2016

UCLA Medical Center, Santa Monica

Community Health Needs Assessment

UCLA Health

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Executive Summary

UCLA Medical Center, Santa Monica is a part of UCLA Health, a world-renowned, nonprofit academic medical center located in Los Angeles, California. UCLA Health has undertaken a Community Health Needs Assessment (CHNA) as required by state and federal law. California Senate Bill 697 and the Patient Protection and Affordable Care Act and IRS section 501(r) (3) direct tax-exempt hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years.

UCLA Medical Center, Santa Monica is located at 1250 16th Street, Santa Monica, California 90404. The service area includes 28 zip codes, representing 18 cities or communities, exclusively in Service Planning Area (SPA) 5 of Los Angeles County.

UCLA Health Service Area

Geographic Area	Zip Code
Bel Air	90077
Beverly Hills	90210, 90211, 90212
Brentwood	90049
Century City	90067
Culver City	90230, 90232
Ladera Heights	90056
Malibu	90263, 90265
Marina del Rey	90292
Pacific Palisades	90272
Palms	90034
Playa del Rey	90293
Playa Vista	90094
Santa Monica	90401, 90402, 90403, 90404, 90405
Venice / Mar Vista	90066, 90291
West Los Angeles	90025, 90035, 90064
Westchester	90045
Westwood	90024

Methods

Secondary Data Collection

Secondary data were collected from a variety of local, county, and state sources to present community demographics, social and economic factors, health care access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health and substance abuse and preventive practices. These data are presented in the context of Los Angeles County and California State, framing the scope of an issue as it relates to the broader community. The report also includes benchmark comparison data that measures UCLA Medical Center, Santa Monica data findings with Healthy People 2020 objectives.

Primary Data Collection

Targeted interviews were used to gather information and opinions from persons who represent the broad interests of the community served by the hospital. Given shared service areas, UCLA Health partnered with Cedars-Sinai Medical Center, Kaiser Foundation Hospital – West Los Angeles and Providence St. John's Health Center to conduct the interviews. Twenty-five (25) interviews were completed from September through November 2015.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, the previous UCLA Medical Center, Santa Monica Community Health Needs Assessment was made widely available to the public on the website and public comment was requested on the assessment report. To date, no written comments have been received.

Overview of Key Findings

This overview summarizes significant findings drawn from an analysis of the data from each section of the report. Full data descriptions, findings, and data sources follow.

Community Demographics

- The population of the UCLA Medical Center, Santa Monica service area is 656,039.
- Children and youth, ages 0-17, make up 16% of the population; 69.7% are adults, ages 18-64; and 14.3% of the population are seniors, ages 65 and over. The median age in the service area is 37.9.
- 60.2% of the service area population is White; 16.5% of residents are Hispanic/Latino; 13% are Asian; 6.2% are African American; and 4.1% are American Indian/Alaskan Native, multiple, or other race/ethnicity.
- English is spoken in the home among 64.4% of the service area population. Spanish is spoken at home among 13.3% of the population; 8.1% of the population speak an Asian language; and 11.8% of the population speaks an Indo-European language at home.

Social and Economic Factors

- In the service area, 11.9% of the population is at or below 100% of the federal poverty level (FPL). Close to one-quarter (24%) of the population in the service area is considered low-income, living at or below 200% of FPL.

Poverty Levels

	UCLA Health Service Area	Los Angeles County	California
<100% FPL	11.9%	17.8%	15.9%
<200% FPL	24.0%	40.3%	35.9%

Source: U.S. Census Bureau, American Community Survey, 2009-2013, S1701. http://factfinder.census.gov

- The median household income ranges from $54,373 in Palms to $168,036 in Bel Air.
- The unemployment rates in service area cities range from 4.8% in Malibu to 8.7% in Los Angeles City.
- Among adults, ages 25 and older, 6.3% of area adults lack a high school diploma, 10.4% of service area adults are high school graduates and 66.5% are college graduates.
- The high school graduation rate for LAUSD (70.2%) and Inglewood Unified School District (72.4%) are lower than the county (77.9%), and state (81%) rates. The Healthy People 2020 objective is an 82.4% high school graduation rate. Culver City (89.5%), Santa Monica-Malibu (92.4%) and Beverly Hills (92.6%) Unified School Districts meet the Healthy People 2020 high school graduation objective.
- Among the homeless population, 43% in SPA 5 are chronically homeless. The rates of chronic homelessness have increased from 2013 to 2015. Those who are homeless in SPA 5 have high rates of mental illness (40.9%) and 20.8% are homeless veterans.

Community Input – Social and Economic Factors

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

- Poverty is a huge issue for people. Lack of health care access drives a lot of disparities.
- A shortage of affordable housing is extreme. We are experiencing a demographic shift, where even the middle class is moving into homelessness.
- Poverty and unemployment impact health. Often, people don't think of poverty on the Westside, it is not visible.
- Whether from not having enough money to pay for basic needs or being around others who are stressed, stress is a driver of toxic environments. Stress and trauma are associated with socioeconomically disadvantaged neighborhoods.
- The top social issues are affordable housing, no matter the population or subpopulation, and transportation.
- The saying "zip code is more important than genetic code" is very clear. The environment contributes to issues of poverty and desperation in an area that doesn't have integrated health and wellness services.
- Housing should be at the top of the list of importance. Housing is a driver of everything else – health, education, jobs.

Health Care Access

- In SPA 5, 92.6% of the population is insured. When insurance coverage for the service area is examined by zip code, 11.8% of area residents are uninsured. There is a large variation between those areas with the best coverage in Bel Air, with 2.6% uninsured, and those with the highest percent of uninsured in Palms, with 20.9% uninsured.

Insurance Status

	SPA 5	Los Angeles County	California
Insured	92.6%	86.7%	88.1%
Uninsured	7.4%	13.3%	11.9%

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

- 17.9% of SPA 5 residents visited an ER over the period of a year, and youth visited the ER at the highest rates (28.3%).
- 14.4% of the residents of SPA 5 delayed or did not get medical care when needed, and 4.4% delayed or did not fill prescriptions.
- 11.3% of children in SPA 5 had never been to a dentist. 19.4% of adults reported not going to the dentist because they were unable to afford dental care.

Community Input – Access to Care

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

- Covered CA has done an amazing job. Healthy Way LA has opened up to help the uninsured in Los Angeles. But now people need to know how to get care, how to use insurance and obtain appointments.
- There are some fundamental issues around health access equity. There are not a lot of Medi-Cal providers and there aren't enough places to access care. There are numerous barriers, distrust of system and people don't have transportation or childcare. These are systemic reasons that society can address to increase access to care and preventive services.
- It can be very challenging to access good care for cultural issues. With the passage of the ACA many people are now eligible for care who were not before. In the last couple of years access has gotten better. Now the access issues have shifted from access to navigation of the system.
- Access to care is very serious, particularly with persons who are uninsured and undocumented, and especially within limited English populations. It is especially difficult to access specialty care. For primary care, it is a bit better with access to community and county clinics. The number of uninsured has decreased but people don't know how to use their benefits.

- Dental care is one of the top community health needs. Dentists who take Medi-Cal rates are needed. There are too few dentists caring for the underserved because reimbursement rates are so low.

Birth Characteristics

- In 2013, there were 6,900 births in the service area.
- Teen births occurred at a rate of 0.9% of total births in the service area.
- Pregnant women in the service area entered prenatal care in the first trimester at a rate of 92.7%. This rate exceeds the Healthy People 2020 objective of 78% of women entering prenatal care in the first trimester.
- The service area rate of low birth weight babies is 6.6% (65.8 per 1,000 live births). The service area rate meets the Healthy People 2020 objective of 7.8% of births being low birth weight.
- Breastfeeding rates at UCLA Medical Center, Santa Monica indicate 96.5% of new mothers use some breastfeeding and 72.4% use breastfeeding exclusively.

Leading Causes of Death

- Heart disease, cancer, and stroke are the top three leading causes of death in the service area. When compared to the county and state, the service area has higher death rates for the top three causes of death.
- In SPA 5, coronary heart disease was the leading cause of premature death, followed by suicide, drug overdose, motor vehicle crashes, and liver disease.

Chronic Disease

- Among the residents in SPA 5, 9.8% indicate they have fair or poor health status. The level of fair or poor health increases among seniors. In SPA 5, 19.3% of seniors consider themselves to be in fair/poor health.
- 7% of the population in SPA 5 has been diagnosed with asthma. Among those with asthma, 28.6% take medication to control their symptoms. Among youth, 7.8% have been diagnosed with asthma.
- 4.6% of adults in SPA 5 reported they have been diagnosed with diabetes. For adults with diabetes, 69.6% in SPA 5 were very confident they can control their diabetes, while 15.7% were not confident.
- For adults in SPA 5, 4.8% have been diagnosed with heart disease. Among these adults, 66.7% are very confident they can manage their condition.
- Rates of HIV/AIDS new diagnoses are highest among males, young adults 20-29, and Blacks/African Americans. 83% of the new cases were reportedly via male-to-male sexual contact, 10% via heterosexual sex, and 6% were cases where IV drug use was implicated.

Community Input – Chronic Disease

Stakeholder interviews identified the following issues, challenges and barriers related to chronic disease:

- Chronic disease is a very big public health issue. HIV rates in minorities are extraordinarily high compared to other groups. There are significant rates of STDs and they are pathways to the spread of HIV. There remains significant stigma to talk about sexual health and HIV among men of color.
- Asthma is particularly challenging. The school district has10-13% of kids with asthma on any given campus, and most of the time they are undiagnosed. A lot of collaboration is needed for kids and families to get connected to manage asthma in home and school environments. Diabetes Type 1 is also extremely challenging in the schools. The schools help coordinate care with insulin.
- Chronic disease is seen among low-income populations, Hispanics, African-Americans, homeless, seniors and immigrants. People that didn't have access to care for years are now going to the doctor and finding out that they have chronic diseases. With insurance, the numbers are increasing with new patients.
- Diabetes and heart disease are getting worse as more people are overweight and are developing pre-diabetes.
- Cancer has gotten worse in the past couple of years. There is low medical reimbursement and lack of understanding of the population on how to access services. More cultural and linguistically targeted education efforts are needed to encourage people to not wait until it's an emergency.

Health Behaviors

- In SPA 5, 38.8% of adults, 24% of teens, and 11.5% of children are overweight. Among adults in SPA 5, 14.5% are obese. This is better than the Healthy People 2020 objective for adult obesity of 30.5%. 16.7% of teens in SPA 5 are obese, which exceeds the Healthy People 2020 objective of 16.1% for teen obesity.

Adults, Ages 20+, Overweight and Obese by Race/Ethnicity

	SPA 5	Los Angeles County	California
African American	79.8%	83.5%	71.2%
Asian	38.6%	41.1%	43.7%
Latino	69.3%	72.6%	72.2%
White	54.1%	60.8%	58.9%

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

- Among adults, 95.8% in SPA 5 indicated that accessing fresh produce (fruits and vegetables) was somewhat or very easy.
- 9.4% of SPA 5 children and teens spend over five hours in sedentary activities after school on a typical weekday. 23.3% spend over 8 hours a day on

sedentary activities on weekend days.

Community Input – Overweight and Obesity

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

- Obesity is definitely a problem. Many kids have BMI over 99%. On the south-side of Santa Monica, kids have a greater number of high BMI over 95% that puts them at health risk.
- In some schools, 70% of kids fail the fitness test, speed coordination, balance, etc. Of that 70%, 30% fail every section. They aren't moving around, they are obese. A campus approach to healthy, active living is needed.
- Overweight/obesity is one of the biggest challenges for school districts. Obesity prevention programs exist right and left, some are more effective than others. Even though there are a lot of groups working on it, obesity has gotten worse in the past few years.

Mental Health and Substance Abuse

- Among adults, 9.0% in SPA 5 experienced serious psychological distress in the past year, while 20% needed help for mental health and/or alcohol and problems. 19.7% of adults saw a health care provider for their mental health and/or alcohol and drug issues in the past year.
- Among SPA 5 teens, 21.6% needed help in the past year for emotional or mental health problems, which was lower than county (22.4%) or state (23.2%) rates. Frequent mental distress was reported during the past month by 23.6% of area teens.
- 7.8% of adults in SPA 5 are current smokers, lower than the Healthy People 2020 objective for cigarette smoking among adults (12%). Among teens in SPA 5, 4.4% have smoked an electronic (vaporizer) cigarette.
- Among adults in SPA 5, 41.4% had engaged in binge drinking in the past year, which is a higher level than found in the county and state.
- Teens in SPA 5 reported having tried alcohol (20.6%) and illegal drugs (14.3%). More teens had used marijuana in the past year (14.3%).

Community Input – Mental Health and Substance Abuse

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

- Mental health is the hardest service for anyone to access, even for people with good insurance; all psychiatrists on the West side are cash only. As income goes down, the county jail is filled with homeless that are seriously mentally ill. It is a very challenging problem.

- Determining where to send kids in crisis is a continuous struggle as is where to obtain regular care. Mental health is a top priority. More crisis intervention and beds are needed.
- There are two issues with mental health. One is stigma, which is different among cultures; people need help learning how to talk about mental illness and seek treatment. The second issue is workforce. If more people started seeking care, will there be care resources available for them?
- Substance abuse is a big issue right next to mental health. There are major impacts in secondary and even middle school students. There is a lack of providers on the treatment side.
- There is not enough funding for substance abuse and not enough integration with mental health.
- In SPA 5 prescription drug overdose and managing medications is a huge issue, especially among higher income individuals and white males. There are significant rates of overdoses and suicide in this middle to upper class group.

Preventive Practices

- In SPA 5, 72.8% of seniors, 62.1% of children 6 months to 17 years of age, 43.4% of adults received a flu shot. Only SPA 5 seniors met the 70% Healthy People 2020 goal for flu vaccination. Area rates of compliance with childhood immunizations upon entry into kindergarten are below the state average (90.4%), with the exception of the Culver City Unified School District, which shows a high rate of compliance (94.1%).
- The Healthy People 2020 objective for mammograms is that 81.1% of women 50-74 years to have a mammogram in the past two years; in SPA 5, 82.5% of women 50-74 have had mammograms, which meets this objective.
- The Healthy People 2020 objective for Pap smears in the past three years is 93% of 21-65 year olds to be screened. In SPA 5, 83.5% of women 21-65 have had a Pap smear in the past three years. The Healthy People 2020 objective for colorectal cancer screening is 70.5% of 50-75 year olds to be screened; SPA 5 (78.5%) exceeds this screening objective.

Community Input – Preventive Practices

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

- It is essential that payment for health needs shift toward prevention. Fee for service has been a downfall. ACA should move society into doing more preventive care and helping people stay healthy.

- Schools are places where more can be done. Schools have a responsibility to see where medical care stops and the educational and wellness systems start. Schools are great places to do more early screenings and interventions.
- The system is set up so there is an emphasis on taking care of really sick people versus preventive care. Why are there so many people with chronic conditions that could have been prevented? More investment in prevention is needed.

Identification of Significant Health Needs

Significant health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of the problem, the health need indicators identified in the secondary data were measured against benchmark data, specifically county rates, state rates and/or Healthy People 2020 objectives. Indicators related to the health needs that performed poorly against one or more of these benchmarks met this criterion to be considered a significant health need.

The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs and discover gaps in resources.

Significant Health Needs

- Access to care
- Asthma
- Cancer
- Community safety
- Dental care
- Diabetes
- Heart disease
- HIV/AIDS
- Homelessness/housing
- Mental health
- Overweight and obesity
- Preventive practices
- Substance abuse

Priority Health Needs

The identified significant health needs were prioritized with input from the community. Interviews with community stakeholders were used to gather input on the significant health needs. The following criteria were used to prioritize the health needs: the perceived severity of a health issue or health factor/driver as it affects the health and lives of those in the community; the level of importance the hospital should place on addressing the issue. Calculations totaling severity and importance scores from the

community stakeholder interviews resulted in the following prioritization of the significant health needs:

Significant Health Need	Priority Ranking (Total Possible Score of 5)
Substance abuse	4.3
Mental health	4.3
Access to care	4.3
Homelessness	4.2
Overweight/obesity	4.0
Diabetes	3.9
Preventive practices	3.9
Heart disease	3.8
Dental care	3.6
Cancer	3.5
Community safety	3.2
HIV/AIDS	3.0
Asthma	3.0

Introduction

Background and Purpose

UCLA Medical Center, Santa Monica is a part of UCLA Health, a world-renowned, nonprofit academic medical center located in Santa Monica, California. UCLA Health is comprised of Ronald Reagan UCLA Medical Center, UCLA Medical Center, Santa Monica, Resnick Neuropsychiatric Hospital at UCLA, Mattel Children's Hospital UCLA, and the UCLA Medical Group, which has a wide-reaching system of primary-care and specialty-care offices throughout the region. Our mission is to deliver leading-edge patient care, research, and education. Our vision is to heal humankind, one patient at a time, by improving health, alleviating suffering and delivering acts of kindness.

The hospital was founded in 1926 by two local physicians - Drs. William S. Mortensen and August B. Hromadka. In 1995, the hospital became part of UCLA Health. The Santa Monica campus of UCLA Health encompasses the operations of UCLA Medical Center, Santa Monica; Orthopaedic Institute for Children (formerly Los Angeles Orthopaedic Hospital); the UCLA Rape Treatment Center; and Mattel Children's Unit at UCLA Medical Center, Santa Monica, which includes the UCLA Daltrey/Townshend Teen and Young Adult Cancer Program. The hospital has 265 inpatient beds and provides the full continuum of services, from neonatal intensive care to geriatric medicine, in a welcoming and technologically advanced facility.

UCLA Health has undertaken a Community Health Needs Assessment (CHNA) as required by state and federal law. California Senate Bill 697 and the Patient Protection and Affordable Care Act and IRS section 501(r) (3) direct tax-exempt hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years.

The Community Health Needs Assessment is a primary tool used by UCLA Health to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the UCLA Health service area.

Service Area

UCLA Medical Center, Santa Monica is located at 1250 16th Street, Santa Monica, California 90404. The service area includes 28 zip codes, representing 18 cities or communities, exclusively in Service Planning Area (SPA) 5 of Los Angeles County. The UCLA Health service area is detailed below by community and zip code.

UCLA Health Service Area

Geographic Area	Zip Code
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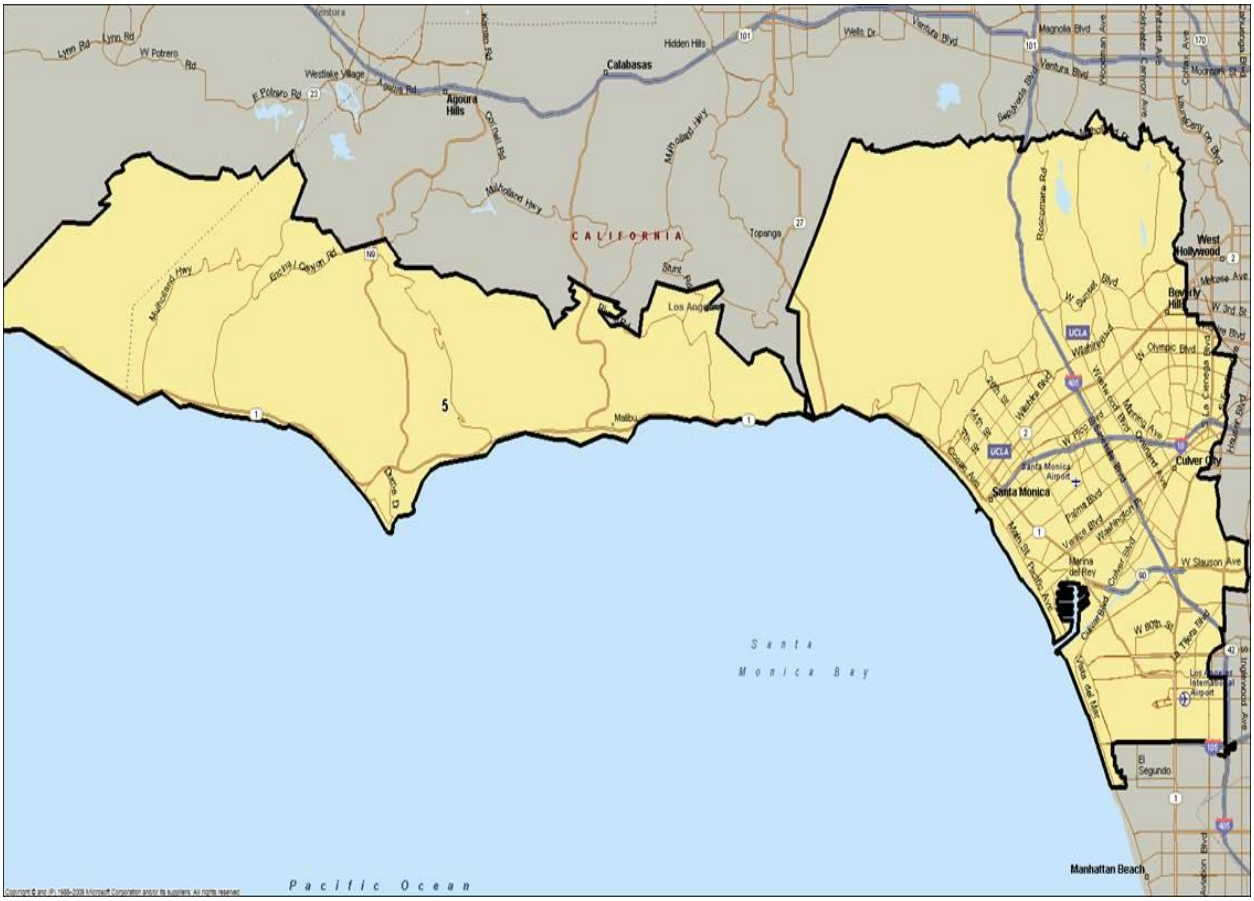
Map of UCLA Health Service Area



Project Oversight

The Community Health Needs Assessment process was overseen by:

Indu Bulbul Sanwal, MBA, MPH
Strategic Development Manager
Office of Health System Strategy and Business Development
UCLA Health

Consultant

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

Methods

Secondary Data Collection

Secondary data were collected from a variety of local, county, and state sources to present community demographics, social and economic factors, health care access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health and substance abuse and preventive practices.

