

# Community Health Needs Assessment

# 2022



# Encino Hospital Medical Center



American Heart Association  
American Stroke Association  
**CERTIFIED**  
Meets standards for  
**Primary Stroke Center**



Member of Prime Healthcare

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# 2022 ENCINO HOSPITAL MEDICAL CENTER COMMUNITY HEALTH NEEDS ASSESSMENT

## EXECUTIVE SUMMARY

Encino Hospital Medical Center (**EHMC**, or the **Hospital**) contracted KEYGROUP to oversee the process of developing a Community Health Needs Assessment (**CHNA**) directly addressing healthcare needs in Encino Hospital Medical Center's service area. This CHNA is designed to comply with California's Senate Bill 697 (**SB 697**) and to meet the requirements under the Patient Protection and Affordable Care Act (**ACA**). This report marks the third iteration of the CHNA process which occurs every three years. The 2022 CHNA builds on the Hospital's 2019 CHNA, and updates conditions found in the community as of 2022. As the process of reviewing and analyzing community needs has progressed, it is clear that while changes have occurred in the San Fernando Valley as a whole, and in Encino Hospital Medical Center's immediate area, the changes have not been uniform throughout the valley.

EHMC's assessment process has concentrated on health issues that can be directly addressed by the Hospital, either on its own, or in concert with other healthcare providers. The primary issues emerging from this process have been problems that impede residents from accessing healthcare at appropriate times, and on making sure that the services provided are made known to the service area, and are provided affordably to clients. The primary methods of obtaining community opinions regarding healthcare needs were focus group meetings with community members, and written surveys collected from community residents.

The Four Issues considered by the focus group to be the most salient to EHMC's ability to impact community needs were:

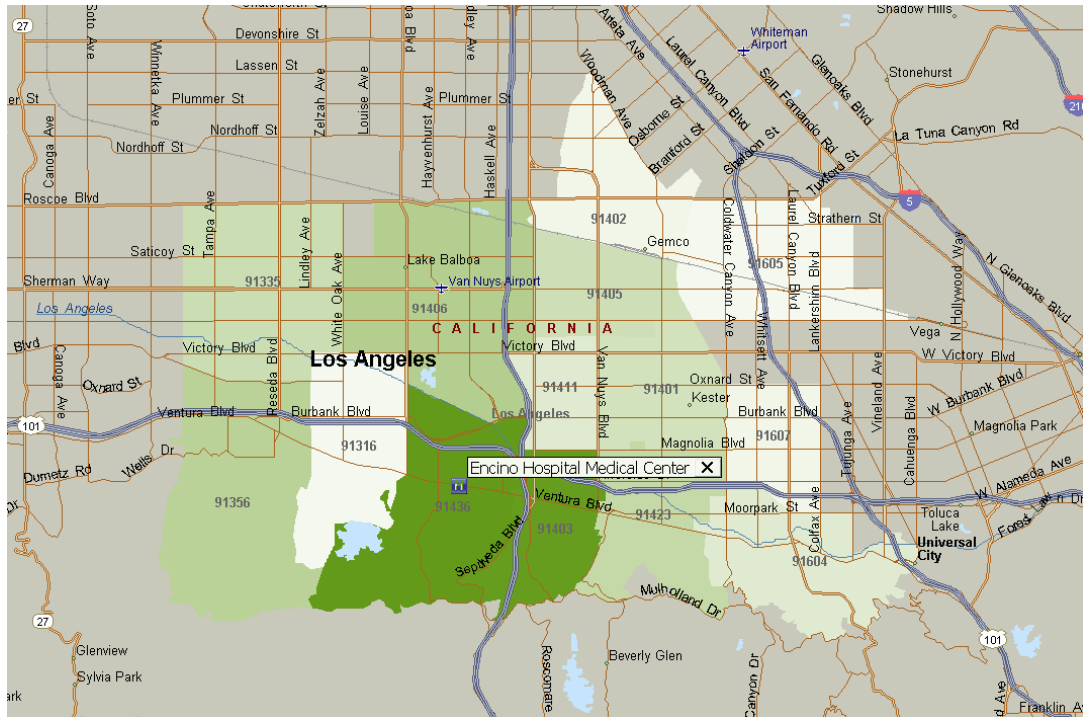
- Mental Health,
- Continuity of Care,
- Homelessness, and
- Employee Issues.

Each of these is addressed in the following sections, following a discussion of EHMC's Primary Service Area.

In addition to the focus group work, community members were invited to complete surveys assessing their opinions on health status, health needs and existing options for healthcare services. Results of these surveys are detailed later in the report.

## SERVICE AREA DISCUSSION

KEYGROUP obtained patient discharge data from EPMC for calendar year 2021, using the 1886 reported inpatient discharges as the universe of potential service areas. Upon review of discharge zip codes, it was determined that only fourteen zip codes originated more than 1% of all discharges over the year. These fourteen zip codes accounted for just under half of all discharges at 47%, and are defined as the Encino Hospital Medical Center Primary Service Area (**EPMC PSA or PSA**). A map of the PSA in 2021 is shown below. All zip codes in color are part of the PSA, with color intensities showing the relative contributions by each. The zip codes in numerical order are:



- 91316 Encino
- 91335 Reseda
- 91356 Tarzana
- 91401 Van Nuys
- 91402 Panorama City
- 91403 Sherman Oaks
- 91405 Van Nuys
- 91406 Van Nuys
- 91411 Van Nuys
- 91423 Sherman Oaks
- 91436 Encino
- 91604 Studio City
- 91606 North Hollywood
- 91607 Valley Village

## FOCUS GROUP SUMMARY

Focus Group interviews were conducted by KEYGROUP, with the KEYGROUP focus group concentrating on issues most important to local participants. Interviews produced a variety of perceived needs, which were reviewed and winnowed down to the most immediate health needs and for EHMC's PSA. Summaries for immediate health needs are provided below, listed in order from highest to lowest priority as listed by respondents in the EHMC PSA.

KEYGROUP has conducted focus group surveys and individual phone interviews with representatives of area health agencies, social service providers, and local government organizations (collectively, **Key Informants**). After initial brainstorming sessions, during which participants were asked to think of healthcare-related problems in the community, over 35 health needs were suggested by the Key Informants, and winnowed down to the four considered most important by the focus group participants.

Preliminary results of interviews indicate a predominance of several issues noted by respondents. These issues represent both community health problems as a group, and individually they represent opportunities for the Hospital to provide improvements. They are outlined below

1. **Mental Health** – This category was the most cited issue, both in terms of number of participants choosing it as important, and in terms of considering it most important. This general term generated many related ideas, and they were consolidated into this general category. Among issues related to mental health was a need for inpatient mental health services, problems with substance abuse that intersected general mental health problems, and issues related to acute physical problems presented at the Emergency Department which are related to mental health problems suffered by the patient.
2. **Continuity of Care** – An emerging topic of discussion within medical and social work circles are **Social Determinants of Health (SDOH)**. SDOH issues include conditions that exist outside a healthcare institution, often in the home or immediate neighborhood, which make it difficult to manage chronic diseases such as diabetes, high blood pressure or osteoporosis. A second issue related to Continuity of Care is the welter of regulations and reimbursement issues that interfere with healthcare providers finding the most appropriate settings for inpatient treatment.
3. **Homelessness** has become a major issue in Los Angeles as more and more residents are living on the streets. It has also been a major topic of litigation, and attempts to deal with it are spilling into the political arena. Several bond issues have passed in the last two elections to provide funds for housing and treatment of unhoused residents, with mixed results. The most recent

election at the end of 2022 resulted in a new slate of City Council representatives who will have different ideas as to how to address the problem.

4. **Employee Retention** – One of the most prominent effects of the Covid pandemic has been the “Great Resignation” in which many employees were either laid off or forced to work from home, and who have elected not to come back to work. In the healthcare field the opposite happened as many staff were required to work punishing hours on site to cope with the influx of patients while simultaneously attempting to protect their own health. As the pandemic has subsided, many employees in all fields have elected not to return to their old employers. This phenomenon has been particularly evident in inpatient healthcare settings, such as hospitals, nursing facilities, and retirement communities. As with homelessness, governmental attempts at solutions have addressed some immediate problems, but often with lingering after-effects, while legislation aimed at increasing staff wages has targeted healthcare providers without an equivalent increase in reimbursement.

## ACKNOWLEDGMENTS

This CHNA 2022 is the result of the commitment and efforts of many individuals who contributed time, expertise and resource to create a comprehensive and effective community assessment. Special thanks go to the Steering Committee and the Advisory Committee members, the staff at Encino Hospital Medical Center, community leaders, and organizations that participated in our interviews and members of the community that took the survey and shared their experiences and information for the benefit of this assessment.

Many data sources were utilized in developing the health profile for the Encino Hospital Medical Center Primary Service Area and larger comparison areas. Data from the U.S. Census Bureau underlies much of the information presented, but several agencies and providers have done important analysis on the Census data. Results of their work are included throughout this document. Important sources include:

- Perception Health database, with data extracted and provided by Encino Hospital Medical Center
- Community Commons.org website
- American Community Survey section of the U.S. Census website

- Valley Community Care Consortium. The Service Planning Area 2 of Los Angeles County data was generated by VCCC from the Community Commons platform website. Updates from the CommunityCommons.org website were used where updates were available.
- The Los Angeles County Department of Public Health’s *Strategic Plan 2018-2023* and *Community Health Improvement Plan 2015-2020* (due to Covid-related delays the 2020-2025 version is not yet available).
- Google Earth Pro Mapping Software
- California Health Care Foundation’s *2022 CHCF California Health Policy Survey*
- Mental Health America’s *The State of Mental Health in America 2021*
- Sparkmap Standard Report 2022

## METHODOLOGY

### Primary Data

Primary data was collected utilizing various methods, such as key informant interviews, focus groups with both health professionals and community residents, and written surveys obtained from residents in the area.

#### *Focus Groups:*

Utilizing a focus group facilitation guide, a two-hour focus group was conducted with 18 community members, leaders, and service providers. The community stakeholders that participated in the CHNA represented the broad interests of the community, and included public health experts and other individuals knowledgeable about the health needs found in the community.

For a copy of the facilitation guide and focus group questions, please refer to **Appendix D**.

#### *Community Surveys:*

A total of 203 written surveys were administered to participants by KeyGroup and EHMC staff. Most of the surveys were solicited from shoppers in the business districts surrounding EHMC. Others came from meetings of civic groups, churches and other community organizations. In addition, a SurveyMonkey version of the survey form was created, and responses solicited via email to mailing lists operated by EHMC. These results were integrated into the results from the written surveys.

### Secondary Data

Secondary data was retrieved through a review of publicly reported demographic and health statistics. Except on rare occasions, data was retrieved via electronic data searches. Demographic data such as age, ethnicity, income, insurance, disease prevalence, and five-year projected estimate information was extracted from the Census Bureau information found in the American Community Survey section of the Census website. Some portions were quoted from various documents that analyzed census data and are cited as used. Additional data on education attainment, region of birth, grandparents caring for their grandchildren, and English proficiency was gathered from the U.S. Bureau of Census (American Factfinder). In addition, the Dignity Health (DH) Community Need Index (CNI) tool was reviewed to assist with the identification of high need areas. Information for this report consisted of both secondary and primary data, and therefore the collection of data came from multiple sources.

Data gathered was analyzed using methods such as grouping and statistical analysis. Data was grouped according to health conditions, co-morbidities, age, gender, and ethnicity, in addition to other specific needs for the CHNA report. The zip code level data collected was used to compare various communities in the Encino Hospital Medical Center service area service area. This comparative data was analyzed to determine areas of disparity in the EHMC PSA compared to the larger areas used for comparison. Where significant

deviations from the large area norms were found, they are presented to show the important disparities between communities. Where the EHMC PSA is similar to the larger areas, the large area data is presented as representative of the EHMC PSA. It should be noted that many health conditions were not covered by the various sources, so direct comparison was not always possible.

## COMMUNITY PROFILE

The Los Angeles County Department of Public Health (**LADPH**) is charged with collecting and analyzing health indicators for the county as a whole. To provide more localized information on various portions of the county, LADPH divides the county into smaller Service Planning Areas (**SPAs**). EHMC is in SPA 2.

SPA 2 incorporates zip codes located mostly in the San Fernando Valley. It is shown in the following map of Los Angeles County. EHMC's approximate location is shown in red. Data for this area is assembled and published in various locations. Summary data comparing SPA 2 with larger geographies is available, and quoted in the sections below. The same data is used by other hospitals in SPA 2, and some of the charts below cite the same sources as these hospitals.

### San Fernando Valley

**Service Planning Area 2, or SPA 2, serves the communities of Burbank, Calabasas, Canoga Park, Canyon Country, Encino, Glendale, La Cañada-Flintridge, San Fernando, Sherman Oaks, Sun Valley, Van Nuys, Woodland Hills, and others.**



To better understand the health needs in the Hospital service area, KEYGROUP reviewed numerous state and county sources. A local literature review was conducted, and community assets and resources were documented. This analysis process concentrated on the whole of SPA 2, and uses data from various years.

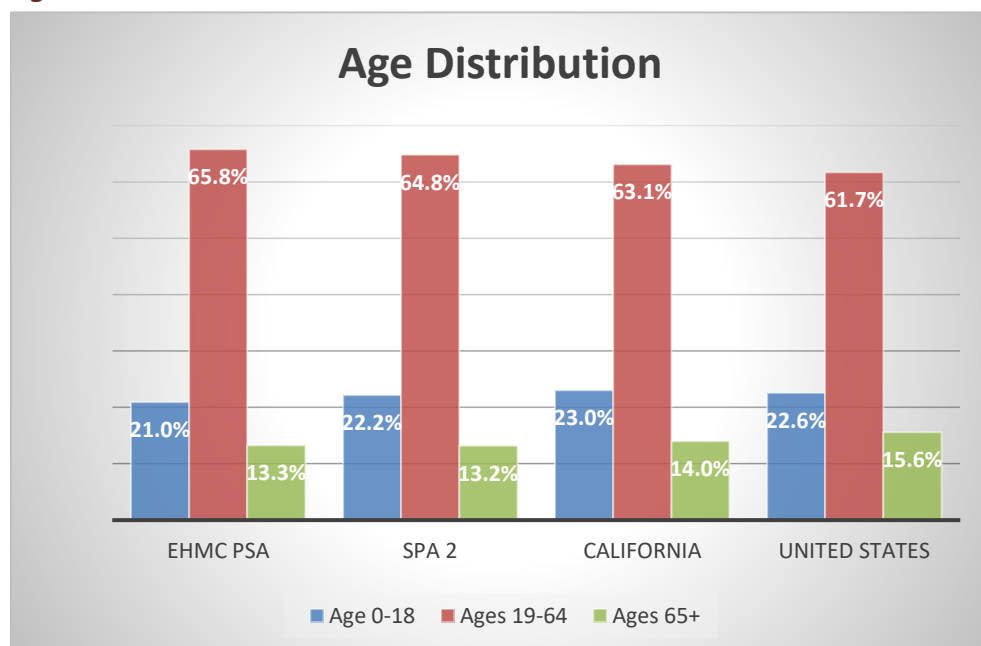
## Demographic Data

Basic population data was drawn from US Census data.

As was shown earlier, Encino Hospital Medical Center’s Primary Service Area (**EHMC PSA or PSA**) covers 14 zip codes in the San Fernando Valley area of Northern Los Angeles County, and was home to more than 582,000 residents as of the 2020 Census. Data gathered from the 2020 U.S. Census American Community Survey estimates show that male and female populations are split almost equally.

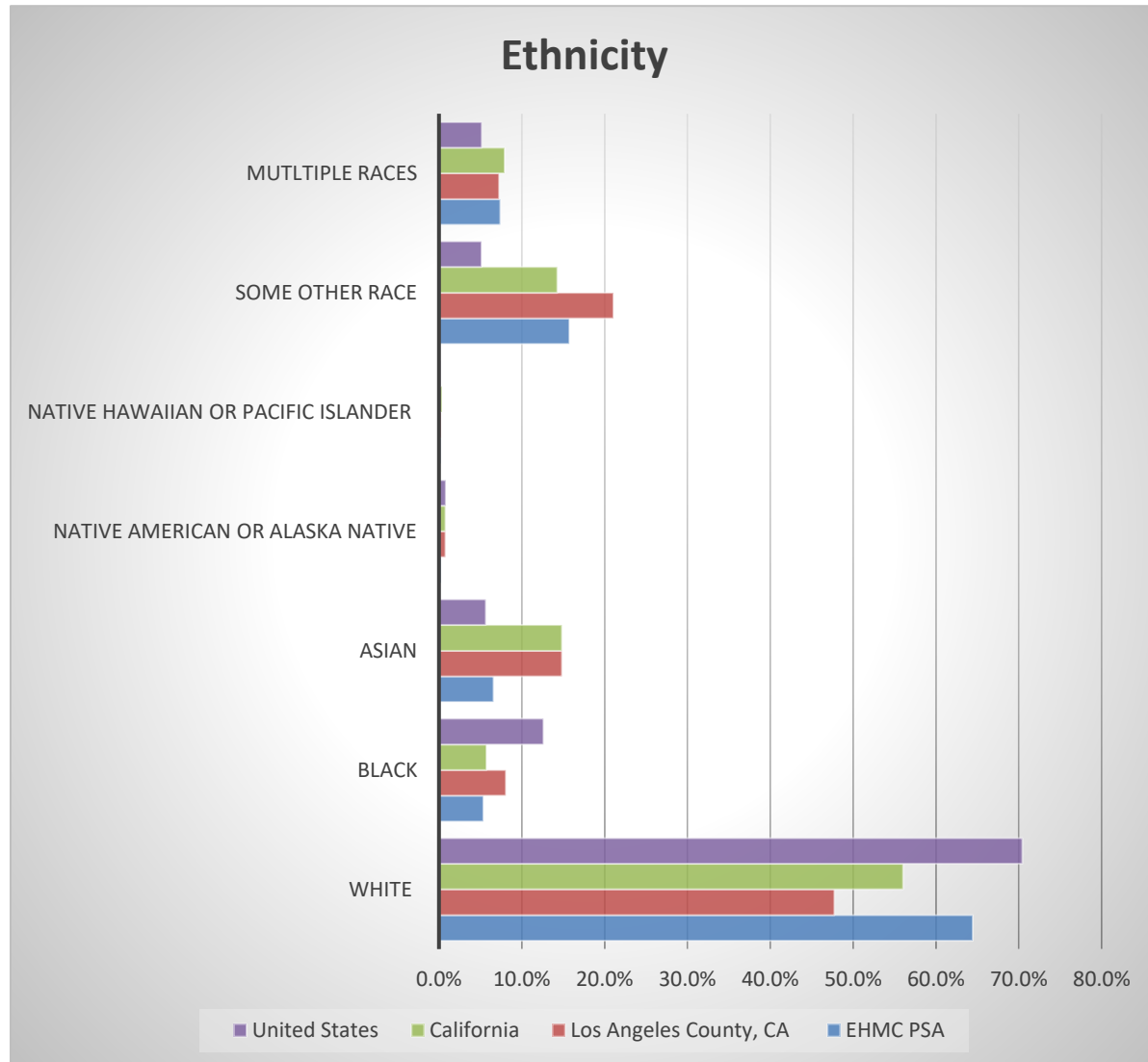
Other basic demographic issues include age distribution, ethnic group distribution, educational achievement and household income distribution.

### Age



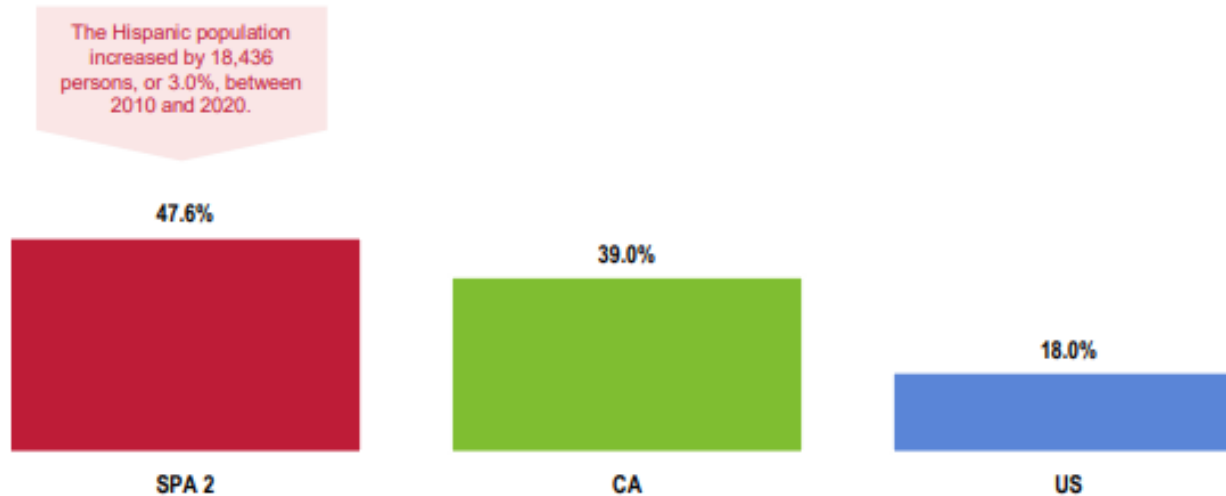
The comparison of age groups for the EHMC PSA, SPA 2, California, and the US, is shown below. Note that EHMC’s PSA has a lower percentage of 18-and-under residents (21.0%), with more middle-age groups (65.8%) than the comparison areas. It also has slightly fewer 65+ residents (13.3%) than either California or the U.S. although it exceeds SPA 2 by a very small margin.

**Ethnicity**



Ethnicity questions were adjusted in the 2020 census, so exact comparisons with data predating that survey are not exact, but the EPMC PSA data and API reports for comparison areas are shown below. It is interesting that the white proportion of the EPMC PSA population is larger than any of the California comparables. Other major ethnic groups (Black and Asian) are represented in roughly equal proportions in the PSA. The standout ethnic group is “some other race”, although it is less predominant than in Los Angeles County overall.

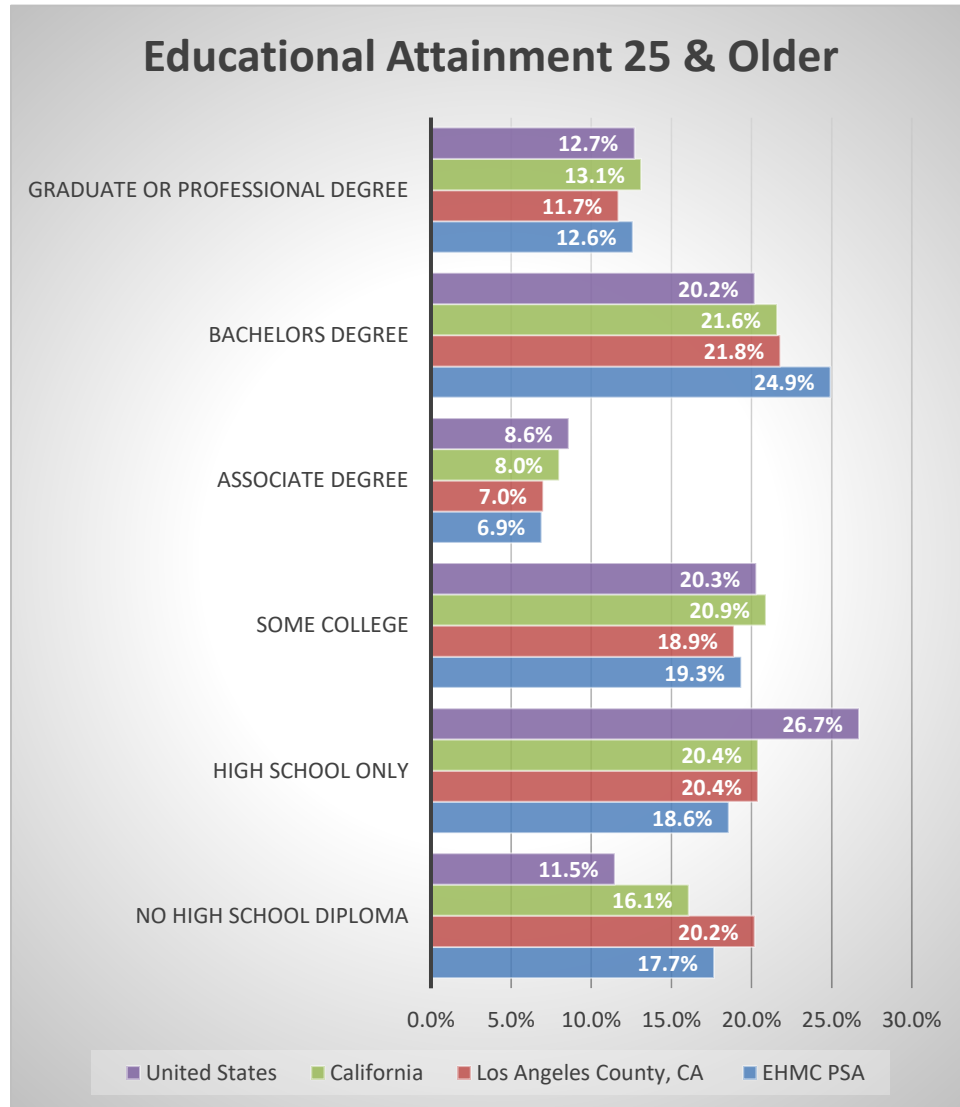
## Hispanic Population (2015-2019)



Sources: • US Census Bureau American Community Survey 5-year estimates.  
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap ([sparkmap.org](http://sparkmap.org)).  
 Notes: • Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

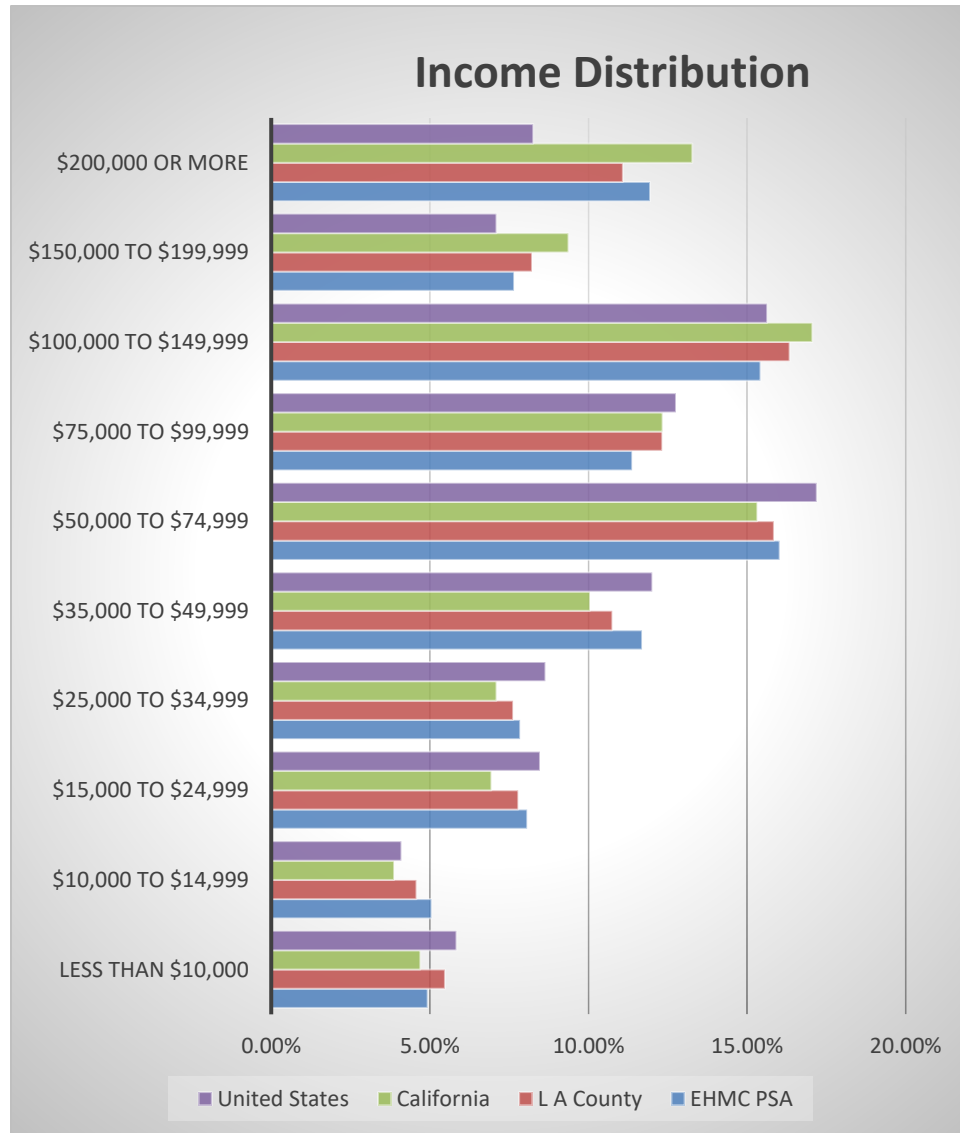
Since Hispanic is not a distinct “race”, it is not listed in the above chart. However, the number of Hispanic/Latino – identifying residents of the EHMC PSA is substantial at 42.1% in the 2020 Census. The mix of dominant ethnicities in SPA 2 was slightly higher, with Hispanic/Latino representing a larger proportion of the total population (47%). The EHMC percentage is roughly between the two ranges, and significantly above the US rate.

**Education Attainment**



Education plays a very significant role in all aspects of life, including maintaining a healthy lifestyle. In the Encino Hospital Medical Center PSA, the highest percentage of adults 25 years or older are those with a bachelor’s degree. The PSA shows a slightly higher proportion of graduate degree holders than the County as a whole, but less than California or the US.

**Income Level**



Low-income levels create obstacles to gaining access to medical services, purchasing healthy foods, and other necessities. EHMC’s distribution of household income tends to group in lower middle-income strata, with fewer very low-income residents, and fewer very high (over \$75,000) income levels, although the \$200,000 plus category exceeds the Los Angeles County distribution.

