this priority area. Short-term evaluation indicators included an increase in the proportion of adults in the service area who receive screenings for cancer, and an increase in the proportion of adults in the service area who receive appropriate care once diagnosed for cancer.

Cancer Care Response 1:

The need was identified to improve access to cancer screenings and services among community residents. Adventist Health Glendale (AHGL) is part of an elite group of facilities across the country raising the standard of care for every patient. We are proud to be recognized by Hologic as a Pink

Ribbon Facility. As a Pink Ribbon Facility, we take pride in providing every woman that comes to us for a mammogram with a digital mammography exam. Digital mammography offers a number of practical advantages and patient conveniences. Because there is no waiting for film to be developed it significantly reduces the need for repeat exams due to under or over exposure. Digital images are easily stored and transferred electronically, eliminating the dependency on one set of original films, which can be misfiled or lost in transit.

Cancer Care Response 2:

In 2017, AHGL introduced a new lung cancer screening program and technology designed to offer health care providers a faster pathway to lung cancer detection and treatment. Like all cancers, the key to lung cancer survival is early detection. In 2011, the National Lung Screening Trial (NLST) showed that screening with low-dose computed tomography (CT) reduced lung cancer deaths among a population of heavy smokers by 20 percent, when compared to using chest X-rays as the diagnostic tool. Adventist Health Glendale has long been at the forefront of offering programs and cutting-edge technology for early detection of a wide range of conditions. The adoption of DynaLync and DynaCAD Lung software from Invivo Corporation provides critical tools to aid with the identification, tracking, and management of relevant information to help the AHGL team reach a quick, definitive diagnosis. Clayton Lau, director of imaging at Adventist Health Glendale explained, "Adventist Health Glendale is in a unique position to be able to offer not only the advanced imaging technology to make early lung cancer detection possible, but the data insights, collaboration and tools that are needed to deliver the quality and consistency required for health systems to succeed in new, evidence-based models of patient care."

Cancer Care Response 3:

Cancer patients and survivors had access to the following services:

- The Positive Image Center distributed wigs, cuts, scarves and caps, blankets, and the Cancer Center offered Prostate and Skin Cancer Screenings at Community Outreach and Fairs and Events, serving 3,400.
- AHGL's Brain Tumor Support Group is open to individuals and their families with primary brain tumors or brain metastases. The group meets the third Wednesday of each month from 6:00PM to 7:30PM in the Cancer Center Conference Room. The group is free and light refreshments are served.
- All cancer survivorship services are community-supported and offered free to any cancer survivor/patient in Glendale, regardless of where they received treatment. Our survivorship programs include:
 - Ingeborg's Place Apart - Ingeborg's provides a warm, non-clinical environment to help people re-energize and feel 100% supported as they battle a cancer diagnosis.
 - Focus on Healing - Provides free access to individual counseling and support groups for any cancer survivor and their loved ones.
 - Cancer fitness classes - These exercise classes are designed specially for cancer patients.
 - Nurse navigator - The AHGL oncology nurse navigator helps patients find doctors, make appointments, provides guidance and simply anticipates patient and family needs to improve services received throughout the entire cancer treatment process.

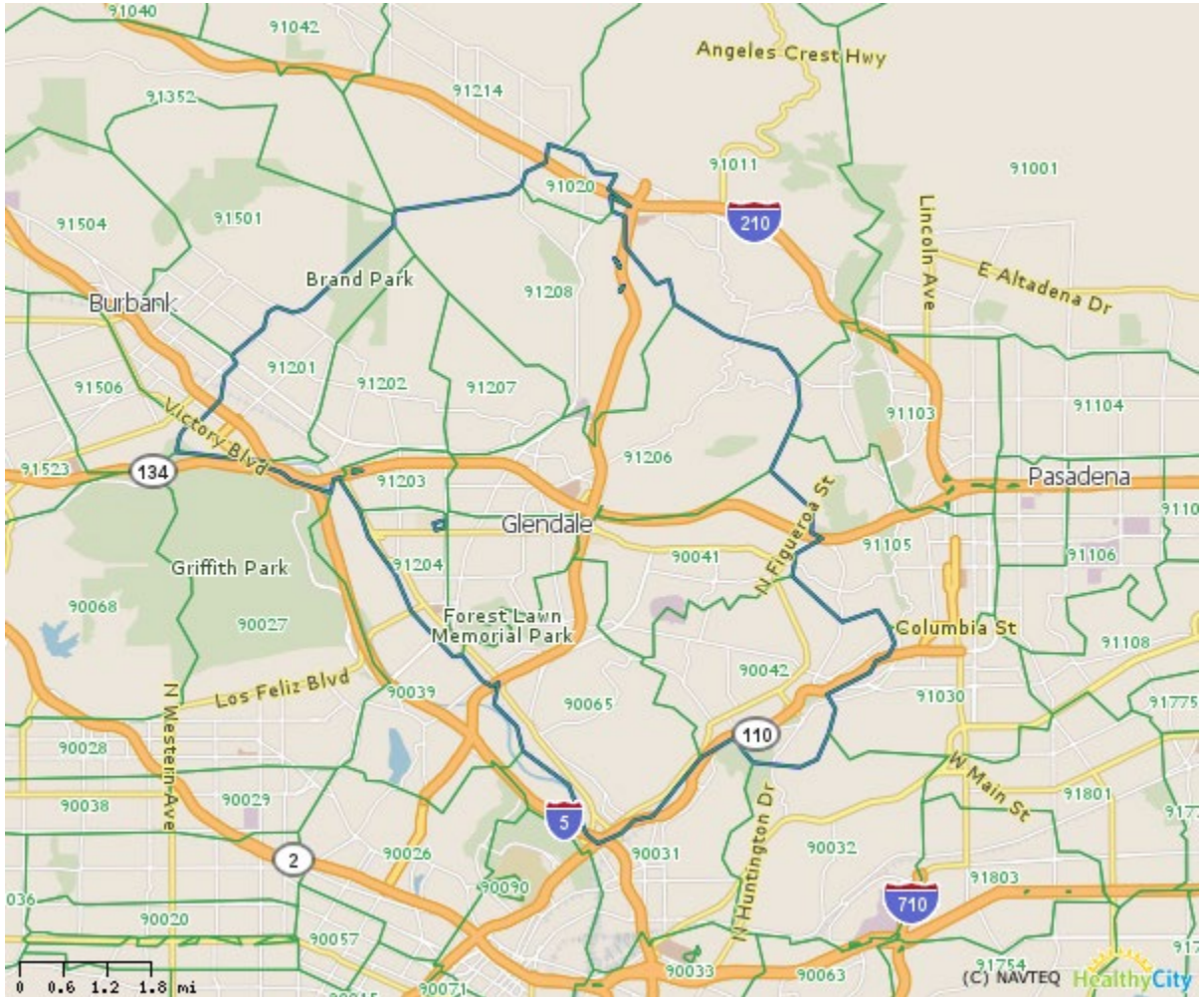
- Patient Education and Resource Center - At the AHGL Cancer Center, we want people to know that they are not alone and that their search for the best treatment can stop at AHGL.
- Write to Heal - A special workshop designed to help cancer patients cope with the diagnosis of cancer.
- Jewelry-Making - A therapeutic class designed to help cancer patients cope with their diagnosis through art and creativity.

For improving access to cancer education, detection, and treatment services, AHGL has received the following Cancer Care Awards:

- AHGL is accredited by the American College of Surgeons' Commission on Cancer as a Community Hospital Comprehensive Cancer Program. This accreditation is given to facilities who meet the requirements for patient-centered care and focus on improving quality and patient outcomes.
- Adventist Health Glendale's Cancer Center is designated a Pink Ribbon Facility by Hologic. Pink Ribbon Facilities are digital imaging centers recognized as providing excellence in breast health paired with their exceptional commitment and support to the women of their community.

Priority Area 4 - Wellness and Support for Patients Diagnosed with Cancer Partners

- American Cancer Society American College of Radiology (ACR)
- American College of Surgeons (ACoS)
- American Lung Association
- Cancer Care Guild through the GAMC Foundation
- Ingeborg Zerne Foundation
- Invivo
- Los Angeles County Department of Health and Human Services
- National Comprehensive Cancer Network (NCCN)
- National Junior Charity League
- Oncology Nursing Society (ONS)
- Referring physicians



III.COMMUNITY PROFILE

Service Area Definition

The Adventist Health Glendale (AHGL) Service Area provides health services in 12 ZIP Codes, four cities or communities, and two Service Planning Areas (SPA) within Los Angeles County. The ZIP Codes in SPA 4–Metro are shaded in white; the ZIP Codes in SPA 2–San Fernando Valley are shaded in gray.

Glendale Adventist Medical Center Service Area

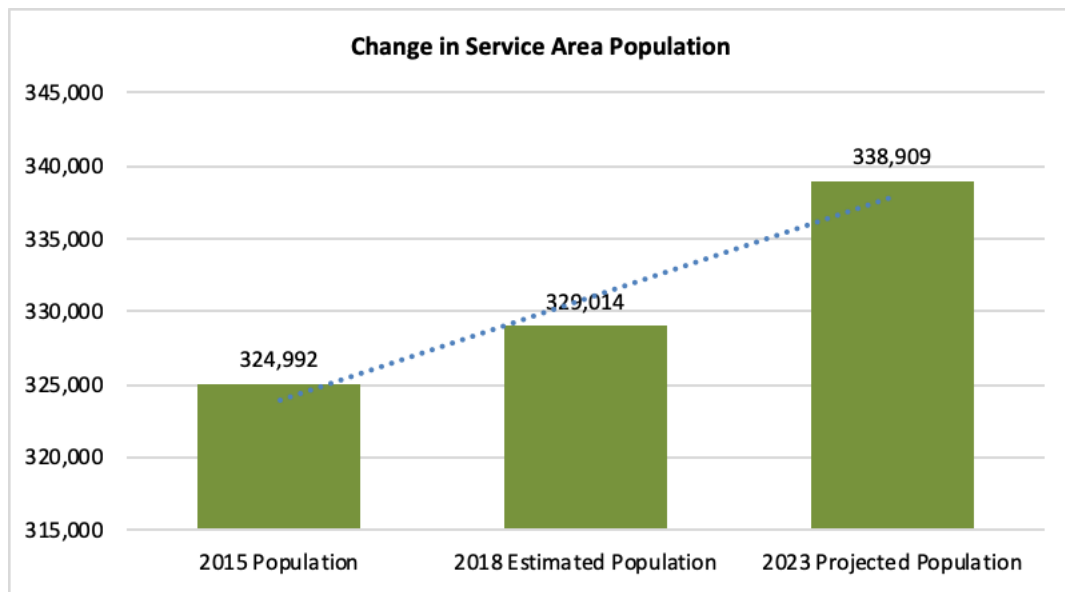
City/Community	ZIP Code	Service Planning Area
Eagle Rock	90041	4
Highland Park	90042	4
Glassell Park	90065	4
Montrose	91020	2
Glendale	91201	2
Glendale	91202	2
Glendale	91203	2
Glendale	91204	2
Glendale	91205	2
Glendale	91206	2
Glendale	91207	2
Glendale	91208	2

Demographic Characteristics

Population

The population in Los Angeles County has grown to 10,231,037, an increase of 4.2% in 8 years, which is lower than the overall proportional growth in California standing at 5.6%. With a state population of 39.5 million people, one in four Californians live in Los Angeles County.⁴ In 2018, the AHGL service area population was estimated at 329,014 residents. In particular, ZIP codes 91203—Glendale (8.3%) and 91020—Montrose (5.9%) experienced the highest percentage of growth.

By 2023, the population is projected to grow in the AHGL service area by approximately 2.9%. The largest population increases are expected to continue in ZIP codes 91203—Glendale (6.0%), 91204—Glendale (4.2%), 91207—Glendale (4.1%), and 91020—Montrose (4.8%)—a larger increase than in Los Angeles County (3.1%), continuing the growth trends observed over the past few years.



Estimated Current-Year Population

City	ZIP Code	2010 Population	2015 Estimated Population	2018 Estimated Population	2023 Projected Population	Percent Increase 2010-15	Percent Increase 2015-2018	Percent Increase 2018-2023
Eagle Rock	90041	27,554	28,266	28,302	29,020	2.52%	0.13%	2.54%
Highland Park	90042	61,895	64,679	64,850	67,136	4.30%	0.26%	3.52%
Glassell Park	90065	45,874	46,935	47,925	49,266	2.26%	2.07%	2.80%

⁴ US Bureau of Census, 2017 American Community Survey

City	ZIP Code	2010 Population	2015 Estimated Population	2018 Estimated Population	2023 Projected Population	Percent Increase 2010-15	Percent Increase 2015-2018	Percent Increase 2018-2023
Montrose	91020	8,392	8,438	8,966	9,392	0.55%	5.89%	4.76%
Glendale	91201	22,982	23,273	23,177	23,537	1.25%	-0.41%	1.55%
Glendale	91202	23,034	23,695	23,969	24,716	2.79%	1.14%	3.12%
Glendale	91203	13,657	13,926	15,181	16,097	1.93%	8.27%	6.03%
Glendale	91204	15,935	16,626	16,975	17,711	4.16%	2.06%	4.34%
Glendale	91205	38,172	38,549	38,917	39,712	0.98%	0.95%	2.04%
Glendale	91206	32,841	33,422	33,338	33,996	1.74%	-1.14%	1.97%
Glendale	91207	10,001	10,510	10,621	11,059	4.84%	1.05%	4.12%
Glendale	91208	16,205	16,673	16,793	17,267	2.80%	0.71%	2.82%
AHGL Service Area		316,542	324,992	329,014	338,909	2.60%	1.22%	2.92%
Los Angeles County		9,818,605	10,136,509	10,231,037	10,554,830	3.14%	0.92%	3.07%

Data Source: Nielsen Claritas, 2018, ZIP Code

Gender

Just under half (48.0%) of the population in the AHGL service area was male while 52.0% of the population was female. In Los Angeles County, there was a slightly higher percentage of males (49.3%) and a slightly lower percentage of females (50.7%). The chart below illustrates gender breakdown by the service planning areas of AHGL, each showing a greater male than female population. These 2 (out of 8) SPAs represent close to a third of the population in Los Angeles County.

Population by Gender

Gender	SPA 2	SPA 4	LAC
Male	54.1%	51.4%	49.3%
Female	45.9%	48.6%	50.7%
Total Pop.	2,181,000	1,147,000	10,088,000 ⁵

Data Source: California Health Interview Survey, 2017, SPA

⁵ The 2017 population estimate from California Health Interview Survey differs slightly from Nielsen Claritas estimate of 10,231,037 in 2018.

Glassell Park had a male population only slightly greater than 50.0% of the total, and two Glendale ZIP codes (91206 and 91207) and Montrose had male populations notably below 50.0% of the total and notably below the service area average (47.1%, 46.8%, and 47.0% respectively).

Age



Population by Age in Los Angeles County

The population within the broader Service Planning Areas of AHGL comprises primarily of adults (63.2% and 62.1% respectively). In comparison with Los Angeles County, the youth age distribution skews slightly lower, and the more densely populated SPA 4 has the most seniors in the entire Los Angeles County.

Population by Age Group	LAC	SPA 2	SPA 4	Range
Child (0-11)	15.1%	16.7%	15.5%	11.4%*-17.6%
Adolescent (12-17)	7.7%	6.8%*	7.0%*	3.2%*-11.9%
Adult (18-64)	63.7%	63.2%	62.1%	62.1%-71.0%
Senior (65+)	13.5%	13.3%	15.4%	9.2%-15.4%*

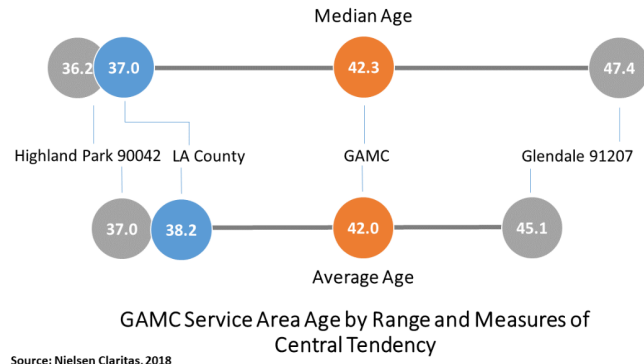
Data Source: California Health Interview Survey, 2017, SPA * = statistically unstable

This same pattern holds true within the specific communities that AHGL serves. Most of the population ranges between the ages of 25 and 64 (56.6%), with Glendale (ZIP Codes 91203 and 91204) topping the service area range. In contrast with Los Angeles County, the AHGL service area skews towards an older population with seniors proportionately higher (17.6%) and youth significantly lower (18.0%) even though Highland Park had a younger population (23.3% below the age of 18, respectively) compared to Los Angeles County's 22.2% rate.

Age Distribution					
	0-17	18-24	25-44	45-64	65+
Mean Percent	18.0%	7.8%	28.3%	28.3%	17.6%
Largest Zip Code Concentrations	90042 (23.3%)	90041 (11.1%)	91203 (31.8%)	91020 (31.5%)	91207 (23.2%)
	90065 (22.6%)	90042 (9.2%)	91204 (31.8%)	91208 (30.7%)	91208 (20.9%)
	91208 (18.0%)	91020 (9.2%)	90042 (31.3%)	91207 (30.0%)	91206 (20.5%)
Los Angeles County	22.2%	9.5%	29.4%	25.5%	13.4%

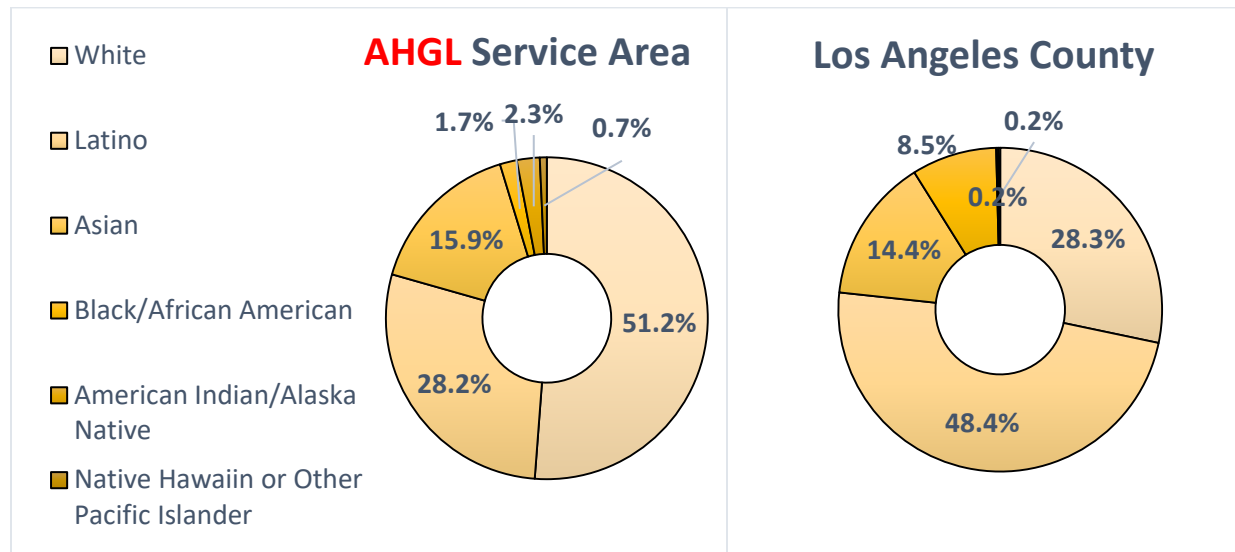
Data Source: Nielsen Claritas, 2018, ZIP Code

In 2018, residents in the AHGL service area were, on average, slightly older (42.0 years old) than the whole of Los Angeles County (38.2 years old). Overall, in the AHGL service area, a higher percentage of residents were represented in older age groups than the rest of Los Angeles County.



Race and Ethnicity

In 2017, a majority of the population living in the AHGL service area was ethnically either White (51.2%) or Hispanic/Latino (28.2%). Los Angeles County had a higher percentage of Hispanic/Latino residents (48.4%) and a lower percentage of White residents (28.3%) than in the AHGL service area. The Black/African-American population in the AHGL service area (1.7%) was less than one quarter that of Los Angeles County (8.5%). The Asian population in the service area (15.9%) was slightly higher than in Los Angeles County (14.4%).



The AHGL service area consists of geographically concentrated ethnic communities that contribute to the area's vibrancy and community-based assets. For example, among the approximate 200,000 residents in the City of Glendale, 72,000 have Armenian heritage. In particular, the foreign born

population skews heavily towards people of Armenian (82.9%) or Persian (7.5%) ancestry.⁶ There is, however, a large Latino population (18.2%) primarily of Mexican heritage.⁷ The dominant language of English Learners in the city's school district is Armenian (59.24%) and Spanish (19.76%).⁸

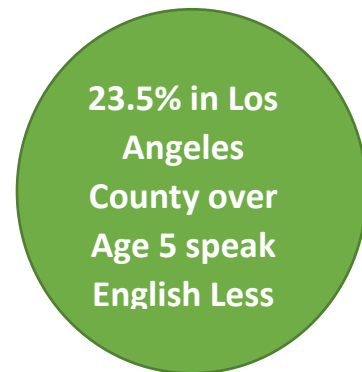
Dating back to at least the 2000 Census, the AHGL service area also includes communities with large Latino populations like Highland Park (90042) where two-thirds of residents are Latino, of which 72.9% have Mexican ancestry. Of the foreign-born population in Highland Park (45.1% of all residents) countries of origin were primarily Mexico (55.3%) and El Salvador (12.0%).⁹

Toward the northern portion the AHGL service area, a large Asian community in Montrose (91020) makes up 33.4% of the population, which is largely of Korean ancestry. Similarly, Eagle Rock's (90041) large Asian population (28.6%) is largely of Filipino ancestry.¹⁰

Language

In comparison with California's population at large, Los Angeles has a significantly greater proportion of monolingual Spanish-speaking households. Language barriers can lead to other barriers in accessing services, including health care.

	Los Angeles County	California
English at Home	42.8%	+12.5%
Spanish at Home	39.7%	-10.5%



In 2018, the percent of residents in the AHGL service area who spoke only English (32.2%) was lower than in Los Angeles County (42.8%). Similarly, the percent of residents in the AHGL service area who spoke only Spanish at home (21.9%) was lower than in Los Angeles County (39.7%).

⁶ U.S. Census. American Community Survey. 2015, 2017.

⁷ Southern California Association of Governments (SCAG) Regional Council. Profile of the City of Glendale. 2019

⁸ California Department of Education. English Learner Students by Language by Grade. 2018-2019

⁹ US Census. American Community Survey. 2013-2017 Five Year Estimates

¹⁰ Nielson Claritas, 2018, ZIP Code

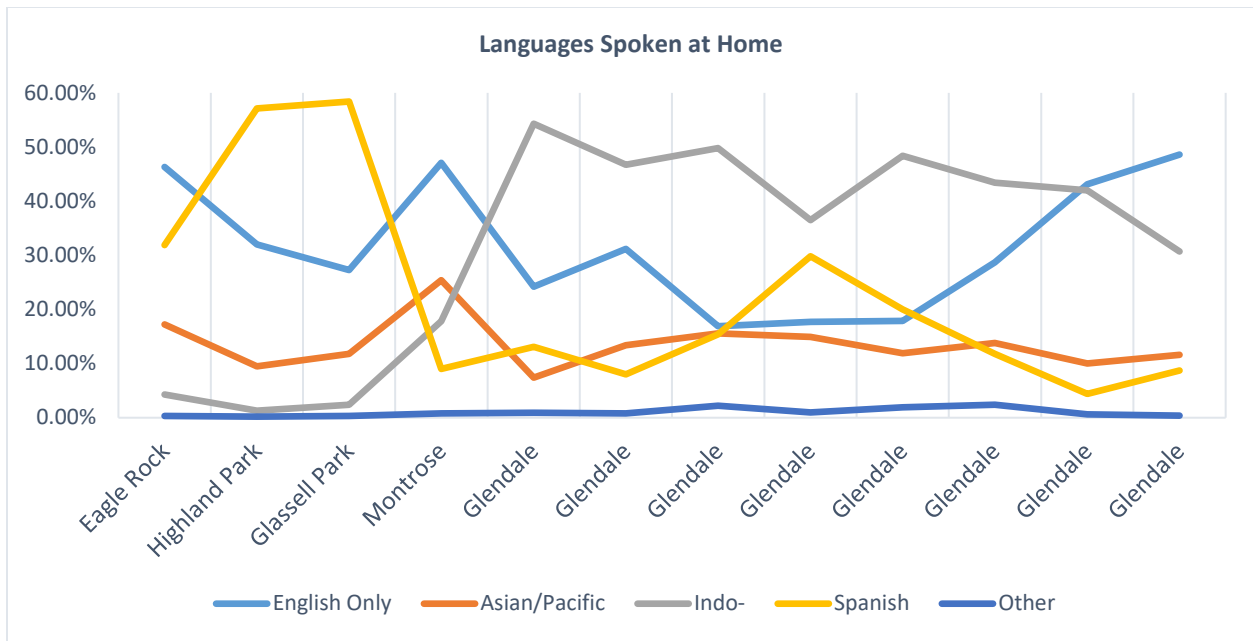
Language Spoken at Home

City	ZIP Code	English Only	Asian/Pacific Islander	Indo-European	Spanish	Other
Eagle Rock	90041	47.5%	20.5%	3.7%	28.0%	0.3%
Highland Park	90042	31.6%	9.6%	1.7%	56.7%	0.3%
Glassell Park	90065	29.2%	13.3%	2.2%	55.2%	0.2%
Montrose	91020	47.1%	25.4%	17.8%	9.0%	0.8%
Glendale	91201	23.6%	7.6%	51.7%	15.5%	1.61%
Glendale	91202	32.5%	11.3%	46.7%	8.1%	1.4%
Glendale	91203	18.1%	17.1%	47.9%	15.5%	1.4%
Glendale	91204	23.3%	14.6%	31.0%	29.9%	1.2%
Glendale	91205	20.5%	12.0%	46.1%	19.9%	1.4%
Glendale	91206	28.3%	13.4%	45.4%	11.3%	1.6%
Glendale	91207	40.5%	9.6%	44.0%	4.8%	1.2%
Glendale	91208	44.6%	14.0%	32.9%	8.3%	0.2%
AHGL Service Area		32.2%	14.0%	30.9%	21.8%	1.0%
Los Angeles County		42.8%	11.0%	5.4%	39.7%	1.1%

Data Source: Nielsen Claritas, 2018, ZIP Code

Various neighborhoods in the AHGL service area disproportionately favor one foreign language. In Eagle Rock, Montrose, and in Glendale ZIP Code 91208 English prevails as the dominant language spoken at home. In Glendale ZIP codes 91201 (51.7%), 91203 (47.9%), 91202 (46.7%), and 91205 (46.1%) however, the percent of Indo-European speakers was nearly ten times the rest of Los Angeles County. The percent of residents in the AHGL service area who only spoke a language native to Asia or the Pacific Islands at home (14.0%) was, for the most part, similar to the Los Angeles County average (11.0%), though certain pockets, like Montrose and Eagle Rock, had a much higher percentages of households speaking an Asian or Pacific Islander language.

As shown in the chart below, communities in the AHGL service area with disproportionately high percentages of monolingual Spanish speakers include Highland Park (90042) and Glassell Park (56.7% and 55.2%, respectively). As a whole, Spanish-speaking households in these communities were significantly more common than elsewhere in the AHGL service area (21.8%) and Los Angeles County (39.7%).



Education

Education is often cited as a key indicator for economic prosperity and good health. Los Angeles County is outperformed by the State of California with regard to high school or higher education degrees held by adults 25 years or older, though Los Angeles County has recently seen a higher percentage increase in completion of educational degrees than the state.

High School Completion or Better ¹¹	2014	2017
Los Angeles County	76.8%	79.6%
California	81.5%	83.3%

College education rates are higher in the AHGL service area than in the county at large. Individuals with a college education (associate degree or higher; 46.2%) outperform Los Angeles County (37.5%). Differences in education level among communities served by AHGL include ZIP code areas 90042 and 90065 where residents are more likely to have not completed a high school diploma (28.3% and 28.0%, respectively, compared to the average of 16.3% for the service area). These areas were also home to disproportionately high rates of monolingual Spanish households.

Meanwhile, four neighborhoods (zip codes 91020, 91206, 91207, 91208) had disproportionately high rates of residents with higher education degrees, with Glendale ZIP codes 91207 and 91208 being home to residents with master’s degrees at nearly twice the Los Angeles County average.

¹¹ US Census, American Community Survey, 2010-2014 and 2013-2017

Educational Attainment

City	ZIP Code	Less than Ninth Grade	Some High School, No Diploma	High School Graduate or GED	Some College, No Degree	Bachelor's Degree	Master's Degree or Higher
Eagle Rock	90041	6.9%	5.7%	15.8%	22.2%	28.9%	13.8%
Highland Park	90042	15.8%	12.5%	20.5%	17.0%	18.8%	8.9%
Glassell Park	90065	16.7%	11.3%	19.5%	16.0%	20.1%	9.8%
Montrose	91020	4.4%	3.1%	15.9%	18.2%	34.5%	14.4%
Glendale	91201	14.2%	8.2%	18.9%	19.2%	21.2%	10.5%
Glendale	91202	8.6%	4.0%	20.1%	16.0%	27.4%	15.6%
Glendale	91203	9.4%	6.1%	24.5%	18.1%	22.1%	8.9%
Glendale	91204	14.1%	8.4%	20.8%	20.7%	19.6%	7.7%
Glendale	91205	15.7%	6.3%	21.9%	20.1%	20.9%	8.3%
Glendale	91206	9.3%	3.7%	17.6%	17.7%	29.1%	15.4%
Glendale	91207	4.3%	1.7%	16.2%	18.8%	30.6%	22.3%
Glendale	91208	2.2%	2.8%	14.4%	17.8%	31.7%	22.5%
AHGL Service Area		10.1%	6.2%	18.7%	18.8%	25.4%	13.2%
Los Angeles County		13.1%	9.1%	21.0%	19.3%	20.1%	10.6%

Data Source: Nielsen Claritas, 2018, ZIP Code

Marital Status

The AHGL service area is home to a higher concentration of married residents, particularly with the spouse present (44.4%), when compared to Los Angeles County where more residents have never married (41.9%). Differences in the population who were married with spouse absent, widowed or divorced between AHGL service area and Los Angeles County are marginal (less than 2%).

