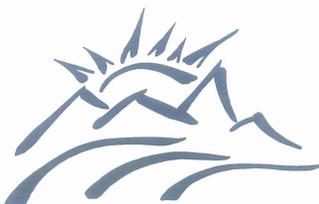


# CITRUS VALLEY HEALTH PARTNERS

2013  
Community Benefit Report  
SB-697





# CITRUS VALLEY HEALTH PARTNERS

## COMMUNITY BENEFIT REPORT

SB 697

### **Foothill Presbyterian Hospital: Supplementary Report**

250 South Grand Ave.

Glendora, CA 91740

**Fiscal Year Report Period: 2013**

**Individuals Preparing Community Benefit Report:**

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Director, Community Benefit Department  
Citrus Valley Health Partners  
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---

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# **Citrus Valley Health Partners**

*Foothill Presbyterian Hospital*

## **2013 Community Benefit Report**

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# Citrus Valley Health Partners

## I

### General Information



## CITRUS VALLEY HEALTH PARTNERS (CVHP)

### GENERAL INFORMATION

Citrus Valley Health Partners (CVHP) was formed in April, 1994 as a result of the merger of Inter-Community Medical Center in Covina and Queen of the Valley Hospital in West Covina. Hospice of East San Gabriel Valley, a free-standing hospice and home care agency in West Covina, became an affiliate of Citrus Valley Health Partners at the same time. Foothill Presbyterian Hospital joined CVHP in November, 1995. Citrus Valley Health Partners is governed by a 21-member Corporate Board of Directors comprised of physicians, business and community leaders. Members of the Immaculate Heart Community, a group of former Catholic Religious Sisters who founded Queen of the Valley Hospital, also serve on this Board.

Citrus Valley Medical Center's **Queen of the Valley Campus** is a fully-accredited 325-bed, non-profit Catholic health care facility founded in 1962 by the Immaculate Heart Community. This campus specializes in oncology and has one of the busiest emergency departments in Southern California - with more than 54,000 visits annually.

Along with the new millennium came Citrus Valley Medical Center's **Family Birth and Newborn Center** at Queen of the Valley Campus. The Center, with approximately 100,000 square feet - combines state-of-the-art technologies with an integrated, family-centered approach to maternal, neonatal and pediatric care. Services include the full continuum of health and wellness care, pre- and post-delivery education and support groups, and access to the most current treatments, provided in an environment that encourages family support and involvement.

Citrus Valley Medical Center's **Inter-Community Campus** was founded more than 75 years ago. It is a 193-bed facility in Covina that provides high-quality health care to the East San Gabriel Valley, with a wide range of medical, surgical and specialty services. Inter-Community campus offers a complete range of inpatient and outpatient services, specializing in cancer treatment, wound care and cardiac care, with the only open heart surgery program in the East San Gabriel Valley.