***Crime Statistics***

The crime data presented here provides Compstat data, drawn from the database that the Los Angeles Police Department (**LAPD**) uses to track crime statistics. New reports are filed monthly for each division of LAPD and are available for public viewing at [www.lapdonline.org/assets/pdf/vnysprof.pdf](http://www.lapdonline.org/assets/pdf/vnysprof.pdf). The chart shown is as seen on the website of November 2022. It includes comparative data for **Years to Date (YTD)** 2020 and 2021. EHMC’s PSA is primarily located in LAPD/s West Valley Division, extending from roughly the 405 Freeway on the east to the Ventura County Line on the west.

The LAPD provides monthly updates to its Compstat listings, which itemize crimes by type and time period for each division. The following chart for the West Valley division is as of November 2022. The most useful columns are the last three on the right, comparing year-to-date statistics for 2022 to those for 2020 and 2021. It should be noted that although Murders and Rapes have decreased over the past two years, virtually every other violent crime rose in relation to older years. Property crimes overall have also increased substantially in the past two years.



# COMPSTAT

## West Valley Area Profile

### 10/30/22 to 11/26/22



<b>WEST VALLEY COMMAND STAFF</b>  Rank: Date of Rank: Date Assigned Area: LAPD Appointment Date:		<b>AREA</b> <b>COMMANDING OFFICER:</b> Brian E. Wendling CAPT-III April 20, 2022 April 10, 2022 June 19, 1989		<b>PATROL DIVISION</b> <b>COMMANDING OFFICER:</b> Alexander K. Chogyoji CAPT-I April 10, 2022 April 10, 2022 August 28, 2000	<b>AREA RANKING</b> <b>WEEK ENDING:</b> 11/26/22  <b>VIOLENT CRIME:</b> 20  <b>PROPERTY CRIME:</b> 20  <b>PART I CRIME:</b> 20
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CRIME STATISTICS for week ending 11/26/22												
VIOLENT CRIMES	10/30/22 TO 11/26/22	10/02/22 TO 10/29/22	% Change	10/02/22 TO 10/29/22	09/04/22 TO 10/01/22	% Change	YTD 2022	YTD 2021	% Change	YTD 2022	YTD 2020	% Change
HOMICIDE	0	0	N.C.*	0	1	-100.0%	7	8	-12.5%	7	7	0.0%
RAPE (121,122)	1	1	0.0%	1	3	-66.7%	27	32	-15.6%	27	40	-32.5%
RAPE(815,820,821)	0	0	N.C.*	0	3	-100.0%	15	16	-6.3%	15	27	-44.4%
<b>TOTAL RAPE</b>	<b>1</b>	<b>1</b>	<b>0.0%</b>	<b>1</b>	<b>6</b>	<b>-83.3%</b>	<b>42</b>	<b>48</b>	<b>-12.5%</b>	<b>42</b>	<b>67</b>	<b>-37.3%</b>
ROBBERY	20	18	11.1%	18	28	-35.7%	275	194	41.8%	275	197	39.6%
AGGRAVATED ASSAULTS	46	53	-13.2%	53	53	0.0%	627	576	8.9%	627	526	19.2%
<b>TOTAL VIOLENT</b>	<b>67</b>	<b>72</b>	<b>-6.9%</b>	<b>72</b>	<b>88</b>	<b>-18.2%</b>	<b>951</b>	<b>826</b>	<b>15.1%</b>	<b>951</b>	<b>797</b>	<b>19.3%</b>
PROPERTY CRIMES	10/30/22 TO 11/26/22	10/02/22 TO 10/29/22	% Change	10/02/22 TO 10/29/22	09/04/22 TO 10/01/22	% Change	YTD 2022	YTD 2021	% Change	YTD 2022	YTD 2020	% Change
BURGLARY	94	92	2.2%	92	72	27.8%	861	641	34.3%	861	617	39.5%
MOTOR VEHICLE THEFT	84	72	16.7%	72	64	12.5%	931	766	21.5%	931	700	33.0%
BTFV	116	132	-12.1%	132	122	8.2%	1,439	1,104	30.3%	1,439	1,175	22.5%
PERSONAL /OTHER THEFT	71	75	-5.3%	75	68	10.3%	902	768	17.4%	902	809	11.5%
<b>TOTAL PROPERTY</b>	<b>365</b>	<b>371</b>	<b>-1.6%</b>	<b>371</b>	<b>326</b>	<b>13.8%</b>	<b>4,133</b>	<b>3,279</b>	<b>26.0%</b>	<b>4,133</b>	<b>3,301</b>	<b>25.2%</b>
<b>TOTAL PART I</b>	<b>432</b>	<b>443</b>	<b>-2.5%</b>	<b>443</b>	<b>414</b>	<b>7.0%</b>	<b>5,084</b>	<b>4,105</b>	<b>23.8%</b>	<b>5,084</b>	<b>4,098</b>	<b>24.1%</b>

Child/Spousal Abuse (Part I & II)*	44	48	-8.3%	48	63	-23.8%	604	586	3.1%	604	566	6.7%
SHOTS FIRED	5	4	25.0%	4	4	0.0%	75	65	15.4%	75	48	56.3%
SHOOTING VICTIMS	0	0	N.C.*	0	3	-100.0%	23	21	9.5%	23	13	76.9%

ARREST STATISTICS for week ending 11/26/22												
ARRESTS	10/30/22 TO 11/26/22	10/02/22 TO 10/29/22	% Change	10/02/22 TO 10/29/22	09/04/22 TO 10/01/22	% Change	YTD 2022	YTD 2021	% Change	YTD 2022	YTD 2020	% Change
HOMICIDE	0	0	N.C.*	0	0	N.C.*	10	7	42.9%	10	5	100.0%
RAPE	0	1	-100.0%	1	3	-66.7%	12	14	-14.3%	12	11	9.1%
ROBBERY	2	6	-66.7%	6	7	-14.3%	65	66	-1.5%	65	69	-5.8%
AGGRAVATED ASSAULT**	32	24	33.3%	24	37	-35.1%	332	309	7.4%	332	284	16.9%
BURGLARY	5	2	150.0%	2	4	-50.0%	48	74	-35.1%	48	75	-36.0%
LARCENY	4	9	-55.6%	9	6	50.0%	82	43	90.7%	82	56	46.4%
MOTOR VEHICLE THEFT	10	5	100.0%	5	9	-44.4%	130	150	-13.3%	130	132	-1.5%
<b>TOTAL VIOLENT</b>	<b>34</b>	<b>31</b>	<b>9.7%</b>	<b>31</b>	<b>47</b>	<b>-34.0%</b>	<b>419</b>	<b>396</b>	<b>5.8%</b>	<b>419</b>	<b>369</b>	<b>13.6%</b>
<b>TOTAL PART I</b>	<b>53</b>	<b>47</b>	<b>12.8%</b>	<b>47</b>	<b>66</b>	<b>-28.8%</b>	<b>679</b>	<b>663</b>	<b>2.4%</b>	<b>679</b>	<b>632</b>	<b>7.4%</b>
<b>TOTAL ALL ARRESTS</b>	<b>142</b>	<b>162</b>	<b>-12.3%</b>	<b>162</b>	<b>215</b>	<b>-24.7%</b>	<b>2,055</b>	<b>2,185</b>	<b>-5.9%</b>	<b>2,055</b>	<b>2,135</b>	<b>-3.7%</b>

\*Part II Child/Spousal Abuse Simple Assaults not included in Part I Aggravated Assaults above to comply with the FBI's Uniform Crime Reporting guidelines.

\*\*Statistics include domestic violence.

N.C. - Not Calculable

Statistics are based on the date the crime or arrest occurred.  
Arrest statistics include arrests made by outside agencies.

## HEALTH STATUS IN SERVICE PLANNING AREA AND COMPARISON AREAS

Measuring the morbidity and mortality of the hospital service area will help to bridge the gaps in services. Assessing the linkage between the social determinants of health and available assets in the community can help to improve the health outcome of the residents who are Hospital clients. In this section of the report, the health status of the communities will be discussed, and the prevalence of major health issues will be presented. The discussion pulls from multiple sources, which provide data in disparate forms. The source cited is referenced in each chart. It should be noted that no data on health indicators is collected on a zip code basis, so the source of the smallest geographic area with useful data is Los Angeles County’s Department of Public Health, with data specific to SPA 2 in some cases. In other cases, the smallest geographic area may be the City or County of Los Angeles.

### Asthma

Asthma is a recurrent cause of hospitalization and chronic illness, both in adults and children. The following table outlines the prevalence in both the adult population and the population of children under the age of 18. Given the Los Angeles Basin’s history of asthma triggers due to air quality and other factors, this is a useful predictor of potential hospitalizations in the affected population.

#### Asthma, Adults and Children, Ages 1-17

	SPA 2	Los Angeles County	California
Ever diagnosed with asthma, adults	18.4%	14.4%	16.0%
Has had an asthma episode/attack in past 12 months, adults	23.7%	27.6%	28.7%
Takes daily medication to control asthma, adults	45.0%	45.5%	44.7%
Ever diagnosed with asthma, ages 1-17	14.5%*	14.2%	13.6%
Has had an asthma episode/attack in past 12 months, ages 1-17	26.6%*	29.5%	27.4%
Takes daily medication to control asthma, ages 1-17	43.7%*	54.0%	50.3%

Source: California Health Interview Survey, 2019 \*Statistically unstable due to sample size. <http://ask.chis.ucla.edu/>

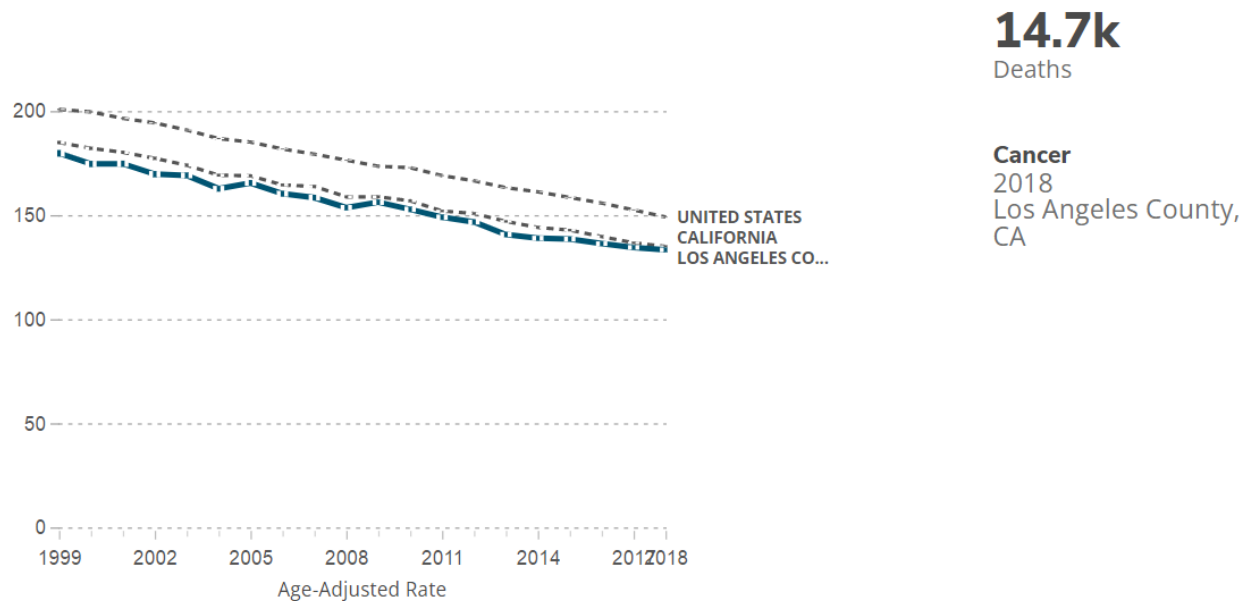
## Cancer

Cancer is the second-leading cause of death in the United States. Roughly 600,000 Americans died from cancer in 2017—nearly 185 deaths for every 100,000 people.

Cancer is caused by the development of neoplasms (tumors) which divide uncontrollably, spreading to and destroying surrounding tissues. There are many kinds of cancer, and many risk factors associated with them—notably tobacco and alcohol use. This report shows mortality data in Los Angeles County from the Centers for Disease Control and Prevention (CDC)'s WONDER database.

Nationally, the mortality rate for cancer has steadily declined since the 1990's. The American Cancer Society attributes this drop to a concurrent decline in smoking rates, as well as better methods for early detection and treatment of cancer.

Cancer Deaths per 100,000 Pop.

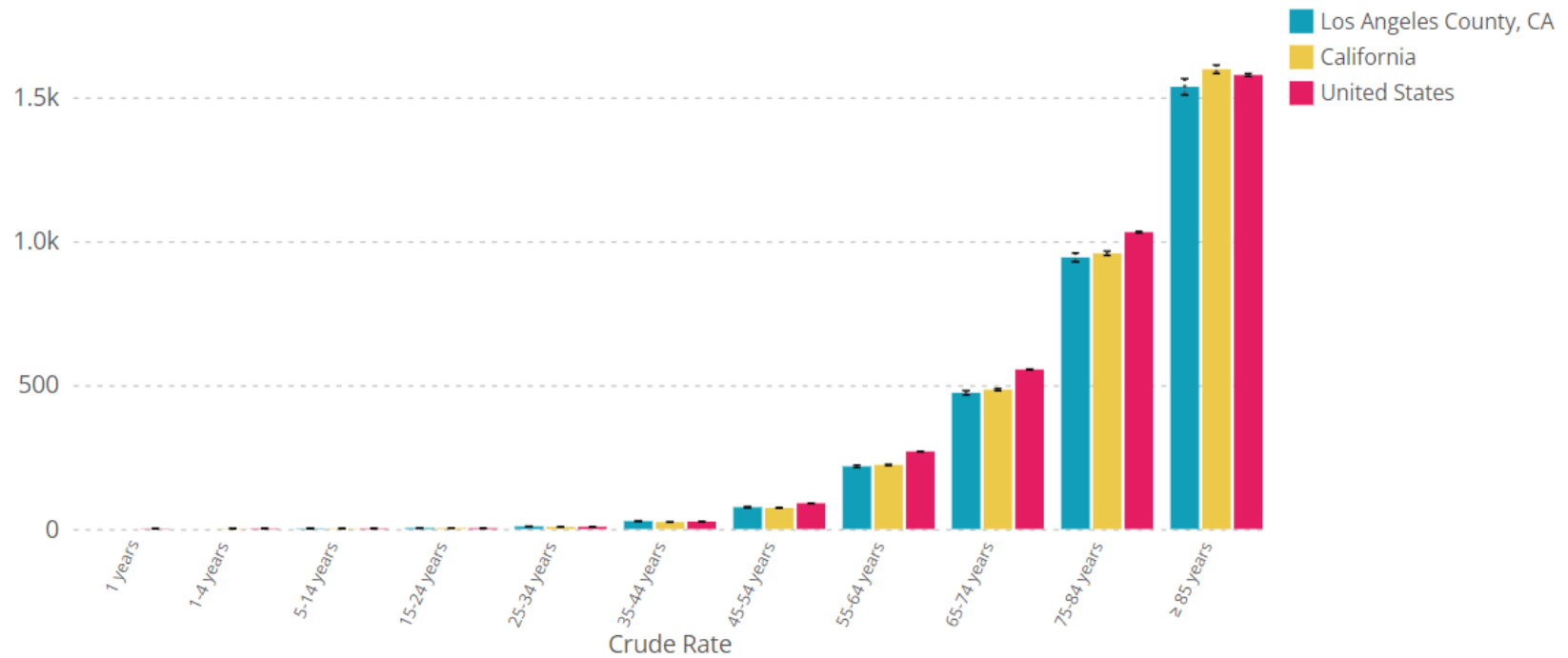


Despite the environmental hazards commonly associated with cancer incidence in the Los Angeles Basin, the death rate for Los Angeles County has closely tracked the rate for California as a whole and has stayed well below the national rate.

**Cancer by Age**

Cancer is largely an old persons’ disease, with death rates climbing steadily from less than 50 per 100,000 population in the 35-45 age range to over 1,500 per 100,000 at 85+ years. It should be noted that cancer death rates in Los Angeles County are consistently lower than for California or the U.S.

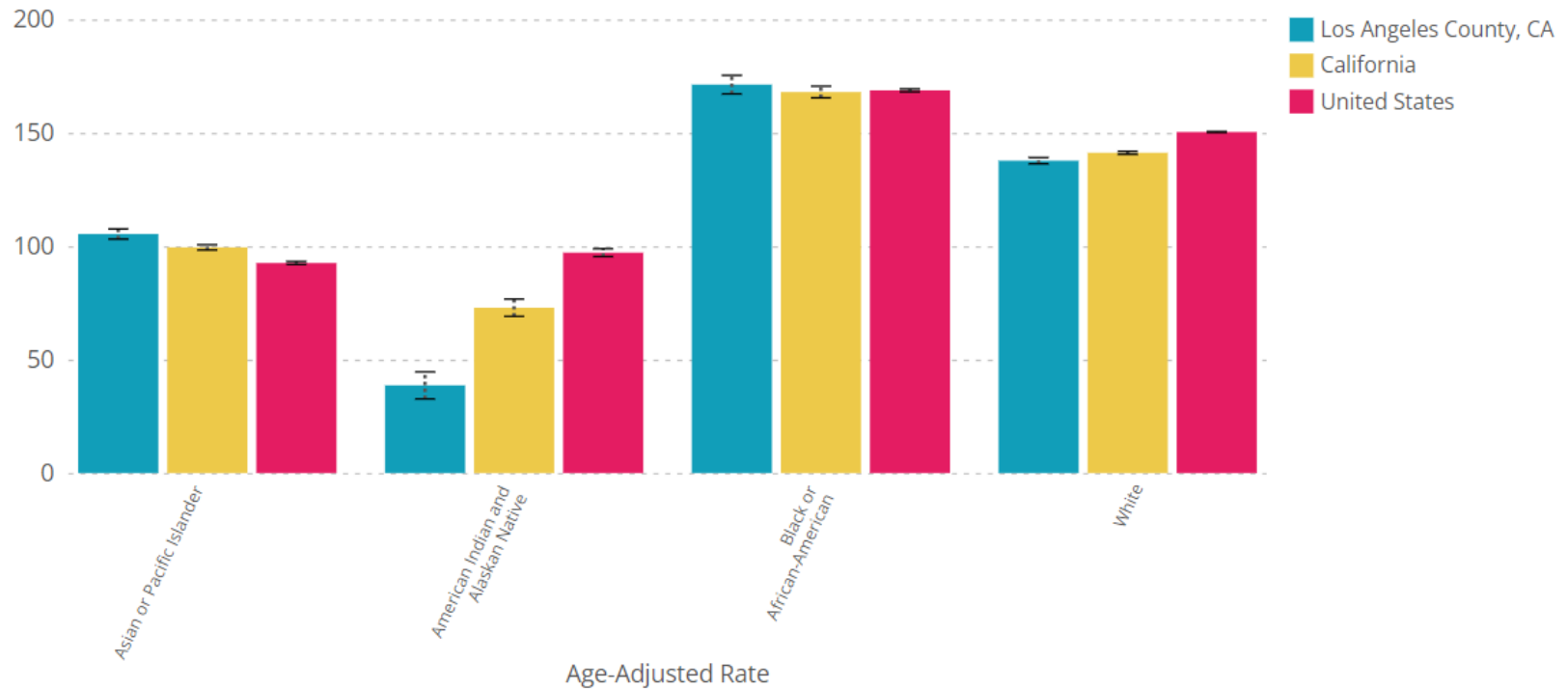
**Cancer Deaths per 100,000: by Age (2018)**



### Cancer by Race

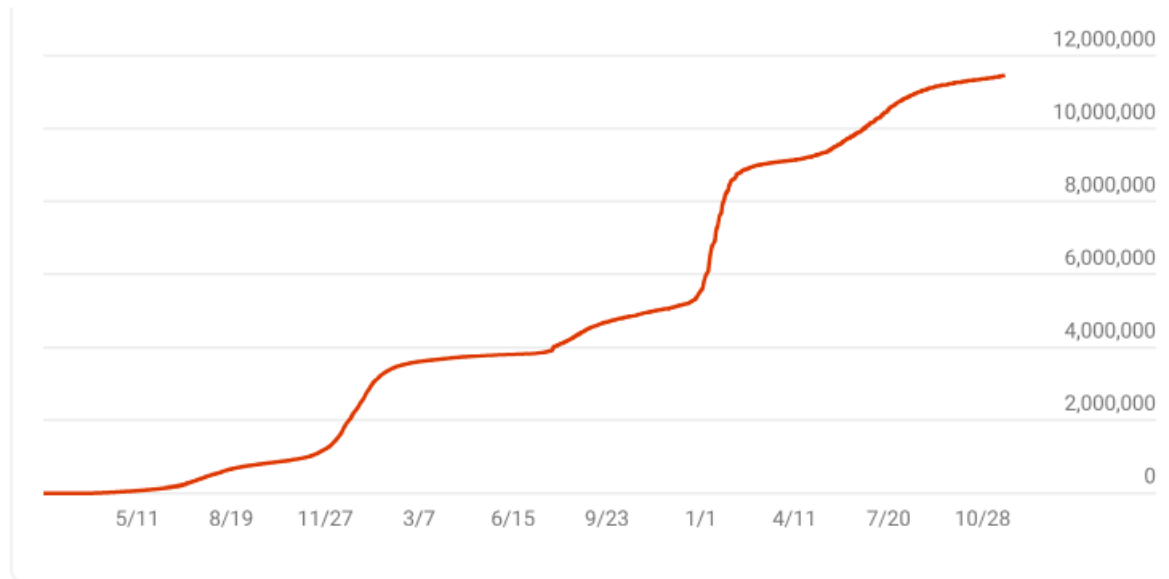
Racial differences are visible in death rates among various ethnic groups, and ongoing research is underway to define the specific causes for the discrepancy. It is interesting that of the three non-white ethnic groups listed, two have significantly lower death rates than the white cohort. Also of interest is that two of the minority groups report higher death rates in Los Angeles County than in the larger populations, while one exhibits markedly lower rates.

#### Cancer Deaths per 100,000: by Race (2018)



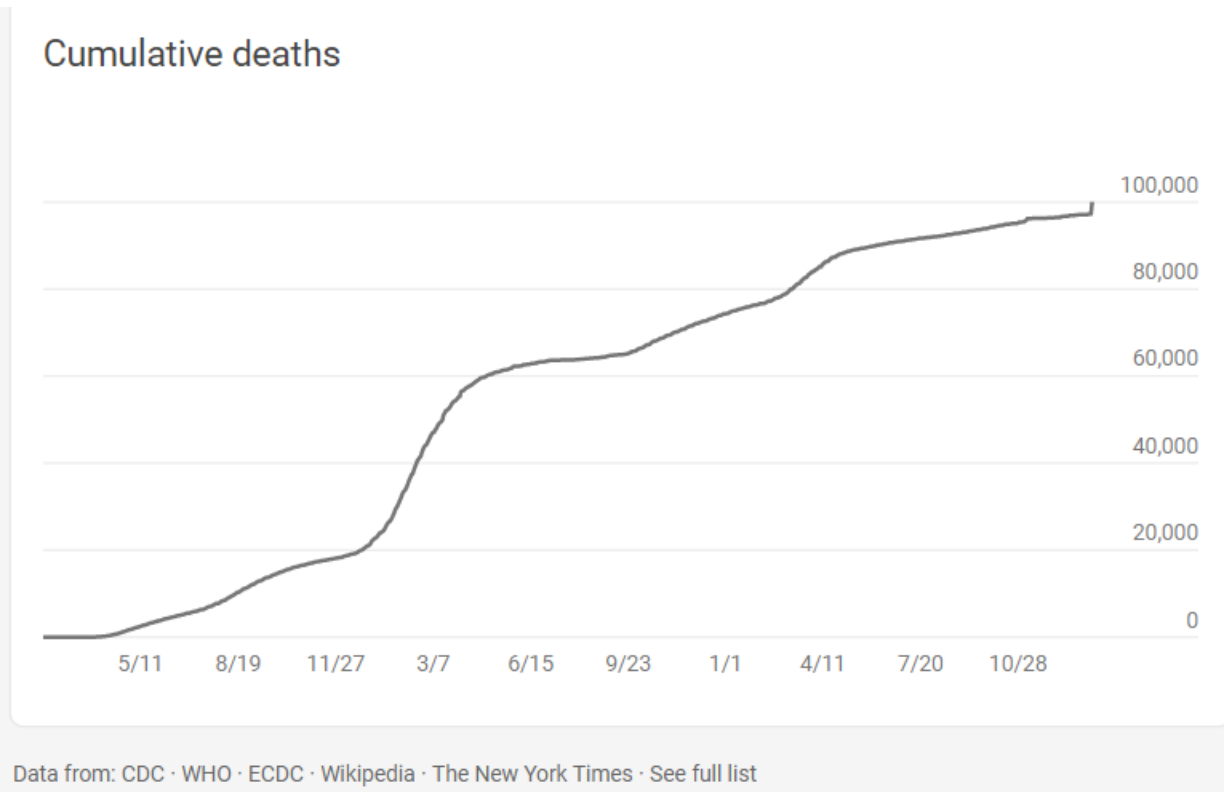
## Covid-19

The single biggest impact on health status in the past three years has been the Covid-19 pandemic. Its stunning growth, from six confirmed cases nationwide in February 2020, to over 5.5 million cases at the end of 2021, with another spike in early 2022, has been front page news. By the end of November 2022, the case count stood at over 11.4 million confirmed cases, as shown below.



Data from: CDC · WHO · ECDC · Wikipedia · The New York Times · See full list

The introduction of vaccines in early 2022 has caused the growth rate to level off somewhat, but new cases continue to appear as variants of the virus evolve to defeat containment efforts. Note that there are two rapid jumps in cumulative cases (11/27/20 to 3/7/21 and 1/1/22 to 4/11/22). Data available at the end of 2021 was forecasting massive growth in cases, hospitalizations and deaths, but only one of the three predictions manifested in early 2022. While there was a spike in new cases, the actual increases in hospitalizations and death rates were much smaller than predicted. As seen in the following chart, the second rise in cases did not lead to a corresponding increase in deaths, showing that containment protocols were successful in limiting the damage of the variant spike.



Since that time, vaccination efforts, mask mandates and probable herd immunity have caused all statistics to level off, and EHMC staff will address plans to deal with future outbreaks or new strains of more-virulent viruses.

## Depression

Diagnosed depression has been on the increase for the past two decades, going from 9% of California’s population to 19% in 2021, according to Statistics 2021 published by Mental Health America. California sits in the upper 30% of states, although its 18.54% rate is very close to the national average at 19.0% This rate translates to a population of over 5.5 million California residents with diagnosed depressive symptoms.

Interestingly, data for smaller geographies is limited, and Los Angeles County’s Department of Mental Health still publishes prevalence statistics for 1999.

Most current data related to depression has been focused on its relationship to Covid-19 conditions. The Psychological Care Institute reported in April 2021 that “Symptoms of Depression increased Dramatically from 2019 to 2020....(they) spiked from 8.5% in 2019 to 27.8% in 2020 when the Covid epidemic began” (Ettman et al., 2020).

Given the rapid rise quoted, and the easing of the pandemic since 2020, it is difficult to quote a prevalence rate for 2021 or later, and any projections based on most recent data would be suspect. Nonetheless, depression is considered a significant health issue, and one that EHMC will be following closely, as part of its focus on Mental Health issues in the community.

The chart below outlines some markers used to diagnose depression. SPA 2 residents generally report lower incidences of symptoms than the comparable groups.

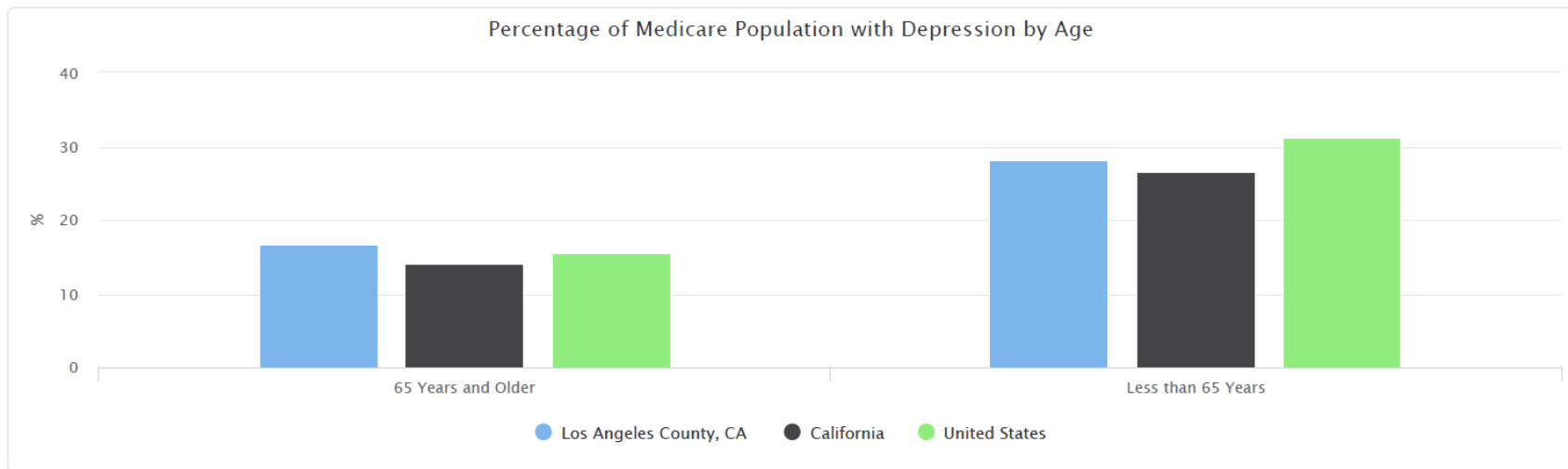
	SPA 2	Los Angeles County	California
<b>Adults who had serious psychological distress during past year</b>	10.2%	13.0%	13.1%
<b>Adults on prescription medicine at least 2 weeks for emotional/mental health issue in past year</b>	7.8%	8.2%	10.3%
<b>Adults reporting family life impairment during the past year</b>	20.1%	20.9%	20.8%
<b>Adults reporting social life impairment during the past year</b>	18.6%	20.8%	20.9%
<b>Adults reporting household chore impairment during the past year</b>	20.1%	20.2%	20.3%
<b>Adults reporting work impairment during the past year</b>	18.4%	21.1%	20.2%
<b>Teens who had serious psychological distress during past year</b>	36.6%	37.3%	29.4%

Source: California Health Interview Survey, 2019. <http://ask.chis.ucla.edu/>

## Percentage of Medicare Population with Depression by Age

This indicator reports the prevalence of depression among Medicare beneficiaries by age.