Analyses were conducted at the most local level possible for the hospital primary service area, given the availability of the data. For example, demographic data, birth and death data are based on zip codes. Housing and economic indicators are available by city. Other data are only available by SPA (Service Planning Area) or county. For the purposes of this needs assessment, when examining data by SPA, the SPA 5 geographic area is presented.

Sources of data include Nielsen/Claritas from the Healthy Communities Institute database, U.S. Census American Community Survey, California Health Interview Survey, California Department of Public Health, California Employment Development Department, Los Angeles County Health Survey, Los Angeles Homeless Services Authority, Uniform Data System, National Cancer Institute, California Department of Education, and others. When pertinent, these data sets are presented in the context of Los Angeles County and California State, framing the scope of an issue as it relates to the broader community.

The secondary data for the hospital service area were collected and documented in data tables with narrative explanation. The tables present the data indicator, the geographic area represented, the data measurement (e.g. rate, number, and/or percent), county and state comparisons (when available), the data source, data year and an electronic link to the data source. Analysis of secondary data included an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measures UCLA Medical Center, Santa Monica data findings with Healthy People 2020 objectives. Healthy People 2020 objectives are a national initiative to improve the public's health by providing measurable objectives and goals that are applicable at national, state, and local levels.

Primary Data Collection

Targeted interviews were used to gather information and opinions from persons who represent the broad interests of the community served by the hospital. Given shared service areas, UCLA Health partnered with Cedars-Sinai Medical Center, Kaiser Foundation Hospital – West Los Angeles and Providence St. John's Health Center to conduct the interviews. Twenty-five (25) interviews were completed during September

through November 2015.

For the interviews, community stakeholders identified by UCLA Health, in partnership with Cedars-Sinai Medical Center, Kaiser Foundation Hospital – West Los Angeles and Providence St. John's Health Center, were contacted and asked to participate in the needs assessment. Interviewees included individuals who are leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have "current data or other information relevant to the health needs of the community served by the hospital facility." Input was obtained from Los Angeles County Department of Public Health officials.

The identified stakeholders were invited by email to participate in a one hour phone interview. Appointments for the interviews were made on dates and times convenient to the stakeholders. At the beginning of each interview, the purpose of the interview in the context of the assessment was explained, the stakeholders were assured their responses would remain confidential, and consent to proceed was given. A list of the stakeholder interview respondents, their titles and organizations can be found in Attachment 1.

Initially, significant health needs were identified through a review of the secondary health data collected and analyzed prior to the interviews. These data were then used to help guide the interviews. The needs assessment interviews were structured to obtain greater depth and richness of information and build on the secondary data review. During the interviews, participants were asked to identify the major health issues in the community, and socioeconomic, behavioral, environmental or clinical factors contributing to poor health. They were asked to share their perspectives on the issues, challenges and barriers relative to the identified health needs, and identify resources to address these health needs, such as services, programs and/or community efforts. The interviews focused on these identified health needs:

- Access to care
- Asthma
- Cancer
- Community safety
- Dental care
- Diabetes
- Heart disease
- HIV/AIDS
- Homelessness/housing

- Mental health
- Overweight and obesity
- Preventive practices
- Substance abuse

Interview participants were asked to provide additional comments to share with UCLA Health. Analysis of the primary data occurred through a process that compared and combined responses to identify themes. All responses to each question were examined together and concepts and themes were then summarized to reflect the respondents' experiences and opinions. The results of the primary data collection were reviewed in conjunction with the secondary data. Primary data findings were used to corroborate the secondary data-defined health needs, serving as a confirming data source. The responses are included in the following Community Health Needs Assessment chapters.

Information Gaps

Information gaps that impact the ability to assess health needs were identified. Specifically, cancer incidence rates are not available at a rate more local than Los Angeles County. Some of the secondary data are not always collected on a regular basis, meaning that some data are several years old. Specifically, the results of the 2015 Los Angeles County Health Survey (a population based telephone survey that provides information concerning the health of Los Angeles County residents) were not yet available during the conduct of this CHNA.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment to be solicited. In compliance with these regulations, the previous UCLA Medical Center, Santa Monica Community Health Needs Assessment and Implementation Strategy were made widely available to the public on the website https://www.uclahealth.org/Pages/about/community/community-health.aspx. Public comment was requested on the reports. To date, no written comments have been received.

Identification of Significant Health Needs

Review of Primary and Secondary Data

Health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of the problem, the health need indicators identified in the secondary data were measured against benchmark data, specifically county rates, state rates and/or Healthy People 2020 objectives. Indicators related to the health needs that performed poorly against one or more of these benchmarks met this criterion to be considered a health need.

The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs and discover gaps in resources.

Significant Health Needs

The following significant health needs were determined:

- Access to care
- Asthma
- Cancer
- Community safety
- Dental care
- Diabetes
- Heart disease
- HIV/AIDS
- Homelessness/housing
- Mental health
- Overweight and obesity
- Preventive practices
- Substance abuse

Resources to Address Significant Needs

Through the interview process, community stakeholders identified community resources to address the significant health needs. The identified community resources are presented in Attachment 2.

Priority Health Needs

The identified significant health needs were prioritized with input from the community. Interviews with community stakeholders were used to gather input on the identified health needs.

The following criteria were used to prioritize the significant health needs: the perceived severity of a health issue or health factor/driver as it affects the health and lives of those in the community; the level of importance the hospital should place on addressing the issue. The stakeholder interviewees was asked to rank each of the identified health need on a scale of 1 to 5 for severity (where 1 was least severe and 5 was most severe), and on a scale of 1 to 5 for importance (where 1 was not important and 5 is very important to address). The total score for each health need was divided by the total number of interviewees who responded to the questions, resulting in an overall average for each health need.

Not all survey respondents answered every question, therefore, the ratings were calculated based on respondents only and not on the entire sample size. The calculations of the community stakeholder survey resulted in the following prioritization of the significant health needs. When ranked by importance, access to care, substance abuse, diabetes, overweight/obesity, heart disease and preventive practices received a score of 4.0 or higher, indicating an issue was important or very important.

Significant Health Need	Severity (Total Possible Score of 5)	Importance (Total Possible Score of 5)
Access to care	3.9	4.6
Substance abuse	4.4	4.2
Diabetes	3.8	4.1
Overweight/obesity	3.9	4.1
Heart disease	3.5	4.0
Preventive practices	3.8	4.0
Mental health	4.4	3.9
Cancer	3.1	3.9
Homelessness	4.6	3.8
Dental care	3.8	3.3
HIV/AIDS	2.8	3.2
Asthma	2.8	3.2
Community safety	3.6	2.9

When the significant health needs were ranked by severity, homelessness, substance abuse and mental health received a score of 4.0 or higher, indicating a health need was severe or very severe.

Significant Health Need	Severity (Total Possible Score of 5)	Importance (Total Possible Score of 5)
Homelessness	4.6	3.8
Substance abuse	4.4	4.2
Mental health	4.4	3.9
Access to care	3.9	4.6
Overweight/obesity	3.9	4.1
Diabetes	3.8	4.1
Preventive practices	3.8	4.0
Dental care	3.8	3.3
Community safety	3.6	2.9
Heart disease	3.5	4.0
Cancer	3.1	3.9
HIV/AIDS	2.8	3.2
Asthma	2.8	3.2

Calculations totaling severity and importance scores from the community stakeholder interviews resulted in the following prioritization of the significant health needs:

Significant Health Need	Priority Ranking (Total Possible Score of 5)
Substance abuse	4.3
Mental health	4.3
Access to care	4.3
Homelessness	4.2
Overweight/obesity	4.0
Diabetes	3.9
Preventive practices	3.9
Heart disease	3.8
Dental care	3.6
Cancer	3.5
Community safety	3.2
HIV/AIDS	3.0
Asthma	3.0

Community input on these health needs is detailed throughout the CHNA report.

Impact Evaluation

In 2013, UCLA Medical Center, Santa Monica conducted their previous Community Health Needs Assessment (CHNA). Significant health needs were identified from issues supported by primary and secondary data sources gathered for the Community Health Needs Assessment. In developing the hospital's Implementation Strategy associated with the 2013 CHNA, UCLA Medical Center, Santa Monica chose to address access to care, health promotion and disease prevention, chronic health conditions, mental health, substance abuse and addiction, aging population, homelessness and dental care through a commitment of community benefit programs and resources. The evaluation of the impact of actions the hospital used to address these significant health needs can be found in Attachment 3.

Community Demographics

Population

The population of the UCLA Medical Center, Santa Monica service area is 656,039.

Population, 5-Year Estimates, 2009-2013

Geographic Area	Zip Code	Population
Bel Air	90077	8,506
Beverly Hills	90210	21,548
Beverly Hills	90211	7,748
Beverly Hills	90212	12,510
Brentwood	90049	35,310
Century City	90067	2,312
Culver City	90230	32,335
Culver City	90232	15,454
Ladera Heights	90056	8,536
Malibu	90263	1,899
Malibu	90265	17,630
Marina del Rey	90292	21,536
Pacific Palisades	90272	22,779
Palms	90034	58,703
Playa del Rey	90293	12,403
Playa Vista	90094	5,852
Santa Monica	90401	6,821
Santa Monica	90402	11,749
Santa Monica	90403	24,864
Santa Monica	90404	20,807
Santa Monica	90405	28,560
Venice	90291	59,031
Venice / Mar Vista	90066	27,253
West Los Angeles	90025	43,555
West Los Angeles	90035	30,999
West Los Angeles	90064	26,103
Westchester	90045	40,272
Westwood	90024	50,964
UCLA Health Service Area		**656,039**
Los Angeles County		**9,893,481**

Source: U.S. Census Bureau, American Community Survey, 2009-2013, DP05.http://factfinder.census.gov

Of the area population, 48.3% are male and 51.7% are female.

Population by Gender

	UCLA Health Service Area	Los Angeles County	California
Male	48.3%	49.3%	49.7%
Female	51.7%	50.7%	50.3%

Source: U.S. Census Bureau, American Community Survey, 2009-2013, DP05. http://factfinder.census.gov

Children and youth, ages 0-17, make up 16% of the population, compared to 23.4% for the county; 69.7% are adults, ages 18-64; and 14.3% of the population are seniors, ages 65 and over, which is higher than the 12.3% found countywide. The median age in the service area is 37.9, higher than Los Angeles County's median age of 35.1.

Population by Age

	UCLA Health Service Area	Los Angeles County
0 – 4	5.1%	6.4%
5 – 9	4.2%	6.4%
10 – 14	4.1%	6.4%
15 – 17	2.6%	4.2%
18 – 20	5.2%	4.3%
21 – 24	6.8%	5.9%
25 – 34	18.4%	15.1%
35 – 44	14.8%	14.1%
45 – 54	13.1%	13.7%
55 – 64	11.5%	11.4%
65 – 74	7.3%	7.0%
75 – 84	4.5%	3.6%
85+	2.5%	1.7%
2015 Median Age	**37.9**	**35.1**

Source: U.S. Census Bureau, American Community Survey, 2009-2013, DP05. http://factfinder.census.gov

When the service area is examined by zip code, Pacific Palisades has the largest percentage of youth, ages 0-17 (25%). Century City has the highest percentage of residents 65 and older (47.8%).

Population by Zip Code, Youth, Ages 0-17, and Seniors, Ages 65+

Geographic Area	Zip Code	Youth Ages 0 – 17	Seniors Ages 65+
Bel Air	90077	20.1%	24.4%
Beverly Hills	90210	20.9%	24.3%
Beverly Hills	90211	17.7%	16.0%
Beverly Hills	90212	20.0%	15.3%
Brentwood	90049	15.9%	19.1%
Century City	90067	8.6%	47.8%
Culver City	90230	20.8%	13.9%
Culver City	90232	18.4%	14.0%
Ladera Heights	90056	18.6%	21.4%
Malibu	90263	1.8%	0.0%
Malibu	90265	20.9%	19.3%
Marina del Rey	90292	9.8%	15.7%
Pacific Palisades	90272	25.0%	21.5%
Palms	90034	16.5%	7.7%
Playa del Rey	90293	7.2%	15.0%
Playa Vista	90094	15.7%	7.3%
Santa Monica	90401	5.6%	16.8%

Geographic Area	Zip Code	Youth Ages 0 – 17	Seniors Ages 65+
Santa Monica	90402	18.0%	21.0%
Santa Monica	90403	13.1%	16.4%
Santa Monica	90404	14.7%	13.9%
Santa Monica	90405	15.2%	13.7%
Venice	90291	13.4%	9.4%
Venice / Mar Vista	90066	18.7%	12.2%
West Los Angeles	90025	11.5%	11.4%
West Los Angeles	90035	19.1%	12.9%
West Los Angeles	90064	20.4%	15.9%
Westchester	90045	17.5%	11.9%
Westwood	90024	6.6%	10.8%
UCLA Health Service Area		**15.9%**	**14.2%**
Los Angeles County		**24.0%**	**11.2%**

Source: U.S. Census Bureau, American Community Survey, 2009-2013, DP05. http://factfinder.census.gov

Race/Ethnicity

In the service area, 60.2% of the residents are White; 16.5% of the population is Hispanic/Latino; 13% are Asian; 6.2% are African American; and 4.1% are American Indian/Alaskan Native, Hawaiian/Pacific Islander, other or multiple race/ethnicity. The service area has a higher percentage of Whites and a lower percentage of Hispanics than found in the county and state.

Race/Ethnicity

	UCLA Health Service Area	Los Angeles County	California
White	60.2%	26.4%	39.7%
Hispanic/Latino	16.5%	48.8%	37.9%
Asian	13.0%	14.0%	13.1%
Black/African American	6.2%	8.0%	5.7%
Other / Multiple	3.8%	2.4%	2.9%
Native Hawaiian/Pacific Islander	0.2%	0.2%	0.4%
American Indian/Alaska Native	0.1%	0.2%	0.4%

Source: U.S. Census Bureau, American Community Survey, 2009-2013, DP05.http://factfinder.census.gov

Language

The languages spoken at home by area residents mirror the racial/ethnic make-up of the service area. English is spoken in the home among 64.4% of the service area population. Spanish is spoken at home among 13.3% of the population; 8.1% of the population speak an Asian language; and 11.8% of the population speaks an Indo-European language at home.

Language Spoken at Home, Population 5 Years and Older

	UCLA Health Service Area	Los Angeles County	California
Speaks only English	64.4%	42.9%	56.3%
Speaks Spanish	13.3%	39.6%	28.8%
Speak Indo-European language	11.8%	5.6%	4.4%
Speaks Asian/Pacific Islander language	8.1%	10.9%	9.6%
Speaks other language	2.4%	1.1%	0.9%

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

When communities in SPA 5 are examined by zip code and the language spoken in the home, several communities have higher percentages of Spanish speakers, including Culver City, Palms, and Venice/Mar Vista. Areas with a high percentage of Asian language speakers include Westwood, Malibu 90263 and Playa Vista. Beverly Hills has higher rates of residents who speak Indo-European languages at home.

Language Spoken at Home by Zip Code

Geographic Area	Zip Code	English	Spanish	Asian/Pacific Islander	Indo European
Bel Air	90077	71.8%	5.3%	3.3%	18.3%
Beverly Hills	90210	50.6%	7.0%	3.3%	35.7%
Beverly Hills	90211	43.7%	5.9%	9.7%	33.2%
Beverly Hills	90212	56.2%	5.7%	7.6%	27.8%
Brentwood	90049	71.1%	5.0%	4.8%	17.9%
Century City	90067	66.0%	2.6%	10.4%	18.1%
Culver City	90230	55.2%	28.6%	8.2%	5.7%
Culver City	90232	57.6%	26.9%	7.5%	5.4%
Ladera Heights	90056	88.5%	6.1%	0.4%	0.5%
Malibu	90263	61.5%	14.4%	16.3%	5.8%
Malibu	90265	84.9%	3.7%	2.9%	8.0%
Marina del Rey	90292	73.1%	6.8%	6.5%	10.1%
Pacific Palisades	90272	82.1%	4.5%	2.3%	9.7%
Palms	90034	49.6%	24.7%	12.4%	10.0%
Playa del Rey	90293	77.7%	6.7%	6.2%	8.9%
Playa Vista	90094	70.9%	2.8%	15.3%	11.0%
Santa Monica	90401	65.4%	11.1%	7.9%	13.4%
Santa Monica	90402	75.7%	6.2%	4.4%	10.9%
Santa Monica	90403	78.3%	4.1%	4.8%	11.9%
Santa Monica	90404	61.8%	20.0%	8.7%	9.2%
Santa Monica	90405	75.5%	10.0%	6.7%	6.5%
Venice	90291	77.3%	14.1%	2.2%	5.9%
Venice / Mar Vista	90066	59.2%	24.3%	8.7%	6.1%
West Los Angeles	90025	57.3%	14.2%	11.7%	15.7%
West Los Angeles	90035	60.0%	9.8%	5.2%	15.7%
West Los Angeles	90064	62.6%	13.5%	12.4%	9.7%
Westchester	90045	72.1%	12.3%	6.0%	6.4%
Westwood	90024	54.9%	8.5%	17.8%	16.2%

Geographic Area	Zip Code	English	Spanish	Asian/Pacific Islander	Indo European
UCLA Health Service Area		**64.4%**	**13.3%**	**8.1%**	**11.8%**
Los Angeles County		**42.9%**	**39.6%**	**10.9%**	**5.6%**
California		**56.3%**	**28.8%**	**9.6%**	**4.4%**

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

Social and Economic Factors

Social and Economic Factors Ranking

The County Health Rankings rank counties according to health factors data. Social and economic indicators are examined as a contributor to the health of a county's residents. California's 58 counties are ranked according to social and economic factors with 1 being the county with the best factors to 58 for that county with the poorest factors. This ranking examines: high school graduation rates, unemployment, children in poverty, social support, and others. Los Angeles County is ranked as 42, in the bottom half of all California counties according to social and economic factors.

Social and Economic Factors Ranking

	County Ranking (out of 58)
Los Angeles County	42

Source: County Health Rankings, 2015. www.countyhealthrankings.org

Poverty

Poverty thresholds are used for calculating all official poverty population statistics. They are updated each year by the Census Bureau. For 2013, the Federal Poverty Level for one person was $11,490 and for a family of four $23,550.

In the UCLA Health service area, 11.9% of the population is at or below 100% of the federal poverty level (FPL), which is a smaller portion of the population in poverty than seen in L.A. County (17.8%) or the state (15.9%). Close to one-quarter (24%) of the population in the service area is considered low-income, living at or below 200% of FPL.

Poverty Levels

	UCLA Health Service Area	Los Angeles County	California
<100% FPL	11.9%	17.8%	15.9%
<200% FPL	24.0%	40.3%	35.9%

Source: U.S. Census Bureau, American Community Survey, 2009-2013, S1701. http://factfinder.census.gov

A view of poverty by zip code shows that the highest rates of poverty are found in Westwood (33.6% of the population). Ten percent (10%) of children in the service area live below the FPL, with Palms, West L.A. and Marina del Rey having the highest percentages of children in poverty. 8.4% of area seniors live in poverty, with the highest rates found in Santa Monica 90401 and 90404, and Venice 90066.

Poverty Levels of Individuals, Children under Age 18, and Seniors 65+

Geographic Area	Zip Code	Individuals	Children	Seniors
Bel Air	90077	3.3%	4.3%	1.9%
Beverly Hills	90210	7.4%	5.7%	8.9%
Beverly Hills	90211	11.7%	9.1%	15.3%
Beverly Hills	90212	7.6%	6.7%	7.8%
Brentwood	90049	6.5%	3.7%	4.3%
Century City	90067	7.6%	12.6%	9.0%
Culver City	90230	10.2%	15.1%	7.1%
Culver City	90232	9.0%	5.3%	9.0%
Ladera Heights	90056	5.3%	9.1%	5.9%
Malibu	90263	0.0%	0.0%	0.0%
Malibu	90265	9.6%	7.5%	6.7%
Marina del Rey	90292	10.3%	19.0%	6.7%
Pacific Palisades	90272	4.6%	4.9%	2.2%
Palms	90034	17.7%	20.7%	10.9%
Playa del Rey	90293	6.7%	3.0%	0.9%
Playa Vista	90094	7.7%	0.0%	9.8%
Santa Monica	90401	13.2%	0.0%	22.2%
Santa Monica	90402	5.4%	3.1%	4.3%
Santa Monica	90403	8.5%	2.1%	14.2%
Santa Monica	90404	15.4%	15.5%	18.7%
Santa Monica	90405	11.8%	4.4%	15.1%
Venice	90291	13.2%	19.6%	12.7%
Venice / Mar Vista	90066	11.1%	13.0%	7.4%
West Los Angeles	90025	12.4%	13.5%	5.5%
West Los Angeles	90035	9.0%	4.8%	16.0%
West Los Angeles	90064	9.8%	8.8%	8.0%
Westchester	90045	11.8%	10.1%	4.9%
Westwood	90024	33.6%	5.0%	8.1%
UCLA Health Service Area		**11.9%**	**10.0%**	**8.4%**
Los Angeles County		**17.8%**	**25.3%**	**12.9%**
California		**15.9%**	**22.1%**	**9.9%**

Source: U.S. Census Bureau, American Community Survey, 2009-2013, S1701. http://factfinder.census.gov

Households

In the UCLA Health service area, there are 288,869 households. The median household income is $82,834 and the average (mean) household income is $126,846. These are significantly higher than for L.A. County as a whole.

Household Income

	UCLA Health Service Area	Los Angeles County
Median Household Income	$82,834	$55,909
Average Household Income	$126,846	$81,416

Source: U.S. Census Bureau, American Community Survey, 2009-2013, DP03. http://factfinder.census.gov

When examined at by zip code, the median household income ranges from $54,373 in Palms to $168,036 in Bel Air.