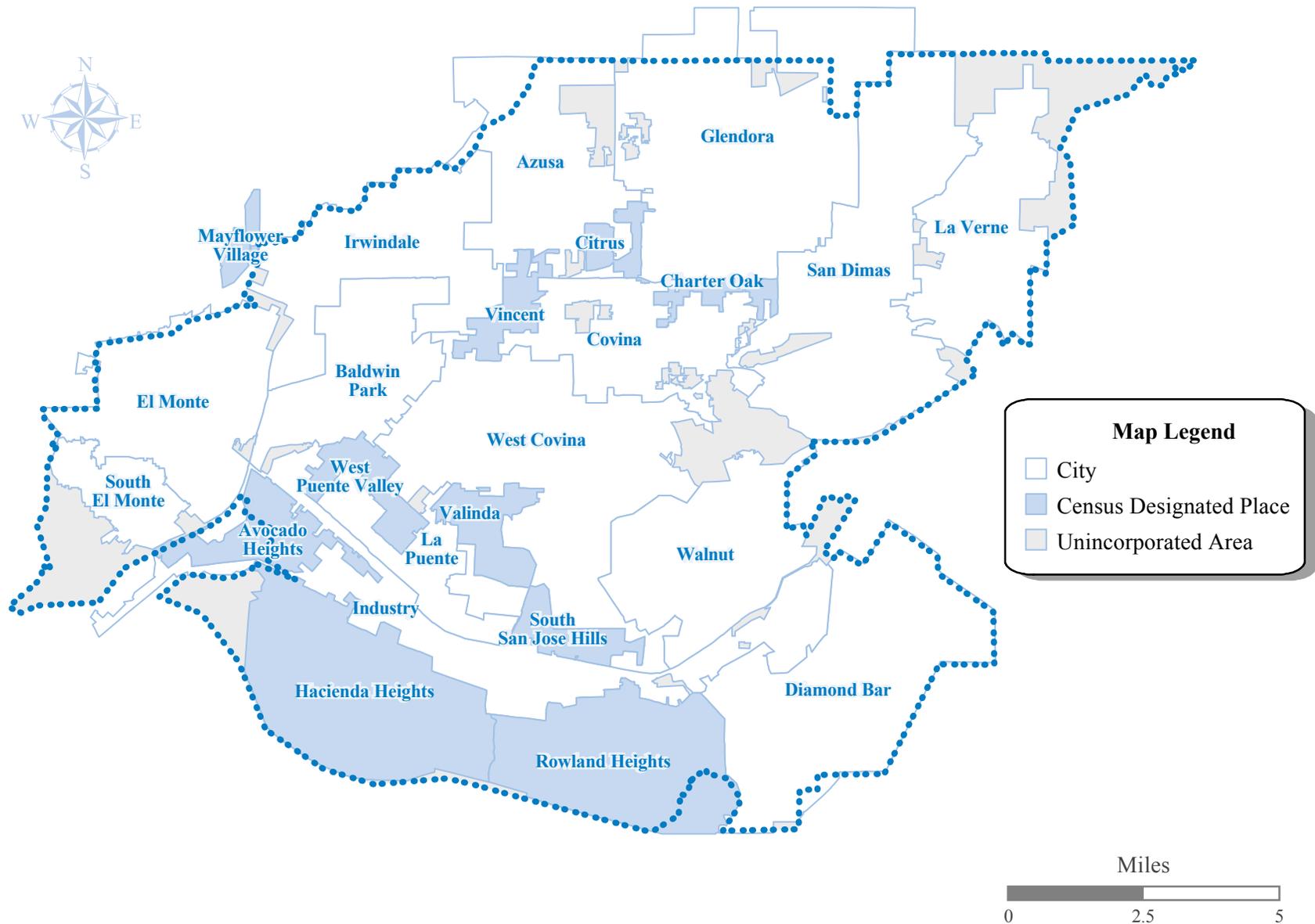
**Foothill Presbyterian Hospital** is a fully accredited facility with 105 beds. Foothill Presbyterian Hospital has proudly served the communities of Glendora, Azusa, La Verne and San Dimas since 1973. In addition to its full service acute program, Foothill Presbyterian Hospital is especially well known for its comprehensive Diabetes Care Unit, its Mountain Search and Rescue emergency service, and its special outreach to the partially sighted.

**Citrus Valley Hospice**, formerly known as **Hospice of the East San Gabriel Valley**, was founded by community leaders in 1979 and is one of the only free-standing hospices in the United States. The Hospice complex was built and is supported through private and community donations. Hospice provides care to all types of patients, age groups and diagnoses meeting the criteria for admission. It has an extensive home care program as well as 10 inpatient beds. Associated with Hospice, **Citrus Valley Home Health** provides physician-supervised skilled nursing care to individuals recovering at home from accidents, surgery or illness.

### **Citrus Valley Health Partners Community Outreach**

CVHP and its numerous Community Partners have been recognized as a State and National Best Practice in various aspects of community health improvement by the following organizations: OSHPD; State of California; VHA; American Hospital Association; National Coalition for Healthier Cities and Communities; Health Research and Education Trust; The Healthcare Forum; The Public Health Institute; and the American College of Health Care Executives. In addition, CVHP was awarded the national 1999 VHA Leadership Award for Community Health Improvement.

# Citrus Valley Health Partners SERVICE AREA





# Citrus Valley Health Partners

## II

Mission  
Vision  
Values



## *Mission Statement*

• • •

Our mission is to help people keep well in body, mind and spirit by providing quality health care services in a compassionate environment.

• • •

## ***Our Vision for the Future***

We are an integral partner in elevating our communities' health.

### **Vision Definitions**

- Integral Partner – CVHP will take a leadership role in developing collaborative partnerships with patients, physicians and other health care providers.
- Elevating – We will improve our communities' health by:
  - Expanding our system's focus to include health promotion and disease prevention.
  - Ensuring access to the right care at the right time at the right place
  - Providing safe, high-quality care and an exceptional customer service experience every time.
  - Providing a comprehensive array of ambulatory programs, including physician services, patient education, disease management and comprehensive ambulatory diagnostic and treatment offerings.
- Communities' Health – Elevating the overall health of the communities we serve.