Marital Status

City	ZIP Code	Never Married	Married, Spouse Present	Married, Spouse Absent	Widowed	Divorced
Eagle Rock	90041	42.1%	37.7%	5.1%	7.0%	8.2%
Highland Park	90042	46.1%	34.1%	7.2%	4.3%	8.3%
Glassell Park	90065	43.4%	36.7%	8.0%	4.4%	7.5%
Montrose	91020	27.5%	52.4%	5.2%	5.9%	8.9%

City	ZIP Code	Never Married	Married, Spouse Present	Married, Spouse Absent	Widowed	Divorced
Glendale	91201	34.3%	47.6%	5.3%	6.3%	6.6%
Glendale	91202	33.3%	48.9%	4.8%	6.4%	6.6%
Glendale	91203	34.2%	42.6%	6.8%	7.3%	9.1%
Glendale	91204	38.7%	38.4%	8.6%	6.4%	7.9%
Glendale	91205	37.6%	40.1%	6.0%	7.7%	8.6%
Glendale	91206	33.0%	47.0%	4.5%	7.3%	8.1%
Glendale	91207	26.3%	52.6%	4.5%	7.3%	9.4%
Glendale	91208	26.5%	54.6%	5.1%	6.4%	7.5%
AHGL Service Area		35.2%	44.4%	5.9%	6.4%	8.1%
Los Angeles County		41.9%	38.2%	6.6%	5.0%	8.3%

Data Source: Nielsen Claritas, 2018, ZIP Code

Nativity

Births

Over the past few years, the general trend of live births has been declining; the decline in Los Angeles County (over 10%) has been steeper than in the rest of California (over 6.1%). Live births in Los Angeles County also had these traits:

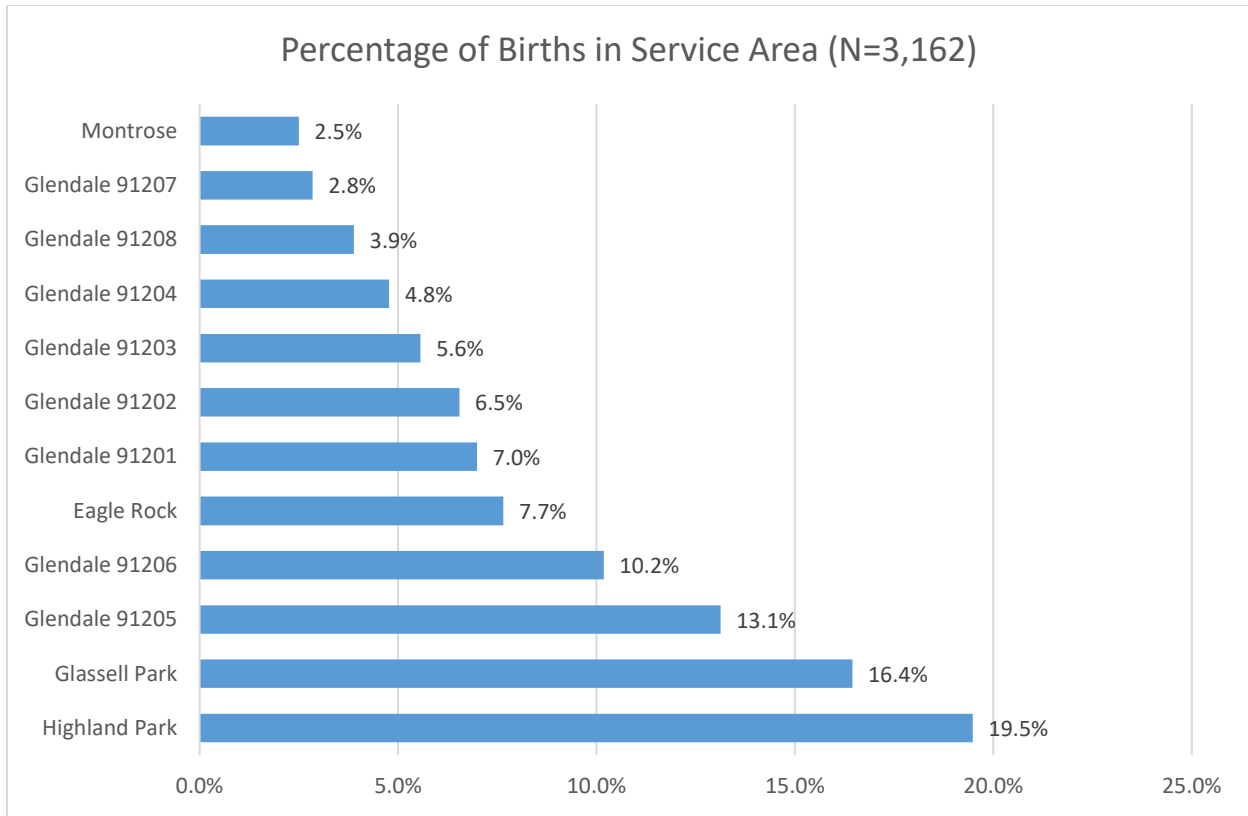
- The percent of live births with mothers who received prenatal care late (in third trimester) or no prenatal care was 3.4%.
- Almost one in 6 live births (17%) was attributed to a teenage mother.¹²

Birth Trend	2014	2017
Los Angeles County	130,289	-10.2%
California	502,579	-6.1%

Data Source: California Center for Disease Control and Prevention, CDCWONDER 2014-2017

Within the AHGL service area in 2017, approximately 3,162 births took place. The highest percentage of births took place in Zip Codes 90042—Highland Park (19.5%), and 90065—Glassell Park (16.4%) which are experiencing a booming real estate market in recent years. Collectively, the Glendale neighborhoods, have the majority (53.9%) of all births in the AGHL service area. However, the distribution of birth rates is unequal in these neighborhoods with Zip Codes 91205 and 91206 representing the larger share at 13.1% and 10.2% respectively.

¹² California Department of Public Health, Center for Health Statistics and Informatics, 2018 Los Angeles County Health Status Profiles, 2018, Los Angeles County



Data Source: California Department of Public Health, 2017

Birth Weight

Babies born with low birth weight face many health risks including disease, disability and even death. Both the State of California and Los Angeles County have met the Healthy People 2020 Objective of keeping low weight births below 7.8% of total live births, though Los Angeles County is behind the rest of the State, at 7.2% and 7.1% respectively.

Low Birth Weight

Geographic Area	Low Weight Births	Percent of Live Births
Los Angeles County (2015-2017)	8,797.0	7.2%
Los Angeles County (2014-2016)	8,965.3	7.1%
California (2015-2017)	33,283.3	6.9%
Healthy People 2020 Objective	--	7.8%

Data Source: California Department of Public Health, Center for Health Statistics and Informatics, 2019 Los Angeles County, Health Status Profiles, 2019, Los Angeles County

Breastfeeding

Recommended by the California Department of Public Health for the first six months of life, breastfeeding is an important element in the mental and physical development of newborns. The

proportion of mothers who breastfed at any frequency in Los Angeles County was very similar to the State rates, as illustrated below.

	Any Breastfeeding		Exclusive Breastfeeding	
	Number	Percent	Number	Percent
Los Angeles County	97,439	93.90%	65,821	63.50%
California	390,082	94.00%	289,803	69.80%

Data Source: California Department of Public Health, California In-Hospital Breastfeeding as Indicated on the Newborn Screening Test Form, Statewide and Maternal County of Residence by Race/Ethnicity, 2017

Service Planning Areas 2 and 4, which include AHGL’s service areas, performed in-line or higher than Los Angeles County in percent of children breastfed for at least 6 months, though SPA 5 outperformed all other areas in Los Angeles County.

	LAC	SPA 2	SPA 4	Highest SPA
Percent of children 0-5 years who were breast fed at least 6 months	49.7%	49.3%	55.9%	SPA 5 WEST- 66.6%

Data Source: California Department of Public Health, California In-Hospital Breastfeeding as Indicated on the Newborn Screening Test Form, Statewide and Maternal County of Residence by Race/Ethnicity, 2017

Disability

An umbrella term for impairments, activity limitations, and participation restrictions, disability is defined by the World Health Organization as “the interaction between individuals with a health condition (e.g., cerebral palsy, Down syndrome, depression) and personal and environmental factors (e.g., inaccessible transportation and public buildings, and limited social supports).”¹³ Examples of disabilities include hearing, vision, movement, thinking, remembering, learning, communication, and/or mental health or developmental disorder.

According to the 2017 Census, in California alone, over 4 million people, or 10.6% of the population, have a disability. The proportion of the population with disabilities increases with age and is impacted by race, e.g., with differing rates among African-American (15.0%), White (11.6%), and American Indian/Alaskan native (16.4%) populations. These trends hold within Los Angeles County which is home to a disabled population of 9.9%, or nearly one in 10 residents. People with disabilities are also more likely than others to be less educated, unemployed, and living below the poverty level.¹⁴

¹³ World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at <http://www.who.int/mediacentre/factsheets/fs352/en/index.html>. Accessed [May19, 2019].

¹⁴ California Department of Public Health’s Living Healthy with a Disability Program and Living Healthy Advisory Committee. Planning for Today, Thinking of Tomorrow—California’s 2011-2016 Strategic Directions for Promoting the Health of People with Disabilities Sacramento, CA. Available at http://www.cdph.ca.gov/HealthInfo/injviosa/ Documents/Planning_for_Today.pdf Accessed [August 2, 2016].

Prevalence

In 2016, the population with a disability status due to physical, mental or emotional conditions was greater in AHGL's Service Planning Areas (31.8% and 34.0%) than in Los Angeles County (30.7%). Similarly, the proportion of adults unable to work due to a physical or mental impairment in these areas than with the whole Los Angeles County.

Report Area	Disability Status Due To Physical, Mental or Emotional Condition, Adults	Inability to Work Due to a Physical/Mental Impairment, Adults
	Percentage	Percentage
SPA 2–San Fernando Valley	31.8%	7.8%
SPA 4–Metro	34.0%	7.3%
Los Angeles County	30.7%	6.9%

Data Source: California Health Interview Survey, 2016, SPA

Special Health Care Needs in Children

Children with Special Health Care Needs (CSHCN) are identified via a Screening Tool from the Foundation for Accountability. The CSHCN screener has three "definitional domains." These are: (1) Dependency on prescription medications; (2) Service use above that considered usual or routine; and (3) Functional limitations.¹⁵

In 2015, a 13.9% of children between 0 and 17 years of age met the criteria for special health care needs in the AHGL service area, which is similar to that in Los Angeles County (14.5%).

Children 0–17 Years old with Special Health Care Needs

Report Area	Percentage
SPA 2–San Fernando Valley	16.0%
SPA 4–Metro	12.3%
AHGL Service Area	13.9%
Los Angeles County	14.5%

Data Source: Los Angeles County Health Survey, 2015, SPA

Almost one in six children between 12 and 17 years old met the criteria for a special health care need in Los Angeles County in 2015.

¹⁵ Los Angeles County Department of Public Health - 2015 Los Angeles County Health Survey - Topics & Data. "Percent of Children (0-17 years old) who Meet Criteria for Having Special Health Care Needs (SHCNs)" <http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2015.htm> [accessed September 1, 2016]

Children 0 to 17 Years old with Special Health Care Needs by Age

Age Group	Percentage
0–5 years old	9.8%
6–11 years old	16.6%
12–17 years old	17.1%

Data Source: Los Angeles County Health Survey, 2015, County

By ethnicity, nearly a third (32.4%) of African-American children met the criteria for special health care need – this is almost twice the next highest percentage, found in White children (17.5%).

Children 0 to 17 Years old with Special Health Care Needs by Ethnicity

Age Group	Percentage
Latino	12.0%
White	17.5%
African-American	32.4%
Asian/Pacific Islander	10.5%
American Indian/Alaskan Native	8.7%

Data Source: Los Angeles County Health Survey, 2015, County

Mortality

Deaths

In 2016, the 3,222 deaths in the AHGL service area comprised 6.0% of the total deaths in Los Angeles County. Most deaths in the service area occurred in 90027—Highland Park at 8.1%.

Total Deaths

City	ZIP Code	Total	Percentage
Eagle Rock	90041	198	5.5%
Highland Park	90042	293	8.1%
Glassell Park	90065	264	7.3%
Montrose	91020	178	4.9%
Glendale	91201	171	4.7%
Glendale	91202	205	5.7%
Glendale	91203	102	2.8%
Glendale	91204	138	3.8%

City	ZIP Code	Total	Percentage
Glendale	91205	300	8.3%
Glendale	91206	283	7.8%
Glendale	91207	95	2.6%
Glendale	91208	100	2.8%
AHGL Service Area		3,625	

Data Source: California Department of Public Health (CDPH), 2016, ZIP Code

Cause of Death

Over the course of the past 7 years, the leading causes of death in the AHGL service area have remained the same though Alzheimer’s has overtaken stroke as the third leading cause with number of cases increasing significantly from 164 in 2010 to 259 in 2016. Heart disease and cancer have proportionately decreased by 1.5-2%, though the number of cases have remained relatively stable.

Leading Causes of Death				
	#1	#2	#3	#4
2010	Heart Disease	Cancer	Stroke	Alzheimer’s
	27.4% (932)	25.3% (859)	6.5% (222)	4.8% (164)
2016	Heart Disease	Cancer	Alzheimer’s	Stroke
	25.9% (938)	23.3% (861)	7.1% (259)	6.5% (234)

Data Source: California Department of Public Health, 2010, 2016, County

V. KEY FINDINGS: HEALTH NEEDS

HEALTH NEED PRIORITY 1: POVERTY & HOMELESSNESS

Poverty

Poverty creates barriers to everyday necessities, including healthy and affordable foods, health care, housing, and other basic needs. Collectively, these barriers impact overall health and well-being.

Poverty Thresholds

The federal government measures the number of people in poverty with thresholds (aka Federal Poverty Level) established and updated by the U.S. Census. In 2017, the Federal Poverty Level for an individual stood at annual income of \$12,060 while for a family of four it was \$24,600. In California, where the cost of living is high, research indicates that families can earn two or more times the Federal Poverty Level and still struggle to meet their basic needs.¹⁶ A comprehensive 2018 state-by-state report by the National Low Income Housing Coalition (NLIHC) demonstrated that renting a two-bedroom apartment in Los Angeles required a household income of \$66,520.¹⁷

The AHGL service area falls within larger geographic Service Planning Areas that differ in their overall poverty profile. Though the county’s highest rates of poverty are in SPA 6 and SPA 1, as described in the chart below, the densely populated SPA 4 has a larger percentage of the population living below FPL than both the neighboring SPA 2 and the entire county: one in four households in SPA 4 were estimated to live below 100% FPL. Youth in the county are similarly impacted with 27.4% living below 100% FPL compared to the state’s rate of 21.0%. In 2017, according to the U.S. Census, 40.6% of Los Angeles County families living below 100% FPL with children under 18, where the head of household was female lived, was in line with the state’s rate of 39.5%.

Population Living Below the Federal Poverty Level		
	Below 100% Poverty	100-200% Poverty
SPA 2 – San Fernando Valley	14.2%	16.8%
SPA 4 – Metro	25.9%	22.7%
HIGHEST POVERTY Area in L.A. County	SPA 6- South: 38.6%	SPA 1- Antelope Valley: 30.4%
Los Angeles County	20.6%	18.2%
California	16.8%	18.1%

Data Source: California Health Interview Survey, 2017, SPA

¹⁶ Making Ends Meet: How Much Does It Cost to Support a Family in California? (December, 2017). California Budget and Policy Center. Available at <https://calbudgetcenter.org/wp-content/uploads/Making-Ends-Meet-12072017.pdf> Accessed [June 13, 2019]

¹⁷ Out of Reach 2018: https://nlihc.org/sites/default/files/oor/OOR_2018.pdf

The U.S. Census Bureau issues poverty thresholds¹⁸ with the purpose of calculating the number of people living in poverty.¹⁹ In 2018, a lower percentage of families in the AHGL service area lived below poverty (10.4%) than families in Los Angeles County (13.5%). Similarly, the percentage of families living below poverty with children (7.0%) was significantly lower than Los Angeles County (10.2%). Several areas with a higher concentration of families living below poverty include 90065-- Glassell Park (16.3%), 90042—Highland Park (15.7%), parts of Glendale: ZIP codes 91204 (14.2%), 91205 (16.4%), and 90065—Glassell Park (16.3%).

Poverty

City	ZIP Code	Families at or Above Poverty	Families at or Above Poverty with Children	Families Below Poverty	Families Below Poverty with Children
Eagle Rock	90041	92.6%	39.9%	7.4%	5.0%
Highland Park	90042	84.3%	39.7%	15.7 %	12.0%
Glassell Park	90065	83.7%	37.3%	16.3%	12.5%
Montrose	91020	94.4%	43.5%	5.6%	5.3%
Glendale	91201	90.1%	28.4%	9.9%	6.4%
Glendale	91202	91.3%	29.3%	8.7%	5.0%
Glendale	91203	90%	34.1%	10.0%	6.7%
Glendale	91204	85.8%	33.0%	14.2%	8.9%
Glendale	91205	83.6%	31.1%	16.4%	9.9%
Glendale	91206	90.5%	33.7%	9.5%	5.8%
Glendale	91207	95.5%	33.3%	4.5%	2.5%
Glendale	91208	92.9%	41.3%	7.1%	3.6%

¹⁸ Detailed (48-cell) matrix of thresholds varies by family size, number of children, and, for 1- & 2-person units, whether or not elderly. Weighted average thresholds vary by family size and, for 1- & 2-person units, whether or not elderly. There is no geographic variation; the same figures are used for all 50 states and D.C.

¹⁹ United States Department of Health and Human Services. Frequently Asked Questions Related To The Poverty Guidelines And Poverty. <https://aspe.hhs.gov/frequently-asked-questions-related-poverty-guidelines-and-poverty#differences> [Accessed September 8, 2013]

City	ZIP Code	Families at or Above Poverty	Families at or Above Poverty with Children	Families Below Poverty	Families Below Poverty with Children
AHGL Service Area		82.5%	35.4%	10.4%	7.0%
Los Angeles County		86.6%	40.9%	13.5%	10.2%

Data Source: Nielsen Claritas, 2018, ZIP Code

Participation in Public Programs

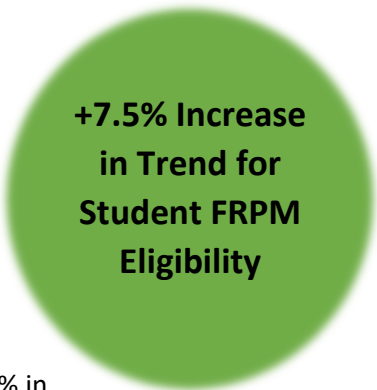
A large segment of the population is 200% below the Federal Poverty Level; over 40% in both California and Los Angeles County in 2016. This income level indicates high risk for food insecurity and qualifies a person for public assistance programs. Yet, it appears that the proportion of eligible residents accessing this resource is much lower. Reasons cited for low access rates include complex application processes, inaccessible case managers, inaccurate records, and bureaucratic bottlenecks, e.g., declined eligibility due to change of address, etc. The percentage of L.A. County residents who used food stamps was 21.7% and TANF/CalWorks was 9.9%. A little over half (52.7%) of qualifying children had access to WIC. These trends hold in AHGL's SPA 2 and 4 though they were not the highest rates in the range. Reported barriers to access include (etc.)

	Not Able to Afford Food (<200%FPL) (1)	Food Stamp Recipients	TANF/CalWorks Recipients	WIC Usage among Qualified Children (Ages 6 and Under)
SPA 2	42.5%	17.5%*	4.1%*	26.8%*
SPA 4	31.9%	27.3%	14.5%*	56.8%*
Highest SPA	SPA 1 53.6%	SPA 6 31.4%	SPA 6 17.7%*	SPA 8 82.7%*
LAC	40.2%	21.7%	9.9%	52.7%
CA	40.8%	23.1%	10.2%	44.7%

Data Source: California Health Interview Survey, 2017 and (1) 2016, SPA * statistically unstable

Student eligibility for Free or Reduced-Price School Meal (FRPM) serves as a proxy measure of low-income families, as the federal poverty threshold tends to underestimate the extent of poverty, particularly in high cost areas.

A larger portion of students in Los Angeles County are eligible for this program than students across the state as a whole. In 2017, the percentage of children eligible for the Free or Reduced-Price School Meal (FRPM) program in L.A. County was 69.3% compared with the California rate of 60.1%. The county rate has been increasing with growth from 61.8% in 2011 to 66.6% in 2015.²⁰



Household Income

L.A. County is home to approximately 3.4 million households of varying income levels. The AHGL service area represents 5.5% of all households in the county. The geographic areas follow a similar bimodal distribution in income levels--- one in ten households subsist on less than \$15,000 per year, while more than three of ten earn incomes greater than \$100,000 and the majority of households earned between \$35,000 and \$75,000 dollars. The AHGL area, however, has a greater proportion of households in the \$15,000-\$24,000 by a margin of 1.4%. Also, L.A. County has a slightly higher income distribution among households with earnings above \$100,000 by a 1.2% margin, suggesting perhaps that AHGL-area households were moderately less wealthy than L.A. County households as a whole.

Household Income

Income level	AHGL Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Below \$15,000	19,089	10.2%	350,981	10.4%
\$15,000–\$24,999	20,178	10.7%	313,021	9.3%
\$25,000–\$34,999	16,599	8.8%	290,148	8.6%
\$35,000–\$49,999	23,848	12.7%	414,717	12.3%
\$50,000–\$74,999	28,901	15.4%	530,614	15.7%

²⁰ Source: California Department of Education, 2011, 2015, 2017

Income level	AHGL Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
\$75,000–\$99,999	20,915	11.1%	394,734	11.7%
\$100,000–\$124,999	16,195	8.6%	301,967	8.9%
\$125,000–\$149,999	11,612	6.2%	215,808	6.4%
\$150,000–\$199,999	12,496	6.7%	234,537	6.9%
\$200,000–\$249,999	6,981	3.7%	122,716	3.6%
\$250,000–\$499,999	7,492	4.0%	136,691	4.0%
Above \$500,000	3,469	1.8%	75,448	2.2%
Total	187,775	100.0%	3,381,382	100.0%

Data Source: Nielsen Claritas, 2018, Service Area

As shown in the table that follows, the average household income of residents in the AHGL service area (\$99,577) was higher than that of Los Angeles County (\$96,019) by 3.7%. In particular, the average household income was significantly higher in the Glendale Zip Codes 91208 (\$149,601), 91207 (\$141,277), 91202 (\$106,537), and 91206 (\$100,649), as well as Eagle Rock (\$109,483).

Household sizes in the AHGL service area ranged from 2.5 and 3.1. The AHGL service area had a slightly smaller average household size (2.7) than the average for L.A. County (3.0). Glendale 91203 and 91205 and Montrose 91020 neighborhoods had the smallest household size averages, while Highland Park and Glassell Park had the largest.

Household Descriptions

City	ZIP Code	Est. Average Household Income	Est. Average Household Size
Eagle Rock	90041	\$109,483	2.7
Highland Park	90042	\$81,881	3.1
Glassell Park	90065	\$93,323	3.1
Montrose	91020	\$98,702	2.5
Glendale	91201	\$89,375	2.8
Glendale	91202	\$106,537	2.6
Glendale	91203	\$74,363	2.5
Glendale	91204	\$73,128	2.7
Glendale	91205	\$61,682	2.6
Glendale	91206	\$100,649	2.5
Glendale	91207	\$141,277	2.6
Glendale	91208	\$149,601	2.6
AHGL Service Area		\$98,333	2.7
Los Angeles County		\$96,019	3.0

Data Source: Nielsen Claritas, 2018, ZIP Code

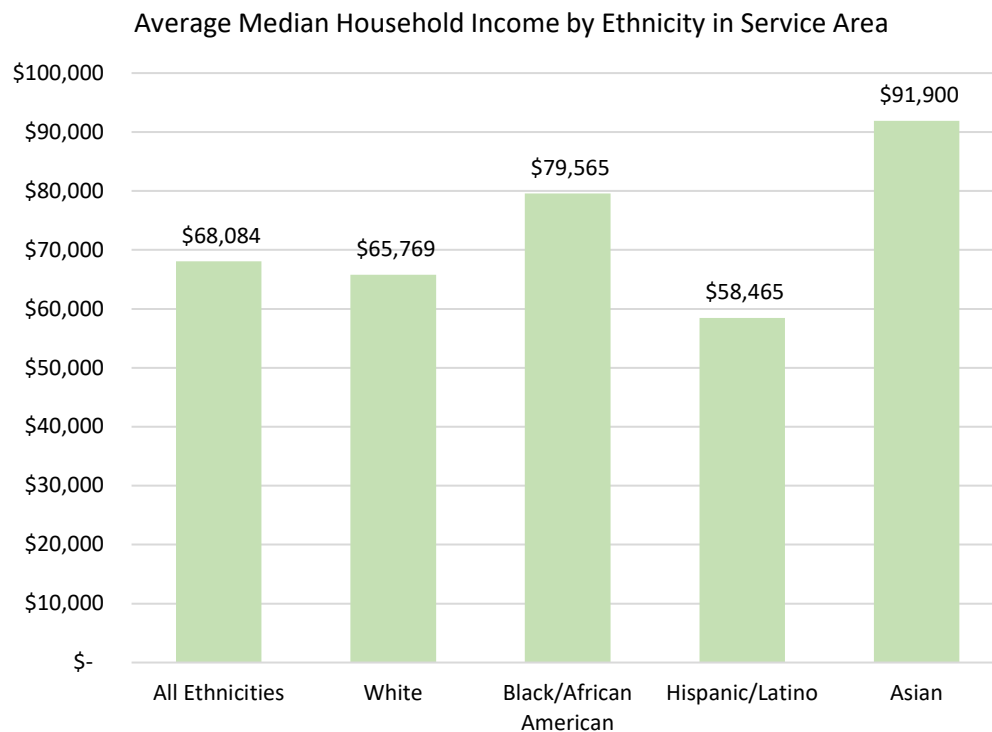
The AHGL service area population varies in its income power. The median household income in the service area ranged between \$114,010 in Glendale 91208 and 91205 (\$61,682). The following chart illustrates ZIP codes with the lowest average household incomes in the service area: Glendale ZIP codes 91203, 91204, and 91205. The income power in these areas has dramatically decreased within three years, with Glendale 91203 showing a more than 20% decrease in median household income. These communities point to a high degree of income disparity.

Lowest Median Household Incomes in Service Area

Featured Zip Codes:	Income 2018	Differential from 2015
Glendale--91203	\$48,868	-20.7%
Glendale--91204	\$48,906	-9.2%
Glendale--91205	\$42,108	-17.1%

Data Source: Clarita Nielsen, 2018, 2015, ZIP Code

In the absence of income data for every individual household to calculate the median for the whole service area, the average median household income was used. Despite limitations of the metric, it does reveal an income disparity by ethnicity with Hispanic/Latino populations having the weakest earning power and Asian populations having the highest earning power.



Data Source: Claritas Nielsen, 2018, Service Area

Employment Status

A majority of the AHGL service area population was employed (60.29%), a slightly higher rate than in Los Angeles County (58.92%). At least a third of the population in both Los Angeles County (35.98%) and in the AHGL service area (36.58%) were not in the labor force. This percentage includes students, retirees, seasonal workers, and individuals taking care of their homes and families (homemakers). The disparity within the AHGL service area of this group is wide, ranging from 28.95% in Montrose to 42.03% in

Glendale: Zip Code 91205--- a gap of nearly 14%. Population breakdown by age may help further explain these disparities among areas. The unemployment rate within the AHGL area stood at just under 5%, moderately lower to the county rate of 5.06%.