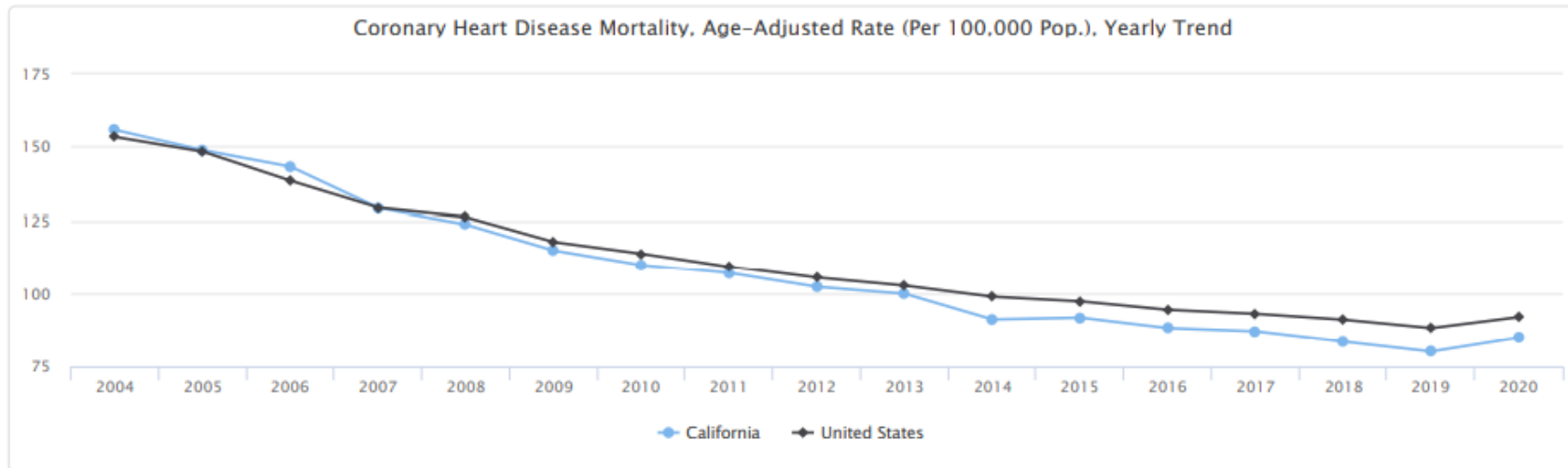
Report Area	65 Years and Older	Less than 65 Years
Los Angeles County, CA	16.64%	28.18%
California	13.93%	26.57%
United States	15.43%	31.21%



## Heart Disease (Adult)

Coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks. Although advances in treatment and prevention caused a reduction in the incidence of death due to heart disease, it remains the preeminent killer of US citizens.

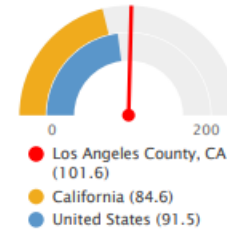
The chart below outlines the decline in deaths for California and the US. Note that the curve turns upward in 2020. Whether this is a result of the Covid pandemic, or some other factor, will be something to watch over the next three years.



Although the overall trend is lower, Los Angeles County's record is less impressive, and the age-adjusted death rate for the County exceeds the rates for the larger areas, as shown in the following graphic.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Los Angeles County, CA	10,077,819	57,165	113.5	<b>101.6</b>
California	39,444,803	189,422	96.0	84.6
United States	326,747,554	1,838,830	112.5	91.5

Coronary Heart Disease Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



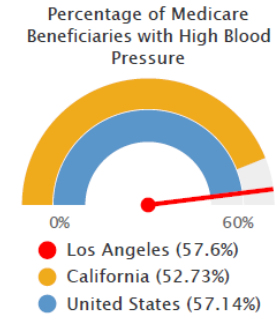
Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

### High Blood Pressure (Medicare Population)

Medicare populations have a higher incidence of high blood pressure than the general population. Los Angeles Medicare recipients' proportion exceeds the California overall rate but is very close to the US average.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with High Blood Pressure	Percent with High Blood Pressure
Los Angeles County, CA	577,330	332,522	57.6%
California	2,845,251	1,500,238	52.73%
United States	33,725,823	19,269,721	57.14%

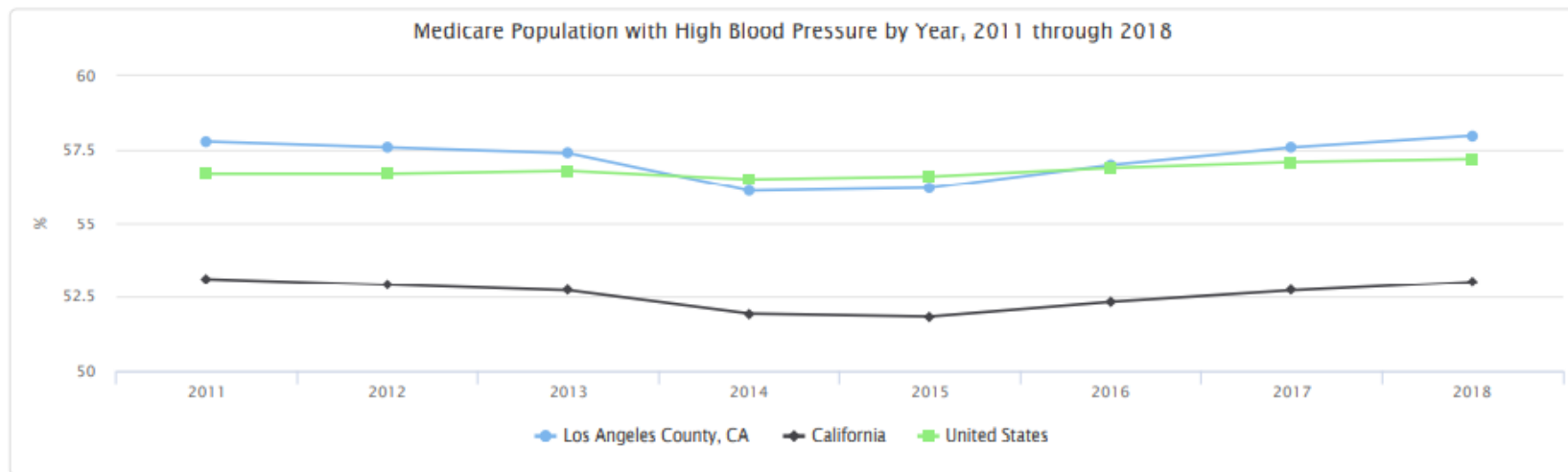


*Note: This indicator is compared to the state average.  
Data Source: Centers for Medicare and Medicaid Services. 2017. Source geography: County*

## Medicare Population with High Blood Pressure by Year, 2011 through 2018

This indicator reports the percentage of the Medicare Fee-for-Service population with high blood pressure over time.

Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Los Angeles County, CA	57.8%	57.6%	57.4%	56.1%	56.2%	57.0%	57.6%	58.0%
California	53.1%	52.9%	52.7%	51.9%	51.8%	52.3%	52.7%	53.0%
United States	56.7%	56.7%	56.8%	56.5%	56.6%	56.9%	57.1%	57.2%



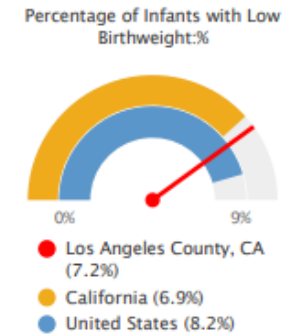
## Low Birth Weight

This indicator reports the percentage of total births that are low birth weight (under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities. Although the Los Angeles County rate is higher than the overall rate for California, it is lower than the U.S. average.

Report Area	Total Live Births	Low Birthweight Births	Low Birthweight Births, Percentage
Los Angeles County, CA	810,390	58,589	7.2%
California	3,275,995	225,684	6.9%
United States	26,896,859	2,203,029	8.2%

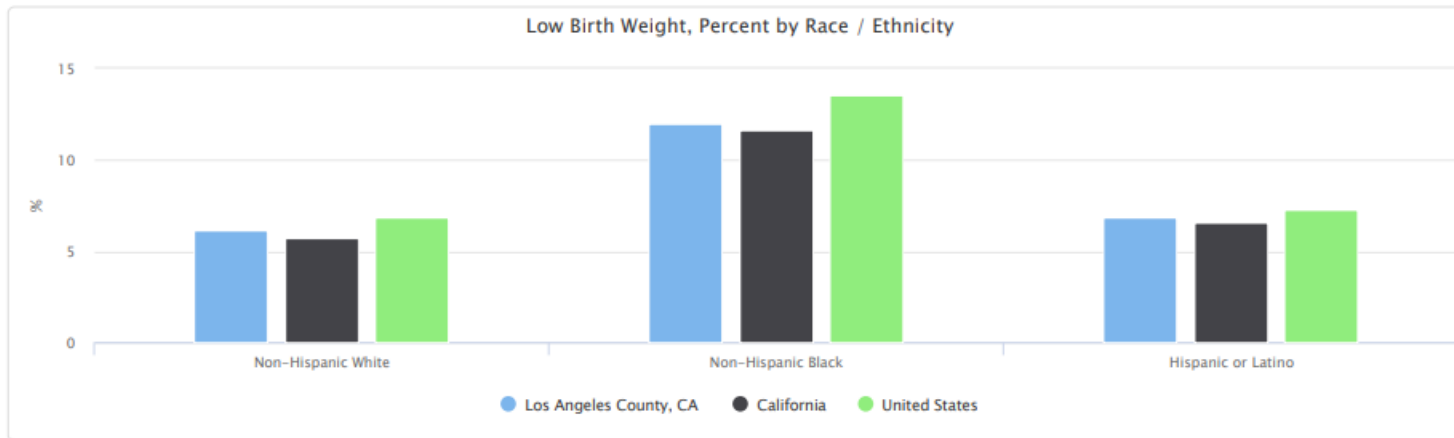
Note: This indicator is compared to the state average.

Data Source: University of Wisconsin Population Health Institute, [County Health Rankings](#). 2014-2020. Source geography: County



The incidence of Low birthweight babies is not evenly distributed among ethnic groups. The graphic following shows the discrepancy.

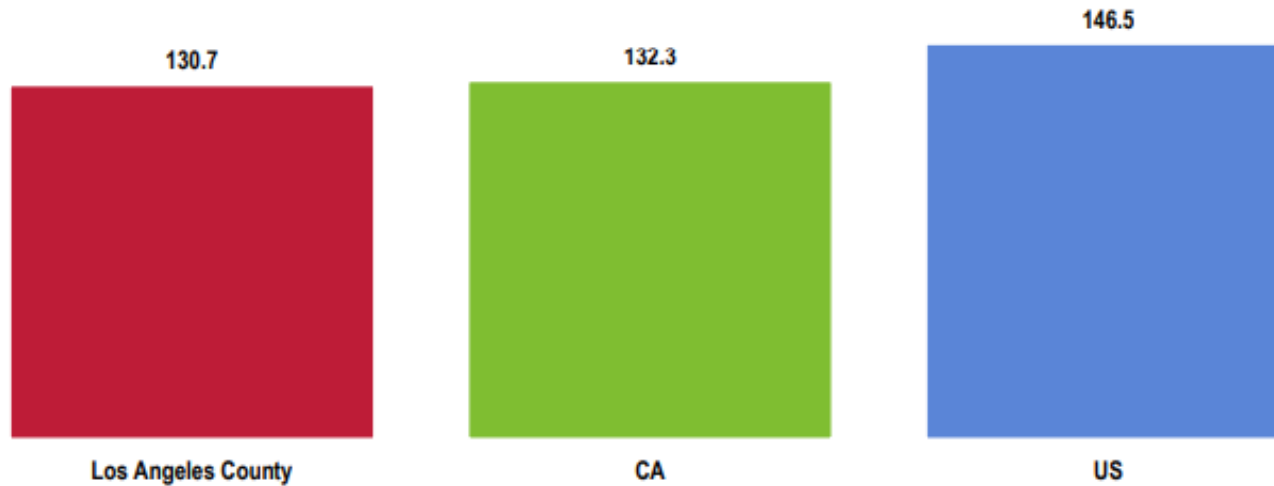
Report Area	Non-Hispanic White	Non-Hispanic Black	Hispanic or Latino
Los Angeles County, CA	6.2%	12.0	6.9%
California	5.8%	11.6	6.6%
United States	6.9%	13.6	7.3%



## Mortality - Cancer

This indicator reports the rate of death due to malignant neoplasm (cancer) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. This indicator is relevant because cancer is a leading cause of death in the United States. The Los Angeles County rate is below the rate for California, and significantly below the national average, although it has not achieved the Healthy People 2030 rate of 122.7 or lower.

### Cancer: Age-Adjusted Mortality (2018-2020 Annual Average Deaths per 100,000 Population) Healthy People 2030 = 122.7 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
  - US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Lung Cancer is the leading cause of death among cancer types.

## Age-Adjusted Cancer Death Rates by Site (2018-2020 Annual Average Deaths per 100,000 Population)

	Los Angeles County	California	US	HP2030
<b>ALL CANCERS</b>	<b>130.7</b>	<b>132.3</b>	<b>146.5</b>	<b>122.7</b>
<b>Lung Cancer</b>	<b>21.8</b>	<b>23.7</b>	<b>33.4</b>	<b>25.1</b>
<b>Prostate Cancer</b>	<b>19.5</b>	<b>19.6</b>	<b>18.5</b>	<b>16.9</b>
<b>Female Breast Cancer</b>	<b>19.1</b>	<b>18.7</b>	<b>19.4</b>	<b>15.3</b>
<b>Colorectal Cancer</b>	<b>12.8</b>	<b>12.2</b>	<b>13.1</b>	<b>8.9</b>

Sources:   
 • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.   
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

### Mortality – Heart Disease

Within the report area the rate of death due to coronary heart disease (ICD10 Codes I20-I25) per 100,000 population is 107.5. This rate is greater than the Healthy People 2020 target of less than or equal to 103.4. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because heart disease is a leading cause of death in the United States. The Los Angeles County death rate for heart disease exceeds the rate for California and U.S. average.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Los Angeles County, CA	10,077,819	57,165	113.5	<b>101.6</b>
California	39,444,803	189,422	96.0	84.6
United States	326,747,554	1,838,830	112.5	91.5

Coronary Heart Disease Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)

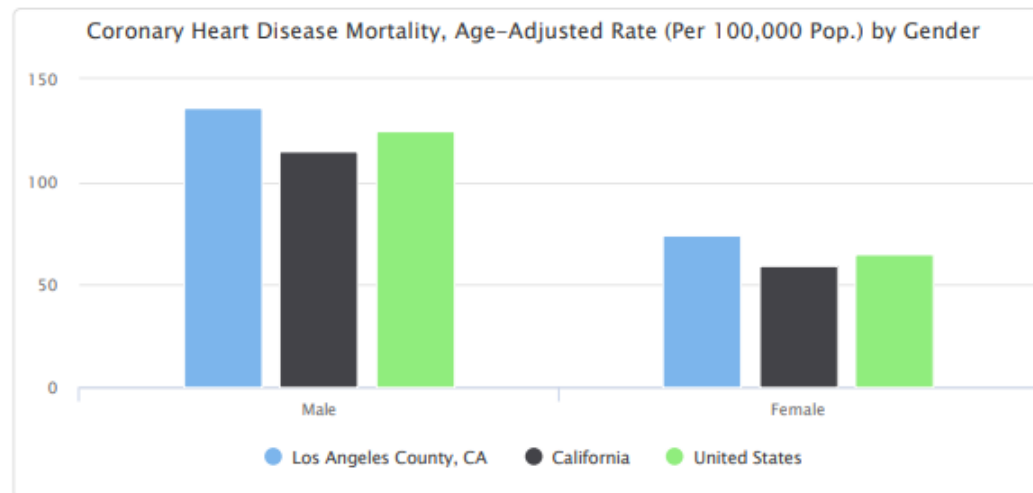


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County → [Show more details](#)

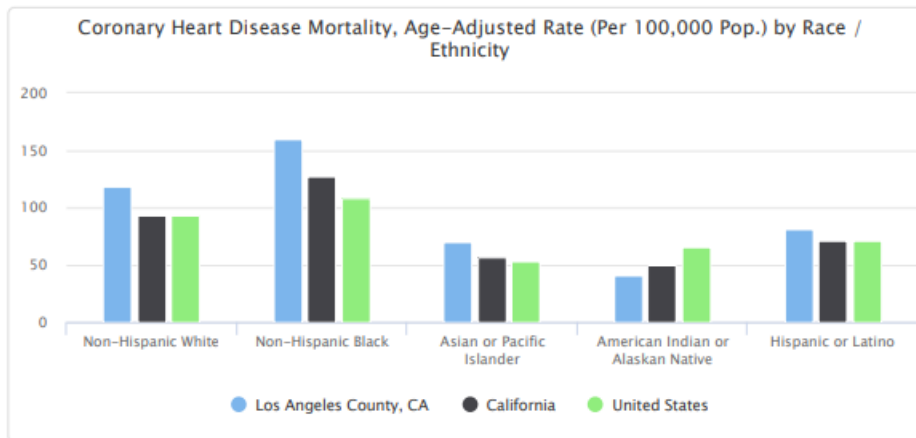
Coronary Heart Disease is gender-specific with much higher incidence in males than females as shown below.

Report Area	Male	Female
Los Angeles County, CA	136.7	73.6
California	115.6	59.5
United States	125.3	64.6



Coronary Heart Disease also varies among ethnic groups. This is shown below.

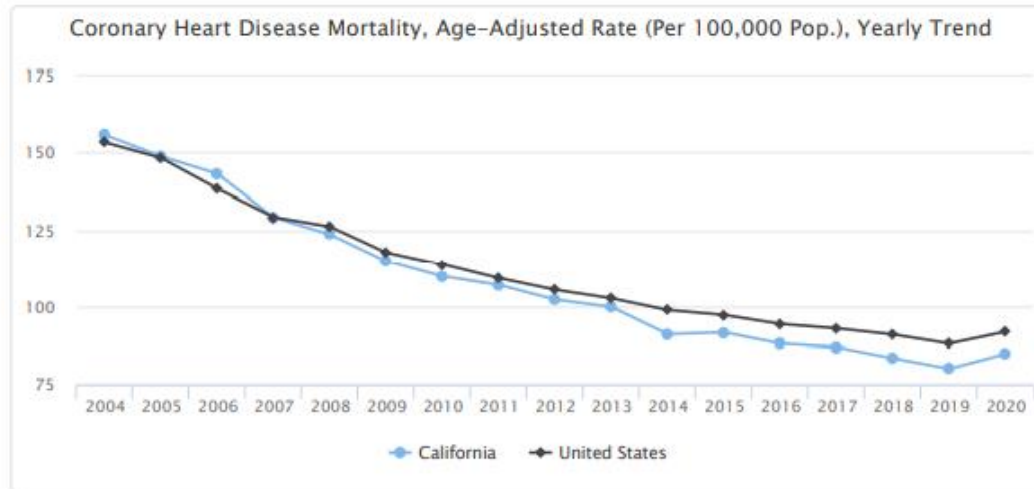
Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Los Angeles County, CA	118.2	159.2	70.1	40.9	80.5
California	93.1	127.5	56.3	49.5	70.4
United States	93.8	108.1	53.3	65.0	71.2



The mortality rate for Coronary Heart Disease had been declining steadily over the past fifteen years, until a slight increase in 2020. It will be interesting to see if the increase is an anomaly or an indicator of an upward trend in 2021 and 2022 when that data becomes available.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	155.6	148.7	143.1	129.1	123.6	114.8	109.8	107.0	102.2	99.8	91.0	91.6	88.0	86.9	83.4	80.0	84.8
United States	153.2	148.2	138.3	129.2	126.1	117.7	113.7	109.2	105.4	102.6	98.8	97.2	94.3	92.9	90.9	88.0	91.8

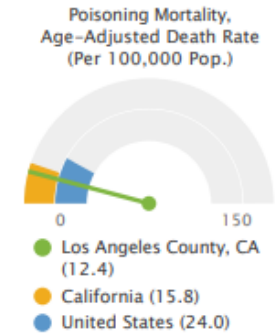
*Note: No county data available. See data source and methodology for more details.*



## Mortality - Drug Poisoning

This indicator reports the rate of death due to drug overdose per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. Considering current issues related to substance abuse, this topic is of high importance. The data presented is cumulative for 2016-2020. Los Angeles County is fortunate to have a much lower mortality rate than California as a whole or than the nation.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Los Angeles County, CA	10,077,819	6,569	13.0	12.4
California	39,444,803	32,711	16.6	15.8
United States	326,747,554	389,651	23.9	24.0



Note: This indicator is compared to the state average.

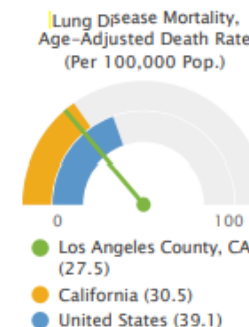
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

## Mortality – Lung Disease

This indicator reports the rate of death due to chronic lower respiratory disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because lung disease is a leading cause of death in the United States.

Despite Los Angeles County’s reputation as an air pollution hotbed, the age-adjusted death rate for the county is lower than California’s rate, and substantially below the nationwide rate.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Los Angeles County, CA	10,077,819	15,176	30.1	27.5
California	39,444,803	67,228	34.1	30.5
United States	326,747,554	783,919	48.0	39.1



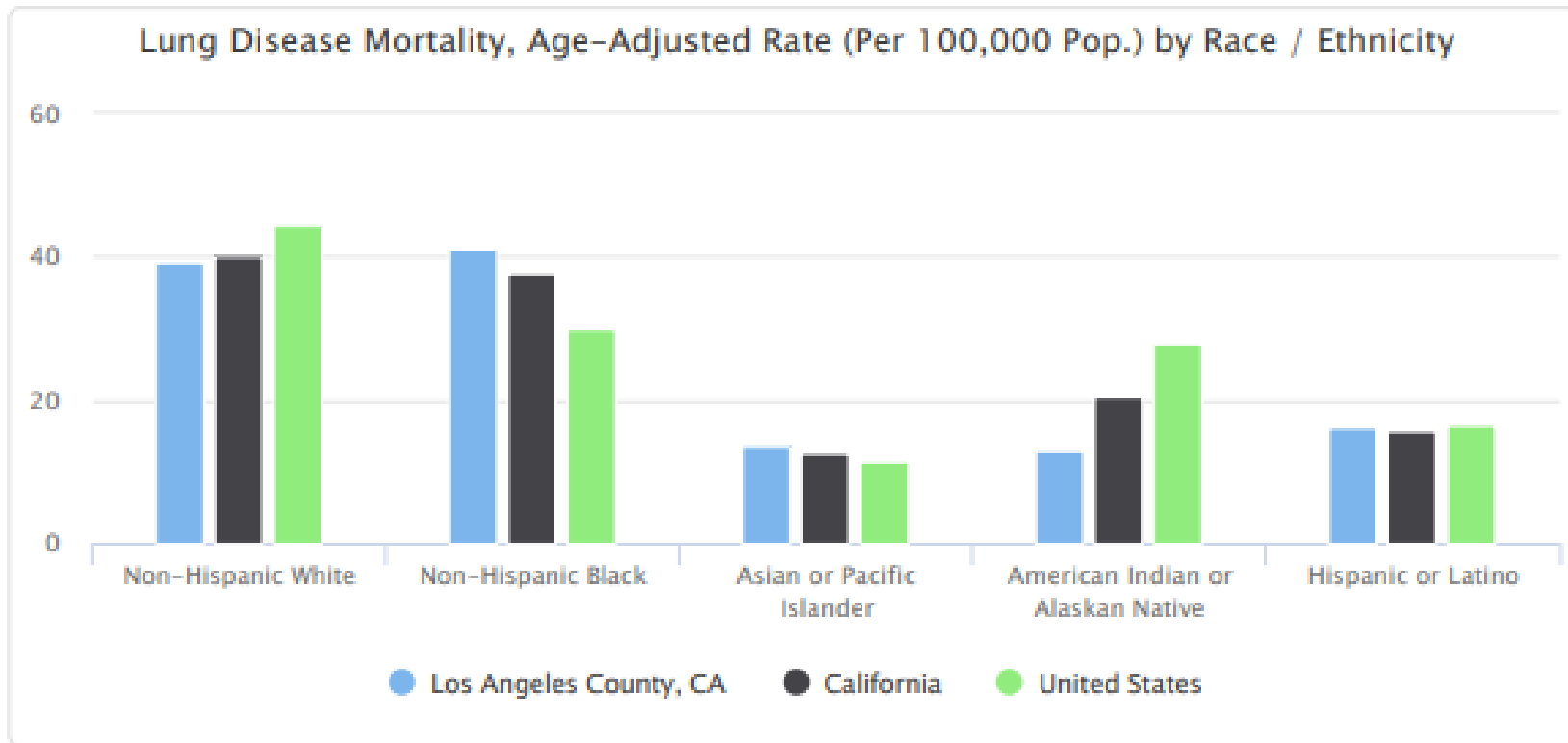
Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Lung disease mortality is differential by gender as shown below.

Report Area	Male	Female
Los Angeles County, CA	32.6	23.9
California	33.9	27.9
United States	43.0	36.3

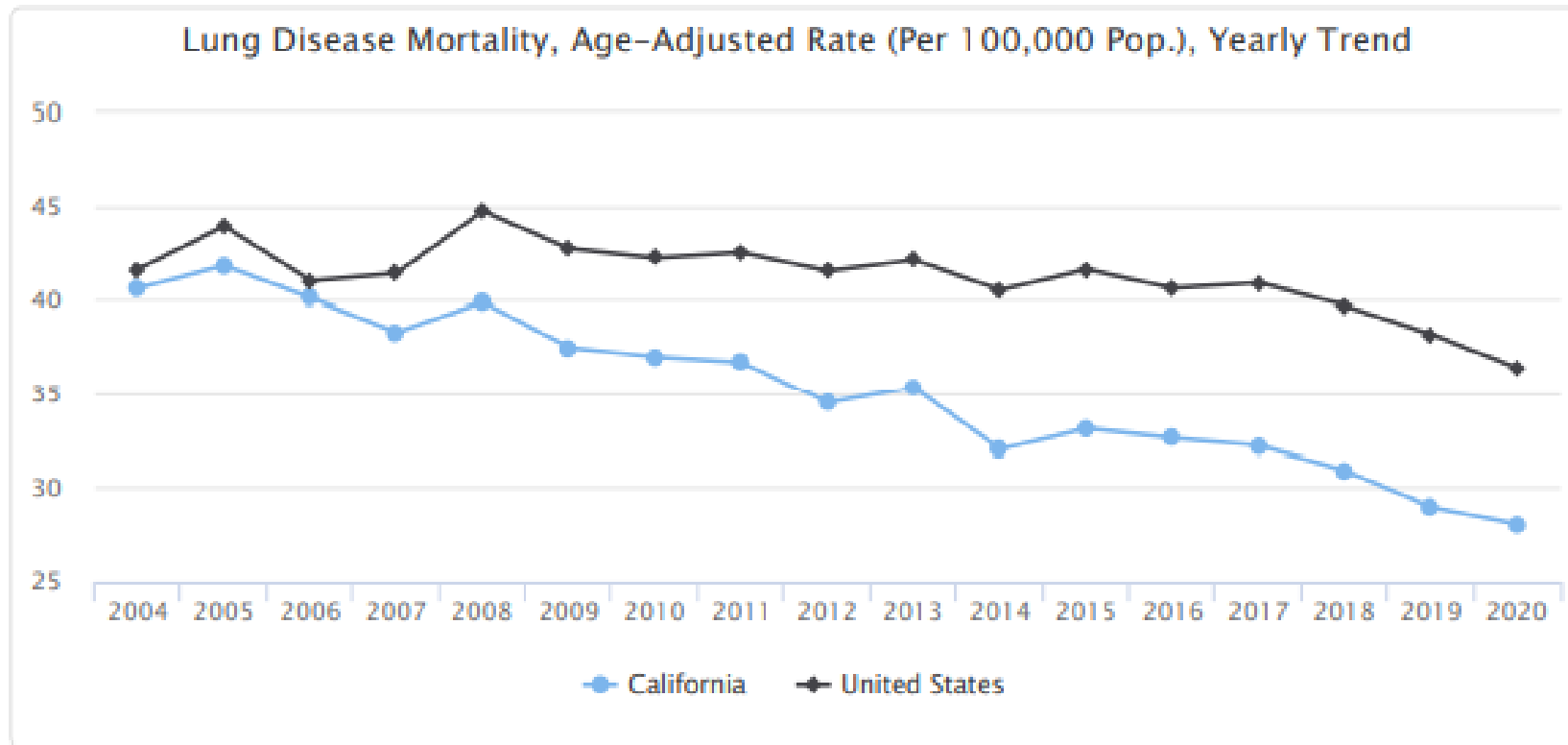
Finally, lung disease mortality differentiates among ethnic groups. This is easily demonstrated graphically.



One encouraging statistic is the trend in Lung Disease Mortality, which is declining over the period shown below.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	40.6	41.8	40.1	38.3	39.9	37.5	37.0	36.7	34.5	35.3	32.0	33.1	32.6	32.2	30.9	29.0	28.1
United States	41.6	43.9	41.0	41.4	44.7	42.7	42.2	42.5	41.5	42.1	40.5	41.6	40.6	40.9	39.7	38.2	36.4

*Note: No county data available. See data source and methodology for more details.*

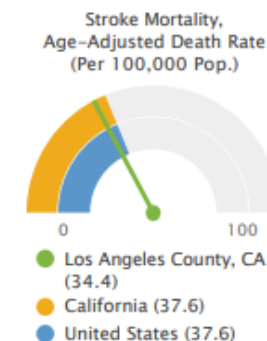


## Mortality – Stroke

Within Los Angeles County, the smallest available report area, there are an estimated 34.4 deaths due to cerebrovascular disease (stroke) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because stroke is a leading cause of death in the United States.