### **Vision Level Metrics (2021)**

- Financial – Achieve and maintain an investment grade rating.
- Community Health – Meet or exceed the Healthy People 2020 obesity objectives in our communities.
- Quality and Customer Experience - Consistently perform at the top for quality and customer service performance metrics.

What does CVHP Look Like in 2021?

- Elevating Health from Sick Care to Health Care
  - A strong focus on preventive care, health education and wellness, including outreach efforts focused on improving community health.
  - CVHP and its partners excel at managing risk-based partnerships with payers and medical groups that improve health and reduce the overall health care costs for our community.
  - Empower patients to take responsibility and to advocate for their own health.
  - Personalized, technologically advanced health care management programs.
  - Extensive clinical integration and care coordination across the care continuum, including health information exchange, ambulatory care protocols, hospice, home health and other activities.
- Culture/People
  - A culture of respect that is welcoming and inclusive of our diverse communities.
  - Culturally and age sensitive service offerings.

- CVHP is an employer of choice that develops and grows its employees.
- Physicians
  - In addition to community physician practices, provide a multi-specialty medical practice foundation with offices throughout the community that serves as an option for physicians.
  - Economic partnerships with physicians.
  - Widespread use of electronic ambulatory health records and linkages between offices, hospitals and other care sites using the latest evidence-based medicine.
- Strategic Partnerships
  - Alliances with academic medical centers and other facilities to provide access to tertiary specialty care, either at CVHP facilities or through transfer agreements.
  - Economic partnerships with physician groups and IPAs.
  - Partnerships with educational institutions that open or expand employee talent pipelines for hard-to-fill positions.
- Facilities
  - Facilities that create a welcoming environment for all patients and their families.
  - Comprehensive ambulatory sites in select areas of our community that include foundation physician offices and system owned or branded outpatient services.

## ***Our Statement of Values***

Patients and their families are the reason we are here. We want them to experience excellence in all we do through the quality of our services, our teamwork, and our commitment to a caring, safe and compassionate environment.

***RESPECT*** – We affirm the rights, dignity, individuality and worth of each person we serve and of each other.

***EXCELLENCE*** – We maintain an unrelenting drive for excellence, quality and safety and strive to continually improve all that we do.

***COMPASSION*** – We care for each person and each other as part of our family.

***INTEGRITY*** – We believe in fairness, honesty and are guided by our code of ethics.

***STEWARDSHIP*** – We wisely care for the human, physical and financial resources entrusted to us.

# Citrus Valley Health Partners

## III

### Governance And Management





## **GOVERNANCE AND MANAGEMENT STRUCTURES TO SUPPORT COMMUNITY BENEFIT ACTIVITY**

**2013 Update**

### **Board and Administration Roles in Community Benefit**

A corporate Senior Vice President for Community Benefit position and the Citrus Valley Health Partners Community Care Department were established in 1994 and charged with the following major tasks:

1. Assist the Board of Directors and Administration in advancing the Mission and Vision of the corporation;
2. Advance Community Benefit as a core value of the Corporation, and integrate community benefit programs and activities as part of the organization's culture and strategy;
3. Develop partnerships with public and private community agencies, individuals, to pursue programs and projects that help improve the health status and quality of life of the communities served by CVHP.

In 2013 the work of community benefits continued under the direction of the Chief Communications Officer, with the staff that the Sr. VP of Community Benefits had trained to continue the work of the community. The staff continued to work with public and private community partners to sustain existing programs and to create new programs to respond to the emerging needs of the community. The primary strategic approach and core of the community benefit efforts at CVHP has been efforts directed toward community capacity building and service to poor, at-risk, vulnerable populations. This work continues.

A Committee of the Citrus Valley Health Partners Board continues to provide direction and guidance. A semi-annual report is provided to the Strategic Planning, Marketing and Community Benefit Committee of the Board.

### **Management and Staff Involvement in Community Benefit**

During 2013 all Administrative and Operations Managers throughout the corporation participated on a more limited basis in Community Benefit activities. Professional staff support for CVHP's community outreach efforts is provided on an as needed basis. [The major departments and divisions from whom Community Benefits draws staff support are: Corporate Development and Planning, Communications, Operations Council and the Strategic Planning, Marketing and Community Benefit Committee of the CVHP Board of Directors.]