Median Household Income

Geographic Area	Zip Code	Households	Median Household Income
Bel Air	90077	3,299	$168,036
Beverly Hills	90210	8,310	$132,254
Beverly Hills	90211	3,503	$68,589
Beverly Hills	90212	5,619	$83,679
Brentwood	90049	16,559	$110,854
Century City	90067	1,425	$90,972
Culver City	90230	13,086	$71,235
Culver City	90232	6,310	$73,103
Ladera Heights	90056	3,613	$86,858
Malibu	90265	6,885	$129,750
Marina del Rey	90292	12,168	$100,441
Pacific Palisades	90272	8,997	$159,696
Palms	90034	25,585	$56,946
Playa del Rey	90293	6,700	$87,308
Playa Vista	90094	2,890	$91,042
Santa Monica	90401	4,362	$62,794
Santa Monica	90402	5,390	$140,139
Santa Monica	90403	13,877	$71,424
Santa Monica	90404	9,729	$59,695
Santa Monica	90405	14,100	$75,717
Venice	90291	14,028	$79,736
Venice / Mar Vista	90066	24,480	$66,744
West Los Angeles	90025	21,197	$73,478
West Los Angeles	90035	13,353	$75,863
West Los Angeles	90064	10,719	$84,579
Westchester	90045	15,262	$77,893
Westwood	90024	17,423	$54,373
UCLA Health Service Area		**288,869**	**$82,834**
Los Angeles County		**3,230,383**	**$55,909**
California		**12,542,460**	**$61,094**

Source: U.S. Census Bureau, American Community Survey, 2009-2013, DP03.http://factfinder.census.gov

Households by Type

When households are examined by type, in the UCLA Health Service Area 19.5% of family households have children under 18 years old. Only 3.3% of area households have a female as head of household and children. 10.2% of area households are seniors 65+ living alone, which is higher than the county and state rates.

Households by Type

	Family Households with Children under 18	Female Head of Household with Children under 18	Seniors Living Alone
UCLA Health Service Area	19.5%	3.3%	10.2%
Los Angeles County	**31.9%**	**7.9%**	**8.0%**
California	**32.7%**	**7.2%**	**8.5%**

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

Free or Reduced Price Meals

The percent of students who are eligible for the free or reduced price meal program is one indicator of socioeconomic status. Among Los Angeles Unified School District schools, over three-fourths (75.6%) of the student population is eligible for the free or reduced price meal program, indicating a high level of low-income families. In the Inglewood Unified School District 78.3% of students qualify for the program. These rates are higher than county and state rates. Note that while examining district totals provides an overview of the student population, this is an average among each district's school enrollments. Within the district there are schools with higher and lower rates of eligible low-income children.

Free or Reduced Price Meals Eligibility

School District	Percent Eligible Students
Los Angeles Unified School District	75.6%
Inglewood Unified School District	72.4%
Culver City Unified School District	34.4%
Santa Monica-Malibu Unified School District	26.4%
Beverly Hills Unified School District	6.7%
Los Angeles County	**66.5%**
California	**58.6%**

Source: California Department of Education, 2014-2015. http://data1.cde.ca.gov/dataquest/

Public Program Participation

In SPA 5, 6.4% of residents living below 200% of the FPL cannot afford food and 3% utilize food stamps. These rates indicate a number of residents who may qualify for food stamps but do not access this resource. 2.3% of SPA 5 residents are Temporary Assistance for Needy Families (TANF)/CalWorks recipients.

Public Program Participation

	SPA 5	Los Angeles County	California
Not able to afford food (<200%FPL)	6.4%	39.5%	38.4%
Food Stamp recipients (<300% FPL)	3.0%	18.7%	18.1%
TANF/CalWorks recipients	2.3%	10.6%	8.4%

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

Unemployment

The unemployment rates in service area cities show a diverse range from 4.8% in Malibu to 8.7% in Los Angeles City.

Unemployment Rate, 2014 Average

Geographic Area*	Unemployment Rate
Beverly Hills	7.9%
Culver City	6.1%
Ladera Heights	8.0%
Los Angeles City	8.7%
Malibu	4.8%
Marina del Rey	5.2%
Santa Monica	7.0%
Los Angeles County	**8.3%**
California	**7.5%**

Source: California Employment Development Department, Labor Market Information; http://www.labormarketinfo.edd.ca.gov/data/unemployment-and-labor-force.html - HIST
** Data available by city, therefore, zip code-only areas in the service area are not listed.*

Educational Attainment

Among adults, ages 25 and older, only 6.3% of area adults lack a high school diploma; which is lower than the county rate of 23.4%. 10.4% of service area adults are high school graduates and 66.5% are college graduates. In comparison, in Los Angeles County 20.5% of residents are high school graduates and 36.5% are college graduates.

Educational Attainment of Adults, 25 Years and Older

	UCLA Health Service Area	Los Angeles County
Less than 9th Grade	3.4%	13.7%
Some High School, No Diploma	2.9%	9.7%
High School Graduate	10.4%	20.5%
Some College, No Degree	16.7%	19.6%
Associate Degree	5.6%	6.9%
Bachelor Degree	34.8%	19.4%
Graduate or Professional Degree	26.1%	10.2%

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

High school graduation rates are determined by taking the number of graduates for the school year divided by the number of freshman enrolled four years earlier. The high school graduation rate for LAUSD (70.2%) and Inglewood Unified School District (72.4%) are lower than the county (77.9%), and state (81%) rates. The Healthy People 2020 objective is an 82.4% high school graduation rate. Culver City (89.5%), Santa Monica-Malibu (92.4%) and Beverly Hills (92.6%) Unified School Districts meet the Healthy People 2020 high school graduation objective.

High School Graduation Rates, 2013-2014

School District	High School Graduation Rate
Beverly Hills Unified School District	92.6%
Culver City Unified School District	89.5%
Inglewood Unified School District	72.4%
Los Angeles Unified School District	70.2%
Santa Monica-Malibu Unified School District	92.4%
Los Angeles County	**77.9%**
California	**81.0%**

Source: California Department of Education, 2015. http://dq.cde.ca.gov/dataquest/.

Community Input – Social and Economic Factors

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

- Poverty is a huge issue for people. Lack of health care access drives disparities.
- Factors include underemployment, homelessness, lack of transportation, unsafe housing, income inequality, poor eating habits, and lack of medical care.
- Lack of education or quality education, homelessness, unemployment, and immigration status are problems in the community.
- Affordable health insurance, adequate benefits for substance abuse and mental health and affordable housing. Lack of support creates instability in the community and affects health and communities.
- Shortage of affordable housing is extreme. We are experiencing a demographic shift, where even the middle class is moving into homelessness.
- Poverty and unemployment. Often, people don't think of poverty on the Westside, as it is not visible.
- Whether from not having enough money to pay for basic needs or being around others who are stressed, stress is a driver of toxic environments. Stress and trauma are associated with socioeconomically disadvantaged neighborhoods.
- Poor job stability and poor living conditions for children.
- The number of undocumented in the community is low but these individuals are lower income and many are monolingual speakers. They are very neglected because it is so hard for them to get services.
- Lack of adequate nutrition as a result of people having to make choices between buying food and medicine or paying rent.
- Top social issues are affordable housing, no matter the population or subpopulation, and transportation.
- The large immigrant population has low levels of education, language and they face ethnic barriers.
- The saying "zip code is more important than genetic code" is very clear. The environment contributes to issues of poverty and desperation in an area that doesn't have integrated health and wellness services.

Homelessness

Every two years, the Los Angeles Homeless Services Authority (LAHSA) conducts the Greater Los Angeles Homeless Count to determine how many individuals are homeless on a given day. Data from this survey show an increase in homelessness from 2013 to 2015. In 2015, SPA 5 had an annualized estimate of 4,276 homeless individuals. In SPA 5, 83.3% of the homeless are single adults and 16.6% are families. The percent of unsheltered homeless has increased from 2013 to 2015, and the percentage of homeless families and unaccompanied minors has decreased since 2013.

Homeless Population*, 2013-2015 Homeless Count Comparison

	SPA 5		Los Angeles County	
	2013	2015	2013	2015
Total homeless	3,667	4,276	35,524	41,174
Sheltered	41.3%	30.0%	36.4%	29.7%
Unsheltered	58.7%	70.0%	63.6%	70.3%
Individual adults	80.0%	83.3%	78.9%	81.1%
Family members	17.6%	16.6%	18.8%	18.2%
Unaccompanied minors (<18)	2.3%	<1%	2.3%	<1%

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

Among the homeless population, 43% in SPA 5 are chronically homeless. According to the U.S. Department of Housing and Urban Development (HUD), to be considered chronically homeless, an individual or head of household must have been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven for the last 12 months continuously or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months (www.hudexchange.info/faqs/2750/what-are-the-main-differences-between-the-previous-definition-of/). The rates of chronic homelessness have increased from 2013 to 2015. Those who are homeless in SPA 5 have high rates of mental illness (40.9%) and 20.8% are homeless veterans. There was a notable increase in the homeless population with a domestic violence experience from 9.2% in 2013 to 27% in 2015.

Homelessness Subpopulations*

	SPA 5		Los Angeles County	
	2013	2015	2013	2015
Chronically homeless	22.4%	43.0%	24.5%	34.4%
Substance abuse	30.1%	26.8%	31.2%	25.2%
Mentally illness	28.1%	40.9%	28.0%	29.8%
Veterans	11.5%	20.8%	11.3%	9.8%
Domestic violence experience	9.2%	27.0%	1.0%	21.4%
Physical disability	18.3%	25.2%	8.9%	19.8%
Persons with HIV/AIDS	1.0%	1.8%	0.6%	0.2%

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

Community Input – Housing and Homelessness

Stakeholder interviews identified the following issues, challenges and barriers related to housing and homelessness:

- Housing belongs at the top of the list. Housing is a driver of everything else – health, education, jobs.
- Lack of affordable housing leaves people cash strapped. Rental costs are too expensive. People are more concerned about getting the rent paid than accessing fresh food and going to the dentist. Instability of housing occurs if people are barely making ends meet; they move around a lot. This causes stress, worry, anxiety and depression, particularly among kids. When kids move around in an unstable housing environment, they have disrupted social and peer networks, lower possibility of coming to school every day, increased absenteeism. The MacArthur Foundation showed that long-term health issues can be traced back to lack of housing stability as a child. Also quality of housing is hugely impactful on health. Mold, rodents, roaches can trigger asthma and other conditions; it is unsanitary. Many old homes have paint issues, lead exposure, and many other issues.
- There are a tremendous number of homeless in the area including veterans. Homelessness is a multi-factorial issue. Often, among veterans, homelessness is not just because of a lost job. They are often addicted and seriously mentally ill. It is an enormous problem with a lot of money being thrown into it, but it is still a challenge.
- LAUSD is aware of 7,000 homeless students, but they move all the time so it is hard to track them. It is well known that many of the undocumented in LA are living on the edge. Also, many of the children from undocumented families live in overcrowded housing; these conditions contribute to asthma, child abuse, and stress from that many families all living together.

- Housing is the number one issue that people identify. For the chronically mentally ill, it is very difficult to get them to accept services. There are huge movements in LA and nationally to place the homeless in a livable situation and then provide supportive wraparound services. This model has helped, but there are more homeless than services and resources. People who have lost jobs now live in cars or couch surf. They would be amenable to support if they could get it. This is a systemic issue.
- Homelessness is getting worse because of a lack of affordable housing. It is so hard to maintain stable housing so they can't even get off the streets. There are some really good health efforts with the departments of Housing and Mental Health. And there is a coordinated entry system with the LA Housing Services Authority working to consolidate services so a person can go to one place for eligibility of services. There is better coordination of services but it is still insufficient to meet the need.

Crime and Violence

Violent crimes include homicide, rape, robbery and assault. Crime statistics indicate that Culver City, Los Angeles and Santa Monica have higher rates of violent crime than the state. Beverly Hills, Culver City and Santa Monica have high rates of property crimes.

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

Geographic Area	Property Crime Rates	Violent Crime Rates
Beverly Hills	3,117.3	256.7
Brentwood	2,243.9	187.5
Culver City	4,452.5	452.8
Los Angeles	2,269.1	481.1
Malibu	2,559.5	116.7
Santa Monica	3,725.3	433.0
California	**2,758.7**	**423.1**

Source: U.S Department of Justice, FBI, Uniform Crime Reporting Statistics, 2012. www.bjs.gov/ucrdata/index.cfm

Calls for domestic violence are categorized as with or without a weapon. The domestic violence calls in the service area were primarily *with* weapons. Santa Monica and UCLA have low percentages of domestic violence calls with weapons.

Domestic Violence Calls, 2014

Geographic Area	Total	Without Weapon	With Weapon
Beverly Hills	114	47.4%	52.6%
Culver City	16	56.3%	43.7%
Los Angeles	19,533	22.6%	77.4%

Geographic Area	Total	Without Weapon	With Weapon
Los Angeles County Sheriff's Department	3,389	13.7%	86.3%
Los Angeles Transit Service	109	2.8%	97.2%
Malibu	17	5.9%	94.1%
Santa Monica	266	89.1%	10.9%
UCLA	62	83.9%	16.1%
Los Angeles County	**39,145**	**34.5%**	**65.5%**
California	**158,547**	**60.9%**	**39.1%**

Source: California Department of Justice, Office of the Attorney General, 2014. https://oag.ca.gov/crime/cjsc/stats/domestic-violence
** Zip code-only areas in the service area are not listed.*

Community Input – Community Safety

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

- Homicide is a significant challenge, particularly among black men. There are issues of equitable health due to latent gang issues that percolate in a community. There are significant levels of injury among children and women with family violence, domestic violence. There are a lot of negative health impacts for everyone involved. Violence is a major driver of what's happening in the community. When you lose someone to violence, it can shake what you feel about all systems – the police, government, and schools.
- With Prop 47, penalties for some crimes have been lowered to misdemeanors. With early prison release, there is a rise in violence. We have insufficient resources to help former prisoners re-enter and rehabilitate and get marketable skills and housing.
- Seniors with disabilities are more vulnerable to crime and fraud.
- There are pockets of gang violence in poor areas that have outbreaks. There is trauma in the community from domestic violence, shootings of homeless, and growing violence among the homeless.

Health Care Access

Health Insurance Coverage

Health insurance coverage is a key component to accessing health care. In SPA 5, 92.6% of the population is insured.

Insurance Status

	SPA 5	Los Angeles County	California
Insured	92.6%	86.7%	88.1%
Uninsured	7.4%	13.3%	11.9%

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

In SPA 5, over half the population (54%) has employment-based insurance. 19.4% of the population has some type of Medicare coverage. 5.2% of the population in SPA 5 has Medi-Cal coverage.

Insurance Coverage

	SPA 5	Los Angeles County	California
Medi-Cal	5.2%	24.4%	22.5%
Medicare only	0.5%	1.4%	1.4%
Medi-Cal/Medicare	2.4%	3.7%	3.0%
Medicare and others	16.5%	7.4%	9.0%
Other public	0.9%	0.8%	1.0%
Employment based	54.0%	41.5%	44.8%
Private purchase	13.1%	7.4%	6.4%
No insurance	7.4%	13.3%	11.9%

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

When insurance coverage for SPA 5 was examined by age groups, adults, ages 18-64, had the highest rate of uninsured. Coverage for children was primarily through employment-based and private purchase insurance. Seniors had low rates of uninsured and high rates of Medicare coverage. The Healthy People 2020 objective is 100% health insurance coverage for children and adults.

Insurance Coverage by Age Group, SPA 5

	Ages 0-17	Ages 18-64	Ages 65+
Medi-Cal	7.6%	6.2%	0.0%
Medicare only	N/A	N/A	2.4%
Medi-Cal/Medicare	N/A	0.0%	12.0%
Medicare and others	N/A	N/A	83.6%
Other public	0.0%	1.4%	0.0%
Employment based	72.8%	65.2%	2.0%
Private purchase	11.1%	17.6%	0.0%
No insurance	8.6%	9.4%	0.0%

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

When insurance coverage for the service area is examined by zip code, 11.8% of area residents are uninsured. There is a large variation between those areas with the best coverage in Bel Air, with 2.6% uninsured, and those with the highest percent of uninsured in Palms, with 20.9% uninsured. The Healthy People 2020 objective is 100% health insurance coverage for children and adults.

Uninsured, 5-Year Estimates, 2009-2013

Geographic Area	Zip Code	Number	Percent
Bel Air	90077	220	2.6%
Beverly Hills	90210	1,064	4.9%
Beverly Hills	90211	1,217	15.7%
Beverly Hills	90212	1,214	9.7%
Brentwood	90049	2,120	6.0%
Century City	90067	122	5.3%
Culver City	90230	4,945	15.3%
Culver City	90232	2,294	14.8%
Ladera Heights	90056	538	6.3%
Malibu	90263	60	3.2%
Malibu	90265	857	5.0%
Marina del Rey	90292	2,412	11.2%
Pacific Palisades	90272	896	3.9%
Palms	90034	12,199	20.9%
Playa del Rey	90293	1,462	11.9%
Playa Vista	90094	620	10.6%
Santa Monica	90401	1,219	17.9%
Santa Monica	90402	501	4.3%
Santa Monica	90403	2,064	8.3%
Santa Monica	90404	2,828	14.0%
Santa Monica	90405	3,417	12.0%
Venice	90291	4,289	15.8%
Venice / Mar Vista	90066	10,238	17.4%
West Los Angeles	90025	6,219	14.3%
West Los Angeles	90035	4,074	13.3%

Geographic Area	Zip Code	Number	Percent
West Los Angeles	90064	2,327	9.0%
Westchester	90045	4,343	10.8%
Westwood	90024	3,237	6.4%
UCLA Health Service Area		**76,996**	**11.8%**
Los Angeles County		**2,177,718**	**22.2%**

Source: U.S. Census Bureau, American Community Survey, 2009-2013, S2701.http://factfinder.census.gov

Sources of Care

Residents who have a medical home and access to a primary care provider improve continuity of care and decrease unnecessary ER visits. 100% of children and seniors in SPA 5 were reported to have a usual source of care. 86.3% of adults have a usual source of care.

Usual Source of Care, SPA 5

	Ages 0-17	Ages 18-64	Ages 65+
Have usual place to go when sick or need health advice	100%	86.3%	100%

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

When access to care through a usual source of care is examined by race/ethnicity, Asians are the least likely to have a usual source of care, and Whites the most likely.

Usual Source of Care by Race/Ethnicity

	SPA 5	Los Angeles County
African American	100%	89.1%
Asian	81.0%	82.5%
Latino	92.1%	79.2%
White	94.5%	91.8%

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

A doctor's office, HMO, or Kaiser is the usual source of care for 71.3% of SPA 5 residents. Clinics and community hospitals are the source of care for 15.2% of residents. The ER or Urgent Care is the usual source of care for a small percentage of area residents (2.1%).

Sources of Care

	SPA 5	Los Angeles County	California
Doctor's office/HMO/Kaiser	71.3%	57.6%	60.7%
Community clinic/government clinic/ community hospital	15.2%	23.6%	23.0%
ER/Urgent care	2.1%	1.7%	1.4%
Other	2.5%	0.9%	0.7%
No source of care	8.9%	16.2%	14.2%

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

17.9% of SPA 5 residents visited an ER over the period of a year, and youth visited the ER at the highest rates (28.3%); these were higher than the rates seen county-wide. SPA 5 residents living in poverty visit the ER at lower rates than seen in the county and the state.

Use of Emergency Room

	SPA 5	Los Angeles County	California
Visited ER in last 12 months	17.9%	16.6%	17.4%
0-17 years old	28.3%	19.7%	19.3%
18-64 years old	17.3%	15.7%	16.5%
65 and older	11.5%	15.5%	18.4%
<100% of poverty level	7.7%	17.7%	20.6%
<200% of poverty level	9.6%	16.7%	19.8%

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

Barriers to Care

Adults in the service area experience a number of barriers to accessing care, including cost of care and lack of a medical home.

Barriers to Accessing Health Care

	SPA 5	Los Angeles County
Adults unable to afford dental care in the past year	19.4%	30.3%
Adults unable to afford medical care in the past year	12.2%	16.0%
Adults unable to afford mental health care in the past year	6.5%	6.1%
Adults unable to afford prescription medication in the past year	9.8%	15.4%
Adults who reported difficulty accessing medical care	17.0%	31.7%

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

Access to Primary Care Community Health Centers

Community Health Centers provide primary care (including medical, dental and mental health services) for uninsured and medically underserved populations. Using Zip Code data for the service area and information from the Uniform Data System (UDS)[1], 24.0% of the population in the service area is categorized as low-income (200% of Federal Poverty Level) and 11.9% of the population are living in poverty.

There are several Section 330 funded grantees (Federally Qualified Health Centers – FQHCs and FQHC Look-Alikes) located in the service area, including: Westside Family Health Center, Venice Family Clinic, Saban Community Clinic, Korean Health Education Information and Research Center, and the Los Angeles LGBT Center.

[1]The UDS is an annual reporting requirement for grantees of HRSA primary care programs:
• Community Health Center, Section 330 • Migrant Health Center, Section 330 • Health Care for the Homeless, Section 330 • Public Housing Primary Care, Section 330

Even with Community Health Centers serving the area, there are a significant number of low-income residents who are not served by one of these clinic providers. The FQHCs and Look-Alikes have a total of 32,747 patients in the service area, which equates to 21.5% penetration among low-income patients and 5% penetration among the total population. From 2012-2014, the clinic providers added 2,972 patients for a 10% increase in patients served by Community Health Centers in the service area. However, there remain 119,223 low-income residents, approximately 78.5% of the population at or below 200% FPL that are not served by a Community Health Center.

Low-Income Patients Served and Not Served by FQHCs and Look Alikes

Low-Income Population	Patients served by Section 330 Grantees In Service Area	Penetration among Low-Income Patients	Penetration of Total Population	Low-Income Not Served	
				Number	Percent
151,970	32,747	21.5%	5.0%	119,223	78.5%

Source: UDS Mapper, 2014. http://www.udsmapper.org

Delayed Care

14.4% of the residents of SPA 5 delayed or did not get medical care when needed, and 4.4% delayed or did not fill prescriptions.

Delayed Care

	SPA 5	Los Angeles County	California
Delayed or didn't get medical care in past 12 months	14.4%	11.7%	11.3%
Delayed or didn't get prescription meds in past 12 months	4.4%	7.9%	8.7%

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

Community Input – Access to Care

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

- Covered CA has done an amazing job. Healthy Way LA has opened up to help the uninsured in Los Angeles. But now people need to know how to get care, how to use insurance and get in for appointments. The health system is typically open 8-5 M-F. More weekend clinics are needed. Also, access to medication is really important.
- There are some fundamental issues around health access equity. There are not a lot of Medi-Cal providers and there aren't enough places to access care. The current insurance system fails people. This may or may not improve in coming years. There are numerous barriers, distrust of system and people don't have transportation or childcare. These are systemic reasons that society can address to increase access to care and preventive services.
- There is a lot of confusion with the Affordable Care Act (ACA) and access to easy immunizations because kids now need to go to their assigned doctor and

not the local clinic. In Malibu, they don't have doctors who take Medi-Cal. There are many undocumented people in the community and to get care they need to get to Santa Monica or go to Agoura Hills.

