



ST. FRANCIS
MEDICAL CENTER
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St. Francis Medical Center Community Health Needs Assessment 2010

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An Overview

Established in 1945, St. Francis Medical Center of Lynwood (SFMC) is the only comprehensive, non-profit health care institution serving Southeast Los Angeles. The Medical Center provides a full range of diagnostic and treatment services for 700,000 adults and 300,000 children who depend on SFMC for high quality and compassionate medical care. SFMC is committed to respecting the dignity of each patient and to caring for the whole person – body, mind and spirit.

The Medical Center operates a 384-bed acute care hospital, with four community-based health clinics, and one of the largest and busiest private emergency trauma centers in Los Angeles County. SFMC's Family Life Center is supported by a Gestational Diabetic Clinic, a Neonatal Intensive Care Unit, and Pediatric Health Unit. Its Center for Heart and Vascular Medicine offers a full range of imaging services including state-of-the-art CT Angiography. In addition, there are specialized centers for Women's Imaging, Behavioral Health, and Wound Care.

Community service programs include a Children's Counseling Center, Health Benefits Resource Center, Casa de Esperanza transitional housing, "Footprints" shoes and clothing for families, and numerous senior wellness and youth mentoring programs. Healthy Community Initiatives bring screenings, immunizations, and education to more than 20,000 adults and children annually, and Vida Sana "Healthy Life" provides a community wellness program targeting heart health, obesity, and diabetes through area churches. St. Francis Career College offers health care career training on campuses in Lynwood and San Jose.

SFMC's wide array of specialized services include:

24-hour Emergency Services and Trauma Center

Approved for Emergency Pediatric Care

Base Station for L.A. County Mobile Intensive Care Squads

Helipad for Emergency Air Transport

Maternal, Child and Family Health Clinics

- Located in Lynwood, Compton, Huntington Park, Downey

Heart and Vascular Center

- Cardiovascular, Endovascular and Open Heart Surgery
- Coronary Care Unit
- Pacemaker Clinic
- 2 Cardiac Catheterization Labs
- 3 Interventional Labs

Inpatient and Outpatient Cancer Care Center

Family Life Center

- Obstetrics, Gynecology, Labor and Delivery
- Neonatal Intensive Care
- Perinatal Diagnostic Services

- Pediatrics

Diagnostic & Therapeutic Radiology

- CT Scan
- MRI/MRA
- Ultrasound
- Mammography
- Fluoroscopy
- Nuclear Medicine
- Radiation Therapy
- Interventional Radiology

36-bed Intensive Care Unit

Outpatient Ambulatory Care Services

Acute Renal Dialysis

Cardiopulmonary Laboratory

Physical, Occupational and Speech Therapy

Skilled Nursing Facility

Behavioral Health Unit

Children's Counseling Center

Social Services

Spiritual Care Services

Patient Advocacy

Healthy Community Initiatives

Health Benefits Resource Center

St. Francis Career College

Wound Care Center

Women's Imaging Center

In fiscal year 2010, SFMC admitted 20,313 patients, delivered 6,097 babies and recorded 201,255 outpatient visits. These statistics include 69,011 emergency room visits (one third of which were children), 1,393 trauma cases and 564 neonatal intensive care admissions. Outreach services included 49,218 community clinic visits, and community-based health screenings, immunizations, and health education to more than 23,000 adults and children. These comprehensive services were delivered by 2,200 employees, 360 affiliated physicians and 276 volunteers and were supported by the commitment of 808 donors.

As a member of the Daughters of Charity Health System, the Mission of SFMC reflects the guiding principal of the Daughters of Charity – serving the sick poor. SFMC is dedicated to nurturing healthy children and families, fostering self-sufficiency, enhancing individual and community well-being, and achieving excellence in facilities and technology. SFMC’s ultimate goal is to dramatically improve the health of the community.

In response to community’s needs, St. Francis Medical Center’s Wellness and Healthy Community Initiatives reflect:

- SFMC’s core values of Respect, Compassionate Service, Simplicity, Advocacy for the Poor and Inventiveness to Infinity
- A long tradition of creating innovative programs designed to meet community needs
- An unwavering commitment to building a healthier community
- Strong relationships with collaborative partners
- A commitment to utilizing the most advanced technology possible while delivering services in a caring and nurturing manner

Building a Healthier Community

Providing high quality, compassionate care for adults and children who are poor and underserved is at the heart of SFMC’s Mission. All strategic planning, budgeting and programming processes are focused on assuring productive use of medical center resources to respond to the changing needs of its community.

The medical center’s operating policy of providing health care for all ill and injured persons, regardless of their ability to pay, has resulted in it being designated by the federal government as a health care institution that serves “a disproportionate share of the medically indigent.” SFMC ranks among the top 10 percent of institutions in this country that serve the medically indigent. It is of note that approximately 79 percent of SFMC’s reimbursements for service are derived from Medi-Cal, Medicare, and L.A. County.

SFMC’s Wellness and Healthy Community Initiatives are enhanced by strong collaborative relationships – both internally and externally. Internal collaboration involves hospital administration, SFMC associates, affiliated physicians, direct service volunteers, leadership volunteers and a cadre of generous donors. Community partners include elected representatives, community organizations, public agencies, churches, public and private schools, local businesses

and individuals from throughout SFMC’s service area that share SFMC’s vision and commitment to the community.

Through SFMC’s Wellness and Healthy Community Initiatives we strive to:

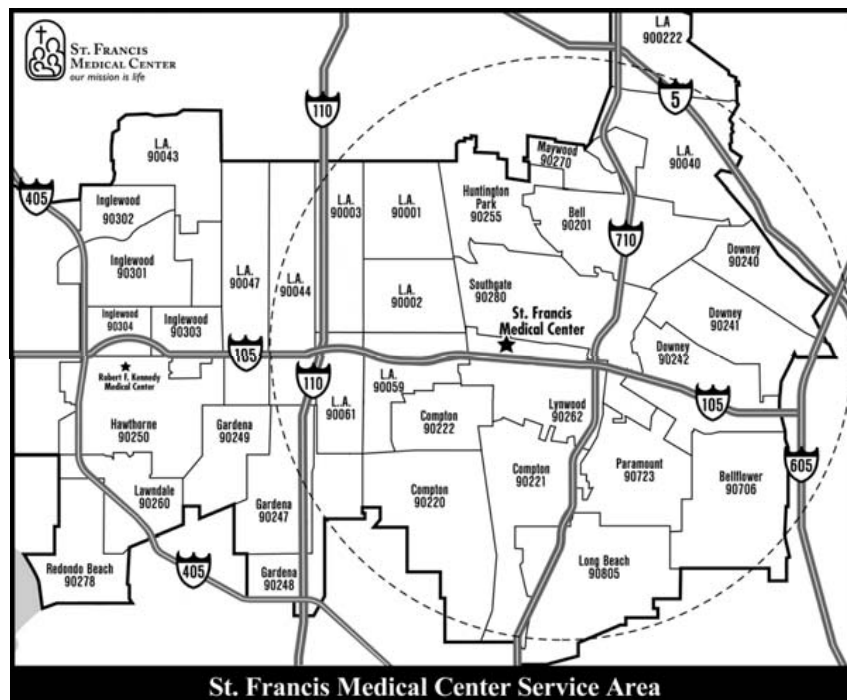
- Nurture Healthy Children and Families
- Foster Self-sufficiency
- Enhance Individual & Community Well-being

Responding to the community’s needs requires an understanding of how key social forces, especially economic and social trends, are shaping SFMC’s local community. Like most of Southern California, SFMC’s service area is part of a dynamic, diverse community. This population presents a wealth of opportunity and also poses significant challenges as we seek to provide effective medical care, educational programs and social services to residents. Innovation, flexibility, mission focus and strong collaborative relationships are essential to SFMC’s efforts to build a healthier community.

SFMC’s Service Area

SFMC provides quality medical care, educational programs and support services to the 1,000,000 residents of communities in Southeast Los Angeles County including Lynwood, South Gate, Downey, Huntington Park, Bell, Cudahy, Paramount, Bell Gardens, Long Beach, Maywood and Compton.

The patients of SFMC, located in Lynwood, California, generally live within a 5-mile area between the 110 Freeway on the West, the 605 Freeway on the East, the 91 Freeway on the South and the Alameda Corridor on the North.



The programs and services developed in response to the Community Health Needs Assessment are designed to meet the needs of a community characterized by significant poverty, high unemployment, poor health, educational deficiencies, prevalent crime and violence, high teen pregnancy rates, a large number of undocumented persons and a lack of health insurance coverage. Many individuals and families in these communities face significant obstacles in accessing the health care, health education and social services they need.

The Community Health Needs Assessment is an integral part of the Medical Center's Strategic Planning process, which is managed by the Medical Center's Management Council. The results of the Needs Assessment are integrated into the Medical Center's long-range planning activity, as well as program specific planning. During the annual update of the Medical Center's strategic plan, data derived from the Community Health Needs Assessment is integrated with the external environment analysis and the organizational analysis. Additional input and information are gathered both informally and through community meetings with stakeholders and community representatives. Continual monitoring and evaluation of existing Wellness and Healthy Community Initiatives provide vital information to the Strategic Planning process. St. Francis Medical Center's Board of Directors reviews and gives final approval of SFMC's Community Benefit Plan.

Methodology

The Community Health Needs Assessment used a variety of methods to collect information about health and social characteristics of the community served by SFMC. For the purposes of this report, the SFMC service area corresponds to Service Provider Areas (SPAs) 6, 7, and 8. The assessment drew primarily from the following information sources: the SFMC 2007 Needs Assessment, the U.S. Census Bureau American Community Survey, the Los Angeles County Department of Public Health, and focus groups with SFMC stakeholders, service providers, and beneficiaries.

Secondary Demographic and Health-Related Data

Data were obtained from a number of secondary public health reports and health databases. Each source is summarized below and all data tables are located in Attachments A and B.

- A comprehensive *Community Needs Assessment* (2007) of St. Francis Medical Center's Service Area. Indicators included personal income, poverty levels, education, employment, ethnicity, age, family size, violence, disease, pregnancy, immunization rates and insurance coverage
- *L.A. HealthDataNow!* This database utilizes tools commonly used by the Department of Public Health (DPH) analysts and incorporates automated statistical analysis into the query system. The project was established by epidemiologists of (DPH)
- *Los Angeles County Health Survey* (2007; 2005) contains statistics on key health indicators in L.A. County, including health-related quality of life, physical and mental health conditions, at-risk behaviors, physical activity and health insurance coverage

- *The California Health Interview Survey (CHIS)*. *Ask CHIS!* is a free on-line database tool supported by the UCLA Center for Health Policy Research that contains data on health indicators at state, county, and SPA levels
- *Mortality in Los Angeles County 2007: Leading causes of death and premature death with trends for 1998-2007*, published by the L.A. County Department of Public Health, Office of Health Assessment and Epidemiology, June 2010
- *Key Indicators of Public Health (2009; 2007; 2005)*, published by the L.A. County Department of Health Services (LACDHS), provides comparative data on 40 top health and well-being indicators for children and adults. Data are based on the L.A. County Health Survey, a tri-annual telephone survey of a sample of L.A. County residents
- *Health Indicators for Women in Los Angeles County Highlighting Disparities by Ethnicity and Poverty Level: A Publication of the Los Angeles County Department of Public Health Office of Women's Health and Office of Health Assessment & Epidemiology*, February 2010
- *An Epidemiologic Profile of HIV and AIDS in Los Angeles County 2009*, HIV Epidemiology Program Division of Communicable Disease Control and Prevention Los Angeles County Department of Public Health (LACDPH)
- *U.S. Census Bureau American Community Survey (ACS)*. The ACS is an ongoing survey that provides data every year. The Census Bureau collects ACS data from a sample of the population in the United States and Puerto Rico--rather than from the whole population. All ACS data are survey estimates. ACS 1-, 3-, and 5-year estimates are period estimates, which means they represent the characteristics of the population and housing over a specific data collection period. Data are combined to produce 12 months, 36 months, or 60 months of data. These are called 1-year, 3-year, and 5-year data
- *Bureau of Labor Statistics* (www.bls.gov/data) contains unemployment statistics
- *L.A. County Seniors Count! Survey of the Older Adult Population*, Community and Senior Services, County of Los Angeles (2008)
- *Acute Communicable Disease Control Program Annual Morbidity Report And Special Studies Report 2008 Los Angeles County Department of Public Health*
- *Death Profiles by Zip Code (2007; 2005; 2002-03)* by the California Department of Public Health provides information regarding deaths at the zip code level
- *Current Population Reports Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050 P25-1130 Issued February 1996*. This report provides a description and the theory behind the cohort component methodology utilized for the population projections in this needs assessment

Focus Groups

Focus groups were conducted to collect qualitative information on health care issues that could elaborate and enhance information gleaned from secondary data sources. Three focus groups were conducted with key stakeholders in the SFMC service area. Participants were identified and recruited by SFMC staff. The groups were mixed by age, race/ethnicity and gender. Forty-six individuals participated in five separate focus groups, including:

- Beneficiaries – Individuals or family members of individuals who receive care or services from SFMC. Separate groups were conducted for English-speaking (N=4) and Spanish-speaking beneficiaries (N=12), with a moderator fluent in Spanish conducting the latter
- Seniors—Senior and elderly community members who participate in activities at the SFMC Center for Senior Services (N= 8)
- Providers – Physicians, nurses, technicians and support personnel who provide health care services to the community on a daily basis at SFMC (N=9)
- Stakeholders – St. Francis Medical staff, a Board member, and representatives from local public agencies and private organizations (N=13)

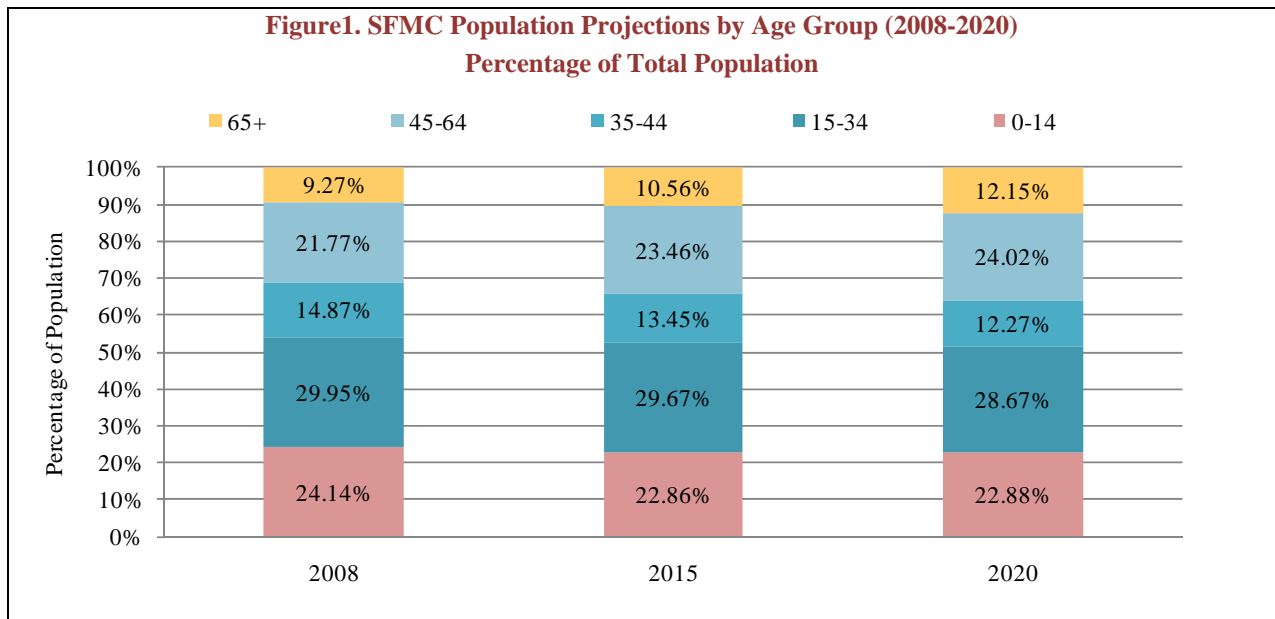
The focus group discussions with these participants assessed:

- Trends in the most important health care and social concerns in the community that SFMC serves
- The availability of health care services and specific areas of service need
- Personal experiences with SFMC services and perceptions of service quality
- Barriers to accessing health care and SFMC services and ways to improve access

Key Demographics

Age & Ethnicity

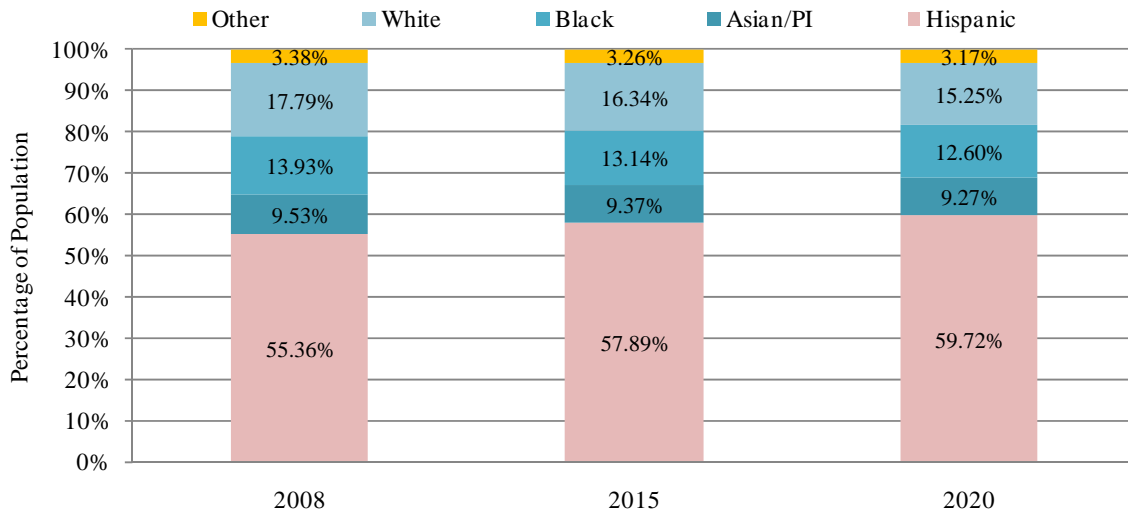
The population in the SFMC service area, similar to county, state, and national trends, is aging. From 2008 to 2015 in the SFMC service area, the most rapidly growing age groups are those between the ages of 55 and 64 and 65 and over (Figure 1). According to projections on age, those within the 65 and over age group will comprise 12.15 percent of the SFMC service area population by 2020, compared to 9.27 percent in 2008. Similarly, those within the combined age groups of 45 to 54 and 55 to 64 will comprise 24.02 percent of the SFMC service area population by 2020, compared to 21.77 percent in 2008. In contrast, those within the 0 to 14, 15 to 34, and 35 to 44 age groups will comprise less of the total SFMC service area population by 2020 compared to 2008, decreasing from 24.14 percent, 29.95 percent, and 14.87 percent, respectively in 2008 to 22.88 percent, 28.67 percent, and 12.27 percent, respectively by 2020.



Note: projections by each of the SFMC SPAs are similar to all SFMC SPAs combined.

According to projections of race/ethnicity in the SFMC SPAs, the Hispanic population will comprise 59.72 percent of the total population by 2020. All other major ethnic groups will comprise less of the total population by 2020, with whites decreasing from 17.79 percent to 15.25 percent, blacks decreasing from 13.93 percent to 12.60 percent, and Asian/Pacific Islanders decreasing from 9.53 percent to 9.27 percent over the same time period (Figure 2).

Figure 2. SFMC Population Projections by Race/Ethnicity (2008-2020)
Percentage of Total Population

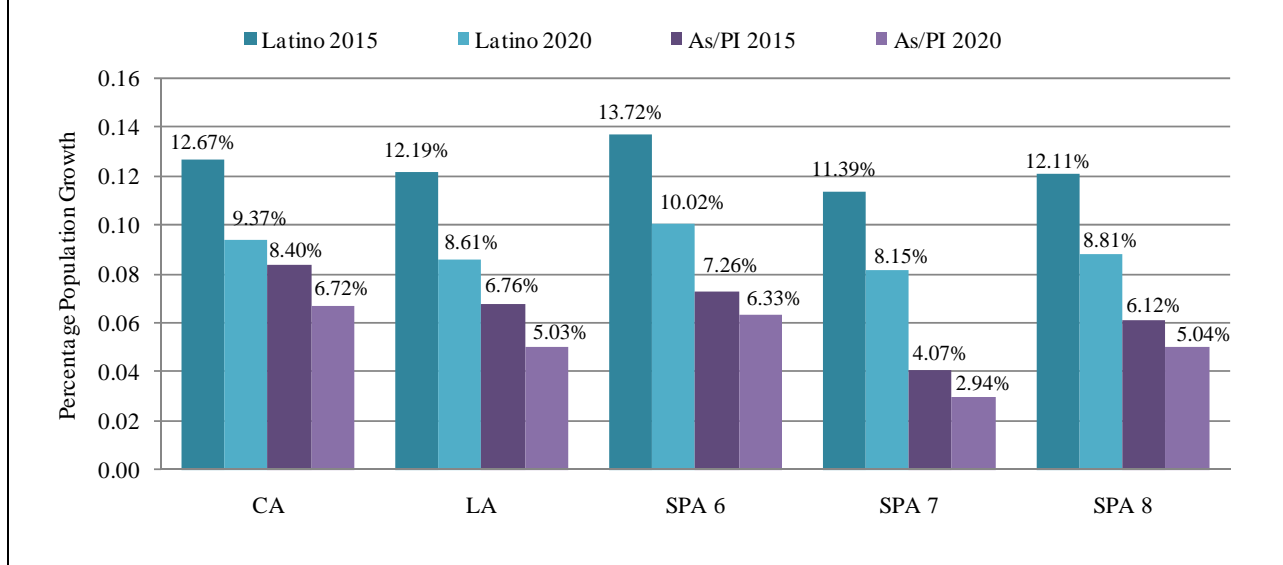


Note: projections by each of the SFMC SPAs are similar to all SFMC SPAs combined.

Rate of growth projections by race/ethnicity indicate that from 2008 to 2020 the fastest growth will be among Hispanics across the state, county, and all SFMC SPAs (Figure 3). By 2015 the population of Hispanics in California is projected to increase 12.67 percent, and from 2015 to 2020 an additional 9.37 percent. In L.A. County, the Hispanic population is projected to increase 12.19 percent from 2008 to 2015, and an additional 8.61 percent by 2020. Among the SFMC SPA's, the growth of the Hispanic population in SPA 6 is projected to exceed that of both the county and state at 13.72 percent from 2008 to 2015 and 10.02 percent from 2015 to 2020.

Although decreasing slightly as percentage of the overall population, after Hispanics, the Asian/Pacific Islander population is projected to experience the fastest growth at the state, county, and SFMC service area levels (Figure 3). Statewide, the Asia/Pacific Islander population is projected to increase 8.4 percent from 2008 to 2015 and an additional 6.72 percent by 2020. In the county, the Asian/Pacific Islander population is projected to grow 6.76 percent from 2008 to 2015 and 5.03 percent from 2015 to 2020. SPA 6 is projected to experience the greatest growth of Asian/Pacific Islanders in the SFMC service area, also exceeding that of the county at 7.26 percent from 2008 to 2015 and an additional 6.33 percent by 2020.