## **Departmental Community Benefit Projects**

A number of departments in the Citrus Valley Medical Center and at Foothill Presbyterian Hospital have developed and participated in Community Benefit activities as department teams. In collaboration with community partners, they continue to organize and lead significant community health improvement programs.

The main departments who serve the ECHO (Every Child's Health Option) program include Radiology, Laboratory, Out Patient Pharmacy, and the Emergency Department. Working with the Public Health Department, the Emergency Department staff helps ensure that our homeless "residents" of local cold/wet weather shelters get the medical help they need. This staff also serves as the safety net for local physicians involved in ECHO (Every Child's Health Option).

The Citrus Valley Health Foundation provides support and has served as the vehicle to facilitate the flow of funding for community benefit partnerships, such as the ECHO (Every Child's Healthy Option) Program.

The CVHP Center for Diabetes Education continues to offer free community lectures and information, glucose screenings, and support groups for type I and type II adults, seniors, adolescents, parents, and a type II Spanish support group throughout the year.

The Public Relations Department continues to support community groups in writing and distributing press releases and ads on events and programs. In addition, the department assists in the design of brochures, invitations, save-the-date cards, maps, etc.

The Auxiliary at CVMC Inter-Community Campus gave five scholarships to students who are furthering their education in the healthcare field. A total of \$5,000 was donated in the year 2013.

The Auxiliary at Foothill Presbyterian also donated nineteen scholarships to community members totaling \$28,500 in the year 2013.

The Food and Nutrition Services departments at CVMC Queen of the Valley Campus and Inter-Community Campus, and Foothill Presbyterian provide meals five days a week for the "Meals on Wheels Program."

*Adopt-A-Family Program* . In the spirit of giving, CVHP employees come together to adopt families in need every Holiday Season. Staff members go to the homes and personally deliver food and gifts for all family members.

Citrus Valley Health Partners, its medical staff and its community Partners have been recognized nationally for their successful collaborative programs directed toward community health improvement and community capacity building. For articles, information and research studies, contact:

Community Care Department, Citrus Valley Health Partners,  
1115 S. Sunset Ave., West Covina, CA 91790, or call (626) 814-2450.

# Citrus Valley Health Partners

## IV

### Charity Care Policy





<input checked="" type="checkbox"/>	CVHP	<input checked="" type="checkbox"/>	CVH	<input checked="" type="checkbox"/>	Policy
<input checked="" type="checkbox"/>	CVMC-ICC	<input checked="" type="checkbox"/>	CVHH	<input checked="" type="checkbox"/>	Procedure
<input checked="" type="checkbox"/>	CVMC-QVC	<input checked="" type="checkbox"/>	FPH	<input checked="" type="checkbox"/>	Attachments

<b>Title: Charity Care</b>		<b>Policy #: A009</b>
<b>Type: Corporate</b>		
Effective: 4/24/02	Reviewed: 7/27/11	Revised: 5/25/05, 7/27/05, 9/24/08

**Statement of Policy**

Our mission is to help people keep well in body, mind and spirit by providing quality health care services in a compassionate environment. This charity policy is the means through which CVHP fulfills its mission as an integrated health care organization committed to maintaining and enhancing the health of all the people of the communities we serve. Those patients that currently do not pay for their medical bills because of an inability to pay are covered under this policy.

**Declarations**

Many Government programs (Medi-Cal, Healthy Families, and Medicare) and other third party coverage programs have been established to provide for or defray the healthcare costs for the individuals who also may be considered needy. In the case where arrangements for payment to the hospital require the hospital to accept the payment amount as payment in full, the balances of these accounts written off are attributable to contractual adjustments and will not be considered charity care. In cases where these programs require the patients to pay co-payments or deductibles and the patients do not have the ability to pay; these amounts will be considered charity care.

Charity determination will be granted on "all, partial, or nothing" basis. There is a category of patients who qualify for Medi-Cal, but do not receive payment for their entire stay. Under the charity policy definition, these patients are eligible for charity care write-offs. In addition, the hospital specifically includes as charity the charges related to denied stays, denied days of care, and non-covered services. These "TAR" denials and any lack of payment for non-covered services provided to Medi-Cal patients are to be classified as charity. These patients are receiving the services and they do not have the ability to pay for it. In addition, Medicare patients who have Medi-Cal coverage for their co-insurance/deductibles, for which Medi-Cal does not make payment and Medicare does not ultimately provide bad debt reimbursement will also be included as charity. These indigent patients are receiving a service for which a portion of the resulting bill is not being reimbursed.