Employment Status

Report Area	ZIP Code	In Armed Forces	Employed	Unemployed	Not in Labor Force
Eagle Rock	90041	0.03%	59.23%	4.38%	36.35%
Highland Park	90042	0.03%	61.84%	5.67%	32.46%
Glassell Park	90065	0.17%	60.56%	4.75%	34.52%
Montrose	91020	0.00%	67.11%	3.94%	28.95%
Glendale	91201	0.00%	56.89%	5.87%	37.24%
Glendale	91202	0.05%	57.17%	4.18%	38.60%
Glendale	91203	0.00%	57.13%	6.16%	36.71%
Glendale	91204	0.00%	59.11%	5.14%	35.75%
Glendale	91205	0.06%	52.26%	5.65%	42.03%
Glendale	91206	0.00%	56.00%	5.01%	38.95%
Glendale	91207	0.00%	55.22%	2.94%	41.84%
Glendale	91208	0.00%	59.65%	2.69%	37.66%
AHGL Service Area		0.04%	58.41%	4.97%	36.58%
Los Angeles County		0.04%	58.92%	5.06%	35.98%

Data Source: Nielsen Claritas, 2018, ZIP Code

Homelessness and Housing

A homeless individual is defined by DPSS as “If they lack fixed and regular nighttime residences. If they share a residence with family or friends on a temporary basis; if they have a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; if they reside in a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; if they have a need for housing in a commercial establishment (e.g. hotel/motel), shelter, publicly funded transitional housing or from a person in the business of renting properties, or received an eviction notice or notice to pay rent or quit. If they are escaping domestic violence and do not have a second residence or support network.”²¹

More than 20 percent of the nation’s homeless population is now living in California. Based on U.S. Department of Housing and Urban Development (HUD) estimates, as of January 2018, an estimated 129,972 people in California experienced homelessness on any given day. Among them, 6.18% or 6,702 were family households, 8.3% or 10,836 were Veterans, 9.5% or 12,396 were unaccompanied young adults (aged 18-24), and 26.4% or 34,332 were individuals experiencing chronic homelessness. Furthermore, “public school data reported to the U.S. Department of Education during the 2016-2017 school year shows that an estimated 246,296 public school students experienced homelessness. Of that total, 7,533 students were unsheltered, 17,061 were in shelters, 10,095 were in hotels/motels, and 211,607 were doubled up.”²²

The homelessness issue is a statewide crisis that is now grabbing recent headlines:

Homelessness is a crisis in California. Why are 2020 candidates mostly ignoring it?

--Los Angeles Times²³

California can’t solve its homelessness crisis without protecting renters--Los Angeles Times²⁴

How California’s Homeless Crisis Grew

²¹ Los Angeles County <http://homeless.lacounty.gov/wp-content/uploads/2017/12/25-Glossary-of-Terms-and-Acronyms.pdf>

²² California Homelessness Statistics, United States Interagency Council on Homelessness. Available at <https://www.usich.gov/homelessness-statistics/ca/http://priorities.lacounty.gov/homeless/>. [Accessed June 4, 2019]

²³ <https://www.latimes.com/politics/la-na-pol-2020-homelessness-presidential-campaign-20190610-story.html> Appeared June 10, 2019. [Accessed June 11, 2019]

²⁴ <https://www.latimes.com/opinion/editorials/la-ed-tenant-protections-bills-homeless-crisis-20190529-story.html> Appeared May 29, 2019. [Accessed June 11, 2019]

Obscenely Out of Control--*Observer*²⁵

In California, more than 58,936 of those experiencing homelessness live in Los Angeles County—a 12% increase despite housing placements increasing 23% from previous year and more than doubling since 2014.²⁶ Ongoing, dedicated revenue and aggressive state action are critical to effectively addressing this crisis. Some steps have already been taken in Los Angeles, such as the county’s Measure H sales tax, which will add about \$460 million this year to the budget.²⁷ Investments have been made for additional housing, with approximately 1,400 units to open this year, and over 10,000 housing units planned to be built.²⁸ Nevertheless, over 500,000 affordable housing units are needed in Los Angeles alone to meet the demand for low income renters.²⁹ A minimum wage earner, at \$13.25 needs to work at least 79 hours per week to afford a one bedroom apartment in Los Angeles.³⁰

These statistics speak directly to an individual’s monthly budget and availability of additional resources to handle his or her current and future medical needs. Hospitals and medical organizations cannot ignore the state of the housing and poverty crisis when planning to meet the health needs of their respective service areas. This crisis adversely impacts the affordability of care.

Prevalence

According to the Los Angeles Homeless Services Authority, “homeless individuals” (as opposed to “homeless families”) include single adults, adult couples with no children, and groups of adults over the age of 18. Most of the homeless individuals in the AHGL service area were living within SPA 4–Metro (27.7%). Of the identified homeless families most are within SPA 4–Metro (22.7%). Of the 125 homeless minors under the age of 18 in all SPAs, most reside within SPA 4–Metro (31.2%).

Homeless by Type				
	Total Homeless	Individuals (Not in Family Units)	Family Members (in Family Units)	Unaccompanied Minors (Under age 18)
SPA 2	7,738	77.2%	22.8%	0.0%
SPA 4	14,218	89.7%	9.9%	0.3%
Highest SPA	SPA 4	SPA 4	SPA 2	SPA 4

²⁵ <https://observer.com/2019/05/california-homeless-crisis-san-francisco/> Appeared May 30, 2019. Accessed [June 11, 2019]

²⁶ County of Los Angeles. Office of Countywide Communications. Los Angeles, CA. Available at <https://www.lahsa.org/documents?id=3437-2019-greater-los-angeles-homeless-count-presentation.pdf> Accessed June 11, 2019]

²⁷ Los Angeles County Homeless Initiative. <http://homeless.lacounty.gov/news/l-a-county-makes-460-million-investment-in-fight-against-homelessness-year-3-measure-h-spending-plan-funds-expansion-of-housing-and-prevention/> Accessed [June 11, 2019]

²⁸ Greater Los Angeles Homeless County, 2019 Results. Los Angeles Homeless Services Authority. Available at <https://www.lahsa.org/documents?id=3437-2019-greater-los-angeles-homeless-count-presentation.pdf> Accessed [June 11, 2019]

²⁹ California Housing Partnership Corporation. (May 2019) Los Angeles County Annual Affordable Housing Outcomes Report.

³⁰ The Federal Home Loan Mortgage Corporation, “Rental Burden by Metro” 2019

LAC 52,765 84.1% 15.8% 0.1%

Data Source: Los Angeles Homeless Service Authority, 2018 Greater Los Angeles Homeless Count Reports, SPA

SPA 4–Metro has the county’s highest percentage of homeless who are mentally ill (29.3%), have substance abuse issues (28.0%), are HIV-positive (45.2%), or are physically disabled (28.0%). These percentages are slightly higher than in Los Angeles County.

Homeless by Special Population

	Chronically Homeless	Substance Abuse	People with HIV/AIDS	Serious Mental Illness	Survivors of Domestic Violence	Veterans
SPA 2	24.6%	15.0%	1.1%	24.4%	26.0%	5.0%
SPA 4	31.7%	17.8%	3.2%	29.4%	31.4%	7.6%
Highest SPA	SPA 3 33.8%	SPA 3 21.7%	SPA 4	SPA 1 34.6%	SPA 3 37.8%	SPA 5 11.0%
LAC	26.6%	13.5%	1.4%	24.2%	5.8%	7.4%

Data Source: Los Angeles Homeless Service Authority, 2018 Greater Los Angeles Homeless Count Reports, SPA

Associated Drivers

Housing instability among poor families is the result of multiple overlapping factors ranging from number of income-earning adults in the home, education level of income-earning adults in the home, health of family members, domestic violence exposure, substance use patterns, and access to social support and health care.³¹ Although Los Angeles is home to the largest health and social services system available to homeless people, given the size of the very poor and homeless population, it faces significant challenges to provide cost effective integrated care for those facing housing instability.³²

Housing

In 2018, the average household income of residents in the AHGL service area (\$99,577) was slightly higher than Los Angeles County (\$96,019). Families and individuals are much more likely to become unstably housed or homeless if they are shouldering a high housing cost burden, typically defined as housing costs that exceed 30% of monthly income. Within the AHGL service area, more than half of residents spend more than 30% of their monthly income on housing. The **ZIP codes most impacted by**

³¹ A Secondary Analysis by ICPH utilizing data from the Fragile Families and Child Well-being Study. Institute for Children, Poverty & Homelessness. <http://www.icphusa.org/index.asp?page=16&report=112&pg=110>. Accessed: [September 2, 2016].

³² Guerrero, E., Henwood, B. and Wenzel, S. (2014). Service Integration to Reduce Homelessness in Los Angeles County: Multiple Stakeholder Perspectives. *Human Service Organizations* 38(1):44-54.

high housing costs as a proportion of income include Glendale 91203 and 91205, where 66.9% and 65.3% of residents, respectively, spend more than 30% of their incomes on housing each month.

Individuals are also more likely to experience housing instability if living in substandard housing situations, defined as the following: a lack of complete plumbing facilities; a lack of complete kitchen facilities; 1.01 or more occupants per room; or, gross rent as a percentage of household income greater than 30%.

Close to half of residents in the AHGL service area spend more than 30% of their income on housing. Communities most severely impacted by housing costs include Glendale--91205 (59.5%), Glendale--91204 (56.8%), and. These same areas are where the percentage of occupied housing units lacking complete plumbing facilities is highest. Overall, the AHGL service area has more than double the rate of occupied housing units in Los Angeles County lacking complete plumbing facilities.

Housing Conditions

Report Area	ZIP Code	Percentage of occupied housing units lacking complete plumbing facilities	Percentage of residents whose monthly housing cost exceeds 30% of income
Eagle Rock	90041	1.4%	39.5%
Highland Park	90042	1.6%	47.2%
Glassell Park	90065	1.0%	45.5%
Montrose	91020	1.0%	55.0%
Glendale	91201	1.5%	53.5%
Glendale	91202	1.2%	52.7%
Glendale	91203	2.6%	53.4%
Glendale	91204	3.2%	56.8%
Glendale	91205	3.3%	59.5%
Glendale	91206	2.1%	50.6%
Glendale	91207	1.5%	43.1%
Glendale	91208	1.1%	37.3%
AHGL Service Area		1.8%	49.5%
Los Angeles County		0.8%	47.0%

Data Source: U.S. Census Bureau, American Community Survey, 2010–14, ZIP Code

Community Input

Much of the concern expressed and discussion involved the far-reaching consequences of poverty and homelessness, citing “Poverty/economics is a pervasive issue that has multiple impacts across health outcomes.” Lack of employment opportunities with decent wages in combination with lack of affordable housing present a difficult situation for individuals and families. Exacerbating the challenges is the difficulties encountered in finding childcare, which presents obstacle for obtaining and maintaining employment.

They noted having observed that the only consistent source of care for the homeless population is emergency (911) service, which puts an undue financial burden on emergency services and creates barriers to access for the larger population. Because the homeless population lives disproportionately with mental health disorders, the reliance on emergency services fails to meet this long-term health care need. The high cost of living puts an undue burden on low-income families that spend a large proportion of their incomes on rent (vs. greater investment in healthy food or recreation). Poverty is expensive, both as a societal cost (\$672 billion per year nationwide) and as a risk factor for stress, hunger, homelessness, and economic catastrophes both large and small for vulnerable families.³³

Stakeholders have also noted an increase in the homeless population and a lack of shelters. Homeless families face unique challenges in accessing education and health care, and there are insufficient social service providers in place to connect these families with homeless services. In focus groups, stakeholders noted as well that veterans comprise an ever-increasing proportion of the homeless population. An overall theme that emerged was the need to understand how address poverty from a health care perspective.

³³ Shriver Center on Poverty Law: <https://theshriverbrief.org/the-high-cost-of-poverty-for-the-poor-and-for-us-all-4b0afde5a88f>

HEALTH NEED PRIORITY 2: MENTAL HEALTH & SUBSTANCE ABUSE

Mental Health

Mental illness increases risk factors for disability and lowers quality of life. Undiagnosed, untreated mental health disorders are linked to substance abuse, risk behaviors, and lack of a support network. Additionally, mental health disorders may seriously impact physical health and are associated with the prevalence, progression, and outcome of chronic diseases³⁴ as well as a family history of mental illness, age, substance abuse, life-event stresses, and self-harm.³⁵

Mental health is associated with many other health factors, including poverty, heavy alcohol consumption, and unemployment, and increases the morbidity of these conditions. Chronic diseases such as cardiovascular disease, diabetes, and obesity are also correlated with mental health disorders and outcomes such as depression and suicide.³⁶ Adverse childhood experiences (ACEs) are linked to higher rates of disordered mental health and risk behaviors.³⁷

AHGL stakeholders identified mental health disorders as one of the top health concerns in their service area, adding that it affects everyone, regardless of age. There is a feedback loop between integrating mental health resources with primary care for a more cohesive service delivery model and improved patient outcomes. Stakeholders emphasized a need for the prevention of mental health episodes, which can be as destructive as (and can cause) economic catastrophe.

Prevalence of Mental Health Conditions

Mental health disorders have become a ubiquitous health crisis in the United States, as demonstrated with these following facts.³⁸



³⁴ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28>. Accessed [May 21, 2019].

³⁵ Public Health Agency of Canada. *Mental Illness*. Available at <http://www.phac-aspc.gc.ca/cd-mc/mi-mm/index-eng.php>. Accessed [May 22, 2019].

³⁶ Centers for Disease Control and Prevention. *Mental Illness Surveillance Among Adults. 2011*. Available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm>. Accessed [May 29, 2019].

³⁷ American Psychology Association, April 2017: The long shadow of adverse childhood experiences: <https://www.apa.org/science/about/psa/2017/04/adverse-childhood>

³⁸ National Alliance on Mental Illness. Available at <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>. Accessed [May 22, 2019]

The mental health crisis is not new to Californians. Voters passed Proposition 63, known as the Mental Health Services Act, where high income residents were taxed to help counties fund the treatment of the mentally ill, though critics increasingly now argue that funds are being mismanaged with resources inadequately reaching those in need.³⁹ In Los Angeles County, psychological distress and depression are prevalent among 8.6% to 9.7% of the population. Two thirds of the population reported receiving adequate social and emotional support (64.0%), leaving the remaining third of the population vulnerable to the risks associated with untreated mental health disorders. This crisis in care most profoundly impacts the teenage population where one in four need urgent care for emotional or mental health crises at least once in the course of a year.⁴⁰

Adults experienced an average 2.6 unhealthy days resulting from poor mental health – much like reports within the county (2.3). Over 8% report feeling depressed.

Mental Health Indicators

Report Area	Activity Limitation Days in Past Month for Adults due to Poor Physical and/ Mental Health	Adults with Serious Psychological Distress in the Last Year ¹	Depression Prevalence	Adequate Social and Emotional Support
	Days	Percentage	Percentage	Percentage
SPA 2–San Fernando Valley	2.5	7.6%	8.0%	69.1%
SPA 4–Metro	2.7	10.9%	10.8%	60.2%
AHGL Service Area	2.6	NA	9.2%	65.3%
Los Angeles County	2.3	9.7%	8.6%	64.0%

Data Sources: Los Angeles County Health Survey, 2015 and (1) California Health Interview Survey (CHIS), 2017, SPA

In addition, adults reported whether their state of mental health has impaired their work, family life, and/or social life within the past year. Despite these impairments being reported by a greater proportion of adults in Service Planning Area 4 than in Service Planning Area 2, more adults in Service Planning Area 2 manage their emotional and/or mental health disorders with prescription medication.

Adult Mental Health Impairment in the past 12 months

³⁹ Los Angeles Times. <https://www.latimes.com/local/california/la-me-mhsa-unspent-balance-20180819-story.html>. Accessed [May 23, 2019]

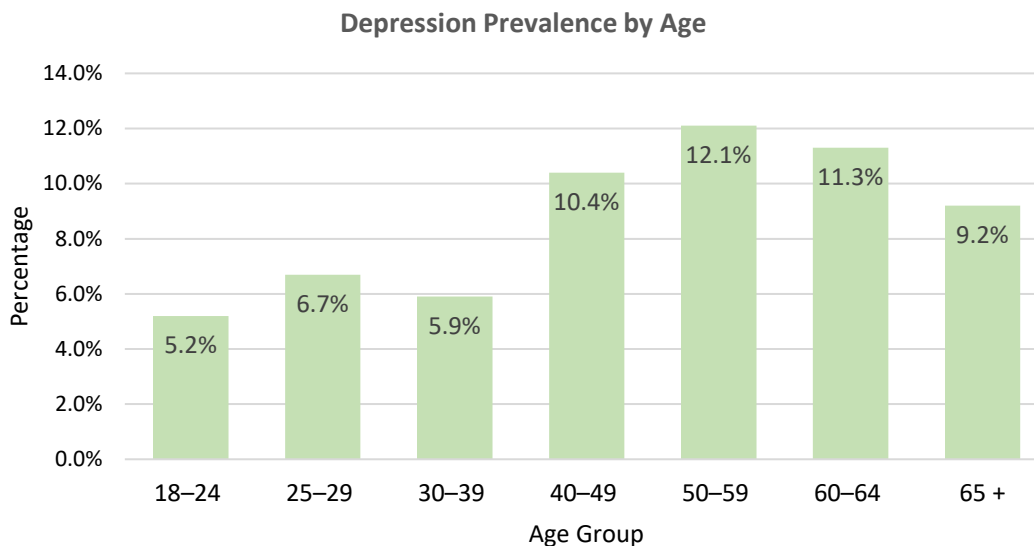
⁴⁰ California Health Interview Survey, 2017

Report Area	Impaired Work	Impaired Family Life	Impaired Social Life	Has Taken Prescription Medicine for Emotional/Mental Health Issue in Past Year
SPA 2 – San Fernando Valley	13.3%*	13.0%*	14.5%*	11.0%
SPA 4 – Metro	18.9%	17.9%	19.1%	8.7%
Los Angeles County	14.6%	15.3%	16.0%	8.8%
California	14.4%	15.7%	16.5%	10.4%

Data Source: California Health Interview Survey, 2017, County, SPA * statistically unstable

Depression

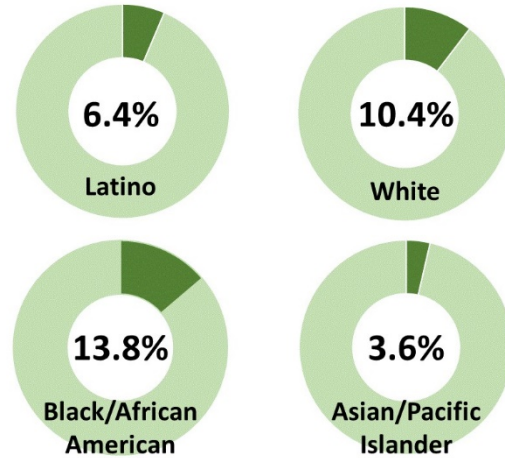
Situational depression is common, and can feel like clinical depression, but the associated health risks differ. In Los Angeles County, those most affected with clinical depression are between the ages of 50 and 64. Around 12.1% of those from age 50 to 59 have been diagnosed with depression, as have 11.3% of those between the ages of 60 and 64. Another 10.4% of those between ages of 40 and 49, and smaller percentages of those age 65 and older (9.2%), 25 to 29 (6.7%), 30 to 39 (5.9%), and 18 to 24 (5.2%), have been diagnosed with clinical depression.



Data Source: Los Angeles County Health Survey, 2015, County

Depression Prevalence by Ethnicity⁴¹

Populations most commonly diagnosed with depression in Los Angeles County were ethnically white (10.4%) and Black (13.8%); populations less commonly diagnosed with depression were in Los Angeles County were ethnically American Indian/Alaskan Native (6.8%), Latino (6.4%), and Asian/Pacific Islander (3.6%). Black adults (15.2%) also show the greatest risk of major depression compared to the county rate of 11.8%. Females (10.1%) are more likely than males (7.1%) to be diagnosed with depression, be treated for it, or have symptoms of depression.



Suicide

Suicide is considered a major preventable public health problem. Suicide remains the tenth leading cause of death among Americans of all ages, and is a greater problem among males than females by a magnitude of 3.54 times. Whites and American Indians and Alaska Natives are Populations more likely to commit suicide are ethnically white (15.85%) and American Indian/Alaska Native (13.42%).⁴² Suicide is the 11th leading cause of death in California and is somewhat lower than the national average. Worth noting is that suicide is the 2nd leading cause of death among those ages 15 – 34 in the state.

Considering Suicide



Data Source: California Health Interview Survey, 2017, SPA

The rate of adults who report considering committing suicide is lower in the Service Planning Area that includes AHGL's service areas than the rates of both Los Angeles County (9.6%) and the State of California (11.6%).

The suicide rate per 100,000 persons in the AHGL service area (8.0) was slightly higher when compared to Los Angeles County (7.5), and below the Healthy People 2020 goal (≤ 10.2).

Suicide Rate per 100,000 Persons

Report Area	Rate
SPA 2 – San Fernando Valley	8.3

⁴¹ Source: Los Angeles County Health Survey, 2015

⁴² American Foundation for Suicide Prevention. <https://afsp.org/about-suicide/suicide-statistics/> Accessed [May 29, 2019].

Report Area	Rate
SPA 4 – Metro	7.8
AHGL Service Area	8.0
Los Angeles County	7.5

Data Source: California Department of Public Health (CDPH), 2013, SPA

Substance Use Disorder

Substance use disorder is measured on a continuum from mild to severe. Each specific substance (e.g., alcohol, tobacco, drugs) is addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), though diagnosed based on the same overarching criteria.⁴³ These disorders can impact physical health, mental health, quality of life, family and social life, and public health and safety. Key determinants—or drivers—of alcohol and substance abuse and tobacco use include biological, social, economic and environmental factors. Disordered substance use abuse is also strongly influenced by interpersonal, household, and community dynamics including access to alcohol and drugs. Among adolescents, family, social networks, and peer pressure are key influencers of substance use.⁴⁴

Additional downstream health risks of disordered substance use include teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide, and suicide.⁴⁵ In two-thirds of cases, disordered substance use can be linked to adverse childhood experiences.⁴⁶

Alcohol Use Disorder

Heavy alcohol consumption is an important determinant of future health needs, including cirrhosis, cancers, and untreated mental and behavioral health needs.

A community's density of alcohol outlets is associated with heavy drinking, drinking and driving, higher rates of motor vehicle-related pedestrian injuries, child abuse and neglect, and other violence.⁴⁷ In 2016, the average number of alcohol outlets per 1,000 persons in the AHGL service area was 1.4. The

⁴³ Substance-Related and Addictive Disorders – American Psychiatric Institute; DSM5 Collection 2013: https://www.psychiatry.org/.../DSM/APA_DSM-5-Substance-Use-Disorder.pdf

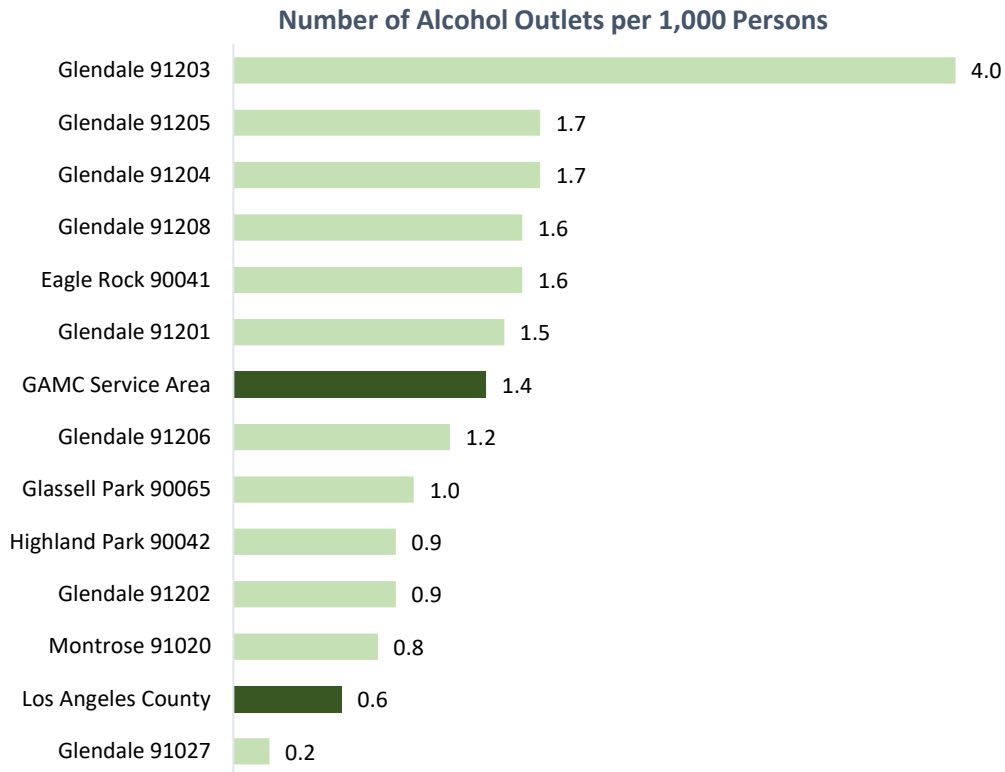
⁴⁴ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/lhi/substanceabuse.aspx?tab=determinants>. Accessed [May 23, 2019].

⁴⁵ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse>. Accessed [June 4, 2019].

⁴⁶ NCMJ, May 1, 2018: <http://www.ncmedicaljournal.com/content/79/3/166.full>

⁴⁷ Stewart, K. (n.d.). How Alcohol Outlets Affect Neighborhood Violence. Calverton, MD. Available at <http://urbanaillinois.us/sites/default/files/attachments/how-alcohol-outlets-affect-nbhd-violence.pdf>. Accessed [August 1, 2016].

rate was almost three times higher for 91203—Glendale (4.0), relative to the service area, and for the service area relative to Los Angeles County (0.6).



Data Source: California Department of Alcoholic Beverage Control (ABC), 2016, ZIP Code

Within the AHGL service area, half (51.7%) of adults (18+ years old) reported drinking alcohol at least once in the past month, while 15.7% of adults reported engaging in binge drinking in the past month.⁴⁸ These rates are in line with county rates.

Adult Alcohol Use in the Past Month

Report Area	Drank Alcohol	Engaged in
	at Least Once	Binge Drinking
SPA 2—San Fernando Valley	55.0%	14.3%
SPA 4—Metro	47.2%	17.6%
AHGL Service Area	51.7%	15.7%

⁴⁸ Binge drinking is defined for females as consumption of four or more drinks and for males, consumption of five or more drinks on one occasion.

Report Area	Drank Alcohol at Least Once	Engaged in Binge Drinking
Los Angeles County	51.9%	15.8%

Data Source: Los Angeles County Health Survey, 2015, SPA

Prescription and Illicit Substance Use

Overall, more adults and teens reported prescription and illicit substance abuse in Service Planning Area 4–Metro relative to SPA 2 and the county. The percentage of adults who reported misusing prescription drugs in the AHGL service area (12.8%) was slightly higher than in Los Angeles County (5.5%), as was the percentage of adults who reported using marijuana in the past year (12.8%). In addition, the county reported higher teen use of marijuana or hashish than the state.

Prescription and Illicit Substance Abuse

Report Area	Adults Who Reported Misusing Any Form of Prescription Drugs in the Past Year ¹	Adults Who Reported Using Any Form of Marijuana in the Past Year ¹	Teens Who Have Ever Tried Marijuana, or Hashish ²
SPA 2–San Fernando Valley	3.9%	11.1%	NA
SPA 4–Metro	7.0%	15.1%	NA
AHGL Service Area	5.2%	12.8%	NA
Los Angeles County	5.5%	11.6%	14.7%
California	NA	NA	12.4%

Data Source: ¹ Los Angeles County Health Survey, 2015 and ² California Health Interview Survey, 2017, SPA

Treatment and/or Hospitalizations

Almost one in six persons (17.1%) in the county reported needing help for mental, emotional, or alcohol/drug issues in 2017 – slightly lower to that reported for the state (18.5%). In general, fewer adults sought help than recognized their need for help in the county and the state, though in Service Planning Area 4, the trend is reversed: More (17.8%) saw a healthcare provider than reported their need for help. A large proportion sought help in Service Planning Area 2 (49.3%) and 4 (27.7%) sought or needed help but did not receive any treatment.

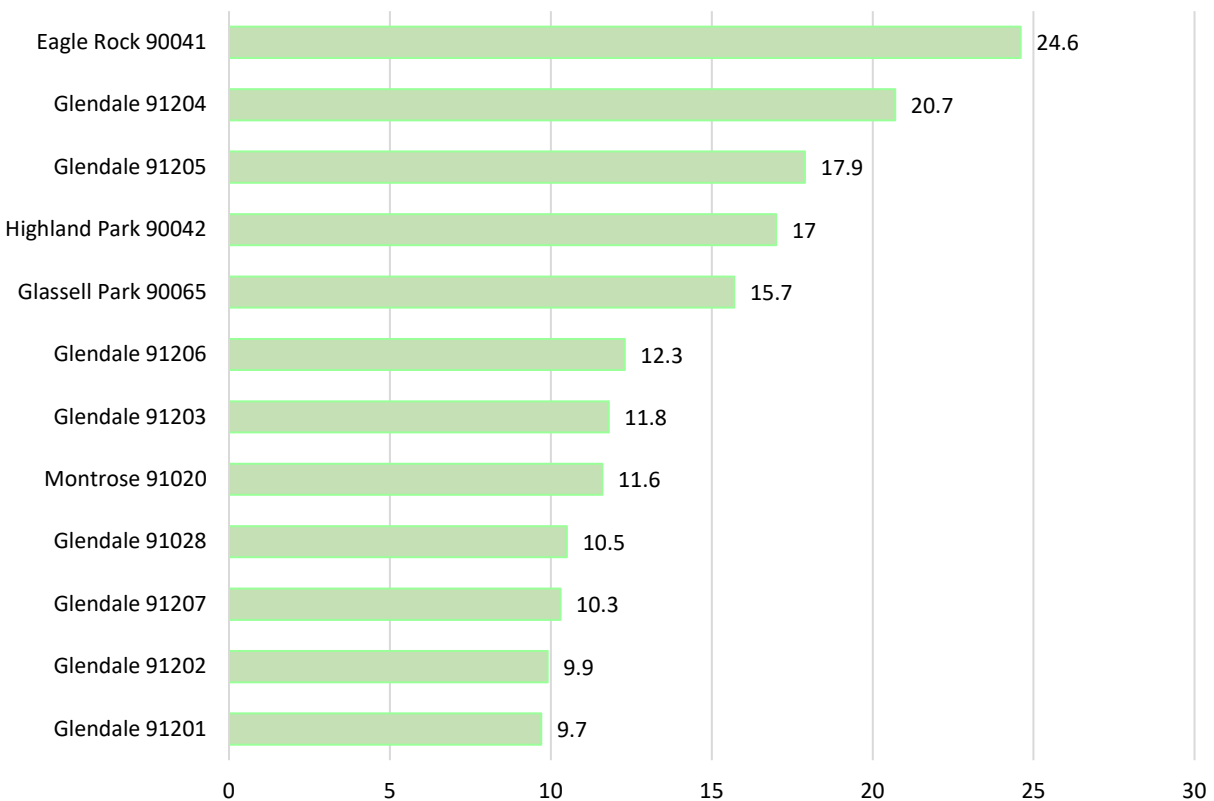
Needed Help for Mental, Emotional, or Alcohol/Drug Issues

Report Area	Adults who Needed Help for Emotional/Mental and/or Alcohol-Drug Issues in Past Year	Adults who Saw a Healthcare Provider for Emotional/Mental Health and/or Alcohol-Drug Issues in Past Year	Sought/Needed Help for Self-reported Mental/Emotional and/or Alcohol-Drug Issues
SPA 2- San Fern. Valley	17.6%*	13.7%	49.3%
SPA 4–Metro	15.5%	17.8%*	27.7%*
Los Angeles County	17.1%	15.1%	39.9%
California	18.5%	15.2%	39.7%

Data Source: California Health Interview Survey, 2017, SPA

Heavy drinking can increase the risk of harmful health conditions and hospitalization in the worst cases. The hospitalization rate due to disordered alcohol use per 10,000 adults varies significantly within AHGL’s service area, ranging from 9.7 in Glendale 91201 to 20.7 in Glendale 91204. The mean rates in Eagle Rock (24.6) and Glendale 91204 (20.7) were the highest in the range.