The reported rate for Stroke mortality in Los Angeles County is lower than comparable rates in California or the U.S.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Los Angeles County, CA	10,077,819	19,079	37.9	34.4
California	39,444,803	83,259	42.2	37.6
United States	326,747,554	746,604	45.7	37.6



Note: This indicator is compared to the state average.

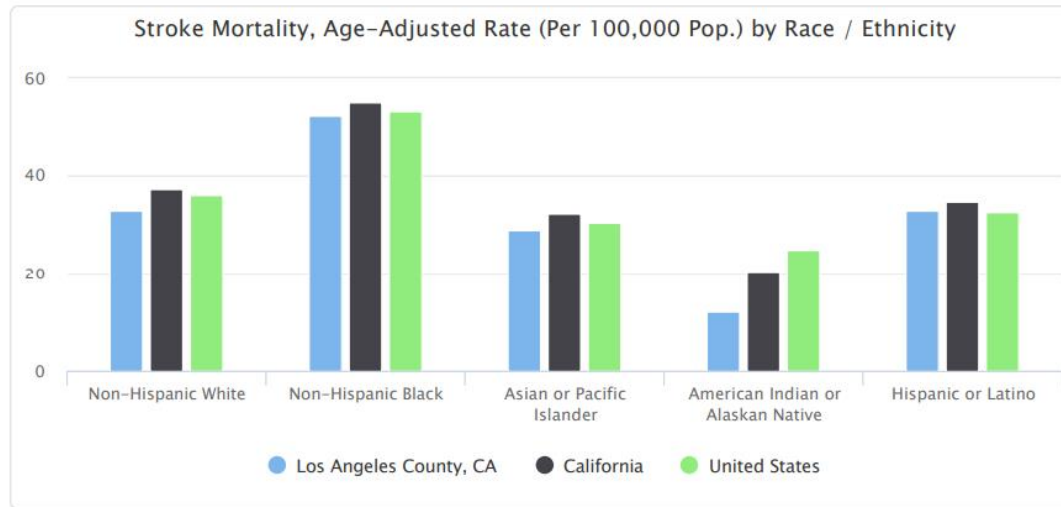
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER, 2016-2020. Source geography: County

Stroke mortality is slightly higher for males than female in all areas, and the difference between males and females is higher in Los Angeles County than in the comparable areas.

Report Area	Male	Female
Los Angeles County, CA	36.7	32.1
California	38.5	36.2
United States	38.1	36.5

Stroke mortality affects different ethnic groups differently as shown below.

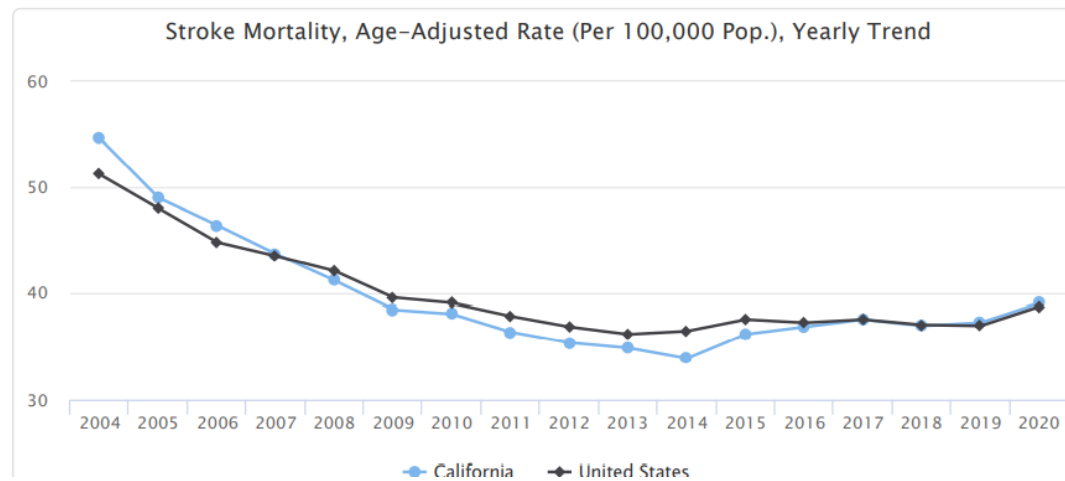
Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Los Angeles County, CA	33.1	52.2	28.9	12.3	33.1
California	37.5	55.0	32.5	20.4	34.8
United States	36.2	53.3	30.4	24.9	32.8



The incidence of stroke mortality in California and nationwide fell from 2004 to 2012, and was nearly level until 2020, when a slight increase was reported. This indicator will bear watching to see if the 2020 change was a one-time anomaly or a harbinger of future increases.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	54.6	49.0	46.4	43.7	41.2	38.5	38.1	36.4	35.4	34.9	33.9	36.2	36.9	37.6	37.0	37.3	39.1
United States	51.2	48.0	44.8	43.5	42.1	39.6	39.1	37.9	36.9	36.2	36.5	37.6	37.3	37.6	37.1	37.0	38.8

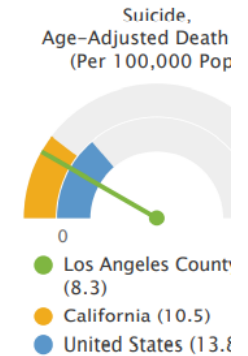
*Note: No county data available. See data source and methodology for more details.*



## Mortality – Suicide

This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health, which is one of the health issues that the Hospital has selected as an area of interest. While any rate is unacceptable, Los Angeles County’s rate is lower than the rates for comparison areas.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Los Angeles County, CA	10,077,819	4,399	8.7	<b>8.3</b>
California	39,444,803	21,677	11.0	10.5
United States	326,747,554	233,972	14.3	13.8



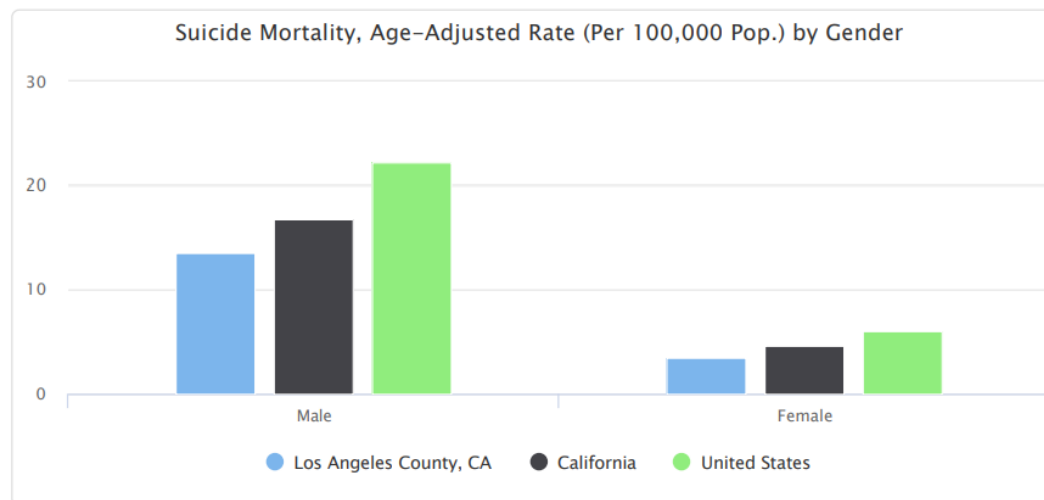
*Note: This indicator is compared to the state average.*

*Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-20. Source geography: County*

Suicide rates are highly gender-specific, with males committing suicide at roughly 3.5 times as often as females.

Report Area	Male	Female
Los Angeles County, CA	13.5	3.4
California	16.7	4.6
United States	22.2	6.0

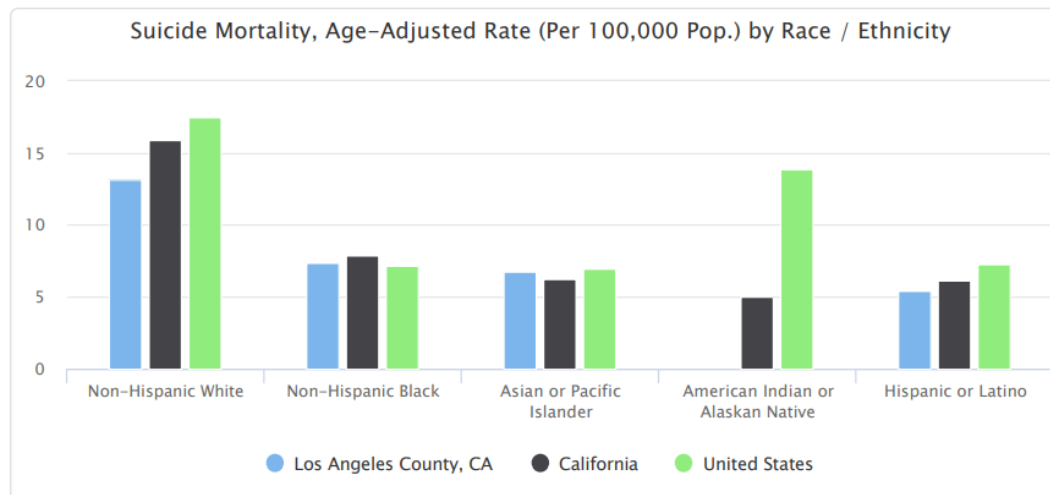
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER, 2016-20.



Suicide is also differentiated by ethnic groups, as shown in the following charts. What is of interest here is that white suicide rates significantly exceed those of any other ethnic groups.

Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Los Angeles County, CA	13.1	7.3	6.7	No data	5.4
California	15.9	7.9	6.2	5.0	6.1
United States	17.4	7.1	6.9	13.8	7.2

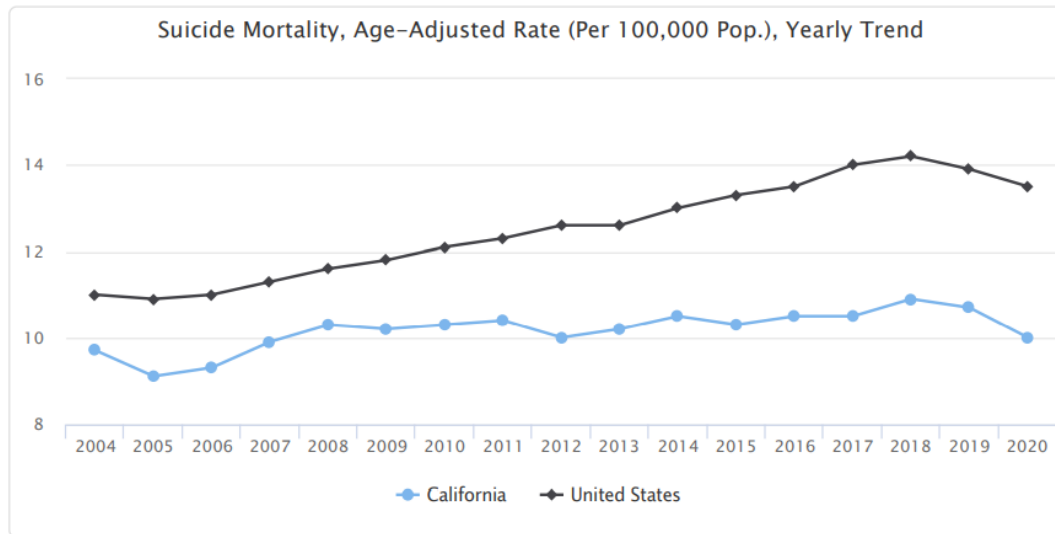
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-20.



Another disturbing statistic is that this cause of death is one which has been increasing over the past 15 years nationally, although California's rate has fluctuated only slightly. While the US rate was increasing until 2018, it has decreased in the past two years, but still remains well above its 2004 rate. California's rate has varied only slightly over the entire period.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	9.7	9.1	9.3	9.9	10.3	10.2	10.3	10.4	10.0	10.2	10.5	10.3	10.5	10.5	10.9	10.7	10.0
United States	11.0	10.9	11.0	11.3	11.6	11.8	12.1	12.3	12.6	12.6	13.0	13.3	13.5	14.0	14.2	13.9	13.5

Note: No county data available. See data source and methodology for more details.  
 Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-20.



## Obesity

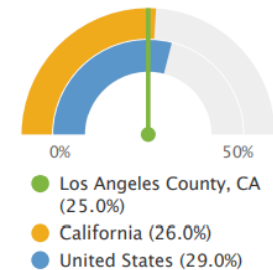
Obesity is defined as a Body Mass Index (**BMI**) of 30.0 or greater. Body mass index (weight [kg]/height [m]<sup>2</sup>) was derived from self-report of height and weight and was self-reported. Those with BMI's greater than 30.0 are considered at excessive risk for further health issues. In Los Angeles County, the proportion of residents exceeding the threshold was just slightly below the California average, and substantially lower than the US average.

25.0% of adults aged 20 and older self-reported that they had a Body Mass Index (BMI) greater than 30.0 (obese) in the report area. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. Persons in the obesity category are particularly susceptible to maladies such as diabetes and high blood pressure, and are at increased risk for heart attacks and strokes.

It should be noted that *Healthy People 2030* sets obesity goals of 36.0% of the population as a maximum. The Los Angeles County average and all comparables are already within the goal range.

Report Area	Population Age 20+	Adults with BMI > 30.0 (Obese)	Adults with BMI > 30.0 (Obese), Percent
Los Angeles County, CA	7,631,443	1,930,755	25.0%
California	29,573,583	7,731,663	26.0%
United States	239,867,275	69,961,348	29.0%

Percentage of Adults Obese (BMI > 30.0), 2019

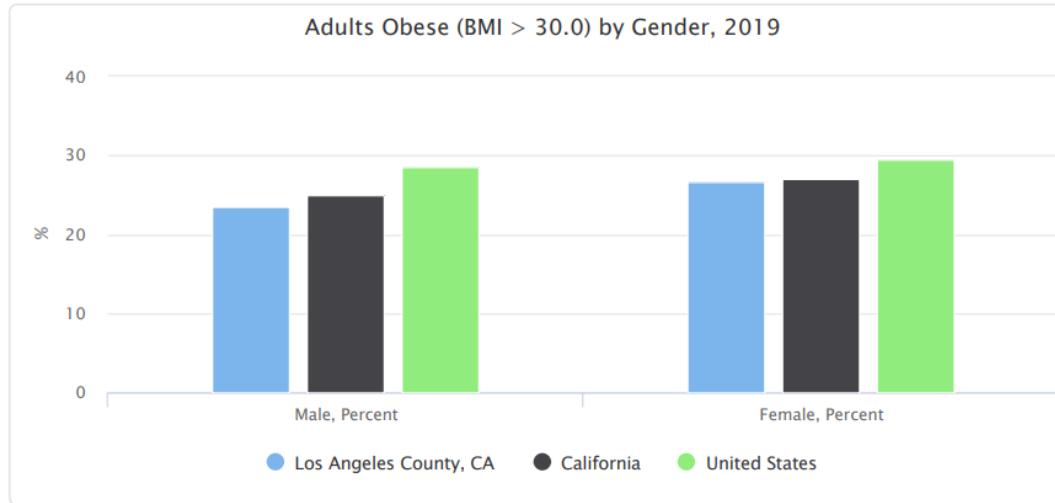


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

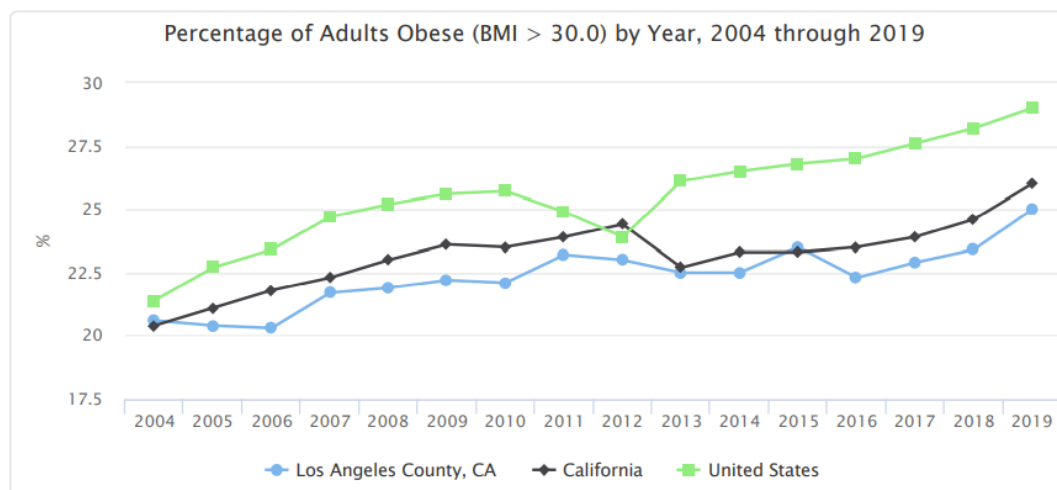
Obesity is marginally more pronounced in the female populations of Los Angeles County, and comparable areas.

Report Area	Male	Male, Percent	Female	Female, Percent
Los Angeles County, CA	879,054	23.4%	1,051,702	26.7%
California	3,672,316	25.0%	4,059,340	27.0%
United States	33,675,337	28.6%	36,285,952	29.5%



Obesity is another indicator for which the trend line has been steadily upward, although the growth rate for the US is much greater than the curves for Los Angeles County and California.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Los Angeles County, CA	20.6%	20.4%	20.3%	21.7%	21.9%	22.2%	22.1%	23.2%	23.0%	22.5%	22.5%	23.5%	22.3%	22.9%	23.4%	25.0%
California	20.4%	21.1%	21.8%	22.3%	23.0%	23.6%	23.5%	23.9%	24.4%	22.7%	23.3%	23.3%	23.5%	23.9%	24.6%	26.0%
United States	21.4%	22.7%	23.4%	24.7%	25.2%	25.6%	25.7%	24.9%	23.9%	26.1%	26.5%	26.8%	27.0%	27.6%	28.2%	29.0%



### Dental Health - Adults

One of the issues cited most often as not covered by most insurance is dental care. Visits to a dentist are used as a proxy for dental health. The table below compares utilization in SPA 2 to the County and California. Although the percentage of the population who have never seen a dentist is higher in SPA 2 than in the comparables, other indicators of dental health in adults show that overall health is roughly equal to the comparables in terms of dental visits and in terms of teeth condition.

	<b>SPA2</b>	<b>Los Angeles County</b>	<b>California</b>
<b>Never been to a dentist</b>	4.4%	3.0%	2.3%
<b>Visited dentist &lt; 6 months to 2 years ago</b>	81.8%	80.4%	82.2%
<b>Visited dentist more than 5 years ago</b>	5.5%	7.5%	7.1%
<b>Condition of teeth: good to excellent</b>	72.1%	70.8%	72.6%
<b>Condition of teeth: fair to poor</b>	26.7%	26.4%	24.9%
<b>Condition of teeth: has no natural teeth</b>	1.2%*	2.8%	2.5%

Source: California Health Interview Survey, 2019 \*Statistically unstable due to sample size. <http://ask.chis.ucla.edu/>

### Dental Health – Children 3-11

In contrast to the adult utilization figures shown previously, residents of SPA 2 have been comparatively more successful in getting dental care for their small children, which is important in creating future dental health. The percentage of children aged 3 to 11 who have seen a dentist in the past six months is several points higher than in the comparable areas.

	<b>SPA 2</b>	<b>Los Angeles County</b>	<b>California</b>
<b>Never been to the dentist</b>	14.8%	14.7%	14.1%
<b>Been to dentist &lt; 6 months ago</b>	76.1%	72.8%	72.9%
<b>Been to dentist &gt; 6 months to 1 year ago</b>	6.5%*	10.1%	9.8%
<b>Been to dentist &lt; 1 to 2 years ago</b>	1.8%*	1.9%*	2.4%
<b>Parent could not afford needed dental care for child†</b>	6.3%*	8.4%	7.3%

Source: California Health Interview Survey, 2017-2019. Years 2017- 2019 pooled to improve sustainability of data. †Data year 2019. \*Statistically unstable due to sample size. <http://ask.chis.ucla.edu/>

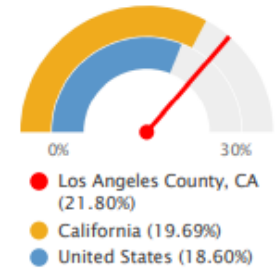
### Poor General Health

This indicator reports the percentage of adults aged 18 and older who self-report having poor or fair health. Within the report area 21.83% of adults aged 18 and older self-report having poor or fair health in response to the question "would you say that in general your health is excellent, very good, good, fair, or poor?" This indicator is relevant because it is a measure of general poor health status. This indicator is one of the most disparate items in the list of indicators, with Los Angeles County significantly higher than all comparable areas.

This survey includes data to 2019, and the reported incidence of Poor General Health reports declined only slightly from the 2012 study rate of 22.1%, a period predating the passage of the Affordable Care Act. To the extent that this statistic reflects the effect of changes due to the ACA and Covered California insurance, it is hard to draw conclusions that the changes had a significant impact on overall health.

Report Area	Total Population (2019)	Adults Age 18+ with Poor or Fair General Health (Crude)	Adults Age 18+ with Poor or Fair General Health (Age-Adjusted)
Los Angeles County, CA	10,039,107	<b>21.80%</b>	21.80%
California	39,512,223	19.69%	19.68%
United States	328,239,523	18.60%	17.80%

Percentage of Adults Age 18+ with Poor or Fair General Health



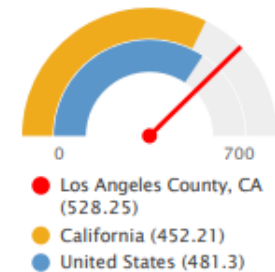
Note: This indicator is compared to the state average.  
 Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019. Source geography: Tract

### STI - Chlamydia

This indicator reports incidence rate of chlamydia cases per 100,000 population. This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices. Los Angeles County’s incidence rate is substantially greater than the comparable large areas. The following chart highlights the higher rate of infection in the County area as opposed to the larger areas.

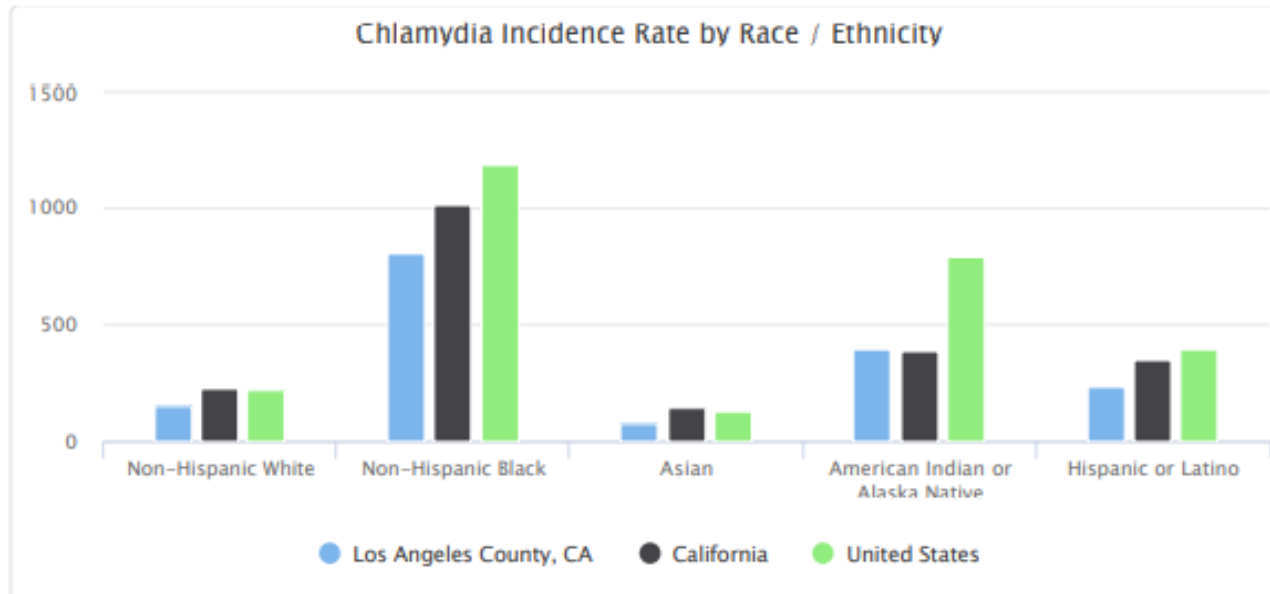
Report Area	Total Population	Chlamydia Infections	Chlamydia Infections, Rate per 100,000 Pop.
Los Angeles County, CA	10,039,107	53,032	<b>528.25</b>
California	39,512,223	178,679	452.21
United States	328,239,523	1,579,885	481.3

Chlamydia Infection Rate (Per 100,000 Pop.)

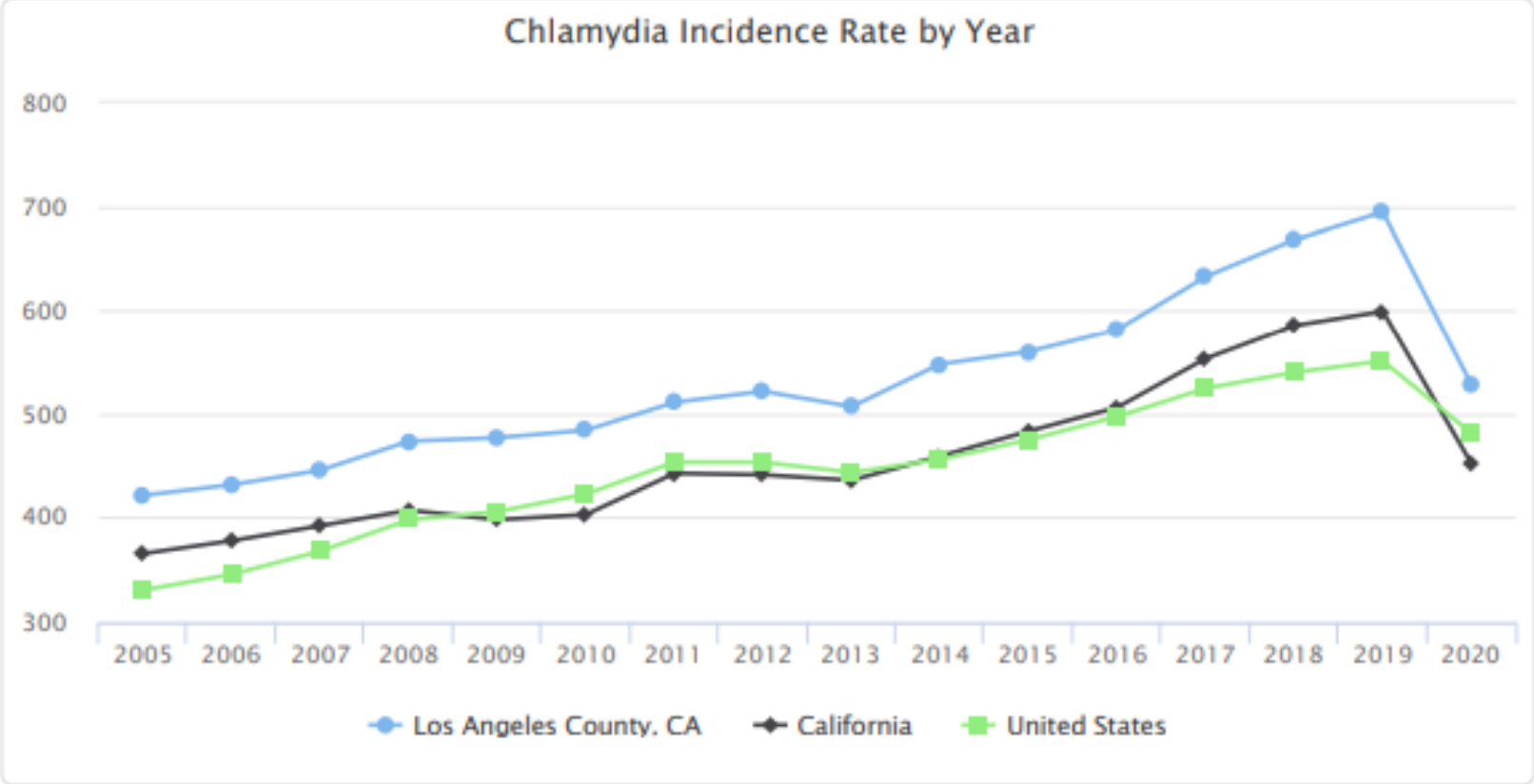


Note: This indicator is compared to the state average.  
 Data Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2020. Source geography: County

This disease is one instance where different ethnic groups experience differing incidence rates. The bar chart below presents the differences visually.



Another interesting statistic is the change in growth rates over the past two years (2018-2020). It could be posited that the drop in incidence rates is related to the effect of lockdowns due to Covid, and projections forward based on this data would need to comment on the unique conditions in that period. It is also interesting that both the Los Angeles County and California downward trends were steeper than the national trend, possibly reflecting the more stringent quarantine restrictions compared to many other areas of the country.



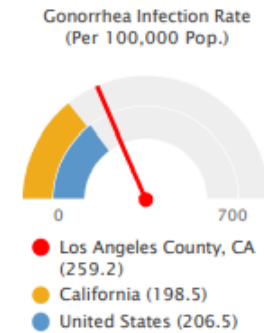
### STI – Gonorrhea

This indicator reports incidence rate of Gonorrhea cases per 100,000 population. This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices. As with Chlamydia, Los Angeles County’s incidence rates are greater than all comparable areas.