**Title: Charity Care**

**Policy#: A009**

**Procedure**

**General Process and Responsibilities**

A. Patients unable to demonstrate financial coverage by third party insurers will be required to complete a financial screening form. Completion of this form:

- 1) Allows the hospital to determine if the patient has declared income and or assets giving them the ability to pay for his/her health care services.
- 2) Authorizes CVHP to obtain a credit report.
- 3) Provides a document to be reviewed by Patient Financial Services to determine the patient's financial liability, if any.

B. All patients not covered by third party insurance

- 1) Pay an advance payment based on estimated charges.
- 2) Insured patients who indicate that they are unable to pay patient liabilities must complete a financial screening form to qualify for any waiver of their co-pays.

C. Charity screening process:

- Obtain individual or family income.
- Obtain individual or family net worth including all assets, both liquid and non-liquid, less liabilities and claims against assets.
- Eligibility for Medi-Cal once some assets are depleted will also be considered.
- Current employment status: patient and/or guarantor.
- Unusual expenses or liabilities.
- Family size. This is used to determine the benchmark for 100% charity, if income is at or below 300% of the Federal Poverty Guidelines.

The attached forms are to be used in the financial screening process:

Form 2: Income Certification form

Form 1: Hospital Screening Assessment form (this form also gives permission to obtain credit information)



**Title: Charity Care**

**Policy#: A009**

Forms 1 and 2 will be available in the primary languages spoken in the hospital's community area, including English and Spanish.

To qualify for a charity care write-off for either the entire hospital bill, or a portion of the hospital bill, the following criteria must be met:

- Coverage-The services being provided are not covered/reimbursed by Medi-Cal or any other third party.
- Income Level—If the patient's income is at 300% or less of the Federal Poverty Guidelines, the entire hospital bill will be written-off, regardless of net worth or size of bill.
- Income Level---If the patient's income is between 300% and 350% of the Federal Poverty Guidelines, then a portion of the hospital bill is written-off based upon a sliding scale, regardless of net worth or size of bill, as follows:
  - 300% - 325% = 75% write-off
  - 326% - 350% = 50% write-off
- Size of Hospital Bill and Net Worth---If the hospital bill exceeds the patient's net worth then the following applies:
  - If the patient meets the net income levels between 300% and 325% of the Federal Poverty Guidelines, the amount of the hospital bill that exceeds the patient's net worth will be written-off
  - If the patient's income is over the 350% of the Federal Poverty Guidelines, then a portion of the bill that exceeds the patient's net worth may be either written-off if approved by the Corporate Director Business Services or his/her designee, or paid through the hospital's monthly payment plan.

**Charity Determination Process**

**Admitting/Registration Department Role**

The admitting department will:

- Financially screen 100% of all self-pay inpatients. If there is no income claimed by the patient and no third party insurance,



**Title: Charity Care**

**Policy#: A009**

**Charity Policy Compared to Charity Determination Process**

**Key points to this policy include:**

- The identification of potential charity patients as close to the time of admission as possible.
- The financial screening form will be used and a credit check performed for all self-pay patients, whenever possible.
- Income, along with net worth when appropriate, will routinely be verified for non-emergent self-pay patients and will be used in all circumstances to determine charity status.
- The actual charity care determinations will be made based upon the criteria expressed in this charity care policy.
- Charity determination will be granted on an “all, partial, or nothing” basis.

**References**

Not Applicable



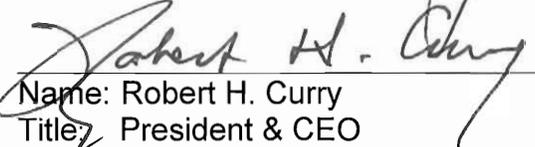
Title: Charity Care

Policy#: A009

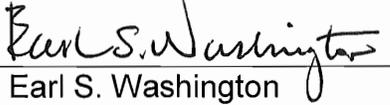
**Signatures**

  
Name: Issa Aqleh  
Title: Corp. Director Business Services  
Date: 08/02/11

  
Name: Lois M. Conyers  
Title: Senior V.P. & CFO  
Date: 7/27/11

  
Name: Robert H. Curry  
Title: President & CEO  
Date: 8/15/11

  
Name: Harold Borak  
Title: Chair, Finance Committee  
Date: 11-30-11

  
Name: Earl S. Washington  
Title: Chair, Board of Directors  
Date: 11-30-11



# Charity Care Policy

## ATTACHMENTS

- I. CVHP Policy #A009 Attachments
- II. FPH Policy # PC-300





# CITRUS VALLEY HEALTH PARTNERS

## FORM I

### HOSPITAL FINANCIAL SCREENING ASSESSMENT FORM

This form needs to be completed by all patients prior to or at the time of admission. This information will be used to determine eligibility for selected hospital programs and services.