Figure 3. SFMC Rate of Population Growth by Race/Ethnicity (2008-2020)



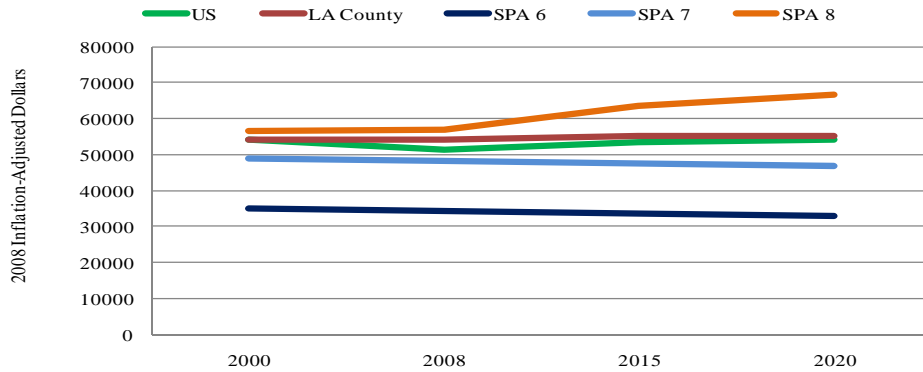
Economic Well-being

The Self-Sufficiency Standard (Standard)ⁱ is an index designed to take into account the true cost of basic living expenditures in a given geographic area and is a recommended benchmark in determining the economic well-being of individuals and families because the Federal Poverty Level (FPL) calculations for determining eligibility for federal assistance are widely considered to be inadequate. Measured against the Standard, L.A. County has an income inadequacy rate of 37 percent, well above the state average. Ranking 10th among all 58 counties in income inadequacy, L.A. County is home to nearly one-third (907,630) of all households in California with incomes below the Standard.

L.A. County's high ranking is largely due to the fact that people of color are disproportionately likely to have inadequate incomes. Latinos have the highest rate of income inadequacy state-wide, with 52 percent of households with insufficient income. Income inadequacy is particularly prevalent among foreign-born or non-citizen Latinos and those who live in households in which English is spoken “less than very well.” The next highest percentage of households with insufficient incomes state-wide is found among African Americans (39%), followed by Native American and Alaska Natives (34%), Native Hawaiian and Pacific Islanders (31%), Asians (26%), and whites (18%).ⁱⁱ

Projections of median household income trends for the SFMC service area indicate a worsening economic situation over the next ten years (Figure 4). SPAs 6 and 7 are projected to experience a steady decline in median household income from 2000 to 2020, compared to a slight decline or stagnation at the national and county levels over the same time period. Both SPAs 6 and 7 have lower estimated median household incomes from 2000 to 2008 than the county and the U.S., and the trend is projected to continue through 2020. SPA 6 has and is projected to continue to have the lowest median household income by a wide margin. In the SFMC service area, only SPA 8 has an estimated median household income higher than both the county and the U.S. and is projected to experience a steady increase in median household income, from 2008 through 2020.

Figure 4. Projected Median Household Income through 2020 (2008 inflation adjusted dollars) U.S, County, SPA Comparison



	2000	2008	2015	2020
U.S.	\$54,184	\$51,528	\$53,557	\$54,012
L.A. County	54,278	54,000	55,279	55,348
SPA 6	35,152	34,268	33,495	32,942
SPA 7	49,109	48,268	47,536	47,013
SPA 8	56,604	57,113	63,437	66,738

In 2008, both SPAs 6 and 7 had higher estimated percentages of individuals with incomes below 300% of the Federal Poverty Level (FPL) than L.A. County and SPA 6 by a large margin (Figure 5). SPA 8 had a slightly lower estimated percentage of individuals below the FPL than the county.

Overcrowded housing negatively impacts both quality of life as well as the incidence of health problems. In 2008, SPAs 6 and 7 also had higher estimated percentages of overcrowded households than L.A. County, with SPA 6 having the highest percentage (Figure 6). SPA 8 had a slightly lower estimated percentage of overcrowded households compared to the county.

Figure 5. Percentage of Population with Income <300% FPL County and SPA Comparison (2008)

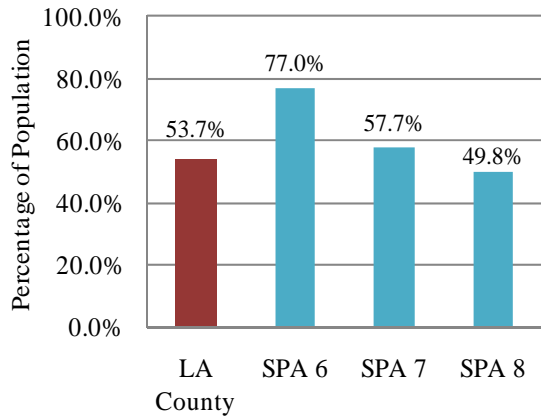
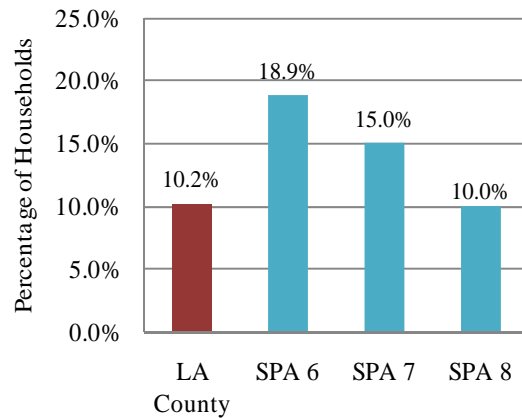


Figure 6. Percentage of Households that are Overcrowded County and SPA Comparison (2008)



As the impact of the recent national recession was just starting to materialize in 2008, the percentage of unemployed in L.A. County was 6.7 percent (Figure 7). In the SFMC SPAs 6 and 7, the percentages of unemployed virtually mirrored those of the county. However, the percentage of unemployed in SPA 6 was much higher than that of the county at 9.2 percent. Once the recession had fully materialized the second half of 2008, the percentage of unemployed increased to 8.2 percent and then jumped to 12.5 percent within a year, continuing to increase at a slower rate to 13.4 percent as of July 2010 (Figure 8). Although estimates are not yet available, it is highly likely that the impact of unemployment in the SFMC SPAs has been disproportionately severe compared to the impact on the county as a whole.

Figure 7. Percentage of Population Unemployed County and SPA Comparison (2008)

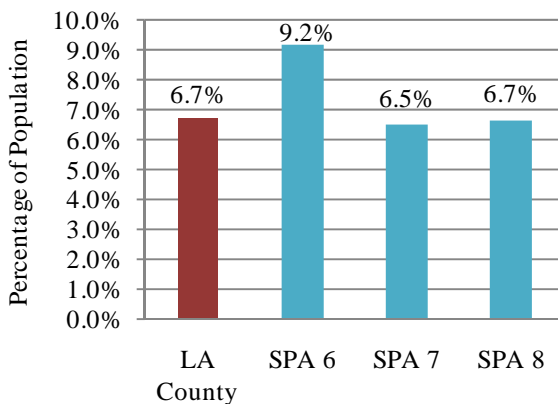
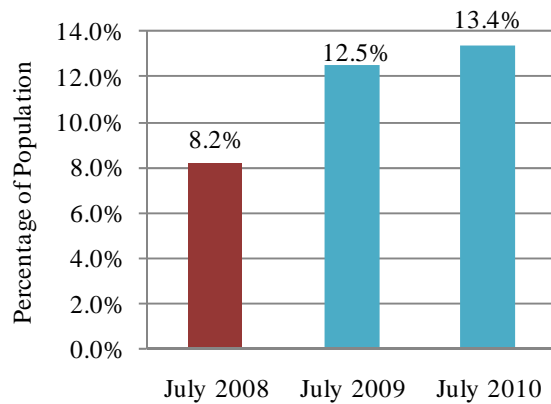
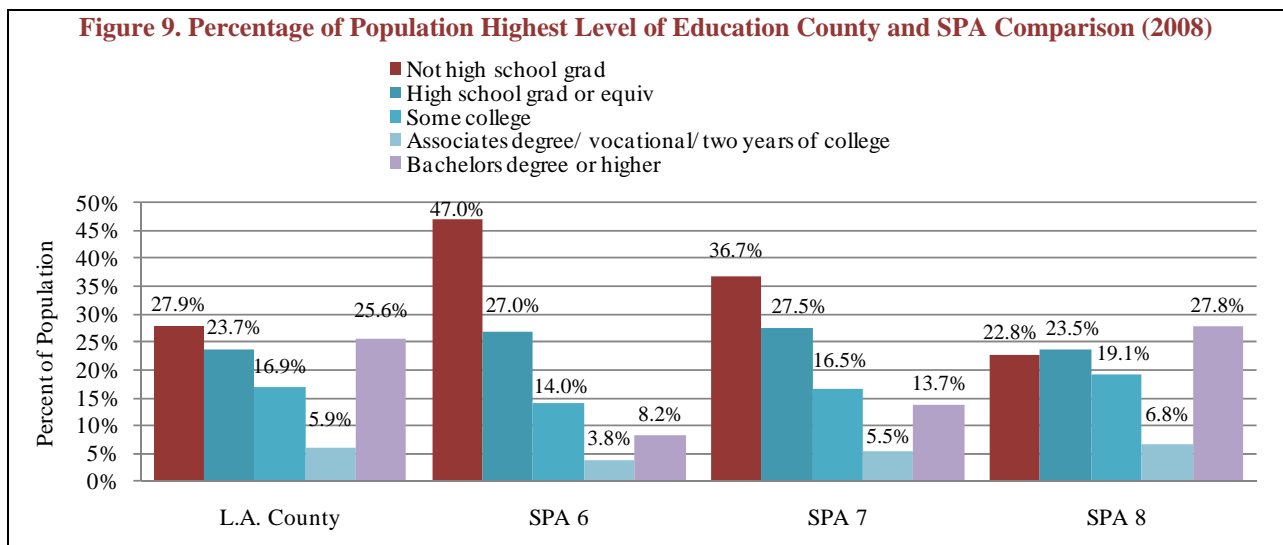


Figure 8. Percentage of Unemployed L.A. County (July 2008-July 2010)



Education/Workforce Readiness

Compounding the problem of unemployment, among the SFMC SPAs in 2008, SPA 6 had the highest percentage of population without a high school diploma (47%) and the lowest percentage of population with any level of college education (26% some college or above) by considerable margins (Figure 9). Thus, SPA 6 is least likely to experience any significant job recovery under circumstances of economic improvement in the near term. SPA 7 had the second highest percentage of population without a high school diploma (36.7%) among SFMC SPAs. In comparison, in L.A. County as a whole, only 27.9 percent of the population lacked a high school diploma in 2008 and 25.6 percent had a Bachelors degree or higher. SFMC SPA 8 had the lowest percentage of population without a high school diploma (22.8 %) among all SFMC SPAs and compared to the county, and a slightly higher percentage of population with a Bachelors degree or higher (27.8%).



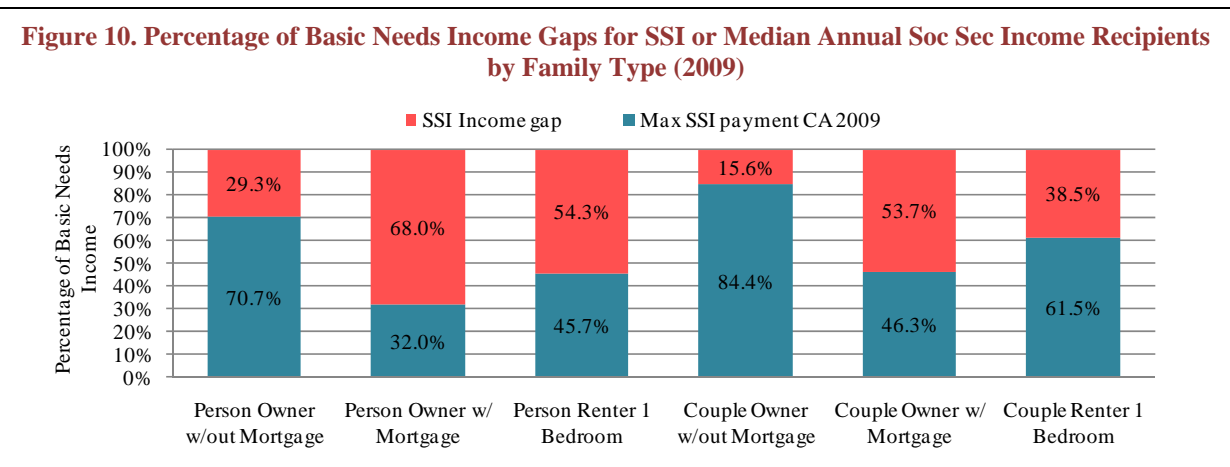
Seniors and Elderly Community Members

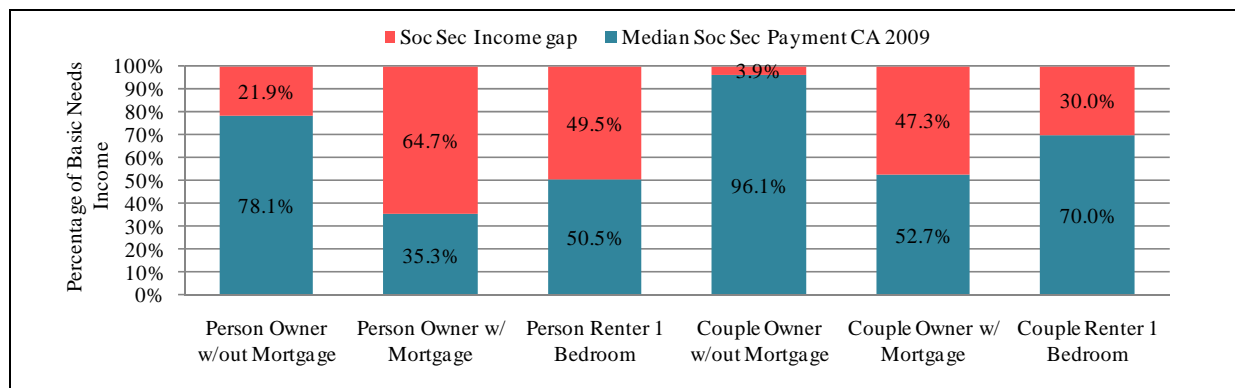
The senior population in Los Angeles is growing at an unprecedented rate. Between 1990 and 2000, the number of seniors age 60 and above increased by 8 percent. From 2000 to 2010, this number is expected to increase by 33 percent; and from 2010 to 2020, the number of seniors over the age of 60 will have grown by an estimated 38 percent. The greatest growth in the senior population to date is among the county’s oldest residents, age 80 and above. Between 1990 and 2000, the number of seniors age 80 and above increased by 35 percent. From 2000 to 2010, this number is expected to increase by 31 percent; and from 2010 to 2020, the number of seniors over the age of 80 will have grown an estimated 15 percent.ⁱⁱⁱ

Cost of Basic Needs

The basic cost of living is a major concern among elderly community members in California and the burden of housing and out-of pocket health care expenditures are overwhelming an increasing number. According to the California Elder Economic Security Standard™ Index (Elder Index),^{iv} a single elderly person in L.A. County who is a renter needs an average income of \$22,841 per year just to meet basic needs, while an older couple that rents needs \$29,741 per year. This is more than twice the 2009 FPL of \$10,830 per year for an individual and \$14,570 per year for a couple, reflecting a much higher cost of living in L.A. County for older adults than what is typically taken into account in calculations for determining eligibility for federal assistance.^v

Figure 10 illustrates the gaps that exist in basic income needs for elderly individuals and couples in various housing circumstances who currently either receive the state's maximum Supplemental Security Income (SSI) program payment (for low-income elders with almost no assets; \$10,440 for individuals and \$18,288 for couples) or the median Social Security (SS) payment (Half of SS recipients in the county receive benefits under this amount; \$11,533 for individuals and \$20,823 for couples). According to the Elder Index, the largest basic needs income gap for elderly individuals or couples subsisting on SSI or the median social security income occurs for homeowners with a mortgage (32 percent of basic income needs for individuals on SSI and 46.3 percent for couples; 35.3 percent for individuals subsisting on the median SS payment and 52.7 percent for couples).





Senior and Elderly Senior Primary Concerns

Financial fraud and where to obtain help regarding financial decisions is the number one issue that concerned senior focus group participants. Provider focus group participants reinforced this concern, noting that some seniors do not know how to use their medical benefits or know the range of benefits for which they might be eligible, and that sometimes they sign and approve something (a wheelchair, for example) that they neither wanted nor needed.

Economic hardship and the ability to keep up with increasing out-of-pocket expenses for prescriptions is a primary challenge for seniors, especially elderly seniors. This was noted by participants in the stakeholder, provider, and senior focus groups. Provider participants explained that sometimes an elderly person has to choose between paying for a prescription or eating, or between one medication and another. Both provider participants and beneficiary participants pointed out that many seniors are also caregivers for their grandchildren, which can limit their benefits. Senior participants noted that cuts in dental services and in-home support (caregivers) had a particularly negative impact on their overall health.

Lack of information about available benefits or services is common among seniors. Provider participants explained that a lot of seniors might be entitled to resources that could help improve their living conditions (for example, meals on wheels or home care), but that they might not know about them or know how to access them. Although today much information is available on-line, senior participants noted that many elderly seniors still do not know how to use a computer or are fearful of exposing themselves to fraudulent activity, despite efforts to train them.

Personal safety is a primary area of concern for elderly seniors that was expressed by both stakeholder and senior focus group participants. Elderly individuals are generally aware of the need to remain active but are concerned about their safety in public places in their communities.

Depression among elderly community members, particularly those who are living in isolation, is a serious concern according to stakeholder and senior participants. Elder abuse was also considered to be a primary concern among stakeholder and senior participants. According to stakeholder participants, the economic recession has forced many people back into living with their parents and this often causes friction that can lead to elder abuse.

A healthy diet and exercise were considered the most important factors in ensuring a healthy life according to senior focus group participants. They expressed that the most important ways to help them stay healthy would be to provide information about nutrition and how to read ingredient labels on food. They also inquired about the availability of classes on nutrition or specific health issues such as diabetes or arthritis.

Communication barriers among non-English speaking immigrant seniors is another primary concern, especially in the SFMC service area, according to stakeholder participants. Participants noted that efforts to provide information or instructions are often insufficient and unsuccessful because of the prevalence of illiteracy among community members.

Elderly seniors' ability to keep track of their medications is a serious problem and many often become overmedicated or mix medications that they should not, according to stakeholder and senior participants. However, the majority of senior participants felt that they had effective systems for managing medications themselves. Senior participants pointed out the need for a centralized place to call for information regarding prescriptions (for example, precautions about mixing with other medications or side effects) or to have basic questions about health concerns answered, for example a nurses hot-line.

Additional areas of concern mentioned by stakeholder and senior participants, include: the lack of convenient transportation and elderly seniors not eating properly.

Some specific suggestions for addressing some of the concerns seniors have include the following:

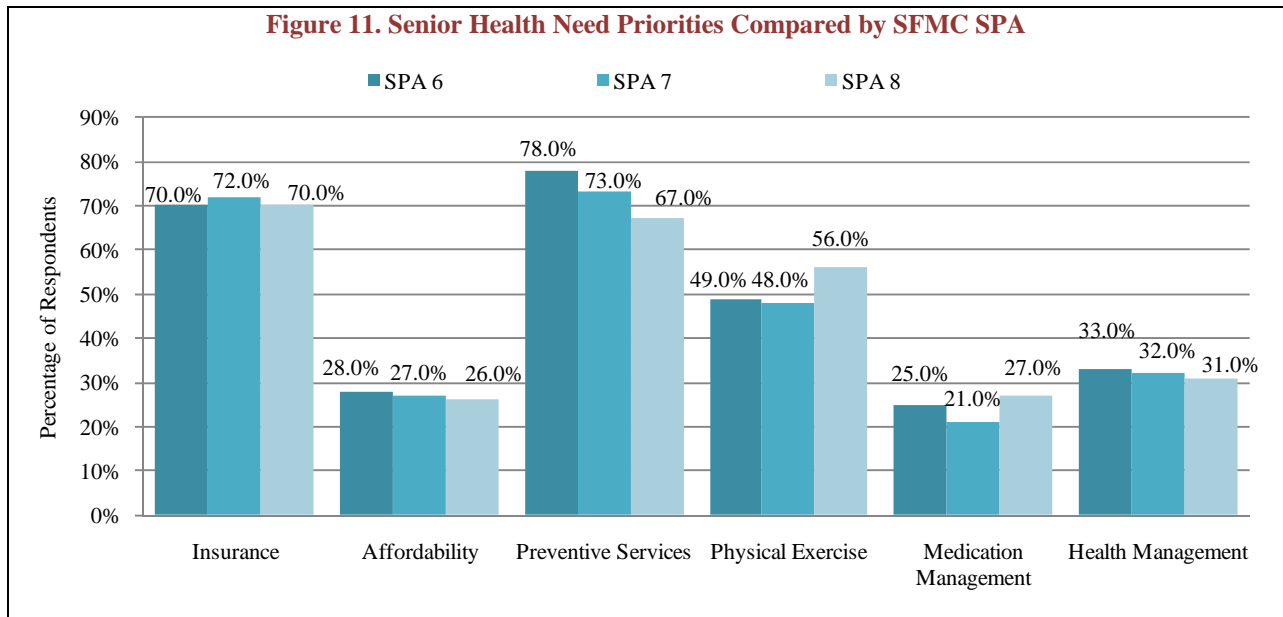
- Stakeholder participants suggested that SFMC work with Parks and Recreation and provide transportation for elderly seniors to a local park to provide exercise and education services
- Stakeholder participants suggested that SFMC sponsor events at parks or notify the public that they are going to be at a park during a certain time to support physic activities; participants expressed that just maintaining a visible presence at a public park might be sufficient to cultivate a sense of safety among seniors and elderly community members to get out and attend activities
- Senior participants suggested that SFMC offer classes at senior centers on topics such as nutrition and fraud awareness
- SFMC provides classes and open question and answer sessions with doctors that are well attended, but senior participants were not aware of these events and suggested that information dissemination be improved
- The senior center's outreach coordinator noted that formal translation services for non-English speaking Hispanic seniors during popular physician-hosted question and answer sessions or some additional Spanish-only sessions would be beneficial
- Senior participants suggested that SFMC utilize community newspapers and local publications, as well as local food establishments to disseminate information
- Senior participants mentioned the challenge in understanding everything they needed to know about their transition into Medicare; they noted that the booklet they receive is

difficult to navigate and suggested that a service to help them navigate the transition information would be valuable

In a 2008 collaboration between L.A. County Community and Senior Services, the City of Los Angeles Department of Aging, and the Los Angeles County Commission on Aging (LACCOA), 16,500 L.A. County residents ages 60 to 74 were surveyed to identify areas of primary need among the county's aging population.^{vi} Among the key findings of the study, are that the oldest of seniors reported needs most often related to social isolation, help needed with daily activities, and home maintenance. These needs, although affecting a smaller number of older residents, have a more serious impact on overall quality of life.^{vii}

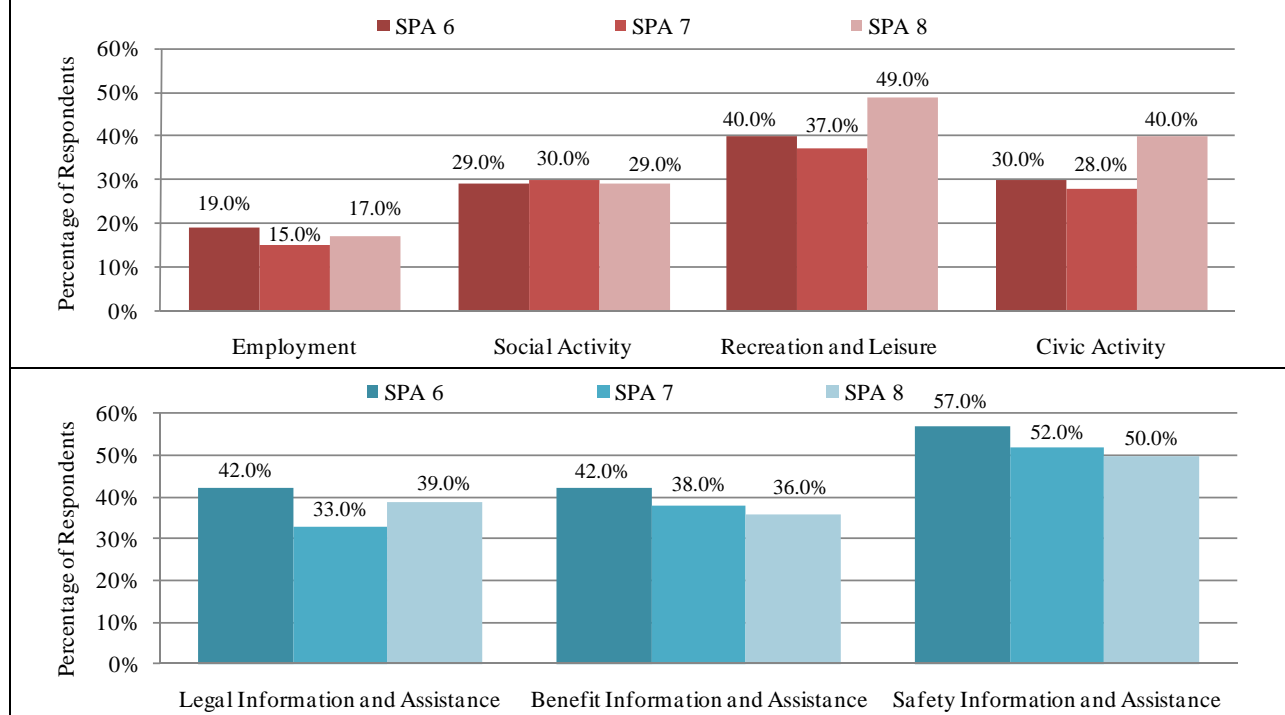
Besides different needs reported by older adults of different ages, the study identified some differences in need priorities among geographic regions within L.A. County, as well as between different racial/ethnic groups. The study did not find any distinct pattern of need among any single subpopulation; but overall, the study did find that ethnic groups expressed higher rates of need than did Caucasian groups. Native Americans, Pacific Islanders, Asians, and residents of multiple ethnicities in L.A. County reported more health needs, needs for employment, concerns about social isolation, caregiving, as well as, housing or transportation needs. The primary need categories identified by the study are broken out into SFMC SPAs below:

SPA 6 had the highest percentage of respondents indicating the need for preventive health services, SPA 7 respondents were most likely to indicate health insurance needs, and SPA 8 respondents were most likely to indicate that medication management is a problem (Figure 11).