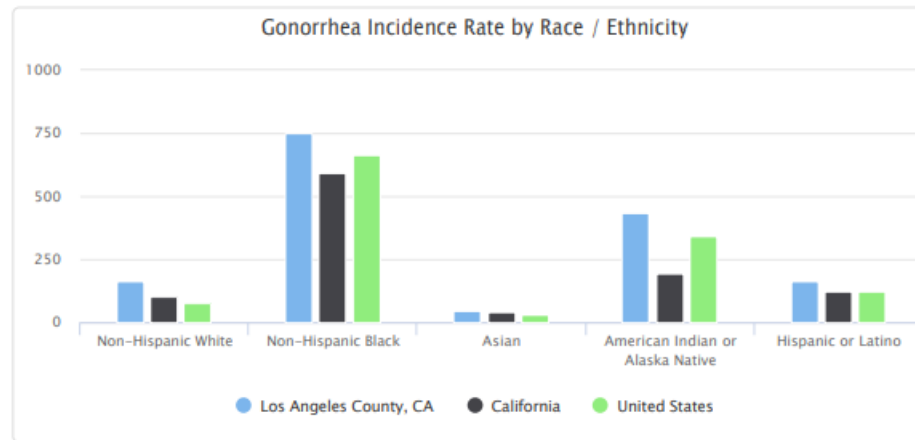
Report Area	Total Population	Gonorrhea Infections	Gonorrhea Infections, Rate per 100,000 Pop.
Los Angeles County, CA	10,039,107	26,021	<b>259.2</b>
California	39,512,223	78,444	198.5
United States	328,239,523	677,769	206.5

*Note: This indicator is compared to the state average.*

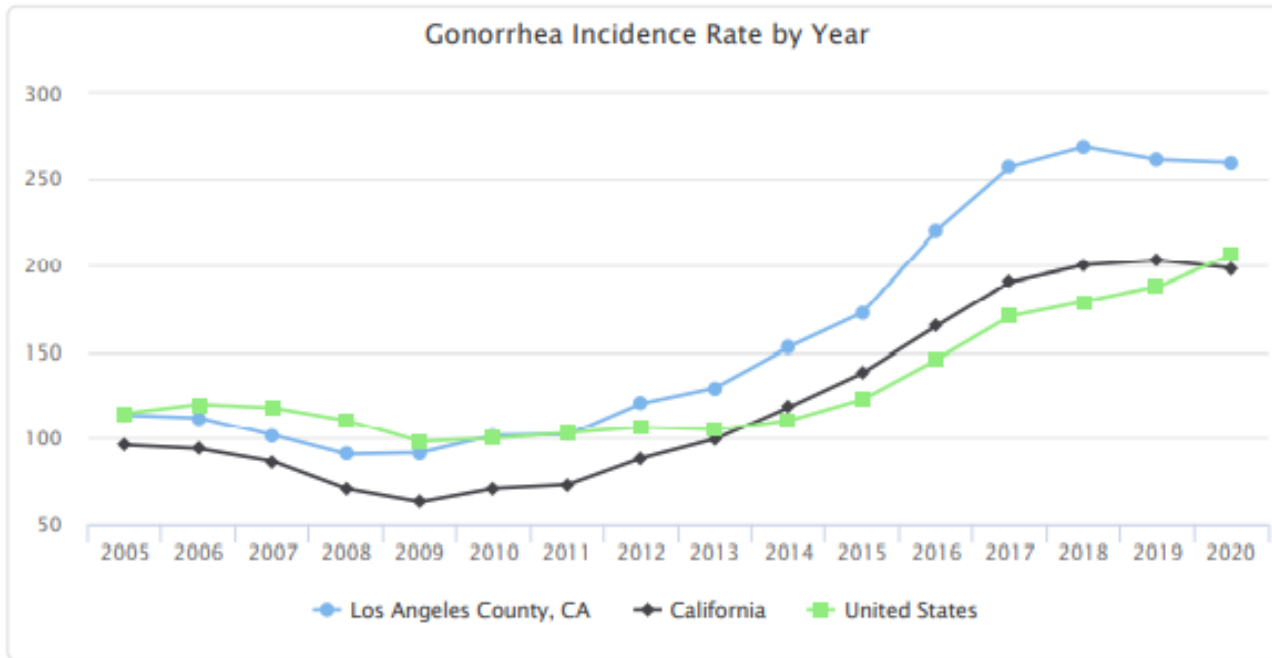
*Data Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2020. Source geography: County*



As with Chlamydia, Gonorrhea incidence is highly differentiated among ethnic groups. See below.



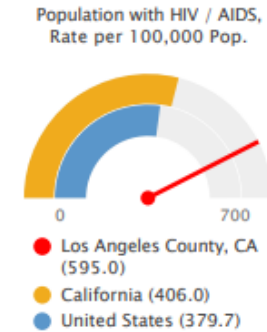
Finally, the trend lines for Gonorrhea are following trends for Chlamydia, with Los Angeles County and California leveling off while US incidence was still rising as of 2020.



## STI – HIV Prevalence

This indicator reports prevalence rate of HIV per 100,000 population. This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices. The San Fernando Valley has a large population of HIV-positive residents and an active cadre of organizations devoted to helping clients manage their condition. Thus the incidence of HIV is much higher than any of the comparison areas.

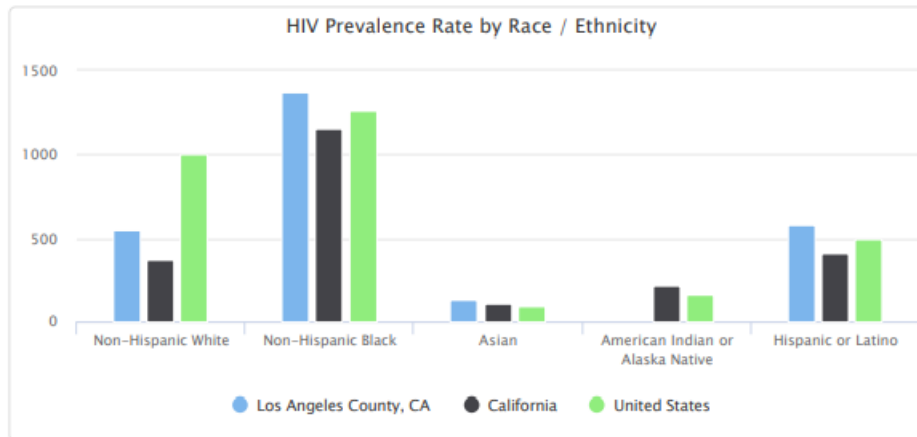
Report Area	Population Age 13+	Population with HIV / AIDS	Population with HIV / AIDS, Rate per 100,000 Pop.
Los Angeles County, CA	8,444,228	50,243	<b>595.0</b>
California	33,099,665	134,381	406.0
United States	277,596,976	1,054,159	379.7



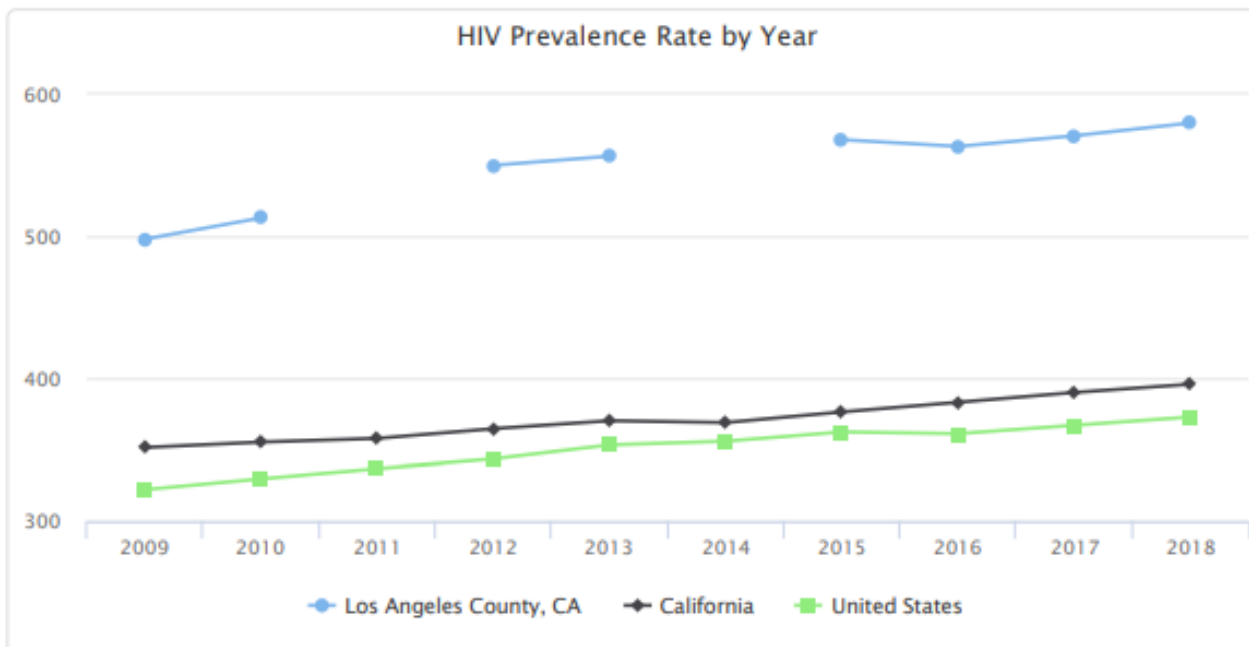
Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2020. Source geography: County

The prevalence of HIV among ethnic groups is highly variable, with greater concentrations in the non-Hispanic Black populations and roughly equivalent incidences in Hispanic and Non-Hispanic White cohorts.



Historic data for HIV prevalence was not provided for 2019 or 2020, so it is not known if this disease followed the trend of Chlamydia and Gonorrhea. The trend until 2019 was upward for all three comparison groups with Los Angeles County reporting rates roughly double those for the larger areas.



## **SURVEY DATA SUMMARY**

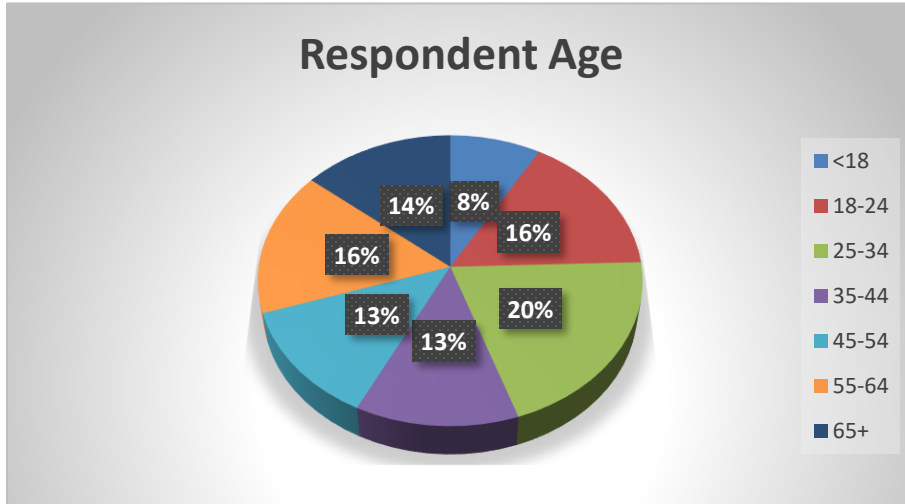
In an attempt to reach out to the community and gather a better understanding of service area needs, EHMC reached out to its patients and community in general through a community needs survey. It was distributed in two languages (English and Spanish) to capture and represent as many groups as possible. It should be noted that the surveys did not differentiate among the various Asian groups, and that many Asian subgroups are present in the area, all of whom would have responded “Asian” to the list of ethnicity options despite significant differences among the various Asian subgroups.

Survey respondents were solicited in shopping areas surrounding EHMC, at meetings of civic and religious groups, among friends of hospital staff, and among people coming to the Hospital.

The 203 surveys obtained from respondents in EHMC’s service area represent a much smaller sample than the discharge data, but provide a more detailed view of each respondent. Since the surveys are distributed by Hospital personnel to their acquaintances and community contacts, they do not represent a true cross-section of the overall PSA population. But the answers provided give insight into some issues that are of interest in analyzing community health needs.

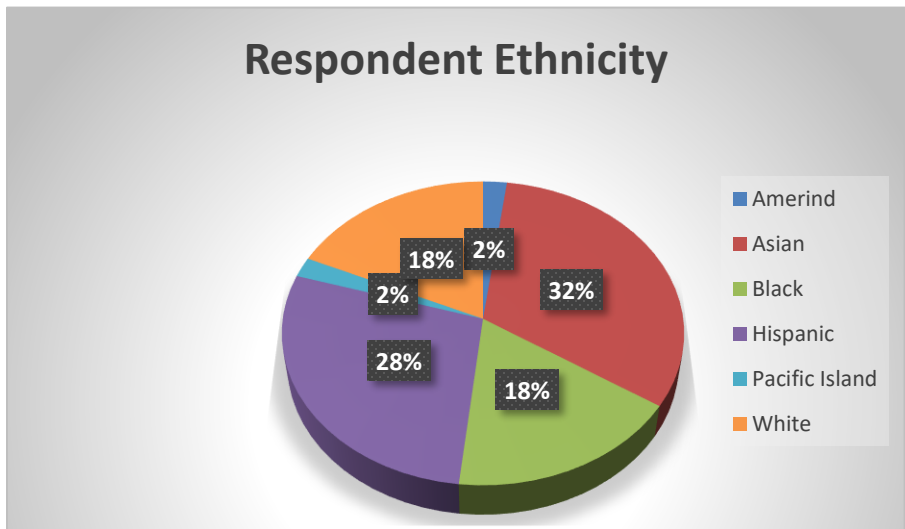
The highlighted items which follow are those where the survey responses deviated from total population data, or where the responses received indicate an area worthy of further analysis. The entire survey results follow the unusual items.

### Survey Respondents' Age



From a planning perspective, the age distribution of the survey respondents was not significantly different from county, state or national norms. The issues of all age groups are important considerations, although the Hospital's service complement tends to skew it toward older clients. The demographic mix also indicates that issues found throughout the county are probably issues that will matter to residents of the PSA

### Population by Race/Ethnicity



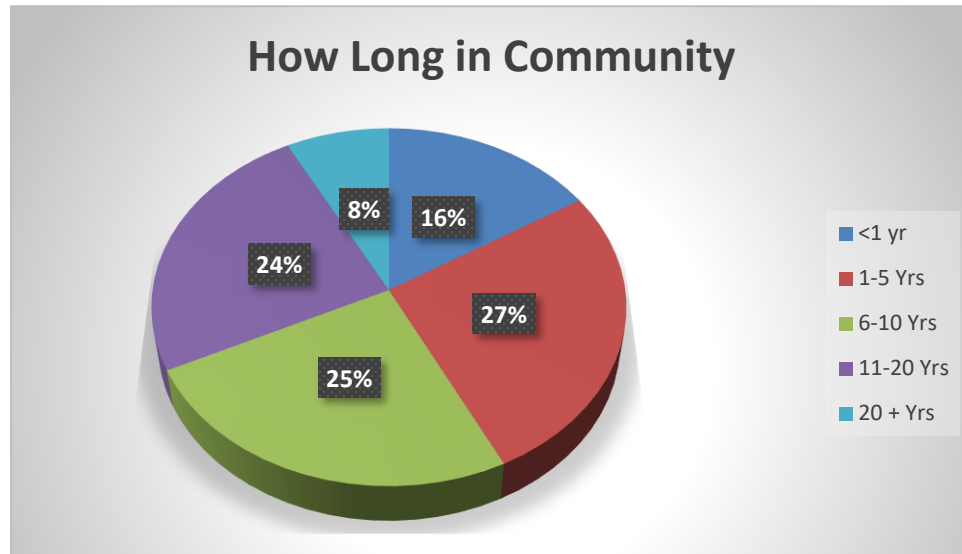
The PSA population reported in 2020 census data was less mixed ethnically than Los Angeles County and California, although more mixed than the US. The percentage of "white only" residents in the PSA (64%) is 17% greater than Los Angeles County as a whole. All non-white ethnic categories are smaller than their Los Angeles County and US counterparts.

The survey results tell a different story about ethnicity in the area than do census reports. The "white" Survey respondents were a much smaller portion of the survey population at 18%, while the Asian population represented a much larger proportion of respondents (32% vs 7% in Census data). Those responding as Hispanic were the second-largest group.

An important conclusion to be drawn from this population distribution is that opportunities exist for EHMC to serve a more diversified population ethnically. Services to the various ethnic groups are an area for further discussion.

Several other items from the survey are considered primary questions, and they are presented first, with responses to all other questions following.

### Tenure in Community

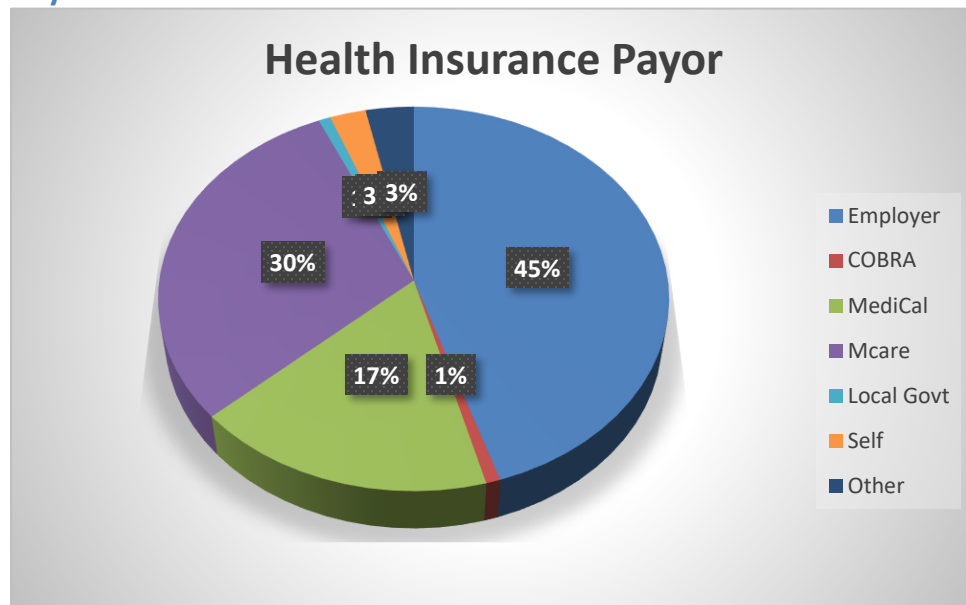


The community tenure response was almost evenly split among middle tenure categories, with the three middle categories reporting 25% plus or minus one or two percent. New residents were rare among the respondents. Long – tenure residents made up the fourth=largest group

How long have you lived in the community?

- Less than one year
- 1 to 5 years
- 6 to 10 years
- 11 to 20 years
- More than 20 years

## Payment for Insurance

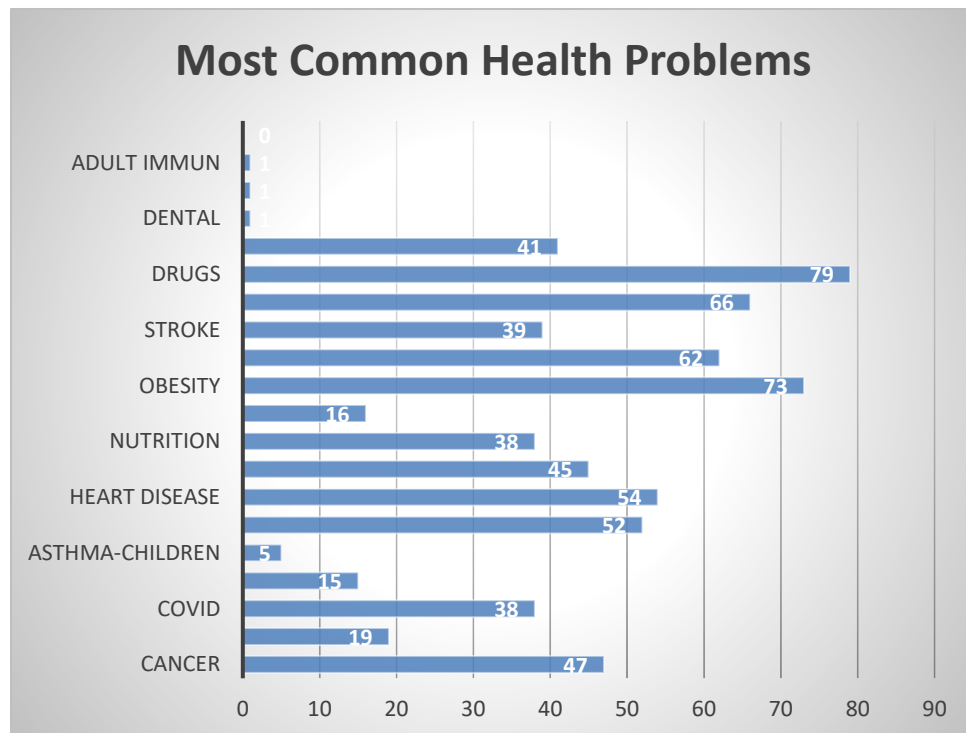


82% of respondents replied they have insurance. The primary payor was reported to be their employer, with smaller portions of Medicare and MediCal respondents. The prevalence of insured residents is significantly different than the statewide ratios, in which roughly one third of the state's population is a MediCal recipient.

10. Who pays for your health insurance (Check all that apply)?

- Current employer (HMO, PPO)
- Former employer (COBRA)
- State government (Medi-Cal)
- National government (Medicare, Medicaid)
- Local government
- Self-funded
- Other (please specify)

## Most Common Health Problems



When asked to name the greatest health problems in the community, the following were highlighted:

- Drugs 79%
- Obesity 73%
- Alcohol 66%
- Smoking 62%
- Heart Disease 54%
- Diabetes 52%

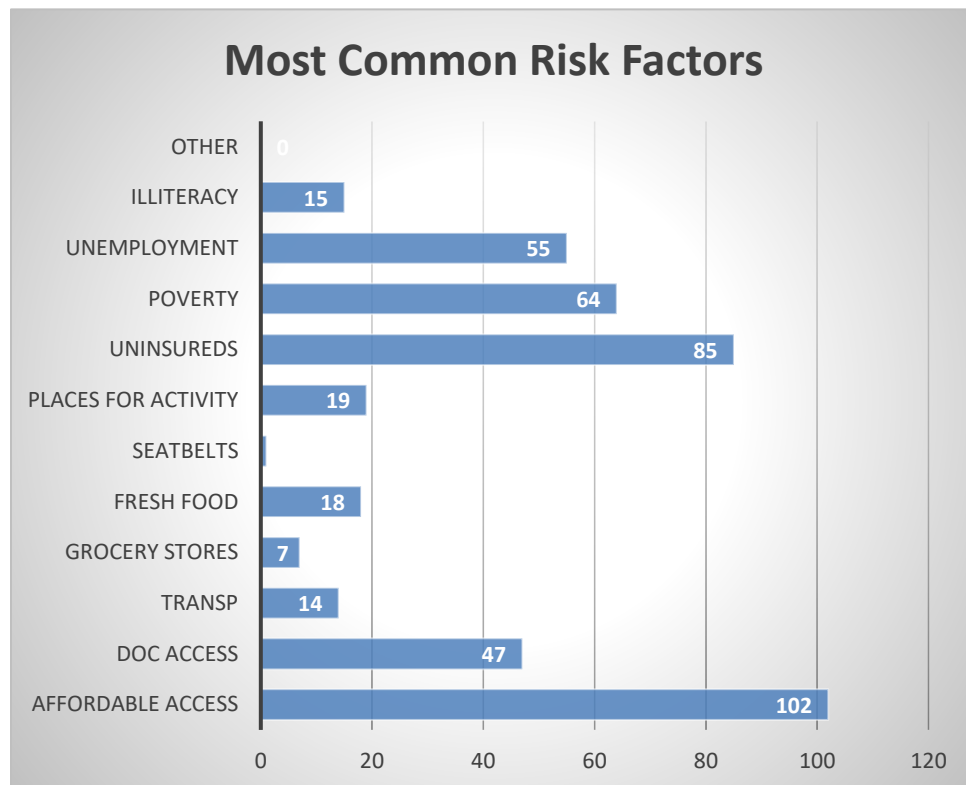
The emergence of drugs as the most cited health problem highlights a split between unhealthy behaviors (Drugs, Alcohol and Smoking) and medical conditions (Obesity, Heart Disease and Diabetes). Both types of problems present opportunities for the Hospital to intervene, although in different ways and locations. All the of the highly ranked issues are candidates for educational programs both inside the Hospital and out in the community.

28. Which four diseases/conditions do you believe are the most common in our community?

- Cancer-general
- Breast Cancer
- Respiratory diseases-adults
- Asthma-children
- Diabetes
- Heart disease
- High Blood Pressure
- Poor Nutrition
- Lack of physical activity
- Obesity
- Smoking

- Stroke
- Substance abuse- alcohol
- Substance abuse-drugs
- Mental Health Disorders
- Dental Problems
- Immunizations- children
- Immunizations- adults
- Other (please specify)

## Most Common Risk Factors



When asked to list three behavioral risk factors are the most common in the community, not all respondents provided answers. Among those who did, the following were highlighted:

- Affordable Access to Health Care 70%
- Uninsured Residents 58%
- Poverty 44%

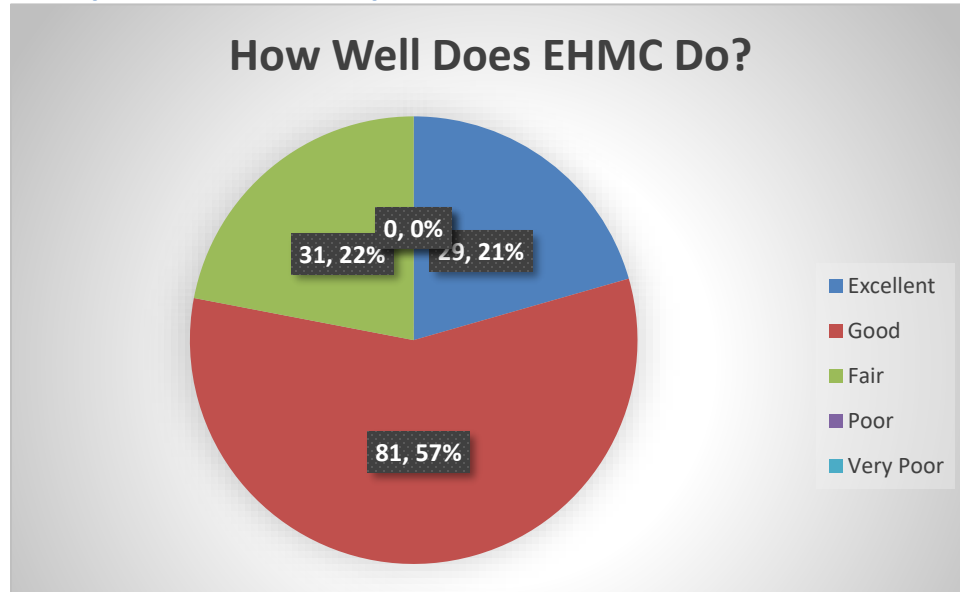
The most common complaint considered a risk factor now focuses on the cost of care. This contrasts with the first time the CHNA was done, before the Affordable Care Act, when the overwhelming problem was lack of affordable insurance. The Affordable Care Act and California's Covered California program have been successful in getting residents into insurance coverage (a third of all Californians are now MediCal clients), but problems remain in assisting insureds with copays and finding physicians willing to accept MediCal payments and patients.

29. Which three behavioral risk factors are the most common in our community?

- Access to affordable health care
- Access to physicians
- Inadequate transportation
- Lack of grocery stores
- Access to fresh, healthy food
- Wearing seatbelts
- Lack of safe places for physical activity
- High number of uninsured people
- Poverty

- Unemployment
- Illiteracy
- Other (please specify)

**Perception of Encino Hospital Medical Center**



The surveyed community also felt that a variety of clinics and programs were doing a good job in promoting health for the community. When asked specifically about EHM, the responses broke down as shown to the left. While the “Good” category got the largest share of responses, the other large responses bookended “Good” at “Fair” and “Excellent”.