Patient Name: \_\_\_\_\_

Patient Social Security No.: \_\_\_\_\_

Total number of dependents: \_\_\_\_\_

Total Annual Income: \$\_\_\_\_\_

Total value of all assets:\$\_\_\_\_\_

Home/Property \_\_\_\_\_

Automobiles \_\_\_\_\_

Investments \_\_\_\_\_

Retirement \_\_\_\_\_

Other \_\_\_\_\_

Total Debts (including mortgages)\$\_\_\_\_\_

Other special circumstances  
(i.e. legal judgments/bankruptcy) \_\_\_\_\_

Please check if either of the following conditions apply:

Disabled \_\_\_\_\_

Injury related to a crime \_\_\_\_\_

Place your signature and date below indicating you are authorizing Citrus Valley Health Partners Representatives to obtain a credit report.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Representative/Financial Counselor

\_\_\_\_\_  
Date



# CITRUS VALLEY HEALTH PARTNERS

## FORMA I

### FORMA DE EVALUACIÓN FINANCIERA DEL HOSPITAL

Esta forma necesita ser completada por los pacientes antes o al tiempo de ser hospitalizado(a). Esta información se utilizará para la determinación de la elegibilidad para programas o servicios seleccionados del hospital.

Nombre del paciente: [PATIENT NAME]

Nombre y apellido de la madre del paciente \_\_\_\_\_

Ciudad y país de nacimiento del paciente \_\_\_\_\_

Numero de seguro social del paciente \_\_\_\_\_

Numero de dependientes \_\_\_\_\_

Total del Ingreso Anual \_\_\_\_\_

Valor en total de todos los bienes \_\_\_\_\_

Casa/Propiedad \_\_\_\_\_

Automóviles \_\_\_\_\_

Inversiones \_\_\_\_\_

Retiro (jubilación) \_\_\_\_\_

Otros bienes \_\_\_\_\_

Total de deudas (incluyendo bienes y raíces) \_\_\_\_\_

Otras circunstancias especiales (i.e., bancarrota, juicios legales) \_\_\_\_\_

Indique si cualquiera de las condiciones siguientes le aplica:

Deshabilitado \_\_\_\_\_ Herido/Condición se debe a un crimen \_\_\_\_\_

Por favor firme y anote la fecha debajo indicando que usted autoriza a los representantes de Citrus Valley Medical Center que obtengan un reporte de crédito.

\_\_\_\_\_  
Firma

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Representante del Paciente o Consejero Financiero (firma y fecha)



# CITRUS VALLEY HEALTH PARTNERS

## FORM II

### INCOME CERTIFICATION

I, [GUARANTOR NAME] CERTIFY THAT MY FAMILY INCOME FOR THE PAST 12 MONTHS HAS BEEN \$ \_\_\_\_\_ AND I CLAIM \_\_\_\_\_ DEPENDENTS. I GIVE PERMISSION FOR THE HOSPITAL TO VERIFY MY INCOME INFORMATION BY CALLING THE FOLLOWING EMPLOYER (S) OR OTHER SOURCES OF INCOME. IN LIEU OF CONTACTING MY EMPLOYER, I AM PROVIDING THE ATTACHED W-2 FORM AND MY LATEST TWO PAYCHECK STUBS.

\_\_\_\_\_  
COMPANY

\_\_\_\_\_  
PHONE #

\_\_\_\_\_  
COMPANY

\_\_\_\_\_  
PHONE #

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



# CITRUS VALLEY HEALTH PARTNERS

## FORMA II

### CERTIFICACIÓN DEL INGRESO

YO, \_\_\_\_\_ CERTIFICO QUE MI INGRESO FAMILIAR POR LOS  
ULTIMOS 12 MESES HA SIDO \$ \_\_\_\_\_ Y RECLAMO \_\_\_\_\_ DEPENDIENTES.  
OTORGO MI PERMISO PARA QUE EL HOSPITAL VERIFIQUE MI INFORMACION  
DEL INGRESO AL LLAMAR A MI EMPLEO (S) O OTROS RECURSOS DEL  
INGRESO, SI ES QUE TENGO ALGUN INGRESO.