Age-adjusted hospitalization rate due to disordered alcohol use per 10,000 Adults⁴⁹



Data Source: California Office of Statewide Health Planning and Development, 2013-2015

Tobacco Use

Tobacco use is known to cause cancer, heart disease, lung disease (such as emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death.⁵⁰

Additionally, secondhand smoke has been known to cause heart disease and lung cancer in adults and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS)

⁴⁹ Average annual age-adjusted hospitalization rate due to acute or chronic alcohol abuse per 10,000 population aged 18 years and older. "Alcohol abuse" includes alcohol dependence syndrome, nondependent alcohol abuse, alcoholic psychoses, toxic Source: California Office of Statewide Health Planning and Development, 2013-2015

effects of alcohol, and excessive blood level of alcohol. Diseases of the nervous system, digestive system, and circulatory system caused by alcohol are also included. Measurement Period 2013-2015 (Confidence Interval).

⁵⁰ 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=41>. Accessed [June 4, 2019].

in infants and children.⁵¹ Smokeless tobacco use such as chewing tobacco can also cause a variety of oral health problems, including cancer of the mouth and gums, tooth loss, and periodontitis. In addition, cigar smoking may cause cancer of the larynx, mouth, esophagus, and lung.⁵²

E-cigarettes represent an emerging threat to public health. E-cigarette use, called vaping, has targeted children with candy and fruit flavors. The use of e-cigarettes is unsafe for kids, teens, and young adults. Nicotine is highly addictive and can harm adolescent brain development, which continues into the early to mid-20s.⁵³

Tobacco use is perhaps the most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the U.S. \$193 billion annually in direct medical expenses and lost productivity.⁵⁴ The percent of self-reported smoking varies between SPA 2 (7.6%) and SPA 4 (11.5%) with the County of Los Angeles reporting 9% of the adult population as current smokers. Among current smokers, nearly a third have smoked at least 100 cigarettes in their lifetime. More than one in six adults have tried e-cigarettes. Within the county, for every five smokers, two were advised by a health professional to quit.

Smoking Prevalence				
Report Area	Smoking Status: Smoker	Smoked 100+ cigarettes in Lifetime	Tried E- cigarette	Got Advice from Health Professional to Quit Smoking
SPA 2—San Fernando Valley	7.6%*	31.6%	18.4%	45.4%*
SPA 4—Metro	11.5%	36.9%	18.3%	29.0%*
Los Angeles County	9.0%	31.7%	17.1%	39.9%

Data Source: California Health Interview Survey, 2017, SPA

In 2017, as shown in the table that follows, over one in six adults in Los Angeles County under 25 years of age were smokers, calling into question the efficacy of widespread public health warnings about disease risks associated with tobacco use. Also, close to 9% of adults 50 and over smoke in Los Angeles County.

⁵¹ 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=41>. Accessed [June 4, 2019].

⁵² 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=41>. Accessed [June 4, 2019].

⁵³ Centers for Disease Control. Available at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/Quick-Facts-on-the-Risks-of-E-cigarettes-for-Kids-Teens-and-Young-Adults.html

⁵⁴ 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=41>. Accessed [June 4, 2019].

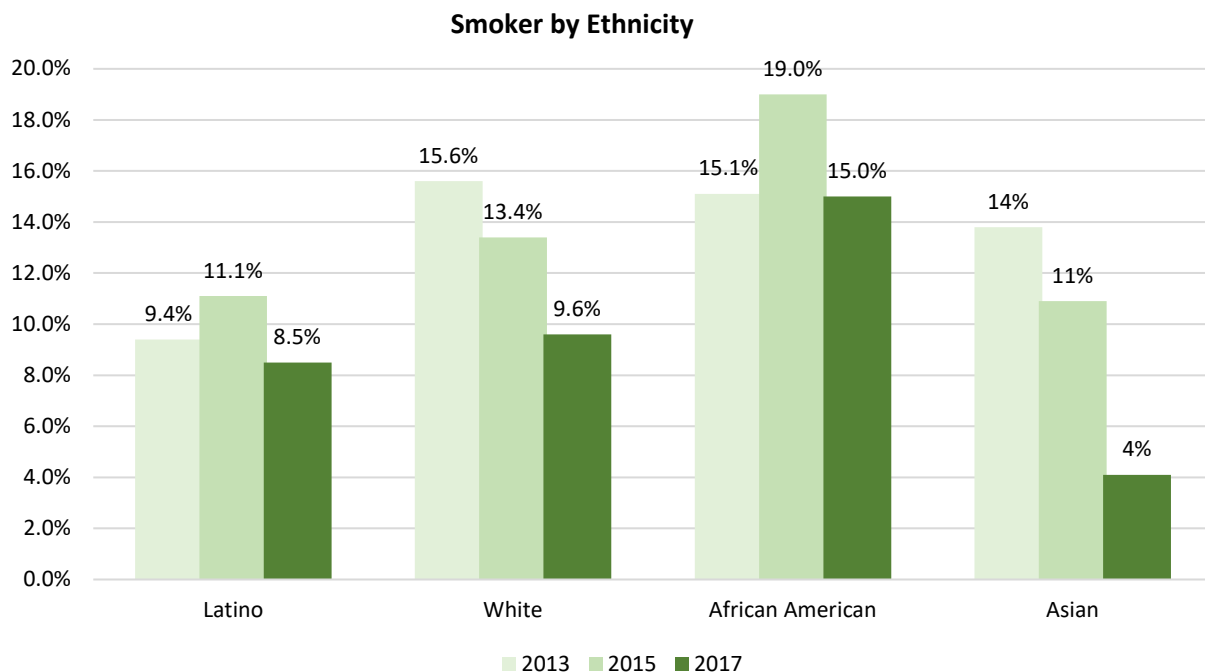
Tobacco Use by Age

Age Group	Percentage
18–24 years old	5.2%
25–34 years old	12.4%*
35–44 years old	8.0%*
45–54 years old	9.4%*
50 and over	8.8%

Data Source: California Health Interview Survey, 2017, County

* statistically unstable

In addition, in Los Angeles County, more ethnically Black populations used tobacco relative to other ethnicities year after year. Among white and Asian populations, the trend to smoke continues to decline. The Latino smoking population generally registers between 8.5% and 11.1%.



Community Input:

Mental health disorders were also rated as a top, if not the top issue affecting all populations. High levels of stress across the board, as well as stress related to the economic burdens, rising housing costs and health issues were cited. Stigmatization around disordered mental health was frequently mentioned as a barrier to obtaining care and was often attributed to societal and cultural stigmas. Lack of mental health resources was also mentioned a challenge. In addition, the need to infuse mental health and all services with a trauma-informed approach was raised. Links to poverty were articulated in terms of individuals not being able to afford needed prescriptions. Furthermore, the toll that economic stress

experienced by those who are unemployed, under-employed, or living in unstable or unsafe housing impacts mental health and well-being. Substance abuse in the form of drugs and alcohol were noted as interlinked with disordered mental health. Concern was expressed regarding the increased use of tobacco, particularly in the form of vaping.

HEALTH NEED PRIORITY 3: ACCESS TO MEDICAL CARE

Access to Medical Care

Access to health care services is important for everyone’s quality of life, which requires the ability to navigate the health care system, access a health care location where needed services are provided, and a health care provider the patient can communicate with and trust.⁵⁵ Access to health care impacts overall physical, social, and mental health status, the prevention of disease and disability, the detection and treatment of health conditions, quality of life, preventable death, and life expectancy for individuals.⁵⁶ In California, Los Angeles County is ranked 45 among 57 counties in the most recent statewide county rankings for health access.⁵⁷



Health Insurance Coverage

The AHGL service area falls within Service Planning Areas 2 and 4 where the population of insured was slightly below the county and state rates. Regardless of the geographic region, health coverage among adults was significantly lower than coverage among children under 18. In L.A. County, however, the coverage gap between the two populations consistently measured at least 10%, while in California at large, the gap stood lower at 8%.

Geographic Area	Total Population	Adults Ages 18-64	Children 17 and Under*
SPA 2 – San Fernando Valley	91.6%	87.7%	97.1%
SPA 4 – Metro	90.8%*	85.2%*	100%
Los Angeles County	92.2%	88.5%	98.1%*
California	92.7%	89.1%	97.8%

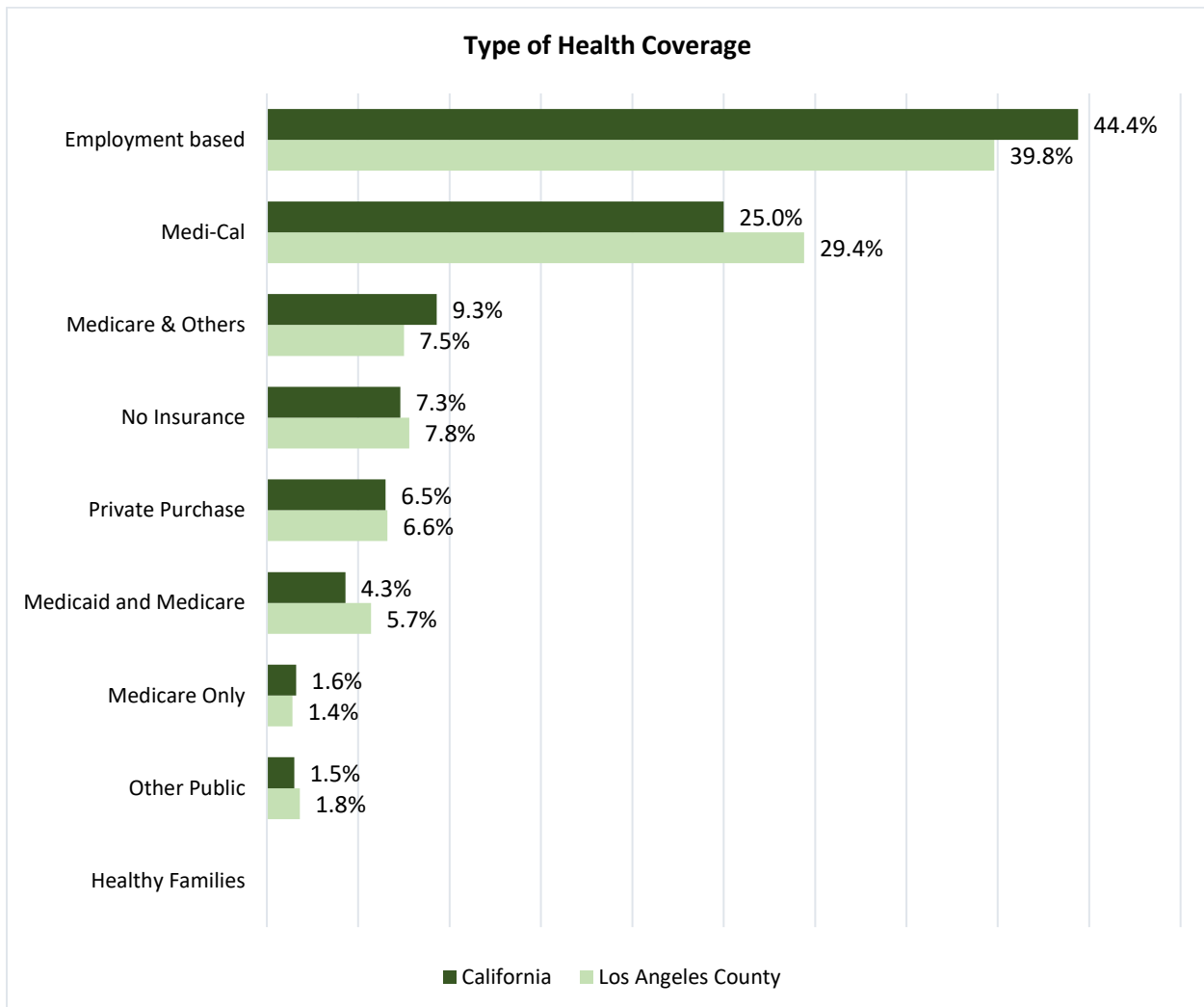
*Data Source: California Health Interview Survey, 2017, SPA *statistically unstable*

⁵⁵ 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=1>. Accessed [May 25, 2019].

⁵⁶ 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=1>. Accessed [May 25, 2019].

⁵⁷ County Health Rankings, 2018 (note: Alpine County was not included in the rankings)

Among those with insurance coverage, the type of insurance varied. The two most popular forms of insurance in both the state and the county were employer-based insurance and Medi-Cal.⁵⁸ A larger portion of residents in California as a whole (44.4%), however, carried employer based insurance than residents of Los Angeles County (39.8%), where Medi-Cal was more prevalent among the insured (29.4%) than in California (25%). Further analysis would be required to determine whether the prevalence of Medi-Cal enrollments in L.A. County is a result of better access to the program or greater need within the geographic area.



Data Source: California Health Interview Survey, 2017, County

⁵⁸ Medi-Cal is California’s Medicaid program, a public health insurance program that provides health care services at no or low cost to low-income individuals. The federal government dictates a mandatory set of basic services, which include but are not limited to physician, family nurse practitioner, nursing facility, hospital inpatient and outpatient, laboratory and radiology, family planning, and early and periodic screening, diagnosis, and treatment for children. In addition to these mandatory services, California provides optional benefits such as outpatient drugs, home- and community-based waiver services, and medical equipment. Please see State of California Department of Health Care Services (2012). Medi-Cal’s Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden, Sacramento, CA. Available at <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf>. Accessed (May 25, 2019)

Different forms of Medicare programs also provided health coverage for many residents.⁵⁹ Medicaid and Medicare represented a larger share of the coverage in Los Angeles County (5.7%) than the State of California (4.3%), while Medicare in combination with other programs was used proportionately more by California residents in general than Los Angeles County residents. The Healthy Families program has been phasing out since January 1, 2013 with no new enrollments accepted and existing enrollees being transferred into the Medi-Cal program.⁶⁰

Finally, some residents struggle with insurance altogether. More than 7% in both the state and Los Angeles County do not have insurance. **More specifically, over 10% of adults in Service Planning Area 2 and 4 (which includes AHGL’s service area) carry no insurance.**

Uninsured by Age		
Age Group	Los Angeles County	California
Under 19	9.8%	11.3%
19–64	88.5%	87.0%
65 and above	1.7%	1.6%

Data Source: American Community Survey, 2013-2017, County

Among all uninsured individuals in Los Angeles County, 9.8% were under the age of 19, 88.5% of the uninsured population were between the ages of 18 and 64, and 1.7% were age 65 or older. In Los Angeles County, though more children have insurance than adults, as shown in the previous tables, the

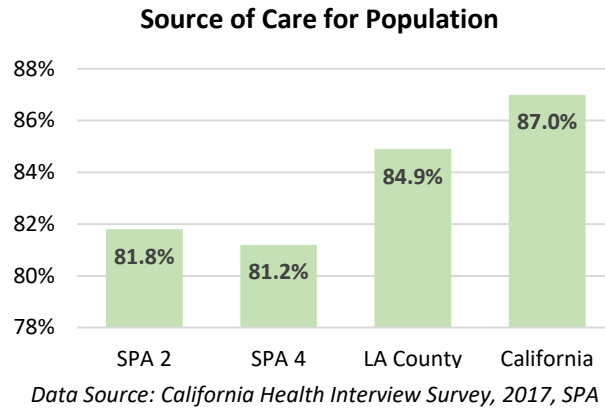
rate of insured lags the state by 1.5%. Among all uninsured in Los Angeles County, 13.1% are white, 5.9% are African American, 10.9% are Asian, and a radically disproportionate 68.6% are Latino.

⁵⁹ Medicare, a federal program administered by the Centers for Medicare & Medicaid Services (CMS), provides health insurance for people age 65 or older, those under age 65 with certain disabilities or ALS (amyotrophic lateral sclerosis, or Lou Gehrig’s disease), and people of any age with End-Stage Renal Disease (kidney failure requiring dialysis or a kidney transplant).⁵⁹ Medicare provides insurance through various parts, including insurance for inpatient hospital, skilled nursing facility, and home health services; coverage for physician services, outpatient hospital services, durable medical equipment, and certain home health services; health plan options are provided by Medicare-approved private insurance companies (e.g., HMOs, PPOs); and insurance coverage for prescription drugs. Please see State of California Department of Health Care Services (2012). Medi-Cal’s Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden, Sacramento, CA. Available at <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf>. Accessed [May 25, 2019].

⁶⁰ The Healthy Families Program offers low-cost insurance that provides health, dental, and vision coverage to children who do not have insurance or who do not qualify for no-cost Medi-Cal. Please see California Department of Health Care Services (2014). The Healthy Families Program Transition to Medi-Cal Final Comprehensive Report. Sacramento, CA. Available at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCHFP.PDF>. Accessed [May 25, 2019].

Source of Care

Most people rely on a visit to a doctor’s office for their specific medical care needs. In fact, based on data from the California Health Interview Survey (2017), over half (59.2%) of California residents have a doctor’s office/HMO or Kaiser Permanente as their source of medical care; the rate among Los Angeles residents is 5% lower. More so than California residents (25.7%), approximately 28% of L.A. County residents visit a community clinic, government clinic or community hospital. Another 2.4% rely on emergency room or urgent care. Still, a significant proportion of L.A. County residents have no source of care at all (15.1%).



Los Angeles County trails the rest of California in residents who have a regular source of care. In service planning areas of Los Angeles County that include AHGL’s service area, rate of residents with a regular source to primary care is lower than both Los Angeles County (84.9%) and the State (87%).⁶¹ The AHGL service area rate (79.5%) trended even lower in 2015.

Larger differences emerge within the population itself as well. Los Angeles County residents appear to lag their counterparts in California in source of care. Regardless of age group, the percentage of residents who had a consistent source of care was higher in California than all of Los Angeles County. For residents below 65 years of age, the Service Planning Areas 2 and 4 that also serve AHGL’s target populations were on the lower end of the range among all SPAs within the County. For residents 65 and over, Service Planning Area 2 and 4 were split between the low and high end of the range which were 84.8% and 96.4% respectively.

Consistent Source of Care by Age

Report Area	Ages 0-17*	Ages 18-64	Ages 65+*
SPA 2 – San Fernando Valley	81.5%	78.9%	96.4%
SPA 4 – Metro	89.1%	77.4%	84.8%
SPA Range	SPA 7: 78.5%	SPA 7: 76.6%	SPA 4: 84.8%
	SPA 6: 97.1%	SPA 1: 87.5%	SPA 5: 96.8%

⁶¹ Source: California Health Interview Survey, 2017

Report Area	Ages 0-17*	Ages 18-64	Ages 65+*
Los Angeles County	88.9%	81.6%	93.9%
California	90.5%	83.7%	95.5%

*Data Source: California Health Interview Survey, 2017, SPA * statistically unstable*

These trends are not dissimilar to the findings in the Los Angeles County Health survey from 2015. As shown in the chart, the percentage of adults who lacked a consistent source of primary care was lower in Los Angeles County (19.7%) when compared to the AHGL service area (20.5%).

Lack of a Consistent Source of Primary Care among Adult Population

Report Area	Percentage
SPA 2–San Fernando Valley	18.6%
SPA 4–Metro	23.0%
AHGL Service Area	20.5%
Los Angeles County	19.7%

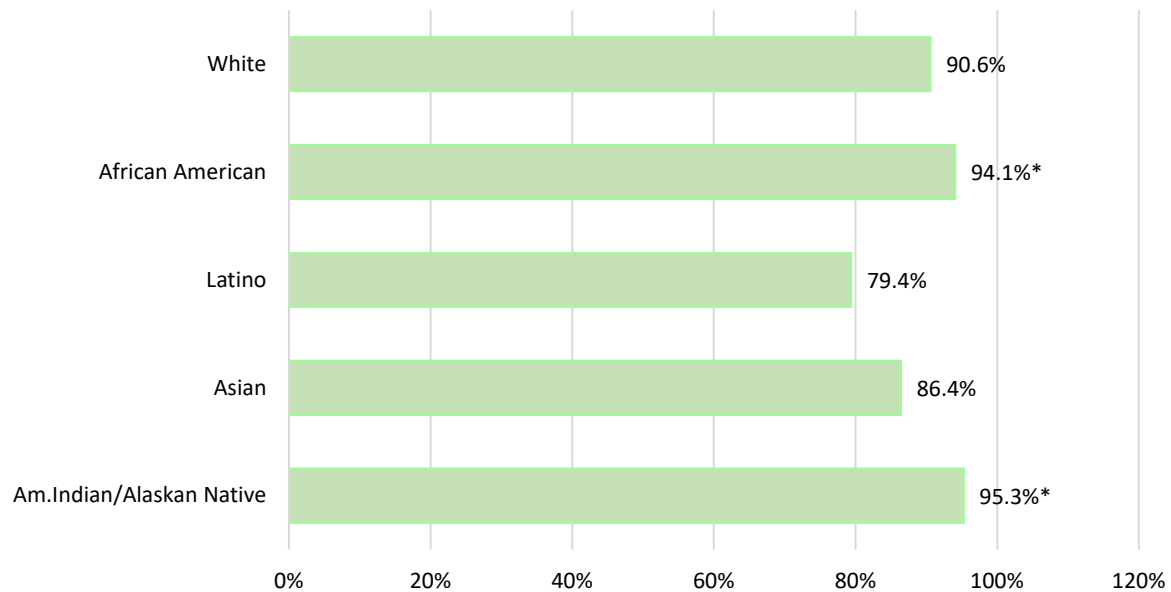
Data Source: Los Angeles County Health Survey, 2015. SPA

Subpopulation Disparities to Access

Without access to primary care providers and other preventive care services, individuals and families would rely more heavily on hospitalizations and emergency care, both of which are more costly. By looking at not only the rates of access to regular sources of care but also the disparities in these rates, hospitals and health care organizations may identify subpopulations in greater need and develop culturally sensitive strategies in their outreach programs.

Populations that are ethnically American Indian/Alaskan Native, Black, and White appeared to have the highest access rates to usual care, at 95.3%, 94.1%, and 90.6% respectively. These county residents had a usual place to go when sick or needed health advice that included the doctor’s office, community clinic, as well as the emergency room/urgent care or some other place. Latino (79.4%) and Asian populations (86.4%) had significantly less access to care.

Access to Care by Ethnicity



Data Source: California Health Interview Survey, 2017, County * statistically unstable

In terms of age distribution, individuals between the ages of 25 and 29 reflect the smallest proportion of the population with a regular source of care (74.8%). Residents of Los Angeles County between the ages of 18 and 24 (78.8%) and 30 to 39 years old (76.9%) exhibit low rates in regular source of compared to age groups with older segment of the population.

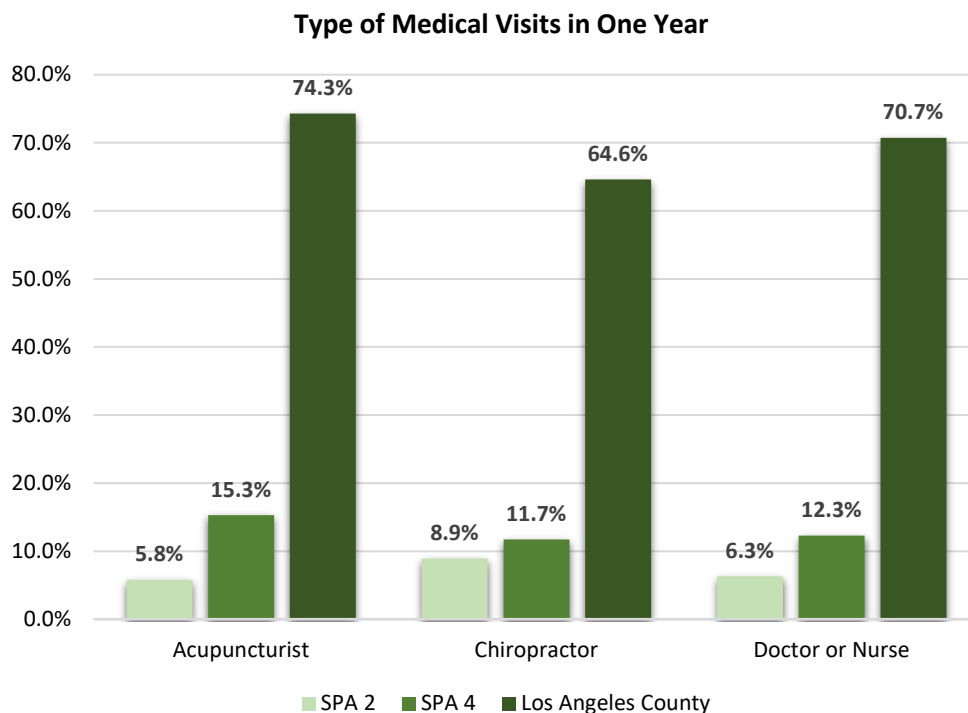
Have Regular Source of Care

Age Group	Percent
18-24 years old	78.8%
25-29 years old	74.8%
30-39 years old	76.9%
40-49 years old	81.4%
50-59 years old	87.5%
60-64 years old	93.3%
65+ years old	93.9%

Data Source:: California Health Interview Survey, 2017,
County

Type of Care

Residents in Los Angeles County were open to different forms of care, from a visit to a doctor, nurse or other primary care professional to acupuncturists and chiropractors. Over 70% of county residents, and above that average in Service Planning Area 2 (74.3%), visited a doctor, nurse or primary care professional for any reason within one year. Approximately 12.3% and 6.3% of residents visited a chiropractor or an acupuncturist, respectively. While a greater proportion of residents in Service Planning Area 4 visited acupuncturists (8.9%) than L.A. County residents, a larger proportion of residents in Service Planning Area 2 visited a chiropractor (15.3%) than county residents (12.3%). Service Planning Area 5, had the highest rate among all Service Planning Areas in all three categories: acupuncturist (10.3%), chiropractor (17.6%) and doctor or nurse (81.6%). Among the AHGL's service areas, Glendale had some of the highest rates in the county for medical visits across all categories- 10.3% for acupuncture, 14.8% for chiropractor and 82.7% for doctor or nurse.



Data Source: Los Angeles County Health Survey, 2015, SPA

Barriers to Care

Many factors can impede residents from accessing medical care, from supply of medical care professionals to cost of care, language barriers, and even transportation.

First, having enough medical professionals to serve the population is critical particularly in vulnerable communities or for certain medical care specialties where the supply may be limited. In Los Angeles County, the ratio of a primary care physician to residents served is 1 to 1,390. California as a whole offers more access to primary care doctors with a ratio of 1 to 1,280. The county has slightly more access to mental health professionals and slightly less access to dentists than statewide, as shown in the table below.

Supply of Health Professionals

Report Area	Primary Care:	Dentist:	Mental Health:
	Population to primary care physician ratio	Population to dental provider ratio	Population to mental health provider ratio
Los Angeles County	1,380:1	1,180:1	320:1
California	1,270:1	1,200:1	310:1

Data Source: County Health Rankings, 2019, County

Within Service Planning Areas 2 and 4, access to primary care and specialty care had more barriers than in Los Angeles County as a whole, as shown in the table below. About a quarter of adults (24.6%) in the AHGL service area had difficulty accessing medical care; slightly higher than Los Angeles County (23.6%). Specifically, a larger percentage of adults in SPA 4-Metro (28.6%) had difficulty accessing medical care overall. Furthermore, at least one out of ten children between the ages of 0 and 17 in the AHGL service area (11.6%) had difficulty accessing medical care. Children in SPA 2 had a significantly greater challenge in access than their counterparts in neighboring SPA 4.