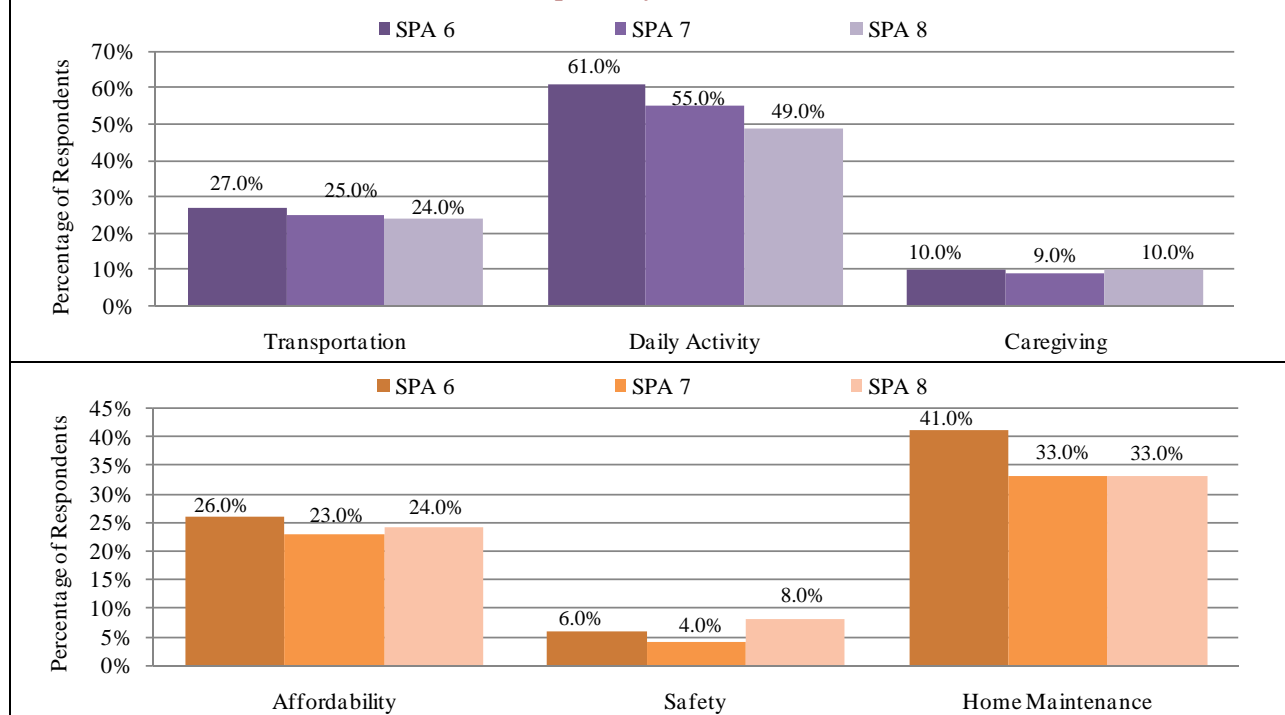
SPA 6 (and SPA 4-not shown) respondents were most likely to indicate an overall need for legal information assistance and benefit assistance, with the greatest need for legal assistance indicated by respondents of SPA 6. SPA 8 residents were more likely to report needs related to recreation and leisure and civic activity (Figure 12).

Figure 12. Senior Productive Activity and Information/Assistance Need Priorities Compared by SFMC SPA



Respondents of SPA 6 also expressed the greatest need for help with daily activities and for assistance with home maintenance (Figure 13).

Figure 13. Senior Transportation, Daily Activity, Caregiving, and Housing Need Priorities Compared by SFMC SPA



In comparison to other needs expressed by respondents to the senior needs survey above, caregiving was not indicated as being as much of a priority as other needs for seniors. However, according to a recent report by the L.A. County Department of Public Health on caregiving that was based upon findings from the 2007 L.A. County Health Survey (LACHS), caregiving is an important public health issue due to the physical, mental, and emotional exhaustion that tends to disproportionately affect caregivers compared to the general population. Moreover, caregivers typically do not seek medical assistance for their symptoms, thus worsening the problem. Results from the 2007 LACHS include the following:^{viii}

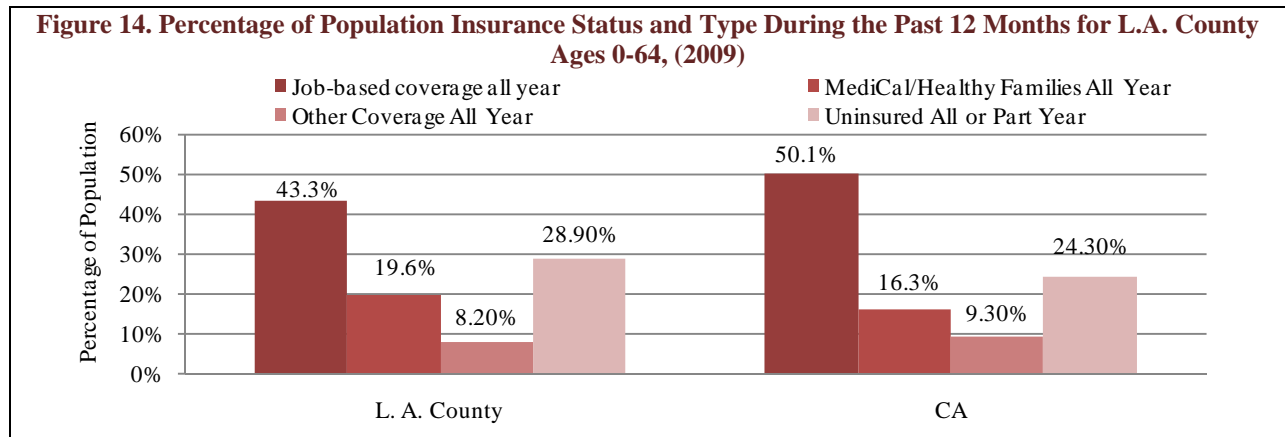
- A higher percentage of caregivers (53.1%) reported having one or more of the following chronic conditions compared to non-caregivers (48.6%): hypertension, high cholesterol, diabetes, heart disease, and depression
- Caregivers reported more unhealthy days in the past month (6.3) compared to non-caregivers (5.2)
- Employed caregivers reported nearly 1 ½ times the number of unhealthy days in the last month (5.2) compared to employed non-caregivers (3.7)
- Caregivers who provided 40 or more hours of care per week were much more likely to report fair or poor self-perceived health (29.7 %) than did caregivers who reported providing fewer than 10 hours of care per week (15.3%)

Also according to the report, L.A. City and County seniors ages 60 to 74 were somewhat more likely to report caregiving burden than more elderly older adults, who according to the study, might have been more often the recipients of care. Native Americans and Alaskan Natives indicated that they faced caregiving burden in greater percentages than any other ethnic group. Among the different SPAs, caregiving need was most prevalent among residents in SPAs 6 and 8.

Access to Health Care

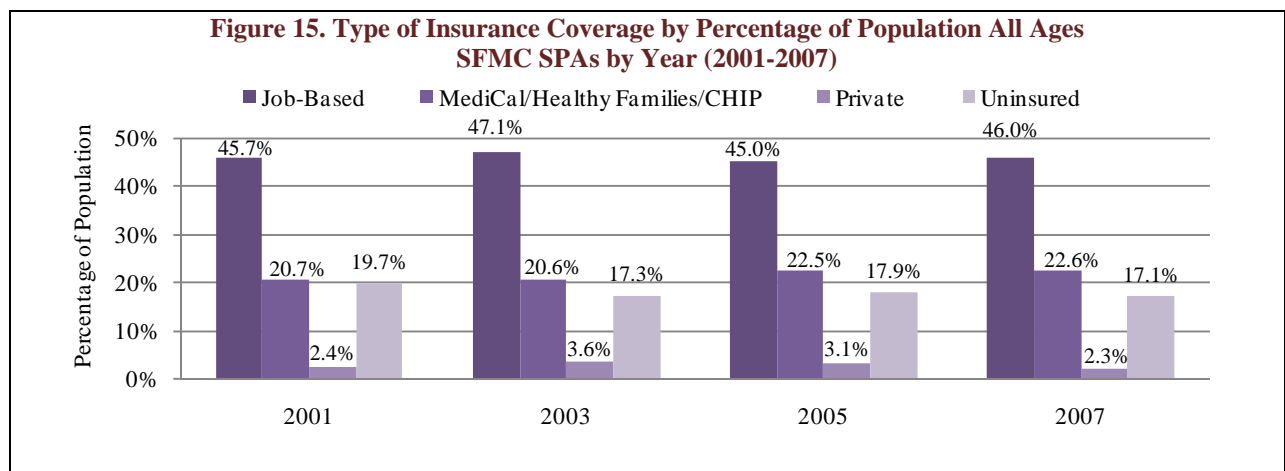
Uninsured

According to a recent report by the UCLA Center for Health Policy Research, nearly two million Californians lost their health insurance in 2008 and 2009, and 8.2 million Californians (nearly one-quarter of the nonelderly population) lacked health insurance for all or part of the year in 2009. This sharp increase from the 6.4 million (or 19.5% of Californians) who were uninsured for all or part of 2007 was a result of large drops in private coverage, which were not fully offset by increases in public programs. The number of uninsured children in California rose from 1.1 million in 2007 to an adjusted estimate of 1.5 million in 2009, as children's losses in coverage through their parents' employment was only partially offset by an increase in public coverage.^{ix}



* Note: The precise calculation for "other" is unknown and thus excluded from graph below

L.A. County had the largest total number of uninsured residents, with 2.7 million nonelderly adults and children (28.9 percent of the total population) experiencing some period of uninsurance in 2009 compared to 24.3 percent for the state. The rate of job-based coverage in L.A. County was also relatively low, at 43.3 percent compared to 50.1 percent for the state (Figure 14).^x



An examination of pre-recession coverage type and rates in the SFMC SPAs from 2001 to 2007 shows higher rates of job-based coverage than that of the county in 2009, higher rates of Medi-Cal/Healthy Families and lower rates of uninsured (Figure 15). The rates of private insurance and the uninsured in SFMC SPAs decreased slightly from 2005 to 2007, while Medi-Cal/Healthy Families enrollment increased slightly over the same time period. It should be noted that these percentages have likely changed considerably in the SFMC SPAs since 2008 with the increase in joblessness, which is not reflected in the 2001-2007 trends.^{xi}

Primary Barriers to Access

In addition to the unemployed (and uninsured), the undocumented continue to utilize hospital emergency rooms (ER). One stakeholder participant pointed out that Hispanic community members are aware that the ER is a safe haven, and that because of the current political climate around immigration many are afraid to go to clinics in their communities for medical services. A provider participant also noted that the number of community members using health services decreases when Hispanic community members hear news stories about raids by immigration officials (ICE) at health clinics, etc. A stakeholder participant noted that there are currently a couple of doctors in the area (within the SFMC service area) that are providing treatments and/or medication underground to community members under false names. Spanish-speaking beneficiaries did mention community clinics as a location where they obtain health care.

Non-English speaking community members continue to lack access to health care information. Spanish-speaking beneficiaries expressed that they had little information about access to health care, so they wanted to be able to find a list of resources advertised in their community. Participants mentioned schools and parks as convenient locations for information dissemination or classes/workshops.

Non-English speaking patients might face bureaucratic obstacles in health care facilities. Many Spanish-speaking beneficiaries recounted being neglected by staff or nurses, as well as paying too much money for simple requests, for example, receiving a couple of painkillers. Participants perceived that people with residency, insurance, or income to pay for services received preferential treatment, for example, in the SFMC ER, but not all were in agreement about this.

Self-medicating/treating through the use of natural remedies has always been common in the Hispanic community, according to a stakeholder participant, but recently the trend seems to be increasing and many are trying to learn of remedies from the older generation of Hispanic community members.

Due to state budget cuts, community clinics are running out of funding to remain in operation. Provider participants noted that a community clinic in Compton recently closed. At the clinic, community members were able to visit with a provider, get medications and get lab work done. This grant program ran out recently and the clinic had to close.

More translation services are needed in the health care field, for example, technology such as the use of telemedicine monitors for people in the hospital, according to one stakeholder participant. The participant noted that it is still common for non-English speaking patients to receive an inadequate diagnosis because of an inability to express an ailment or a lack of opportunity for a

patient to feel comfortable to express what is wrong. The participant also explained that if physicians do not have sufficient time to interact with patients the problem is exacerbated.

Many low-income community members (working poor) are unable to afford health care but do not qualify for public assistance. One beneficiary participant explained that she was uninsured and unable to obtain coverage for her child or herself because she did not qualify for Medi-Cal or Healthy Families. She said that this was a problem for others in her community as well, and that low-cost health care programs were needed. Spanish-speaking beneficiaries expressed that they were very concerned about the out-of-pocket costs of their health care.

Working family members experience difficulties accessing community clinics because of their limited hours of operation. Beneficiary participants suggested that if extended hours during the week or weekend hours were offered, more people would utilize their services rather than the ER. Beneficiary participants also expressed that a nurse's advice line (with non-English options) would be valuable to community members.

Mental illness limits access to care. According to provider participants, the mentally ill (which comprise about 80,000 of people in community) often are not aware that they have a chronic condition and unless they receive the expensive psychotropic drugs they need, they are less likely to seek care or make informed decisions regarding their care. Provider participants also noted that there is a huge gap in adolescent mental health and that providers do not yet know how to reach this population. One participant said that such adolescents are invisible to most people and there is no real access for them. Moreover, psychological issues are not well understood and people do not want to discuss mental health because of the stigma associated with it.

Stakeholder and beneficiary participants offered specific suggestions for steps that SFMC could take to improve access to health care information/services in their service area:

- *Vida Sana* has been a successful community outreach program and the model for outreach has been to utilize local churches; other participants suggested expanding the outreach model to utilize local schools due to their direct access to such a large percentage of the population. One participant representing the school district noted that it would be possible to reach "16,000 people tomorrow"
- One stakeholder participant explained that when she was involved with the American Cancer Society as a breast cancer facilitator, she would go into the adult schools because so many adults were going back to school. She would get permission from the principal to invite a doctor or a nutritionist to the school and gain an audience with adult students. She pointed out that this would also provide opportunities to talk about parenting and other topics
- Getting information out more effectively about the Community Health Resource Center at SFMC would be a great value to people, for example, educating community members about how to access assistance or services through Healthy Families, First-5, or Medi-Cal

- SFMC Board members have been discussing the possibility of advertising in Sunday bulletins or missalettes in church to conduct outreach to community members about the services available at the Community Health Resource Center
- Existing popular sources of community information in the SFMC service area noted by stakeholder participants were the Los Angeles Unified School District (LAUSD), organizations such as Churches in Action, community centers, senior centers, and recreation centers behind the community outreach programs
- Both English speaking and Spanish speaking beneficiaries recognized schools as convenient and effective venues at which to obtain health information, and English speaking beneficiaries also considered churches to be effective. English speaking beneficiaries explained that at the school they are able to receive physical checkups at mobile units, and that at church adults can receive mammograms and diabetes check-ups
- A representative from the resource center could make weekly, monthly, or bimonthly visits to city hall, community centers, or senior centers to conduct enrollments or answer questions about the services at SFMC
- SFMC could increase its presence in the community through the provision of community health fairs or mobile clinics at schools, churches or parks; past health fairs were considered a success, for example, in Compton last year
- Presence in the community needs to be consistent to build trust. Events should be offered on a continuous basis, have a specific purpose, targeted services, and be offered at consistent days and times
- SFMC could invite local service club members or board presidents from Rotary, Lions, Elks Lodge, etc., who might be able to assist with outreach advertising costs, donations, or sponsors to educate them about health problems in the area or engage them in a campaign
- SFMC could place a community page in El Aviso magazine listing the resources that are available to Spanish speaking community members
- Placing information pamphlets in clinic/hospital waiting rooms and/or playing educational DVD's while patients wait could help to provide information, as well as disseminating informational CD's or DVD's at local establishments

Births

Infant Death Rate

The infant death rate has decreased slightly in L.A. County from 5.4 per 1,000 in 2002-03 to 4.9 per 1,000 in 2007 (Figure 16). SPA 6 also showed a decrease from 6.5 per 1,000, which was significantly higher than the rate for all other SPAs combined in 2002-03 to 5.4 per 1,000 in 2007. The rates for SPAs 7 and 8 remained relatively stable from 2002-03 to 2007 at approximately 5 per 1,000.

Figure 16. Infant Death Rate (per 1,000 live births) for SFMC SPAs and L.A. County			
Region	2002-03	2005	2007
SPA 6	6.5	6.0	5.4
SPA 7	4.7	4.2	4.7
SPA 8	5.0	5.1	5.0
L.A. County	5.4	5.0	4.9

Teen Births

The rate of births (per 1,000) live births to teens ages 15 to 19 for L.A. County in 2002-03 was 44.4, then spiked in 2005 at 93.6, and declined again in 2007 to 40 (Figure 17). The pattern was similar for SPAs 6, 7, and 8. The rate for SPA 6 in 2002-03 was 85.7 and significantly higher than that of all other SPAs combined. In 2005, the SPA 6 rate rose to 149.6, and declined in 2007 to 74.1, but was again significantly higher than that of all other SPAs combined. The rate for SPA 7 in 2002-03 was 58 and significantly higher than the rate of all other SPAs combined, 101 in 2005, and 42.7 in 2007, significantly higher than that of all other SPAs combined. To the contrary, the rate for SPA 8 in 2002-03 was 40.8 and significantly lower than the rate of all other SPAs combined, in 2005 rose to 86.4, and declined in 2007 to 35.3, again significantly lower than that of all other SPAs combined.^{xii}

Figure 17. Rate of Births (per 1,000 live births) to Teens Ages 15-19 for SFMC SPAs and L.A. County			
Region	2002-03	2005	2007
SPA 6	85.7	149.6	74.1
SPA 7	50.8	101	42.7
SPA 8	40.8	86.4	35.3
L.A. County	44.4	93.6	40.0

Low-weight Births

Rates of low-weight births have increased in both L.A. County and the SFMC SPAs from 2002-03 to 2007 (Figure 18). In 2002-03, the rate in SPA 6 (7.3 per 1,000) was significantly higher than the rate of all other SPAs combined, increasing to 8.3 per 1,000 in 2005, and to 8.5 per 1,000 in 2007, again significantly higher than that of all other SPAs combined. Although increasing from 2002-03 to 2007, the rate in SPA 7 was significantly lower than that of all other SPAs combined in 2002-03 (6.1 per 1,000) and again in 2007 (6.9 per 1,000).

**Figure 18. Percentage of Low-weight (<2,500 grams) Births (per 1000 live births)
for SFMC SPAs and L.A. County**

Region	2002-03	2005	2007
SPA 6	7.3%	8.3%	8.5%
SPA 7	6.1%	6.3%	6.9%
SPA 8	6.7%	7.3%	7.5%
L.A. County	6.7%	7.1%	7.4%

Chronic Disease

According to a recent study by the UCLA Center for Health Policy Research, chronic health conditions are the leading cause of death and disability in the U.S. and the largest component of health care costs. Chronic health conditions are defined as “non-communicable illnesses that are prolonged in duration, do not resolve spontaneously, and are rarely cured completely.” In addition, chronic health conditions impact adults and children alike. According to the study, health care for people with chronic health conditions constitutes more than 70 percent of the nation’s total annual health care costs.

As highlighted in the study, chronic health care conditions that are deemed Ambulatory Care Sensitive Conditions (ACSCs) are considered to be controllable with proper outpatient care and disease management. Some mental health conditions, such as depression and psychological distress, result in higher use of medical care and thus are also considered ACSCs. The failure to effectively manage these chronic conditions due to poor quality, uncoordinated care and/or insufficient access to care can result in increases in emergency room (ER) usage and hospital services, poor overall health, and mortality. By understanding the burden of these chronic health conditions, health care programs can target their efforts to improve chronic disease management and treatment.^{xiii}

L.A. County falls into the second quintile (group 2) among all counties in terms of rates of adults with one or more chronic conditions (Figure 19). All SFMC SPAs have a higher percentage of adults with one or more chronic conditions than L.A. County overall. Moreover, SPA 6 falls into the 4th quintile of rates for adults with chronic conditions among other SPAs. SPA 6 also has a rank of 4 for rates of adults with chronic conditions with frequent health care use (62.8 percent of those with chronic conditions) and a rank of 5 for adults with chronic conditions that experience barriers to health care use (41.4 percent of those with chronic conditions).

Figure 19. Chronic Condition Indices and Access Indicators Adults Age 18+ (2007)

Region	Adults with One or More Chronic Condition			With Frequent Health care Use [^]		With Barriers to Health care Use	
	Number	%	Group	%	Group	%	Group
SPA 6	257,000	38.5	4	62.8	4	41.4	5
SPA 7	343,000	36.2	3	56.3	2	20.3	2
SPA 8	412,000	35.1	2	62.6	4	23.5	3
LA County	2,551,000	34.8	2	59.4	3	27.8	4

The rates from counties and SPAs were ranked from lowest to highest and then divided into five groups or quintiles. Group 1 = areas with lowest percentage of chronic conditions (best rates); Group 5 = areas with highest percentage of chronic conditions (worst rates).

[^] = Adults with 4 or more doctor visits within the last 12 months or went to ER within last 12 months

L.A. County has a much higher rate of children with chronic conditions relative to the rates of other counties (Figure 20). The county falls within the 4th quintile in rates of chronic conditions for children among all counties with 17.5 percent of children in the county having one or more chronic conditions. Both SFMC SPAs 6 and 8 have higher rates of chronic conditions among children than the county overall, however, at 20.1 percent and 18.8 percent respectively. Moreover, SPA 6 falls within the 5th quintile in rates of chronic conditions relative to other SPAs and SPA 8 falls within the 4th. Of the SFMC SPAs, SPA 7 has the highest percentage of

children with one or more chronic conditions that are also frequent health care users (66.3%) compared to 58 percent for the county, 54.5 percent for SPA 8, and 52.5 percent for SPA 6.