32. How well does Encino Hospital Medical Center promote good health?

- Excellent
- Good
- Fair
- Poor
- Very Poor

When asked what EHM could do better to promote good health, the most common responses included:

- More online ads
- More health fair participation
- Free Vaccinations
- Education
- Home Visits
- Have preventive medicine screenings
- Program for staff/exercise room

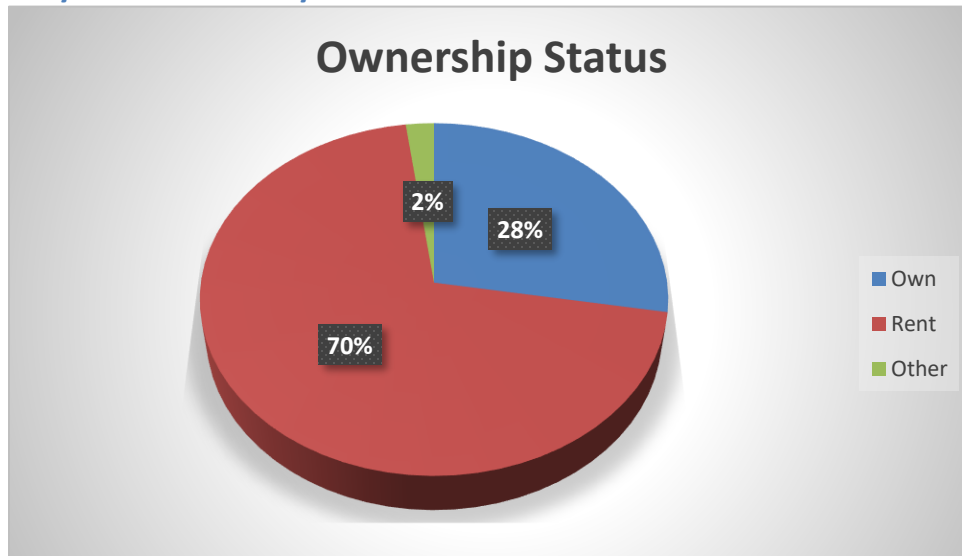
- Marketing & Incentives
- Offer healthy food options
- Farmers Market
- Continue with outreach programs
- Interact more with at-risk groups

Finally, the most pressing health care needs for those in the community that took part in the survey were the following:

- Mental Health
- Bringing awareness of resources to new residents
- In-home care
- Underage drinking
- Access to health checkups
- Healthy eating education
- Prescription access to name brands
- Homeless services
- Affordable insurance
- Urgent care (colds, flu, pink eye, ear infections)
- More parks to exercise
- In network, nearby specialists
- Affordable healthcare, secondary insurances
- Not sure - need to think on that
- Substance abuse
- Stress
- Access to Physicians on weekends and nights

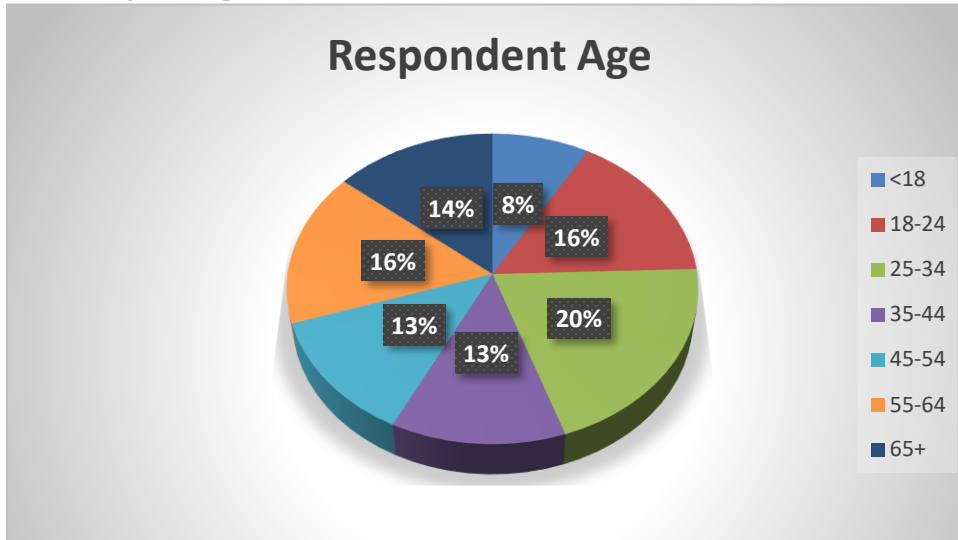
The rest of the questions on the survey are presented below, with the questions as posted on the survey, and the range of responses presented in the charts.

**Do you own or rent your residence?**



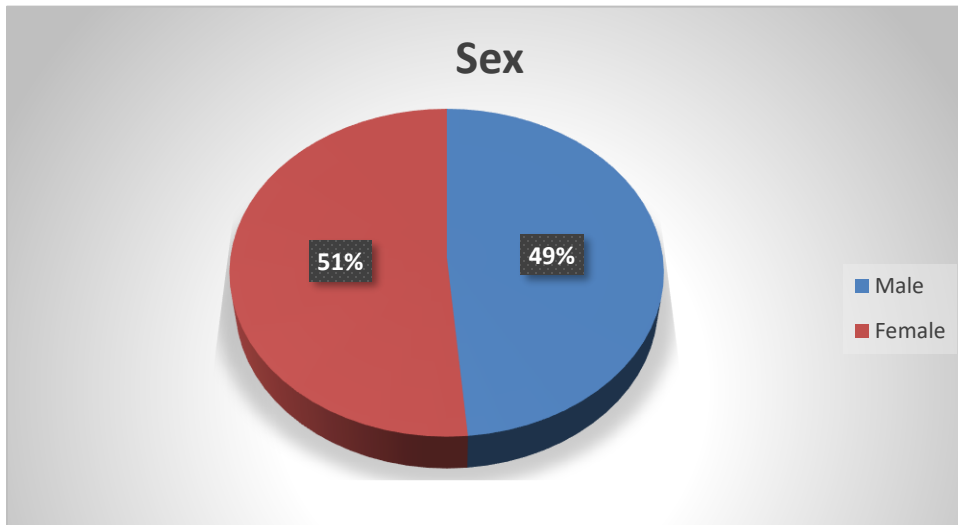
- Own
- Rent
- Other (please specify)

What is your Age bracket?



1. What is your age bracket?
- Under 18
  - 18 – 24
  - 25 – 34
  - 35 – 44
  - 45 – 54
  - 55 – 64
  - Over 65

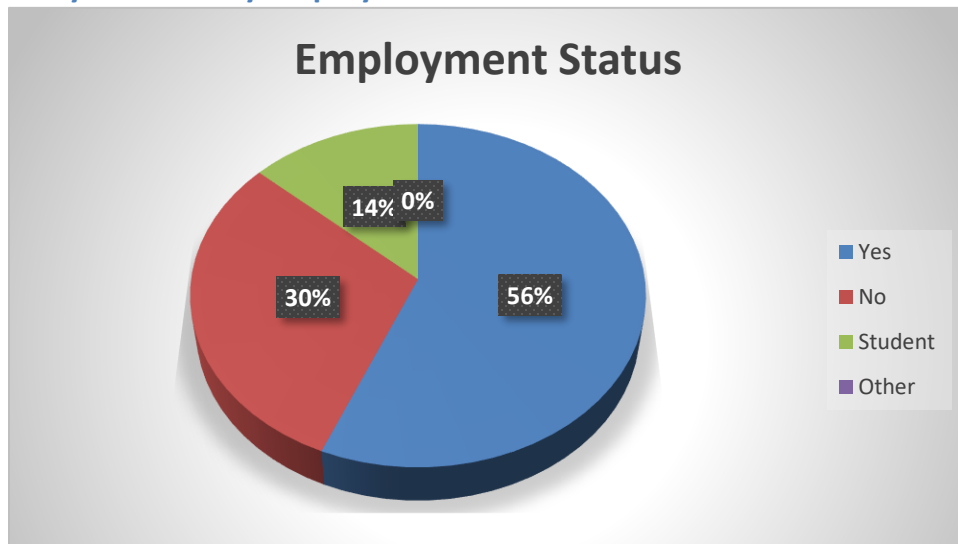
What Is Your Gender?



- Male
- Female
- Non-Binary
- Other (please specify) \_\_\_\_\_
- Decline to state

A Non-Binary option was offered, along with Other and Decline to state, but none of these options was selected by respondents.

Are you currently employed?

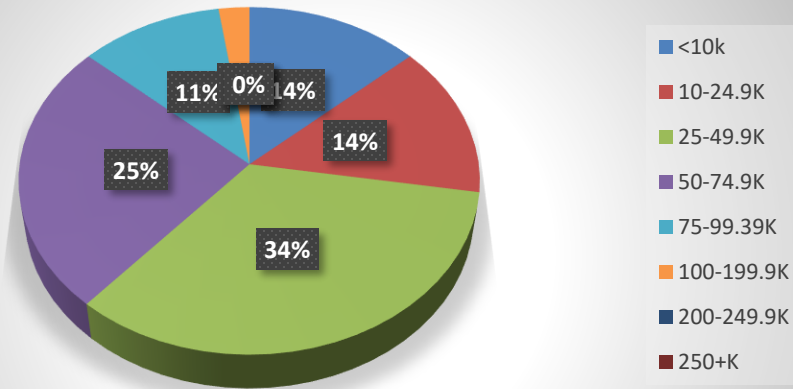


- Yes
- No
- Full-time Student
- Other (please specify)

“Other” responses typically classed themselves as retired.

## What are your income and your total household income?

### Personal Income

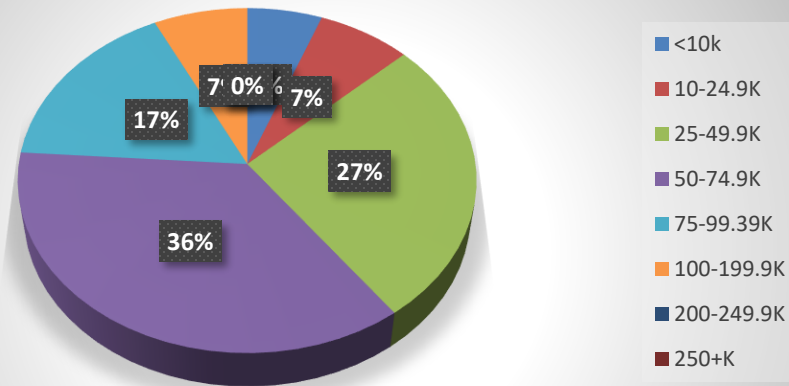


### Your income

- Under \$10,000
- \$10,000 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$199,999
- \$200,000 to \$249,999
- Over \$250,000

The respondents this year had a higher average personal income than the last time the survey was done, although incomes in nearly all categories were reported.

### Household Income

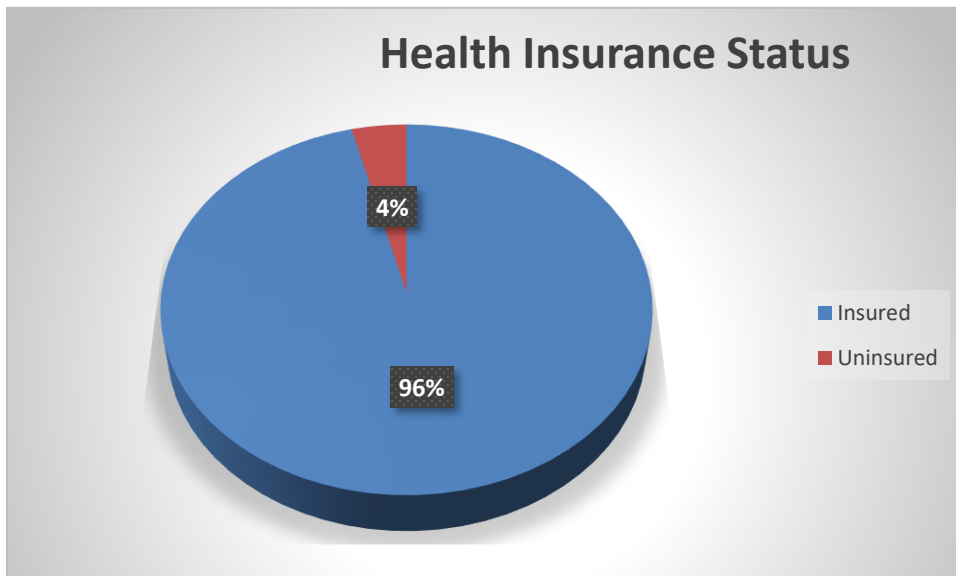


### Total household

- Under \$10,000
- \$10,000 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$199,999
- \$200,000 to \$249,999
- Over \$250,000

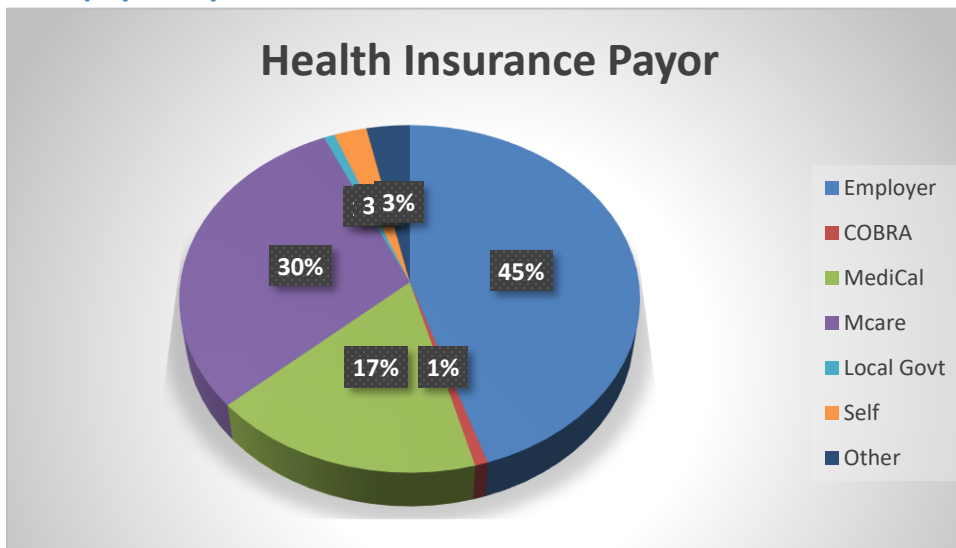
The presence of several two-income households pushed many respondents into higher income brackets.

Do you currently have health insurance?



- Yes
- No

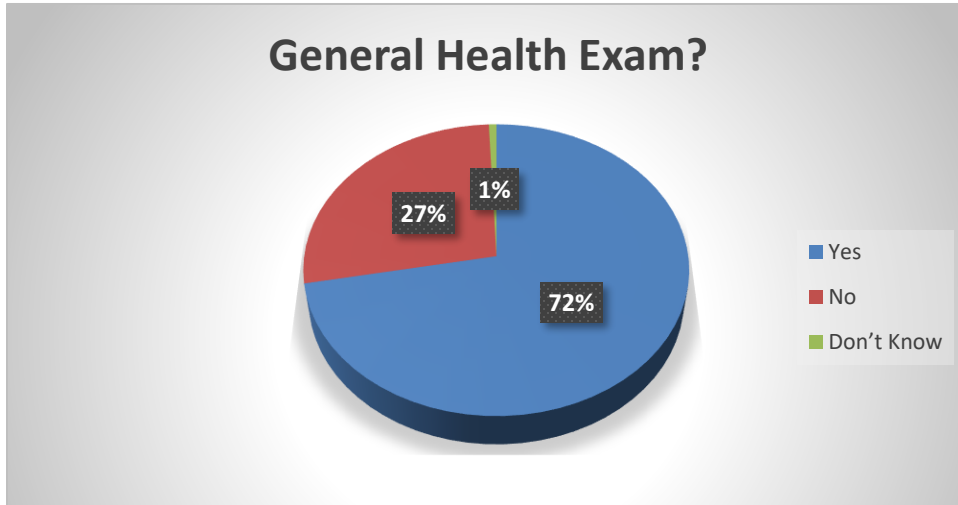
Who pays for your health insurance?



- Current employer (HMO, PPO)
- Former employer (COBRA)
- State government (Medi-Cal)
- National government (Medicare, Medicaid)
- Local government
- Self-funded
- Other (please specify)

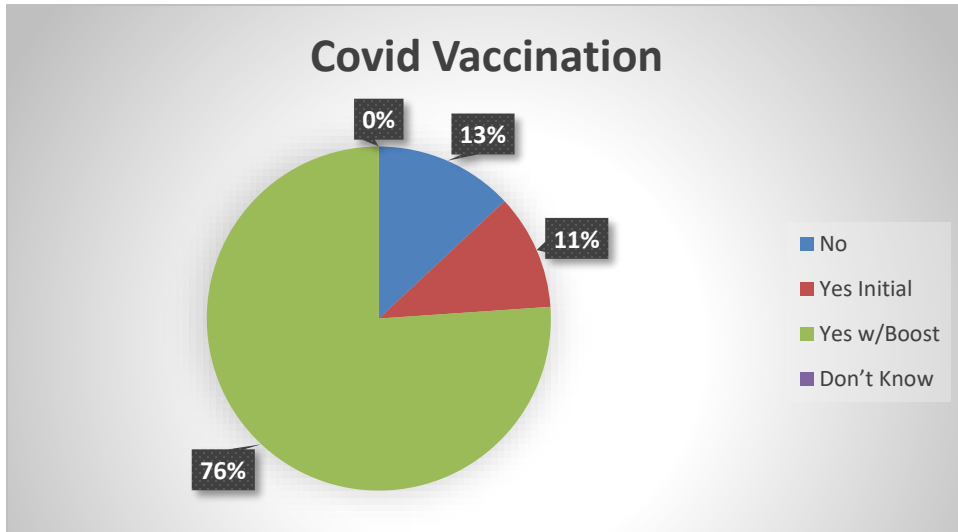
In the past 12 months, have you had a:

General Health Exam



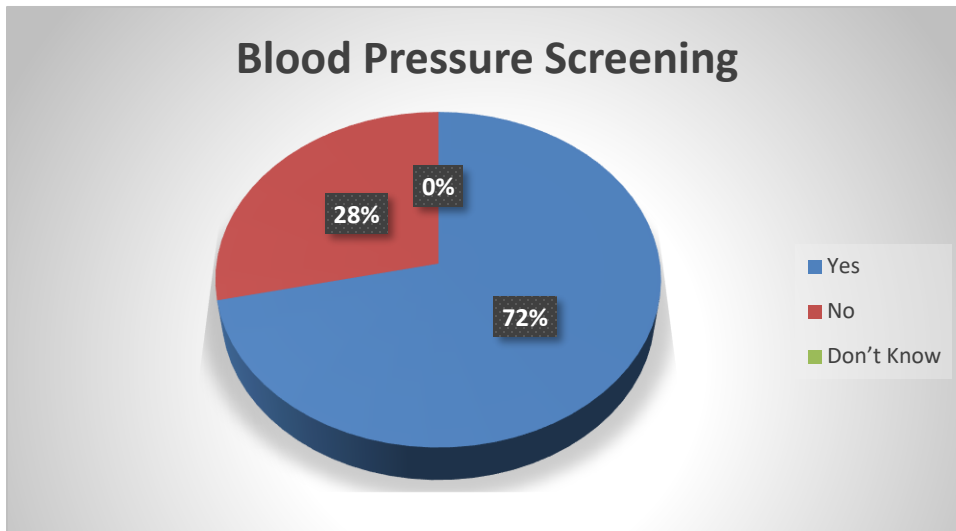
- Yes
- No
- Do not know

Covid-19 Vaccination



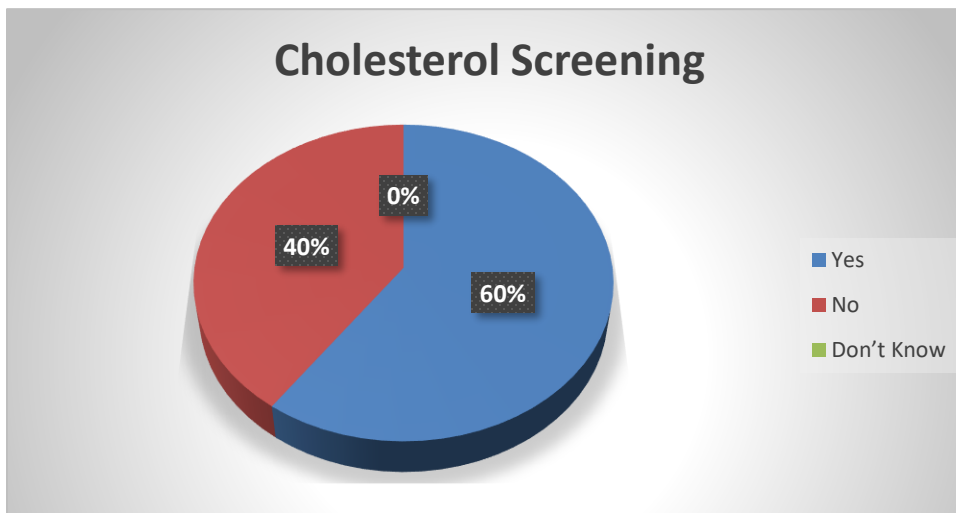
- No
- Yes, Initial sequence only
- Yes, including booster
- Do not know

### Blood Pressure Check



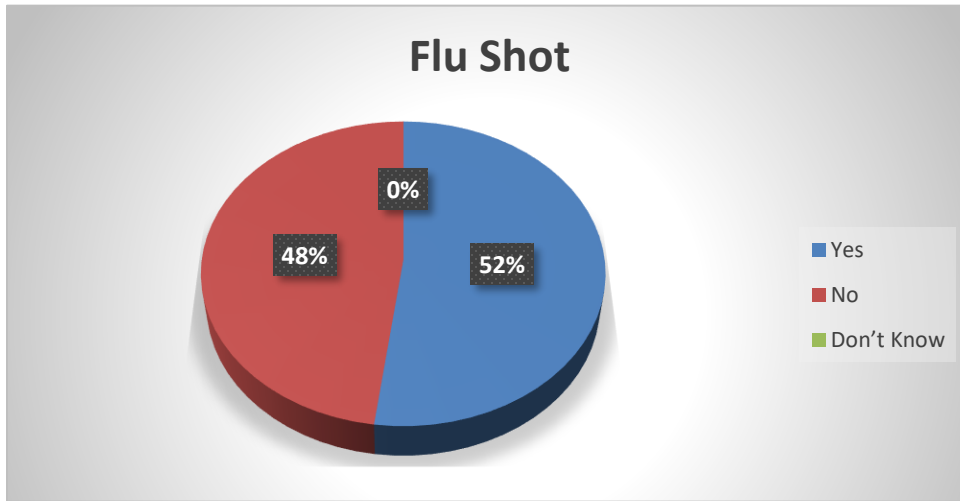
- Yes
- No
- Do not know

### Cholesterol Check



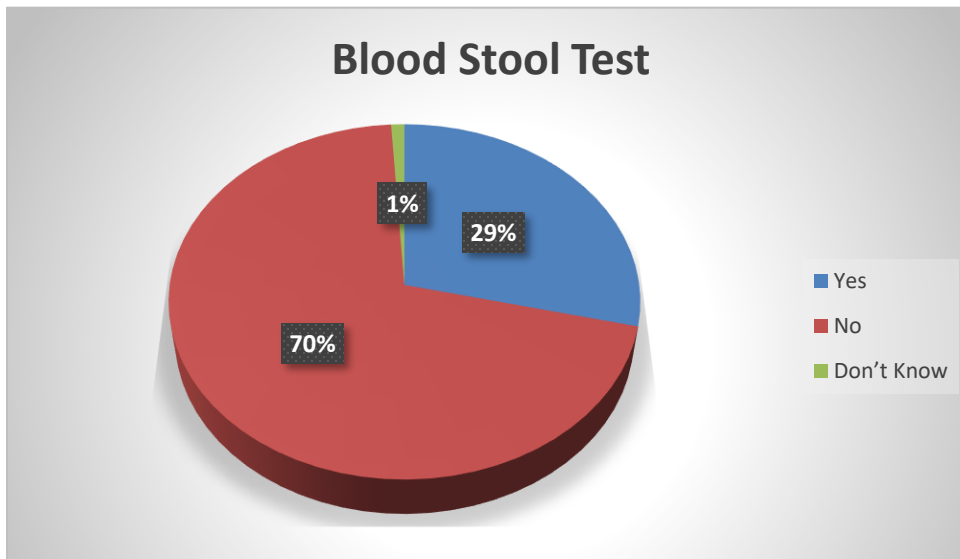
- Yes
- No
- Do not know

### Flu Shot



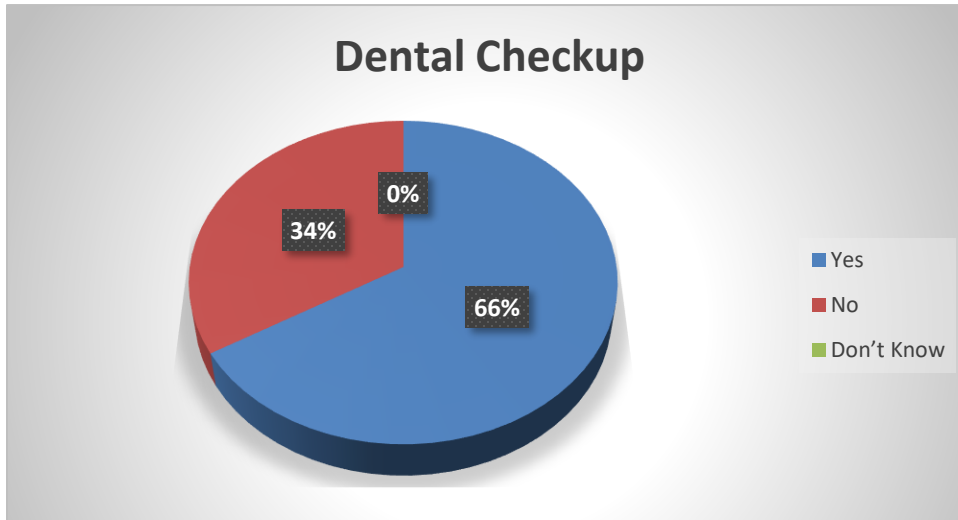
- Yes
- No
- Do not know

### Blood Stool Test



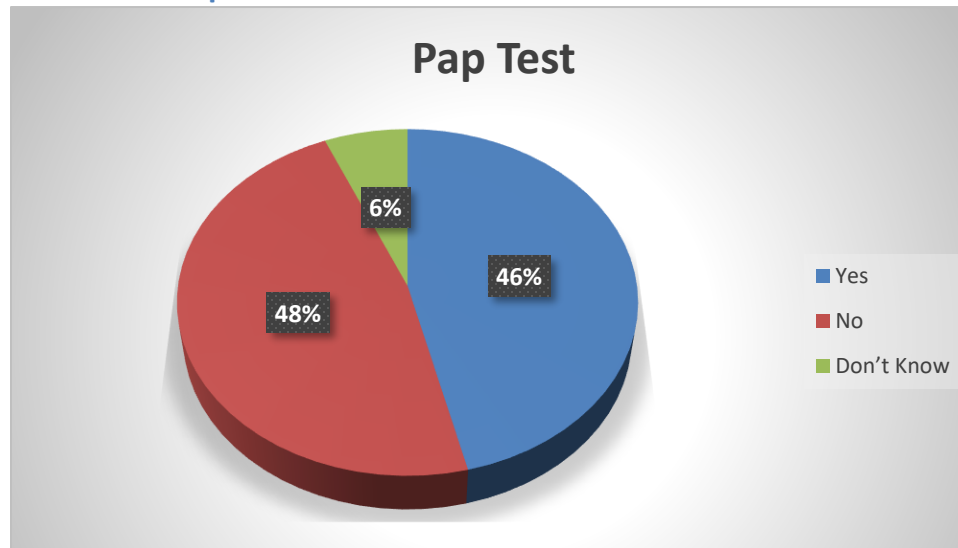
- Yes
- No
- Do Not Know

Dental Exam/Teeth Cleaned



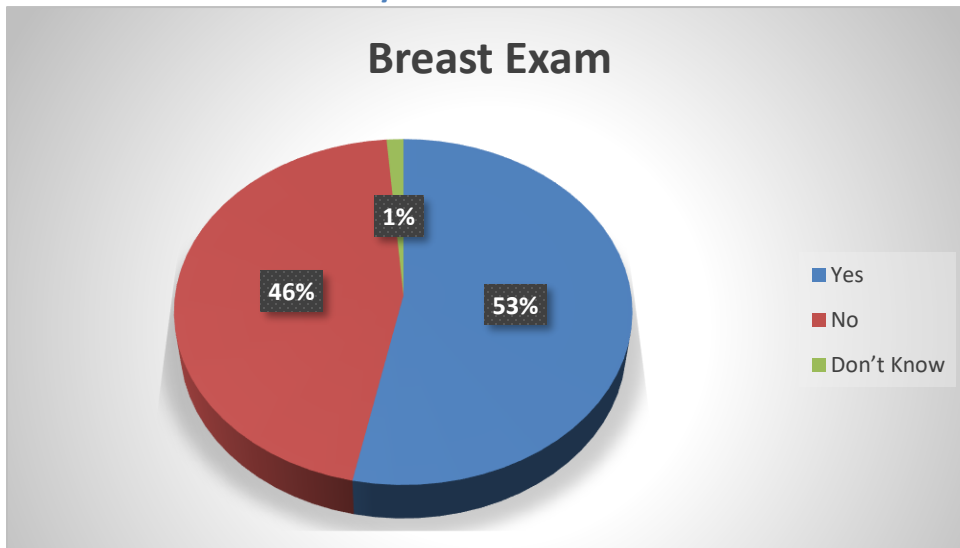
- Yes
- No
- Do not know

IF FEMALE: Pap Test



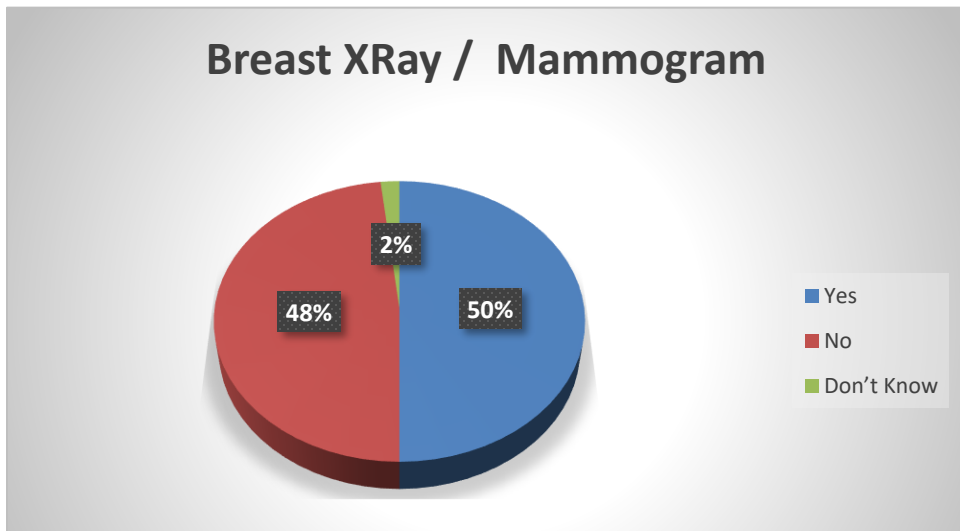
- Yes
- No
- Do not know

**IF FEMALE: Breast Exam by a Health Care Provider**



- Yes
- No
- Do not know

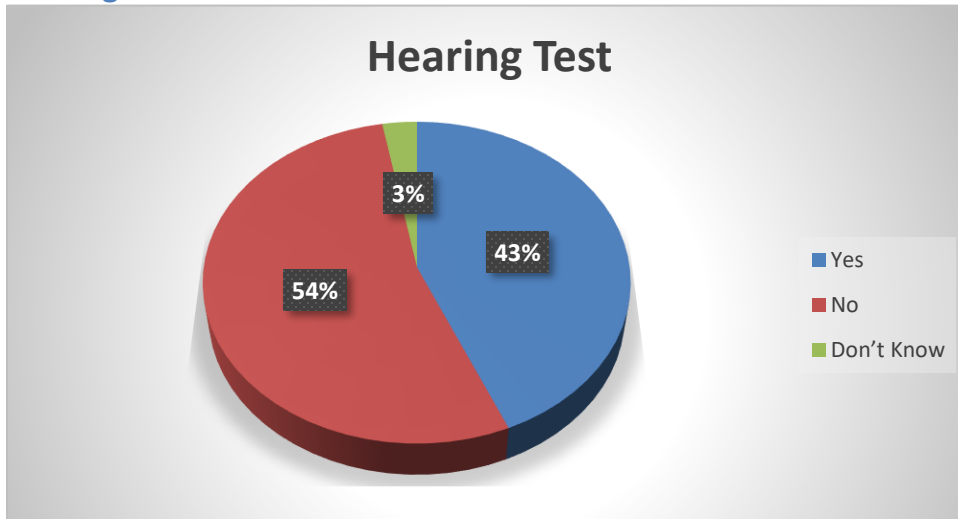
**IF FEMALE: Breast X-Ray or Mammogram**