Challenges to Accessing Medical Care

Report Area	Difficulty Finding Primary Care, Adults (1)	Difficulty Finding Specialty Care, Adults (1)	Adults (Age 18+) (2)	Children (Age 0-17) (2)
SPA 2–San Fernando Valley	6.7%	14.2%	21.6%	9.4%
SPA 4–Metro	5.4%	13.3%	28.6%	14.5%
AHGL Service Area	NA	NA	24.6%	11.6%
Los Angeles County	5.0%	11.5%	23.6%	11.0%

Data Source: (1) California Health Interview Survey (2017) & (2) Los Angeles County Health Survey (2015), SPA

Delays in care may also occur because of a lack of insurance or unaffordability of care, because the hours of available services were not convenient, or for other reasons. Residents in Service Planning Area 2 and 4 delayed care or did not get care at higher rates than the residents in Los Angeles County (9.5%). Their rate of delay due to a lack of insurance (47.1% and 55.3% respectively) was also greater than the rate of all residents in Los Angeles County (46%). Rates in delaying or not getting prescription medications were split in the represented Service Planning Areas with SPA 2 residents reporting 7.4%, SPA 4 residents reporting 9.0% and LA County residents reporting 8.2%.

Report Area	Delayed care due to cost or lack of insurance	Delayed or Didn't Get Medical Care in the Past 12 Months	Delayed or Didn't Get Prescription Meds in the Past 12 Months
SPA 2–San Fernando Valley	47.1%	10.2%	7.4%
SPA 4–Metro	55.3%	10.5%	9.0%
Los Angeles County	46.0%	9.5%	8.2%
California	45.6%	10.3%	8.5%

Data Source: California Health Interview Survey, 2017, SPA

Other factors such as language isolation or lack of transportation may also impact residents' ability to access care. In comparison to Los Angeles County, residents of SPA 4 (where language barriers are higher) had a greater difficulty understanding their doctor (3.8%) and having transportation to access care (9.7%). By contrast, residents of SPA 2 (where language barriers are lower) had moderately fewer challenges in understanding their doctor (3.6%) and having transportation to access care (7.4%).⁶²

Emergency Department Access

Over one in five residents in Los Angeles County visited the emergency department within one year. The rate of ER access was higher for residents in Service Planning Area 2 than Service Planning Area 4. Across all geographic regions, residents 65 and older frequented the ER in greater numbers than their younger counterparts. A quarter of L.A. County residents with income 100% below the Federal Poverty Level also frequented the ER, though the rate of visits by residents in Service Planning Area 2 was significantly elevated (44.8%).

Emergency Department Usage

	Visited ED in last 12 months	0-17 years old	18-64 years old	65 and older	<100% FPL
Service Planning Area 2- San Fernando	25.8%	26.3%	25.2%	27.7%*	44.8%
Service Planning Area 4- Metro	16.3%	15.6%*	15.4%	21.2%*	9.4%*
Los Angeles County	21.7%	18.9%	22.1%	25.0%	25.1%
California	20.6%	18.0%	21.0%	23.6%	26.0%

Data Source: California Health Interview Survey, 2017, SPA

⁶² Source: California Health Interview Survey, 2014 and 2017

HEALTH NEED PRIORITY 4: CARDIOVASCULAR DISEASES

Cardiovascular Diseases

Cardiovascular disease—also called heart disease and coronary heart disease—includes several health conditions related to plaque buildup in the walls of the arteries, or atherosclerosis. As plaque builds up, the arteries narrow, restricting blood flow and creating the risk of heart attack. **According to the American College of Cardiology, “coronary events, in the United States in 2019, are expected to occur in about 1,055,000 individuals, including 720,000 new and 335,000 recurrent coronary events.”**⁶³ In addition to being one of the leading causes of death in the United States, heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.⁶⁴

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 in childhood, high cholesterol, congenital heart defects, diabetes, heart attack, heart failure, high blood pressure, HIV, heavy alcohol consumption, metabolic syndrome, obesity, pericarditis, peripheral artery disease (PAD), and stroke.⁶⁵

The leading risk factors for heart disease are high blood pressure, high cholesterol, smoking, diabetes, poor diet, physical inactivity, and overweight and obesity. The toxic stress of adverse childhood experiences (ACEs) is linked to cardiovascular disease and related risk behaviors.⁶⁶ Cardiovascular disease is closely linked with and can often lead to stroke.

Prevalence and Management

In Los Angeles County, the rate of adults diagnosed with heart disease has increased moderately each year, from 5.4% in 2015 to 5.6% in 2016 and 6.6% in 2017. This trend is more pronounced in Service Planning Area 4, Metro, where the diagnosis rate in 2015 was 2.6%, and the change in rate was +3.8% in 2016, and an additional +0.5% in 2017. Within the county, White populations had a nearly one in 10 rate of heart disease (9.5%), with comparable rates among Black populations (8.2%) and lower rates for Latino (5.6%) and Asian populations (2.8%).

A large percentage of the population in SPA 2—San Fernando (94.7%) received assistance from a care provider to manage their disease. The rate is higher than that in Los Angeles County by an 18% margin. Among diagnosed adults managing their condition, more than half in the county (53.5%) were confident they could control their condition. Approximately 94.5% in SPA 4- Metro were either confident or

⁶³ Heart Disease and Stroke Statistics-2019 Update: A Report From the American Heart Association. *Circulation* 2019;Jan 31. Benjamin EJ, Muntner P, Alonso A, et al. Available at <https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2019/02/15/14/39/aha-2019-heart-disease-and-stroke-statistics>. Accessed [May 26, 2019]

⁶⁴ Ibid

⁶⁵ 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 [May 26, 2019].

⁶⁶ American Heart Association, Dec. 18, 2017: https://professional.heart.org/professional/ScienceNews/UCM_498092_Adverse-Childhood-Experiences-Addressing-Health-Disparities-through-Prevention.jsp

somewhat confident about managing their condition, whereas in SPA 2-San Fernando, this rate was lower (91.9%) and skewed more heavily towards those exhibiting greater confidence (67.9%). Approximately 9% in Los Angeles County felt no confidence in managing their heart disease diagnosis. This rate is significant given that there is estimated to be approximately 512,000 adults in the county with heart disease.

Heart Disease Indicators					
Report Area	Heart Disease Prevalence	Heart Disease Management Plan	Confidence Level to Control Condition (1) *		
	Percentage	Percentage	Very Confident	Somewhat Confident	Not Confident
	SPA 2–San Fernando Valley	6.2%	94.7%*	67.9%	24.0%
SPA 4–Metro	7.8%*	63.1%	45.1%	49.4%	5.5%
Los Angeles County	6.6%	76.3%	53.5%	37.5%	9.0%

Data Source: California Health Interview Survey (CHIS), 2017 and (1) 2016, SPA * statistically unstable

Hospitalizations

For heart failure and hypertension, the emergency room visit rates for the AHGL service area were 6.0% and 33.6%, respectively. The highest rates for Chronic Obstructive Pulmonary Disease, heart failure, and hypertension were found in Glendale: Zip Code 91204 and 91205 had the highest COPD rates, while Zip Code 91203 carried the highest rates for both heart failure (11.2) and hypertension (50.7).

Emergency Room Visits per 10,000 Persons

City	ZIP Code	Average Annual Age Adjusted Rate		
		COPD	Heart Failure	Hypertension
Eagle Rock	90041	10.1	5.4	32.3
Highland Park	90042	9.7	5.6	24.6
Glassell Park	90065	5.9	5.5	28.8
Montrose	91020	7.3	NA	24.8
Glendale	91201	6.3	7.2	31.3
Glendale	91202	5.3	5.6	48.2

City	ZIP Code	Average Annual Age Adjusted Rate		
		COPD	Heart Failure	Hypertension
Glendale	91203	7.6	11.2	50.7
Glendale	91204	19.8	6.3	52
Glendale	91205	14.1	5.1	36
Glendale	91206	4.5	4.6	23.8
Glendale	91207	6.9	3.0	19.5
Glendale	91208	7.3	3.5	15.2
AHGL Service Area		8.7	6.0	33.6

Data Source: California Department of Public Health 2013-2015, ZIP Code

Mortality

A higher heart disease mortality rate per 100,000 persons was reported in SPA 2 service area (574.4) than in SPA 4 (552.3). Neither SPA that serves the AHGL community falls on the high or low end of the range.

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

Report Area	Rate
SPA 2—San Fernando Valley	574.4
SPA 4—Metro	552.3
Lowest Rated SPA—SPA 5	483.3
Highest Rated SPA- SPA 6	726.6

Data Source: California Department of Public Health (CDPH), 2016, SPA

Cholesterol Prevalence and Management

Some health conditions, as well as lifestyle and genetic factors, can put people at a higher risk for developing high cholesterol. Age is a contributing factor; as people get older, cholesterol level tends to rise. Diabetes can also lead to the development of high cholesterol. Some behaviors can also lead to high cholesterol, including a diet high in saturated fats, trans-fatty acids (trans fats), dietary cholesterol, or triglycerides. Being overweight and/or physically inactive can also contribute to high cholesterol.

A quarter (25.2%) of the population in the AHGL service area were diagnosed with high cholesterol. Among individuals with cholesterol, two thirds (66.8%) in the AHGL service area received disease

management services for their condition. The population in the AHGL service area had similar rates in cholesterol prevalence and management as the population in Los Angeles County.

Cholesterol Indicators		
Report Area	Cholesterol Prevalence	Cholesterol Management
	Percentage	Percentage (1)
SPA 2–San Fernando Valley	24.9%	68.0%
SPA 4–Metro	25.7%	65.1%
AHGL Service Area	25.2%	66.8%
Los Angeles County	25.2%	68.7%

Data Source: Los Angeles County Health Survey, 2015 and (1) California Health Interview Survey, 2014, SPA

Hypertension Prevalence and Management

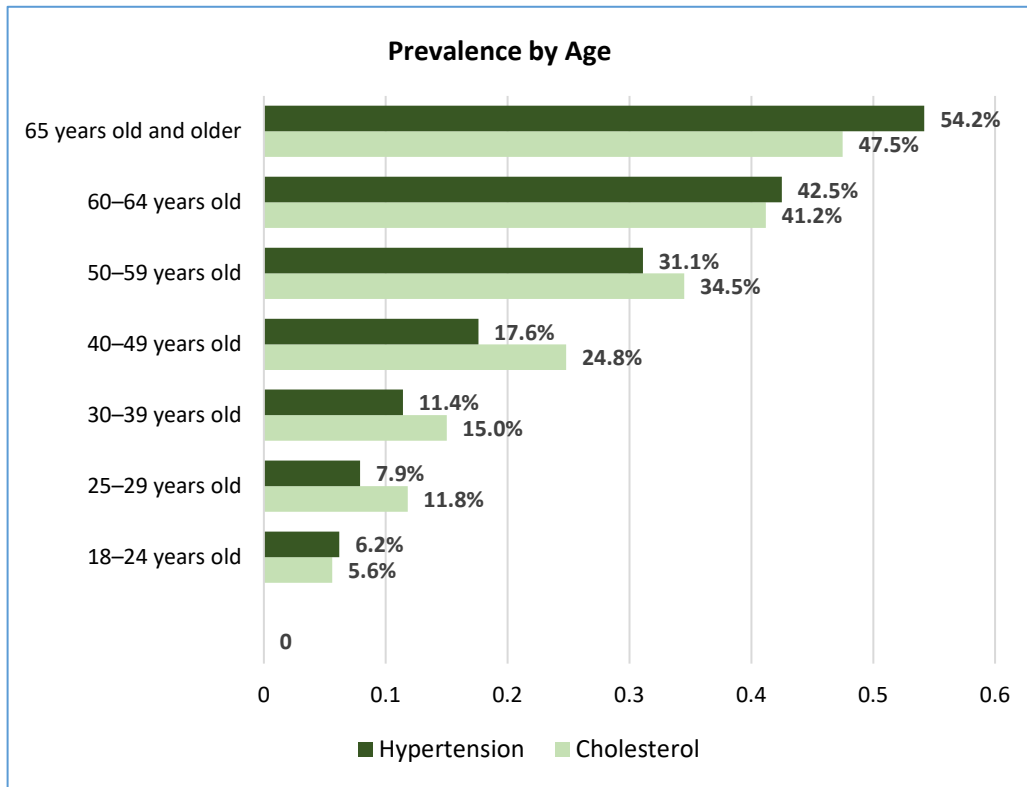
One of the leading risk factors for cardiovascular disease is high blood pressure. Smoking, obesity, the regular consumption of salt and fat, excessive drinking, and physical inactivity are risk factors for hypertension. People who have previously had a stroke, have high cholesterol, or have heart or kidney disease are also at higher risk of developing hypertension.

The populations in Service Planning Areas 2 and 4 are slightly less prone to hypertension (29.9% and 24.4%) than in Los Angeles County overall (30.0%). In these SPAs, more than seven out of ten with high blood pressure took medication to control their high blood pressure, while in the county, a larger proportion of the population managed the condition with medication (72.6%).

Indicators of High Blood Pressure		
Report Area	Prevalence	Management
SPA 2–San Fernando Valley	29.0%	71.6%%
SPA 4–Metro	24.4%*	71.3%*
SPA Range	SPA 5: 22.5%	SPA 5: 63.9%*
	SPA 7: 34.4%	SPA 6: 78.2%*
Los Angeles County	30.0%	72.6%

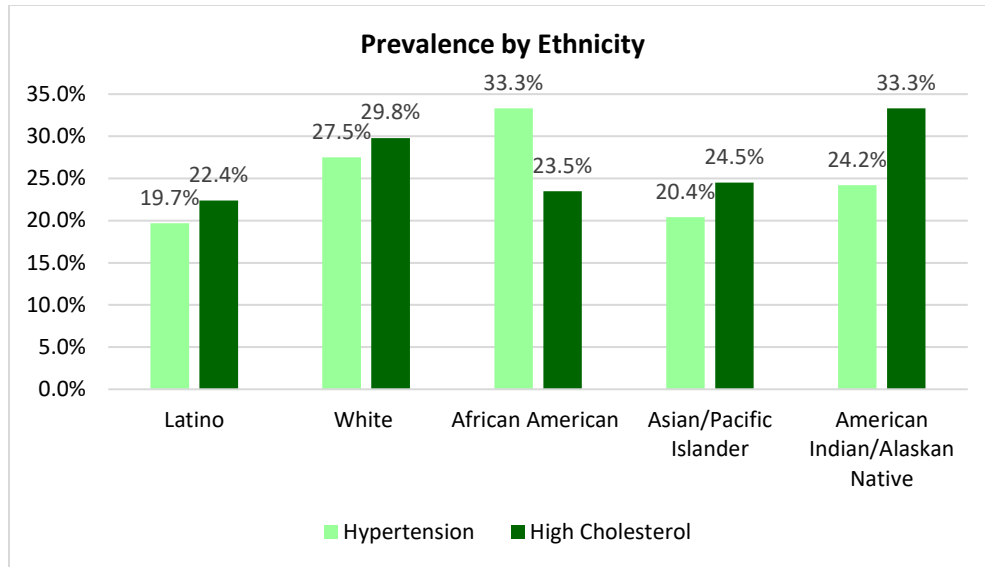
Data Source: California Health Interview Survey, 2017, Los Angeles County
Health Survey (1) 2015 (2) 2014, SPA

Elevated risks of cardiovascular disease are associated with high cholesterol prevalence and hypertension.⁶⁷ In general, younger populations were afflicted more by cholesterol than hypertension,



while the older population group (65 and older) had proportionately more hypertension (54.2%) than cholesterol (47.5%) cases. As early as age 25, at least 11.8% of people suffered high cholesterol. That rate and their risk for cardiovascular disease more than double by the time they reached 40-49 and tripled at 50-59 years of age. As expected, however, the two oldest population groups had the highest rates in both health categories, demonstrating an increasing rate with age.

⁶⁷ Centers for Disease Control and Prevention. High Blood Pressure and Cholesterol <http://www.cdc.gov/vitalsigns/cardiovascular-disease/> Accessed [May 26, 2019].



Data Source: Los Angeles County Health Survey, 2015, County

Regardless of ethnic background, at least one in four in Los Angeles County’s population faced hypertension and even more faced high cholesterol (at least 22.5%). Among the various ethnic groups, the Latino population appears to exhibit the least risk in both hypertension (19.7%) and cholesterol (22.4%). African American populations had the highest prevalence in hypertension (33.3%) while American Indian/Alaskan Native populations exhibited the highest proclivity to cholesterol among all ethnic groups. The White population was equally highly impacted by both risk factors, with 27.5% showing signs of hypertension, and 29.8% having high cholesterol.

Mortality from Heart Disease

Based on complications of heart disease, the age-adjusted death rate from coronary heart disease ranged between 87.7 and 148.4 per 100,000 persons in the Service Planning Areas of Los Angeles County. The age adjusted death rate from stroke ranged in the Service Planning Areas between 27.6 and 40.4 per 100,000 persons. Service Area Planning Area 2 was at the lower end of the range.

Age-Adjusted Death Rate by 100,000 persons in Heart Disease

Report Area	Coronary Heart Disease	Stroke
SPA 2–San Fernando Valley	118.5	28.5
SPA 4–Metro	116.5	31.5
SPA Range	SPA 1: 148.4 SPA 5: 87.7	SPA 6: 40.4 SPA 5: 27.6

Data Source: California Department of Public Health, 2016, SPA

HEALTH NEED PRIORITY 5: PREVENTIVE WELLNESS

Preventive Wellness

Preventive wellness involves keeping healthy and preventing health problems from getting worse. Good health practices include access to mental and medical care and timely physical and medical tests. Adequate, regular primary care can prevent the development of health problems and maintain positive health conditions. Preventive wellness also includes a healthy diet, activity level, sleep, and stress management, all of which have profound effects on our physical health. Health care providers can make a significant contribution to preventive wellness through trauma informed care.⁶⁸

Medical Prevention: Health Check-Ups

As examined in greater detail in Module 5 of this report, medical access and continuity of care help to treat a medical condition before complications and medical costs multiply. An annual check-up is the first step towards proactively preventing and managing health conditions. As shown in the chart below, the rate at which Los Angeles County residents visited a doctor, nurse, or other health care professional within one year was 70.7%, which suggests that 29.3%, or nearly a third of the population, did not receive such care. In SPA 2-San Fernando Valley, 74.3% of the population visited a doctor, nurse, or other health professional; this rate was slightly better than the county rate.

The percentage of residents in the AHGL service area who visited a doctor, nurse, or other health care professional was about the same (70.1%) as the county rate. Conversely, a higher percentage of individuals residing in the AHGL service area visited a dentist or a dental clinic (62.8%) than in Los Angeles County as a whole (59.3%). The gap in care between medical and dental is significant, with fewer residents in L.A. County and AHGL service area accessing dental care.

Visited Health Care Professional in Past Year

Report Area	Saw Doctor, Nurse, or Other Health Care Professional in the Past Year	Saw Dentist or Visited Dental Clinic in the Past Year
SPA 2–San Fernando Valley	74.3%	65.1%
SPA 4–Metro	64.6%	59.7%
AHGL Service Area	70.1%	62.8%
Los Angeles County	70.7%	59.3%

Data Source: Los Angeles County Health Survey, 2015, SPA

⁶⁸ SAMHSA 2016: Key Ingredients for Successful Trauma-Informed Care Implementation: https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Medical Prevention: Immunizations and Vaccines

Over the past decade, an anti-vaccination movement based on bogus facts and science eroded public confidence in childhood immunizations. When Disneyland faced a measles outbreak in 2014, the California legislature took action and eliminated exemptions based on religious or personal beliefs that allowed children to skip their immunizations to attend public school. Since that time, immunizations for children have trended higher such that 95% of children in Los Angeles County met all required immunizations for the 2017-2018 school year.⁶⁹

Influenza and pneumonia have been a top ten leading cause of death in Los Angeles County with an age adjusted death rate of 22.3 per 100,000 persons compared to the California rate of 16.3 per 100,000 persons.⁷⁰ Even though over 2,125 people died from influenza and pneumonia, a benchmark for this cause of death was not identified in the Healthy People 2020 Objective. Within the County population, seniors and youth under 18 receive the highest rates of vaccination--- the senior flu vaccination rate moderately trails the state (69.3%), and children’s flu vaccination rate is significantly higher than the state by +4.8%. In addition, fewer pneumonia vaccinations (62.0%) are administered among seniors than flu vaccinations, though higher vaccination rates in Service Planning Area 2 and 4 means that nearly two-thirds of the senior population are vaccinated.

Vaccination by Age

Report Area	Flu Vaccination			Pneumonia Vaccination (1)
	0-17 Years Old	18-64 Years Old	65+ Years Old	65+ Years Old
SPA 2–San Fernando Valley	48.4%	35.5%	74.0%	65.0%
SPA 4–Metro	69.1%*	35.4%	63.2%*	65.8%
Los Angeles County	54.4%	34.3%	67.4%	62.0%
California	49.6%	37.7%	69.3%	NA

Data Source: California Health Interview Survey, 2017 and (1) Los Angeles County Health Survey, 2016, SPA

Preventable Hospitalizations

With immunizations and vaccinations, the need for hospitalization for influenza and pneumonia may be mitigated or altogether prevented. Although not all such hospitalizations can be avoided, admission rates in populations and communities can vary depending on access to primary care, care-seeking behaviors, and the quality of care available. Because hospitalization tends to be costlier than outpatient or primary care, potentially preventable hospitalizations often are tracked as markers of health system

⁶⁹ California Department of Public Health.

<https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/2017-2018KindergartenSummaryReport.pdf> Accessed [May 26,2019]

⁷⁰ Source: California Department of Public Health, Center for Health Statistics and Informatics, 2015 County Health Status Profiles, 2015, County. Please note that data is 3-year average for 2011-2013.

efficiency. The number and cost of potentially preventable hospitalizations also can be calculated to help identify potential cost savings associated with reducing these hospitalizations overall and for specific populations.⁷¹

The age-adjusted hospitalization rate due to immunization—preventable pneumonia or influenza for adults per 10,000 for individuals age 65 and over ranged between 1.3 and 3.1 for the reported AHGL service areas. In particular, ZIP code 91205-Glendale (3.1) appeared to have the highest rate in comparison to the other reported AHGL service areas.

**Hospitalization Rate Due to Immunization-
Preventable Pneumonia and Influenza Age 18+**

City	ZIP Code	Rate
Eagle Rock	90041	2.5
Highland Park	90042	1.3
Glassell Park	90065	1.8
Montrose	91020	---
Glendale	91201	2.6
Glendale	91202	1.9
Glendale	91203	---
Glendale	91204	---
Glendale	91205	3.1
Glendale	91206	2.2
Glendale	91207	---
Glendale	91208	---

*Data Source: California Office of Statewide Health Planning and Development OSHPD Patient Discharge Data, 2013-2015, ZIP Code*⁷²

Medical Prevention: Cancer Screenings

With new technological developments, different forms of cancer screenings have been gaining traction. The colorectal cancer screening was benchmarked at 70.5% in the Healthy 2020 Objective, and more benchmarks will likely emerge as new screening tests become standard practice. However, statistical measurements in this area appear to not be publicly available with only a 2008-2010 model estimate available for Los Angeles County that measured the rate at which patients of any ethnicity over 50 years of age had a colorectal endoscopy or took a home-based fecal occult blood test over a two year period or over. This rate was 55.1% for the County while a more recent figure for California was had the screening rate at 75.9%.⁷³

⁷¹ <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a23.htm>

⁷²

<https://www.thinkhealthla.org/index.php?module=indicators&controller=index&action=view&indicatorId=148&localeId=6278>
Accessed [May 27, 2019]

⁷³ Source: For California, 2016 BRFSS Survey Data collected by the Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Centers for Disease Control and Prevention. For LA County, 2008-2010 County Level Modeled Estimate Combining BRFSS & NHIS).

In women’s health, gendered cancer screenings have become standard practice. Mammogram screenings among women 30 years and older over a two-year period were moderately higher in Los Angeles County (78.2%) than the state (76.1%). The county rate had increased by a 17% margin from 5 years earlier, but failed to meet the 81.1% benchmark set in Healthy People 2020 Objective. A breakdown by Service Planning Area offered a mixed picture with Service Planning Area 2 having a rate (85.6%) close to the highest rated SPA, while Service Planning 4 was, in fact, the lowest rated SPA in the County. Pap smear screening rates were higher with 84.4% of women in Los Angeles County screened, though similar to the mammogram rate, offered a mixed picture at the Service Planning Area level.

Women’s Health Screenings

Report Area	Mammogram Rate	Pap Smears Rate (1)
SPA 2–San Fernando Valley	85.6%*	88.2%
SPA 4–Metro	71.5%*	78.4%
Highest Rated SPA	SPA 6: 86.6%	SPA 1: 89.3%
Los Angeles County	78.20%	84.4%
California	76.10%	NA

Data Source: California Health Interview Survey, 2016, and (1) Los Angeles County Health Survey, Los Angeles County Department of Public Health 2015, SPA

Nutrition and Healthy Activities

With regard to healthy nutrition, 69.6% of children and teens ate five or more servings of fruits and vegetables within a day in Los Angeles County.

Nutrition

Report Area	Fruit Consumption: 2 or more servings per day	Fruit or Vegetable Consumption: Five or More Servings in Past Day		Fast Food Consumption 3 or more Times per Week (1)	
	17 and Under	Children	Teen	Total Population	17 and Under
SPA 2–San Fernando Valley	69.7%	32.0%	25.2%*	28.1%*	22.5%
SPA 4–Metro	66.6%	26.6%*	--	22.9%	21.2%*
Los Angeles County	69.6%	24.6%	32.4%	28.0%	22.4%
California	66.9%	26.7%	25.6%	25.0%	23.4%

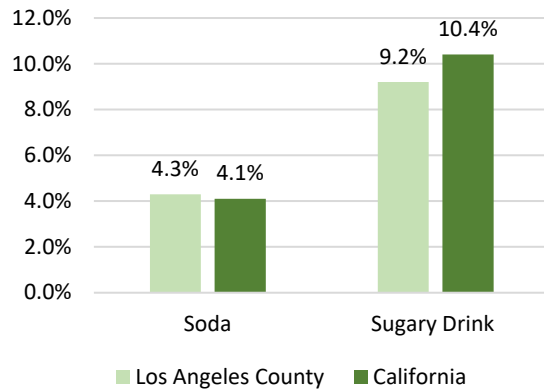
Data Source: California Health Interview Survey, 2017 and (1) 2016, SPA

The reverse of this trend appears in Service Planning Area 2. More than two thirds of youth consumed at least two fruits per day, but a greater proportion of teens in Los Angeles County (69.6%) consumed more than all teens in California (66.9%). With regards to unhealthy food consumption, almost one in five youth (0-17) consumed fast food at least three times per week within Los Angeles County (22.4%) and California (23.4%).

With regard to soda consumption, over a quarter of adults in Los Angeles County (25.1%) consumed at least two or more sodas per week, a rate not too dissimilar to the State rate of 24.1%.⁷⁴

Among youth under 18 in California, at least one in ten consumed two or more sugary drinks per day, or the equivalent of at least 14 drinks per week. The rate was slightly lower among Los Angeles County Youth. Soft drinks were less favored by this population with only 4.1% in California and 4.3% in Los Angeles County consuming soft drinks regularly at least twice per day.

Consumption (2 or more per day) by Youth under 18



With regard to physical activity, more than three quarters of children in Los Angeles County engaged vigorous physical activity at least three times per week. The rate was higher in Service Planning Areas 2 (80%) and 4 (88.3%). Similarly, more than eight out of 10 children visited a park, playground, or open space in all reported geographic areas. The proportional differences among these areas were nominal.

Rates of no physical activity per week among children and teens were significantly higher at the state level (8.3% of children and 9.2% of teens) than the county level. At 4.3%, the county had nearly half the rate of child inactivity of the state.

⁷⁴ California Health Interview Survey, 2017

Physical Activity

Report Area	Vigorous Physical Activity at Least 3 Days per Week	No Physical Activity per Week	No Physical Activity/Week (1) *	Youth Visited Park/Playground /Open Space*
	Child	Child	Teen	17 and Under
	SPA 2–San Fernando Valley	80.0%	-	-
SPA 4–Metro	88.3%	-	33.7%	86.5%
Los Angeles County	77.2%	4.3%	6.1%	83.3%
California	78.3%	8.3%	9.2%	83.9%

Data Source: California Health Interview Survey, 2017 and (1) 2016, SPA * statistically unstable

HEALTH NEED PRIORITY 6: STROKE PREVENTION

Stroke Prevention

A stroke occurs when a blood clot or burst blood vessel inhibits blood supply to the brain. Cardiovascular disease is closely linked with and can often lead to stroke. Generally, stroke can cause five types of disabilities: paralysis or problems controlling movement; sensory disturbances including pain; problems using or understanding language; problems with thinking and memory; and emotional disturbances.⁷⁵

You can't control some stroke risk factors, like heredity, age, gender, and ethnicity. Some medical conditions—including high blood pressure, high cholesterol, heart disease, diabetes, overweight or obesity, and previous stroke or transient ischemic attack (TIA)—can also raise your stroke risk. Avoiding smoking and drinking too much alcohol, eating a balanced diet, and getting exercise are all choices you can make to reduce your risk.⁷⁶

The leading risk factors for heart disease are high blood pressure, high cholesterol, smoking, diabetes, poor diet, physical inactivity, and overweight and obesity. The toxic stress of adverse childhood experiences (ACEs) is linked to cardiovascular disease, stroke, and related risk behaviors.⁷⁷

People who have previously had a stroke, have high cholesterol, or have heart or kidney disease are also at higher risk of developing hypertension. In addition, oral health conditions such as periodontal (gum) disease have been linked to heart disease and stroke, as well as diabetes and premature, low-weight births.⁷⁸

Improvement in cardiovascular health and quality of life is achieved through prevention, detection and treatment of risk factors for heart attack and stroke, early identification and treatment of heart attacks and strokes, and prevention of repeat cardiovascular events. Strategies include stroke risk assessment activities, such as increasing the proportion of adults who have had their blood pressure measured within the preceding two years, and access to stroke support groups, stroke awareness, and clinical services.