- It can be very challenging to access good care for cultural issues. With the passage of the ACA, many people are now eligible for care who were not before. In the last couple of years, access has gotten better. Now the access issues have shifted from access to navigation of the system. We have a lot of people who need complete support in getting enrolled, and staying in the system. Case managers and navigators are critical to the process.
- Low-income African American and Hispanic families cannot afford the health insurance copayments. There are a number of people not eligible for Medi-Cal or Covered CA because they are undocumented or homeless. Other populations that have trouble accessing care are seniors, veterans, young parents and youth.
- Language is a big issue, access to insurance has helped, but there are still barriers to care because there so many languages spoken and the undocumented still have access to care issues. There are large and increasing numbers of people seen in community clinics and FQHCs.
- An available health care work force for mental health, primary care and preventive care for newly insured individuals is lacking. There has been a challenge to get care for the newly insured, but other than that, we are seeing some improvements to accessing care.
- Access to care is very serious, particularly with persons who are uninsured and undocumented, and especially within limited English populations. It is especially difficult to access specialty care. For primary care, it is a bit better with community and county clinics. The number of uninsured has decreased but people don't know how to use their benefits. Even though they have My Health LA, there is fear and lack of knowledge on how to access care. But accessing specialty care is really tough, and it has gotten worse in the past couple of years for multiple reasons. The low reimbursement rates are unattractive to those who serve that population and possibly not feasible. Also, the need to address cultural and linguistic issues to engage people in specialty care makes it even harder.
- Access to care will improve. It seems to be on the initial tip of starting to improve with the ACA. More people have access as they enroll in insurance and those access challenges will start to be addressed with more people insured. Will people know how to use it, maximize it? That is yet to be seen. Improved levels of literacy around health benefits are needed.

Dental Care

11.3% of children in SPA 5 had never been to a dentist. No teens reported never seeing a dentist.

Delay of Dental Care among Children and Teens

	SPA 5	Los Angeles County
Children never been to the dentist	11.3%	16.0%
Children been to dentist less than 6 months to 2 years	98.1%	83.9%
Teens never been to the dentist	0.0%	2.1%
Teens been to dentist less than 6 months to 2 years	100%	96.0%

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

In SPA 5, 28.4% of the children have no dental insurance and 8.5% were unable to receive dental care.

Children Access to Dental Care

	SPA 5	Los Angeles County
Children no dental insurance	28.4%	21.8%
Children who were unable to receive dental care	8.5%	12.6%

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

60.6% of SPA 5 adults have dental insurance, and 72.2% of all adults reported going to the dentist within the past year. 19.4% of adults reported not going to the dentist because they were unable to afford dental care.

Adult Dental Care

	SPA 5	Los Angeles County
Adults who have dental insurance that pays for some or all of their routine dental care	60.6%	48.2%
Adults who reported their last visit to a dentist was less than 12 months ago	72.2%	55.8%
Adults unable to obtain dental care because they could not afford it	19.4%	30.3%

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

Community Input – Dental Care

Stakeholder interviews identified the following issues, challenges and barriers related to dental care:

- People prioritize other things as being more important than their teeth. They don't mind having a cavity. It's really about prevention and education that poor oral health can lead to infections and portals to other diseases. Kids don't have a lot of dental insurance. When the big free health service events like Care Harbor occur, the dental lines are ridiculously long.
- Dental care is something that is extremely lacking. When coordinating big events

for health services to veterans, dental care is priority one. USC's dental school has a mobile van that always attends.

- There is never enough dental care. This is a large focus for seniors. Access is a little better now with Denti-Cal but many conditions are still not covered.
- Dental care is one of the top community health needs. Not enough dentists take Medi-Cal rates. There are too few dentists caring for the underserved because reimbursement rates are so low.
- Populations impacted and needing dental care are low-income adults, chronically homeless, substance abusers, veterans, and kids.
- Oral health screening is a huge issue. When conducting free screenings at the high schools, extraordinary amounts of oral disease are discovered each year: 7% of students have abscesses and 50% need to see a dentist.
- Dental problems affect kids and cause them to miss school days. They have subclinical diseases that result in pain and suffering that gets in the way of their ability to learn. Lack of dental care is a low level issue that is so prevalent that it is a major issue. But it doesn't rise to the level of awareness of other issues like asthma. Dental disease goes undetected until it is a very big problem. There are not enough dentists who will care for low-income populations.

Birth Characteristics

Births

In 2013, there were 6,900 births in the service area.

Teen Birth Rate

In 2013, teen births occurred at a rate of 0.9% of total births in the service area. This rate is lower than the teen birth rate in the state (6.2%) and county (6.3%). When examining geographic areas with a small occurrence, it is important to use caution when drawing conclusions from data as small occurrences may result in high rates. Ladera Heights had the highest rate of teen births (6.7%).

Births to Teenage Mothers (Under Age 20)

Geographic Area	Zip Codes	Births to Teen Mothers	Live Births	Percent of Live Births
Bel Air	90077	0	94	0.0%
Beverly Hills	90210	0	174	0.0%
Beverly Hills	90211	0	78	0.0%
Beverly Hills	90212	0	97	0.0%
Brentwood	90049	1	327	0.3%
Century City	90067	1	23	4.3%
Culver City	90230	7	361	1.9%
Culver City	90232	2	174	1.1%
Ladera Heights	90056	4	60	6.7%
Malibu	90265	1	101	1.0%
Marina del Rey	90292	0	308	0.0%
Pacific Palisades	90272	0	185	0.0%
Palms	90034	11	694	1.6%
Playa del Rey	90293	1	134	0.7%
Playa Vista	90094	1	136	0.7%
Santa Monica	90401	1	68	1.5%
Santa Monica	90402	0	95	0.0%
Santa Monica	90403	0	271	0.0%
Santa Monica	90404	3	205	1.5%
Santa Monica	90405	2	255	0.8%
Venice / Mar Vista	90066	10	689	1.5%
Venice	90291	3	282	1.1%
West Los Angeles	90025	2	509	0.4%
West Los Angeles	90035	4	519	0.8%
West Los Angeles	90064	0	298	0.0%
Westchester	90045	6	469	1.3%
Westwood	90024	1	294	0.3%
UCLA Health Service Area		**61**	**6,900**	**0.9%**
Los Angeles County		**8,147**	**128,512**	**6.3%**
California		**30,814**	**494,332**	**6.2%**

Source: California Department of Public Health, Open Data Portal, 2013. https://cdph.data.ca.gov/browse?category=Demographics

Prenatal Care

Pregnant women in the service area entered prenatal care in the first trimester at a rate of 92.7%. This rate of early entry into prenatal care is higher than the LA County rate of 84.9% and the state rate of 83.6%, and exceeds the Healthy People 2020 objective of 78% of women entering prenatal care in the first trimester. Ladera Heights had the lowest rate of early entry into prenatal care (73.6%), and did not meet the Healthy People 2020 objective.

Early Entry into Prenatal Care (In First Trimester)

Geographic Area	Zip Codes	Early Prenatal Care	Live Births*	Percent of Live Births
Bel Air	90077	75	80	93.8%
Beverly Hills	90210	123	130	94.6%
Beverly Hills	90211	58	61	95.1%
Beverly Hills	90212	72	76	94.7%
Brentwood	90049	290	299	97.0%
Century City	90067	13	16	81.3%
Culver City	90230	303	344	88.1%
Culver City	90232	150	164	91.5%
Ladera Heights	90056	39	53	73.6%
Malibu	90265	85	92	92.4%
Marina del Rey	90292	278	289	96.2%
Pacific Palisades	90272	171	174	98.3%
Palms	90034	572	642	89.1%
Playa del Rey	90293	126	129	97.7%
Playa Vista	90094	126	129	97.7%
Santa Monica	90401	58	62	93.5%
Santa Monica	90402	83	85	97.6%
Santa Monica	90403	249	257	96.9%
Santa Monica	90404	177	195	90.8%
Santa Monica	90405	228	248	91.9%
Venice / Mar Vista	90066	593	659	90.0%
Venice	90291	249	272	91.5%
West Los Angeles	90025	429	461	93.1%
West Los Angeles	90035	375	402	93.3%
West Los Angeles	90064	250	267	93.6%
Westchester	90045	404	439	92.0%
Westwood	90024	256	268	95.5%
UCLA Health Service Area		**5,832**	**6,293**	**92.7%**
Los Angeles County		**105,257**	**124,010**	**84.9%**
California		**406,080**	**485,583**	**83.6%**

Source: California Department of Public Health, Open Data Portal, 2013; https://cdph.data.ca.gov/browse?category=Demographics
**Births in which the first month of prenatal care is unknown are not included in the tabulation.*

Low Birth Weight

Low birth weight is a negative birth indicator. Babies born at a low birth weight are at higher risk for disease, disability and possibly death. For this measurement, a lower rate is a better indicator. The service area rate of low birth weight babies is 6.6% (65.8 per 1,000 live births). This is lower than the county rate (7%) and the state rate (6.8%). The service area rate meets the Healthy People 2020 objective of 7.8% of births being low birth weight. When examined by community, Bel Air, Ladera Heights and Santa Monica have rates of low birth weight babies that exceed the Healthy People 2020 objective. When examining geographic areas with a small occurrence it is important to use caution when drawing conclusions as small occurrences may result in high rates.

Low Birth Weight (Under 2,500 g)

Geographic Area	Zip Codes	Low Birth Weight	Live Births	Percent of Live Births
Bel Air	90077	10	94	10.6%
Beverly Hills	90210	9	174	5.2%
Beverly Hills	90211	4	78	5.1%
Beverly Hills	90212	3	97	3.1%
Brentwood	90049	26	327	8.0%
Century City	90067	0	23	0.0%
Culver City	90230	22	361	6.1%
Culver City	90232	10	174	5.7%
Ladera Heights	90056	6	60	10.0%
Malibu	90265	6	101	5.9%
Marina del Rey	90292	24	308	7.8%
Pacific Palisades	90272	9	185	4.9%
Palms	90034	43	694	6.2%
Playa del Rey	90293	12	134	9.0%
Playa Vista	90094	9	136	6.6%
Santa Monica	90401	8	68	11.8%
Santa Monica	90402	12	95	12.6%
Santa Monica	90403	20	271	7.4%
Santa Monica	90404	17	205	8.3%
Santa Monica	90405	13	255	5.1%
Venice / Mar Vista	90066	46	689	6.7%
Venice	90291	22	282	7.8%
West Los Angeles	90025	30	509	5.9%
West Los Angeles	90035	22	519	4.2%
West Los Angeles	90064	22	298	7.4%
Westchester	90045	35	469	7.5%
Westwood	90024	14	294	4.8%
UCLA Health Service Area		**454**	**6,900**	**6.6%**
Los Angeles County		**9,058**	**128,519**	**7.0%**
California		**33,798**	**494,365**	**6.8%**

Source: California Department of Public Health, Open Data Portal, 2013; https://cdph.data.ca.gov/browse?category=Demographics

Infant Mortality

The infant (less than one year of age) mortality rate in the service area was 2.9 deaths per 1,000 live births, which is well below the county rate (4.3) and the state rate (4.5). The infant death rate is also much less than the Healthy People 2020 objective of 6.0 deaths per 1,000 births.

Infant Mortality Rate, 2012

	Infant Deaths	Live Births	Death Rate
UCLA Health Service Area	20	6,897	2.9
Los Angeles County	**567**	**131,697**	**4.3**
California	**2,247**	**503,788**	**4.5**

Source: California Department of Public Health, 2012. http://informaticsportal.cdph.ca.gov/chsi/vsqs/; http://www.cdph.ca.gov/data/statistics/Documents/DeathZip2012.pdf

Breastfeeding

Breastfeeding has been proven to have considerable benefits to baby and mother. The California Department of Public Health highly recommends babies be fed only breast milk for the first six months of life. Data on breastfeeding are collected by hospitals on the Newborn Screening Test Form. Breastfeeding rates at UCLA Medical Center, Santa Monica indicate 96.5% of new mothers use some breastfeeding and 72.4% use breastfeeding exclusively. These rates are higher than the breastfeeding rate among hospitals in the county and statewide.

In-Hospital Breastfeeding

	Any Breastfeeding		Exclusive Breastfeeding	
	Number	Percent	Number	Percent
UCLA Medical Center, Santa Monica	1,417	96.5%	1,064	72.4%
Los Angeles County	**109,455**	**92.8%**	**62,955**	**53.3%**
California	**396,602**	**92.9%**	**275,706**	**64.6%**

Source: California Department of Public Health, Breastfeeding Hospital of Occurrence, 2013 https://www.cdph.ca.gov/data/statistics/Documents/MO-MCAH-HospitalTotalsReport2013.pdf

Mortality/Leading Causes of Death

Leading Causes of Premature Death

In Los Angeles County, 43% of people in 2011 died before they reached age 75, with deaths prior to 75 years of age determined by the Los Angeles County Department of Public Health to be premature. In SPA 5, coronary heart disease was the leading cause of premature death, followed by suicide, drug overdose, motor vehicle crashes, and liver disease.

Leading Cause of Premature Death, SPA 5

SPA 5	Los Angeles County
Coronary Heart Disease	Coronary Heart Disease
Suicide	Homicide
Drug overdose	Motor Vehicle Crash
Lung cancer	Liver disease
Liver disease	Suicide

Source: LA County Department of Public Health, Mortality in Los Angeles County, 2012. http://publichealth.lacounty.gov/dca/data/documents/mortalityrpt12.pdf

Death Rate

The mortality rate for all causes of death in the service area is 618.7 per 100,000 persons. This is higher than the county rate (583.9 per 100,000 persons) and lower than the state rate of death (626.9 per 100,000 persons).

Crude Death Rate per 100,000 Persons, 5-Year Average Total, 2008-2012

	Average Annual Deaths	Rate
UCLA Health Service Area	4,059	618.7
Los Angeles County	**57,773**	**583.9**
California	**236,089**	**626.9**

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012, http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx

Leading Causes of Death

Heart disease, cancer, and stroke are the top three leading causes of death in the service area. When compared to the county and state, the service area has higher death rates for the top three causes of death. Crude rates are subject to wide variation due to variations in median age from zip code to zip code.

Leading Causes of Death, Crude Rate per 100,000 Persons, 5-Year Total, 2008-2012

	UCLA Health Service Area		Los Angeles County	California
	Average Annual Deaths	Rate	Rate	Rate
Diseases of the heart	1,133	173.3	162.5	157.1
Cancer	1,044	159.7	140.1	148.8
Stroke	245	37.5	33.3	35.9
Chronic Lower Respiratory Disease/ Chronic Obstructive Pulmonary Disease	182	27.8	29.6	34.7
Alzheimer's disease	175	26.7	22.9	28.7
Pneumonia and flu	170	26.0	20.9	16.3

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012, http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx

In Los Angeles County, the leading cause of death for infants was low birthweight prematurity, for 1-4 year olds it was birth defect, and for 5-14 year olds motor vehicle crash. The leading cause of death in Los Angeles County for 15-24 year olds was homicide.

Leading Causes of Death by Age, Children and Youth, Los Angeles County

	<1 Year Old	1-4 Years Old	5-14 Years Old	15-24 Years Old
#1 cause	Low birthweight	Birth defect	Motor vehicle crash	Homicide
#2 cause	Sudden Infant Death Syndrome	Motor vehicle crash	Birth defect	Motor vehicle crash
#3 cause	Heart defect	Homicide	Leukemia	Suicide
#4 cause	Complication of placenta/cord	Drowning	Homicide	Drug overdose
#5 cause	Maternal complication	Perinatal period condition	Brain/nervous system cancer	Leukemia

Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Mortality in Los Angeles County, 2012: Leading causes of death and premature death with trends for 2003-2012. August 2015.
http://publichealth.lacounty.gov/dcareportspubs.htm

Heart Disease Mortality

The service area has a high rate of death due to heart disease at 173.3 per 100,000 persons, which is higher than the county and state rates.

Diseases of the Heart, Crude Death Rate per 100,000 Persons, 5-Year Average, 2008-2012*

Geographic Area	Zip Code	Average Annual Deaths	Rate
Bel Air	90077	18	206.9
Beverly Hills	90210	52	242.2
Beverly Hills	90211	17	224.6
Beverly Hills	90212	21	169.5
Brentwood	90049	67	190.9
Century City	90067	12	501.7
Culver City	90230	64	197.3
Culver City	90232	31	199.3
Ladera Heights	90056	25	292.9
Malibu	90265	26	146.3
Marina del Rey	90292	32	148.6
Pacific Palisades	90272	41	180.9
Palms	90034	67	114.5
Playa del Rey	90293	22	177.4
Playa Vista	90094	5	88.9
Santa Monica	90401	14	208.2
Santa Monica	90402	25	209.4
Santa Monica	90403	47	189.8
Santa Monica	90404	55	265.3
Santa Monica	90405	51	177.2
Venice / Mar Vista	90066	96	351.5
Venice	90291	31	51.8
West Los Angeles	90025	60	138.7
West Los Angeles	90035	60	194.2
West Los Angeles	90064	54	206.9
Westchester	90045	71	176.3
Westwood	90024	69	136.2
UCLA Health Service Area		**1,133**	**173.3**
Los Angeles County		**16,074**	**162.5**
California		**59,177**	**157.1**

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012.
http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx
**When examining geographic areas with a small population, such as zip codes, it is important to use caution when drawing conclusions from data; small occurrence of a health problem may result in a high rate.*

Cancer Mortality

The crude death rate for all cancers in the service area is 159.7 per 100,000 persons, which is higher than the county or state rate for cancer mortality.

All Cancers, Crude Death Rate per 100,000 Persons, 5-Year Average, 2008-2012*

Geographic Area	Zip Code	Average Annual Deaths	Rate
Bel Air	90077	20	235.1
Beverly Hills	90210	48	222.8
Beverly Hills	90211	16	206.5
Beverly Hills	90212	20	159.9
Brentwood	90049	67	188.6
Century City	90067	13	553.6
Culver City	90230	55	170.1
Culver City	90232	24	156.6
Ladera Heights	90056	25	295.2
Malibu	90265	27	152.0
Marina del Rey	90292	39	180.2
Pacific Palisades	90272	48	212.5
Palms	90034	59	100.5
Playa del Rey	90293	18	145.1
Playa Vista	90094	5	92.3
Santa Monica	90401	16	237.5
Santa Monica	90402	26	219.6
Santa Monica	90403	39	157.7
Santa Monica	90404	39	186.5
Santa Monica	90405	46	162.5
Venice / Mar Vista	90066	90	331.0
Venice	90291	31	52.9
West Los Angeles	90025	54	124.4
West Los Angeles	90035	53	171.0
West Los Angeles	90064	46	177.8
Westchester	90045	60	148.0
Westwood	90024	60	117.3
UCLA Health Service Area		**1,044**	**159.7**
Los Angeles County		**13,861**	**140.1**
California		**56,040**	**148.8**

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012.
http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx
**When examining geographic areas with a small population, such as zip codes, it is important to use caution when drawing conclusions from data; small occurrence of a health problem may result in a high rate.*

Stroke Mortality

The crude death rate for stroke in the service area is 37.5 per 100,000 persons, higher than the county and state rates.

Stroke, Crude Death Rate per 100,000 Persons, 5-Year Average, 2008-2012*

Geographic Area	Zip Code	Average Annual Deaths	Rate
Bel Air	90077	3	37.6
Beverly Hills	90210	12	53.8
Beverly Hills	90211	4	51.6
Beverly Hills	90212	5	38.4
Brentwood	90049	13	37.9
Century City	90067	3	138.4
Culver City	90230	14	42.1
Culver City	90232	6	36.2
Ladera Heights	90056	5	58.6
Malibu	90265	8	47.6
Marina del Rey	90292	8	36.2
Pacific Palisades	90272	10	44.8
Palms	90034	9	15.3
Playa del Rey	90293	3	22.6
Playa Vista	90094	1	10.3
Santa Monica	90401	2	32.3
Santa Monica	90402	7	57.9
Santa Monica	90403	12	49.1
Santa Monica	90404	11	53.8
Santa Monica	90405	9	32.9
Venice / Mar Vista	90066	24	87.3
Venice	90291	8	13.6
West Los Angeles	90025	14	32.1
West Los Angeles	90035	10	32.3
West Los Angeles	90064	13	48.3
Westchester	90045	16	40.2
Westwood	90024	15	30.2
UCLA Health Service Area		**245**	**37.5**
Los Angeles County		**3,296**	**33.3**
California		**13,528**	**35.9**

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012.
http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx
**When examining geographic areas with a small population, such as zip codes, it is important to use caution when drawing conclusions from data; small occurrence of a health problem may result in a high rate.*

Lung Disease Mortality

Chronic Lower Respiratory Disease and Chronic Obstructive Pulmonary Disease include emphysema and bronchitis. The crude death rate for lung disease in the service area is 27.8 per 100,000 persons, which is lower than county and state rates.

Lung Disease, Crude Death Rate per 100,000 Persons, 5-Year Average, 2008-2012*

Geographic Area	Zip Code	Average Annual Deaths	Rate
Bel Air	90077	2	25.9
Beverly Hills	90210	7	34.3
Beverly Hills	90211	4	46.5
Beverly Hills	90212	4	28.8
Brentwood	90049	11	31.2
Century City	90067	2	77.9
Culver City	90230	10	31.5
Culver City	90232	5	29.8
Ladera Heights	90056	4	44.5
Malibu	90265	8	43.1
Marina del Rey	90292	7	32.5
Pacific Palisades	90272	6	24.6
Palms	90034	14	23.5
Playa del Rey	90293	4	33.9
Playa Vista	90094	1	10.3
Santa Monica	90401	2	29.3
Santa Monica	90402	5	40.9
Santa Monica	90403	6	24.1
Santa Monica	90404	10	50.0
Santa Monica	90405	9	32.2
Venice / Mar Vista	90066	15	56.5
Venice	90291	5	9.1
West Los Angeles	90025	8	17.9
West Los Angeles	90035	8	26.5
West Los Angeles	90064	6	21.5
Westchester	90045	11	28.3
Westwood	90024	8	16.5
UCLA Health Service Area		**182**	**27.8**
Los Angeles County		**2,927**	**29.6**
California		**13,080**	**34.7**

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012.
http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx
**When examining geographic areas with a small population, such as zip codes, it is important to use caution when drawing conclusions from data; small occurrence of a health problem may result in a high rate.*

Alzheimer's Disease Mortality

The crude death rate for Alzheimer's disease in the service area is 26.7 per 100,000 persons, which is higher than the county rate but lower than the state rate.