EN LUGAR DE LLAMAR A MI EMPLEO, ESTOY INCLUYENDO LA FORMA W-2  
AJUNTO CON MIS DOS ULTIMOS TALONES DE CHEQUE.

\_\_\_\_\_  
COMPANIA

\_\_\_\_\_  
# DE TELEFONO

\_\_\_\_\_  
COMPANIA

\_\_\_\_\_  
# DE TELEFONO

\_\_\_\_\_  
FIRMA

\_\_\_\_\_  
FECHA





# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

PATIENT NAME : [PATIENT NAME]  
ACCOUNT # : [ACCOUNT #]  
ADMIT/SVC DATE: [ADM/SER DATE]  
TOTAL CHARGE : \$[AR CHG TOTAL]

Dear [GUARANTOR NAME]:

Citrus Valley Health Partners was pleased to serve you during your need for medical care. You may be eligible for financial assistance with your hospital bill. Please complete and sign the attached forms and return to our office in the enclosed self addressed postage paid envelope.

FORM I - HOSPITAL FINANCIAL SCREENING ASSESSMENT FORM  
FORM II - INCOME CERTIFICATION  
PROOF OF CURRENT INCOME (BOTH IF MARRIED)  
(TAX FORMS OR W-2/CURRENT PAY STUBS)

If any of the above forms are not submitted, we require a written statement from the patient or responsible party as to why the information is not available.

Sincerely,

Business Services  
(626)732-3100  
(8:00a.m.-4:00p.m.)

015 (Cover letter)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY, STATE ZIP]

RE: Nombre del Paciente: [PATIENT NAME]  
Número de Cuenta : [ACCOUNT #]

Estimado(a):

Fue un placer para Citrus Valley Health Partners el poder servirle en su necesidad de ayuda médica. Usted podrá ser elegible para asistencia comunitaria para su factura del hospital. Por favor llene los siguientes documentos y envíelos en el sobre adjunto a nuestra oficina.

FORMA I - FORMA DE EVALUACIÓN FINANCIERA DEL HOSPITAL  
FORMA II - CERTIFICACIÓN DEL INGRESO  
COMPROBANTE DE INGRESO ACTUAL (DE AMBOS SI CASADOS)  
(FORMAS DE INGRESOS OR FORMA W-2/TALONES RECIENTES DE CHEQUE)

Si alguno de los documentos no es sometido, se necesitara una declaración escrita del paciente o la persona responsable en cuanto porque no esta disponible.

Su aplicación será revisada y recibirá notificación de la decisión por correo.

Sinceramente,

Dept. De Contabilidades del Paciente

014 (Cover letter -Sp)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

PATIENT NAME: [PATIENT NAME]  
ACCOUNT #: [ACCOUNT #]  
ADMIT/SERVICE DATE: [ADM/SER DATE]  
TOTAL CHARGES: \$[AR CHG TOTAL]

Dear [GUARANTOR NAME]:

The application submitted for the Community Assistance Program is incomplete. Under federal regulations, this information is required to substantiate your application. Please submit the following:

- \_\_\_\_\_ FEDERAL INCOME TAX FORMS
- \_\_\_\_\_ W-2 FORMS
- \_\_\_\_\_ CURRENT PAY STUBS FOR THE LAST THREE MONTHS
- \_\_\_\_\_ SIGNATURE IS MISSING
- \_\_\_\_\_ SIGNED AFFIDAVIT EXPLAINING CURRENT FINANCIAL SITUATION OR EMPLOYMENT STATUS.
- \_\_\_\_\_ COPY OF UNEMPLOYMENT/DISABILITY STATUS
- \_\_\_\_\_ (OTHER)\_\_\_\_\_

Thank you in advance for your cooperation.

Sincerely,

Business Services  
626)732-3100  
(8:00a.m.-4:00p.m.)