Prevalence

According to the Centers for Disease Control, someone in the United States has a stroke every 40 seconds. Every four minutes, someone dies of stroke. Every year, about 795,000 people in the United States have a stroke. About 610,000 of these are first or new strokes; 185,000 are recurrent strokes. Stroke is an important cause of disability. Stroke reduces mobility in more than half of stroke survivors age 65 and over. Stroke costs the nation \$34 billion annually, including the cost of health care services, medications, and lost productivity.

Between 2000 and 2010, the relative rate of stroke deaths dropped by 35.8% in the United States. However, each year stroke affects nearly 800 000 individuals, with many survivors experiencing

⁷⁵ National Institute of Neurological Disorders and Stroke. Available at <https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Post-Stroke-Rehabilitation-Fact-Sheet>

⁷⁶ Centers for Disease Control. Available at: https://www.cdc.gov/dhbsp/data_statistics/fact_sheets/fs_stroke.htm

⁷⁷ American Heart Association, Dec. 18, 2017: https://professional.heart.org/professional/ScienceNews/UCM_498092_Adverse-Childhood-Experiences-Addressing-Health-Disparities-through-Prevention.jsp

⁷⁸ Centers for Disease Control and Prevention. Available at <https://www.cdc.gov/diabetes/ndep/pdfs/ppod-guide-dental-professionals.pdf>. Accessed May 27, 2019].

persistent difficulty with daily tasks as a direct consequence. More than two thirds of stroke survivors receive rehabilitation services after hospitalization.⁷⁹

Stroke Awareness

Common Stroke Warning Signs and Symptoms:

- Sudden numbness or weakness of the face, arm, or leg—especially on one side of the body.
- Sudden confusion, trouble speaking or understanding.
- Sudden trouble seeing in one or both eyes.
- Sudden trouble walking, dizziness, loss of balance or coordination.
- Sudden severe headache with no known cause.

Ongoing Medical Care Associated with Stroke

According to a study by the American Stroke Association⁸⁰ in collaboration with other stroke institutes, examples for need of skilled nursing services include (but are not limited to) the following: Bowel and bladder impairment, skin breakdown or high risk for skin breakdown, impaired bed mobility, dependence for activities of daily living (ADLs), inability to manage medications, and high risk for nutritional deficits.

Examples for need of regular contact by a physician include (but are not limited to) the following: Medical comorbidities not optimally managed (e.g., diabetes mellitus and hypertension), complex rehabilitation issues (e.g., orthotics, spasticity, and bowel/bladder), acute illness (but not severe enough to prevent rehabilitation care), and pain management issues

Examples for need of multiple therapeutic interventions include (but are not limited to) the following: Moderate to severe motor/sensory deficits, and/or cognitive deficits, and/or communication deficits.

Mortality from Stroke

The age adjusted death rate from stroke ranged in the Service Planning Areas between 27.6 and 40.4 per 100,000 persons.

Report Area	Coronary Heart Disease	Stroke
SPA 2—San Fernando Valley	118.5	28.5
SPA 4—Metro	116.5	31.5

⁷⁹ AHA Journals: Stroke, 4 May 2016, Vol. 47, No. 6, Winstein et. al., Available at <https://www.ahajournals.org/doi/10.1161/STR.0000000000000098>

⁸⁰ Ibid.

SPA Range	SPA 1: 148.4	SPA 6: 40.4
	SPA 5: 87.7	SPA 5: 27.6

Data Source: California Department of Public Health, 2016, SPA

Over the course of the past seven years, the leading causes of death in the AHGL service area have remained the same though Alzheimer’s has overtaken stroke as the third leading cause with number of cases increasing significantly from 164 in 2010 to 259 in 2016. Heart disease and cancer have proportionately decreased by 1.5-2%, though the number of cases have remained relatively stable.

Leading Causes of Death				
	#1	#2	#3	#4
2010	Heart Disease	Cancer	Stroke	Alzheimer’s
	27.4% (932)	25.3% (859)	6.5% (222)	4.8% (164)
2016	Heart Disease	Cancer	Alzheimer’s	Stroke
	25.9% (938)	23.3% (861)	7.1% (259)	6.5% (234)

Data Source: California Department of Public Health, 2010, 2016, County

Stroke Rehabilitation

According to the American Stroke Association (ASA), stroke – the No. 2 most common cause of death worldwide – is preventable, treatable and beatable. ASA says that 1 in 3 ischemic strokes has an unknown cause. Collaboration by neurologists, cardiologists, electrophysiologists and other integral team members may reveal the answers needed to provide targeted treatment for preventing recurrent strokes.

Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, other caregivers (e.g., personal care attendants), physicians, nurses, physical and occupational therapists, speech-language pathologists, recreation therapists, psychologists, nutritionists, social workers, and others. Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline. Without communication and coordination, isolated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential.⁸¹

Post-stroke rehabilitation involves physicians; rehabilitation nurses; physical, occupational, recreational, speech-language, and vocational therapists; and mental health professionals.⁸²

⁸¹ Ibid.

⁸² National Institute for Neurological Disorders and Stroke. Available at <https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Post-Stroke-Rehabilitation-Fact-Sheet>

HEALTH NEED PRIORITY 7: ONCOLOGY

Cancer Prevention, Identification, and Treatment

Tobacco use is known to cause cancer.⁸³ Additionally, secondhand smoke has been known to cause heart disease and lung cancer in adult.⁸⁴ Smokeless tobacco use such as chewing tobacco can also cause a variety of oral health problems, including cancer of the mouth and gums. In addition, cigar smoking may cause cancer of the larynx, mouth, esophagus, and lung.⁸⁵

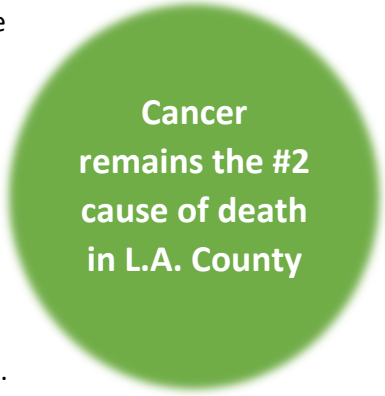
Findings suggest that obesity increases the risks for cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and more.⁸⁶ Heavy alcohol consumption is an important determinant of future cirrhosis and cancers.

Cancer prevention strategies include an increase in the proportion of adults in the service area who receive screenings for cancer, and an increase in the proportion of adults in the service area who receive appropriate care once diagnosed for cancer.

Prevalence

Between 1991 and 2015, the overall rate of death by cancer in the United States fell by 26%. This is attributed to an increase in screenings to detect cancers at a treatable stage and a decline in smoking, which is a leading cause of cancer. However, the U.S. population is aging, and age is a cause of cancer, as is obesity, which is also on the rise.

According to the National Cancer Institute, approximately 38.4% of men and women will be diagnosed with cancer at some point during their lifetimes (based on 2013–2015 data). The most common cancers (listed in descending order according to estimated new cases in 2018) are breast cancer, lung and bronchus cancer, prostate cancer, colon and rectum cancer, melanoma of the skin, bladder cancer, non-Hodgkin lymphoma, kidney and renal pelvis cancer, endometrial cancer, leukemia, pancreatic cancer, thyroid cancer, and liver cancer. Cancer mortality is higher among men than women (196.8 per 100,000 men and 139.6 per 100,000 women). When comparing groups based on race/ethnicity and sex, cancer mortality is highest in African American men (239.9 per 100,000) and lowest in Asian/Pacific Islander women (88.3 per 100,000). Estimated national expenditures for cancer care in the United States in 2017 were \$147.3 billion. In future years, costs are likely to increase as the population ages and cancer



Cancer
remains the #2
cause of death
in L.A. County

⁸³ 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=41>. Accessed [June 4, 2019].

⁸⁴ 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=41>. Accessed [June 4, 2019].

⁸⁵ 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=41>. Accessed [June 4, 2019].

⁸⁶ National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [August 2, 2016].

prevalence increases. Costs are also likely to increase as new, and often more expensive, treatments are adopted as standards of care.⁸⁷

Cancer Screenings

With new technological developments, different forms of cancer screenings have been gaining traction. The colorectal cancer screening was benchmarked at 70.5% in the Healthy 2020 Objective, and more benchmarks will likely emerge as new screening tests become standard practice. However, statistical measurements in this area appear to not be publicly available with only a 2008-2010 model estimate available for Los Angeles County that measured the rate at which patients of any ethnicity over 50 years of age had a colorectal endoscopy or took a home-based fecal occult blood test over a two year period or over. This rate was 55.1% for the County while a more recent figure for California was had the screening rate at 75.9%.⁸⁸

Cancer Screenings and Women’s Health

In women’s health, gendered cancer screenings have become standard practice. Mammogram screenings among women 30 years and older over a two-year period were moderately higher in Los Angeles County (78.2%) than the state (76.1%). The county rate had increased by a 17% margin from 5 years earlier, but failed to meet the 81.1% benchmark set in Healthy People 2020 Objective. A breakdown by Service Planning Area offered a mixed picture with Service Planning Area 2 having a rate (85.6%) close to the highest rated SPA, while Service Planning 4 was, in fact, the lowest rated SPA in the County. Pap smear screening rates were higher with 84.4% of women in Los Angeles County screened, though similar to the mammogram rate, offered a mixed picture at the Service Planning Area level.

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Report Area	Mammogram Rate	Pap Smears Rate (1)
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⁸⁷ National Cancer Institute. Available at <https://www.cancer.gov/about-cancer/understanding/statistics>

⁸⁸ Source: For California, 2016 BRFSS Survey Data collected by the Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Centers for Disease Control and Prevention. For LA County, 2008-2010 County Level Modeled Estimate Combining BRFSS & NHIS).

Cancer Treatments

The National Cancer Institute lists the following array of modalities⁸⁹ used to treat cancer:

- **Surgery:** When used to treat cancer, surgery is a procedure in which a surgeon removes cancer from the patient's body.
- **Radiation therapy:** Radiation therapy is a type of cancer treatment that uses high doses of radiation to kill cancer cells and shrink tumors.
- **Chemotherapy:** Chemotherapy is a type of cancer treatment that uses drugs to kill cancer cells.
- **Immunotherapy:** Immunotherapy is a type of treatment that helps your immune system fight cancer.
- **Targeted therapy:** Targeted therapy is a type of cancer treatment that targets the changes in cancer cells that help them grow, divide, and spread.
- **Hormone therapy:** Hormone therapy is a treatment that slows or stops the growth of breast and prostate cancers that use hormones to grow.
- **Stem cell transplant:** Stem cell transplants are procedures that restore blood-forming stem cells in cancer patients who have had theirs destroyed by very high doses of chemotherapy or radiation therapy.
- **Precision medicine:** Precision medicine helps doctors select treatments that are most likely to help patients based on a genetic understanding of their disease.

Coping with Cancer and Cancer Treatments

According to the National Cancer Institute, the symptoms and side effects of cancer and its treatment may cause certain physical changes, but they can also affect the way you feel and how you live.⁹⁰ This can include feeling overwhelmed, denial, anger, fear and worry, stress and anxiety, sadness and depression, guilt, and loneliness – and also, hope and gratitude. Physical side effects of cancer treatment can include nausea and vomiting, fatigue, cognitive impairment and delirium, pain, gastrointestinal complications, hot flashes and night sweats, and sleeping disorders. Cancer patients commonly feel they have to be strong and protect their friends and families, seek support and turn to loved ones or other cancer survivors, ask for help from counselors or other professionals, and/or turn to their faith to help them cope.

According to the National Comprehensive Cancer Network, sharing about their experience in a support group setting helps individuals understand that others like them are trying to work through the same experiences. Different types of cancer support groups make it possible for a patient or caregiver to find a resource that meets their needs⁹¹, including:

⁸⁹ National Cancer Institute. Available at: <https://www.cancer.gov/about-cancer/treatment/types>

⁹⁰ National Cancer Institute. Available at: <https://www.cancer.gov/about-cancer/coping>

⁹¹ National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org/patients/resources/life_with_cancer/managing_symptoms/support.aspx

- Patient-only. For some people, attending groups without partners can be liberating and allow them to share, and have validated, their feelings and frustrations.
- Patient and Spouse/Caregiver. Alternatively, for some, attending meetings with a partner can strengthen that bond and demonstrate how a commitment to working together can be an added comfort. Meeting with other couples can also be an opportunity to discuss topics common to many partners living with cancer, including frustration and fear of loss.
- Spouse or Caregiver. Similarly, a forum where caregivers can discuss their challenges can also be very helpful and effective. Caring about and/or for a cancer patient can be an exhausting and emotionally taxing experience on several levels. Coping and support strategies are often exchanged.
- Children. Faced with an uncertain future, children often will appreciate a place where they can open up and share their concerns and fears.

HEALTH NEED PRIORITY 8: GERIATRIC SUPPORT

Geriatric Support

Hospitals are shouldering the complex care needs of a growing number of geriatric patients. Older adults are one of the fastest-growing cohorts of the nation's population. By 2030, over 20% of the U.S. population will be comprised of people 65 and over.⁹² The fastest-growing segment of our population, by age, are adults over 85.⁹³

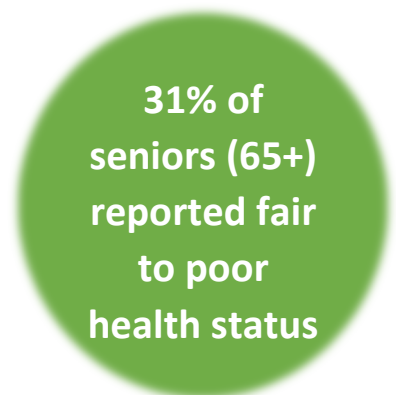
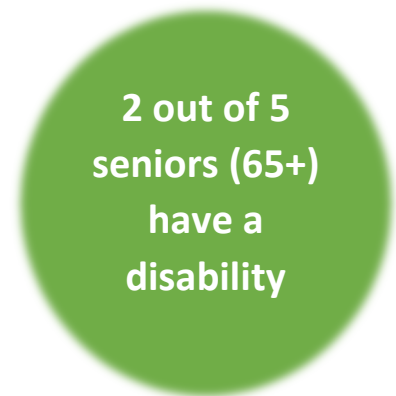
Older adults have special healthcare needs that can make their medical care more complicated. More than half of adults age 65 and older have three or more medical problems, such as heart disease, diabetes, arthritis, Alzheimer's disease, and high blood pressure.⁹⁴ Geriatric care requires a team approach to address the medical, social, emotional, and other needs of the patient, with the close involvement of family members and other caregivers. Some of the health concerns common among older adults include incontinence, vision and hearing loss, memory loss, bone density loss, falls, and managing multiple chronic conditions and medications.

To maintain good health and reduce risk of disease and disability, seniors 65 and over are advised to engage in exercise, maintain good nutrition, receive regular health screenings, vaccinate, get enough sleep, and participate in activities of interest.

Aging Indicators

As a percent of the total population, the AHGL service area has a larger population of adults over 65 (16.3%) compared to the Los Angeles County average (13.5%). In these areas, including Glendale ZIP codes 91206 (19.2% 65 years of age or older), 91207 (21.9% 65 years of age or older) and 91208 (19.2% 65 years of age or older), nearly one in five residents was 65+ years old.

Within Los Angeles County, the population 65 years of age or older was distinct from the entire resident population in a few notable ways. The 65+ population reported very reduced rates of binge drinking (4.2% vs. 15.9%). The 65+ population reported an easier time obtaining medical care when needed (only 9.3% reported this is somewhat or very difficult, compared to 23.6% of the entire population). Additionally, 66.6% of the 65+ population reported seeing a dentist or visiting a dental clinic in the past year, compared with 59.3% of the Los Angeles County resident population.



⁹² United States Census: An Aging Population: <https://www.census.gov/prod/2014pubs/p25-1140.pdf>

⁹³ United States Census: 2010 Census: https://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn192.html

⁹⁴ <http://www.healthinaging.org/aging-and-health-a-to-z/topic:geriatrics/> Accessed [May 29, 2019].

However, when compared to the Los Angeles County resident population, specific needs among the 65+ population emerge. For example, a larger percentage of the 65+ population were diagnosed with diabetes (21.2%), hypertension (54.2%) or high cholesterol (47.5%) than the Los Angeles County population in general (9.8%, 23.5% and 25.2%, respectively). Additionally, 47.7% of the 65+ population reported low or no physical activity, compared with 34.8% of the general population.

Mortality due to Alzheimer’s disease remained an area of high concern for California. While Santa Clara appeared to improve with respect to its Alzheimer’s disease death rate, this improvement is actually due to reporting inconsistencies by this county. Even after accounting for this large artificial decrease, California still demonstrated a 16.3 percent increase in the rate of Alzheimer’s deaths compared to the prior 2012-2014 three-year rate, which resulted in a current mortality rate of 35.7 per 100,000. With the exception of Santa Clara County, seven out of California’s 10 most populous counties showed an Alzheimer’s death rate increase of over 20 percent from the prior period. See technical notes and Table 8 for more information regarding Alzheimer’s disease.

The chart on the next page is a compilation of these and other data values available for the 65 and over subpopulation. Many of these indicators have already been covered in other modules of this report. But, given that American population is aging as the Baby Boomer generation reaches retirement age, it is important to consider how these indicators change over time in the next several years. These values present a benchmark from which further trends may be analyzed.

A Closer Look at Falls

The rate of elderly hospitalized due to falls is roughly 28% in both Los Angeles County and California. Comparatively, seniors in Service Planning Area 2 and 4 had significantly fewer falls. The AHGL service area showed a lower percentage of elderly hospitalized from falls (17.8%) than both Los Angeles County (28.0%) and California (28.5%). Among fall victims within a given year, close to one in three changed their daily routine. The Service Planning Areas of interest to AHGL saw a similar proportion of seniors changing their routine. Differences among SPAs were marginal (less than 3%).

Typically, eight out of 10 physicians in California recommend physical therapy or activity after a fall. In the AHGL service area, fewer physicians/professionals recommended physical therapy or exercise due to falls (76.9%) in comparison to Los Angeles County (83.9%) and California (80.4%). SPA 4-Metro had the lowest percentage (69.8%) of physicians recommending physical therapy out of all reported areas in the chart below.

After a fall, a third of physicians in California reviewed seniors’ medications, a rate that was significantly lower than Los Angeles County and Service Planning Area 4. Furthermore, the AHGL service area (35.9%) was significantly lower than Los Angeles County (40.2%) but moderately higher than California (33.7%).

Elderly (65+) Falls in Past Year

Report Area	Was Hospitalized Due to Falls	Changed daily Routines because of fall in past year	Professional Recommended Physical Therapy/Exercise due to falls	Professional reviewed medication after fall
SPA 2–San Fernando Valley	21.6%	30.0%	86.7%	40.8%

Report Area	Was Hospitalized Due to Falls	Changed daily Routines because of fall in past year	Professional Recommended Physical Therapy/Exercise due to falls	Professional reviewed medication after fall
SPA 4–Metro	12.8%	32.9%	69.8%	29.5%
AHGL Service Area	17.8%	31.3%	79.4%	35.9%
Los Angeles County	28.0%	33.5%	83.9%	40.2%
California	28.5%	33.3%	80.4%	33.7%

Data Source: Los Angeles County Health Survey, 2015, SPA

Benchmark Health Indicators for Adults over the age of 65

Health Indicator	Percent Adults (65+ years old)	Percent of LAC Residents
Ever Diagnosed with Depression AND Either Currently Being Treated for Depression or Currently Having Symptoms of Depression	9.2%	8.6%
Ever Diagnosed with Diabetes	21.2%	9.8%
Ever Diagnosed with Hypertension	54.2%	23.5%
Ever Diagnosed with High Cholesterol	47.5%	25.2%
Obese	20.2%	23.5%
Overweight	40.7%	35.9%
Binge Drinking*	4.2%	15.9%

Glendale Memorial Hospital and Health Center
2019 Community Health Needs Assessment

Health Indicator	Percent Adults (65+ years old)	Percent of LAC Residents
Physical Aerobic Activity: Activity Does not Meet Guidelines or Engage in No Activity**	47.7%	34.8%
Reported misusing any form of prescription drugs in the Past Year	3.6%	5.5%
Reported Receiving the Social and Emotional Support They Need (i.e., Always or Usually	70.2%	64%
Reported Seeing a Dentist or Visited a Dental Clinic for Any Reason in Past Year	66.6%	59.3%
Reported Accessing Mental Health	5.6%	8.5%
Reported Having a Disability	41.9%	22.6%
Reported that Obtaining Medical Care When Needed Is Somewhat or Very Difficult	9.3%	23.6%
Reported Fair/Poor Health Status	30.8%	21.5%
Have a Regular Source of Care	94.2%	80.3%
Vaccinated for pneumonia	65.5%	62.0%
Vaccinated for Influenza	66.8%	69.0%
Current Smokers within age group	7.4%	13.3%
Reported having a mammogram in last 2 years	82.6%	77.3%
Reported number of days in a month limited activity due to poor health and/or mental health	3.1	2.3
Reported perception of neighborhood safety from crime	89.3%	84.0%
Reported consumption of fruits/vegetables in a day – 5 or more servings	14.9%	14.7%
Reported consumption of one soda or sugary drink per day	15.3%	31.4%

Data Source: Los Angeles County Health Survey, 2015, County

* Binge drinking for females is drinking 4 or more drinks and males 5 or more drinks on one occasion at least one time in the past month. Heavy drinking is males consuming more than 60 drinks and females more than 30 drinks in the previous month.

** To meet Physical Activity Guidelines for aerobic activity at least one of the following criteria must be fulfilled: 1) Vigorous activity for at least 75 minutes a week, 2) Moderate activity for at least 150 minutes a week, or 3) A combination of vigorous and moderate activity for at least 150 minutes a week

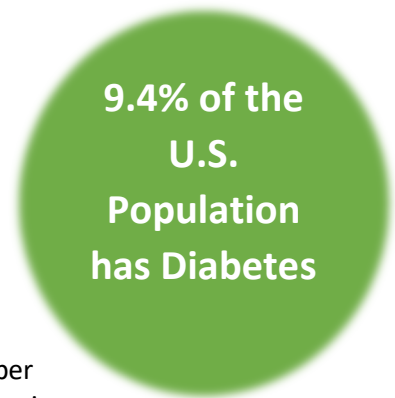
*** Disability is defined as a positive response to any one of the following: 1) Limited activity because of physical, mental, or emotional problem(s), 2) Health problem requiring use of special equipment, 3) Self-perception of being disabled.

HEALTH NEED PRIORITY 9: DIABETES

Diabetes

In the previous AHGL Community Health Assessment Report (2016), stakeholders identified diabetes as one of the top three most important health problems in the Glendale community. They also added that outreach regarding available community resources and family-based intervention is important, especially among Black and Latino subpopulations. Care providers expressed that prevention and maintenance education, as well as expanded access to preventive and maintenance care, would support the communities most impacted by diabetes.

This appears to have changed. In 2019, diabetes was not rated by local stakeholders as a top priority issue affecting the AHGL service area. While diabetes affects an estimated 30.3 million people in the United States, it appears the condition is more prevalent East of the Mississippi, as indicated in a CDC report.⁹⁵ As the seventh leading cause of death in California, death from diabetes is only a fraction of the leading cause of death statewide-- coronary heart disease was 5.5 times deadlier. 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.⁹⁶ In Los Angeles County, the age-adjusted death rate per 100,000 persons is 2,190.3 for diabetes, while for coronary heart disease is 11,824.7, followed by stroke which has a rate of 3,310.⁹⁷ Diabetes diagnosis can also indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity.



Factors associated with diabetes include overweight; high blood pressure or high cholesterol, high blood sugar (or glucose); physical inactivity; smoking; and, unhealthy eating. Other factors include age, race, gender, and having a family history of diabetes.⁹⁸ Research suggests that diabetes is associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis.⁹⁹

The steady rise in the number of people with diabetes, and the earlier onset of Type 2 diabetes, raises concerns about growing diabetes-related complications, as well as the risk of further overwhelming the health care system. Recent discoveries about the individual and societal benefits of improved diabetes management and prevention may help curb some of these reverberating effects and bring life-saving

⁹⁵ National Diabetes Statistics Report, 2017, Estimates of Diabetes and its Burden on the United States. Available at <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf> Accessed [May 28, 2019]

⁹⁶ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes>. Accessed [May 28, 2019].

⁹⁷ Based on 2011-2013 3-year average. Source: California Department of Public Health, Center for Health Statistics and Informatics, 2015 County Health Status Profiles, 2015.

⁹⁹U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes>. Accessed [May 28, 2019].

care into wider practice. In addition, prevention at the primary care level among those at risk for developing diabetes would complement these efforts.¹⁰⁰

Obesity / Overweight

Obesity, a condition closely linked with diabetes, in which a person has a high proportion of body fat (BMI over 30), has risen to epidemic levels in the United States. Nearly 70% of adults age 20 years and older are overweight or obese.¹⁰¹ Excess weight is linked to impaired health outcomes as well as risk behaviors that impact health in other ways. In the U.S., 33.9% of adults are obese; The Healthy People 2020 goal brings obesity rates below or equal to 30.5%.¹⁰²

Obesity reduces life expectancy and increases the risk of coronary heart disease, stroke, high blood pressure, diabetes, and 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 more.¹⁰³ Researchers have found a strong graded relationship between adverse childhood experiences (ACEs), obesity, and risk behaviors that contribute to obesity.¹⁰⁴ Obesity prevention is associated with healthier food access, healthcare access, and access to grocery stores, parks, and open space. Obesity is exacerbated by food insecurity and nutritional deficits, in particular iron deficiency.

Prevalence of Obesity and Overweight

Data trends for the adult population revealed a decrease in the rate of overweight people between 2015 and 2017 in L.A. County by 4.6% and California by 2.3%. The rate remained unchanged for obese adults in L.A. County, while the California rate also decreased by 5.7%. Within Service Planning Areas of interest to the AHGL, the drop in the adult overweight rate was higher: -5.8% change in SPA 2 to 32.6% and -10.3% in SPA 4 to 31.2%. By contrast, obesity increased in SPA 2 by 2.5% to 27.5% in 2017, and in SPA 4 by 6.3% to 28.7%. This may suggest that those who are obese face barriers to losing weight.

Overweight and Obese Populations				
Report Area	Overweight Adults	Obese Adults	Overweight Children	Overweight Teens (Age 12 to 17)
SPA 2–San Fernando Valley	32.6%	27.5%	14.2%*	----
SPA 4–Metro	31.2%	28.7%	17.8%*	----
Los Angeles County	32.9%	28.2%	11.4%	12.5%
California	33.9%	26.4%	14.5%	15.1%

¹⁰⁰U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes>. Accessed [May 28, 2019].

¹⁰¹ National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [August 2, 2016].

¹⁰² Healthy People 2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status>

¹⁰³National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [August 2, 2016].

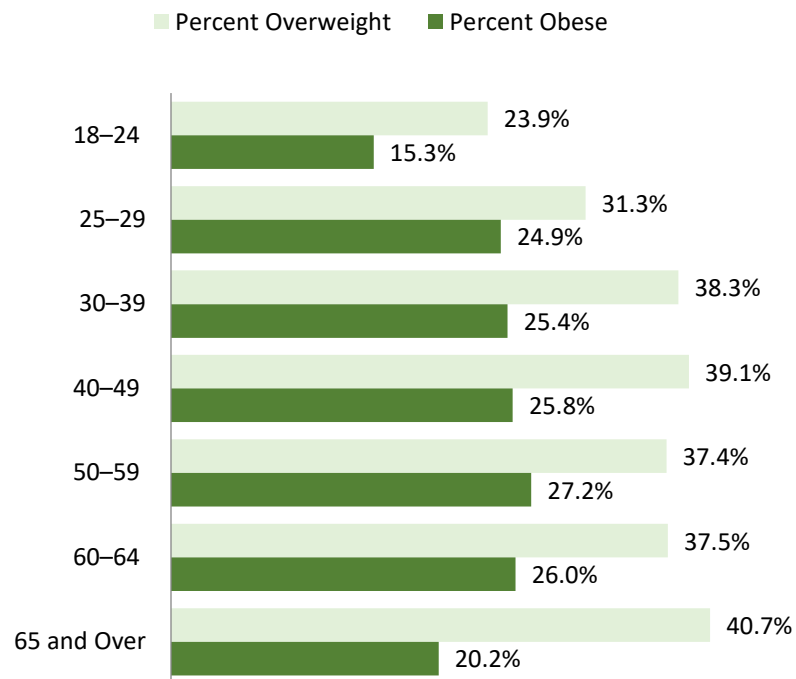
¹⁰⁴ American Journal of Preventive Medicine, 2019: <https://www.sciencedirect.com/science/article/pii/S0749379719301436>

*Data Source: California Health Interview Survey, 2017, SPA *statistically unstable*

Trends for the youth population revealed a mixed picture: In California, the rate for overweight and obese children (14.5%) has seen a moderate 3.3% reduction over three years. However, in Los Angeles County, the rate was 11.4% in 2017 which is an increase of 12.5% over the same longitudinal period. SPA 2 and SPA 4 are home to a larger proportion of overweight children than the rates logged for LA County (11.4%) and 14.5% for California--- Service Planning Areas 2 and 4 saw rates of 14.2% and 17.8% respectively.

Over a third of the adult population over 25 population in Los Angeles County was overweight and obese. Rates by age: 65 years old and older (40.7%), age 40 to 49 (39.1%), age 30 to 39 (38.3%), age 60 to 64 (37.5%), age 50 to 59 years old (37.4%), and age 25 to 29 (31.3%). Less than a third of those between the ages of 18 and 24 (23.9%) were considered overweight.