Alzheimer's Disease, Crude Death Rate per 100,000 Persons, 5-Year Average, 2008-2012*

Geographic Area	Zip Code	Average Annual Deaths	Rate
Bel Air	90077	2	25.9
Beverly Hills	90210	10	45.5
Beverly Hills	90211	2	25.8
Beverly Hills	90212	3	27.2
Brentwood	90049	9	26.6
Century City	90067	2	69.2
Culver City	90230	7	21.6
Culver City	90232	6	36.2
Ladera Heights	90056	3	37.5
Malibu	90265	4	25.0
Marina del Rey	90292	4	19.5
Pacific Palisades	90272	11	48.3
Palms	90034	9	14.7
Playa del Rey	90293	3	25.8
Playa Vista	90094	1	10.3
Santa Monica	90401	2	23.5
Santa Monica	90402	6	49.4
Santa Monica	90403	7	26.5
Santa Monica	90404	10	48.1
Santa Monica	90405	8	27.3
Venice / Mar Vista	90066	14	52.8
Venice	90291	6	9.8
West Los Angeles	90025	12	28.5
West Los Angeles	90035	9	28.4
West Los Angeles	90064	7	27.6
Westchester	90045	8	20.9
Westwood	90024	10	19.2
UCLA Health Service Area		**175**	**26.7**
Los Angeles County		**2,263**	**22.9**
California		**10,794**	**28.7**

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012.
http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx
**When examining geographic areas with a small population, such as zip codes, it is important to use caution when drawing conclusions from data; small occurrence of a health problem may result in a high rate.*

Pneumonia and Influenza Mortality

The crude death rate for pneumonia and flu in the service area is 26.0 per 100,000 persons, which is higher than county and state rates.

Pneumonia and Influenza, Crude Death Rate per 100,000 Persons, 5-Year Average, 2008-2012*

Geographic Area	Zip Code	Average Annual Deaths	Rate
Bel Air	90077	2	25.9
Beverly Hills	90210	6	27.8
Beverly Hills	90211	4	54.2
Beverly Hills	90212	3	24.0
Brentwood	90049	12	34.0
Century City	90067	3	112.5
Culver City	90230	13	40.8
Culver City	90232	4	27.2
Ladera Heights	90056	4	44.5
Malibu	90265	2	13.6
Marina del Rey	90292	5	21.4
Pacific Palisades	90272	9	41.3
Palms	90034	11	18.1
Playa del Rey	90293	1	9.7
Playa Vista	90094	1	13.7
Santa Monica	90401	2	35.2
Santa Monica	90402	3	28.9
Santa Monica	90403	8	33.0
Santa Monica	90404	10	47.1
Santa Monica	90405	6	21.0
Venice / Mar Vista	90066	12	43.3
Venice	90291	4	7.5
West Los Angeles	90025	11	24.8
West Los Angeles	90035	8	27.1
West Los Angeles	90064	6	24.5
Westchester	90045	10	23.8
Westwood	90024	10	19.6
UCLA Health Service Area		**170**	**26.0**
Los Angeles County		**2,067**	**20.9**
California		**6,154**	**16.3**

Source: California Department of Public Health, Public Health Statistical Master Files 2008-2012.
http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx
**When examining geographic areas with a small population, such as zip codes, it is important to use caution when drawing conclusions from data; small occurrence of a health problem may result in a high rate.*

Chronic Disease

Health Status

Among the residents in SPA 5, 9.8% indicate they have fair or poor health status. The level of fair or poor health increases among seniors. In SPA 5, 19.3% of seniors consider themselves to be in fair/poor health.

Health Status, Fair or Poor Health

	SPA 5	Los Angeles County	California
Fair or poor health	9.8%	19.3%	17.0%
18-64 years old	9.4%	22.0%	19.3%
65+ years old	19.3%	31.4%	27.9%

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

Disability

In SPA 5, 25.5% of adults have a physical, mental or emotional disability. The rate of disability in the county is 28.6%. Disabled persons in SPA 5 (97.6%) were more likely to report having health insurance than disabled persons in the county and state.

Population with a Disability

	SPA 5	Los Angeles County	California
Adults with a disability	25.5%	28.6%	28.5%
Disabled persons with health insurance	97.6%	84.5%	87.8%

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

Asthma

7% of the population in SPA 5 has been diagnosed with asthma. Among those with asthma, 28.6% take medication to control their symptoms. Among youth, 7.8% have been diagnosed with asthma.

Asthma

	SPA 5	Los Angeles County	California
Diagnosed with asthma, total population	7.0%	11.4%	14.0%
Diagnosed with asthma, 0-17 years old	7.8%	10.5%	14.5%
ER visit in past year due to asthma, total population	0.0%	4.7%	9.6%
ER visit in past year due to asthma, 0-17 years old	0.0%	2.4%	13.9%
Takes daily medication to control asthma, total population	28.6%	41.0%	44.2%
Takes daily medication to control asthma, 0-17 years old	0.0%	27.7%	39.0%

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

Diabetes

Diabetes is a growing concern in the community. 4.6% of adults in SPA 5 reported they have been diagnosed with diabetes. For adults with diabetes, 69.6% in SPA 5 were very confident they can control their diabetes, while 15.7% were not confident.

Adult Diabetes

	SPA 5	Los Angeles County	California
Diagnosed pre/borderline diabetic	4.0%	8.8%	10.5%
Diagnosed with diabetes	4.6%	10.0%	8.9%
Very confident to control diabetes	69.6%	56.9%	56.5%
Somewhat confident	14.7%	33.7%	34.7%
Not confident	15.7%	9.3%	8.8%

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

Rates of diabetes reported by African American (4%), White (3.9%) and Latino (2.5%) residents of SPA 5 were lower than rates for those groups at county and state levels.

Adult Diabetes by Race/Ethnicity

	SPA 5	Los Angeles County	California
African American	4.0%	16.9%	12.4%
Asian	9.4%	10.0%	9.4%
Latino	2.5%	11.0%	10.0%
White	3.9%	7.1%	7.7%

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

Heart Disease

For adults in SPA 5, 4.8% have been diagnosed with heart disease. Among these adults, 66.7% are very confident they can manage their condition.

Adult Heart Disease

	SPA 5	Los Angeles County	California
Diagnosed with heart disease	4.8%	5.7%	6.1%
Very confident to control condition	66.7%	53.5%	53.6%
Somewhat confident to control condition	30.7%	36.0%	34.9%
Not confident to control condition	2.6%	10.4%	11.5%
Has a management care plan	89.8%	55.5%	67.1%

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

High Blood Pressure

A co-morbidity factor for diabetes and heart disease is hypertension (high blood pressure). In SPA 5, 26.8% of adults have high blood pressure. Of these, 60.6% reported taking medication for their high blood pressure.

High Blood Pressure

	SPA 5	Los Angeles County	California
Diagnosed with high blood pressure	26.8%	27.3%	28.5%
Takes medication for high blood pressure	60.6%	67.2%	68.5%

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

Cancer

Cancer incidence rates are available at the county level. In Los Angeles County, cancer levels are lower overall, than at the state level; however, the colorectal cancer rate (41.3 per 100,000 persons), uterine cancers, (25.1 per 100,000), ovarian cancer, (12.5 per 100,000) and thyroid cancer (12.5 per 100,000 persons) exceed the state rates.

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

	Los Angeles County	California
Cancer, All Sites	**405.6**	**424.9**
Prostate (males)	122.0	126.9
Breast (female)	116.9	122.1
Lung & Bronchus	41.6	47.9
Colon & Rectum	41.3	40.0
In Situ Breast (female)	25.5	29.1
Uterine ** (females)	25.1	24.1
Non-Hodgkin Lymphoma	18.4	18.8
Urinary Bladder	16.7	18.5
Kidney and Renal Pelvis	13.6	14.3
Leukemia *	12.3	12.5
Ovary (females)	12.5	12.1
Thyroid	12.5	12.0

*Source: The Centers for Disease Control and Prevention, National Cancer Institute, State Cancer Profiles, 2008-2012 http://www.cancer-rates.info/ca/ * = Myeloid & Monocytic + Lymphocytic + "Other" Leukemias ** = Uterus, NOS + Corpus Uteri*

HIV/AIDS

In 2013, 51 cases of HIV/AIDS were diagnosed in SPA 5 (8 per 100,000 persons). The rate of HIV/AIDS diagnosed has decreased from 2012 to 2013. Rates of diagnosis of HIV/AIDS are lower than found in the county. Rates of new diagnoses are highest among males, young adults 20-29, and Blacks/African Americans. 83% of the new cases were reportedly via male-to-male sexual contact, 10% via heterosexual sex, and 6% were cases where IV drug use was implicated.

HIV/AIDS Diagnoses, Number and Rate per 100,000 Persons, 2012 – 2013

	2012		2013	
	Number	Rate	Number	Rate
SPA 5	96	15	51	8
Los Angeles County	**1,911**	**19**	**1,268**	**13**

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

Sexually Transmitted Diseases (STDs)

In SPA 5, rates of chlamydia (316.5), gonorrhea (90.6), primary and secondary syphilis (7.7) and early latent syphilis (11.1), are lower than county rates of these STDs. Females have the highest rates of chlamydia. Young adults, ages 20-24, have the highest rates of chlamydia and gonorrhea, and residents ages 25-29 have the highest syphilis rates. Blacks/African Americans have the highest rates of STDs.

STD Cases, Rate per 100,000 Persons, 2012

	SPA 5	Los Angeles County
Chlamydia	316.5	521.3
Gonorrhea	90.6	122.9
Primary & Secondary Syphilis	7.7	9.4
Early Latent Syphilis	11.1	13.7

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

Teen Sexual History

75.2% of area teens reported that they had never had sex; this was a lower rate of abstinence than seen at the county (78.4%) or state (82.9%).

Teen Sexual History

	SPA 5	Los Angeles County	California
Never had sex	75.2%	78.4%	82.9%
First encounter under 15 years old	24.8%	10.7%	7.6%
First Encounter Over 15 Years Old	0.0%	10.9%	9.5%

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

Hospitalization and ER Rates by Diagnosis

At UCLA Medical Center, Santa Monica the top five primary diagnoses resulting in hospitalization are for digestive system, pregnancies, births, circulatory system, and musculoskeletal system issues.

Hospitalization Rates by Principal Diagnosis, Top Ten Causes

	UCLA Medical Center, Santa Monica
Digestive System	10.8%
All Pregnancies	9.8%
Births	9.1%
Circulatory System	8.7%
Musculoskeletal System	8.2%
Injuries / Poisonings / Complications	7.7%
Infections	7.5%
Cancer	7.0%
Respiratory System	6.5%
Genitourinary System	5.2%

Source: Healthy Communities Institute, California Office of Statewide Health Planning and Development, 2014. http://report.oshpd.ca.gov/?DID=PID&RID=Facility_Summary_Report_Hospital_Inpatient

A look at the hospital's ER principal diagnoses indicates that injuries/ poisonings/ complications and 'symptoms' are the top two primary diagnoses presenting at the ER, followed by musculoskeletal system, respiratory system, and nervous system diagnoses. Mental disorders are 4% of ER diagnoses.

Emergency Room Rates by Principal Diagnosis, Top Ten Causes

	UCLA Medical Center, Santa Monica
Injuries / Poisonings / Complications	26.7%
Symptoms	23.0%
Musculoskeletal System	7.6%
Respiratory System	7.3%
Nervous System	6.9%
Genitourinary System	5.3%
Mental Disorders	4.0%
Skin Disorders	3.9%
Digestive System	3.8%
Circulatory System	2.0%

Source: Healthy Communities Institute, California Office of Statewide Health Planning and Development, 2014. http://report.oshpd.ca.gov/?DID=PID&RID=Facility_Summary_Report_Emergency_Department

Community Input – Chronic Disease

Stakeholder interviews identified the following issues, challenges and barriers related to chronic disease:

- Chronic disease is a very big public health issue. HIV rates in minorities are extraordinarily high compared to other groups. There are significant rates of STDs and they are pathways to the spread of HIV. There remains significant stigma to talk about sexual health and HIV among men of color; this is a community barrier to having open and frank discussions.
- When talking about chronic disease, stroke is a very big concern. Unsafe communities provide barriers to address these things personally or as a community. Fear of violence can make it challenging to walk around the neighborhood and exercise. If residents don't have access to fresh quality food, like the corner store and farmer's markets, there isn't access. It isn't reasonable to expect people to have to drive outside of their neighborhoods to go to a good grocery store; a lot of people rely on public transportation.
- Schools keep getting information that all kids should be able to check their asthma levels and know if they are in the green or yellow zone. But the local doctors don't follow this protocol or teach the kids and families about it, so there is a lack of a coordinated care plan. No kid should miss school, but doctors are just writing notes for kids with asthma to stay home.
- Asthma is particularly challenging. The school district has 10-13% of kids with asthma on any given campus, and most of the time they are undiagnosed. A lot of collaboration is needed for kids and families to get connected to manage

asthma in home and school environments. Diabetes Type 1 is also extremely challenging in the schools. The schools help coordinate care with insulin.

- A huge part of the clinic's practice is chronic disease management. HIV is at the top of that list; the clinic has around 5,000 primary care clients and 3,000 of them have HIV.
- Chronic disease is seen among low-income populations, Hispanics, African-Americans, homeless, seniors and immigrants. People that didn't have access to care for years are now going to the doctor and finding out that they have chronic diseases. Now, with insurance, the numbers are increasing with new patients.
- Diabetes and heart disease are getting worse as more people are overweight and are developing pre-diabetes.
- A large percentage of older adults have chronic diseases. It is important to look at the whole person and consider how chronic disease impacts them and how to help them function from a holistic perspective so they can stay in their community. This includes helping them with things such as meals or transportation or advocating for their health needs.
- Veterans with cancer keep this diagnosis very private. They don't want to be perceived as being weak. They keep it secret for so long that practitioners only find out about it when they are terminal and incapacitated.
- Cancer has gotten worse in the past couple of years. This is due in part to low medical reimbursement and a lack of understanding of the population on how to access services. More cultural and linguistically targeted education efforts are needed to encourage people to not wait until it's an emergency. Prevention is key.

Health Behaviors

Health Behaviors Ranking

The County Health Rankings examine healthy behaviors and ranks counties according to health behavior data. California's 58 counties are ranked from 1 (healthiest) to 58 (least healthy) based on a number of indicators that include: adult smoking, obesity, physical inactivity, excessive drinking, sexually transmitted infections, and others. A ranking of 17 puts Los Angeles County in the top 50% of California counties for health behaviors.

Health Behaviors Ranking

	County Ranking (out of 58)
Los Angeles County	17

Source: County Health Rankings, 2015. www.countyhealthrankings.org

Overweight and Obese

In SPA 5, 38.8% of adults, 24% of teens, and 11.5% of children are overweight.

Overweight

	SPA 5	Los Angeles County	California
Adult (18+ years)	38.8%	36.2%	35.5%
Teen (ages 12-17)	24.0%	14.4%	16.3%
Child (under 12)	11.5%	11.5%	13.6%

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

Among adults in SPA 5, 14.5% are obese. This is better than the Healthy People 2020 objective for adult obesity of 30.5%. 16.7% of teens in SPA 5 are obese, which exceeds the Healthy People 2020 objective of 16.1% for teen obesity.

Obese

	SPA 5	Los Angeles County	California
Adult (ages 20+ years)	14.5%	27.2%	27.0%
Teen (ages 12-17 years)	16.7%	14.9%	14.6%

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

In SPA 5, 79.8% of adult African Americans are overweight or obese. Among adult Latinos, 69.3% are overweight or obese. Over half of Whites (54.1%) are overweight or obese, while among Asians, the rate is 38.6%.

Adults, Ages 20+, Overweight and Obese by Race/Ethnicity

	SPA 5	Los Angeles County	California
African American	79.8%	83.5%	71.2%
Asian	38.6%	41.1%	43.7%
Latino	69.3%	72.6%	72.2%
White	54.1%	60.8%	58.9%

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

The physical fitness test (PFT) for students in California schools is the FitnessGram®. One of the components of the PFT is measurement of body composition (measured by skinfold measurement, BMI, or bioelectric impedance). Children who do not meet the "Healthy Fitness Zone" criteria for body composition are categorized as needing improvement or at high risk (overweight/obese).

In LAUSD and the Inglewood Unified School District, over half of 5th grade students tested as needing improvement or at health risk for body composition. Among 9th graders, the rates were improved. Rates for both grades were above state averages. Beverly Hills, Culver City, and Santa Monica-Malibu Unified School Districts were below county and state averages for the categories of "needs improvement and health risk" for body composition.

5th and 9th Graders, Body Composition, Needs Improvement + Health Risk

School District	Fifth Grade	Ninth Grade
Los Angeles Unified School District	50.1%	44.4%
Inglewood Unified School District	55.2%	50.4%
Beverly Hills Unified School District	28.8%	26.1%
Culver City Unified School District	33.6%	22.6%
Santa Monica-Malibu Unified School District	27.6%	24.7%
Los Angeles County	**44.6%**	**38.6%**
California	**40.5%**	**35.8%**

Source: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2013-2014. http://data1.cde.ca.gov/dataquest/page2.asp?Level=District&submit1=Submit&Subject=FitTest

Fast Food

In SPA 5, 23% of adults and 4% of children consume fast food 3 or more times a week. These rates are lower than county and state levels.

Fast Food Consumption, 3 or More Times a Week

	SPA 5	Los Angeles County	California
Adult, ages 18-64, fast food consumption	23.0%	25.5%	24.9%
Children and youth, 0-17 years of age, fast food consumption	4.0%	15.1%	14.6%

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

Soda Consumption

The percentage of adults who consume seven or more sodas in a week is 9.6% in SPA 5, which is lower than the county rate (10.2%) and state rate (10.1%).

Adults Average Weekly Soda Consumption; 7 or more

	SPA 5	Los Angeles County	California
Adult soda consumption	9.6%	10.2%	10.1%

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

Fruit Consumption

Children in SPA 5 (81%) are much more likely to eat two or more servings of fruit a day than in L.A. County (63.4%). Teens are less likely to eat two or more servings of fruit a day (61.3%) than children.

Consumption of Fruit, Two or More Servings a Day, Children and Teens

	SPA 5	Los Angeles County	California
Children	81.0%	63.4%	68.8%
Teens	61.3%	43.6%	51.4%

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

Access to Fresh Produce

Among adults, 95.8% in SPA 5 indicated that accessing fresh produce (fruits and vegetables) was somewhat or very easy. This is a higher rate than seen in the county.

Adults who Reported Accessing Fresh Produce was Very or Somewhat Easy

	SPA 5	Los Angeles County
Adults, 18+ years old	95.8%	89.7%

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

Physical Activity

9.4% of SPA 5 children and teens spend over five hours in sedentary activities on a typical weekday. 23.3% spend over 8 hours a day on sedentary activities on weekend days. 90.5% of teens had been to a park, playground or open space in the past month.

Physical Activity

	SPA 5	Los Angeles County	California
5+ hours spent on sedentary activities after school on a typical weekday - children and teens	9.4%	9.3%	10.2%
8+ hours spent on sedentary activities on a typical weekend day - children and teens	23.3%	8.9%	7.2%
Teens no physical activity in a typical week	0.0%	11.9%	8.6%
Teens visited park/playground/open space in past month	90.5%	62.1%	69.2%

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

Community Input – Overweight and Obesity

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

- Obesity is definitely a problem. Many kids have BMI over 99%. On the south-side of Santa Monica, kids have a greater number of high BMI over 95% that puts them at health risk.
- In some schools, 70% of kids fail the fitness test, speed coordination, balance, etc. Of that 70%, 30% fail every section. They aren't moving around; they are obese. A campus approach to healthy, active living is needed.
- Overweight/obesity is one of the biggest challenges for school districts. Obesity prevention programs exist right and left; some are more effective than others. Even though there are a lot of groups working on it, obesity has gotten worse in the past few years.
- Visibility and public awareness are growing on this issue. The Department of Public Health is taking it seriously. Good prevention programs will pay dividends in the future.
- Inadequate diet, limited time, energy, and space for recreation are all contributors. A sedentary lifestyle is a huge contributor: people on computers, video games, etc. The conversation needs to be reframed – drink water, have healthy options at the front of the cafeteria counter at schools, rezone fast food restaurants, and get grocery stores in areas where they are needed.

Mental Health and Substance Abuse

Mental Health

Among adults, 9.0% in SPA 5 experienced serious psychological distress in the past year, while 20% needed help for mental health and/or alcohol and problems. 19.7% of adults saw a health care provider for their mental health and/or alcohol and drug issues in the past year.

10.1% of SPA 5 adults had taken a prescription medication for at least two weeks for an emotional or mental health issue in the past year. Over a third (37%) of adults who needed help for an emotional or mental health problem did not receive treatment. The Healthy People 2020 objective is for 64.6% of adults with a mental disorder to receive treatment, which equates to 35.4% who do not receive treatment.

Mental Health Indicators, Adults

	SPA 5	Los Angeles County	California
Adults who had serious psychological distress during past year	9.0%	9.6%	7.7%
Adults who needed help for emotional-mental and/or alcohol-drug issues in past year	20.0%	18.0%	15.9%
Adults who saw a health care provider for emotional/mental health and/or alcohol-drug issues in past year	19.7%	13.0%	12.0%
Has taken prescription medicine for emotional/mental health issue in past year	10.1%	9.2%	10.1%
Sought/needed help but did not receive treatment	37.0%	43.2%	56.6%

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

Among SPA 5 teens, 21.6% needed help in the past year for emotional or mental health problems, which was lower than county (22.4%) or state (23.2%) rates. Frequent mental distress was reported during the past month by 23.6% of area teens, which was higher than the county (7.3%) and the state (5.8%) rates.