Figure 20. Chronic Condition Indices and Access Indicators Children Ages 1-17 (2007)

Region	Children with One or More Chronic Condition			With Frequent Health care Use [^]		With Barriers to Health care Use	
	Number	%	Group	%	Group	%	Group
SPA 6	66,000	20.1	5	52.5	2	*	*
SPA 7	70,000	17.2	4	66.3	3	*	*
SPA 8	78,000	18.8	4	54.5	2	*	*
LA County	465,000	17.5	4	58	2	24.6	3

Group 1 = areas with lowest percentage of chronic conditions (Best health group); Group 5 = areas with highest percentage of chronic conditions (Worst health group).

* = Unstable estimate due to small sample size.

[^] = Children with 3 or more doctor visits within last 12 months or went to the ER within last 12 months.

Compared to other SFMC SPAs and L.A. County, SPA 6 has the highest percentages of adults living with at least one of several chronic health conditions (Figure 21). Hypertension by far is most prevalent among adults from all SFMC SPAs and the county overall, with SPA 6 reporting the highest percentage at 29 percent. The next most prevalent chronic condition among adults is diabetes, followed by asthma. SPA 6 also has approximately double the percentage of adults living with psychological distress than other SFMC SPAs and the county at seven percent. Stakeholder focus group participants noted that asthma rates continue to be a problem among community members who reside along the 710 corridor where air pollution remains particularly severe.

Figure 21. Percentage of Adults (Age 18+) with Chronic Condition County and SPA Comparison (2007)

Region	% Active Asthma	% Congestive Heart Failure	% Diabetes	% Hypertension	% Psych Distress
L.A. County	6.8	1.6	8.8	25.5	3.8
SPA 6	8.3	2.9	9.9	29	7
SPA 7	6.2	1.3	8	25.3	2.9
SPA 8	8.1	1.6	8	25.3	2.9

Obesity and Diabetes

Stakeholder focus group participants emphasized that obesity and diabetes have been primary concerns and are becoming increasingly severe in the SFMC service area. Stakeholders noted that obesity is particularly a concern among children. Both English speaking and Spanish speaking beneficiary focus group participants also expressed concerns about obesity and diabetes. Beneficiary participants explained that places to obtain healthy foods such as farmers markets and other health food stores are either located outside of their community or too expensive. Provider participants noted that grocery stores on the Westside (for example, Culver City or Beverly Hills) have grocery stores with more healthy food options, such as vegetables and fruits, but in the Compton/Watts area, grocery stores tend to be filled with “walls of potato chips” and fewer healthy food options.

Concerns about obesity and diabetes are supported by a recent study by the UCLA Center for Health Policy Research. The study found that the prevalence of obesity in the U.S. has increased dramatically over the past 30 years, as has the prevalence of diabetes, more than doubling during the same time period. Obesity is a significant risk factor for diabetes and both conditions are significant risk factors for heart disease and other serious medical conditions. According to the study, in California, both obesity and diabetes continue to increase and the two conditions are highly related. The prevalence of diabetes is more than four times as high among adults who are obese, compared to adults of normal weight (15.8% vs. 3.7%).^{xiv}

Among the study's findings are that in California, the prevalence of both obesity and diabetes is higher among American Indians, African Americans, and Latinos than among whites or Asians. In addition, the prevalence of both conditions increased among all racial and ethnic groups from 2001 to 2007 with significant increases among whites, Latinos, and Asians. When controlling for age, additional racial and ethnic disparities were found. For example, Latinos, African Americans, and American Indians experience much larger increases in diabetes with age compared to whites. Among adults ages 50 to 64, approximately 20 percent of Latinos, African Americans, and American Indians have diabetes, nearly double the prevalence among whites. Among adults age 65 and above, 40 percent of American Indians and 28 percent of Latinos and African Americans have diabetes compared to just 14 percent of whites. In addition, although the prevalence of diabetes among Asian adults is similar to that of whites among younger adults, diabetes prevalence is significantly higher among older Asians compared to older whites (20% vs. 14%).

Other factors related to diabetes and obesity are education, income, and among immigrants, length of residence in the U.S. For example, second and third generation immigrants are much more likely to suffer from the two conditions than immigrants who have not lived long in the U.S.

In L.A. County, the percentage of obese children in grades 5, 7, and 9 rose from 21.9 percent in 2002-03 to 22.9 percent in 2007 (Figure 22). During the same time period, the percentages of obese children in SFMC SPAs 6 and 7 remained higher than those for L.A. County and SPA 8, increasing from 26.8 percent and 24.5 percent, respectively in 2002-03 to 28.9 percent and 26 percent, respectively in 2007 (Figure 22). Moreover, in 2007, the percentages of obese children in SPAs 6 and 7 were significantly higher than percentages of all other SPAs combined.

Figure 22. Percentage of children in grades 5, 7, & 9 who are obese (BMI > 95th percentile) for SFMC SPAs and L.A. County

Region	2002-03	2005	2007
SPA 6	26.8%	29.0%	28.9%
SPA 7	24.5%	26.5%	26.0%
SPA 8	21.1%	21.7%	21.3%
L.A. County	21.9%	23.3%	22.9%

For adults in L.A. County, obesity percentages rose from 19.3 percent in 2002-03 to 22.2 percent in 2007 (Figure 23). For adults in SFMC SPAs 6, 7, and 8, percentages of obesity remained higher than those for L.A. County from 2002-03 to 2007, and the percentages for SPAs 6 and 7 were significantly higher than the percentages for all other SPAs combined during the 2002-03 to

2007 time period (Figure 23). In 2007, the percentages of obese adults in SPAs 6 and 7 were 35.4 percent and 26.6 percent, respectively.

Figure 23. Percentage of adults who are obese (BMI > 30%) for SFMC SPAs and L.A. County

Region	2002-03	2005	2007
SPA 6	30%	30.0%	35.4%
SPA 7	23.6%	27.3%	26.6%
SPA 8	21.2%	21.0%	24.4%
L.A. County	19.3%	20.9%	22.2%

Diabetes prevalence also increased in L.A. County from 7 percent in 2002-03 to 8.7 percent in 2007 (Figure 24). Percentages of adults diagnosed with diabetes in SFMC SPAs 6 and 7 remained higher than percentages for L.A. County over the same time period, increasing from 9.1 percent and 9 percent, respectively in 2002-03 to 12.3 percent and 11 percent, respectively in 2007 (significantly higher than the percentage of all other SPAs combined in both 2005 and 2007).

Figure 24. Percentage of Adults Ever Diagnosed with Diabetes for SFMC SPAs and L.A. County

Region	2002-03	2005	2007
SPA 6	9.1%	11.7%	12.3%
SPA 7	9.0%	9.7%	11.0%
SPA 8	7.8%	8.3%	8.8%
L.A. County	7.0%	8.1%	8.7%

Focus group participants offered some suggestions for steps SFMC could take to address the issue of obesity:

- One stakeholder participant pointed out that to address child obesity the Lynwood school district implements healthy meal programs and maintains a partnership with the city of Lynwood to offer after school preschool programs sponsored with First-five funding; SFMC could work with the district to provide education to parents on healthy eating
- Beneficiary participants expressed that providing education on how to exercise and eat healthy, remaining active when 50 or 60 years old, as well as offering counseling or support groups in their community would be helpful in addressing obesity in their community; places they would be comfortable attending these groups were local schools, community centers, and local parks
- Beneficiary participants pointed out that many families in their community are single mother families with grandparents raising the children while the mother works; thus, they agreed that nutrition classes should target grandparents in addition to parents and children
- Beneficiary participants expressed that they did not trust the advice of their physician and often would not follow recommendations because they felt that the physician was unconcerned about them personally; beneficiaries suggested that improving this behavior would increase the likelihood that they would trust and follow recommendations

Communicable and Sexually Transmitted Diseases

Communicable and sexually transmitted diseases continue to be important health concerns in L.A. County and the SFMC service area. Approximately 50,000 new curable STDs (Chlamydia, Gonorrhea, and Syphilis) occur each year— almost 60 percent of them among young people 15 to 24 years of age. In 2009, laboratories and providers reported a total of 43,816 cases of Chlamydia, 8,532 cases of Gonorrhea, and 1,595 cases of early Syphilis in L.A. County. In 2008, the Centers for Disease Control and Prevention ranked L.A. County number one in the number of reported Chlamydia and primary and secondary Syphilis cases and number three in the number of reported Gonorrhea cases, compared to all other county and city health jurisdictions in the nation.^{xv}

STD Visits and Number of Patients Tested

- In 2009, LAC DPH's STD clinics had nearly 46,000 STD related visits and tested over 29,000 patients for Chlamydia, Gonorrhea, Syphilis, and/or HIV
- The number of STD related visits in 2009, increased from 44,289 in 2005 to 45,589, an increase of 2.9 percent
- The number of patients tested for Chlamydia, Gonorrhea, Syphilis, and/or HIV increased from 25,834 in 2005 to 29,002 in 2009, an increase of 12.3 percent

Chlamydia

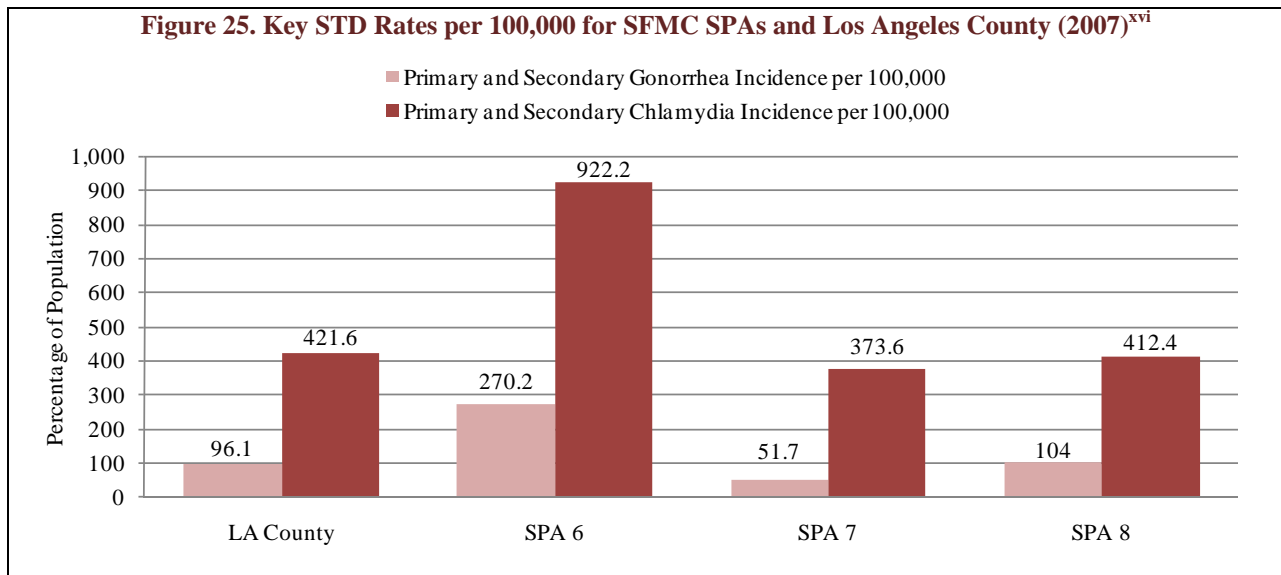
- In 2009, a total of 27,980 Chlamydia tests were performed at LAC DPH's STD clinics, yielding 3,148 positive results, an 11.3 percent prevalence
- The number of Chlamydia tests increased from 24,560 in 2005 to 27,980 in 2009, an increase of 13.9 percent
- The number of positive tests increased from 3002 in 2005 to 3148 in 2009, an increase of 4.8 percent
- The prevalence of Chlamydia at LAC DPH's STD clinics decreased from 12.2 percent in 2005 to 11.3 percent in 2009, a decrease of 7.4 percent

Gonorrhea

- In 2009, a total of 28,073 Gonorrhea tests were performed at LAC DPH's STD clinics, yielding 1,257 positive results, a 4.5 percent prevalence
- The number of Gonorrhea tests increased from 24,780 in 2005 to 28,073 in 2009, an increase of 13.3 percent
- The number of positive tests decreased from 1,786 in 2005 to 1,267 in 2009, a decrease of 2.9 percent
- The prevalence of Gonorrhea at LAC DPH's STD clinics decreased from 7.2 percent in 2005 to 4.5 percent in 2009, a decrease of 37.5 percent

- In 2009, a total of 25,973 Syphilis tests were performed at LAC DPH's STD clinics, yielding 168 positive results for early syphilis, a 0.6 percent prevalence
- The number of Syphilis tests increased from 22,410 in 2005 to 24,973 in 2009, an increase of 15.9 percent
- The number of positive tests increased from 121 in 2005 to 168 in 2009, an increase of 38.8 percent
- The prevalence of early Syphilis at LAC DPH's STD clinics increased from 0.5 percent in 2005 to 0.6 percent in 2009, an increase of 16.7 percent

STD rates of Chlamydia and Gonorrhea were significantly higher in SPA 6 than in other SFMC SPAs and the county in 2007 (Figure 25). The incidence rates of Chlamydia and Gonorrhea in SFMC SPA 6 were 922.2 per 100,000 and 270.2 per 100,000, respectively. L.A. County had the next highest rate of Chlamydia at 421.6 per 100,000 and for SFMC SPAs, SPA 8 experienced the next highest rate of Gonorrhea at 104 per 100,000. The rates of both diseases for SPAs 6 and 8 were statistically significantly higher than the rates for all other SPAs combined. The rates of Chlamydia and Gonorrhea for SFMC SPA 7 at 373.6 and 51.7 per 100,000, respectively, were significantly lower than all other SPAs combined.



Tuberculosis (TB)

The number of TB cases in the county has declined steadily since 1992. In 2007, there were 816 confirmed cases of TB in L.A. County, representing a 7.9 percent decrease from 2006 (886 cases) and a 62.9 percent decrease since 1992 (2,198 cases). This is the fifteenth consecutive year of decline since the peak of the TB epidemic in 1992 and marks the fifth year in a row where the county's TB burden fell below 1,000.^{xvii}

The TB rate among foreign-born individuals remains disproportionately high. In the U.S. in 2007, 58 percent of TB cases were foreign-born. In California, Asians and Hispanics comprised

46.3 percent and 36.4 percent of the total cases in 2007, respectively. In L.A. County in 2007, 647 (79.3%) cases were foreign-born. In 2007, Hispanics comprised the racial/ethnic group with the largest proportion of cases in the county (358 cases, 43.9%), followed by Asians (329 cases, 40.4%).

HIV

As of June 30, 2009, a cumulative total of 74,886 persons with HIV have been reported in L.A. County. Of these, a cumulative total of 55,738 persons have been diagnosed with AIDS, of which 31,391 have died, for a cumulative case-fatality rate of 56 percent.^{xviii}

The HIV epidemic in L.A. County differs greatly compared with the national epidemic by race/ethnicity, gender, and mode of exposure. In L.A. County, Latinos comprise the largest number of HIV/AIDS cases, while nationally, blacks are the racial/ethnic group most affected. In the U.S., injection drug use (IDU) accounted for 30 percent of reported HIV cases in the 1990's, and now, heterosexual transmission accounts for over 30 percent; whereas in L.A. County, neither IDU nor heterosexual risk has ever accounted for more than 10 percent of HIV cases.

While Latinos now account for the highest number and proportion of AIDS cases in L.A. County, blacks have been more heavily impacted by AIDS than any other racial/ethnic group. The annual black adult and adolescent AIDS rate for males, while decreasing over the past decade, continues to be more than twice that for white and Latino males. The AIDS rate for black females in L.A. County is five and 14 times higher than for Latinas and white females, respectively.

Among persons with HIV in L.A. County, injection drug users had the highest odds of being co-infected with Tuberculosis (TB) – three to four times higher than males having sex with males (MSM), who had the lowest prevalence of co-infection.

- The number of positive tests for HIV increased from 145 in 2005 to 190 in 2009, an increase of 31.0 percent
- The prevalence of HIV infection at L.A. County Department of Public Health LACDPH STD clinics increased from 0.7 percent in 2005 to 0.8 percent in 2009, an increase of 14.3 percent

HIV/AIDS SPA 6

A total of 5,466 persons had been reported with AIDS in the SPA 6 by June 30, 2008, with living AIDS rates ranging from 193 to 355 per 100,000 persons. Forty-three percent of people with AIDS were living (PLWA) at the end of 2007. This SPA has the highest proportion of female PLWA cases (21 %), which is almost twice that for L.A. County overall (11 %). If persons living with HIV (PLWH) are taken into account, the proportion of female cases increases to 25 percent, which is more than twice the overall estimate (12 %) for L.A. County. Of all SPAs, SPA 6 had the highest proportion of black PLWA. Among PLWA in SPA 6, 53 percent were black and 42 percent Latino.

The proportions of black and Latino cases did not change much when PLWH are included. Male-to-male sexual contact, including MSM/IDU, accounted for 52 percent of AIDS cases in SPA 6, 14 percent were infected through heterosexual contact (with an HIV-positive or high-risk partner) and eight percent through injection drug use (non-MSM). Among people living with HIV/AIDS (PLWHA) in SPA 6, 62 percent were infected through MSM and MSM/IDU combined, while an estimated 22 percent and 11 percent were infected through heterosexual contact and other IDU, respectively.

HIV/AIDS SPA 7

Of the 3,184 cumulative AIDS cases reported from the SPA 7, 1,480 (46%) persons were still living at the end of 2007, 86 percent of whom were male. Belvedere Gardens and South Gate have the highest living PLWA rates at 137 and 106 per 100,000 persons, respectively. PLWA in SPA 7 were predominately Latino (76%) giving SPA 7 the highest proportion of Latino PLWA. By the end of 2007, 64 percent of PLWA reported MSM or MSM/IDU as their mode of exposure, 10 percent reported heterosexual exposure, and 6 percent IDU. Among PLWHA in SPA 7, 74 percent reported MSM or MSM/IDU as their mode of transmission, and 15 percent reporting heterosexual contact.

HIV/AIDS SPA 8

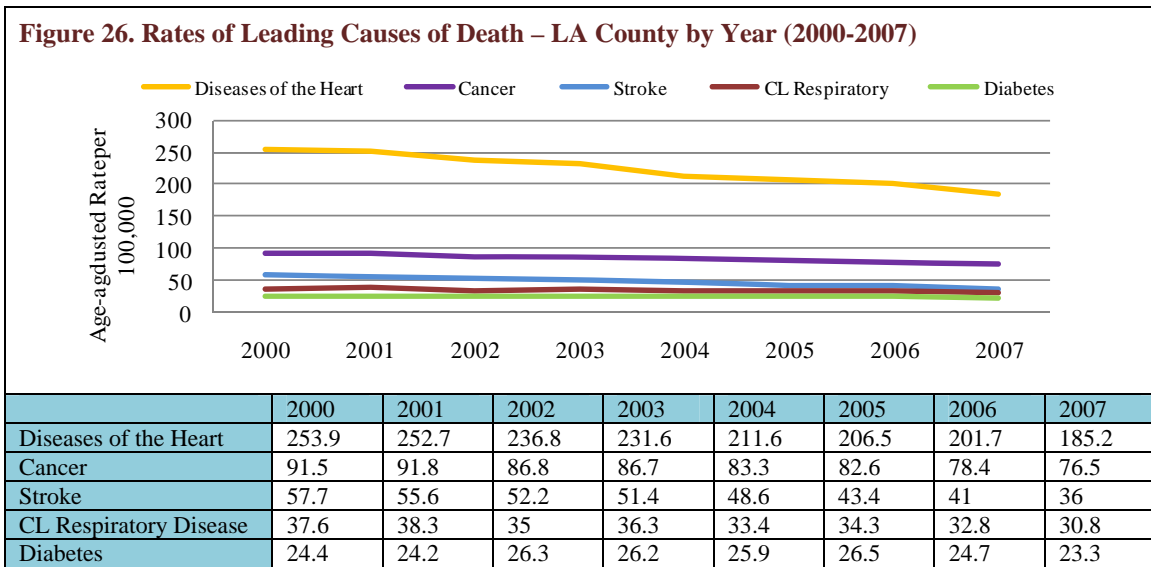
SPA 8 has the second highest AIDS rate in L.A. County. As of June 2008, the cumulative number of persons reported with AIDS in the South Bay was 8,866, of which 49 percent were living. In 2007, the City of Long Beach had the highest living AIDS rate (550 per 100,000 persons) in SPA 8. Among PLWA in SPA 8, 87 percent were male, 40 percent were white, 31 percent Latino, 25 percent black, and three percent Asian/Pacific Islander. The proportion of cases by race/ethnicity and gender is not noticeably different when PLWH are included in the analysis. Among PLWA in SPA 8, 74 percent were either MSM (66 %) or MSM/IDU (8 %), while seven percent were other IDU and 10 percent were infected through high-risk heterosexual contact. After adjusting for mode of exposure, 77 percent of PLWHA were MSM and MSM/IDU combined, while 13 percent acquired the virus through heterosexual contact.

STD and HIV Co-Morbidity

- In 2009, at LACDPH STD clinics, among the 190 patients who test positive for HIV infection, the prevalence of Chlamydia was 14.7 percent, Gonorrhea was 18.4 percent, early Syphilis was 12.1 percent and 5.3 percent had both Chlamydia and Gonorrhea

Leading Causes of Death

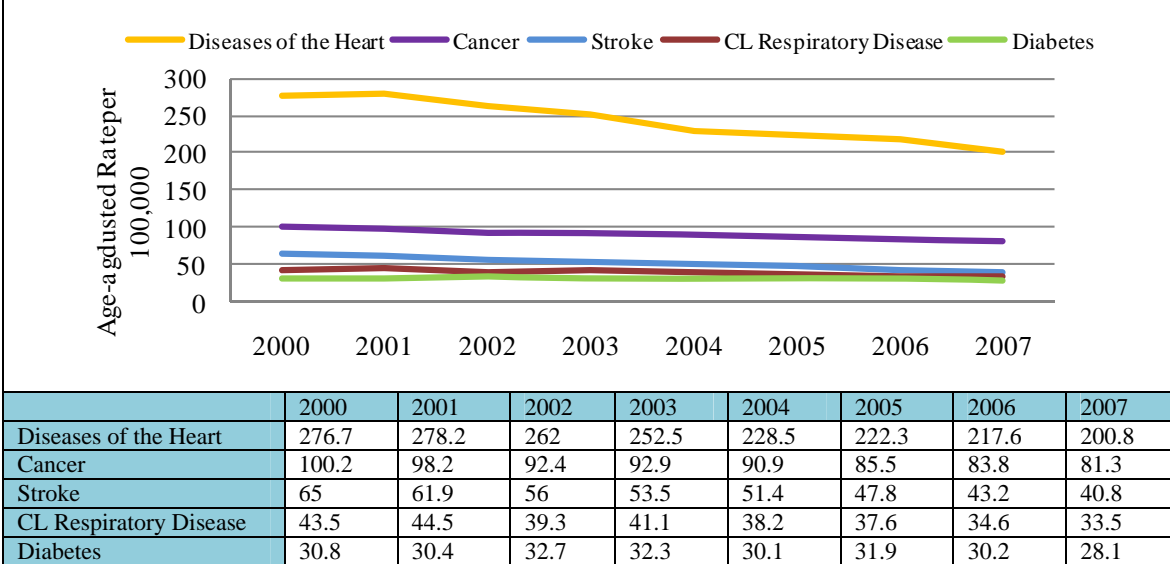
The leading causes of mortality in L.A. County from 2000 to 2007 were heart disease, cancer, stroke, chronic lower-respiratory diseases, and diabetes (Figure 26). Heart disease mortality declined steadily over this period from a rate of 253.9 deaths per 100,000 in 2000 to a rate of 185.2 by 2010, yet it remained the most prevalent cause of death, more than double the rates of the next leading cause of death in the county, cancer. Cancer mortality rates declined steadily, albeit slightly, from 91.5 per 100,000 in 2000 to 76.5 per 100,000 by 2007. Mortality rates for stroke and chronic lower-respiratory diseases also declined slightly, while the mortality rate for diabetes remained virtually unchanged over the seven-year period.^{xix}



Trends for the leading causes of mortality in the SFMC service area for the 2000-2007 period mirrored those for the county, but with higher rates for each leading cause of death (Figure 27).