- Yes
- No
- Do not know

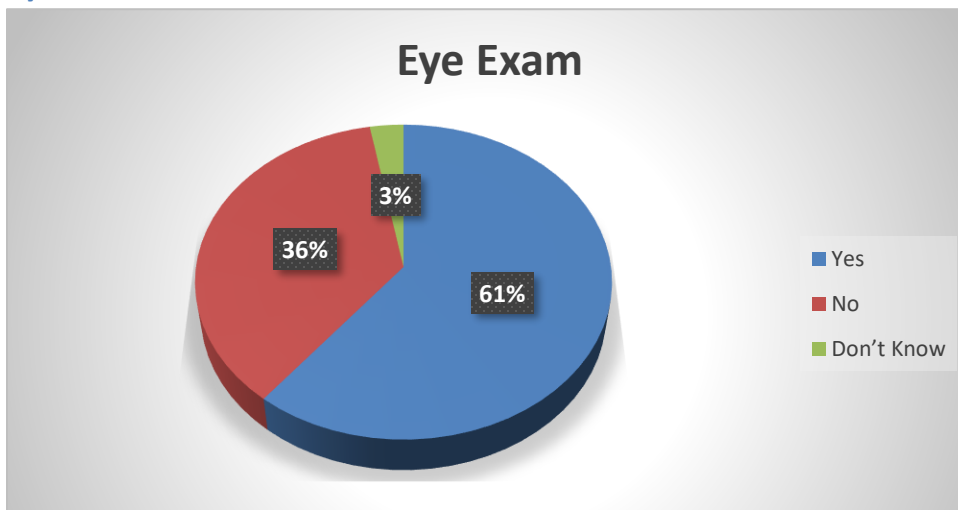
In the past 5 years, have you had a (fill in all that apply):

### Hearing Test



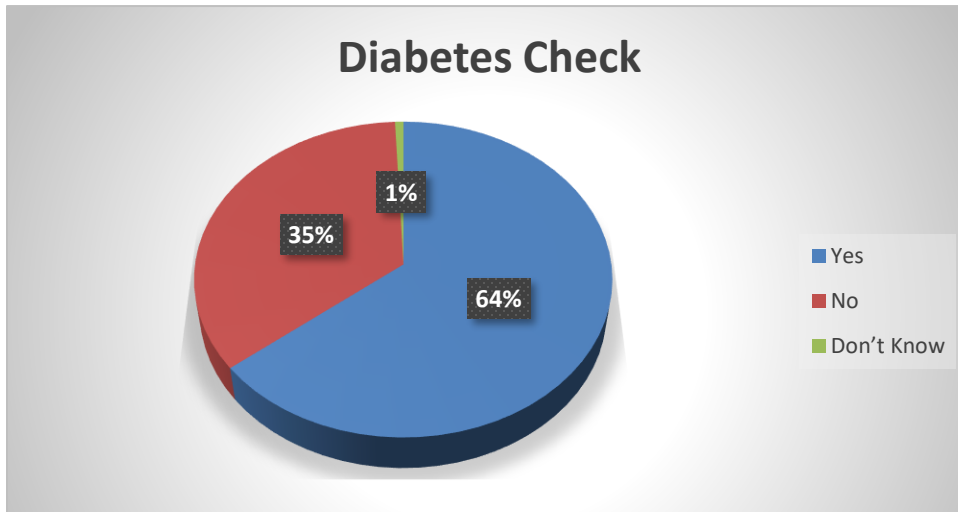
- Yes
- No
- Do not know

### Eye Exam



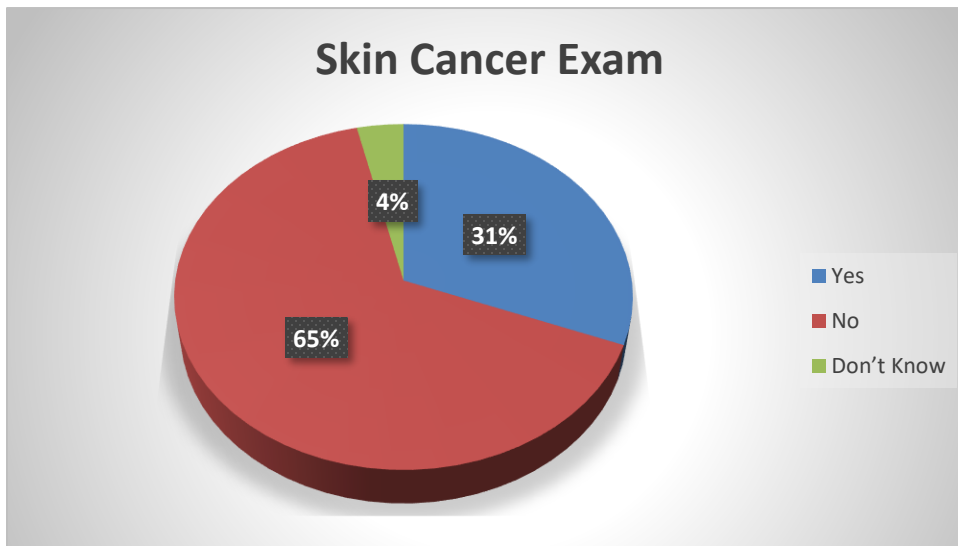
- Yes
- No
- Do not know

### Diabetes Check



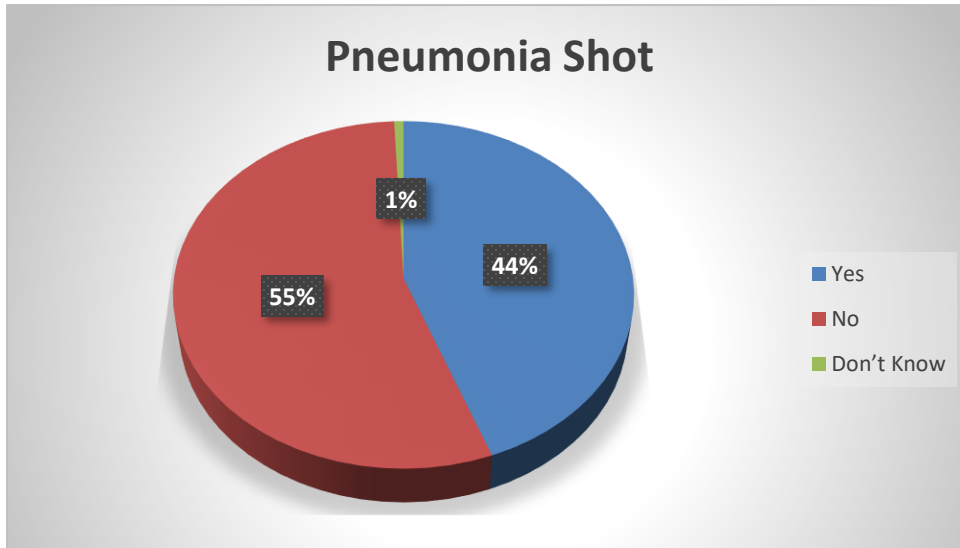
- Yes
- No
- Do not know

### Skin Cancer Screen



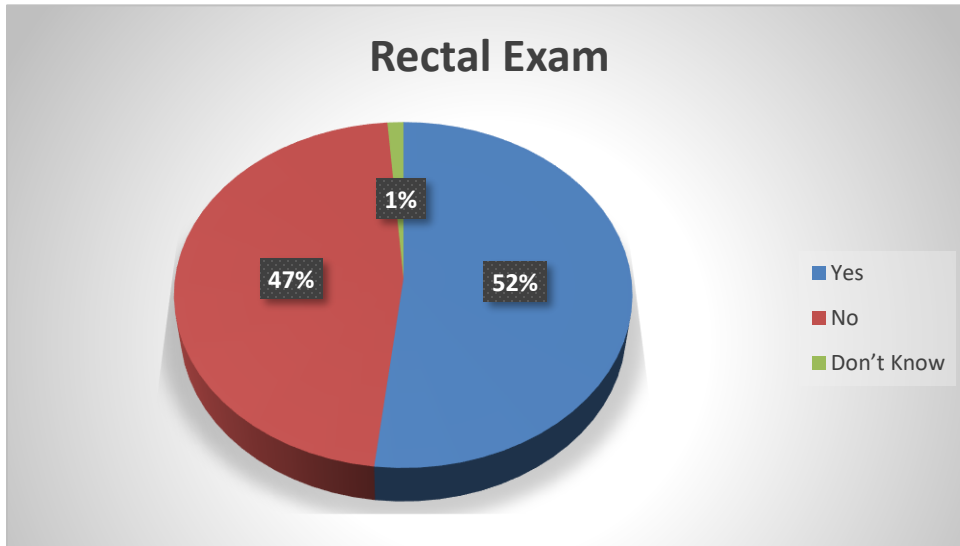
- Yes
- No
- Do not know

### Pneumonia Shot



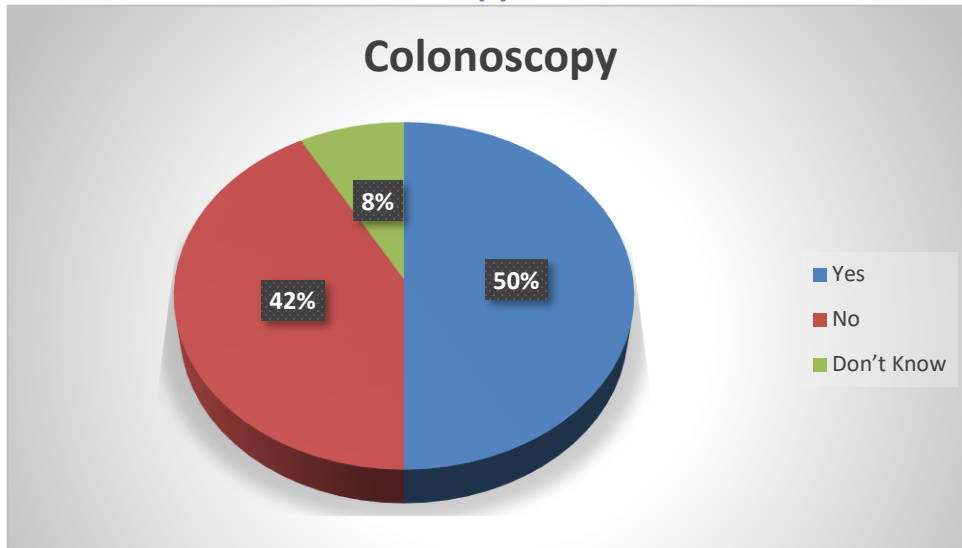
- Yes
- No
- Do not know

### IF AGE 40 or OLDER: Rectal Exam



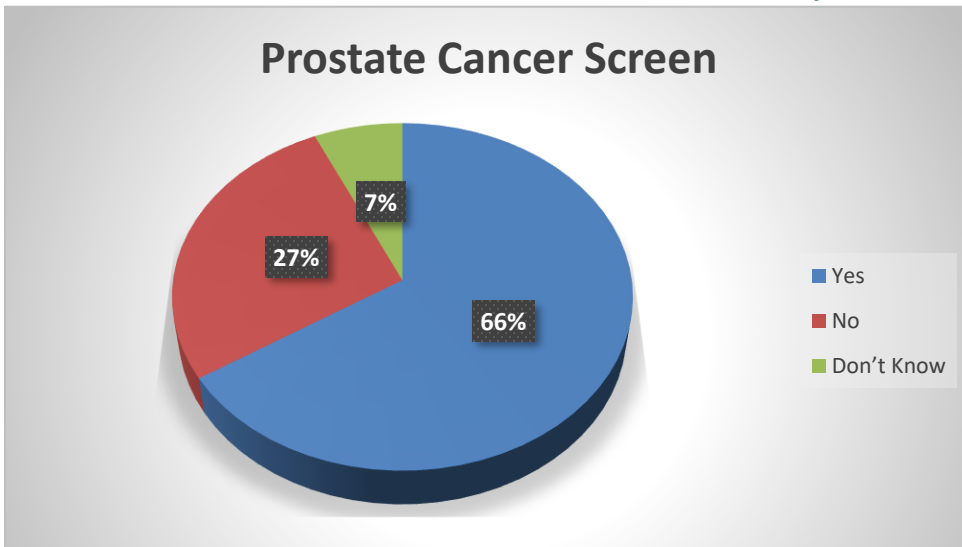
- Yes
- No
- Do not know

**IF AGE 50 or OLDER: A Colonoscopy**



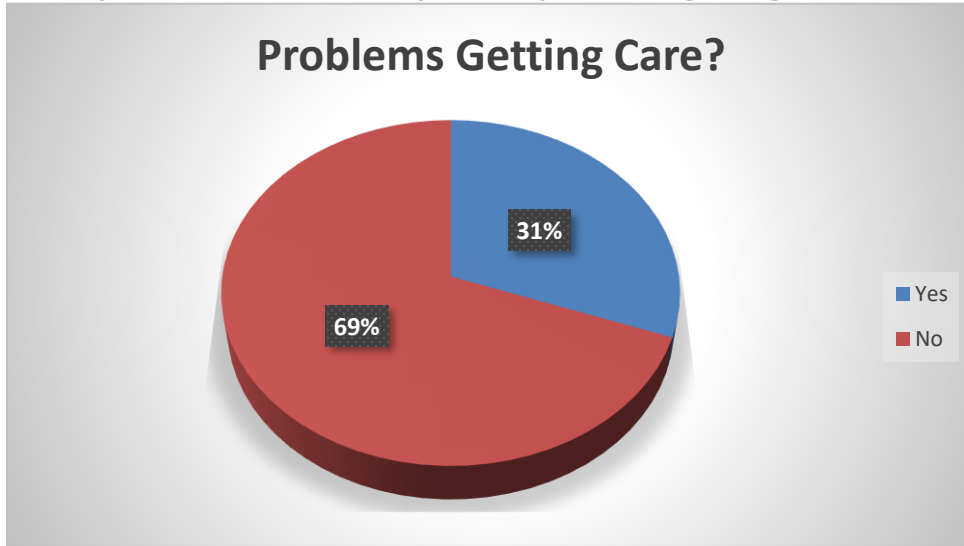
- Yes
- No
- Do not know

**IF MALE and AGE 40 or OLDER: A Prostate Cancer Screen/PSA**



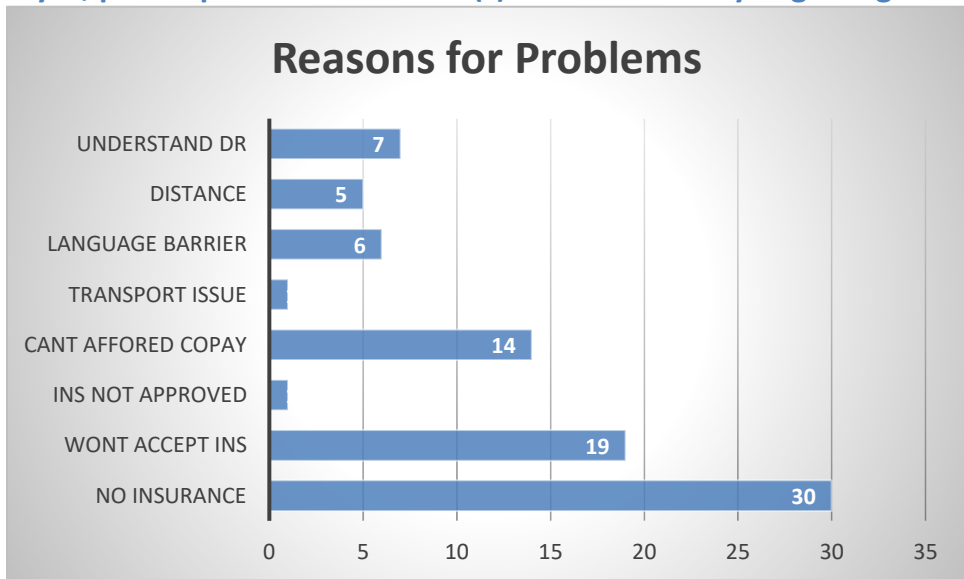
- Yes
- No
- Do not know

In the past 12 months, have you had problems getting needed health care?



- Yes
- No

If yes, please provide the reason(s) for the difficulty in getting healthcare.



- Lack of insurance
- Health care provider would not accept insurance
- Insurance would not approve pay for care
- Cannot afford co-pay
- Lack of transportation
- Language barriers
- Travel distance to provider too great
- Cannot understand my doctor

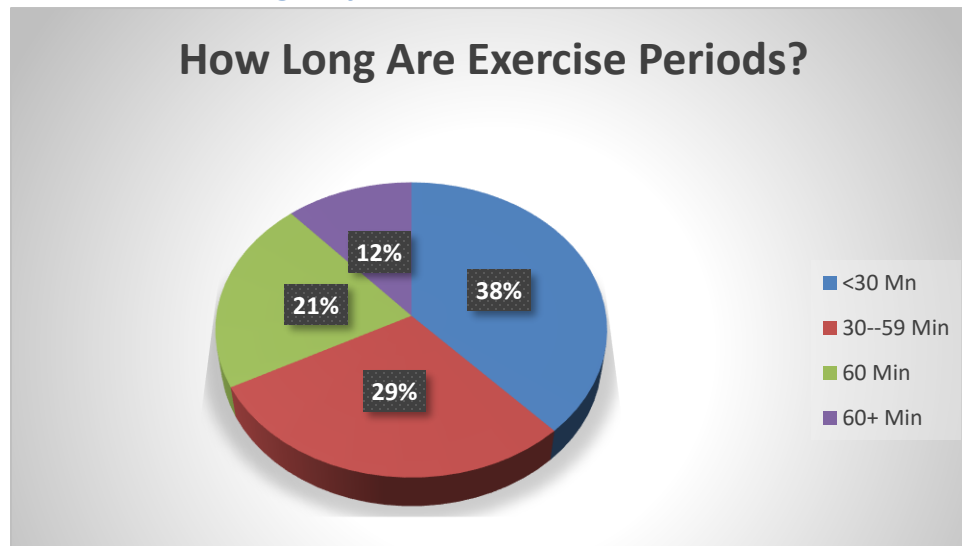
Many respondents who mentioned a problem getting care did not provide a reason. This is the distribution of the responses received.

How many times a week do you exercise?



- 0
- 1-2
- 3-4
- 4-7

For about how long do you exercise?

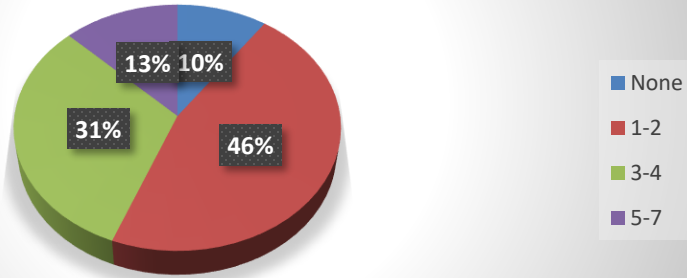


- Less than 30 minutes
- 30 minutes
- 1 hour
- Over 1 hour

While most respondents indicate that they exercise, many spend relatively short periods doing so.

How many days per week do you eat at least 5 servings of fruits and/or vegetables?

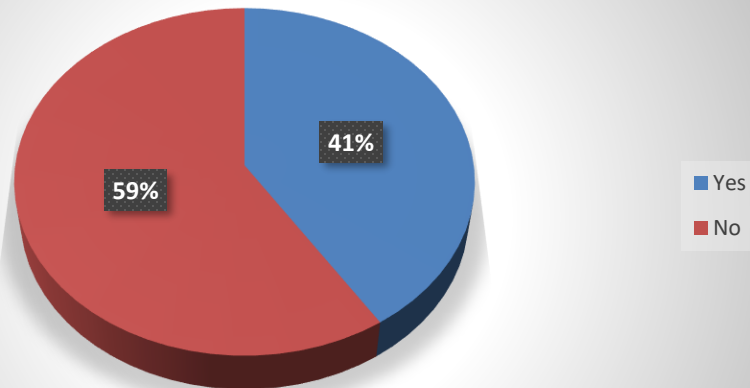
How Many Days/Week Do You Get Fresh Vegetables?



- 0 days a week
- 1-2 days a week
- 3-4 days a week
- Over 5 days a week

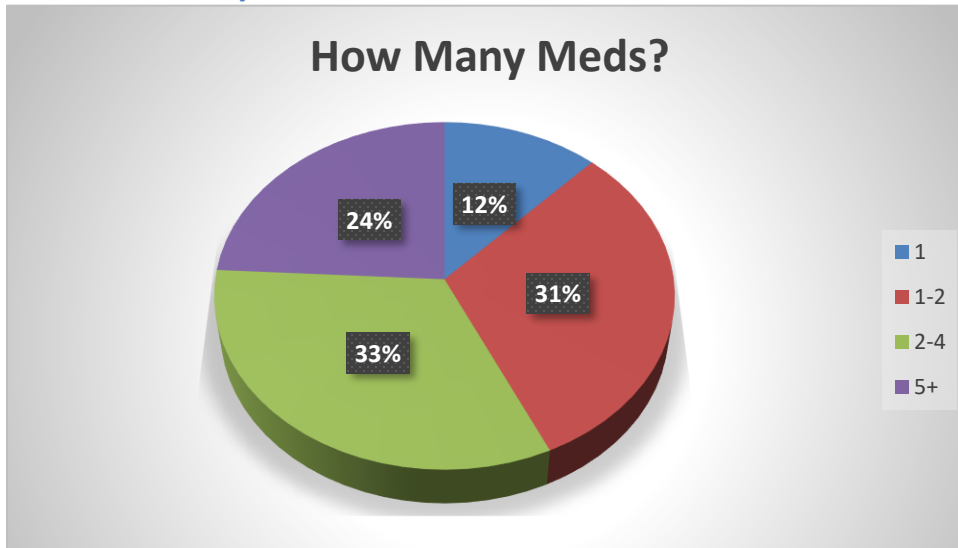
Are you on any medications?

Are You Taking Medications?



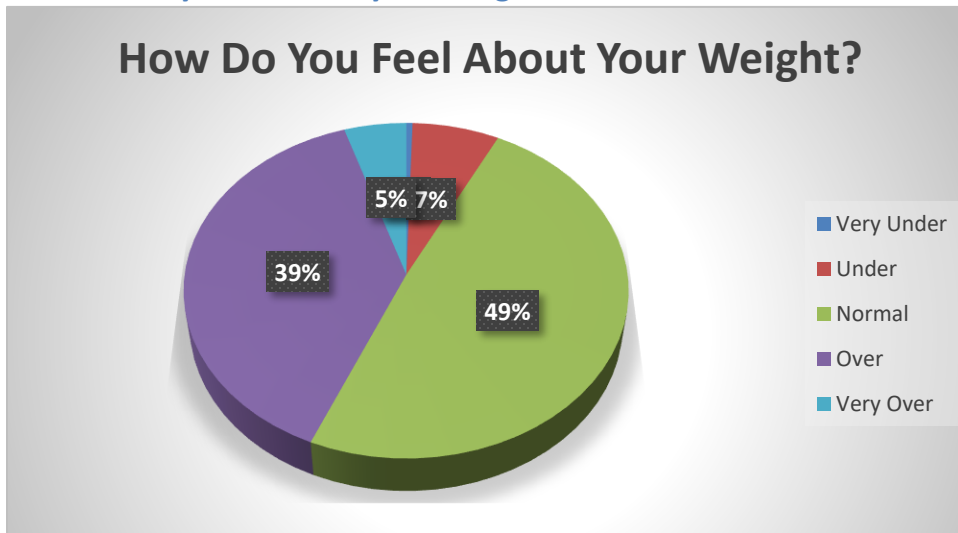
- Yes
- No

If Yes, how many?



- Just one
- 1 to 2
- 2 to 4
- Over 5

How would you describe your weight?



- Very underweight
- Slightly underweight
- About right
- Slightly overweight
- Very Overweight

The largest group of respondents indicated they felt about normal weight-wise, but the next-largest group responded with overweight. Very overweight, and underweight were minor portions of the response tabulation.

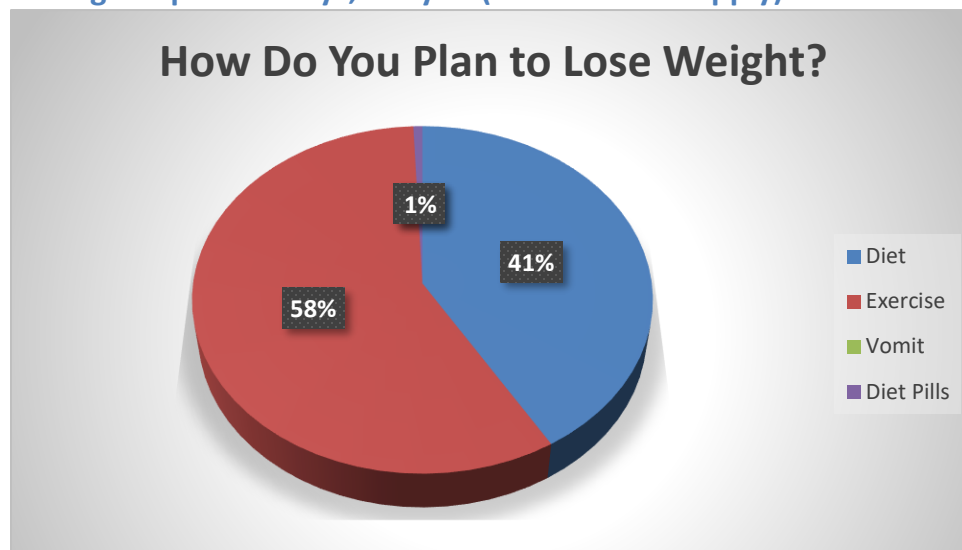
Which of the following are you trying to do about your weight?



- Lose weight
- Gain weight
- Stay the same weight
- I am not trying to do anything about my weight

These responses echo the respondents' self-assessments, with the largest group planning no attempts to change their weight. Losing weight and staying the same weight were nearly equal portions of the responses.

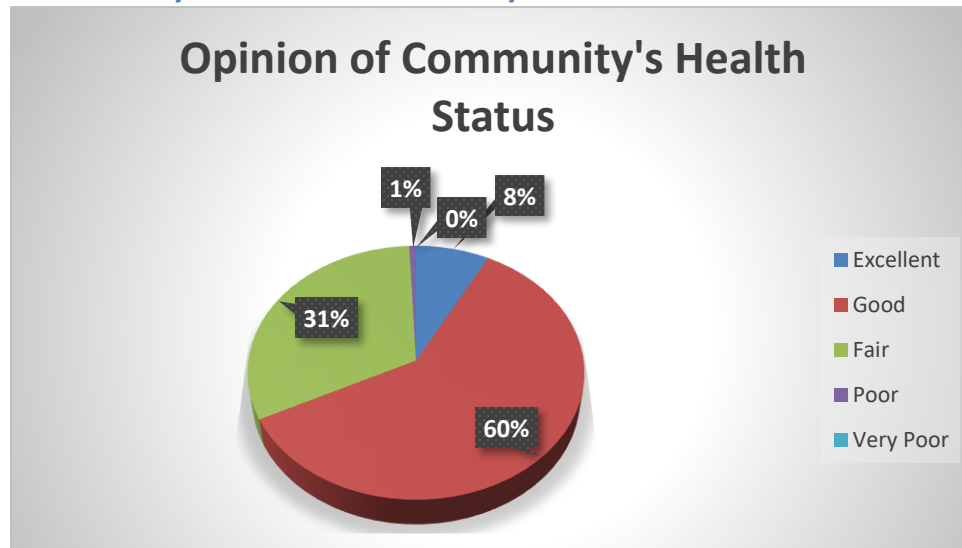
During the past 30 days, did you (Check all that apply):



- Diet to lose weight or to keep from gaining weight
- Exercise to lose weight or to keep from gaining weight
- Vomit, or take laxatives to lose weight or to keep from gaining weight
- Take diet pills to lose weight or to keep from gaining weight

Respondents trying to lose weight are uniformly working on healthy ways to achieve that goal.

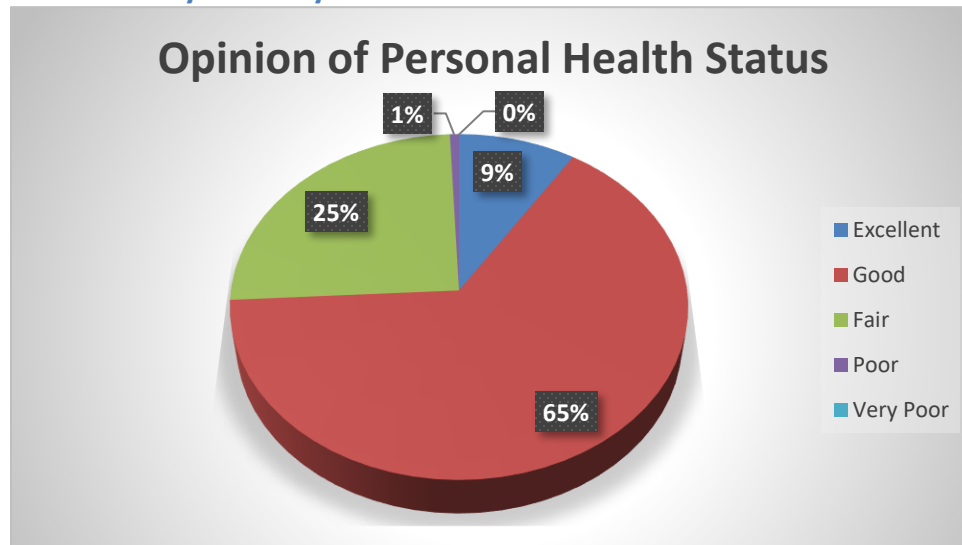
How could you rate our community's overall health status?