Mental Health Indicators, Teens

	SPA 5	Los Angeles County	California
Teens who needed help for emotional or mental health problems in past year	21.6%	22.4%	23.2%
Teens who had frequent mental distress during the past month*	23.6%	7.3%	5.8%

Source: California Health Interview Survey, 2014 & 2012 (*). http://ask.chis.ucla.edu/

Community Input – Mental Health

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

- Mental health is the hardest service for anyone to access, even for people with good insurance; all psychiatrists on the west side are cash only. As income goes down, the county jail is filled with homeless that are seriously mentally ill.
- It is a very challenging problem.
- The mental health system in schools has psych social workers assigned to schools. They deal with problems that happen in schools with behavioral health and respond to them.
- Determining where to send kids in crisis is a continuous struggle as is where to obtain regular care. Mental health is a top priority. More crisis intervention and beds are needed. Even if schools did more screenings, there is nowhere to send the kids who are at risk. Schools have waitlists for kids who are so needy that administrators are left sitting on the edge of their chairs, hoping nothing happens. And parents have no ability to help. When kids threaten suicide, an assessment is completed. If a child is determined to be at moderate to severe risk, Psychiatric Emergency Team (PET) is called, and administrators need to stay with the child until PET shows up, sometimes 6-8 hours later. And PET won't even come out if they can't secure a bed. If PET cannot secure a bed and they don't come out, administrators have to tell parents to go to ED with their kids and hope they do. Often, the police are called. The same protocol must be followed if a kid threatens to harm others in the school.
- Mental health is an overwhelming condition. There is a stigma associated with mental health problems. Parent education, home visiting program and more focus on intergenerational support are needed. Often kids are alone and unsupervised in these poor neighborhoods. Afterschool programs have them stay on campus, but then a safety issue is how they get home.
- A problem is people need to identify mental illness as an issue. Public service campaigns around reducing the stigma and linking people to services are needed.
- There are two issues with mental health. One is stigma, which is different among cultures; people need help learning how to talk about mental illness and seek treatment. The second issue is workforce. If more people started seeking care, will there be care resources available for them?
- Proposition 63 has infused funding, allowing the system to try innovative approaches, and raise the expertise of the workforce. Changes are occurring with ACA health plans as moderate health issues are now getting reimbursed. Before it used to be only severe conditions could receive treatment. So there is now more early intervention.

- This is a public policy issue. Funds are from the Mental Health Services Act and recovery is based on volunteer engagement. It is voluntary, not mandatory. No one can be forced to get treatment.
- There is an uptick of vets self-disclosing mental health issues. There is not a lack of stigma, but it has been minimized. It is now appropriate for them to say they have an issue. Five years ago people would be cautious to say that.
- Depression and anxiety are key factors in readmissions to the Emergency Department.
- Stigma of mental illness has decreased in some ethnic groups. There is a greater recognition of need to factor in mental health care with primary care.

Tobacco/Alcohol/Drug Use

Cigarette Smoking

The 2014 California Health Interview Survey indicated that 7.8% of adults in SPA 5 are current smokers, lower than L.A. County (10.8%), the state (11.6%) and the Healthy People 2020 objective for cigarette smoking among adults (12%).

Cigarette Smoking, Adults

	SPA 5	Los Angeles County	California
Current smoker	7.8%	10.8%	11.6%
Former smoker	22.9%	22.4%	22.4%
Never smoked	69.2%	66.8%	66.0%

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

Among teens in SPA 5, while none surveyed reported being a cigarette smoker, 4.4% have smoked an electronic (vaporizer) cigarette; these rates are lower than for the county and the state.

Smoking, Teens

	SPA 5	Los Angeles County	California
Current cigarette smoker	None	2.3%	3.5%
Ever Smoked an e-Cigarette	4.4%	11.3%	10.3%

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

Alcohol and Drug Use

Binge drinking is defined as consuming a certain amount of alcohol within a set period of time. For males, this is five or more drinks per occasion and for females, it is four or more drinks per occasion. Among adults in SPA 5, 41.4% had engaged in binge drinking in the past year, which is a higher level than found in the county and state.

Binge Drinking, Adults

	SPA 5	Los Angeles County	California
Adult binge drinking past year	41.4%	31.5%	32.6%

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

Teens in SPA 5 reported having tried alcohol (20.6%) and illegal drugs (14.3%). More teens had used marijuana in the past year (14.3%) than L.A. County (9.4%) or California teens (8.6%).

Teen Alcohol and Illegal Drug Use

	SPA 5	Los Angeles County	California
Teen ever had an alcoholic drink	20.6%	19.1%	22.5%
Ever tried illegal drugs, including marijuana, cocaine, sniffing glue or others*	14.3%	14.7%	12.4%
Use of marijuana in past year*	14.3%	9.4%	8.6%

Source: California Health Interview Survey, 2014 & 2012 (*); http://ask.chis.ucla.edu/

Community Input – Substance Abuse

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

- Substance abuse is a big issue right next to mental health. There are major impacts in secondary and even middle school students. There is a lack of providers on the treatment side. Also, a lot of treatment is geared toward adults, like 12 step programs, which are not right for kids. The system is set up to address treatment and conditions once they are significant, not the early stages.
- Substance abuse is rampant; not enough is being done. The number of green stores is so high; access is so easy and in your face. LA County care isn't great when someone is addicted to heroin or meth. For alcohol and pot, there is not enough education and access to counseling.
- As people become more acculturated, substance abuse rises. First generations are so focused on working, but their kids get into it. This is the case with the Korean community. The first generation works hard and the kids are unsupervised. These kids are influenced by American culture and lots of drug and alcohol abuse. When immigrants come here, their prior education isn't accepted, their status from their home country isn't accepted and as a result, the family culture goes upside down. Kids can navigate through this new society quicker so they end up outpacing the parents.
- There is not enough funding for substance abuse and not enough integration with mental health.
- There are really not a lot of services available. There is a lack of short-term residential treatment. The provider community recognizes it and has gotten

better but funding has not kept up.

- In SPA 5, prescription drug overdose and managing medications is a huge issue, especially among higher income individuals and white males. There are significant rates of overdoses and suicide in this middle to upper class group.

Preventive Practices

Flu and Pneumonia Vaccines

In SPA 5, 72.8% of seniors, 62.1% of children 6 months to 17 years of age, and 43.4% of adults received a flu shot. Only SPA 5 seniors met the 70% Healthy People 2020 goal for flu vaccination.

Flu Vaccine

	SPA 5	Los Angeles County	California
Received flu vaccine, 65+ years old	72.8%	69.7%	72.8%
Received flu vaccine, 18-64	43.4%	32.5%	37.4%
Received flu vaccine, 6 months-17 years old	62.1%	47.8%	53.7%

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

64.1% of the seniors in SPA 5 had obtained a pneumonia vaccine, which does not meet the Healthy People 2020 objective of 90% of seniors to have a pneumonia vaccine.

Pneumonia Vaccine, Adults 65+

	SPA 5	Los Angeles County
Adults 65+, had a pneumonia vaccine	64.1%	61.3%

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

Immunization of Children

Area rates of compliance with childhood immunizations upon entry into kindergarten are below the state average (90.4%), with the exception of the Culver City Unified School District, which shows a high rate of compliance (94.1%). Beverly Hills USD (77.4%), LAUSD (78.9%) and Santa Monica-Malibu USD (81.1%) are below the county level of 86% of Kindergarten children having up-to-date immunizations.

Up-to-Date Immunization Rates of Children Entering Kindergarten, 2014-2015

School District	Immunization Rate
Los Angeles Unified School District	78.9%
Inglewood Unified School District	87.5%
Beverly Hills Unified School District	77.4%
Culver City Unified School District	94.1%
Santa Monica-Malibu Unified School District	81.1%
Los Angeles County	**86.0%**
California	**90.4%**

Source: California Department of Public Health, Immunization Branch, 2014-2015.
https://www.cdph.ca.gov/programs/immunize/Pages/ImmunizationLevels.aspx

Mammograms

The Healthy People 2020 objective for mammograms is that 81.1% of women 50-74 years to have a mammogram in the past two years; in SPA 5, 82.5% of women 50-74 have had mammograms, which meets this objective.

Pap Smears

The Healthy People 2020 objective for Pap smears in the past three years is 93% of 21-65 year olds to be screened. In SPA 5, 83.5% of women 21-65 have had a Pap smear in the past three years, which is higher than the county rate (82.8%), but does not meet the Healthy People 2020 objective.

Women Mammograms and Pap Smears

	SPA 5	Los Angeles County
Women 50-74 years, had a mammogram in past two years	82.5%	79.8%
Women 21-65; Pap smear in past three years	83.5%	82.8%

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

Colorectal Cancer Screening

The Healthy People 2020 objective for colorectal cancer screening is 70.5% of 50-75 year olds to be screened; SPA 5 (78.5%) exceeds this screening objective. Of adults advised to obtain screening, 72.3% were compliant at the time of the recommendation.

Colorectal Cancer Screening, Adults 50 to 75 years old

	SPA 5	Los Angeles County	California
Sigmoidoscopy, colonoscopy or fecal occult blood test	78.5%	74.0%	78.0%
Compliant with screening at time of recommendation	72.3%	65.3%	68.1%

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

Community Input – Preventive Practices

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

- Easy access to immunizations is needed. Families have no way to get to the doctor in a timely manner. Kids can't go to school until they are immunized so they often miss school. There are missed workdays for parents and missed school days for kids because they are assigned to a doctor in downtown LA and they can't get there.
- It is particularly important to address newly arrived populations, being aware of culture and linguistically issues.
- It is very important to be proactive about screenings based on evidence-based

best practices. Clinics have the ability to flag consumers when they need screenings.

- It is essential that payment for health needs shift toward prevention. Fee for service has been a downfall. ACA should move society into doing more preventive care and helping people stay healthy.
- Schools are places where more can be done. Schools have a responsibility to see where medical care stops and the educational and wellness systems start. Schools are great places to do more early screenings and interventions.
- The system is set up so there is an emphasis on taking care of really sick people versus preventive care. Why are there so many people with chronic conditions that could have been prevented? More investment in prevention is needed.
- We have a lot of prevention programs reaching the highest risk populations. There are measures we follow to prevent disease, immunizations and vaccinations.
- Increased numbers of people are getting care because they are now insured. But it's taking place in community health centers. Community clinics and really big insurers like Kaiser are doing more outreach services.
- Hepatitis B is the biggest challenge with the Asian population. There are so many subgroups in the community and many are not English proficient. Consequently, targeted care within their cultural enclaves is needed. It's hard, but worth the effort because cancer may be preventable.

Community Input

In addition to offering input on the significant health needs in the communities served by UCLA Health, the community stakeholders were asked what health or social services were most difficult to access or are missing in the community. Their responses included:

- Dental services
- Mental health services
- Access to care (insurance coverage, homeless care, culturally competent, linguistically accessible)
- Substance abuse services (counseling, treatment, residential treatment, LGBT competent)
- Specialty care (orthopedics, gastroenterology, cardiology, oncology, psychiatry and dermatology)
- Transportation
- Permanent supportive housing
- Vision care (low-cost glasses)
- Legal services

Additional Comments or Concerns

Finally, interview participants were asked if they had any other comments or concerns they wanted to share with UCLA Health. Their responses included:

- Hospitals play a pivotal role in capturing patients at their sickest. It's important for hospitals to collaborate with health plans to help coordinate transitions.
- It is important for organizations to work together on policy issues to address priority needs and work on implementing or changing policy to address issues.
- UCLA Health is really respected in the community. So anything they do toward communication of health and preventive care, and improving health behaviors and increasing resources is really important and worthwhile.
- Encourage partnerships between hospitals and community-based providers to provide health services at community-based organizations to avoid coming to the ER. Make rooms available at the hospital so that community-based partners can use the space to serve their clients.
- Hospitals need to collaborate on health information. Create a universal health information exchange so that primary care providers and specialists can share information and coordinate care. There is no shared health information so medical records have to be re-created each time patients see a new doctor or specialist. A lot of the patient portals are on different data platforms, but if there is a way to make it universal so that health information can be shared among providers, it will make health care more coordinated.

- There is still a lack of coordination between systems as many organizations are seeing the same patients for various reasons and they don't coordinate care.
- Organizations can work together to address needs and change policy on issues of housing and poverty. Hospitals can work together on issues of how the physical environment affects asthma. Also, provide training for youth for an entry point into health care workforce.
- Hospitals can support community-based efforts though grants and collaboratives.

Attachment 1. Community Stakeholder Interviewees

Community input was obtained from public health professionals and representatives from organizations that represent medically underserved, low-income, or minority populations.

Name	Title	Organization
Chris Baca	CEO	Meals on Wheels
Christopher Brown	Director of Health and Mental Health Services	Los Angeles LGBT Center
Stephanie Caldwell	Chief of Staff	LA County Department of Public Health
Maria Calleros	Director Safety Net Initiatives	LA Care Health Plan
Maureen Cyr	Supervisor	LA County Department of Mental Health
Lucia Diaz	Director	Mar Vista Family Center
Patrick Dowling, MD	Chairperson, Department of Family Medicine	UCLA
Deb Farmer	CEO	Westside Family Health Center
Elizabeth Forer, MSW, MPH	CEO	Venice Family Clinic
Alison Herrmann, PhD	Assistant Director	UCLA Kaiser Permanente Center for Health Equity
Louise Jaffe, EdD	Trustee	Santa Monica College, Santa Monica Lifelong Learning Community
Jan King, MD, MPH	SPA 5 and SPA 6 Public Health Officer	LA County Department of Public Health
Tod Lipka	CEO	Step Up on Second
John Maceri	CEO	Ocean Park Community Center/OPCC
Ivan Mason, MPA	Executive Director	U.S. Veterans Initiative
Lora Morn	Nurse Coordinator, Student Services	Santa Monica-Malibu Unified School District
Suzanne Peckels	Director, Program Development and Community Relations	Wise and Healthy Aging
Maryjane Puffer, BSN, MPA	Executive Director	LA Trust for Children's Health
Vivian Sauer, LCSW	Director of Quality Management and Program Development	Jewish Family Services of Los Angeles
Elan Shultz	Head Deputy	LA County Supervisor, 3rd District Office of Supervisor Sheila Kuehl
Wayne Sugita	Interim Executive Director	Substance Abuse Prevention and Control, LA County Department of Public Health
Msgr. Torgerson	Pastor	St. Monica Catholic Church
Kimberly Uyeda, MD, MPH	Assistant Director	Los Angeles Unified School District
Rosemary Veniegas, PhD	Program Officer	California Community Foundation
Jacquelyn Wilcoxen	District Chief	LA County Department of Mental Health

Attachment 2. Community Resources

Community resources to address the identified significant health needs are listed in the table below. This is not a comprehensive list of all available resources. For additional resources refer to Think Health LA at www.thinkhealthla.org and 211 LA County at https://www.211la.org/.

Significant Health Needs	Community Resources
Access to care	Westside Family Health Center, Venice Family Clinic, school-based health centers, school wellness centers, Healthy Way LA, primary care providers, UCLA International Medical Graduate program, Simms Mann Clinic, Wise and Healthy Aging, Didi Hirsch Mental Health Services, Supportive Services for Veterans Families, COACH for Kids mobile health van, Ocean Park Community Center (OPCC), Los Angeles LGBT Center
Cancer	UCLA Health, Providence St. John's Health Center Santa Monica, Kaiser Permanente, Marina Del Rey Hospital, Brotman Medical Center, county hospital, Venice Family Clinic, LGBT Health Alliance, Cancer Support Community Benjamin Center, American Cancer Society, primary care providers, Los Angeles Department of Public Health Office of Women's Health
Chronic disease (asthma, diabetes, heart disease, HIV/AIDS)	Breathmobile, Venice Family Clinic, UCLA Health, primary care physicians, Westside Family Health Center, Wise and Healthy Aging, Alzheimer's Association, Common Ground, Saban Clinic, Homeless Access Center, county clinics, hospitals, American Diabetes Association, First Ladies Club, schools and school districts, HIVLA.org, Jeffrey Goodman Clinic
Community safety	Libraries, schools and school districts, faith institutions, law enforcement, Department of Transportation, parks, shelters and day centers, Safe Routes to School program, gang intervention programs, Summer Night Lights program, Los Angeles LGBT Center, Homeboy Enterprises, Salvation Army, Parks after Dark
Dental care	Venice Family Clinic, private dentists, schools – screening and varnish programs, UCLA Health Dental clinic, county hospital, USC Dental program, St. John's Well Child and Family Center, Saban Clinic, free health clinics
Homelessness	Ocean Park Community Center (OPCC), PATH, United Way, HOPICS, Providence St. John's Health Center, Santa Monica, UCLA Family Medicine and nursing staff homeless clinics, Los Angeles LGBT Center, Veterans Administration, West Hollywood Housing Development, Mar Vista Housing, Los Angeles Homeless Services Authority, LA County Department of Public Health, Department of Mental Health, homeless access center, St. Joseph's Center, My Friend's Place, Safe Place for Youth, Daniel's Places, Step Up
Mental health	LA County Department of Mental Health, community clinics, Didi Hirsch Mental Health Services, Providence St. John's Health Center, Santa Monica, My Health LA, county mental health clinics, law enforcement, Wise and Healthy Aging, Los Angeles LGBT Center,

	UCLA Nathanson Family Resilience Center, UCLA Behavioral Health Associates, UCLA Behavioral Health Network, Resnick Neuropsychiatric Hospital at UCLA, St. Joseph's Center, Ocean Park Community Center (OPCC), schools and school districts, Step Up
Overweight and obesity	LA County Department of Public Health, Cedars-Sinai Medical Center's Healthy Habits program, community clinics, primary care providers, Mar Vista Family Center, American Diabetes Association, UCLA Family Center, policy work in communities, community-based coalitions and collaboratives
Preventive practices	Nonprofit social service agencies, churches, schools and school districts, community clinics, LA County Department of Public Health, COACH for Kids, primary care providers, libraries, Vaccines for Children (VFC), Los Angeles LGBT Center, high school wellness centers, promotoras, policy work in communities, St. Joseph's Center, UCLA Family Clinic, Kaiser Permanente, My Friend's Place, Safe Place for Youth
Substance abuse	Didi Hirsch Mental Health Services, Mar Vista Family Center, LA County Department of Public Health, LA County Department of Mental Health, AA programs, law enforcement, schools and school districts, CLARE Foundation, community-based substance abuse treatment providers, Wise and Healthy Aging, Venice Family Clinic, Providence St. John's Health Center, Santa Monica, Resnick Neuropsychiatric Hospital at UCLA, Los Angeles LGBT Center

Attachment 3. Impact Evaluation

UCLA Health developed and approved an Implementation Strategy to address significant health needs identified in the 2013 Community Health Needs Assessment. The Implementation Strategy addressed the following health needs through a commitment of community benefit programs and resources: access to care, health promotion and disease prevention, chronic health conditions, mental health, substance abuse and addiction, aging population, homelessness and dental care.

To accomplish the Implementation Strategy, goals were established that indicated the expected changes in the health needs as a result of community programs and activities. Strategies to address the priority health needs were identified and impact measures tracked. The following section outlines the impact made on the selected significant health needs since the completion of the 2013 CHNA.

Priority Health Need: Access to Care

Goal: Increase access to health care for the medically underserved.

Mobile Clinic Project

The Mobile Clinic Project (MCP) at UCLA aims to improve the health outcomes and quality of life of the homeless and other vulnerable populations in the greater Los Angeles area by connecting clients to the existing continuum of care through direct medical care, health promotion and disease prevention activities, legal advocacy and referrals to health and social services. MCP is staffed by medical students with oversight from attending physicians from a variety of medical specialties who work on-site to ensure that clients receive the best care possible. Volunteers record medical histories, provide treatment or referrals, dispense medication and supplies and help clients with social or legal issues. Services range from basic check-ups and disease prevention and education to treatment of cuts, infections, coughs, etc. MCP operates at three sites in Santa Monica, including a homeless shelter and a mental health center.

<u>Program Impact</u>

- Decreasing the uninsured individuals who access care from MCP from 36% (Sept 2013 to Aug 2014) to 30% in 2015. This was a result of MCP's on-site insurance enrollment through our collaboration with student organization Connecting Californians to Care and also the Affordable Care Act.
- Providing vision services to those who would otherwise not have access to vision care. A sample of clients who received vision services from MCP were surveyed and 93% said that they do not go anywhere else for vision services.
- Increasing opportunities to access housing. In 2015, over 25 homeless clients have taken the Coordinated Entry System (CES) survey to have an opportunity to access permanent supportive housing, and two individuals have been

determined to be eligible for housing through CES (a system to match people with available housing resources in Los Angeles).

- Half (50%) of patients reported that UCLA MCP is their primary source of health care (MCP primary patients); for these persons, 63.1% indicate the clinic is their only source of care.
- 81.3% of patients believe UCLA MCP has improved access to other health care resources in Los Angeles.
- Patients are 'completely satisfied' with clinic services (Mean = 3.8; SD = 0.47)
- 62% have recommended MCP services to others.
- 89.6% of UCLA MCP patients would choose the clinic over the ER for treatment of a nonemergency condition.

UCLA Mobile Eye Clinic

The UCLA Mobile Eye Clinic provides high-quality eye care to underserved populations, particularly children and the elderly, who lack access to health care as a result of finances, transportation problems or cultural and language barriers. The UCLA Mobile Eye Clinic and its staff of ophthalmologists, ophthalmology residents, technicians and volunteers make weekly visits to Southern California community locations including public and private schools, free clinics, social services agencies working with abused and foster children, low-income families and the homeless. Ophthalmologists perform basic eye examinations to determine the need for prescriptive lenses and to rule out the need for further treatment of any eye condition or disease.

Program Impact

The UCLA Mobile Eye Clinic served individuals from free clinics, schools, social service agencies, low-income working families, and the homeless. They provided services at the Inner City Arts School, Chuco Justice Center, Venice Family Clinic, St. Joseph homeless shelter, St. Francis Center, and many other sites.

Services	July 2013 - June 2014	July 2014 – June 2015
Site visits	330	438
Vision screenings	15,113	20,000
Comprehensive eye exams	3,194	3,381
UCLA Mobile Eye Clinic vehicle trips to help the underserved	725	945
Individuals served	17,074	21,422
Abnormal findings	3,194	3,381
Free glasses distributed	2,046	2,511

Services	July 2013 - June 2014	July 2014 – June 2015
Referred to specialists for moderate to severe amblyopia, exotropia, esotropia, narrow angle, trichiasis, chalazion, and ptosis	296	881
First 5 LA Grant Pre-school children served	15,113	20,000
Children received free eyeglasses	1,421	1,894

Care Harbor

Care Harbor transforms arenas and other large venues into working clinics treating thousands of people in the space of a few days. Since the beginning of this event in 2010, the American Academy of Ophthalmology EyeSmart EyeCheck and the UCLA Mobile Eye Clinic, under the direction of Anne L. Coleman, MD, PhD, has been one of these community partners providing full eye exams and referrals to specialists.