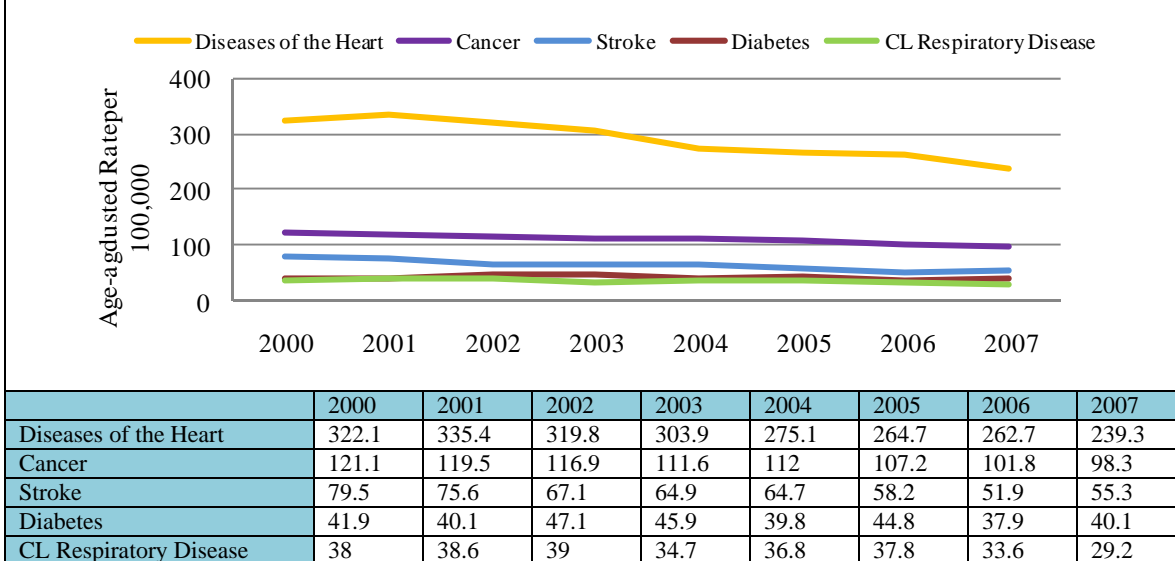
The greatest disparity among leading causes of mortality is evident in rates for heart disease. The mortality rate for heart disease was 22.8 per 100,000 higher in 2000 and 15.6 per 100,000 higher in 2007 in the SFMC service area than rates for corresponding time periods in L.A. County. However, that gap has diminished slightly since 2002 (Figure 27).

Figure 27. Rates of Leading Causes of Death – SFMC SPAs by Year (2000-2007)

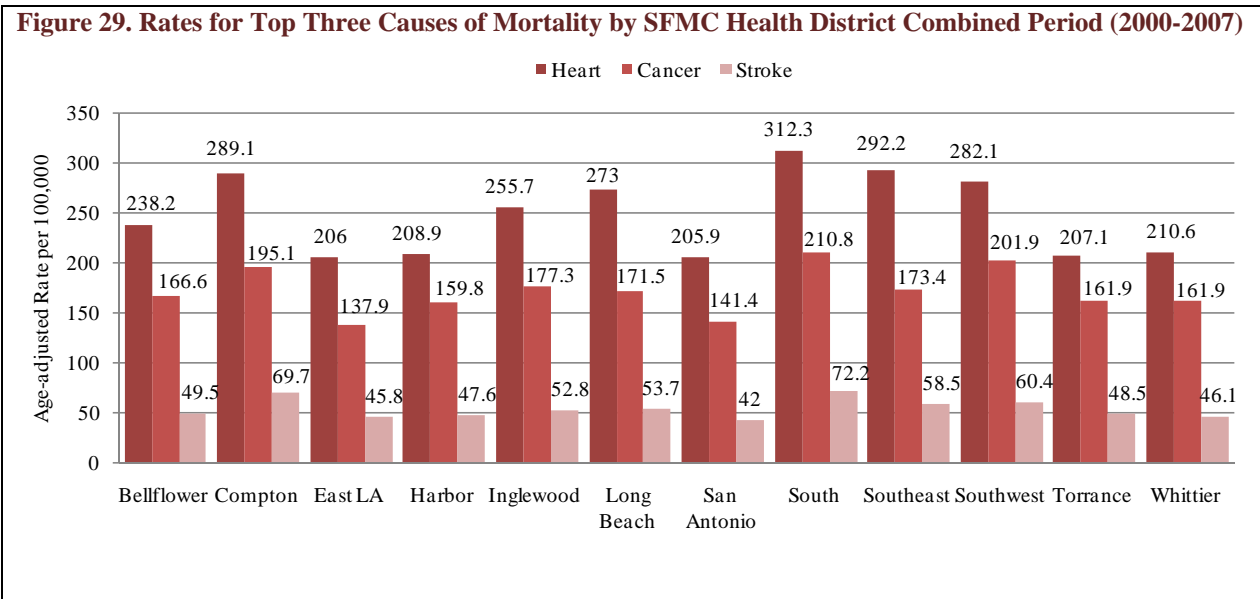


An even greater disparity exists between rates of leading causes of mortality in SPA 6 and those of L.A. County (Figure 28). In SPA 6, the mortality rate for heart disease was approximately 83 per 100,000 higher in both 2001 and 2002 and 54.1 per 100,000 higher in 2007 than rates for corresponding time periods in the county.

Figure 28. Rates of Leading Causes of Death – SPA 6 by Year (2000-2007)

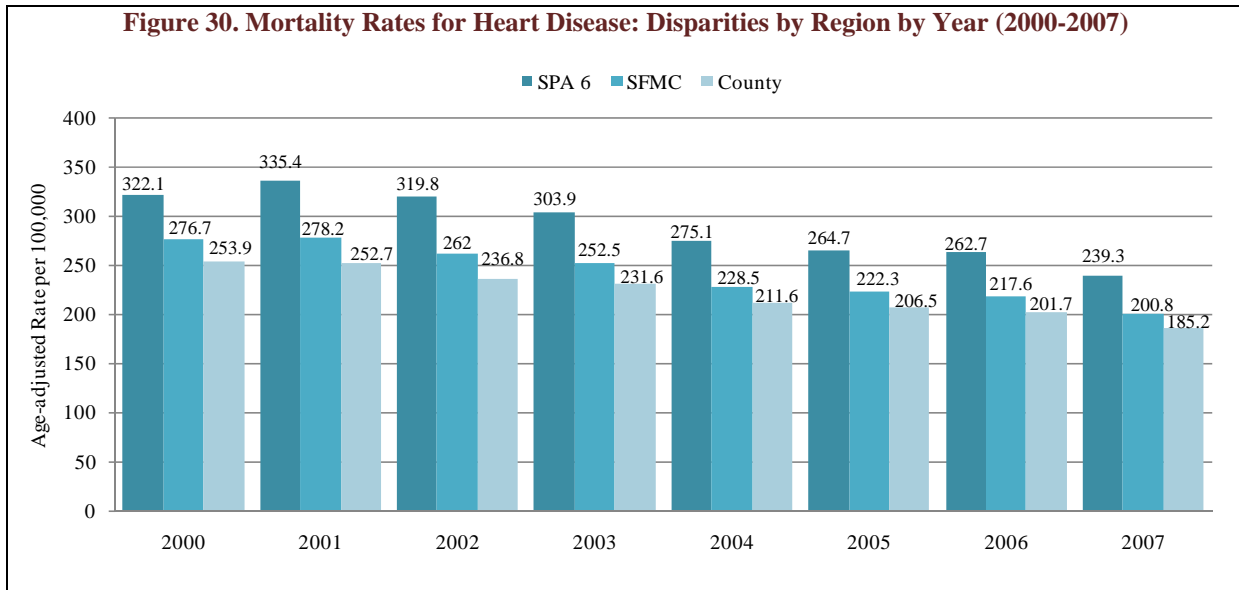


Similar to SFMC SPAs, the top three causes of mortality over the combined 2000-2007 period across all SFMC health districts (HD) were heart disease, cancer, and stroke (Figure 29). The South HD had the highest rates of heart disease, cancer, and stroke among all health districts. Compared to the South, the Southeast, Compton, and Southwest HDs had the next highest rates of heart disease. The Southwest, Compton, Inglewood, Southeast, and Long Beach HDs had the next highest rates of cancer, and Compton and the Southwest HDs the next highest rates of stroke compared to the South.

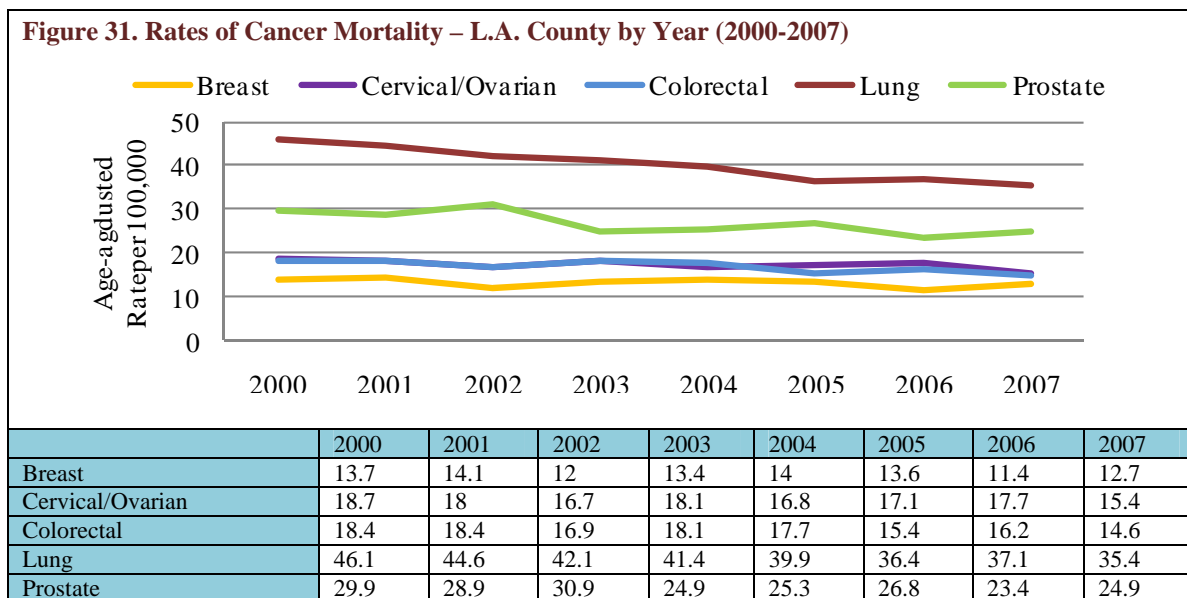


Note: mortality rates are combined over the seven year period due to high fluctuations in each HD from year to year.

A comparison of heart disease by County, SFMC service area, and SPA 6 reveals considerable regional disparities (Figure 30). All regions showed a steady decline in the rates of heart disease from 2001 to 2007. Nevertheless, the SFMC service area consistently experienced higher rates of heart disease than L.A. County each year from 2000 to 2007. SPA 6 experienced a steady decline in rates of heart disease from 322.1 per 100,000 in 2001 to 239.3 per 100,000 in 2007, but consistently had higher rates than other SFMC SPAs and the county.

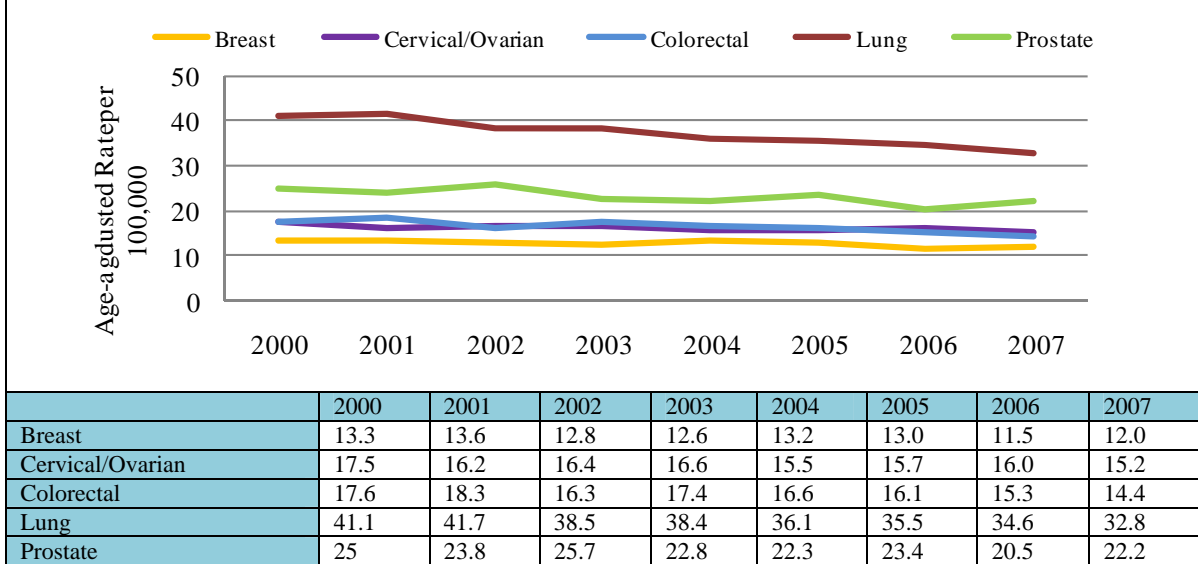


Trends in incidence of cancer from 2000 to 2007 in L.A. County show that lung cancer was the leading cause of mortality among all other forms of cancer by a wide margin, followed by prostate cancer, with colorectal and cervical cancer rates very similar to each other over the same time period (Figure 31). Overall, rates for all forms of cancer decreased slightly from 2000 to 2007 in L.A. County.



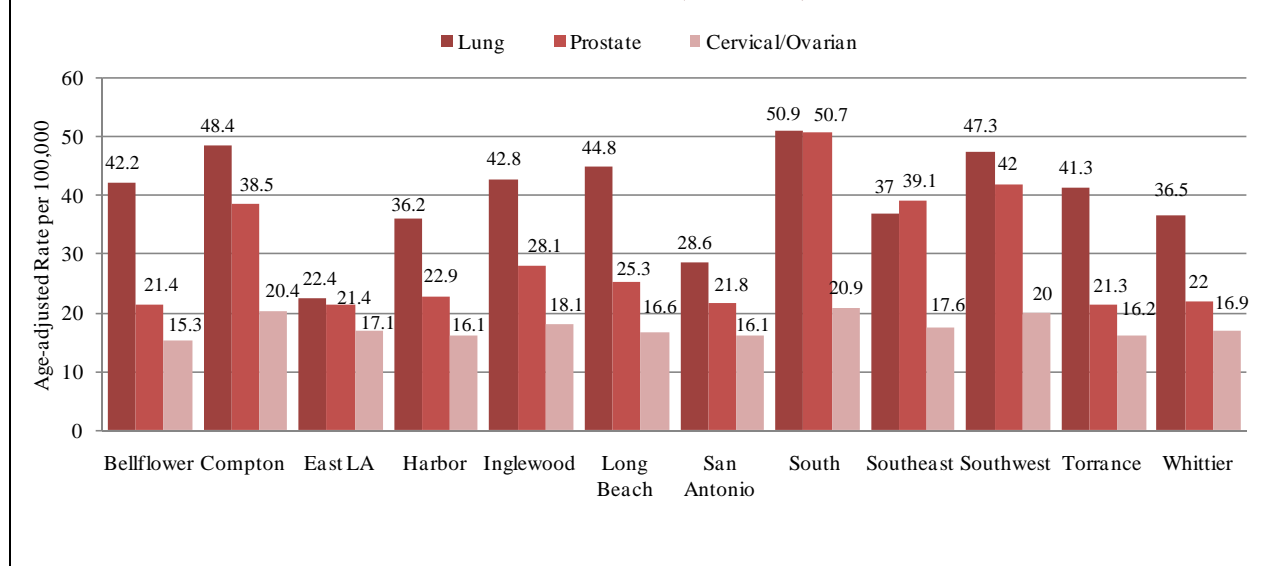
Although the mortality rates for the leading forms of cancer were slightly higher for all forms from 2000 to 2007, the SFMC service area trends virtually mirror those of the county (Figure 32). Mortality rates were highest for lung cancer by a wide margin, followed by prostate cancer, with colorectal and cervical cancer rates very similar. Also similar to the county, mortality rates for all leading forms of cancer declined slightly from 2000 to 2007.

Figure 32. Rates of Cancer Mortality – SFMC SPAs by Year (2000-2007)



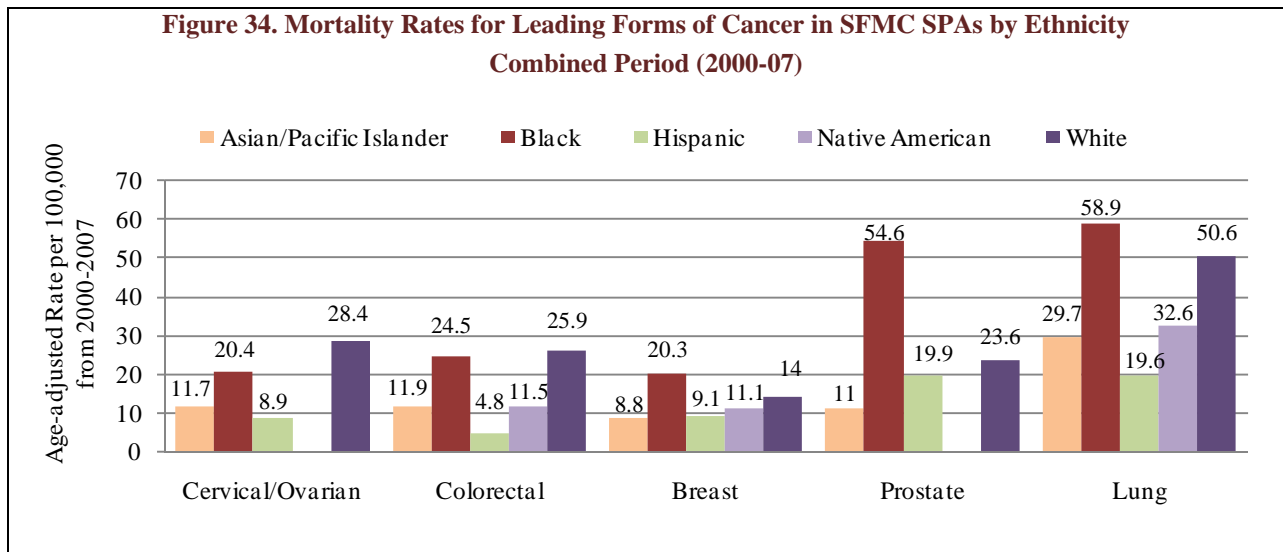
An analysis of the three leading forms of cancer across health districts for the combined period of 2000 to 2007 shows that the South HD had the highest rates of lung, prostate, and cervical/ovarian cancer at 50.9, 50.7, and 20.9 per 100,000 respectively (Figure 33). The Compton and Southwest HDs had the next highest rates of lung cancer followed closely by the Long Beach, Inglewood, Bellflower, and Torrance HDs. The next highest rates of prostate cancer were experienced in the Southwest, Southeast, and Compton HDs. Cervical/ovarian cancer rates were relatively similar across all HDs. The lowest rates of lung cancer were experienced in the East L.A. and San Antonio HDs and rates of prostate cancer were relatively low in the Torrance, Bellflower, East L.A., San Antonio, and Whittier HDs.

Figure 33. Mortality Rates for Three Leading Forms of Cancer by SFMC Health District Combined Period (2000-2007)



Note: mortality rates are combined over the seven year period due to high fluctuations in each HD from year to year.

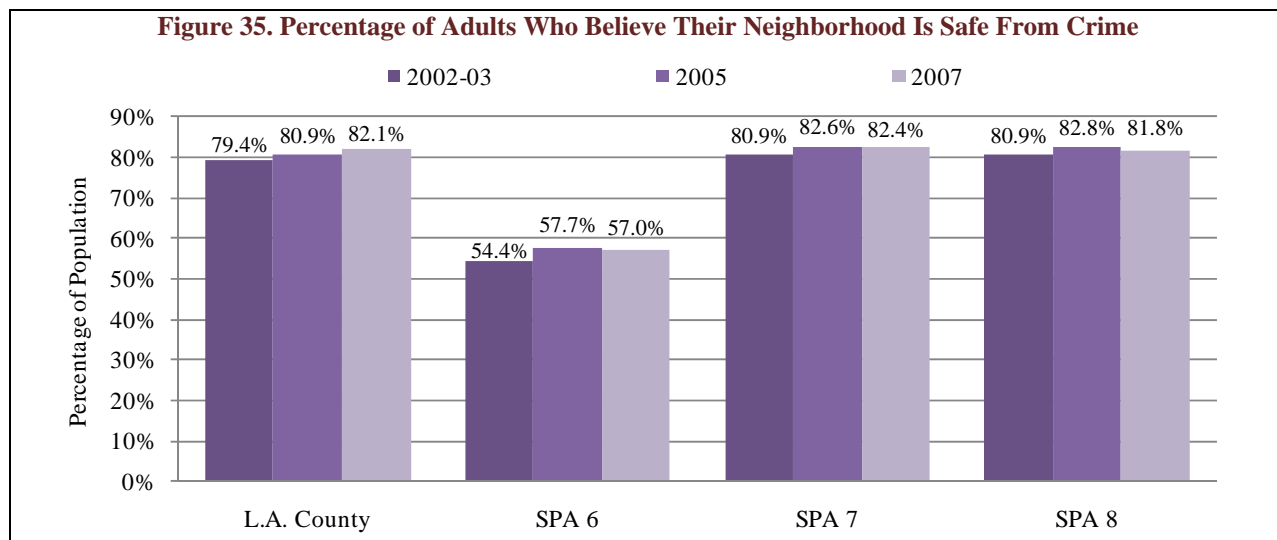
An examination of cancer rates by ethnicity and type in the SFMC SPAs for the combined period of 2000 to 2007 shows that blacks experienced the highest rates of all forms of cancer except for cervical/ovarian cancer in which they were surpassed by whites and whites experienced the second highest rates of all forms of cancer except cervical/ovarian (Figure 34). Blacks had the highest rates of lung and prostate cancer by a wide margin at 58.9 and 54.6 per 100,000 respectively. Whites approached the rates of blacks for incidence of lung cancer at 50.6 per 100,000.



Note: mortality rates are combined over the seven year period in order to show comparison on this graph.