- Excellent
- Good
- Fair
- Poor
- Very Poor

Respondents chose Good as the primary response to this question, with Fair as next most common. There were some Excellent, and one Very Poor.

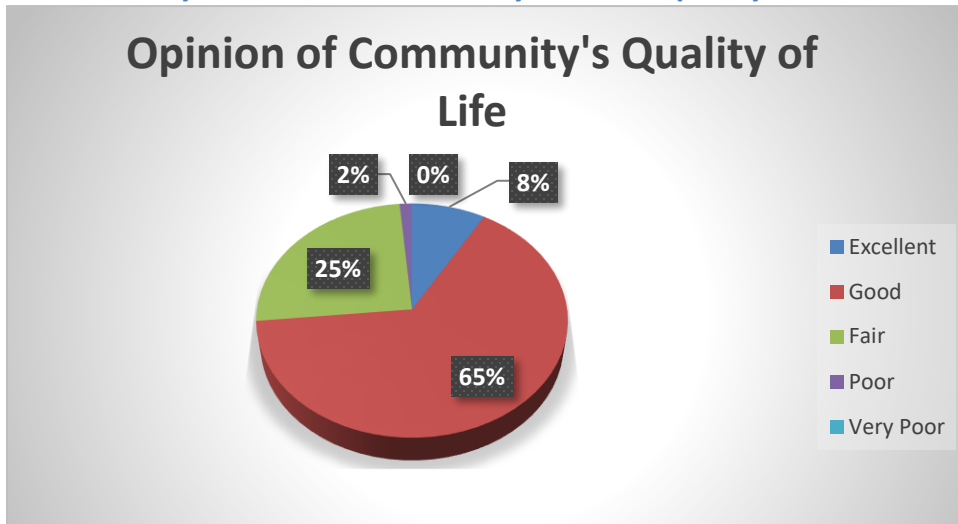
How would you rate your own health status?



- Excellent
- Good
- Fair
- Poor
- Very Poor

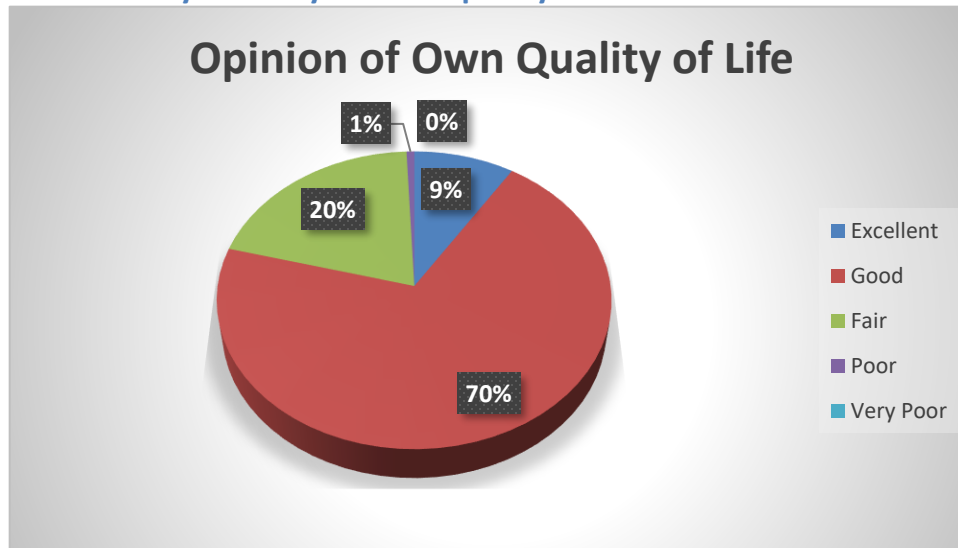
Most respondents thought their own health Good, with one quarter rating only Fair. Poor and Very Poor were almost nonexistent.

How would you rate our community's overall quality of life?



- Excellent
- Good
- Fair
- Poor
- Very Poor

How would you rate your own quality of life?



- Excellent
- Good
- Fair
- Poor
- Very Poor

## PRIMARY DATA KEY FINDINGS

### Community Input

The longstanding partnership and collaboration with various local agencies including L.A County departments helped Encino Hospital Medical Center and KeyGroup to identify representatives from health and mental health departments who serve the broad interests of the communities in the Encino Hospital Medical Center service area. In addition, focus groups were conducted with patients, social service agencies, law enforcement, post-acute care providers, school staffs, and other community residents. A list of stakeholders can be found in the Appendix.

Encino Hospital Medical Center’s Health Need Ranking identified 32 needs. They include the following:

- Access to Medical Insurance
- Alcoholism
- Continuity of Care
- Covid-Caused Alcoholism
- Covid-Caused Substance Abuse
- Covid Spousal Abuse
- Crime
- Diabetes Issues
- Dialysis Transportation
- Dialysis for Covid Patients
- Elder Care
- Employee Retention
- Endocrine Disorders
- Fentanyl Abuse
- Gaps in Coverage
- Homelessness
- Hyperlipidemia
- Hypertension
- Limitations of Medical Care



***Crime*** – As was noted earlier, both violent crimes and property crimes have increased in the EHMC PSA over the past two years. This has a direct effect in terms of traumatic injuries treated by emergency crews and Hospital staff. A less direct effect is the feeling of dread that accompanies the awareness of increasing crime. This has mental health implications.

***Diabetes Issues*** – Diabetes is a chronic illness that responds to management and can allow patients to stay at home and live relatively normal lives. The hospital sees diabetics when they fail to manage their illness, and while each episode is an opportunity to get the client back into a management regimen, the fact that some people are not actively managing their conditions is an opportunity for community intervention.

***Dialysis Transportation***– While area residents with renal failure can find centers for treatment, many are unable to drive to their appointments. No formal transportation network currently exists to assure that they can make their appointments. This is another opportunity for coordination with transportation providers.

***Dialysis of Covid Patients*** – This issue was particularly critical during the Covid quarantine period, when physical contact was discouraged. Since dialysis patients can't stop using dialysis services, many became hospital inpatients, increasing the stress on hospitals to provide beds. AS the crisis has eased, the surviving renal patients have been able to return to their previous regimens, but the presence of new Covid strains is an additional risk factor that they must cope with.

***Elder Care*** – This a broad category that encompasses geriatric acute care, as well as issues related to problems associated with seniors attempting to cope with declining health while living at home. Unless changes in health status are managed while residents are still living at home, they risk becoming long-term care patients in some institutional setting. This issue is getting more exposure and a new moniker: Social Determinants of Health (SDOH). Health providers embracing this idea are finding ways to explore home and community conditions that contribute to declines in health and addressing these conditions before they become acute.

***Employee Retention*** – Selected as a primary “Continuing Need” to be addressed in the Hospital’s Implementation Plan, this issue was the subject of much focus group discussion. Much has been made of the “Great Resignation” with employers in all industries seeing losses of staff. The problem is particularly acute in healthcare, since demand for healthcare providers escalated during the quarantine and many of these providers were among the first to be affected by the virus. As the pandemic eased, many healthcare workers found other less-taxing jobs. Keeping the remaining employee base and finding replacements for the losses has been “Job One” for many organizations in the healthcare field.

***Endocrine Disorders***– Endocrine disorders encompass a full range of diseases, the most-common of which is Diabetes. But many other disorders, such as Hypoglycemia, Hyperthyroidism, Hypothyroidism, Graves Disease, Hashimoto’s Disease and others are also common. Most are manageable with adequate supervision.

***Fentanyl Abuse*** – This drug has become a rampant contributor to emergency-room admissions nationwide, and is particularly critical among school-age children. Several local deaths of teenagers have focused community attention on the problem, and public education efforts are underway. Meanwhile, hospitals are some of the front-line responders to the those impacted.

***Gaps in Coverage*** – This problem is related to Continuity of Care, as it focuses on the portions of healthcare services that insurance covers poorly or not at all.

***Homelessness*** – This condition was selected as a primary “Continuing Need” to be addressed in the Hospital’s Implementation Plan. The homeless residents of Los Angeles are a major political issue, and possible solutions to the problem are a source of continuing debate and innovation. Hospitals serve as first responders to many homeless residents, and encounter problems finding placements for them once the acute problems have been addressed. Government agencies at all levels are developing programs to address the issue, new funding sources are being developed and new modalities are being proposed and implemented. Encino Hospital Medical Center is working with social service agencies, government bureaus and other care providers to work on solutions to the issue. But the state of the art is evolving rapidly and much remains to be done. This issue will be followed closely over the next three years.

***Hyperlipidemia***–Most commonly known as high cholesterol, the condition is associated with increased risk of heart attacks and strokes. It is treatable, and is one of the Social Determinants of Health that lends itself to routine management.

***Hypertension*** – Known as high blood pressure, it is a precursor to stroke. As with Hyperlipidemia, it is a manageable condition and amenable to monitoring and ongoing medication therapy.

***Limitations of Medical Treatment*** – Different patients need different care courses as they recover from various diseases. A constant source of friction in the medical community is the practice of most health insurers to specify how much follow-up care is warranted for a specific diagnosis. Payment is often limited to that amount, which often may not be adequate to complete the course of treatment needed for some patients, possibly resulting in a relapse or readmission to the hospital.

***Managed Care Authorizations*** – This is a subset of the Limitations of Medical Treatment issue above. In this case the managed care organization requires referrals to a specialist to be authorized by either the primary care provider or a review committee within the Managed Care Organization. Medical personnel resent the second-guessing, and delay involved in the review process, and patients see it as unnecessary bureaucracy.

***MediCal Rules That Don’t Work for Patients*** – This is another limitation on medical treatment. While MediCal officially allows patients to see any doctor they wish, the payment rates to physicians mean that many physicians won’t accept MediCal patients. If a former private-insurance patient loses his/her job and transfers health coverage to MediCal, he/she may find the doctor will no longer accept

this insurance. This issue is particularly problematic when referrals to specialists are needed, as many specialists will not accept MediCal referrals.

***Mental Health*** – This topic is the first issue selected as a primary “Continuing Need” to be addressed in the Hospital’s Implementation Plan. It is receiving significant publicity, and professionals in the specialty have succeeded in advocating treatment as an illness, with legislation mandating coverage for mental health issues as part of basic coverage under the Affordable Care Act. While progress has been made in bringing mental health care into the medical mainstream, it still needs to increase its prominence and funding

***Monkeypox*** – Monkeypox was front-page news while the focus groups were being held, and at the time there was fear that it could be the next Covid pandemic. As this report was being prepared, no breakout had occurred.

***Reimbursement from Payor*** – Any healthcare provider that deals with health insurers has issues with payment. As with any insurance transaction, the payor attempts to pay only what coverage demands, and the covered entity attempts to maximize the amount received. This is another “Limitations of Treatment” issue.

***Renal Disorders*** – Diseases of the kidneys can result in renal failure, making the patient a dialysis client for the rest of his/her life. Treatment for most renal maladies is available but often deferred, putting the patient at risk of renal failure. Early diagnosis and treatment can save the patient a lifetime of dependence on machines, and the insurance industry millions in cost.

***Substance Abuse*** – This is the catch-all category for all the drug-abuse syndromes, such as alcoholism, opiate addiction, and methamphetamine abuse. Each substance has its unique problems and solutions, but they share a lifestyle-based condition that needs to be addressed in a unique fashion. Hospitals can have an active role in advocating these alternative treatments.

***Supply Chain Issues*** – This problem came into sharp focus in the early days of the Covid quarantine. Hospitals suddenly could not obtain basic personal protective equipment (PPE) and mechanical equipment such as respirators. The PPE problems have largely been resolved, although questions remain as to how much manufacturing capacity should be U.S. based. But some supplies, such as specific drugs, remain in short supply, or have increased radically in price. Recent legislation purports to resolve some of these issues, but it remains to be seen how well the legislated fixes work.

***Teenage Substance Abuse Resources***– The need for awareness education in schools came into high relief with the deaths of several teens due to fentanyl overdoses. Education resources have been diverted from other teen issues to address this problem, but a longer-term program is needed to contain the threat.

*Transition from Medical to Home Care* – This topic is a subset of the Continuity of Care issue that is one of the “Community Issues” that will be a focus of the Hospital’s Implementation Plan. Many of the patients treated at EHMC are released either to a step-down unit for continuing rehabilitation or directly to home. In many cases, the home may be a cause of the original admission to the hospital, since it may contain hazards such as loose carpets, poor nutritional resources, or a medicine cabinet with prescriptions from several different physicians. The Implementation Plan will address the Hospital’s plan to address some of these problems.

*Transportation* – Many of the Hospital’s clients are unable to drive, and depend on public transportation for the daily errands. This often poses a problem when these clients need to see medical providers in locations not easily accessible by their usual transit providers. This can result in missed appointments, which under the Social Determinants of Health umbrella become a healthcare issue to be addressed. EHMC currently provides payment for transportation services for some hospital-based services, but a gap still exists in getting these clients to non-hospital-based services.

*Unlicensed Elder Care* – Among EHMC’s clients are many elderly residents who need care but are unable to qualify for In Home Supportive Services (IHSS) care. Some of these patients may enlist relatives or unlicensed care providers to help them with their daily activities. While these care providers are a better solution than no care, they may be unqualified to provide the level of services the client requires. Either unwittingly or through provision of inappropriate care, they may put the resident in danger, or possibly in the hospital. This is another SDOH issue.

## APPENDIX A

### STEERING COMMITTEE

The steering committee for the CHNA is composed of the operating management of the hospital, along with board members overseeing the foundation.

<b>Name</b>	<b>Title</b>	<b>Role in Community</b>
Sunny Bhatia, M.D.	Chief Medical Officer	Chairman of the Board
EM V. Garcia	Hospital Administrator	Vice-Chairman of the Board
Roland L. Santos	Chief Nursing Officer	Ex Officio Board Member
J. Nathan Rubin, M.D.	Chief of Staff	Voting Board Member
Rick Mahalingam	Regional Chief Financial Officer	Ex Officio Board Member
Kenn Phillips	Community Board Member	Community Board Member
David Thorson	Community Board Member	Community Board Member
Christopher Cooper	Community Board Member	Community Board Member
Jason Greenspan, M.D.	Regional Medical Director for Emergency Services	Member-at-Large

Not all members of the steering committee were available for meetings, but the committee approved the analysis of needs and will oversee the implementation of programs to meet the needs as outlined in the Implementation program.

## APPENDIX B

### FOCUS GROUPS

Encino Hospital Medical Center Focus Group Invitees		
7/28/2022 Focus Group		
First Name	Last Name	Organization
Rosalinda	Borja	California Healthcare and Rehabilitation Center
Vickie	Bourdes Martinez	Sherman Oaks Chamber of Commerce
Julian	Canales	LAPD Mental Evaluation Unit
Harlette	DeLeon	EHMC Director of Medical Surgical Services
Laarni	Go	California Healthcare and Rehabilitation Center
Marlena	Hakobyan	EHMC Director of clinical Services
Alan	Hamilton	Los Angeles Police Department
Gargoles	Josh	Woodland Care Center
Jones	Karina	Woodland Care Center
Alphonsus	Market	Holiday Manor Care Center
Richel	Martinez	EHMC SOH Admitting Manager
Peyman	Pedram	EHMC SOH Infection Control Director
Kenn	Phillips	Community Board Member
Trevor	Richmond	Los Angeles Fire Department
PJ	Rust	ReNew Health
Robert	Schlesinger	LAPD Van Nuys Division
Shirley	Sunn	EHMC/SOH Mental Health Unit
Alexandra	Telles	Burbank Healthcare and Rehabilitation Center
Mark	Wheeler	LAPD Mental Evaluation Unit

## APPENDIX C

### COMMUNITY RESOURCES

The following lists are extracted from various websites. Los Angeles County maintains a health information website which allows searches for specific services near a given zip code. The webpage is accessible at [www.211LA.com](http://www.211LA.com).

The following names are some of the resources addressing the health needs of the EHMC PSA. The list is not comprehensive, but represents some of the options available.

#### Access to Care

- Care Harbor
- Child Development Institute
- Community Clinics
- California State University, Northridge
- Eisner Health
- Federally Qualified Health Centers
- Los Angeles Care Health Plan
- Los Angeles County Department of Health Services
- Los Angeles County Department of Public Health
- Los Angeles County Department of Workforce Development
- Los Angeles Department of Aging
- MEND – Meet Every Need with Dignity
- Mid-Valley Comprehensive Health Center
- Mission Community Clinic
- My Health LA
- Northeast Valley Clinic
- ONEgeneration
- Partners in Care Foundation
- Proyecto del Barrio
- Strength United
- Tarzana Treatment Center
- Valley Care Community Consortium

## Cancer

- Centers for Disease Control and Prevention
- Kaiser
- Los Angeles County Medical Association
- UCLA Jonsson Comprehensive Cancer Center
- USC Norris Comprehensive Cancer Center

## Coronavirus Disease/COVID-19

- 986 Pharmacy Aging Services
- California Governor's Office
- Comprehensive Community Health Center
- Centers for Disease Control and Prevention
- Federally Qualified Health Centers
- Housing for Health
- Los Angeles Homeless Services Authority
- Los Angeles County Department of Public Health
- MEND
- ONEgeneration
- Public-Private Partnerships for Covid Testing/Vaccines
- Telehealth
- Valley Care Community Consortium

## Dementia/Alzheimer's Disease

- AARP
- Adult Day Programs
- Alzheimer's Association
- Alzheimer's Los Angeles
- Brandman Center
- California Alzheimer's Disease Centers
- Housing for Health

- Los Angeles County DHS Hospital
- Los Angeles Department of Aging
- Northeast Valley Health Corporation
- ONEgeneration
- Partners in Care Foundation
- USC Family Caregiver Support Center
- Valley Community Center

## Diabetes

- American Diabetes Association
- Centers for Disease Control and Prevention
- Department of Public Health
- Diabetes Education Programs
- Enhanced Care Management
- Federally Qualified Health Centers
- Home and Community Based Alternative
- Health Self-Management Classes
- Hope of the Valley
- Los Angeles County Medical Association
- MEND
- Mid-Valley Clinic
- Multipurpose Senior Services Program
- Northeast Valley Clinic
- North Valley Caring Services Food Distribution
- Northeast Valley Health Corporation
- Valley Community Center

## Heart Disease & Stroke

- American Heart Association
- Federally Qualified Health Centers
- Los Angeles Care Health Plan
- MEND
- Valley Care Community Consortium

## Homelessness

- Abode Communities
- AIDS Healthcare Foundation
- Catholic Charities
- Hope of the Valley Shelter
- LA Family Housing
- LAPD Community Safety Partnership
- Los Angeles Housing Authority
- MEND
- Midnight Mission Family Housing Project
- New Economics for Women
- San Fernando Valley Rescue Mission
- San Fernando Valley Homeless Coalition
- Shelter Hotline
- SPA 2 Homeless Coalition
- Transitional Living Center for Women & Children

## Mental Health

- American Foundation of Suicide Prevention
- Child and Family Guidance Center
- Child Care Resource Center
- Child Development Institute
- Community Psychiatry Telehealth
- Cornerstone Counseling Center

- Didi Hirsch Center Suicide Prevention Line
- El Centro de Amistad
- EL Nido Family Center
- Federally Qualified Health Centers
- Find Your Balance Center
- Hope of the Valley
- LA Care Family Resource Center
- Los Angeles County Homeless Services Authority
- Los Angeles Department of Mental Health
- MEND
- Ness Counseling Center
- Northeast Valley Health Corporation
- Open Paths Counseling Center
- Pacific Asian Counseling Services
- Phoenix House San Fernando Valley
- Community Mental Health San Fernando
- Valley Rescue Mission
- Strength United
- Sycamores
- Tarzana Treatment Center
- Valley Center for the Prevention of Family Violence
- Valley Family Housing

### Oral Health

- California Dental Association
- Child Development Institute
- Delta Dental
- Denti-Cal Program
- Federally Qualified Health Centers
- Los Angeles County Department of Oral Health Services
- UCLA Community Dental Resource

- Valley Care Community Consortium

### Sexual Health

- Centers for Disease Control and Prevention
- Los Angeles County Department of Health Services
- Los Angeles County Division of HIV and STD Programs
- Tarzana Treatment Center

### Substance Abuse

- Alcoholics Anonymous/Narcotics Anonymous
- California Department of Healthcare Services
- Centers for Disease Control and Prevention
- Cri-Help
- El Proyecto Del Barrio
- Exodus Recovery
- Center Los Angeles County Department of Public Health
- Gateways Hospital and Mental Health
- Los Angeles County Department of Public Health Substance Abuse Prevention & Control
- Los Angeles Department of Mental Health
- NAMI
- Northeast Valley Health Corporation
- Olive View Medical Center
- Penny Lane Centers
- Phoenix House
- Substance Abuse Prevention and Control
- Tarzana Treatment Center
- Valley Prevention and Treatment Center

## APPENDIX D

### Primary Data Collection Instruments

#### *Key Informant Interview Questions*

Thank you for agreeing to be a Key Informant. KeyGroup is conducting multiple needs assessments so the information you share will be part of a larger SPA 2 Community Health Needs Assessment Report as well as part of some specific hospital reports if your services are provided within their hospital service areas.

1. What are the most significant health problems in the community you serve? What ages and ethnic groups are affected by the issue?
2. What are the most significant educational/environmental & socio-economic factors affecting the community? What ages and ethnic groups are impacted?
3. What are the riskiest behaviors affecting the community? What age groups most impacted?
4. What other problems or concerns affect the health of your clients/patients/people you serve? What age and ethnic group is most impacted?
5. What are the common concerns/issues you and/or your staff hear from your patients/clients?
6. If you could prioritize the issues in your community, what are the top 5 issues? Please rank the issues 1 being the most important and 5 being the least important.
7. You have shared a list of concerns, what are some of the community resources/assets that you are aware of that could help address the issues identified as a health need?
8. What are some of the barriers to accessing care?
9. What solutions would you like to share to address the identified community needs?
10. Thank you for participating as a key informant. Do you have any final health needs and or solutions you would like to offer?

## Appendix D 1: Focus Group Questionnaire

### *Focus Group Questions*

#### **Problems and concerns**

1. What are the most significant health problems in the community? What ages and ethnicities are most affected by the issue?
2. What is the most significant educational/environmental/socio-economic factors affecting the community? Who is most impacted?
3. What are the riskiest health behaviors affecting the community? What age and ethnicity is most impacted?
4. What other problems or concerns are affecting the community?

#### **Resources and Barriers**

1. Reviewing the list of problems you mentioned, what are some the existing community resources to support the community to address the issues?
2. What are some of the barriers to accessing these resources?

#### **Solutions**

1. Suggest some possible solutions to the issues

#### **Prioritization**

1. Again reviewing the list, what are some of your suggestions for prioritization of the concerns/solutions listed?
2. Suggest methods for prioritization of issues?
3. What can be realistically accomplished?
4. Please prioritize the top 10 issues and concerns that you think need immediate attention.

## Appendix D 2: Community Survey Questionnaire (English version)



June 2022

**Encino Hospital Medical Center** has engaged **KEYGROUP** to gather information about day-to-day living habits that may affect your health and some questions about the care that is provided in the community you live. Your participation is voluntary. The survey will only take about 15-20 minutes and your answers will be kept strictly confidential.

This information will be very important to determine which services are provided and assess the health needs of your community. We are grateful for your time and cooperation.

If you have any questions, please contact **Paulo Macalino** at (818) 907-4540 or at pmacalino@primehealthcare.com.

Thank you.

**GENERAL INFORMATION**

1. What zip code do you live in?

2. How long have you lived in the community?

- Less than one year
- 1 to 5 years
- 6 to 10 years
- 11 to 20 years
- More than 20 years

3. Do you own or rent your residence?

- Own
- Rent
- Other (please specify)

4. What is your age bracket?

- Under 18
- 18 – 24
- 25 – 34
- 35 – 44
- 45 – 54
- 55 – 64
- Over 65

5. How would you describe yourself? (Choose one or more from the following racial groups)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White (non-Hispanic)

6. What is your gender (optional, choose all that apply)?
- Man
  - Woman
  - Non-Binary
  - Other (please specify) \_\_\_\_\_
  - Decline to state

7. Are you currently employed?
- Yes
  - No
  - Full-time Student
  - Other (please specify)

8. What are your income and your total household income?

*Your income*

- Under \$10,000
- \$10,000 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$199,999
- \$200,000 to \$249,999
- Over \$250,000

*Total household*

- Under \$10,000
- \$10,000 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$199,999
- \$200,000 to \$249,999
- Over \$250,000

9. Do you currently have health insurance?
- Yes
  - No (Skip to Question 11)

10. Who pays for your health insurance (Check all that apply)?

- Current employer (HMO, PPO)
- Former employer (COBRA)
- State government (Medi-Cal)
- National government (Medicare, Medicaid)
- Local government
- Self funded
- Other (please specify)

11. Why do you currently not have health insurance (Check all that apply)?

- Cannot afford insurance
- Lost employment
- Insurance company refused coverage for health reasons
- Employer does not pay for insurance
- Not eligible for employer-paid insurance
- Do not believe in insurance
- Do not need insurance
- Dissatisfied with previous insurance plan or provider
- Other (please specify)

**HEALTH HABITS**

12. In the past 12 months, have you had a (fill in all that apply):

*General Health Exam*

- Yes
- No
- Do not know

*Covid-19 Vaccination*

- No
- Yes, Initial sequence only
- Yes, including booster
- Do not know

*Blood Pressure Check*

- Yes
- No
- Do not know

*Cholesterol Check*

- Yes
- No
- Do not know

*Flu Shot*

- Yes
- No
- Do not know

*Blood Stool Test*

- Yes
- No
- Do not know

*Dental Exam/Teeth Cleaned*

- Yes
- No
- Do not know

*IF FEMALE: Pap Test*

- Yes
- No
- Do not know

*IF FEMALE: Breast Exam by a Health Care Provider*

- Yes
- No
- Do not know

*IF FEMALE: Breast X-Ray or Mammogram*

- Yes
- No
- Do not know

13. In the past 5 years, have you had a (fill in all that apply):

*Hearing Test*

- Yes
- No
- Do not know

*Eye Exam*

- Yes
- No
- Do not know

*Diabetes Check*

- Yes
- No
- Do not know

*Skin Cancer Screen*

- Yes
- No
- Do not know

*Pneumonia Shot*

- Yes
- No
- Do not know

*IF AGE 40 or OLDER: Rectal Exam*

- Yes
- No
- Do not know

*IF AGE 50 or OLDER: A Colonoscopy*

- Yes
- No
- Do not know

*IF MALE and AGE 40 or OLDER: A Prostate Cancer Screen/PSA*

- Yes
- No
- Do not know

14. In the past 12 months, have you had problems getting needed health care?

- Yes
- No

15. If yes, please provide the reason(s) for the difficulty in getting healthcare.

- Lack of insurance
- Health care provider would not accept your insurance
- Insurance would not approve<sup>1</sup> pay for care
- Cannot afford co-pay
- Lack of transportation
- Language barriers
- Travel distance to provider too great
- Cannot understand my doctor

16. How many times a week do you exercise?

- 0
- 1-2
- 2-4
- 4-7

17. For about how long do you exercise?

- Less than 30 minutes
- 30 minutes
- 1 hour
- Over 1 hour

18. How many days per week do you eat at least 5 servings of fruits and/or vegetables?

- 0 days a week
- 1-2 days a week
- 3-4 days a week
- Over 5 days a week

19. Are you on any medications?

- Yes
- No

20. If Yes, how many?

- Just one
- 1 to 2
- 2 to 4
- Over 5

21. How would you describe your weight?

- Very underweight
- Slightly underweight
- About right
- Slightly overweight
- Very Overweight

22. Which of the following are you trying to do about your weight?

- Lose weight
- Gain weight
- Stay the same weight
- I am not trying to do anything about my weight

23. During the past 30 days, did you (Check all that apply):

- Diet to lose weight or to keep from gaining weight
- Exercise to lose weight or to keep from gaining weight
- Vomit, or take laxatives to lose weight or to keep from gaining weight
- Take diet pills to lose weight or to keep from gaining weight

#### COMMUNITY INFORMATION

24. How could you rate our community's overall health status?

- Excellent
- Good
- Fair
- Poor
- Very Poor

25. How would you rate your own health status?

- Excellent
- Good
- Fair
- Poor
- Very Poor

26. How would you rate our community's overall quality of life?

- Excellent
- Good
- Fair
- Poor
- Very Poor

27. How would you rate your own quality of life?

- Excellent
- Good
- Fair
- Poor
- Very Poor

28. What do you see as the greatest health problems in our community?

29. Which four diseases/conditions do you believe are the most common in our community?

- Cancer-general
- Breast Cancer
- Covid-19
- Respiratory diseases-adults
- Asthma-children
- Diabetes
- Heart disease
- High Blood Pressure
- Poor Nutrition
- Lack of physical activity
- Obesity
- Smoking
- Stroke
- Substance abuse- alcohol
- Substance abuse-drugs
- Mental Health Disorders
- Dental Problems
- Immunizations- children
- Immunizations- adults
- Other (please specify)

30. Which three behavioral risk factors are the most common in our community?

- Access to affordable health care
- Access to physicians
- Inadequate transportation
- Lack of grocery stores
- Access to fresh, healthy food
- Wearing seatbelts
- Lack of safe places for physical activity
- High number of uninsured people
- Poverty
- Unemployment
- Illiteracy
- Other (please specify)

31. Who in our community does a good job of promoting health?

32. Who in our community does not promote good health?

33. How well does Encino Hospital Medical Center promote good health?

- Excellent
- Good
- Fair
- Poor
- Very Poor

34. What could Encino Hospital Medical Center do better to promote good health?

35. If you were in charge of improving health in our community, what would you do first?

36. What is the most pressing health care related need for you, your family or our community?