Program Impact

- 2014: 335 full-eye exams, 178 referrals
- 2015: 204 full-eye exams, 69 referrals to eye specialists in the community for further treatment and care of these patients. The eye specialists in the community were ophthalmologists who take the referrals from Care Harbor free of charge.

West Hollywood Homeless Project

At the weekly West Hollywood Homeless Project, UCLA Medical Students provide free medical services and examinations to homeless individuals. This clinic has been in existence for over 10 years. Since August 2015, the UCLA Mobile Eye Clinic (UMEC) program has worked with this clinic to provide more thorough eye exams with Stein Eye Institute Ophthalmologists. Before UMEC's involvement, the clinic was able to conduct vision screenings and prescribe glasses to patients, but now, with the help of UMEC doctors, patients are given a full eye exam and, if necessary, referrals to eye specialists.

Program Impact

- 4 clinics have been attended
- 32 patients were seen
- 30 prescription glasses were distributed
- 5 referrals to eye specialists for the treatment of amblyopia (lazy eye), strabismus (cross eye), clinically significant refractive error, or other conditions

LA County Library Adult Outreach

2014: This new partnership with the Youth Policy Institute resulted in 13 trips to the Los

Angeles Public Libraries. The UMEC helped promote the Promise Neighborhoods Initiative of transforming underserved community by examining 189 individuals. All 189 individuals had abnormal findings; 159 received a free pair of eye glasses, and 19 individuals were referred to specialists.

2015: 36 Trips to Los Angeles County libraries, 357 people were seen, and 314 glasses were distributed.

Venice Family Clinic Uninsured Cohort Pilot Program

The Venice Family Clinic (VFC) Uninsured Cohort pilot program was developed to improve access to specialty care and hospitalizations to a cohort of up to 1,200 uninsured, adult patients utilizing the VFC's Irma Colen Health Center as their medical home. The UCLA outpatient subspecialty services available to these primary care patients are: Gastroenterology, Neurology, Ophthalmology, Orthopedics, Podiatry, Rheumatology, Surgery (General), and Urology. Enrolled adults are assigned to one of three VFC Irma Colen Health Center primary care physicians (PCPs) who are responsible for managing their patients' health care needs. If an enrolled patient needs to be hospitalized, UCLA hospitalists will manage the inpatient care and communicate/coordinate the patient's transition to the outpatient setting with the appropriate VFC Irma Colen Health Center PCP.

Program Impact

- Provided uninsured adult patients at the Colen Health Center in Mar Vista with more rapid and geographically convenient access to specialty clinics at UCLA at no cost. As a result of this program, the patient wait time for a specialty care visit was reduced. Typically, specialty care appointments may take months and over a year if accessed through the Los Angeles County system.
- Since 2010, 484 patients were registered and 367 referrals completed. From 2013 there have been 3 new patients registered and 7 referrals. This program has been put on hold with the expansion of Medi-Cal.

Priority Health Need: Health Promotion and Disease Prevention

Goal: Improve community health through health promotion and preventive practices.

Tobacco Free Campus Initiative

The "Tobacco-Free Campus" Action Research Team (ART) is a student-led research project formed to raise awareness and analyze UCLA's tobacco-free policy. The overall objective of the team's research was to analyze the change in tobacco use before and after the implementation of the ban.

Program Impact

- Increased overall awareness of tobacco ban on campus.
- Compiled a film that featured hundreds of pictures of UCLA students and faculty promoting the upcoming policy change.
- Created a project website and Facebook page to inform students, other colleges, and the general public about our work.
- Attended several Earth Day events with visual and educational displays, including informational posters that highlighted key statistics regarding the environmental consequences of tobacco production and disposal.
- "Great Butt Hunt" – ART + 15 student volunteers, walked throughout UCLA's campus and picked up nearly 10,000 cigarette butts

General research findings

Decreased cigarette litter: Cigarette Litter Counts were conducted bi-weekly for eight weeks. There were decreased amounts of cigarette litter collected after the ban was implemented. Overall decrease in median cigarette butt counts at five of seven monitored sites, and an overall decrease in median cigarette butt counts across the combined site counts. Across all sites, 595.5 cigarette butts formed the median before the ban, with a standard deviation of 148.8, while post-ban analysis shows a 159.5 cigarette butt median and a 32.89 standard deviation. Using median values, the amount of cigarette litter throughout all of our samples sites decreased by 73.2%.

UCLA Fit for Healthy Weight Clinic

UCLA Fit for Healthy Weight Clinic sees children who are overweight or obese (BMI percentile over 85%) and who have not been able to lower their BMI with help from their primary care provider. The UCLA Fit for Healthy Weight Clinic is staffed by a multidisciplinary team, composed of a pediatrician specializing in nutrition, a psychologist, and a dietician. Patients and their families enjoy the benefit of seeing all three providers at every appointment. After an initial evaluation, a treatment plan is made with appropriate phone and/or clinic follow up. Pediatric subspecialists and a weight-loss surgeon are also available as needed. The UCLA Fit for Healthy Weight Clinic is piloting a program with satellite clinics from Venice Family Clinic (Simms Mann Telemedicine Fit Clinic) and Los Angeles Unified School District (LAUSD) to offer consultation with the Fit for Healthy Weight Clinic using telemedicine technology. The program also has an in-person clinic at UCLA.

Program Impact

From July 1, 2014 through June 30, 2015, a retrospective chart review of 18 unduplicated patients receiving care through the telemedicine clinics at Los Angeles Unified School District and Venice Family Clinic showed positive clinical outcomes, with 94% of patients stabilizing or decreasing weight within 6 months, and 40% of patients

with blood pressures in the pre-hypertensive or hypertensive range at baseline having normal blood pressure at follow-up.

Sound Body Sound Mind

UCLA Health Sound Body Sound Mind was founded in 1999 to address the growing obesity epidemic among Los Angeles adolescents by promoting healthy lifestyle choices and the self-confidence needed to sustain them. To this end, we provide state-of-the-art fitness centers to middle and high schools in LAUSD along with an innovative physical education program designed to help students develop confidence and competence in a variety of physical activities.

The ultimate goal of UCLA Health Sound Body Sound Mind is to ensure that every student has the opportunity, knowledge and appropriate tools to pursue a healthy lifestyle through physical fitness. The equipment in our workout facilities is varied and plentiful enough to be accessible to all students and to keep large classes engaged. Each new fitness center includes a selection of commercial-grade cardiovascular equipment (ellipticals, hybrid cycles, spin bikes and arm cycles), strength training equipment (weights and strength machines), and mobile equipment such as jump ropes and agility ladders. Ultimately, UCLA Health Sound Body Sound Mind hopes to empower students to maintain a lifetime of healthy habits through exercise and fitness.

The program has over 100 fitness centers serving over 100,000 students every year. Over 85% of our partner schools are located in low-income communities, where students have limited access to safe fitness resources.

<u>Program Impact</u>

FITNESSGRAM tests assess student fitness levels in the following areas: flexibility, aerobic capacity, body composition, muscular strength and endurance. Six tests are administered to students in order to make the aforementioned assessments, including: BMI, sit and reach (stretching test), trunk lift (stretching test), pacer (running test), push-ups and sit-ups. A comparative analysis of pre and post FITNESSGRAM scores is completed to evaluate the impact of UCLA Health Sound Body Sound Mind programming and curriculum on overall student health at each school where our program is implemented.

UCLA Health Sound Body Sound Mind requires the physical education staff at each school where our program is implemented to administer a survey to students before and after program implementation. These surveys measure student attitudes toward exercise, body image and fitness knowledge. As with the FITNESSGRAM data, UCLA Health Sound Body Sound Mind performs an analysis of pre- and post-survey results to identify changes in student perceptions toward fitness and exercise.

Results from 2015:

- 61.75% of students reported that participation in the UCLA Health Sound Body Sound Mind Curriculum effectively motivated them to exercise more outside school.
- 88.17% of students reported feeling some greater degree of fitness after training with the UCLA Health Sound Body Sound Mind Curriculum.
- 92.7% of students reported feeling some greater degree of knowledge about fitness and exercise after training with the UCLA Health Curriculum.

***Fitnessgram* Data Collection Summary, 2014-2015 Academic Year**

School	Number of students passing the *Fitnessgram before* implementing SBSM Curriculum	Number of students passing the *Fitnessgram after* implementing SBSM Curriculum	Percent increase in *Fitnessgram* passing rates
Alliance Alice M. Baxter College-Ready Academy High School	33/100	75/100	127%
East Valley High School	15/100	26/100	73%
Markham Middle School	34/100	51/100	50%
Thomas Alva Edison Middle School	37/100	66/100	78%
USC Hybrid High School	79/100	88/100	11%
Average increase in Fitnessgram test passing rates:			54%

Health Seminars

UCLA Health provides health education and outreach on a variety of health topics. Education and community events are open the public and provided free of charge.

Program Impact

2013: 1,233 participants attended these education sessions

- Affordable Health Act Update
- Aging Eyelids
- Arthritis and Yoga
- Bladder and Urinary Tract Cancers
- Cancer in the Elderly
- Constipation Update
- Coughs
- Crohn's Disease and Ulcerative Colitis
- Dental Implants
- Evolving Strategies for Breast Cancer
- Fall Prevention
- Focal Therapy for Prostate Cancer
- Health Screens as we Age
- Healthy Lifestyle for Memory Function
- Image-Guided Cancer Therapy
- Introduction to East-West Medicine
- Is Robotic Surgery Better or it is More Dangerous?
- Is your Thyroid Healthy?
- Lowering Your Risk of Alzheimer's Disease
- Nutrition and Weight Loss
- Osteoarthritis

- Osteoporosis
- Peripheral Vascular Disease
- Planning for the End of Life
- Preventing Diabetes and Obesity
- Preventing Heart Disease
- Sleep Changes as We Age
- Sleep Update
- Spine Surgery Advances
- Targeted Prostate Biopsy
- Therapeutic Massage Treatment
- Thyroid Health
- Understanding Medicare
- Ups and Downs of Blood Pressure
- Uterine Fibroid Update
- Vaccinations for Older Adults
- Wellness and Longevity
- When Do I need to see a Podiatrist?
- Zumba Gold

2014: 2,402 participants attended these education sessions

- ABCs of Autism
- Advance Directives
- Affordable Care Act
- Age-Related Hearing Loss
- Aging Eyelids
- Allergies Update
- Alternative Medicine
- Aortic Stenosis Update
- Arthritis of the Hand
- Asthma and COPD
- Back, Hip, Arm and Leg Pain
- Better Body, Better Bones
- Better Bones, Better Health
- Bone Tumors
- Caregiver Stress and Depression
- Celiac Disease and Gluten Sensitivity
- Celiac Disease and Non-Celiac Gluten Sensitivity
- Constipation
- Coughs
- Dementia Medications
- Dizziness
- Fall Prevention
- Fit Feet After Fifty
- Gastrointestinal Cancer
- Gluten Free
- Guide to Antibiotic Use
- Half of What I Read is Wrong!
- Heart Failure in Older Adults
- High Blood Pressure
- Hoarseness
- How Hormones affect Body Fat
- How to Start and Maintain Healthy Habits
- Hypertension
- Integrative Approach to Healthy Eyes
- Integrative Medicine
- Joint Pains
- Knee Osteoarthritis
- Lung Cancer
- Lung Cancer Screening
- Lung Cancer Update
- Make the Most of Your Trip to the Doctor
- Making Friends as We Age
- Management of Aortic Stenosis
- Managing Osteoarthritis
- Menopause- What's New?
- Metabolic Syndrome and Obesity
- My Legs Hurt – Why?
- Neuropathy Update
- Nutrition for Young Children
- Oh My Aching Back
- Optimizing Nasal Appearance
- Osteoporosis Update
- Polycystic Kidney Disease
- Preserving and Enhancing Your Skin
- Principles of Balance
- Prolapse and Incontinence
- Promoting Brain Health
- Prostate Cancer Screening

- Prostate Cancer Update
- Protecting Your Skin
- Psoriasis Update
- Restorative Yoga
- Rotator Cuff Tears
- Sleep Apnea Update
- Sleep Update
- Street Smarts for Seniors
- Stress Management Strategies
- Stroke
- Thyroid Disease Update
- Thyroid Update
- Tips for Staying Healthy
- Tomorrow Comes! Plan for it Today
- Tremors
- Understanding Medicare
- Understanding OCD
- Ups and Downs of Blood Pressure
- Urinary Incontinence
- Vitamins and Supplements
- Volunteer for Medical Research
- Weight Gain After Bariatric Surgery
- Women's Health
- Your Eyes

2015: 2,384 participants attended these education sessions

- 10 Habits to Add Vitality to Your Life
- Advance Directives
- Alzheimer's Disease and Dementia
- Aortic Stenosis
- Asthma Update
- Back, Hip, Arm and Leg Pain
- Benefits of Exercise
- Better Health Through Better Understanding
- Blood Pressure
- Bone Health
- Brain Health
- Brain PETS
- Cholesterol Update
- Colon Cancer Screening
- Common Gastrointestinal Diseases
- Concussions
- Constipation and Bowel Leaks
- Dementia y enfermidad de Alzheimer's
- Diabetes
- Dieta Saludable
- Digestive Problems in the Aging
- Diverticular Disease
- East-West Primary Care
- Emphysema Update
- Facial Aesthetics
- Fall Prevention
- Fibroids Update
- Finding Your Balance
- Fit Feet After 50
- Foot and Toe Pain
- Gout Update
- Hair Loss
- Healthy Aging
- Healthy Weight Loss
- Hearing Loss Update
- Heartburn Salud cardiovascular
- Insomnia
- Integrative Medicine
- Introduction to Qi Gong
- Keeping Yourself Healthy
- Kidney Disease and High Blood Pressure
- Knee Osteoarthritis
- Living with COPD
- Lowering your Risk of Alzheimer's Disease
- Lymphoma
- Neuropathy Update
- Nutritional Issues in Older Adults
- Obesity and Weight Loss
- Obsessive Compulsive Disorder

- Optimizing Nasal Appearance
- Osteoporosis
- Planning for the End of Life
- Posture and Ergonomics
- Prevent and Detect Skin Cancer
- Reducing Risk of Cancer
- Resilience
- Riding the Cancer Wave
- Role of Stress in Cancer Therapy
- Rotator Cuff Tears
- Testosterone Replacement Therapy
- Understanding Medicare
- Understanding OCD
- Ups and Downs of Blood Pressure
- Vaccine Recommendations
- Virtual Colonoscopy
- Vitamins/Minerals
- What You Need to Know before going to ER
- Your Eyes

Community Events/Health Fairs
UCLA Health provides health education, outreach and screenings in the community.

2013: Over 3,750 participants at health and wellness fairs, health lectures and conferences. Screenings were provided for: varicose veins, blood pressure, flexibility/posture, and fall prevention.

2014: Over 7,900 participants at health and wellness fairs, health lectures and conferences. Screenings were provided for: nutrition, blood pressure, fall prevention, and varicose veins.

2015: Over 4,625 participants at health and wellness fairs, health lectures and conferences. Screenings were provided for: varicose veins, posture, blood pressure, and fall prevention.

Annual Community Flu Shot Clinics
Flu shots were given to seniors at UCLA Urgent Care sites and at CVS Minute Clinics. The following number of flu shots was given to adults 50 years old and over.
2013 – 200 flu shots
2014 – 142 flu shots
2015 – 229 flu shots

Priority Health Need: Management of Chronic Conditions
Goal: Reduce impact of chronic conditions on health and increase focus on prevention, treatment and support.

Simms/Mann – UCLA Center for Integrative Oncology
Part of the Jonsson Comprehensive Cancer Center at UCLA, the Simms/Mann Center is a special place designed to help patients and their families face the challenges brought about by cancer and its treatments. The majority of Center programs, including support groups and psychosocial care, are offered to individuals free of charge.

Program Impact

Insights Into Cancer is a monthly lecture series on a variety of cancer topics.
2013: 1,020 persons attended the education sessions.
2014: 1,014 persons attended the education sessions.
2015: 297 persons attended the education sessions.

Support Groups provide both educational, healing and support opportunities. The groups held at the Simms/Mann Center are:

- Acupressure
- Breast cancer support
- Circle of Reflection
- Caregivers support group
- Grief Work
- Healing through art
- Partners of women with cancer
- Li Bailey Living Beyond Limits
- Look Good, Feel Better
- Looking ahead
- Meditation: Inner healing
- Mindfulness meditation
- Qigong
- Young adult cancer support

The support group participants evaluated the groups on a scale of 0 to 10 at a 9.8, where 0 is not beneficial and 10 is extremely beneficial.

UCLA Breathmobile

The UCLA Breathmobile is the traveling doctor's office of Mattel Children's Hospital UCLA. The Breathmobile van travels to inner-city schools and provides medical care to children that cannot otherwise afford it. The UCLA Breathmobile provides:

- Physical exam and consultation with a Pediatric Allergist
- Spirometry
- Pulse oximetry
- Vital signs
- Allergy skin testing
- Education to parents and patients on the proper use of medicines, metered dose inhalers, spacing devices, nebulizer treatments, and education on environmental control measures

Program Impact

The UCLA Breathmobile provided care to 422 pediatric patients across 844 visits during the time period September 1, 2013 to December 31, 2014. Additionally, the Breathmobile participated in several health fairs including the 2013 Health Fair

Extravaganza, the 4th Annual Operation Backpack and the 2013 Northeast Los Angeles Health and Community Fair. At the Health Fairs, asthma and allergy screenings were conducted on attendees and education and referrals were provided.

From October 1, 2013 to September 30, 2014, the UCLA Breathmobile provided services at 20 schools in Long Beach in zones 1a, 2a, and 3a. Visits were made to the schools at least 3 days per week. Visits to each school site occurred every 6-8 weeks or sooner depending on need. Special visits were made for school fairs, health fairs, nurse meetings and administrative meetings/school outreach. The regular visits to the schools included registration of patients and assessment of eligibility to qualify for health care programs such as Healthy Families and Medi-Cal. Efforts were made to enroll families in these programs where applicable. Intake by the Nurse included assessment of vital signs, height, weight, spirometry, evaluation of environmental risk factors, and knowledge of their treatment plan (for return patients only). A detailed evaluation by a physician and development of a respiratory health management plan was made. Following the visit with the physician, all patients received education by a registered nurse about their respiratory condition, medications, asthma action plan and a follow up appointment was made if indicated. Additionally, the Breathmobile participated in several Community Health Fairs where asthma and allergy screenings were conducted on attendees and education and referrals were provided.

The UCLA Long Beach Breathmobile program provided care to 422 pediatric patients across 844 visits to schools in zones 1a, 2a and 3a at the pre-selected sites during the time period: September 1, 2013 to December 31, 2014. Patients were predominately Hispanic (53%) or African-American (35%) and 57% were male. A total of 350 (83%) diagnosed with asthma had the following baseline severity: 33% intermittent, 42% mild, 19% moderate and 6% severe. In children who returned for follow-up care, 78.5% achieved well controlled asthma by their third visit to the program. Children who visited the Breathmobile program for at least six months showed a significant reduction in ED (Emergency Department) visits and hospitalizations. In 98% of follow-up visits, patients reported no ED visits or hospitalizations during the interval preceding the visit. In the year preceding treatment on the Breathmobile, a total of 121 ED visits for asthma occurred compared to only 17 ED visits for children engaged in the Breathmobile program for at least six months. In the year preceding treatment on the Breathmobile, a total of 10 hospitalizations occurred compared to only 1 hospitalization for children following engagement in the program for at least six months.

Children who participated in the Breathmobile program showed significant reduction in school absenteeism due to asthma. A total of 59.4% of children missed school due to asthma in the year preceding treatment on the Breathmobile compared to only 26.2 % of children in the year following treatment on the Breathmobile. 6.8% of children missed

greater than 10 days of school due to asthma symptoms pre-treatment year compared to only 1.7 % following treatment on the Breathmobile. 19.5% of children engaged in the Breathmobile program missed 5-10 days of school due to asthma in the pre-year compared to only 2.5% in children engaged in the Breathmobile program during the post year of treatment. 33.1% of children missed 1-4 days of school due to asthma in the preceding year compared to only 22% in the post year of treatment on the Breathmobile. Though we did not track missed work days, one can estimate that there were significant decreases in parents' missed work days due to their child's asthma following treatment on the Breathmobile with numbers that would correlate with missed school days.

In May 2014, a cost analysis of Breathmobile operations was conducted. The estimates from the analysis showed that the UCLA Breathmobile was saving local Long Beach hospitals between $12,000 and $27,000 per school year in prevented emergency department visits. The overall return on investment in the 2012-2013 school-year was $4.69 per dollar invested.

UCLA Diabetes Program
UCLA offers diabetes self-management education (DSME), one-on-one counseling, free talks in the community, and participation in health fairs.

Program Impact
Insulin Connection (IConnect) support groups are free for people with Type 1 diabetes offered every other month in Westwood and in the Conejo Valley (Thousand Oaks). Monthly, 4-12 persons attend the support groups.

Annual Diabetes Patient Conference: Healthy Living With Diabetes
A half-day free patient conference with lectures, breakout sessions and foot screenings was provided for people with Type 1 and Type 2 diabetes. Over 130 people attended in 2015 and 2016.

UCLA Fit for Healthy Weight Clinic
See impact information under Health Promotion and Disease Prevention

Priority Health Need: Mental Health Disorders and Substance Abuse and Addiction

Goal: Increase access to mental health care and substance abuse services and resources.

The UCLA Hospital System consists of three licensed hospitals: Ronald Reagan UCLA Medical Center, Resnick Neuropsychiatric Hospital at UCLA, and UCLA Medical Center, Santa Monica. Resnick Neuropsychiatric Hospital at UCLA is the psychiatric teaching

facility of the David Geffen School of Medicine (DGSOM) and is located on the fourth floor of Ronald Reagan UCLA Medical Center.

As part of the UCLA Health System, Ronald Reagan UCLA Medical Center and UCLA Medical Center, Santa Monica collaborate with Resnick Neuropsychiatric Hospital at UCLA and its psychiatric medical staff to address the mental health disorders and substance abuse and addiction issues in the community.

Didi Hirsch Crisis Follow-Up Service and Suicide Prevention

The Didi Hirsch Crisis follow-up service and suicide prevention at UCLA enrolls patients discharged from the hospital or the UCLA ER who are in crisis and need follow up services. This includes phone calls and outreach from Didi Hirsch's suicide prevention team to assist in making appointments, generate safety plans, and re-assessing self-injury.