At-Risk/Safety and Survival

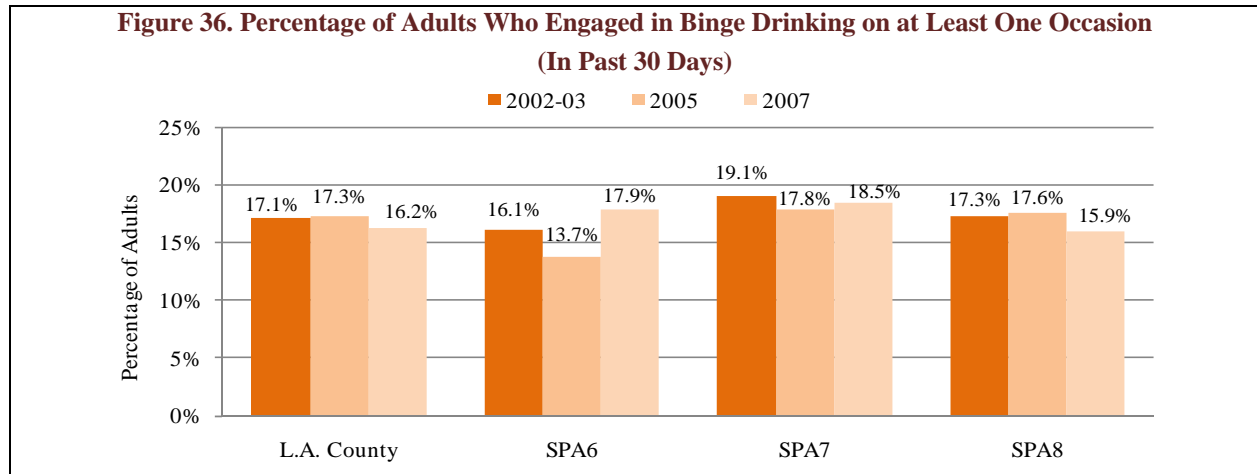
Residents of SPA 6 continue to rank lowest in the perception of neighborhood safety (Figure 35). The percentage of adults who perceive their neighborhood to be safe has remained relatively unchanged in all SFMC SPAs. The percentage of adults in SPA 6 who believe their neighborhood is safe has been consistently and significantly lower than other SFMC SPAs and the county at 54.4 percent in 2002-03, 57.7 percent in 2005, and 57 percent in 2007. The percentages of SFMC SPAs 7 and 8 were very similar to those of the county overall during the same time period.



Alcohol use is known to be associated with threats to public safety either due to an increased likelihood of traffic accidents or an increased likelihood of various forms of physical violence, for example, intimate partner violence (IPV). The percentage of adults who report binge drinking has decreased slightly in L.A. County from 2005 to 2007 (Figure 36). Both SFMC SPAs 6 and 7, however, have experienced increases in the percentage of adult binge drinkers from 2005 to 2007 and SPA 6 the greatest increase from 13.7 percent in 2002-03 to 17.9 percent in 2007. Also, the percentage of binge drinkers in SPA 7 (18.5%) was significantly higher than that for all other SPAs combined in 2007.

Drug use is also known to be associated with threats to public safety. Methamphetamine abuse and addiction among youth in the SFMC service area is on the rise according to stakeholder focus group participants.

Homicides remain a serious concern in SPA 6, consistently ranking as the sixth leading cause of death each year from 2000 to 2007. In 2007, the age-adjusted homicide rate per 100,000 was 21.9. In SPA 6, over the combined period of 2000 to 2007, the South HD experienced the highest rate of homicides by a considerable margin (40.1 per 100,000), followed by the Southwest HD (29 per 100,000), Compton HD (28.8 per 100,000), and the Southeast HD (26.3 per 100,000).



Note: Binge drinking = 5+ drinks for men and 4+ drinks for women on a single occasion

Intimate Partner Violence (IPV)

According to a recent study on Intimate Partner Violence (IPV), the phenomenon is a public health problem that affects more than 32 million Americans. It includes actual, and/or threats of, physical or sexual violence and psychological or emotional abuse.^{xx} Victims of IPV and adult children who have been exposed to IPV are both more likely to be diagnosed with chronic disease such as ischemic heart disease, cancer, liver disease, and chronic lung diseases in adult life. Furthermore, women are shown to be at greater risk of acute conditions such as stomach ulcers, spastic colon, arthritis, migraines, and sexually transmitted diseases. Studies also report that both men and women who experience IPV in their relationship are not only more likely to be diagnosed with substance abuse and chronic mental illness but are also more likely to exhibit signs and symptoms of depression.^{xxi}

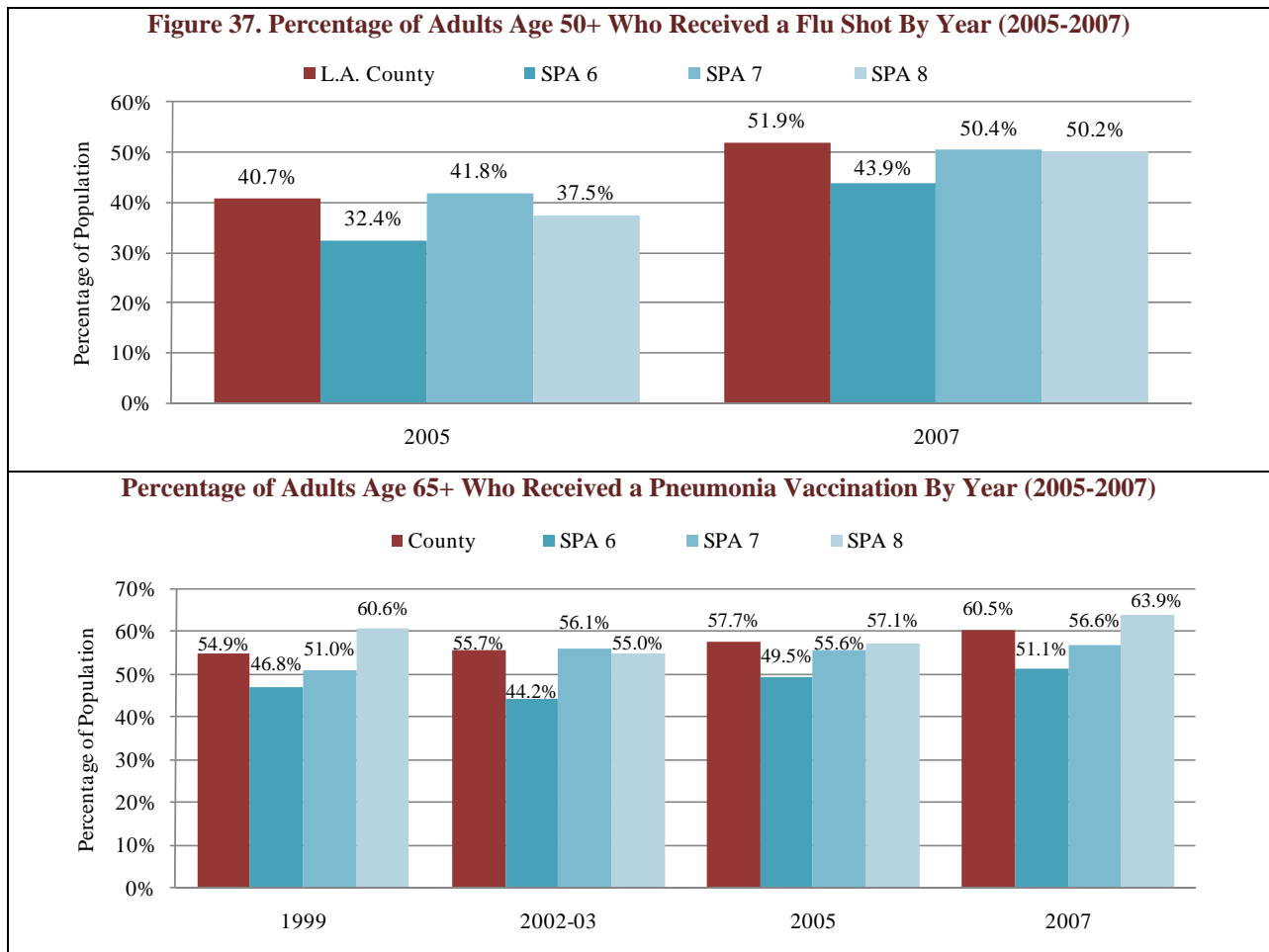
The approximately 958,000 recent California IPV victims (4.1% of the total population), are nearly evenly split between men (50.4%) and women (49.6%) reporting an incident in the past 12 months. However, sharp gender differences emerge for recent sexual IPV (14% male vs. 86% female). For past 12 month IPV, rates among African Americans (30.6%) and Latinos (28.3%) are highest and significantly higher than the rate for whites (21.5%).

More than one-third of IPV victims (34.1%) reported that their partner appeared to be drinking alcohol during the most recent violent incident. One in five IPV victims (19.5%) report that their partner was using drugs during the most recent incident. Women are significantly more likely than men to report that their partner was using alcohol (40.5% vs. 27.9%), and that their partner was using drugs (25.4% vs. 13.6%). While alcohol or other drug use may not directly cause IPV, it may increase the risk of violence. Rates of binge drinking are higher among IPV victims of recent incidents over the past year (52.8%) compared to non-IPV victims (32.4%). Nearly one in ten IPV victims (11.2%) report daily to weekly binge drinking compared to 3 percent of non-victims of recent IPV.

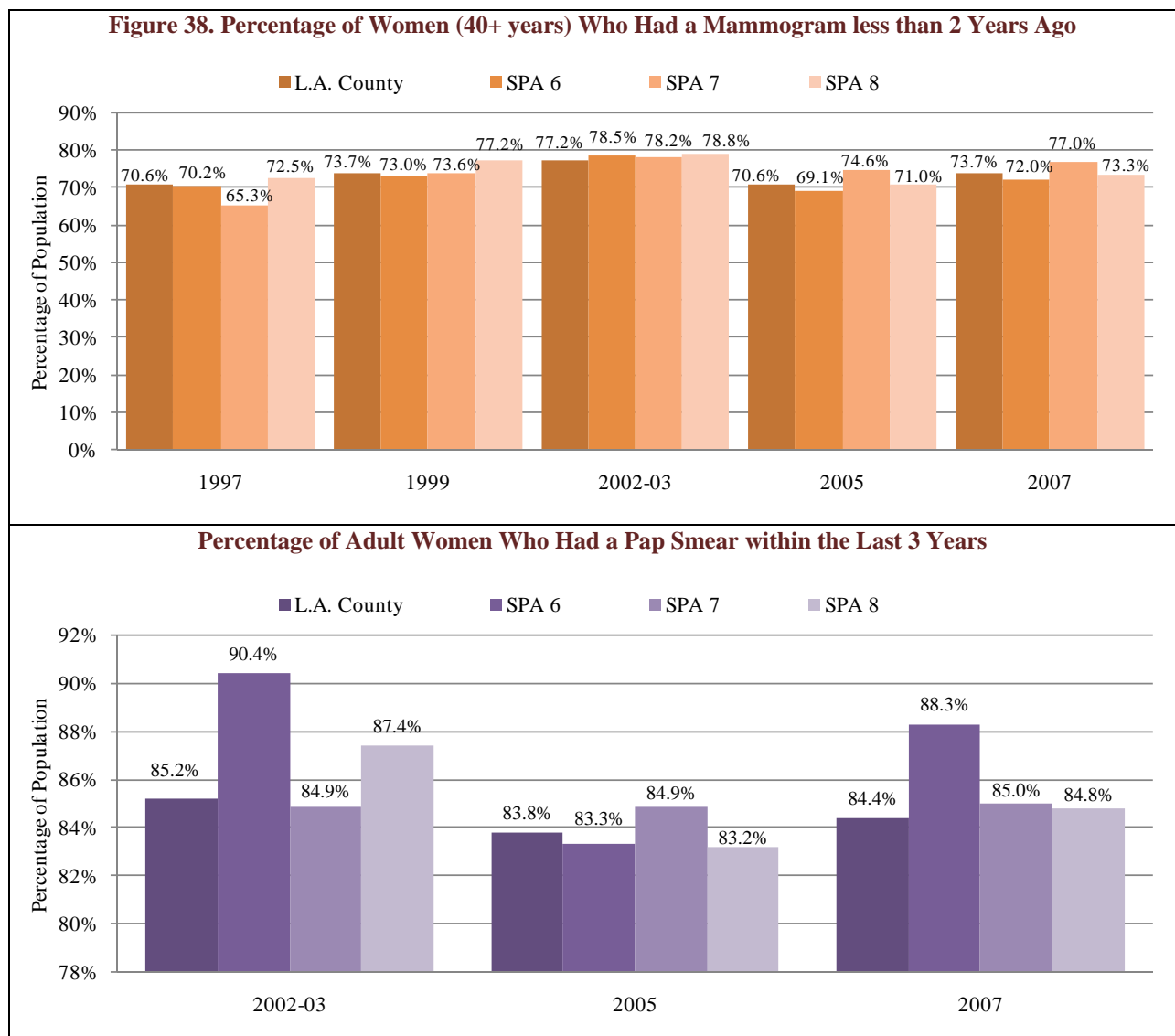
Preventive Health care

Provider focus group participants emphasized the need for more preventative health services. Participants agreed that they need to promote healthier eating habits before chronic conditions develop. However, participants expressed difficulties in successfully informing the community about the availability of basic health resources. One provider participant explained that as a public health agency, they offer those basic services, but that they are consistently underutilized. The participant said that the issue was getting information out and persuading people of its importance. The participant noted, for example, that community members remain unconvinced that vaccines prevent illnesses. Other participants agreed.

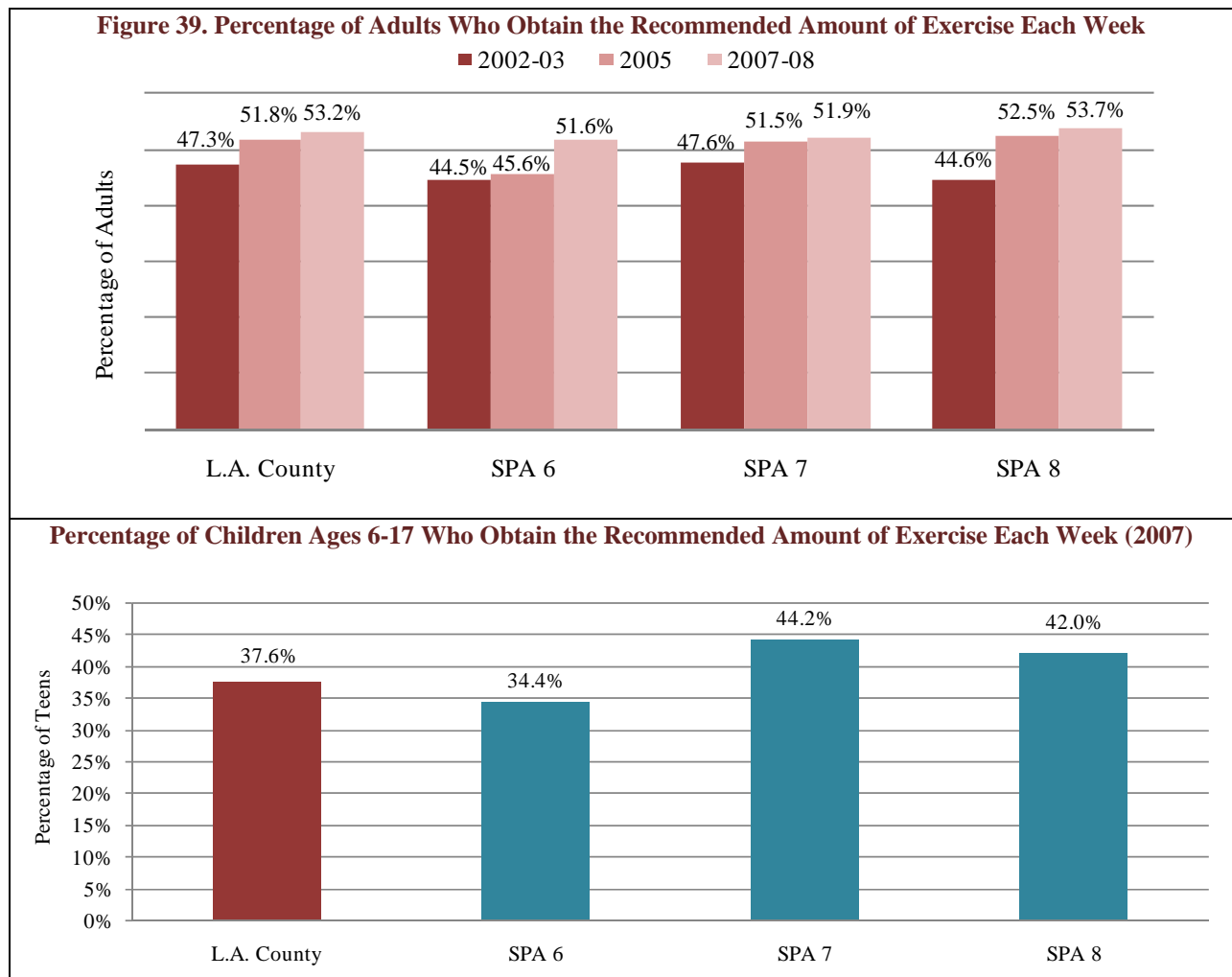
Immunization rates overall are slowly increasing. The percentage of adults age 50 and over who reported receiving a flu shot increased in all SFMC SPAs and the county from 2005 to 2007 (Figure 37). However, SPA 6 had the lowest percentage in both 2005 and 2007 at 32.4 percent and 43.9 percent, respectively, and significantly lower than that for all other SPAs combined in 2007. The percentage of adults age 65 and over who reported having received a pneumonia vaccination increased slightly in the county and all SFMC SPAs from 1999 to 2007. SPA 6 consistently had the lowest percentages of reported pneumonia vaccinations among those age 65 and over from 1999 to 2007 and SPA 8 the highest (with the exception of 2002-03 and 2005).



Women's preventive care shows mixed results. The percentage of women 40 and over who reported having a mammogram within the last two years increased for the county and SFMC SPAs from 1997 to 2002-03, but decreased for the county and SFMC SPAs from 2002-03 to 2007, showing the steepest decline from 2002-03 to 2005 (Figure 38). From 2005 to 2007 the county and all SFMC SPAs again showed a slight increase in the percentage of women reporting mammograms. SPA 7 experienced the greatest increase in the percentage of women 40 and over reporting mammograms from 1997 to 2007, and had the highest percentages in both 2005 and 2007. SPA 6 had the lowest percentages from 1999 to 2007. The percentage of women who reported receiving a Pap smear within the last three years decreased for the county and SFMC SPAs 6 and 8 from 2002-03 to 2005, raising slightly again in 2007 but not back to 2002-03 levels (Figure 38). The percentage of women in SPA 7 who reported receiving a Pap smear within the last three years remained virtually the same from 2002-03 to 2007.



Proper diet and exercise are the most important behaviors in decreasing the risks of chronic disease such as obesity, diabetes, and heart disease, yet these behaviors are severely lacking in adults and children across the county and within the SFMC service area. Just over 50 percent of adults in L.A. County and all SFMC SPAs reported obtaining the recommended amount of exercise each week in 2007 and this percentage has only slightly increased since 2002-03 (Figure 39). SPA 8 showed the greatest increase, increasing from 44.6 percent in 2002-03 to 53.7 percent in 2007. For children ages 6 to 17, the problem is even more severe, with only 37 percent of children in L.A. County obtaining the recommended amount of exercise each week. Among the SFMC SPAs, children from SPAs 7 and 8 were slightly more likely than children from the county as a whole to have obtained the recommended amount of exercise at 44.2 percent and 42 percent, respectively, but only 34.4 percent of children in SPA 6 did so in 2007.



Barriers to Preventive Care

Changing preventive behavior depends on knowledge and trust. People need to be educated how to utilize their health benefits according to provider participants. Sometimes people have insurance, for example, Medi-Cal, but if they do not know how to use their benefits they avoid

obtaining preventive care. Participants explained that part of the problem is that health information needs to be easier to understand. Wording and language on health care forms and information packets must be written at a level that people with low-levels of education or literacy are able to comprehend. Provider participants expressed that disseminating information that is easier to read and understand could have a significant impact on gaining trust from community.

Furthermore, in order to improve preventive health care behaviors, providers need a better understanding of the challenges that community members are facing, according to provider participants. Lack of trust, being unemployed, struggling to put food on the table, and fear of disclosing any information that can identify immigration status are common issues among SFMC community members. Provider participants explained that some ethnic groups (for example, Vietnamese or Latino) that have been living in the U.S. for 15 to 20 years are still wary about disclosing personal information to providers. Distrust is also prevalent in the African-American community. One provider participant recounted that during flu season, some community members that visited the health center for H1N1 vaccines thought that the vaccine was “poison” or were skeptical about the effect it could have on them. Despite clinic workers' efforts to explain that the vaccine was safe, there was still a huge amount of distrust.

Appendix A: Population Projections

Note: The cohort component methodology was utilized for all population projections in this needs assessment

Table 1.1 Total Population, by Race/Ethnic Group, Area and Year

Year	Area	Total	Hispanic	2 or more	Am Indian	Asian/PI	Black	Pac Isl.	White	Other
2008	CA	36,418,499	12,656,574	1,255,193	167,056	4,406,653	2,191,013	124,856	15,491,507	125,647
2015	CA	38,564,190	14,259,798	1,311,697	172,725	4,775,041	2,272,648	137,273	15,505,925	129,082
2020	CA	40,371,502	15,595,818	1,359,271	177,504	5,093,740	2,341,609	148,449	15,523,306	131,806
2008	LA	9,831,675	4,502,552	297,745	23,038	1,258,910	847,202	24,091	2,844,597	33,540
2015	LA	10,482,595	5,051,383	311,062	23,434	1,343,545	862,888	26,178	2,829,757	34,349
2020	LA	10,983,288	5,486,066	321,666	23,559	1,410,858	873,580	27,741	2,804,981	34,837
2008	SPA 6	991,421	638,113	18,075	1,574	21,332	265,779	1,991	41,091	3,466
2015	SPA 6	1,082,532	725,668	18,851	1,586	22,881	265,368	2,135	42,501	3,542
2020	SPA 6	1,159,101	798,389	19,404	1,614	24,410	265,769	2,190	43,735	3,590
2008	SPA 7	1,317,789	920,553	31,483	3,765	120,762	43,313	2,313	191,870	3,730
2015	SPA 7	1,423,807	1,025,372	32,829	3,913	125,597	44,684	2,491	185,113	3,808
2020	SPA 7	1,508,280	1,108,938	33,821	4,020	129,238	46,019	2,610	179,759	3,875
2008	SPA 8	1,534,288	569,195	59,320	3,079	209,422	226,239	10,548	450,888	5,597
2015	SPA 8	1,620,725	638,116	61,304	3,118	222,046	232,395	11,390	446,667	5,689
2020	SPA 8	1,689,260	694,319	62,953	3,114	233,144	237,200	12,065	440,694	5,771

Table 1.2 Total Population Growth, by Race/Ethnic Group, Area and Year

Year	Area	Total	Hispanic	2 or more	Am Indian	Asian/PI	Black	Asian Islander	White	Other
2008	CA									
2015	CA	5.9%	12.7%	4.5%	3.4%	8.4%	3.7%	9.9%	0.1%	2.7%
2020	CA	4.7%	9.4%	3.6%	2.8%	6.7%	3.0%	8.1%	0.1%	2.1%
2008	LA									
2015	LA	6.6%	12.2%	4.5%	1.7%	6.7%	1.9%	8.7%	-0.5%	2.4%
2020	LA	4.8%	8.6%	3.4%	0.5%	5.0%	1.2%	6.0%	-0.9%	1.4%
2008	SPA 6									
2015	SPA 6	9.2%	13.7%	4.3%	0.7%	7.3%	-0.2%	7.3%	3.4%	2.2%
2020	SPA 6	7.1%	10.0%	2.9%	1.8%	6.7%	0.2%	2.6%	2.9%	1.4%
2008	SPA 7									
2015	SPA 7	8.0%	11.4%	4.3%	3.9%	4.0%	3.2%	7.7%	-3.5%	2.1%
2020	SPA 7	5.9%	8.1%	3.0%	2.7%	2.9%	3.0%	4.8%	-2.9%	1.8%
2008	SPA 8									
2015	SPA 8	5.6%	12.1%	3.3%	1.3%	6.0%	2.7%	8.0%	-0.9%	1.6%
2020	SPA 8	4.2%	8.8%	2.7%	-0.1%	5.0%	2.1%	5.9%	-1.3%	1.4%

Table 1.3 Total SFMC Population, by Race/Ethnic Group and Year

Year	Total	Hispanic	2 or more	Am Indian	Asian/PI	Black	White	Other
2008	3,843,498	2,127,861	108,878	8,418	366,368	535,331	683,849	12,793
2015	4,127,064	2,389,157	112,984	8,617	386,540	542,447	674,281	13,038
2020	4,356,641	2,601,646	116,178	8,748	403,657	548,989	664,188	13,236