Adult Overweight and Obesity Prevalence by Age

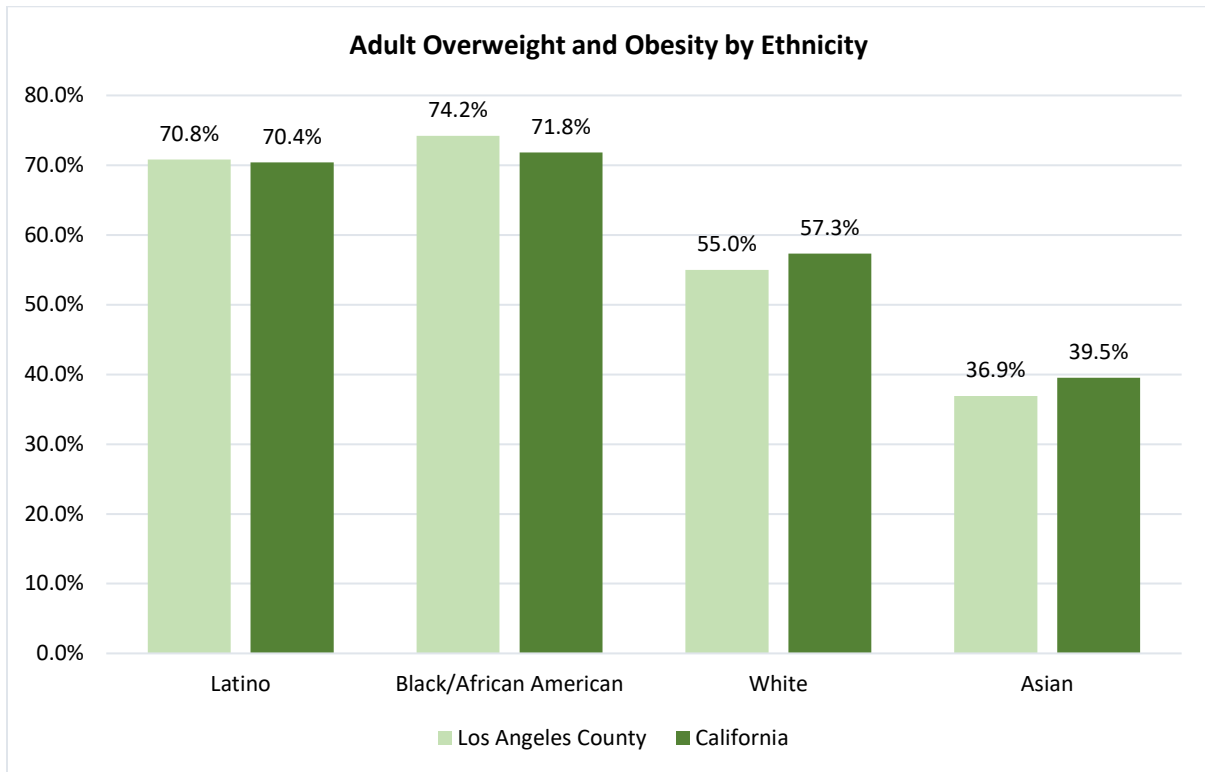


Data Source: Los Angeles County Health Survey, 2015, County

A review of prevalence by age group indicated that adults 65 and over had the highest proportion of overweight people (40.7%), while adults between 50-59 years of age had the highest obesity rate (27.2%). While adults 18-24 had the lowest rates, close to one in 4 were overweight and over one in six were obese. In general, for adults 25 and over, the overweight population ranged between 20.2% and 27.2%.

A review of prevalence by ethnicity that the Black population had the highest and the Latino population had the second highest combined rate for both overweight and obese adults (74.4% and 70.8%, respectively), while the Asian population had the lowest rate: 36.9%. More than half of the white population was overweight or obese (55.0%). Latino and African American populations in Los Angeles

County were slightly above the California rate for overweight or obesity, while the white and Asian populations in the county had a moderately lower rate than the state.



Data Source: California Health Interview Survey, 2017, County

Prevalence and Management of Diabetes

The statistics offered in 2017 seem counterintuitive to the level of priority given to diabetes by AHGL stakeholders. Approximately 12% of adults in Los Angeles County are diagnosed with diabetes, a rate that has increased by 12% since 2015. The rate of adults diagnosed as pre-diabetic or borderline diabetic stood even higher, at 17.4%. This rate has increased by 24.3% since 2015 which seems to suggest that more people are at risk of being fully diabetic. The condition also appears to be more prevalent in the county than in California or the Service Planning Areas of interest to AHGL. In Service Planning Area 2, for instance, 9.6% are diabetic and 16.7% are pre to borderline diabetic.

Prevalence in Diabetes

	Diagnosed with Diabetes	Rate of Change 2015-2017	Diagnosed Pre /Borderline Diabetic	Rate of Change 2015-2017
SPA 2- San Fernando Valley	9.6%	-9.4%	16.7%	-7.2%
SPA 4- Metro	11.6%*	16.0%	14.0%*	-10.3%

Los Angeles County	12.1%	12.0%	17.4%	24.3%
California	10.7%	9.2%	15.6%	15.6%

Data Source: California Health Interview Survey, 2017, SPA

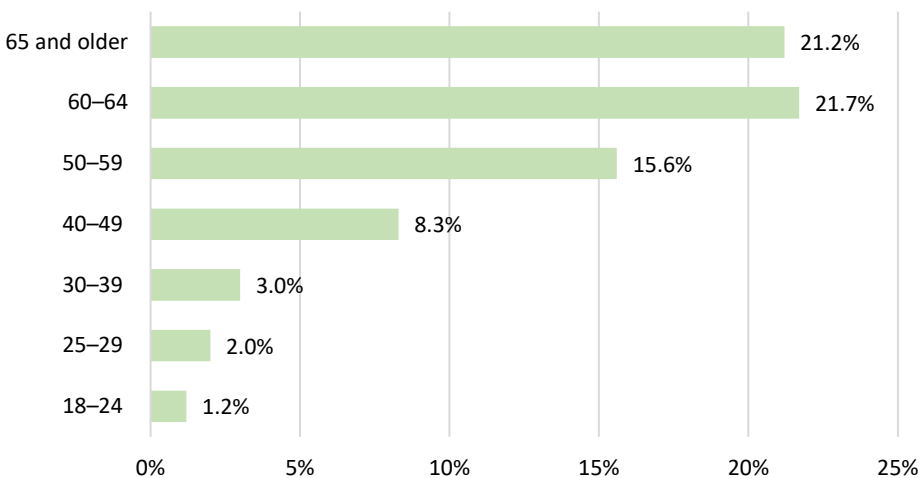
Among diabetic adults in Los Angeles County, approximately 56.7% felt very confident about their ability to control their condition and 33.5% felt somewhat confident. Almost one in 10 had no confidence in controlling the condition. Views of adults in Service Planning Area 2 and 4 appear to be split, with San Fernando residents exhibiting more confidence than their Metro peers in controlling the condition. In the Metro area, the rate of diabetic adults with no confidence to control their condition (13.7%) appeared higher than both the county (9.9%) and the state (7.2%)

Confidence Levels to Control Diabetes

Report Area	Very Confident	Somewhat Confident	Not Confident
SPA 2- San Fernando Valley	58.1%*	35.0%*	6.9%*
SPA 4- Metro	54.4%	31.9%*	13.7%*
Los Angeles County	56.7%	33.5%	9.9%*
California	60.1%	32.7%	7.2%*

Older adults experience a higher prevalence of diabetes. In Los Angeles County, 42.9% or more than two in five adults aged 60 and over were diagnosed with diabetes. The percentage of diabetes prevalence drops significantly with each younger age group.

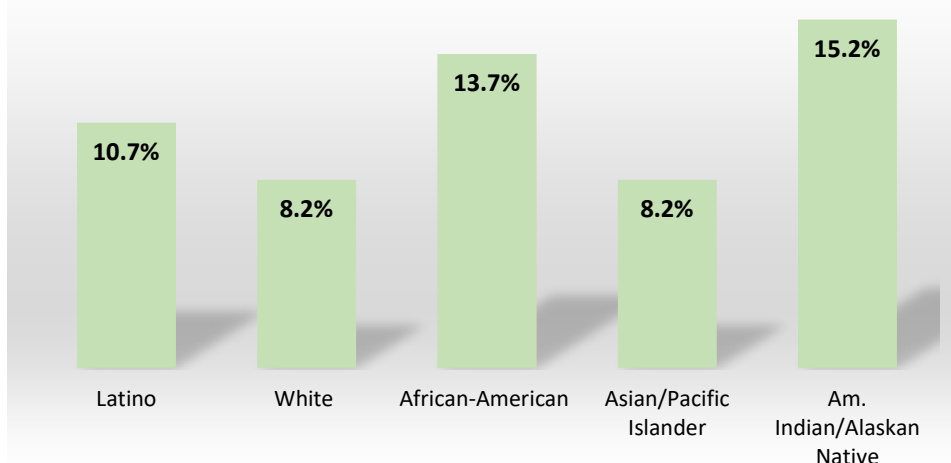
Diabetes Prevalence by Age



Data Source: Los Angeles County Health Survey, 2015, County

Population groups most impacted by diabetes were American Indian/Alaskan Native (15.2%) and Black (13.7%), by ethnicity. The least impacted population groups, by ethnicity, were the White and Asian/Pacific Islander, with approximately 8.2% of their populations affected by the condition.

Diabetes Prevalence by Ethnicity



Data Source: Los Angeles County Health Survey, 2015, County

Hospitalizations

Hospitalization rates of adults over 18 years of age in the AHGL service areas for diabetes ranged between 4.9 and 25.9 per 10,000. The highest rates were reported in Glendale: ZIP code 91204 (25.9 per 10,000), Highland Park: Zip Code 90042 (21.0 per 10,000) as well as 90065—Glassell Park (20.8).

Average Annual Age-Adjusted Rate Due to Diabetes per 10,000 Population (18 and Over)

City	ZIP Code	Diabetes Hospitalizations ¹⁰⁵ (1)	Diabetes Emergency Room ¹⁰⁶ (2)	Hospitalizations Resulting from Uncontrolled Diabetes
Eagle Rock	90041	13.0	15.8	---

¹⁰⁵ Average annual age-adjusted hospitalization rate due to diabetes per 10,000 population aged 18 years and older. Both Type 1 and Type 2 are included. Cases of gestational diabetes are excluded. Measurement Period 2013-2015 (Confidence Interval).

¹⁰⁶ Average annual age-adjusted emergency room visit rate due to diabetes per 10,000 population aged 18 years and older. Both Type 1 and Type 2 are included. Cases of gestational diabetes are excluded. Rates were calculated using population figures from the 2010 U.S. Census. Rates based on fewer than 10 emergency room visits or a population of less than 300 are unstable and are not reported. In October 2015, health care facilities began using International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) for diagnosis and procedure coding of admissions and visits. Due to the increased specificity for diagnosis and procedure codes with ICD-10, please use caution when comparing prior time periods. Measurement Period 2013-2015 (Confidence Interval).

City	ZIP Code	Diabetes Hospitalizations ¹⁰⁵ (1)	Diabetes Emergency Room ¹⁰⁶ (2)	Hospitalizations Resulting from Uncontrolled Diabetes
Highland Park	90042	21.0	24.1	1.6
Glassell Park	90065	20.8	29.2	2.0
Montrose	91042	---	15.9	---
Glendale	91201	11.3	10.9	---
Glendale	91202	9.9	9.3	---
Glendale	91203	12.6	8.1	---
Glendale	91204	25.9	28.0	2.4
Glendale	91205	14.2	17.1	1.7
Glendale	91206	11.3	13.0	---
Glendale	91207	6.6	7.3	---
Glendale	91208	4.9	7.1	---
AHGL Service Area		13.5	16.7	1.7

Data Source: (1) Office of Statewide Health Planning and Development (OSHPD) and (2) California Department of Public Health, ZIP Code

The diabetes emergency room hospitalization rate of adults in the service area ranged slightly higher between 7.1 and 29.2 per 10,000. The highest rates were reported in Glassell Park: Zip Code 90065 (29.2 per 10,000) and Glendale: ZIP code 91204 (28.0).

Furthermore, a frequency distribution reveals that rates of emergency use are higher than rates for hospitalization, suggesting that perhaps better diabetes management and education among adults may help reduce the need for costlier acute care services.



2019 CHNA approval

This community health needs assessment was adopted on 10/17/19 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2019.

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To request a copy, provide comments or view electronic copies of current and previous community health needs assessments or community benefit implementation strategies, please visit the Community Benefits section on our website at <https://www.adventisthealth.org/about-us/community-benefit/>

Appendix A

Scorecard

Identification of Health Needs and Health Drivers

In partnership with the Center for Nonprofit Management (CNM) Glendale Adventist Medical Center and Glendale Memorial Hospital conducted Phase I of the 2019 Community Health Needs Assessment (CHNA) earlier this year. This included review of data from various public and private secondary data sources. Additional information was gathered through a community focus group representing providers and stakeholders from across the Glendale hospitals service area including public health experts, community leaders, and public agency officials.

This process highlighted numerous health needs and health drivers in the Glendale hospital 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. 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.

Year of Data	Healthy People 2020 Target	California	Los Angeles County	SPA 2 - San Fernando	SPA 4 - Metro
DATA INDICATOR					
Legend An italicized indicator denotes qualitative data collected in a focus group or interview Two dashes [--] = no data available SPA = Service Planning Area Black boxes indicate that the area performed worse than the benchmark Red boxes indicate the variable was identified as a health driver in 2016 scorecard (*) = Restricted data					

DATA INDICATORS

- Indicators, or standard measures of health, are highlighted in the first column
- Qualitative data collected in the community focus group is indicated by an *italicized indicator*
 - Count reflects the number of times a participant voted for the health need during the focus group
- 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 from secondary sources aggregated using ZIP codes in the hospital service area

^Data from secondary sources reflecting the entire Service Planning Area (SPA)

COMPARISON LEVEL

- The hospital service area is compared against benchmarks at the State or County-level depending on data available
 - CA: State of California
 - LAC: Los Angeles County
- SPA

2019 Glendale CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR		Year of Data	Healthy People 2020 Target	California	Los Angeles County	SPA 2 - San Fernando	SPA 4 - Metro
Legend							
An italicized indicator denotes qualitative data collected in a focus group or interview							
Two dashes (-) = no data available							
SPA = Service Planning Area							
Black boxes indicate that the area performed worse than the benchmark							
Red boxes indicate the variable was identified as a health driver in 2016 scorecard							
(*) = Restricted data							
HEALTH CHARACTERISTICS, NEEDS AND DRIVERS/PREDICTORS							
Demographics							
Population Characteristics							
Percent of population that are Children (Age 0-11)	2017	--	15.1%	16.70%	15.50%		
Percent of population that are Adolescents (Age 12-17)	2017	--	7.7%	6.8%*	7.0%*		
Percent of population that are Adults (Age 18-64)	2017	--	63.7%	63.20%	62.10%		
Percent of population that are Seniors (Age 65+)	2017	--	13.5%	13.30%	15.40%		
Percent of population: Male	2017	--	49.3%	54.10%	51.40%		
Percent of population: Female	2017	--	50.7%	45.90%	48.60%		
Language spoken at home: English	2017	55.6%	43.1%				
Language spoken at home: Spanish	2017	28.9%	39.4%				
Citizenship: Not a US Citizen	2017	13.4%	16.9%				
Average family size	2017	3.54	3.69				
Social and Economic Factors Ranking LA county vs. 58 CA counties	2018		23				
Educational attainment							
Highest Educational Attainment: Grades 1-8	2017	--	10.8%	11.6%*	16.6%*		
Highest Educational Attainment: Grades 9-11	2017	--	7.9%	7.5%†	5.2%†		
Highest Educational Attainment: High School	2017	--	21.5%	20.0%†	15.9%		
Highest Educational Attainment: Some college (AA/AS degree)	2017	--	5.5%	4.4%†	6.5%*		
Highest Educational Attainment: Bachelor's degree	2017	--	23.1%	24.3%†	24.8%		
Highest Educational Attainment: No formal education	2017	--	1.9%	0.3%†	--		
High School Graduation Rate	2017	83.3%	79.6%				
Percent 25 years and older who have high school diploma or higher education	2017	83.2%	79.6%	--	--		
Current Employment Status: FTE	2017		53.8%	57.8%	51.2%		
Current Employment Status: PTE	2017		10.7%	10.4%†	11.0%		
Current Employment Status: Unemployed and looking for work	2017		4.4%	5.3%†	4.8%†		
Current Employment Status: Unemployed and NOT looking for work	2017		30.8%	26.2%	32.6%		
Access to Health Care: Health insurance coverage, Type of Coverage							
Percent of adults without health insurance	2017	9.0%	9.6%	10.2%	11.9%		
Percent of youth (age 0-17) without health insurance	2017	2.2%	1.9%	--	--		
Health Insurance Coverage; Percent Total Population who are currently insured	2017	92.7%	92.2%	91.6%	90.8%		
Health Insurance Coverage; Percent of Adults Ages (18-64) who are currently insured	2017	89.1%	88.5%	87.7%	85.2%		
Health Insurance Coverage; Percent of youth (17 and under) who are currently insured	2017	97.8%	98.1%	97.1%	100.0%		
Type of Insurance Coverage							
Medi-Cal	2017	25.0%	29.4%				
Healthy Families	2017	--	--				
Medicare Only	2017	1.6%	1.4%*				
Medicaid and Medicare	2017	4.3%	5.7%				
Medicare & Others	2017	9.3%	7.5%				
Other Public	2017	1.5%	1.8%				
Employment based	2017	44.4%	39.8%				
Private Purchase	2017	6.5%	6.6%				
No Insurance	2017	7.3%	7.8%				
Insurance Coverage: Age 0-17							
Medi-Cal	2017	44.1%	46.5%				
Healthy Families	2017	--	--				
Medicare Only	2017	--	--				
Medicaid and Medicare	2017	--	--				
Medicare & Others	2017	--	--				
Other Public	2017	1.1%	0.8%*				
Employment based	2017	46.5%	44.4%				

2019 Glendale CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target			
		California	Los Angeles County	SPA 2 - San Fernando	SPA 4 - Metro
Legend An italicized indicator denotes qualitative data collected in a focus group or interview Two dashes (--) = no data available SPA = Service Planning Area Black boxes indicate that the area performed worse than the benchmark Red boxes indicate the variable was identified as a health driver in 2016 scorecard (*) = Restricted data					
Private Purchase	2017	5.1%	4.9%		
No Insurance	2017	2.2%	1.9%*		
<i>Insurance Coverage: Age 18-64</i>					
Medi-Cal	2017	18.7%	21.0%		
Healthy Families	2017	--	--		
Medicare Only	2017	0.8%	0.7%*		
Medicaid and Medicare	2017	1.9%*	2.1%*		
Medicare & Others	2017	0.2%*	0.2%*		
Other Public	2017	1.8%	1.9%		
Employment based	2017	51.5%	45.8%		
Private Purchase	2017	8.9%	8.9%		
No Insurance	2017	10.9%	11.5%		
<i>Insurance Coverage: Age 65+</i>					
Medi-Cal	2017	0.7%*	1.8%*		
Healthy Families	2017	--	--		
Medicare Only	2017	7.7%	6.9%*		
Medicaid and Medicare	2017	22.0%	32.2%		
Medicare & Others	2017	64.4%	55.2%		
Other Public	2017	0.3%*	0.2%*		
Employment based	2017	3.9%	2.9%*		
Private Purchase	2017	0.3%*	0.4%*		
No Insurance	2017	0.7%*	0.5%*		
Access to Health Care: Health insurance, source of care, delay of care					
<i>Source of Care</i>					
Source of Care: Dr. Office/HMO/Kaiser Permanente	2017	59.2%	54.2%		
Source of Care: Community Clinic/Govt. Clinic/Community Hospital	2017	25.7%	28.0%		
Source of Care: Emergency Room/Urgen Care	2017	1.6%	2.4%		
Source of Care: Other	2017	0.5%	0.4%*		
Source of Care: None	2017	13.0%	15.1%		
Percent who have a usual source of care	2017	87.0%	84.9%	81.8%	81.2%
Percent of youth (age 0-17) who have a usual source of care	2017	90.5%	88.9%	81.5%	89.1%
Percent of adults (age 18-64) who have usual source of care	2017	83.7%	81.6%	78.9%	77.4%
Percent of seniors (65 and over) who have a usual source of care	2017	95.5%	93.9%	96.4%	84.8%
<i>Delay of Care</i>					
Percent of adults who delayed or didn't get medical care	2017	12.4%	11.4%	12.4%	13.3%
Percent of youth (age 0-17) delayed or didn't get medical care	2017	3.7%	3.2%	--	--
Percent of total population who had to forgo needed medical care	2017	62.1%	63.7%	65.1%	64.6%
Percent of adults who had to forgo needed medical care	2017	64.6%	65.6%	70.1%	66.1%
Percent who have used an emergency room in the past 12 months	2017	20.6%	21.7%	25.8%	16.3%
Percent of youth (Age 0-17) who have used an emergency room in the past 12 months	2017	18.0%	18.9%	26.3%	15.6%
Percent of adults (18-64) who have used an emergency room in the past 12 months	2017	21.0%	22.1%	25.2%	15.4%
Percent of seniors who have used an emergency room in the past 12 months	2017	23.6%	25.0%	27.7%	21.2%
Percent living under 100% Federal Poverty Level who have used an emergency room in the past 12 months	2017	26.0%	25.1%	44.8%	9.4%
Percent living between 100-199% Federal Poverty Level who have used an emergency room in the past 12 months	2017	24.2%	23.6%	31.4%	12.3%
Percent of adults who could not afford their medication	2011	--	15.4%	15.8%	15.3%
Percent of adults who delayed or didn't get prescription medicine	2017	10.1%	9.6%	8.7%	11.6%
Percent of youth (age 0-17) who delayed or didn't get prescription medicine	2017	3%	3.3%	--	--
Percent who delayed care due to cost or lack of insurance	2017	45.6%	46.0%	47.1%	55.3%
Percent of youth (Age 0-17) who delayed care due to cost or lack of insurance	2017	31.4%	60.9%	--	--
Percent of adults who had difficult time accessing primary care	2017	5.7%	5.0%	6.7%	5.4%

2019 Glendale CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR		Year of Data	Healthy People 2020 Target	California	Los Angeles County	SPA 2 - San Fernando	SPA 4 - Metro
Legend							
An italicized indicator denotes qualitative data collected in a focus group or interview							
Two dashes (-) = no data available							
SPA = Service Planning Area							
Black boxes indicate that the area performed worse than the benchmark							
Red boxes indicate the variable was identified as a health driver in 2016 scorecard							
(*) = Restricted data							
Percent who had a difficult time accessing services for their child		2011			12.3%	9.6%	12.1%
Percent living in a Health Professional Shortage Area		2015		25.2%	31.4%	--	--
Percent of adults who needed to see a medical specialist in the past year		2017		38.8%	37.4%	38.1%	32.8%
Percent who had a difficult time finding specialty care		2017		11.5%	11.5%	14.2%	13.3%
Ratio of population to primary care providers		2018		1,280:1	1,390:1	--	--
Transportation							
Percent unable to obtain medical care due to a lack of transportation		2014		--	7.4%	6.1%	9.7%
Chronic Diseases							
Health Status							
Percent who have a fair or poor health status		2017		16.6%	19.3%	16.3%	26.6%
Percent of youth who have a fair or poor health status		2017		4.6%	3.6%	--	--
Percent of seniors who have a fair or poor health status		2017		24.1%	29.4%	27.5%	37.4%
Asthma							
Percent of total population diagnosed with asthma		2017		15.4%	15.1%	17.2%	12.6%
Percent of youth (Age 0-17) diagnosed with asthma		2017		13.8%	15.1%	17.6%	--
Male Youth Age 0-17 diagnosed with asthma		2017		13.3%	15.7%		
Female Youth Age 0-17 diagnosed with asthma		2017		14.4%	14.5%		
Ethnicity: Latino youth (Age 0-17) diagnosed with asthma		2017		14.3%	15.3%		
Ethnicity: White youth (Age 0-17) diagnosed with asthma		2017		11.4%	7.9%		
Ethnicity: African American youth (Age 0-17) diagnosed with asthma		2017		27.6%	28.0%		
Ethnicity: Asian youth (Age 0-17) diagnosed with asthma		2017		10.4%	--		
Percent of population who take medication to control their asthma		2017		43.5%	43.5%	49.8%	46.2%
Percent of youth (Age 0-17) who take medication to control their asthma		2017		39.2%	36.5%	--	--
Percent who went to the emergency room/urgent care for asthma in the last 12 months		2016		12.7%	13.1%	11.4%	26.0%
Percent of youth who went to the emergency room/urgent care for asthma in the last 12 months		2016		10.5%	2.3%	--	--
Cancer, in General							
Rate of cancer incidence per 100,000 pop.		2015		404.0	(*)	--	--
Rate of breast cancer incidence per 100,000 pop.		2015		121.5	(*)	--	--
Rate of cervical cancer per 100,000 pop.		2015		7.2	(*)	--	--
Rate of colorectal cancer incidence per 100,000 pop.		2015		36.2	(*)	--	--
Rate of prostate cancer incidence per 100,000 pop.		2015		101.2	(*)	--	--
Rate of lung cancer incidence per 100,000 pop.		2015		43.3	(*)	--	--
Cardiovascular Disease/Heart Disease							
Percent of adults diagnosed with heart disease		2017		6.6%	6.6%	6.2%	7.8%
Percent of adults who feel very confident in their ability to manage their heart disease		2014		53.6%	53.5%	56.2%	29.4%
Percent of adults who feel somewhat confident in their ability to manage their heart disease		2014		34.9%	36.0%	42.0%	53.2%
Percent of adults who do not feel confident in their ability to manage their heart disease		2014		11.5%	10.4%	1.8%	17.4%
Percent who have a heart disease management plan		2017		76.3%	78.8%	94.7%	63.1%
Diabetes							
Adult Diabetes: percent Diagnosed with diabetes		2017		10.7%	12.1%	9.6%	11.8%
Adult Diabetes: Percent diagnosed pre/borderline diabetic		2017		15.6%	17.4%	16.7%	14.0%
Adult Diabetes: Percent very confident to control condition		2017		60.1%	66.7%	58.1%	54.4%
Adult Diabetes: Percent confident to control condition		2017		32.7%	33.5%	35.0%*	31.9%*
Adult Diabetes: Percent not confident to control condition		2017		7.2%*	9.9%*	6.9%*	13.7%*
Disability							
Percent of adults diagnosed with a disability		2016		29.7%	30.7%	31.8%	34.0%
Percent who could not work due to a physical/mental impairment		2016		7.0%	6.9%	7.8%	7.3%
HIV/AIDS							
Percent of adults who have ever been tested for HIV		2017		49.8%	52.5%	49.1%	56.0%
Rate of HIV diagnosis per 100,000 pop.		2016		<=13.0	19.0	13.0	48.0

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Legend							
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Two dashes (--) = no data available							
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Black boxes indicate that the area performed worse than the benchmark							
Red boxes indicate the variable was identified as a health driver in 2016 scorecard							
(*) = Restricted data							
Rate of AIDS diagnosis per 100,000 pop.		2016		--	7	4	15
Rate of those living with HIV per 100,000 pop.		2017		--	501.0	330.0	1,547.0
Rate of deaths from HIV per 100,000 pop.		2016		--	6	3	13
Hypertension							
Percent diagnosed with high blood pressure		2017	<=20.0%	29.0%	30.0%	29.0%	24.4%
Percent who take medication for high blood pressure		2017		70.7%	72.6%	71.6%	71.3%*
Early Childhood Development and Health							
Maternal and Infant Health							
Percent of infants with low birth weight (under 2500 grams)		2017	7.80%	6.8%	7.1%		
Percent of live births with mothers who entered prenatal care late		2017		3.7%	3.4%		
Percent of children (Age 3 and under) who were breastfed or fed breast milk		2017		92.3%	96.3%	100.0%	100.0%
Percent of children 0-5 years who were breast fed at least 6 months		2017		--	49.7%	49.3%	55.9%
Percent of Children (age 1 - 5 years) who were Breastfed by their Biological Mothers at least 12 Months.		2015		--	27.6%	37.9%	24.7%
Infant mortality per 1,000 live births		2017	6	4.6%	4.4%		
Early Childhood Development and Parenting							
Percent of children attending preschool, nursery school or head start		2017			17.0%	13.2%	10.8%
Percent of youth at-risk for a Developmental Delay (PEDS)		2014		58.6%	60.3%	58.2%	69.8%
Percent of Children (0-5 years old) Whose Parent/Guardian/Decision Maker Reported That it Is Easy (Very or Somewhat) to Find Someone To Talk To When They Need Advice on How To Raise Their Child.		2015			86.6%	86.5%	86.1%
Mental Health							
Average Number of Activity Limitation Days in the Past Month for Adults (18+ years) Due to Poor Physical and/or Mental Health.		2015			2.3	2.5	2.7
Percent who ever seriously thought about committing suicide		2017		11.6%	9.6%	7.9%	8.7%
Percent of Adults who had serious psychological distress in past year		2017		10.0%	9.7%	7.6%	10.9%
Percent of teens and adults who likely has had serious psychological distress during past month		2017		4.4%	4.4%	3.2%	5.1%
Percent of adults who needed help with an emotional/mental health problem from use of alcohol or drugs		2017		18.5%	17.1%	17.6%	15.5%
Percent of teens who needed help with an emotional/mental health problem from use of alcohol or drugs		2017		19.8%	24.3%	--	--
Percent of adults who took prescription medication for an emotional/mental health issue in the past year		2017		10.4%	8.8%	11.0%	8.7%
Percent of adults who saw a healthcare provider for an emotional/mental and/or alcohol or drug issue in the past year		2017		15.2%	15.1%	13.7%	17.8%
Percent of teens who received psychological and emotional counseling in the past 12 months		2017		14.8%	16.8%	11.2%	--
Percent who sought help for self-reported mental/emotional and/or alcohol-drug issue(s)		2017		39.7%	39.9%	49.3%	27.7%
Percent of adults whose emotions impaired their work in the past 12 months		2017		14.4%	14.6%	13.3%	18.9%
Percent of adults whose emotions impaired their family life in the past 12 months		2017		15.7%	15.3%	13.0%	17.9%
Percent of adults whose emotions impaired their social life in the past 12 months		2017		16.0%	16.6%	14.5%	19.1%
Preventative Health Behaviors							
Preventative Health Care							
Percent of Adults (age 65+ years) Who Ever had a Pneumonia Shot.		2015	93	--	62.0%	65.0%	65.8%
Percent of Seniors (65 and over) who received an influenza vaccination in the past year		2016		69.3%	67.4%	74.0%	63.2%*
Percent of Adults (Age: 18-64) who received an influenza vaccination in the past year		2016		37.7%	34.3%	35.5%	35.4%
Percent of youth (Age 0-17) who received an influenza vaccination in the past year		2016		49.6%	54.4%	48.4%	69.1%*
Percent who visited a doctor in the last year		2014		80.9%	80.6%	80.2%	72.9%
Percent of youth who visited a doctor in the last year		2014		87.8%	91.9%	92.2%	92.8%
Physical activity							