Program Impact

This program has been successful in creating a linkage between UCLA and a community center to provide important after care and safety planning for patients at risk for suicide.

	January – December 2013	January – December 2014	January-March 2015
Clients referred for follow-up	24	40	18
Number of clients contacted	10	24	15
Percentage of Clients Contacted (out of total referred)	42%	60%	83%
Percentage of Clients Given Referrals (out of total contacted)	60%	38%	38%
Number of contacts initiated	Data not available	207	110
Total Contacts Made	Data not available	54	38
Mental Health Referrals	Data not available	8	15
Other Services Referrals	Data not available	4	0

Student Health Insurance Plan Behavioral Health Services

The Student Health Insurance Plan (SHIP) Behavioral Health Services aims to provide high level behavioral health services to the student population at UCLA, allowing them to remain in school through graduation. This program provides dedicated access for students, addresses acute mental health disorders, and provides substance abuse and dual diagnosis services to UCLA students, both undergraduates and graduates, under

their SHIP Insurance. Students with behavioral health needs beyond what can be provided through UCLA Counseling and Psychological Services (CAPS) are referred to the Department of Psychiatry for extended services. In addition, the clinical staff at CAPS receives teaching, in-service, and case review. SHIP Behavioral Health Services also works with CAPS, Arthur Ashe Student Health & Wellness Center, and campus to assess and plan for future needs for students, recognizing the increased need for behavioral health among this population.

Program Impact

The referrals from the UCLA Counseling and Psychological Services to Behavioral Health Services for September 2015 to May 2016 show that approximately 23% of the referrals are considered urgent and 77% are routine for a total of 424 mental health and substance abuse referrals.

Month	Urgent Referrals	Routine Referrals	Total Referrals
September 2015	1	41	42
October 2015	6	68	74
November 2015	10	45	55
December 2015	11	31	42
January 2016	21	43	64
February 2016	13	31	44
March 2016	24	38	62
April 2016	10	24	34
May 2016	3	4	7
Total	99	325	424

Strategy for Enhancing Early Developmental Success (SEEDS) Infant Preschool and School Readiness Program

The SEEDS Infant Toddler (SEEDS-IT) Program and the SEEDS School Readiness (SEEDS-SR) Program at UCLA were designed to mitigate early risk of school failure of children with prenatal alcohol exposure. Due to the implications of this exposure, these children are more likely to have significant behavioral, socioeconomic, and learning problems, placing them at a greatly increased risk for school failure. The SEEDS programs aim to increase these vulnerable children's opportunities for success in school and life.

Program Impact

- Preliminary analyses of SEEDS-SR outcome data suggest improvements in child self-regulation and early literacy skills, increased parent knowledge and advocacy skills, and reductions in parent stress.

Memory Education Programs

The Memory Education Programs include multiple programs that help individuals deal with memory loss and provide caregiver support. The Memory Training Classes teach strategies to enhance memory ability and function. The Senior Scholars Program offers adults age 50 and older the opportunity to attend UCLA undergraduate courses and learn in an intergenerational environment. The Memory Care Program is a weekly program designed for persons with mild dementia and their caregivers to address memory issues and stress.

Program Impact

Memory Training: Approximately 100 people participate on site at UCLA annually. At external sites, both locally and nationwide, we estimate that approximately 5,000 people participate in Memory Training every year. Improvements in both objective and subjective memory have been observed.

Senior Scholars: The program continues to grow by approximately 10% every quarter. Greater interest has led to the access to online courses this past year. **Senior Scholars Participants**	
FY 2013-2014	412
FY 2014-2015	461
FY 2015-2015	512

Memory Care: When the program was launched in September 2013, 1 group with 4 couples participated. Currently, 2 groups with 10 couples in each group are participating. Reduction in stress has been observed.

UCLA Family Development Program

The UCLA Family Development Program (FDP) is a home and hospital visiting program designed for new parents to help overcome adversities that compromise healthy development in infants and toddlers. The goal of the program is to interrupt the intergenerational transmission of trauma and build resilience in new parents and their families. This program empowers new parents to approach caregiving so that it can be joyful, intimate, and child-centered. FDP provides education and developmental guidance to parents in order to support healthy social and emotional development in their children—which FDP believes ultimately translates into the child's development of strong, supportive relationships as adults. In addition, the program provides integrated mental health assessments to monitor and treat post-partum psychological health challenges.

Program Impact

The Family Development Program's efficacy was first evaluated in a randomized

controlled trial funded by the National Institutes of Mental Health. Based on assessments taken at 12 and 24 months, the families who participated in FDP, in comparison to the control families, experienced:

- Greater feelings of support from their partner and family member(s)
- Increased maternal responsiveness to the child
- Improvements in the child's sense of security
- Enhanced maternal encouragement of the child's independence
- Positive development of the child's "separate self"

After 24 months, the mothers who participated in FDP intervention also demonstrated:

- Greater ability to verbally set limits
- Their children were more likely to respond positively to those boundaries

Mobile Health for Mental Health/ Salud Móvil para Salud Mental

Mobile Health for Mental Health (MH2) is a web/mobile application to optimize early stimulant medication treatment for children with ADHD by improving communication among the parent, teacher, and prescriber. Parents and teachers input symptoms and medication side-effect ratings, and the information is aggregated into a web interface accessible to providers during clinic appointments.

Salud Móvil para Salud Mental (SM2) is the Spanish adaptation, which allows limited English proficiency (LEP) parents to fill out daily ratings in their native language.

Pilot-testing of both versions is underway at:

- Augustus Hawkins— a community mental health clinic that services predominantly low-income children and families in South Central Los Angeles
- Child & Family Guidance Center—a mental health clinic in Northridge that serves predominantly Hispanic families.

<u>Program Impact</u>

Nine English-speaking parents and one Spanish-speaking parent have piloted the MH2/SM2 web app. Preliminary qualitative linguistic analysis of video recorded data show that parents and providers use the tool to varying degrees, with some providers integrating it into the clinic appointments and others engaging less with the tool.

The following are positive impacts on communication during the clinical visit:

- A visual aid to teach parents about how stimulant medication works
- A starting point for eliciting detailed narratives about specific problem incidents that occurred between visits

- An aid for explaining providers' medication recommendations so parents can better understand the reasons for the provider's medication decisions.
- An aid in achieving patient-centered care and promoting parent agency, by linking provider medication decisions to recorded observations by parents

In one case, the MH2 app also had a positive impact on the child himself: the child felt more comfortable taking the new medication because he knew that the provider would have a record of all his side-effects and of whether or not the medication was working.

Community Partners in Care

The Community Partners in Care (CPIC) compared a Community Engagement and Planning (CEP) model to a Resources for Services (RS) model in a rigorous randomized trial involving over 1,000 depressed clients drawn from 93 health care and community-based programs. The clients were primarily African American and Latino, the majority met federal poverty criteria and had multiple chronic medical conditions, nearly half were uninsured and at high risk for being homeless, and many had substance abuse problems.

The key feature of a CEP approach is community engagement, with equal power sharing and authority in the planning process, to develop an evidence-based toolkit for depression. The planning is followed by training as directed and supervised by the community planning group, comprising strong community leaders and clinical experts.

RS is a model focused primarily on health care sectors alone, using the same evidence-based toolkits to improve depression services and outcomes. The implementation is based on a technical assistance model.

<u>Program Impact</u>

The 6-month client outcomes show that community engagement compared to technical assistance:

- Improved mental health-related quality of life and physical activity
- Lowered the chances of being either currently homeless or having multiple risks for homelessness
- Lowered rate of hospitalization for a behavioral health condition
- Shifted outpatient services from specialty medication visits toward primary care, faith-based, and park depression services

The 12-month client outcomes show that community engagement compared to technical assistance:

- Improved mental health-related quality of life

- Lowered rate of hospitalization for a behavioral health condition compared to the baseline rate

Implications: The community engagement model activated the community to provide more complete support for health and social recovery—people were stabilized and received more support where they were already receiving other services in the community.

EXPORT/STRIVE (Support to Reunite, Involve, and Value Each Other)
The EXPORT/STRIVE randomized control trial project examines the efficacy of a 5 session family-based intervention to improve the reentry of formerly incarcerated delinquent youth by reducing substance abuse, other HIV risk behaviors and psychiatric disorders, and improving family functioning. EXPORT/STRIVE has been in the field since October 2014, and has since recruited in different community locations, with an emphasis on the juvenile delinquency courts. Given the high prevalence of the Latino families in the juvenile justice system, the intervention is delivered in both English and Spanish.

<u>Program Impact</u>

- Over 700 youth—parent/guardian dyads have been approached to participate in the project.
- Based on current experience, being able to deliver the assessment in Spanish is key to meeting the needs of the population and enrollment goals for the study.
- Recruitment, assessment, and intervention delivery are ongoing. Follow up assessments (3, 6, and 12 months) are being completed and 92 families are enrolled, with a total of 182 participants (92 youth and 92 parents/guardians).
- Baseline data are currently being analyzed and several professional posters and manuscripts are in preparation.
- The work of EXPORT/STRIVE has also been disseminated to communities of interest, which enhance public understanding about evidence-based family interventions for youth involved in the juvenile justice system.

The following presentations were also delivered during 2015-2016:
<u>Conference Presentations</u>

- American Psychological Association Poster Presentation: Ayala Lopez, S., Mizel, M., Bath, E., Amani, B., Comulada, S., & Norweeta Milburn. (August, 2015). Emotional regulation, conduct problems and resilience among newly homeless youth with PTSD.

<u>Outreach to Stakeholder Groups and Community based Organizations</u>

- Outreach Health Fair with Aztec Rising May 2015

- Outreach Meetings with Los Angeles County Department of Mental Health, and Probation, Juvenile Delinquency Court System (Quarterly)
- Outreach Presentations with Community based organization, Soledad Enrichment for Action (Quarterly)
- UCLA Master of Social Work Leadership Fair (Biannual)

University-Based Outreach and Education Seminars

- Charles R. Drew University of Medicine and Science: Weekly seminar on issues of health disparities and social justice at. The name of the seminar series is "Conversations on Health and Politics." The seminar explores a wide variety of health topics that impact communities of color such as community mental health, reproductive health, gentrification, and incarceration.
- UCLA Family Stress, Trauma and Resilience (STAR) Seminar. Working with ethnically diverse at-risk adolescents: Lessons, Recommendations and Surprises. March, 2016.

B-Resilient: Addressing disparities in mental health through community-partnered app development

B-Resilient is a text-messaging intervention co-developed by academic and community partners that supports self-management of depressive symptoms and personal resiliency and addresses disparities in mental health.

Program Impact

In 2015, a pretest of the tool was conducted with 30 community members who used it for 30 days and held a workgroup to collect initial feedback. Experiences were generally positive from all attendees and users felt it was easy to use ("I am not technically savvy. And [the app] was simplistic...I didn't have to think about it, how to figure stuff out"). None of the participants opted out of receiving text messages. Users expressed a desire for expanded content including additional guidance to perform cognitive restructuring techniques and additional support services available within the community.

We also evaluated the Participatory Technology process through qualitative interviews and a survey of community-based participatory engagement23 that was adapted by the workgroup. There were three overall qualitative themes from the partners' experiences:
(1) The Chorus platform reduced the barriers to entry for creating apps collaboratively;
(2) The Participatory Technology method enabled community-centered content generation;
(3) The project stimulated partners' thinking and motivation to participate in future app development including expanding the initial app, leading to this grant application ("This project has given me the idea that there are other ways that you can create things, using the technology, to change things and to make quality of life better for people").

The partners also confirmed the participatory nature of the project and supported proceeding with further B-RESILIENT development and pilot testing.

Health Neighborhoods Initiative

The Health Neighborhoods Initiative (HNI) is a Los Angeles County wide project that aims to improve the health and wellness of our communities by joining together the support of the Department of Mental Health, the Department of Public Health, the Department of Health Services, LA Care, and other health and mental health providers, public health and substance abuse treatment providers, along with a variety of social service and community support agencies. Thus far, the HNI has focused on coordination of care between mental health, health, and substance abuse services to improve access to care. In addition, HNI will include supporting clients in such social services as housing, employment coaching, tutoring to complete a GED, and partnering with non-traditional and trusted members of a community to support the health and mental health of individuals in their community, provide preventative programs, and facilitate early detection and referral to treatment for behavioral health concerns.

Program Impact

- Phase I of the HNI led to development of agreements to share and coordinate services across 15-20 programs within 8 pilot neighborhoods
- Phase II includes a call for proposals for multiple-year contracts for community agencies to address mental health and social risk factors and structural determinants including violence/trauma and housing/homelessness

With the conglomeration of DMH, DPH and DHS still being negotiated in Los Angeles County the trajectory of the Health Neighborhoods Initiative and other community engaged initiatives will continue to be articulated in new ways.

MyCoachConnect

MyCoachConnect (MCC) is a novel telephone-based engagement and assessment technique for patients with severe mental illness. MCC has completed an initial pilot implementation between August 2015 and February 2016 of 40 participants located at ROADS Community Care Clinic in Compton, CA. ROADS enrolls patients with severe mental illness such as schizophrenia, bipolar disorder, and major depression who also are dually-eligible for Medicare and Medi-Cal. Patients call the automated telephone number approximately twice a week for four months and answer open-ended questions about their health status. These answers are transcribed and then made available to their providers to integrate into their care planning and assessment. In addition, the voice responses are analyzed to identify novel predictors of clinical outcome in this

population (for example, being able to detect if a patient is not well while at home, in between office visits).

Program Impact

This project is currently in the evaluation phase of the pilot stage. It was successfully implemented with 40 participants and their providers in a community care setting of a vulnerable and high-risk population with severe mental illness. Patients found the MyCoachConnect system:

- Acceptable, and through feedback and workgroup sessions, they found the system to be very helpful in their lives
- Helped address loneliness and made participants feel more positive about their lives
- Helped patients plan more for their week and address personal goals related to their care

Preliminary results of speech samples from participants suggest that the samples can be predictive of individual clinical outcomes. These results can be very impactful for community health needs – increasing access to supportive interventions using telephone/automated based technologies, increasing scalability of remote assessment of clinical status and outcomes tracking using this automated system, and focus on prevention of symptoms and outcomes such as acute care utilization through predictive analytic approaches utilized around speech responses.

Los Angeles County Department of Mental Health Joint Mental Health Joint Mental Health Operations

Through an affiliation agreement with the Los Angeles County Department of Mental Health (LACODMH), UCLA provides academic services, training and GME services, and other academic training service to support and/or develop training of public mental health staff that is related to key LACODMH priorities. These priorities include jail diversion, transition age youth, homelessness, and Integrated Substance Abuse Program services for co-occurring mental health and substance use disorders.

Program Impact

45 persons have been trained in the past three years through this program. They trained at the Edelman Mental Health Clinic, Augustus F. Hawkins Mental Health Clinic, and the GENESIS program for seniors.

UCLA Center for Child Anxiety Resilience Education and Support

The UCLA Center for Child Anxiety Resilience Education and Support (CARES) aims to reduce the burden of childhood anxiety and enhance family and community resilience, through education/prevention, training, innovation, research, and enhanced public education and advocacy. CARES was involved in the implementation of classroom-

based programs designed to foster self-awareness, focus and resiliency, and overall wellbeing. In addition, CARES created community-based parenting workshops and teacher/staff workshops to help manage child anxiety.

Program Impact

Two pilot programs were offered in one elementary school and two high schools; over 550 students were trained in skills-building techniques for emotion regulation.

In the high school FOCUS programs, students were taught resilience through the skills of emotion regulation, communication, problem-solving, goal setting, and managing stress reminders. The team found that after group completion, students had significantly improved overall internal resilience scores, as well as significantly improved scores on subscales of problem-solving and empathy. Findings from focus groups illustrated that the groups helped build connections between students, as well as between students and teachers. The groups also helped destigmatize mental health issues in the school environment.

In the elementary school Calm Classroom program, students and staff practiced mindfulness-based brief exercises two to three times daily every day. Students under the age of 8 (in pre-K through 2nd grade; n=207) reported that Calm Classroom made them feel “very happy,” “happy,” or “neutral/calm.” Young students were able to identify parts of their bodies affected by the exercises.

Students 8 and over (in 3rd through 5th grade; n=196) initially reported equally positive and negative impressions of the exercise. Approximately half of older students felt that the techniques helped them regulate their emotions, while half did not. Teachers and staff (n=72) reported feeling that the program was relaxing/calming, easy to do, gave classes an opportunity to slow down/refocus, and that it helps students focus. Staff also reported that the majority of students enjoyed doing the techniques. The vast majority of staff believed that students could use the techniques to regulate their emotions.

Behavioral Health Associates

Behavioral Health Associates (BHA) was established in November 2012 as an evidence-based, all-payer collaborative care program within UCLA Health dedicated to effectively delivering population-based services across a broad geographic area. BHA provides short-term (up to 15 weeks) behavioral health treatment to children and adults, including cognitive behavioral and/or supportive therapy or medication consultation by a psychiatrist. Upon completion, stable patients transition back to primary care provider care for ongoing medication management. Patients with longer-term treatment needs are referred for additional behavioral health services. The co-location of behavioral

health care services into primary care settings promotes enhanced visibility among clinicians and accessibility for patients.

Program Impact

- After receiving BHA treatment, patients had a 13% reduction in emergency department utilization, approximately 204 averted visits. At an average health plan payment of $2,000 per visit, this amounts to approximately $408,000 in reduced total cost of care.
- For the past three years, BHA providers have seen 5,569 new patients, an average of 166 per month.
- For the past three years, the percentage of UCLA Health's primary care population diagnosed with a behavioral health disease (approx. 44,000) receiving behavioral health services increased from 4% to 13%.

Mobile Clinic Project
See impact information under Access to Care.

Priority Health Need: Social Issues, including aging population, homelessness, and dental care

Goal: Increase access to needed health and social services for vulnerable populations.

UCLA-First 5 LA 21st Century Dental Homes Project
In Partnership with 12 Federally Qualified Health Centers (FQHCs), the Dental Homes Project (DHP) aims to deliver quality dental care to 13,000 young children and increase parents' and child care providers' awareness of the importance of oral health care for young children. The project also aims to increase oral health services for pregnant women who receive primary care at these clinics. The dental and medical clinical staff members in participating clinics receive didactic and hands-on trainings in how to provide oral health care for young children and pregnant women.

Program Impact
Data reported as of December 2015 indicate delivery of dental/oral health services for children ages 0-5 in DHP participating clinics has increased substantially as follows:

- 3-fold increase in preventive services (more than 10,000 preventive visits from October-December 2015)
- 2-fold increase in diagnostic visits and treatment visits
- Implementation of the Quality Improvement Learning Collaborative has helped dental and medical personnel in 7 DHP participating clinics learn how to apply quality improvement methods to improve care delivery and performance.

UCLA-First 5 LA Children's Dental Care Program

Building off the work of DHP, the Children's Dental Care Program (CDCP) aims to develop an integrated health care delivery system that provides quality, ongoing dental care for 41,000 underserved young children in Los Angeles communities. In partnership with 10 additional community clinics, the CDCP will serve as a prototype for transforming the oral health care system for young children throughout Los Angeles County and beyond. The project also aims to increase oral health services for pregnant women who receive primary care at these clinics. The dental and medical clinical staff members in participating clinics receive didactic and hands-on trainings in how to provide oral health care for young children and pregnant women.

Program Impact

- Data compiled as of March 2016 indicate that we are on target to achieve the project's annual milestones for additional children receiving services.
- Implementation of the Quality Improvement Learning Collaborative has helped dental and medical personnel in 6 CDCP participating clinics learn how to apply quality improvement methods to improve care delivery and performance.

Educating Staff at Skilled Nursing Facilities

SMUCLA identified an opportunity to promote health by decreasing preventable readmissions from Skilled Nursing Facilities (SNFs). Nursing developed a plan and implemented a number of initiatives to educate staff at SNFs to decrease pressure ulcers, infections, and improve handover communication between SMUCLA and SNFs.

Program Impact

- Educated SNF staff on pressure ulcer prevention and skin health through workshops developed by SMUCLA Wound, Ostomy, and Continence Nurse (WOC).
- Developed a SNF handover report form by SMUCLA Geriatric unit to ensure complete transfer of information on patient condition and meds to promote patient safety and improve communication between SMUCLA and SNF staff.
- Included SNF staff in SMUCLA Transitions of Care Symposium to better align patient safety and health promotion goals.
- Conducted needs assessment to gather information and develop curriculum for Skills Day offered to SMUCLA and SNF staff.

Happy Feet Clinic

The Happy Feet Clinic unites UCLA undergraduates and medical students to provide comfort to homeless one foot at a time by setting up podiatry clinics at multiple sites in Los Angeles. These include Ocean Park Community Center in Santa Monica, Union Rescue Mission in downtown LA, and New Image Emergency Center in South LA.

After documenting a short health history, volunteers wash and clean clients' feet. Under the supervision of a physician or podiatrist, medical students perform a foot exam to screen for the most common foot pathologies. Simple procedures and medications are provided as needed and referrals for more complex situations are provided. Clients are also provided with supplies to help maintain feet health. Throughout the entire process, medical students and volunteers provide helpful education on how to maintain good foot health. The Happy Feet Clinic is held twice a quarter.

Program Impact

2014-2015 Impact	Union Rescue Mission	Downtown Women's Center	Ocean Park Community Center
Number of patients	193	116	40
Homeless	179 (92.5%)	82 (70.7%)	31 (77.5%)
Chief Complaint(s)			
• Pain in feet	31	30	8
• Callous/Dry	19	27	3
• Fungus	18	6	5
• Check up	21	5	0
• Shoes/Supplies	4	6	1
• Other/None	31	42	23
Foot problem(s) diagnosed			
• No problem	26	28	15
• Tinea Pedis	96	29	10
• Onychomycosis	94	33	10
• Bunion	29	20	2
• Callous/Corn	63	38	9
• Diabetic Foot Ulcer	3	0	0
• Diabetic Neuropathy	7	5	2
• Ingrown Toenail	8	7	4
• Other	38	28	7

Mobile Clinic Project
See impact information under Access to Care.

West Hollywood Homeless Project
See impact information under Access to Care.

UCLA Mobile Eye Clinic
See impact information under Access to Care.

Health Seminars
See impact information under Health Promotion and Disease Prevention.

Community Events/Health Fairs
See impact information under Health Promotion and Disease Prevention.