Table 2.1 Total Population, by Age, Area and Year

Year	Area	Total	0-14	15-24	25-34	35-44	45-54	55-64	65+
2008	CA	36,418,499	7,737,926	5,458,057	5,186,319	5,424,328	5,067,140	3,541,484	4,003,245
2015		38,564,190	7,936,569	5,360,822	5,451,270	5,217,699	5,319,216	4,413,319	4,865,295
2020		40,371,502	8,226,884	5,094,465	5,561,099	5,223,212	5,304,398	4,965,628	5,995,816
2008	LA	9,831,675	2,119,380	1,490,636	1,387,810	1,522,415	1,359,605	925,854	1,025,975
2015		10,482,595	2,214,609	1,499,064	1,447,863	1,452,960	1,461,876	1,168,298	1,237,926
2020		10,983,288	2,355,652	1,400,599	1,528,843	1,393,051	1,490,645	1,323,717	1,490,781
2008	SPA 6	991,421	264,539	182,215	147,526	136,078	117,255	72,066	71,742
2015		1,082,532	274,785	184,129	169,517	141,099	127,090	97,560	88,353
2020		1,159,101	291,256	175,532	188,152	147,145	134,116	113,714	109,188
2008	SPA 7	1,317,789	321,169	213,992	179,870	193,483	165,702	116,656	126,917
2015		1,423,807	332,348	229,776	194,000	186,540	178,992	147,575	154,575
2020		1,508,280	357,297	212,972	218,981	179,231	189,952	160,364	189,483
2008	SPA 8	1,534,288	342,274	218,687	208,668	242,146	218,165	146,759	157,589
2015		1,620,725	336,344	239,871	207,212	227,525	234,644	182,193	192,936
2020		1,689,260	348,205	224,736	228,789	208,311	234,590	213,806	230,824

Table 2.2 Total Population Growth, by Age, Area and Year

Year	Area	Total	0-14	15-24	25-34	35-44	45-54	55-64	65+
2008	CA								
2015	CA	5.9%	2.6%	-1.8%	5.1%	-3.8%	5.0%	24.6%	21.5%
2020	CA	4.7%	3.7%	-5.0%	2.0%	0.1%	-0.3%	12.5%	23.2%
2008	LA								
2015	LA	6.6%	4.5%	0.6%	4.3%	-4.6%	7.5%	26.2%	20.7%
2020	LA	4.8%	6.4%	-6.6%	5.6%	-4.1%	2.0%	13.3%	20.4%
2008	SPA 6								
2015	SPA 6	9.2%	3.9%	1.1%	14.9%	3.7%	8.4%	35.4%	23.2%
2020	SPA 6	7.1%	6.0%	-4.7%	11.0%	4.3%	5.5%	16.6%	23.6%
2008	SPA 7								
2015	SPA 7	8.0%	3.5%	7.4%	7.9%	-3.6%	8.0%	26.5%	21.8%
2020	SPA 7	5.9%	7.5%	-7.3%	12.9%	-3.9%	6.1%	8.7%	22.6%
2008	SPA 8								
2015	SPA 8	5.6%	-1.7%	9.7%	-0.7%	-6.0%	7.6%	24.1%	22.4%
2020	SPA 8	4.2%	3.5%	-6.3%	10.4%	-8.4%	0.0%	17.4%	19.6%

Table 2.3 Total SFMC Population, by Age Group and Year

Year	Total	0-14	15-24	25-34	35-44	45-54	55-64	65+
2008	3,843,498	927,982	614,894	536,064	571,707	501,122	335,481	356,248
2015	4,127,064	943,476	653,776	570,729	555,165	540,726	427,328	435,864
2020	4,356,641	996,759	613,240	635,921	534,687	558,657	487,883	529,494

Table 3.1 Household Income Projections 2015 and 2020

Region	Year	Inflation-adjusted 2008 dollars	
US	1980	\$49,822.00	
	1990	\$51,266.00	
	2000	\$54,148.00	
	2008	\$51,528.00	
	2015	\$53,557.10	
	2020	\$54,012.25	
	LA	1980	\$51,874.00
LA	1990	\$59,844.00	
	2000	\$54,278.00	
	2008	\$54,000.00	
	2015	\$55,279.34	
	2020	\$55,347.71	
	SPA 6	1980	
		1990	
2000		\$35,152.00	
2008		\$34,268.00	
2015		\$33,494.50	
2020		\$32,942.00	
SPA 7		1980	
	1990	\$50,153.00	
	2000	\$49,109.00	
	2008	\$48,268.00	
	2015	\$47,536.23	
	2020	\$47,012.68	
	SPA 8	1980	
1990		\$45,573.00	
2000		\$56,604.00	
2008		\$57,113.00	
2015		\$63,437.37	
2020		\$66,737.60	

Appendix B: Age-Adjusted Mortality Rates

Table 3. Age-adjusted Mortality Rates from Selected Causes*
in Los Angeles County from 2000 to 2007 Stratified by Year,
Underlying Cause.

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2000	Diseases of the Heart	19,420	253.9	250.3	257.5
	Malignant Neoplasms	7,072	91.5	89.4	93.7
	Cerebrovascular Diseases	4,410	57.7	56.0	59.4
	Chronic Lower Respiratory Diseases	2,861	37.6	36.2	39.0
	Diabetes Mellitus	1,879	24.4	23.3	25.5
	Chronic Liver Disease and Cirrhosis	1,121	13.7	12.9	14.5
	Homicide	989	10.0	9.4	10.6
	Suicide	711	8.0	7.4	8.6
	Hypertension / Hypertensive Renal Disease	606	7.9	7.3	8.5
	HIV	506	5.6	5.1	6.0
2001	Diseases of the Heart	19,432	252.7	249.2	256.3
	Malignant Neoplasms	7,176	91.8	89.7	93.9
	Cerebrovascular Diseases	4,259	55.6	53.9	57.2
	Chronic Lower Respiratory Diseases	2,931	38.3	37.0	39.7
	Diabetes Mellitus	1,890	24.2	23.1	25.3
	Chronic Liver Disease and Cirrhosis	1,009	12.0	11.3	12.8
	Homicide	1,093	10.7	10.1	11.4
	Hypertension / Hypertensive Renal Disease	672	8.7	8.1	9.4
	Suicide	761	8.2	7.6	8.8
	HIV	558	5.9	5.4	6.4
2002	Diseases of the Heart	18,988	236.8	233.4	240.1
	Malignant Neoplasms	7,006	86.8	84.7	88.8
	Cerebrovascular Diseases	4,168	52.2	50.6	53.8
	Chronic Lower Respiratory Diseases	2,770	35.0	33.7	36.3

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Diabetes Mellitus	2,122	26.3	25.2	27.5
	Chronic Liver Disease and Cirrhosis	1,083	12.4	11.7	13.1
	Homicide	1,147	11.1	10.5	11.8
	Hypertension / Hypertensive Renal Disease	700	8.7	8.1	9.4
	Suicide	727	7.8	7.2	8.3
	HIV	502	5.2	4.8	5.7
2003	Diseases of the Heart	19,246	231.6	228.3	234.9
	Malignant Neoplasms	7,200	86.7	84.7	88.7
	Cerebrovascular Diseases	4,249	51.4	49.8	52.9
	Chronic Lower Respiratory Diseases	2,958	36.3	35.0	37.6
	Diabetes Mellitus	2,178	26.2	25.1	27.3
	Chronic Liver Disease and Cirrhosis	1,053	11.8	11.1	12.5
	Homicide	1,063	10.2	9.6	10.9
	Hypertension / Hypertensive Renal Disease	715	8.7	8.0	9.3
	Suicide	727	7.6	7.0	8.2
	HIV	497	5.1	4.7	5.6
2004	Diseases of the Heart	18,072	211.6	208.5	214.7
	Malignant Neoplasms	7,092	83.3	81.4	85.3
	Cerebrovascular Diseases	4,121	48.6	47.1	50.1
	Chronic Lower Respiratory Diseases	2,783	33.4	32.1	34.6
	Diabetes Mellitus	2,201	25.9	24.8	27.0
	Chronic Liver Disease and Cirrhosis	1,035	11.4	10.7	12.0
	Homicide	1,069	10.2	9.6	10.8
	Hypertension / Hypertensive Renal Disease	819	9.6	8.9	10.3
	Suicide	694	7.1	6.6	7.7
	HIV	498	5.1	4.6	5.5
2005	Diseases of the Heart	18,063	206.5	203.4	209.5
	Malignant Neoplasms	7,179	82.6	80.7	84.5
	Cerebrovascular Diseases	3,774	43.4	42.1	44.8

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Chronic Lower Respiratory Diseases	2,933	34.3	33.0	35.5
	Diabetes Mellitus	2,305	26.5	25.4	27.6
	Chronic Liver Disease and Cirrhosis	1,058	11.3	10.7	12.0
	Homicide	1,065	10.1	9.5	10.7
	Hypertension / Hypertensive Renal Disease	869	9.9	9.3	10.6
	Suicide	695	7.1	6.6	7.6
	HIV	438	4.4	4.0	4.8
2006	Diseases of the Heart	17,899	201.7	198.7	204.7
	Malignant Neoplasms	6,958	78.4	76.6	80.3
	Cerebrovascular Diseases	3,622	41.0	39.7	42.3
	Chronic Lower Respiratory Diseases	2,836	32.8	31.5	34.0
	Diabetes Mellitus	2,188	24.7	23.6	25.7
	Chronic Liver Disease and Cirrhosis	1,102	11.5	10.8	12.1
	Hypertension / Hypertensive Renal Disease	898	10.1	9.5	10.8
	Homicide	1,043	9.9	9.3	10.5
	Suicide	662	6.6	6.1	7.1
	HIV	414	4.1	3.7	4.5
2007	Diseases of the Heart	17,213	185.2	182.4	188.0
	Malignant Neoplasms	6,990	76.5	74.7	78.4
	Cerebrovascular Diseases	3,322	36.0	34.7	37.2
	Chronic Lower Respiratory Diseases	2,772	30.8	29.6	31.9
	Diabetes Mellitus	2,127	23.3	22.3	24.3
	Chronic Liver Disease and Cirrhosis	1,133	11.6	10.9	12.3
	Hypertension / Hypertensive Renal Disease	864	9.3	8.7	10.0
	Homicide	868	8.1	7.6	8.7
	Suicide	667	6.6	6.1	7.1
	HIV	391	3.9	3.5	4.2
Age-adjusted Mortality Rate per 100,000 Population					

Table 3. Age-adjusted Mortality Rates from Selected Causes*
in Los Angeles County in Selected Spas (6, 7, and 8) from 2000 to 2007
Stratified by Year, Underlying Cause.

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2000	Diseases of the Heart	7,359	276.7	270.4	283.1
	Malignant Neoplasms	2,766	100.2	96.4	103.9
	Cerebrovascular Diseases	1,727	65.0	61.9	68.0
	Chronic Lower Respiratory Diseases	1,162	43.5	41.0	46.0
	Diabetes Mellitus	847	30.8	28.7	32.9
	Chronic Liver Disease and Cirrhosis	479	16.0	14.6	17.5
	Homicide	610	15.6	14.4	16.9
	Hypertension / Hypertensive Renal Disease	263	9.9	8.7	11.1
	Suicide	223	6.8	5.9	7.7
	HIV	198	5.8	5.0	6.7
	2001	Diseases of the Heart	7,487	278.2	271.9
Malignant Neoplasms		2,749	98.2	94.5	101.9
Cerebrovascular Diseases		1,660	61.9	58.9	64.9
Chronic Lower Respiratory Diseases		1,198	44.5	41.9	47.0
Diabetes Mellitus		848	30.4	28.3	32.4
Homicide		619	15.3	14.1	16.5
Chronic Liver Disease and Cirrhosis		425	13.9	12.5	15.2
Hypertension / Hypertensive Renal Disease		291	10.8	9.6	12.1
Suicide		260	7.5	6.6	8.5
HIV		229	6.5	5.7	7.4
2002		Diseases of the Heart	7,354	262.0	256.0
	Malignant Neoplasms	2,662	92.4	88.8	95.9
	Cerebrovascular Diseases	1,566	56.0	53.3	58.8
	Chronic Lower Respiratory Diseases	1,101	39.3	37.0	41.6
	Diabetes Mellitus	939	32.7	30.6	34.7

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Homicide	674	16.5	15.3	17.8
	Chronic Liver Disease and Cirrhosis	466	14.6	13.3	15.9
	Hypertension / Hypertensive Renal Disease	295	10.5	9.3	11.7
	Suicide	245	7.0	6.1	7.9
	HIV	214	5.9	5.1	6.7
2003	Diseases of the Heart	7,389	252.5	246.7	258.3
	Malignant Neoplasms	2,768	92.9	89.4	96.3
	Cerebrovascular Diseases	1,556	53.5	50.8	56.1
	Chronic Lower Respiratory Diseases	1,189	41.1	38.7	43.4
	Diabetes Mellitus	962	32.3	30.3	34.4
	Homicide	624	15.2	14.0	16.4
	Chronic Liver Disease and Cirrhosis	438	13.6	12.3	14.9
	Hypertension / Hypertensive Renal Disease	303	10.4	9.3	11.6
	Suicide	235	6.6	5.7	7.4
	HIV	201	5.6	4.8	6.4
2004	Diseases of the Heart	6,920	228.5	223.1	233.9
	Malignant Neoplasms	2,783	90.9	87.5	94.3
	Cerebrovascular Diseases	1,541	51.4	48.8	53.9
	Chronic Lower Respiratory Diseases	1,134	38.2	36.0	40.4
	Diabetes Mellitus	924	30.1	28.2	32.1
	Homicide	641	15.4	14.2	16.6
	Chronic Liver Disease and Cirrhosis	430	13.1	11.8	14.3
	Hypertension / Hypertensive Renal Disease	342	11.3	10.1	12.5
	Suicide	225	6.2	5.4	7.0
	HIV	212	5.8	5.0	6.6
2005	Diseases of the Heart	6,900	222.3	217.1	227.6
	Malignant Neoplasms	2,668	85.5	82.3	88.8
	Cerebrovascular Diseases	1,474	47.8	45.3	50.2
	Chronic Lower Respiratory Diseases	1,150	37.6	35.4	39.8

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Diabetes Mellitus	995	31.9	29.9	33.9
	Homicide	663	15.9	14.7	17.2
	Chronic Liver Disease and Cirrhosis	437	12.9	11.7	14.2
	Hypertension / Hypertensive Renal Disease	360	11.7	10.5	12.9
	Suicide	213	5.8	5.0	6.6
	HIV	180	4.9	4.2	5.6
2006	Diseases of the Heart	6,864	217.6	212.4	222.8
	Malignant Neoplasms	2,661	83.8	80.6	87.0
	Cerebrovascular Diseases	1,370	43.2	40.9	45.6
	Chronic Lower Respiratory Diseases	1,072	34.6	32.5	36.7
	Diabetes Mellitus	965	30.2	28.3	32.1
	Homicide	615	14.7	13.5	15.8
	Chronic Liver Disease and Cirrhosis	439	12.7	11.5	13.9
	Hypertension / Hypertensive Renal Disease	385	12.2	11.0	13.4
	Suicide	208	5.6	4.8	6.4
	HIV	153	4.1	3.5	4.8
2007	Diseases of the Heart	6,627	200.8	195.9	205.6
	Malignant Neoplasms	2,654	81.3	78.1	84.4
	Cerebrovascular Diseases	1,347	40.8	38.6	43.0
	Chronic Lower Respiratory Diseases	1,076	33.5	31.5	35.5
	Diabetes Mellitus	924	28.1	26.3	29.9
	Chronic Liver Disease and Cirrhosis	505	14.4	13.1	15.6
	Homicide	498	11.8	10.7	12.8
	Hypertension / Hypertensive Renal Disease	337	10.2	9.1	11.3
	Suicide	208	5.5	4.7	6.3
	HIV	174	4.7	4.0	5.4
Age-adjusted Mortality Rate per 100,000 Population					

Table 3. Age-adjusted Mortality Rates from Selected Causes*
in Los Angeles County in SPA 6 from 2000 to 2007 Stratified
by Year, Underlying Cause.

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2000	Diseases of the Heart	1,842	322.1	307.3	336.9
	Malignant Neoplasms	710	121.1	112.2	130.1
	Cerebrovascular Diseases	455	79.5	72.2	86.8
	Diabetes Mellitus	247	41.9	36.6	47.2
	Chronic Lower Respiratory Diseases	220	38.0	32.9	43.1
	Homicide	311	31.0	27.4	34.6
	Hypertension / Hypertensive Renal Disease	102	17.9	14.4	21.4
	Chronic Liver Disease and Cirrhosis	117	17.7	14.4	20.9
	HIV	83	10.9	8.5	13.3
	Suicide	46	5.4	3.8	7.0
2001	Diseases of the Heart	1,923	335.4	320.3	350.5
	Malignant Neoplasms	703	119.5	110.6	128.4
	Cerebrovascular Diseases	434	75.6	68.4	82.7
	Diabetes Mellitus	237	40.1	34.9	45.2
	Chronic Lower Respiratory Diseases	224	38.6	33.5	43.7
	Homicide	337	31.6	28.2	35.1
	Hypertension / Hypertensive Renal Disease	102	17.7	14.3	21.2
	Chronic Liver Disease and Cirrhosis	110	16.7	13.6	19.9
	HIV	90	10.9	8.6	13.2
	Suicide	44	4.9	3.4	6.4
2002	Diseases of the Heart	1,918	319.8	305.4	334.2
	Malignant Neoplasms	706	116.9	108.3	125.6
	Cerebrovascular Diseases	403	67.1	60.5	73.7
	Diabetes Mellitus	286	47.1	41.6	52.6
	Chronic Lower Respiratory Diseases	237	39.0	33.9	44.0

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Homicide	355	33.5	29.9	37.1
	Hypertension / Hypertensive Renal Disease	107	17.8	14.4	21.2
	Chronic Liver Disease and Cirrhosis	119	17.0	13.9	20.1
	HIV	87	10.4	8.1	12.6
	Suicide	44	5.3	3.6	6.9
2003	Diseases of the Heart	1,871	303.9	290.1	317.8
	Malignant Neoplasms	697	111.6	103.3	120.0
	Cerebrovascular Diseases	401	64.9	58.5	71.3
	Diabetes Mellitus	289	45.9	40.5	51.2
	Chronic Lower Respiratory Diseases	213	34.7	30.0	39.4
	Homicide	315	29.3	26.0	32.7
	Hypertension / Hypertensive Renal Disease	106	17.5	14.1	20.8
	Chronic Liver Disease and Cirrhosis	106	14.7	11.9	17.5
	HIV	96	11.5	9.2	13.9
	Suicide	41	4.5	3.0	5.9
2004	Diseases of the Heart	1,742	275.1	262.1	288.1
	Malignant Neoplasms	720	112.0	103.7	120.2
	Cerebrovascular Diseases	407	64.7	58.4	71.0
	Diabetes Mellitus	258	39.8	34.9	44.7
	Chronic Lower Respiratory Diseases	229	36.8	32.0	41.7
	Homicide	356	32.4	29.0	35.9
	Hypertension / Hypertensive Renal Disease	123	19.4	16.0	22.9
	Chronic Liver Disease and Cirrhosis	118	16.6	13.5	19.6
	HIV	106	12.7	10.2	15.1
	Suicide	46	5.0	3.5	6.5
2005	Diseases of the Heart	1,722	264.7	252.1	277.3
	Malignant Neoplasms	697	107.2	99.2	115.2
	Cerebrovascular Diseases	376	58.2	52.3	64.2
	Diabetes Mellitus	294	44.8	39.7	50.0

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Chronic Lower Respiratory Diseases	246	37.8	33.1	42.6
	Homicide	372	34.1	30.6	37.7
	Hypertension / Hypertensive Renal Disease	117	18.1	14.8	21.4
	Chronic Liver Disease and Cirrhosis	102	13.6	11.0	16.3
	HIV	76	8.8	6.8	10.8
	Suicide	33	3.4	2.2	4.7
2006	Diseases of the Heart	1,728	262.7	250.2	275.2
	Malignant Neoplasms	676	101.8	94.0	109.5
	Cerebrovascular Diseases	349	51.9	46.4	57.4
	Diabetes Mellitus	256	37.9	33.2	42.6
	Chronic Lower Respiratory Diseases	224	33.6	29.2	38.1
	Homicide	310	27.9	24.7	31.1
	Hypertension / Hypertensive Renal Disease	144	22.1	18.4	25.7
	Chronic Liver Disease and Cirrhosis	120	15.5	12.7	18.3
	HIV	57	6.8	5.0	8.6
	Suicide	46	4.8	3.4	6.2
2007	Diseases of the Heart	1,636	239.3	227.6	251.0
	Malignant Neoplasms	663	98.3	90.7	105.8
	Cerebrovascular Diseases	377	55.3	49.7	60.9
	Diabetes Mellitus	275	40.1	35.3	44.9
	Chronic Lower Respiratory Diseases	197	29.2	25.1	33.3
	Homicide	245	21.9	19.1	24.7
	Hypertension / Hypertensive Renal Disease	124	18.3	15.1	21.5
	Chronic Liver Disease and Cirrhosis	122	15.9	13.1	18.8
	HIV	76	9.0	7.0	11.1
	Suicide	38	4.0	2.7	5.3
Age-adjusted Mortality Rate per 100,000 Population					

Table 3. Age-adjusted Mortality Rates from Selected Causes*
in Los Angeles County in SPA 7 from 2000 to 2007 Stratified
by Year, Underlying Cause.