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Percent of adults physically active at least 20 minutes a day in a week	2017	19.2%	18.9%	19.1%	19.3%
Percent who walked to work (Age 16 and over)	2017	2.7%	2.7%		
Percent of children or teens who visited a park or other open space in the last month	2017	83.9%	83.3%	88.0%	86.5%
Percent of children who did not engage in physical activity in a given week	2017	8.3%	4.3%	--	--
Percent of teens who did not engage in physical activity in a given week	2016	9.2%	6.1%	--	33.7%
Percent of children who engaged in physical activity 3 or more days a week	2017	78.3%	77.2%	80.0%	88.3%
5th graders: Fitnessgram test- Percent in Healthy Fitness Zone in Aerobic Capacity	2018	61.9%	58.9%		
7th graders: Fitnessgram test- Percent in Healthy Fitness Zone in Aerobic Capacity	2018	63.6%	60.1%		
9th graders: Fitnessgram test- Percent in Healthy Fitness Zone in Aerobic Capacity	2018	61.7%	56.2%		
Nutrition					
Percent of adults who consumed at least two or more sodas per week	2017	24.1%	25.3%	24.7%	26.9%
Percent of children who ate 5 or more fresh fruits and vegetables per day	2017	26.7%	24.6%	32.0%	26.6%
Percent of teen who ate 5 or more fresh fruits and vegetables per day	2017	25.6%	32.4%	25.2%	--
Percent of children and teens who consumed two or more fruit servings the day before	2017	66.9%	66.6%	69.7%	66.6%
Percent of children and teens who consumed two or more glasses of soda the day before	2017	4.1%	4.3%		
Percent of children and teens who consumed two or more glasses of sugary drinks (other than soda) the day before	2017	10.4%	9.2%		
Percent of population who ate fast food 3 or more times in the past week	2016	25.0%	28.0%	28.1%	22.9%
Percent of youth (Age 0-17) who ate fast food 3 or more times in the past week	2016	23.4%	22.4%	22.5%	21.2%
Percent of adults (18-64) who ate fast food 3 or more times in the past week	2016	32.3%	26.4%	--	--
Percent of seniors (65 and over) who ate fast food 3 or more times in the past week	2016	28.2%	32.5%	--	--
Ratio of mental health care providers to population	2016	360:1	370:1	--	--
County Health Behavior Ranking (out of 58)	2018		11		
Women's Health					
Women 30+ Years, Had a Mammogram in Past Two Years	2016	76.1%	79.2%	85.6%*	71.5%*
Percent of Women (ages 21-65 years) Who Reported Having a Pap Smear within the Past 3 Years	2015	--	84.4%	88.2%	78.4%
Oral Health Behaviors					
Oral Health Care					
Dentist ratio to population	2018	1,210:1	1,200:1	--	--
Condition of Teeth: Percent of adults with poor dental health or no natural teeth	2017	9.5%	9.5%	10.4%	10.0%
Percent of adults who have never been to a dentist	2017	2.5%	3.3%	2.5%	4.5%
Percent of teens who have never been to dentist	2017	1.2%	--	--	--
Percent of children who have never been to dentist	2017	14.0%	12.4%	21.0%	10.0%
Percent of adults who visited a dentist in the last year	2017	72.8%	70.2%	73.2%	62.0%
Percent of children who visited a dentist in the last year	2017	84.4%	85.7%	75.9%	90.0%
Percent of Children (age 3-17 years) Who Were Unable to Afford Dental Care and Check-Ups in the Past Year	2015		11.5%	10.3%	15.5%
Dental Care Access					
Percent living in a dental provider Health Professional Shortage Area	2015	4.9%	2.0%	--	--
Percent of adults with dental insurance	2017	65.1%	61.1%	60.8%	56.1%
Percent of teens who have never been to a dentist due to cost or lack of insurance	2014	30.6%	39.0%	17.1%	54.2%
Percent of children who have never been to a dentist due to cost or lack of insurance	2014	10.4%	10.0%	11.4%	9.2%
Percent of youth with dental insurance	2017	87.6%	86.1%	87.7%	76.3%
Ratio of dentists to population	2016	1,260:1	1,260:1	--	--
Obesity/Overweight					
Percent of adults who are overweight...	2017		33.9%	32.9%	32.6%
Percent of adults who are obese	2017	%	26.4%	28.2%	27.5%
Percent of teens who are overweight	2017		15.1%	12.5%	--
Percent of teens who are obese	2017		14.6%	14.0%	--

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Percent of children who are overweight	2017	14.5%	11.4%	14.2%	17.8%
Ethnicity: Percent of Adult African Americans with Body Mass Index considered overweight or obese	2017	71.8%	74.4%		
Ethnicity: Percent of Adult Asians with Body Mass Index considered overweight or obese	2017	39.5%	36.9%		
Ethnicity: Percent of Adult Latinos with Body Mass Index considered overweight or obese	2017	70.4%	70.8%		
Ethnicity: Percent of Adult Whites with Body Mass Index considered overweight or obese	2017	57.3%	55.0%		
5th graders: Fitnessgram test- body composition area needs improvement/health risk	2018	21.3%	24.9%		
7th graders: Fitnessgram test- body composition area needs improvement/health risk	2018	19.8%	22.7%		
9th graders: Fitnessgram test- body composition area needs improvement/health risk	2018	18.4%	20.7%		
At Risk Behaviors					
Sexual Behavior and Health					
Percent of teens who are not sexually active	2017	86.4%	86.5%	76.7%	100.0%
Rate of chlamydia incidence per 100,000 pop.	2015	459.9	541.4		
Rate of gonorrhea incidence rate per 100,000 pop.^	2015	118.5	151.3		
Rate of primary and secondary syphilis incidence per 100,000 pop.^	2015	10.0	11.9		
Rate of early latent syphilis per 100,000 pop.	2015	8.9	14.8		
Percent of live births to teen mothers (15-19 years old)	2018	21.0%	20.9%		
Alcohol and Substance Abuse					
Percent of adults who binge drank (5 or more) in the past year	2015	34.7%	33.8%	35.6%	45.1%
Percent of teens who binge drank (5 or more) in the past year	2017	5.8%	7.3%	--	--
Percent of teens who ever had an alcoholic drink	2017	22.6%	21.2%	41.3%	--
Percent of population who are smokers	2018	11.0%	11.0%		
Percent of adults who currently smoke	2017	10.2%	9.0%	7.6%	11.5%
Percent of young adults 18-24 years old who smoke	2017	7.4%	5.2%	4.1%	--
Percent of adults who have ever smoked e-cigarette's	2017	17.9%	17.1%	18.4%	18.3%
Percent who ever tried marijuana or Hashish (Age 17 and under)	2017	12.4%	14.7%	--	--
Air Quality					
Number of days where Ozone levels were above the standard	2016	22	60	--	--
Annual average particulate matter concentration (micrograms per cubic meter)	2016	9	12	--	--
Other Family and Community Socio-Economics					
Cultural and Linguistic Barriers					
Percent who had a difficult time understanding their doctor	2017	3.1%	3.6%	3.4%	3.8%
Percent who live in homes in which English is not spoken (linguistically isolated)	2014	9.5%	12.7%	--	--
Percent who speak a language other than English	2014	19.1%	25.8%	--	--
Economic Security					
Percent of population living with income below 100% Federal Poverty Level	2017	16.8%	20.6%	14.2%	25.9%
Percent of population living with income below 100-199% Federal Poverty Level	2017	18.1%	18.2%	16.8%	22.7%
Percent of Population living 200-299 below the Federal Poverty Level	2017	12.9%	13.6%	15.8%	9.5%
Percent of Population living more than 300% below the Federal Poverty level	2017	52.3%	47.5%	53.2%	42.0%
Percent of Youth (0-17) living 100% below the Federal Poverty Level	2017	21.0%	27.4%	14.8%	37.2%
Percent of Youth (0-17) living 100-199% below the Federal Poverty Level	2017	19.5%	15.2%	16.6%	21.6%
Percent of Youth (0-17) living 200-299 below the Federal Poverty level	2017	13.4%	15.8%	17.3%	--
Percent of Youth (0-17) living more than 300% below the Federal Poverty level	2017	46.0%	41.5%	51.4%	35.8%
Youth (under 18) in poverty	2017	20.7%	24.0%		
Female head of household with youth (under 18) in poverty	2017				
Percent of households where housing costs exceed 30% of total household income	2014	45.0%	49.9%	--	--
Elderly single/couple income below county cost of living thresholds	2017	23.0%	28.0%	20.6%	47.9%
Percent of students eligible for free/reduced price meals	2017	60.1%	69.3%	--	--
WIC usage among qualified adults	2014	53.5%	69.7%	54.1%	87.1%

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Percent on WIC--children 6 years and younger	2016	44.7%	52.7%	26.8%	56.8%
Percent receiving food stamps	2016	23.1%	21.7%	17.5%	27.3%
Percent receiving TANF or CalWORKS	2016	10.2%	9.9%	4.1%	14.5%
Rate of unemployment	2017	7.7	7.8	--	--
Access to Food					
Percent who are unable to afford enough food (food insecurity)	2017	40.8%	40.2%	42.5%	31.9%
Percent of Children (0-17 years old) Whose Parent/Guardian/Decision Maker Reported Rating Community's Access to Fresh Fruits/Vegetables as Excellent or Good.	2015	--	75.0%	81.4%	69.8%
Percent who reported the availability of affordable fresh fruits and vegetables in their neighborhood	2014	98.9%	98.8%	99.6%	99.9%
Community Safety and Violence Among Youth					
Percent of teens who feared being attacked at school in the past year	2017	9.2%	--	--	--
Percent of teens who perceive their neighborhood park or playground as safe	2017	94.9%	93.2%	100.0%	68.3%
Percent of youth(1-17 years old) Reported Easy Access to a Park, Playground or Other Safe Place to Play	2015	--	86.8%	86.3%	81.9%
Percent of Children (0-17 years old) Whose Parent/Guardian/Decision Maker Reported Rating Community's Public Safety as Excellent or Good.	2015	--	63.6%	71.0%	55.5%
Percent of teens who received threats of violence or physical harm by peers in the past year	2017	9.1%	2.9%*	--	--
Rate of juvenile felony arrest per 1,000 youth	2015	5.3	5.1	--	--
Arrest Rate of persons under age 18 (per 100,000 aged 10-17) for Robbery	2014	65.0	77.0	--	--
Arrest Rate of persons under age 18 (per 100,000 aged 10-17) for Loitering/Curfew	2014	76.0	119.0	--	--
Percent of public school staff reporting High School Student bullying/harassment is a problem at school	2015	34.1	31.9	--	--
Rate of homicide per 100,000 pop.	2017	<=5.5	4.6	5.6	--
Rate of non-fatal assaults per 100,000 pop.	2017	266.1	330.5	--	--
Rate of violent crimes per 100,000 pop.	2017	450.7	583.4	--	--
Rate of robberies per 100,000 pop.	2017	142.9	205.3	--	--
CAOTS Ranking: Total Fatal and Injury by County (out of 58)	2016		2		
CAOTS Ranking: Pedestrian collision by County (out of 58)	2016		3		
CAOTS Ranking: Drinking Driver under 21 by County (out of 58)	2016		18		
CAOTS Ranking: Nighttime (9:00pm - 2:59am) by County (out of 58)	2016		1		
Access to Shelter					
Homelessness					
Total number of homeless individuals	2018	--	49,955	7,478	14,218
Total number of homeless youth	2015	--	280	40	73
Total number of homeless that are mentally ill	2015	--	12,253	2,095	3,408
Total number of homeless with a physical disability	2015	--	8,148	1,097	2,035
Total number of homeless with a substance abuse problem	2015	--	10,388	1,403	2,843
Total number of veterans who are homeless	2015	--	4,016	567	1,237
Homelessness: Percent of homeless who are single adults	2018		84.1%	77.2%	89.7%
Homelessness: Percent of homeless who are families	2018		15.8%	22.8%	9.9%
Homelessness: Percent of homeless who are unaccompanied minors	2018		0.1%	0.0%	0.3%
Homelessness: Percent chronically homeless	2018		26.6%	24.6%	31.7%
Homelessness: Percent with substance abuse	2018		14.8%	17.2%	19.0%
Homelessness: Percent who have HIV/AIDS	2018		1.5%	1.3%	3.4%
Homelessness: Percent who have serious Mental Illness	2018		26.8%	27.9%	31.4%
Homelessness: Percent who are survivors of domestic violence	2018		29.6%	29.7%	33.5%
Homelessness: Percent who are veterans	2018		7.1%	5.0%	7.6%
Homelessness: Percent who are under 18	2018		9.5%	12.7%	6.2%
Housing					
Percent of occupied housing with one or more substandard conditions	2014	47.5%	54.0%	--	--

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	Year of Data	Healthy People 2020 Target	California	Los Angeles County	SPA 2 - San Fernando	SPA 4 - Metro
Percent of housing units that are vacant	2014		8.5%	6.4%	--	--
Rate of HUD-assisted units per 10,000 housing units	2013		368.3	439.3	--	--
Housing units: owner occupied	2017		54.9%	46.9%		
Housing units: renter occupied	2017		45.5%	54.1%		

Appendix B

Primary Data Gathering Tools

Glendale 2019 Community Health Needs Assessment

The Center for Nonprofit Management (CNM) is working with the City of Glendale's Healthier Community Coalition to conduct the 2019 Community Health Needs Assessment.

We are reaching out to health experts, providers, and other key stakeholders to obtain their perspective on the most important health issues facing the local community. Please take a few minutes to complete this survey. Thank you in advance for your time, we appreciate your input into this important process! All responses will be kept confidential.

1. What data do you use to monitor community health trends and conduct planning?

2. What specific sources do you consult? (e.g., reports, websites...)

3. What trends have you noticed in the past three years related to the health of the Glendale community?

4. What are the three top health needs for the Glendale community?

1.

2.

3.

5. Who or what groups in the community are most affected by these issues?

6. Of the health issues listed below, what are the top five for the Glendale community? (please select only 5)

- | | | |
|--|---|---|
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Access to primary care | <input type="checkbox"/> Substance use disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Teen births | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Mental health | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dental health | <input type="checkbox"/> Chlamydia | |

Other (please specify)

7. What are the biggest challenges to achieving health and well-being from an individual and community perspective?

8. Specifically, what challenges does your organization face in serving your target populations and in addressing these issues?

9. What do you think are effective strategies for addressing these issues?

10. What resources exist in the community to help address these health issues? (e.g., people, organizations or agencies, programs, or other community resources) *

11. What else is important for us to know about significant health needs in the community?

12. Have you used the 2016 Glendale Community Health Needs Assessment Report?

Yes

No

13. If the answer to the previous question was "yes," can you describe: what was most helpful? What would make the report more helpful?

14. Check here if you would be interested in participation in upcoming Community Health Needs Assessment activities.

Yes, I would be interested.

15. Participant Information (to be used exclusively for reporting purposes):

Name: (Optional)

Organization:

Organization ZIP code:

Title:

Primary area of expertise:

Primary service population:

Primary geographic service areas:

Email (we will not publish, share, or sell your email address in any way):

16. What (statistical) data do you collect that you might be able to share?

17. What other data or information/perspective do you collect that you might be able to share?

2019 Glendale CHNA Prioritization

The Center for Nonprofit Management (CNM) is conducting the 2019 Community Health Needs Assessment (CHNA) for Glendale Adventist Medical Center, Dignity Health Glendale Memorial Hospital and we need your assistance.

We have gathered data from local and regional sources and valuable insights from service providers and community members about the communities served by the hospitals. After reviewing this input, in conjunction with a range of health indicators from public and private data sources, the CNM CHNA team developed the following list of prominent health needs and drivers/predictors. Please note that the health needs are listed in alphabetical order, and NOT by order of importance.

We need your input to help prioritize these health needs and drivers and determine which represent the areas of greatest need. The following confidential survey should take about 10 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. (Provided as an attachment.)

The results from this survey will inform Glendale Adventist Medical Center, Dignity Health and Glendale Memorial Hospital in developing strategies for their Community Benefits Plans.

Please complete this survey by 5 pm, Wednesday, May 3, 2019. Thank you very much for your time and assistance!

Please contact Maura Harrington at mharrington@cnmsocal.org or Gigi Nang at gnang@cnmsocal.org with any questions about this survey.

2019 Glendale CHNA Prioritization

1. Please tell us about yourself (for analysis purposes).

Name

Organization

Email

2. Please define your service area by selecting from the list of hospital service areas and cities/communities below. (Select all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Glendale Adventist Medical Center | <input type="checkbox"/> La Canada/Flintridge |
| <input type="checkbox"/> Dignity Health Glendale Memorial Hospital | <input type="checkbox"/> La Crescenta |
| <input type="checkbox"/> USC Verdugo Hills Hospital | <input type="checkbox"/> Los Feliz |
| <input type="checkbox"/> Altadena | <input type="checkbox"/> Montrose |
| <input type="checkbox"/> Eagle Rock | <input type="checkbox"/> Pasadena |
| <input type="checkbox"/> Glassell Park | <input type="checkbox"/> Sunland |
| <input type="checkbox"/> Glendale | <input type="checkbox"/> Sylmar |
| <input type="checkbox"/> Griffith Park | <input type="checkbox"/> Tujunga |
| <input type="checkbox"/> Highland Park | <input type="checkbox"/> Verdugo City |
| <input type="checkbox"/> Hollywood | |

2019 Glendale CHNA Prioritization					
Identified Health Needs					
Please refer to the Prioritization Criteria Scale when selecting your responses.					
3. Cancer					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Cardiovascular Disease					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Communicable/Infectious Diseases					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Diabetes	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Mental Health					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Obesity					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Sexual Health/STDs					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Stroke					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2019 Glendale CHNA Prioritization					
Drivers of Health					
Please refer to the Prioritization Criteria Scale when selecting your responses.					
11. Access to Health Care					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Dental Care					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Geriatric Support					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Homelessness and Housing					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Poverty					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Preventative Wellness					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. Substance Abuse	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Transportation					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Violence/Injury/Safety					
	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESOURCES - The availability of community resources and assets to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COMMUNITY READINESS- Community readiness to effectively implement and support programs to address this health need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>20. 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.)</p> <p>Health Need or Driver:</p> <input type="text"/> <p>Health Need or Driver:</p> <input type="text"/>					

Appendix C

Stakeholders

Appendix C—Stakeholders

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Aghazadeh	Shirin	AHGL Family Medicine Residency Program			X
Akhavan	Jamshid	AHGL Family Medicine Residency Program			X
Artyunyan	Mary	Leisure Glen Post Acute	Administrator	X	
Avanesyan	Melinie	Leisure Glen Post Acute	Marketer	X	
Azza	Ban			X	
Banks	Kiara	Ascencia			X
Bedoyan	Isabel	AHGL FMRP			X
Beers	Yasmin	City of Glendale	City Manager	X	
Bergh, DDS	Brian	Bergh Orthodontics		X	
Bickle	Scoti	Glendale Police Department			X
Bourdon	Irene	Healthcare Foundation at Adventist Health Glendale	President	X	
Broussalian	Susan	City (Commission on Status of Women)			X
Burns	Lynda	Commission Status			X

Glendale Memorial Hospital and Health Center
2019 Community Health Needs Assessment

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Carrillo	Erik	Adventist Health Glendale - Champions for Change	Program Coordinator	X	
Carver	Danny	Glendale Police Department	Lieutenant	X	X
Chinn	Sylvia	YMCA of Glendale			X
Cooney	Betty	Southern California Conference of SDA	Health Response Steering Committee - Chair	X	X
Crabtree Warner	Meredith	American Heart Association			X
Crawford	Beth	YMCA of Glendale	COO	X	
Crowe	Nina	Glendale Arts			X
Cuestas Galdamez	Mario Ernesto	Anthem		X	X
Davis-Moore	Sheryl	Glendale Police Department			X
Davtyan	Lilyt	Pueblo Y Salud			X
Dickson	Jill	Adventist Health Glendale	Director, Cancer Services	X	
Dudley	Catherine	Glendale Community College		X	
Duncan, Ph.D.	Laura	Ascencia	Acting Executive Director	X	X
Duncan, Ph.D.	Trisha	FML Resident			X
Durfalian	Laura	Glendale Unified School District			X

Glendale Memorial Hospital and Health Center
2019 Community Health Needs Assessment

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Espinoza	Vincent	Glendale Arts			X
Farag	Mina	Anthem		X	
Filipian	Marie	Dignity Health Glendale Mem Hospital & Health Ctr	Community Health Manager	X	
Fortuno	Marissa	American Heart Association	Strategic Initiatives & Planning	X	X
Gamble, FACHE	Mark	Hospital Association of Southern California	Senior Vice President & COO	X	
Gano	Andrew	Glendale Fire Department		X	
Garcilazo	Al	Adventist Health Glendale	Senior Chaplain	X	
Ghaleehyan	Kristine			X	
Glickmen	Elissa	Glendale Arts			X
Gorman	Dale	Kids' Community Dental Clinic	Executive Director	X	X
Gukasyan, EdM	Stella	Elevation Health Partners	Quality Improvement Champion	X	X
Hamidi	Sayed	Catholic Charities		X	
Hasan	Marah	Glendale District			X
Hill, Ed.D	Robert	Glendale Community College	Dean of Student Services.	X	

Glendale Memorial Hospital and Health Center
2019 Community Health Needs Assessment

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Hinekley	Bruce	Glendale Polica, Verdugo Hills BSA, Glendale Free Clinic			X
Hobbs	Keith	USC Verdugo Hills Hospital	President & CEO	X	
Holland	Lindsay	Health Services Advisory Group			X
Hyah	Stephen	AHGL Family Medicine Residency Program			X
Isayan	Aylin	City of Glendale			X
Issai	Alice	Adventist Health Glendale	President	X	
Joseph	Ashley			X	
Kampe	Katherine	AHGL Family Medicine Residency Program			X
Karinski	Edna	Community Foundation of the Verdugos	CEO & GHCC Chair	X	X
Kaufman	Margaret			X	
Kavarian	Maggie	City of Glendale		X	X
Keenan	Holly	Planned Parenthood			X
Kelly, Psy.D	Patrick	Didi Hirsch Mental Health Services	Assistant Program Director	X	
Kerkyasharian	Salpi	Glendale Unified School District			X
Kesheshian	Mher	All For Health, Health For All, Inc.	QI Director	X	X
Khanoyan	Sivard	AHGL Family Medicine Residency Program	PHYSICIAN	X	
King	Kelly	Glendale Unified School District			X

Glendale Memorial Hospital and Health Center
2019 Community Health Needs Assessment

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Klaric	Joan	Adventist Health Glendale	Office Coordinator	X	
Kombazdjian	Mary	AHGL Family Medicine Residency Program			X
Kuder	Mary	AHGL FMRP			X
Kuo, MD	Tony	LA County Department of Public Health		X	
Kuo, MD, MSHS	Tony	LA County Department of Public Health			X
Le	George	GAMC FMRP			X
Leach	Travis	Glendale Community College		X	
Lee	Cameron	FML Resident			X
Lehman	Nathan	LA County Department of Public Health		X	X
Leonard	Todd	Glendale City SDA Church	Senior Pastor	X	
Lopez	Oscar	Health Services Advisory Group		X	
Lopez	Irma			X	
Lymbertos	Andrea	Pacific Clinics Headstart	Heath and Nutrition Coordinator	X	
Maghaguian	John	City of Glendale	Community Services Supervisor	X	X
Magran, Ed.D	Ilin	Glendale Unified School District	Assistant Director, Student Support Services	X	X

Glendale Memorial Hospital and Health Center
2019 Community Health Needs Assessment

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Malick	Devon	Glendale YMCA		X	
Markarian	Evelina	Pacific Clinics		X	
Markarian	Alvart	LA County Department of Public Health		X	
Martinez	Corina	AltaMED			X
Maxey	Simone	Health Service Advisory Group			X
McCarty	Rev. Cassie	Dignity Health Glendale Mem Hospital & Health Ctr	Dir, Mission Integration & Spiritual Care Svcs	X	X
McDowell	Michael	The Soldiers Project	Executive Director	X	
Melkonian	Araz	AHGL Family Medicine Residency Program			X
Mercado	Marylou	Planned Parenthood PS GV			X
Mettler	Markus	Healthcare Management Services LLC	President & COO	X	
Mozian	Rita	LA County Department of Public Health	Health Educator	X	
Murphy	Theresa	USC Verdugo Hills Hospital	CNO	X	
Najarian	Ara	City of Glendale	City Council Member	X	
Nelson	Bruce	Adventist Health Glendale	Administrative Director, Community Research	X	
Nelson	Kerry	Adventist Health Glendale	We Own the Health of Our Community & TCPi	X	

Glendale Memorial Hospital and Health Center
2019 Community Health Needs Assessment

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Norhajuion	John	City of Glendale	Community Services Supervisor	X	
Ochoa	Karen	Health Services Advisory Group		X	X
Olivares	Joe	City of Glendale - Library, Arts & Culture		X	
Ortiz-Luis	Anthony	Valley Care Community Consortium	Director	X	
Paddock	Nina	Pacific Clinics Headstart			X
Parker	Tanya	Planned Parenthood of Pasadena and San Gabriel Valley		X	
Pecache	Margita	Adventist Health Glendale		X	
Pelaez	Yudies	FML Resident			X
Pelayo	Silverio	Pueblo Y Salud			X
Pezeshkian	Gayaneh	Harmony Health MD	Community Liaison	X	
Port	Christian	Planned Parenthood of Pasadena and San Gabriel Valley		X	X
Portantino	Senator Anthony	California State Senate - 25th District		X	
Powers	Christine	City of Glendale	Program Supervisor	X	X
Poyiazzs	Carl	Glendale Police Department			X
Ramirez	Elaine			X	

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Resterdian	Merl	AFH, HFA	QI/AM Members	X	
Reyes	Toni	Glendale Community College	Program Manager II	X	
Rivera	Martha	Adventist Health Glendale - Champions for Change	Project Director	X	
Rivera	Guadulesa	AHGF			X
Roberson Jr. Ed.D	Winfred	Glendale Unified School District	Superintendent	X	
Romanowski	Lynn			X	
Saikali	George	YMCA of Glendale	CEO	X	
Schlatter	Jason	Glendale Communitas Initiative	Executive Director	X	X
Seidman	Lila	Glendale News-Press		X	
Stella	Petros	Glendale Unified School District			X
Tamayac	Alicia	Adventist Health Glendale - Champions for Change	Health Educator	X	
Tchakian	Arda	Senator Portantino's Office - 25th District	District Representative	X	X
Tolentino, RN	Angelo	Glendale Community College	Health Sciences Division, Nursing	X	
Tomczyszyn	Taylor	American Heart Association			X
Townsend	Sharon	Children's Burn Foundation	Executive Director	X	

Glendale Memorial Hospital and Health Center
 2019 Community Health Needs Assessment

Last Name	First Name	Organization	Professional Title	Focus Group Health Summit October 2018	Prioritization Forum Participation
Trumbo	Shelly	Adventist Health	Community Health Executive	X	
Twu	Pamela	AHGL Family Medicine Residency Program			X
Van Wagner	Janice	YMCA of Glendale			X
Wang, MD, DrPH, CPE	William	Dignity Health Glendale Mem Hospital & Health Ctr	CMO	X	X
Weirick	Deborah	USC Verdugo Hills Hospital	Special Projects Manager	X	
Welton	Jill	Dignity Health Glendale Mem Hospital & Health Ctr	President & CEO	X	
Yarian	Lusine	Glendale Police Department			X
Yeghiayan	Lisa	Glendale Arts			X
Yu	Jack	AHGL FMRP			X
Zulli	Alice	Adventist Health Glendale	Chaplain	X	

Appendix D

Data Sources

Data Sources/Bibliography

In Order of Appearance in the Report.

1. Dignity Health Memorial Hospital (2018). Community Benefit 2018 Report. Retrieved from <https://www.dignityhealth.org/about-us/community-health/community-health-programs-and-reports/community-health-needs-assessments>
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