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2000	Diseases of the Heart	2,376	257.9	247.5	268.3
	Malignant Neoplasms	882	92.3	86.2	98.4
	Cerebrovascular Diseases	527	57.3	52.4	62.2
	Chronic Lower Respiratory Diseases	375	40.6	36.5	44.7
	Diabetes Mellitus	315	33.2	29.5	36.9
	Chronic Liver Disease and Cirrhosis	197	19.4	16.7	22.2
	Hypertension / Hypertensive Renal Disease	82	8.8	6.9	10.8
	Homicide	106	7.9	6.4	9.5
	Suicide	76	6.8	5.3	8.4
	HIV	32	2.8	1.8	3.8
2001	Diseases of the Heart	2,360	253.8	243.5	264.1
	Malignant Neoplasms	821	84.5	78.7	90.3
	Cerebrovascular Diseases	493	53.0	48.3	57.7
	Chronic Lower Respiratory Diseases	378	40.5	36.4	44.6
	Diabetes Mellitus	337	34.9	31.2	38.7
	Chronic Liver Disease and Cirrhosis	161	15.4	13.0	17.8
	Hypertension / Hypertensive Renal Disease	96	10.4	8.4	12.5
	Homicide	107	7.7	6.2	9.2
	Suicide	82	6.7	5.2	8.1
	HIV	42	3.6	2.5	4.8
2002	Diseases of the Heart	2,279	233.5	223.9	243.1
	Malignant Neoplasms	784	78.3	72.8	83.8
	Cerebrovascular Diseases	513	52.5	47.9	57.0
	Chronic Lower Respiratory Diseases	348	35.8	32.0	39.6
	Diabetes Mellitus	350	35.3	31.6	39.0

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Chronic Liver Disease and Cirrhosis	185	17.1	14.6	19.6
	Homicide	129	9.0	7.4	10.5
	Hypertension / Hypertensive Renal Disease	85	8.9	7.0	10.8
	Suicide	70	5.7	4.4	7.1
	HIV	42	3.4	2.4	4.5
2003	Diseases of the Heart	2,284	221.0	211.9	230.1
	Malignant Neoplasms	832	80.1	74.6	85.5
	Cerebrovascular Diseases	479	46.4	42.2	50.5
	Chronic Lower Respiratory Diseases	419	41.0	37.0	44.9
	Diabetes Mellitus	336	32.3	28.8	35.7
	Chronic Liver Disease and Cirrhosis	177	16.2	13.8	18.5
	Hypertension / Hypertensive Renal Disease	97	9.4	7.5	11.3
	Homicide	117	8.2	6.7	9.7
	Suicide	80	6.5	5.0	7.9
	HIV	38	3.2	2.2	4.2
2004	Diseases of the Heart	2,190	203.7	195.1	212.3
	Malignant Neoplasms	843	78.9	73.5	84.2
	Cerebrovascular Diseases	499	46.6	42.5	50.7
	Chronic Lower Respiratory Diseases	385	36.5	32.9	40.2
	Diabetes Mellitus	356	33.4	29.9	36.9
	Chronic Liver Disease and Cirrhosis	173	15.5	13.2	17.8
	Hypertension / Hypertensive Renal Disease	107	9.9	8.0	11.8
	Homicide	108	7.4	6.0	8.8
	Suicide	67	5.3	4.0	6.6
	HIV	35	2.8	1.9	3.7
2005	Diseases of the Heart	2,200	199.8	191.5	208.2
	Malignant Neoplasms	808	74.2	69.1	79.3
	Cerebrovascular Diseases	460	42.0	38.2	45.9
	Diabetes Mellitus	381	34.8	31.3	38.3

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Chronic Lower Respiratory Diseases	341	31.4	28.1	34.8
	Chronic Liver Disease and Cirrhosis	176	15.4	13.2	17.7
	Hypertension / Hypertensive Renal Disease	105	9.6	7.7	11.4
	Homicide	130	9.0	7.4	10.5
	Suicide	67	5.4	4.1	6.6
	HIV	35	2.9	1.9	3.8
2006	Diseases of the Heart	2,216	197.6	189.3	205.8
	Malignant Neoplasms	801	72.3	67.3	77.4
	Cerebrovascular Diseases	421	37.5	33.9	41.1
	Diabetes Mellitus	366	32.8	29.5	36.2
	Chronic Lower Respiratory Diseases	342	31.3	28.0	34.6
	Chronic Liver Disease and Cirrhosis	163	14.0	11.8	16.1
	Hypertension / Hypertensive Renal Disease	112	9.8	8.0	11.6
	Homicide	126	8.6	7.1	10.2
	Suicide	57	4.4	3.3	5.6
	HIV	31	2.5	1.6	3.3
2007	Diseases of the Heart	2,117	180.1	172.4	187.8
	Malignant Neoplasms	807	70.7	65.8	75.7
	Cerebrovascular Diseases	435	37.0	33.5	40.5
	Chronic Lower Respiratory Diseases	378	33.0	29.7	36.4
	Diabetes Mellitus	310	27.0	24.0	30.0
	Chronic Liver Disease and Cirrhosis	199	16.7	14.4	19.1
	Hypertension / Hypertensive Renal Disease	95	7.9	6.3	9.6
	Homicide	108	7.3	5.9	8.7
	Suicide	65	5.0	3.8	6.2
	HIV	28	2.2	1.4	3.0
Age-adjusted Mortality Rate per 100,000 Population					

Table 3. Age-adjusted Mortality Rates from Selected Causes*
in Los Angeles County in SPA 8 from 2000 to 2007 Stratified
by Year, Underlying Cause.

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2000	Diseases of the Heart	3,141	269.5	260.0	278.9
	Malignant Neoplasms	1,174	96.2	90.7	101.7
	Cerebrovascular Diseases	745	64.0	59.4	68.6
	Chronic Lower Respiratory Diseases	567	48.3	44.3	52.2
	Diabetes Mellitus	285	23.5	20.7	26.2
	Homicide	193	12.6	10.8	14.4
	Chronic Liver Disease and Cirrhosis	165	12.5	10.6	14.4
	Suicide	101	7.3	5.9	8.7
	Hypertension / Hypertensive Renal Disease	79	6.8	5.3	8.3
	HIV	83	5.6	4.4	6.8
2001	Diseases of the Heart	3,204	270.0	260.6	279.4
	Malignant Neoplasms	1,225	98.9	93.3	104.5
	Cerebrovascular Diseases	733	62.3	57.8	66.9
	Chronic Lower Respiratory Diseases	596	50.3	46.3	54.4
	Diabetes Mellitus	274	22.2	19.6	24.8
	Chronic Liver Disease and Cirrhosis	154	11.3	9.5	13.1
	Homicide	175	11.2	9.5	12.9
	Suicide	134	9.5	7.9	11.1
	Hypertension / Hypertensive Renal Disease	93	7.8	6.2	9.4
	HIV	97	6.3	5.1	7.6
2002	Diseases of the Heart	3,157	257.0	248.0	266.0
	Malignant Neoplasms	1,172	92.0	86.7	97.3
	Cerebrovascular Diseases	650	53.7	49.5	57.8
	Chronic Lower Respiratory Diseases	516	42.1	38.5	45.7
	Diabetes Mellitus	303	23.6	20.9	26.2

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Homicide	190	12.0	10.3	13.7
	Chronic Liver Disease and Cirrhosis	162	11.5	9.8	13.3
	Suicide	131	8.9	7.3	10.4
	Hypertension / Hypertensive Renal Disease	103	8.4	6.8	10.0
	HIV	85	5.5	4.3	6.6
2003	Diseases of the Heart	3,234	253.5	244.7	262.2
	Malignant Neoplasms	1,239	94.1	88.9	99.4
	Cerebrovascular Diseases	676	53.6	49.6	57.7
	Chronic Lower Respiratory Diseases	557	44.1	40.4	47.8
	Diabetes Mellitus	337	25.8	23.1	28.6
	Homicide	192	12.2	10.5	13.9
	Chronic Liver Disease and Cirrhosis	155	11.0	9.2	12.7
	Hypertension / Hypertensive Renal Disease	100	7.9	6.4	9.5
	Suicide	114	7.6	6.2	9.0
	HIV	67	4.3	3.3	5.4
2004	Diseases of the Heart	2,988	226.7	218.5	234.8
	Malignant Neoplasms	1,220	90.5	85.4	95.6
	Cerebrovascular Diseases	635	49.0	45.2	52.8
	Chronic Lower Respiratory Diseases	520	40.1	36.7	43.6
	Diabetes Mellitus	310	23.0	20.4	25.6
	Homicide	177	11.0	9.4	12.7
	Chronic Liver Disease and Cirrhosis	139	9.6	8.0	11.2
	Hypertension / Hypertensive Renal Disease	112	8.6	7.0	10.2
	Suicide	112	7.5	6.1	8.9
	HIV	71	4.5	3.5	5.6
2005	Diseases of the Heart	2,978	220.4	212.5	228.4
	Malignant Neoplasms	1,163	84.5	79.6	89.4
	Cerebrovascular Diseases	638	47.6	43.9	51.4
	Chronic Lower Respiratory Diseases	563	42.5	39.0	46.1

Year	Underlying Cause	Total Deaths**	Mortality Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit
	Diabetes Mellitus	320	23.3	20.8	25.9
	Chronic Liver Disease and Cirrhosis	159	10.7	9.0	12.4
	Hypertension / Hypertensive Renal Disease	138	10.4	8.6	12.1
	Homicide	161	10.0	8.5	11.6
	Suicide	113	7.4	6.1	8.8
	HIV	69	4.4	3.3	5.4
2006	Diseases of the Heart	2,920	212.8	205.1	220.6
	Malignant Neoplasms	1,184	84.2	79.4	89.1
	Cerebrovascular Diseases	600	43.7	40.2	47.2
	Chronic Lower Respiratory Diseases	506	37.5	34.3	40.8
	Diabetes Mellitus	343	24.6	22.0	27.2
	Homicide	179	11.2	9.5	12.8
	Chronic Liver Disease and Cirrhosis	156	10.2	8.6	11.8
	Hypertension / Hypertensive Renal Disease	129	9.4	7.8	11.1
	Suicide	105	6.8	5.5	8.2
	HIV	65	4.0	3.0	5.0
2007	Diseases of the Heart	2,874	199.4	192.1	206.8
	Malignant Neoplasms	1,184	82.0	77.3	86.7
	Cerebrovascular Diseases	535	37.2	34.1	40.4
	Chronic Lower Respiratory Diseases	501	35.7	32.6	38.9
	Diabetes Mellitus	339	23.3	20.8	25.7
	Chronic Liver Disease and Cirrhosis	184	11.8	10.0	13.5
	Homicide	145	8.9	7.5	10.4
	Hypertension / Hypertensive Renal Disease	118	8.2	6.7	9.7
	Suicide	105	6.7	5.4	8.0
	HIV	70	4.3	3.3	5.4
Age-adjusted Mortality Rate per 100,000 Population					

End Notes

ⁱ The Self-Sufficiency Standard (Standard) was developed to provide a more accurate, nuanced, and up-to-date measure of income adequate for basic needs. While designed to address the major shortcomings of the FPL, the Standard also reflects the realities faced by today's working parents, such as child care and taxes. The Standard is a "bare bones" budget appropriate to family composition; it does not include any restaurant or take-out food, savings, emergency funds, or credit card or loan payments. The Standard is calculated for 37 states and the District of Columbia. It uses data that are drawn from scholarly and/or credible sources such as the U.S. Census Bureau, and that meets strict criteria of being accurate, regularly updated using standardized and consistent methodology, and which is age- and/or geography-specific. For California, the Standard is calculated for all 58 counties and 156 possible household combinations. The 2008 calculation for the Standard in L.A. County is \$26,430 for a single adult, \$52,090 for two adults and an infant, and \$64,166 for two adults, an infant and a preschooler; by comparison, the 2009 annual FPL for the aforementioned family-types is \$10,830, \$18,310, and \$22,050 respectively.

ⁱⁱ Pearce, Diana M. (2009). *Overlooked and Undercounted 2009: Struggling to make ends meet in California*. San Francisco, CA: United Way of the Bay Area.

ⁱⁱⁱ Los Angeles County Senior Services Initiative. (2009). *Seamless Senior Services*.

^{iv} The Elder Economic Security Standard Index is the basic income needed to make ends meet for retired persons ages 65 and older. It reflects actual costs at the county level and varies by housing type and health status. The annual amounts shown are for individuals and couples who own their residences (with and without a mortgage) and who rent. The amount shown is for elders in good health (the median health status). Unlike the Elder Index, the FPL is uniform across the United States and was designed in the 1960s based on consumption patterns of the 1950s. Not only have consumption patterns changed significantly since then, but the FPL fails to account for the above-average costs of housing and other expenses in California.

^v UCLA Center for Health Policy Research. (2010). *Los Angeles County (excluding LA City), CA 2009 Elder Economic Security Standard™ Index Elder Index Per Year, Annual Comparisons, and Basic Monthly Expenses for Selected Household Types*. Accessed from http://www.healthpolicy.ucla.edu/eess0910_pdf/Los-Angeles.pdf on 09/20/2010.

^{vi} The printed survey was available in seven languages including English, Spanish, Chinese, Tagalog, Korean, Armenian and Japanese.

^{vii} Community and Senior Services. (2010). *L.A. County Seniors Count!: Survey of the Older Adult Population*. Los Angeles, CA: County of Los Angeles.

^{viii} Office of Health Assessment and Epidemiology (2010). *Informal Caregiving: Implications for Public Health*, LA Health. Los Angeles, CA: County of Los Angeles Department of Public Health.

^{ix} Lavarreda, Shana A. Et al. (2010). *Number of Uninsured Jumped to More Than Eight Million from 2007 to 2009*. Los Angeles, CA: UCLA Center for Health Policy Research.

^x The following L.A. County estimates are based on projected estimates of 2009 insurance status from a predictive model that simulated 2009 insurance status using changes in unemployment rates by county from the California Employment Development Department (EDD) and the 2007 California Health Interview Survey (CHIS).

^{xi} Type of Insurance Coverage Data obtained from ASK CHIS data base at <http://www.chis.ucla.edu> on 09/24/2010.

^{xii} Office of Health Assessment and Epidemiology. (2009; 2007; 2005). *Key Indicators of Health by Service Planning Area*. Los Angeles, CA: County of Los Angeles Department of Public Health.

^{xiii} Lui, Camillia, Wallace, Steven P. (2010). *Chronic Conditions of Californians 2007 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research.

^{xiv} Diamant Allison L., Susan H. Babey, Joelle Wolstein and Malia Jones. (2010). *Obesity and Diabetes: Two Growing Epidemics in California*. Los Angeles, CA: UCLA Center for Health Policy Research.

^{xv} Sexually Transmitted Disease Program. (2009). *STD Clinic Morbidity Report*. Los Angeles, CA: County of Los Angeles Public Health. Accessed from http://publichealth.lacounty.gov/std/docs/STDclinicreport2009_final.pdf on 07/10/2010.

^{xvi} Office of Health Assessment and Epidemiology. (2009). *Key Indicators of Health by Service Planning Area, 2002-03*. Los Angeles, CA: County of Los Angeles Department of Public Health.

^{xvii} Meyer, David. (2009). *Brief Report of the TB Burden in Los Angeles County*. *The Public's Health* (9): 3.

^{xviii} HIV Epidemiology Program. (2009). *An Epidemiologic Profile of HIV and AIDS in Los Angeles County*. Los Angeles, CA: County of Los Angeles Department of Public Health.

^{xix} Office of Health Assessment and Epidemiology (2010). Mortality in Los Angeles County 2007: Leading causes of death and premature death with trends for 1998-2007. Los Angeles, CA: County of Los Angeles Department of Public Health.

^{xx} DeCarli, James, M. MPH, MPA, CHES. (2008). Intimate Partner Violence & Depression Awareness. The Public's Health, News letter for medical professionals in Los Angeles County (8) 9.

^{xxi} Zahnd, Elaine, David Grant, May Aydin, Y. Jenny Chia and Imelda Padilla-Frausto. (2010). Nearly Four Million California Adults Are Victims of Intimate Partner Violence. Health Policy Research Brief. Los Angeles, CA: UCLA Center for Health Policy Research.

Profile of SFMC's Service Area Demographic and Health Status Information – 2010

Key Health Indicators ⁱ	2002	2005	2007	2002-03			2005			2007		
	LA	LA	LA	SPA6	SPA7	SPA8	SPA6	SPA7	SPA8	SPA6	SPA7	SPA8
Rate of births (per 1,000 live births) to teens ages 15-19	44.4	93.6	40.0	85.7	50.8	40.8	149.6	101.0	86.4	74.1	42.7	35.3
Infant death rate (per 1,000 live births)	5.4	5.0	4.9	6.5	4.7	5.0	6.0	4.2	5.1	5.4	4.7	5.0
Percent of low weight (<2,500 grams) births (per 100 live births)	6.7%	7.1%	7.4%	7.3%	6.1%	6.7%	8.3%	6.3%	7.3%	8.5%	6.9%	7.5%
Percent of all live births where mother received late (2nd or 3rd trimester) or no prenatal care	13.5%	10.1%	9.3%	19.1%	14.3%	13.6%	13.4%	11.9%	8.7%	11.8%	9.7%	9.7%
Percent of children 0-5 years for whom parents report difficulty finding child care	37.6% ²	35.8%	36.9%	43.4% ²	37.3% ²	29.2%	48.6%	29.2%	31.1%	35.2%	40.0%	40.4%
Percent of adults ever diagnosed with diabetes	7.0%	8.1%	8.7%	9.1%	9.0%	7.8%	11.7%	9.7%	8.3%	12.3%	11.0%	8.8%
Diabetes death rate (age adjusted per 100,000)	22.9	25.3	24.7	38.3	33.2	21.0	39.2	33.1	22.5	37.9	32.8	24.6
Coronary heart disease death rate (age-adjusted per 100,000)	199.9	176.1	167.6	268.3	203.1	211.7	229.7	172.9	187.8	217.6	164.0	172.5
Percent of adults with current asthma	6.1%	6.5%	6.5%	6.9%	6.2%	6.6%	7.2%	5.1%	6.7%	8.2%	5.5%	8.0%
Percent of children ages 0-17 with current asthma	7.9%	8.8%	7.9%	5.9%	6.9%	9.8%	9.0%	8.8%	11.0%	7.8%	8.8%	9.5%
Prostate Cancer (age-adjusted per 100,000) ⁱⁱ	25.7	23.4	22.2	51.3	27.6	24.7	37.6	18.3	29.3	44.2	15.8	24.0
Lung Cancer (age-adjusted per 100,000)	39.8	35.3	34.6	51.0	35.7	44.3	46.0	34.3	39.7	42.0	30.0	36.0
Breast Cancer (age-adjusted per 100,000)	23.5	23.1	20.7	22.6	22.8	26.2	27.8	21.1	25.3	24.0	22.0	22.0
Cervical Cancer (age-adjusted per 100,000)	3.5	1.5	3.3	6.9	3.9	5.8	N/A	3.5	3.0	4.6	5.1	3.8
Colorectal Cancer (age-adjusted per 100,000)	16.0	16.2	15.3	22.0	15.0	16.0	23.2	14.8	16.8	21.4	14.4	15.0
Incidence of AIDS (annual new cases per 100,000 population (ages 13+ years))	15.8	11.5	12.8	18.0	8.7	20.6	15.9	5.8	18.9	16.4	5.2	22.4
Incidence of primary and secondary Syphilis (annual new cases per 100,000)	4.0	6.8	8.7	2.5	1.5	2.3	7.6	3.4	3.7	8.6	6.2	4.1
Incidence of Gonorrhea (annual new cases per 100,000)	N/A	N/A	96.1	N/A	N/A	N/A	N/A	N/A	N/A	270.2	51.7	104.0
Incidence of Chlamydia (annual new cases per 100,000)	N/A	N/A	421.6	N/A	N/A	N/A	N/A	N/A	N/A	922.2	373.6	412.4
Incidence of Tuberculosis (annual new cases per 100,000)	11.1	9.4	8.4	12.4	8.9	10.3	12.0	7.1	8.1	10.6	6.5	8.1
Percent of adults ever diagnosed with depression	9.7%	12.9%	13.6%	7.0%	9.7%	9.4%	12.2%	13.2%	13.7%	13.6%	13.4%	13.8%

Note: Highlights in **Bold Red** = rates or percentages that are worse than all SPAs combined; **Bold** = Better than all SPAs combined.

Key Health Indicators	2002	2005	2007	2002-03			2005			2007-08		
	LA	LA	LA	SPA6	SPA7	SPA8	SPA6	SPA7	SPA8	SPA6	SPA7	SPA8
Percent of adults with frequent mental distress (14 or more days in past month)	N/A	N/A	9.3%	N/A	N/A	N/A	N/A	N/A	N/A	13.7%	10.1%	9.3%
Percent of adults who believe their neighborhood is safe from crime	79.4%	80.9%	82.1%	54.4%	80.9%	80.9%	57.7%	82.6%	82.8%	57.0%	82.4%	81.8%
Percent of adults who binge drink (men who had 5+, women 4+ drinks on at least one occasion in past 30 days)	17.1%	17.3%	16.2%	16.1%	19.1%	17.3%	13.7%	17.8%	17.6%	17.9%	18.5%	15.9%
Percent of teens ages 14-17 who consumed at least one alcoholic drink in past 30 days	41.6%	38.7%	24.6%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent of adults who smoke cigarettes	14.3%	13.9%	14.3%	14.2%	15.0%	16.9%	17.3%	10.7%	16.7%	19.7%	13.8%	15.5%
Percent of teens ages 14-17 who smoke cigarettes	13.9%	11.8%	12.8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent of children 0-17 regularly exposed to tobacco smoke at home one or more days in past week * New methodology-not comparable to previous years	N/A	N/A	13.2%	N/A	N/A	N/A	N/A	N/A	N/A	9.4%	17.3%	14.3%
Percent of Children (0-17 Years Old) Who Are Publicly Insured (CHIS)	34.5%	43.3%	47.7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent of adults ages 18-64 who are uninsured Publicly Insured	12.7%	17.7%	17.1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent of adults ages 18-64 who are uninsured	26.2%	21.8%	22.0%	36.4%	28.7%	22.5%	31.7%	23.2%	17.7%	32.9%	24.2%	17.9%
Percent of children ages 0-17 who are uninsured	10.3%	8.3%	7.0%	17.7%	10.2%	9.6%	11.3%	10.0%	7.1%	9.7%	8.9%	4.6%
Percent of adults with no regular source of healthcare	19.3%	19.8%	19.2%	21.1%	18.6%	15.9%	26.9%	19.1%	17.0%	20.9%	19.4%	16.5%
Percent of children ages 0-17 with no regular source of healthcare	6.6%	8.2%	7.4%	8.7%	5.9%	6.0%	12.0%	8.6%	6.8%	10.2%	7.3%	7.5%
Percent of adults who did not obtain dental care (including check-ups) in the past year because they could not afford it.	24.1%	25.6%	22.3%	27.2%	26.6%	22.1%	35.1%	26.7%	24.4%	28.8%	24.0%	22.1%
Percent of children ages 0-17 who did not obtain dental care (including check-ups) in the past year because they could not afford it.	N/A	17.1%	13.7%	N/A	N/A	N/A	18.6%	17.0%	17.2%	17.7%	15.0%	13.3%
Adults (50+years) vaccinated for influenza	N/A	40.7%	51.9%	N/A	N/A	N/A	32.4%	41.8%	37.5%	43.9%	50.4%	50.2%
Adults (65+) vaccinated for pneumonia	55.7%	57.7%	60.5%	44.2%	56.1%	55.0%	49.5%	55.6%	57.1%	51.1%	56.6%	63.9%
Women (40+ years) who had a mammogram <2 years ago	77.2%	70.6%	73.7%	78.5%	78.2%	78.8%	69.1%	74.6%	71.0%	72.0%	77.0%	73.3%
Percent of adult women who had a Pap smear within the last 3 years	85.2	83.8%	84.4%	90.4%	84.9%	87.4%	83.3%	84.9%	83.2%	88.3%	85.0%	84.8%

Key Health Indicators	2002	2005	2007	2002-03			2005			2007-08		
	LA	LA	LA	SPA6	SPA7	SPA8	SPA6	SPA7	SPA8	SPA6	SPA7	SPA8
Percent of Adults who obtain recommended amount of exercise each week	47.3%	51.8%	53.2%	44.5%	47.6%	44.6%	45.6%	51.5%	52.5%	51.6%	51.9%	53.7%
Percent of children ages 6-17 who obtain recommended amount of exercise each week	N/A	N/A	37.6%	N/A	N/A	N/A	N/A	N/A	N/A	34.4%	44.2%	42.0%
Percent of adults reporting fair to poor health	21.6%	20.6%	18.5%	30.1%	24.6%	21.0%	33.4%	23.2%	20.5%	27.1%	19.1%	17.4%
Percent of children ages 0-17 perceived by parents in fair to poor health	15.5%	12.7%	8.4%	24.6%	16.2%	12.4%	17.6%	13.1%	11.4%	12.3%	10.1%	8.2%
Average # unhealthy days due to poor physical/physical + mental health in the past month reported by adults	2.5	6.4	5.4	2.7	2.3	2.5	7.9	6.2	6.2	6.8	5.1	5.3
Percent of adults who provided care or assistance during past month to another adult living with long-term illness or disability	N/A	N/A	17.0%	N/A	N/A	N/A	N/A	N/A	N/A	16.6%	16.6%	17.7%
Percent of adults who are obese (BMI > 30%)	19.3%	20.9%	22.2%	30.0%	23.6%	21.2%	30.0%	27.3%	21.0%	35.4%	26.6%	24.4%
Percent of children in grades 5, 7, &9 who are obese (BMI > 95th percentile)	21.9%	23.3%	22.9%	26.8%	24.5%	21.1%	29.0%	26.5%	21.7%	28.9%	26.0%	21.3%
Percent of adults ever diagnosed with hypertension	20.1%	23.4%	24.7%	25.1%	19.9%	22.6%	29.0%	23.9%	24.5%	29.0%	25.3%	25.0%

ⁱ Office of Health Assessment and Epidemiology. (2009; 2007; 2005). Key Indicators of Health by Service Planning Area. Los Angeles, CA: County of Los Angeles Department of Public Health.

ⁱⁱ Accessed L.A. HealthDataNow!: Mortality Dataset <http://dqs.hasten.ladhs.org> on 09/24/2010. Los Angeles County Department of Public Health (2010).