(017 – CAP incomplete ltr)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

NOMBRE DEL PACIENTE: [PATIENT NAME]  
NUMERO DE CUENTA: [ACCOUNT #]  
FECHA DE SERVICIO: [ADM/SER DATE]  
COBROS EN TOTAL: \$[AR CHG TOTAL]

[GUARANTOR NAME]:

Su aplicación para el programa de asistencia comunitaria esta incompleta. Bajo las reglas federales del gobierno esta información se requiere para sustentar su aplicación. Favor de someter la siguiente información:

\_\_\_\_ FORMAS DE LOS INGRESOS  
\_\_\_\_ FORMA W-2  
\_\_\_\_ COPIAS DE LOS TALONES DE CHEQUES PARA LOS ULTIMOS 90 DIAS  
\_\_\_\_ FIRMA  
\_\_\_\_ CARTA EXPLICATORIA DE SU SITUACION FINANCIERA  
\_\_\_\_ CARTA COMPROBANDO SUS BENEFICIOS DE DESEMPLEO  
(MISCELANIO)\_\_\_\_\_

Si esta información no se ha recibo dentro de 10 días su cuenta es sujeto para referencia a agencia externa de colecciones y probablemente usted se requiere aplicar bajo las reglas de la agencia respectivamente.

Gracias en adelantado por su cooperación.

Representante de pacientes  
Departamento Financiero  
(626)732-3100

018 (CAP incomplete ltr - Sp)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

PATIENT NAME: [PATIENT NAME]  
ACCOUNT #: [ACCOUNT #]  
ADMIT/SVC DATE: [ADM/SER DATE]  
TOTAL CHARGES: \$[AR CHG TOTAL]

Dear [GUARANTOR NAME]:

Based on the information you have submitted to Citrus Valley Health Partners you do not qualify for financial assistance.

If you have any questions regarding your outstanding accounts or would like to make payment arrangements, please contact Business Services.

Sincerely,

Business Services  
(626)732-3100  
(8:00a.m.-4:00p.m.)

-----  
I HEREBY AUTHORIZE CITRUS VALLEY HEALTH PARTNERS TO CHARGE MY:

VISA  MASTER CARD  AMERICAN EXPRESS  DISCOVER

PRINT NAME: \_\_\_\_\_

CARD#: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

AUTHORIZED AMOUNT: \$ \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

MAIL PAYMENTS TO: CITRUS VALLEY HEALTH PARTNERS  
DEPT. 0147  
LOS ANGELES, CA 90084-0147

ACCOUNT #[ACCOUNT #]

060 (Denial letter)



# CITRUS VALLEY HEALTH PARTNERS

DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

NOMBRE DEL PACIENTE: [PATIENT NAME]  
NUMERO DE CUENTA: [ACCOUNT #]  
FECHA DE SERVICIO: [ADM/SER DATE]  
COBROS EN TOTAL: \$[AR CHG TOTAL]

Dear [GUARANTOR NAME]:

Basado en la información que usted proporciono a Citrus Valley Health Partners, no califa para asistencia financiera.

Si tiene alguna pregunta tocante sus cuentas pendientes o si quiere hacer un arreglo de pagos póngase en contacto con nosotros.

Sinceramente,

Business Services  
(626)732-3100  
(8:00a.m.-4:00p.m.)

-----  
AUTORIZO QUE CITRUS VALLEY HEALTH PARTNERS COBRE A MI:  
\_\_\_ VISA \_\_\_ MASTER CARD \_\_\_ AMERICAN EXPRESS \_\_\_ DISCOVER

NUMERO DE TARJETA: \_\_\_\_\_  
FECHA DE EXPIRACION: \_\_\_\_\_  
CANTIDAD AUTORIZADA: \$ \_\_\_\_\_ FECHA:: \_\_\_\_\_  
FIRMA: \_\_\_\_\_

ENVIE PAGOS A: CITRUS VALLEY HEALTH PARTNERS  
DEPT. 0147  
LOS ANGELES, CA 90084-0147

NUMERO DE CUENTA: [ACCOUNT #]

060S (Denial letter – Spanish)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

PATIENT NAME: [PATIENT NAME]  
ACCOUNT #: [ACCOUNT #]  
ADMIT/SVC DATE: [ADM/SER DATE]  
BALANCE: \$[PT BALANCE]

Dear [GUARANTOR NAME]:

Based on the financial information you submitted, we are pleased to inform you that you have been approved for financial assistance on this account.

The amount due listed above was determined after reviewing and calculating your information provided based on our financial assistance guidelines. You have qualified for a percentage of the total bill, and the balance is now due and payable. Please remit in full or contact us to make further payment arrangements.

Sincerely,

Business Services  
(626)732-3100  
(8:00a.m.-4:00p.m.)

-----  
I HEREBY AUTHORIZE CITRUS VALLEY HEALTH PARTNERS TO CHARGE MY:

VISA  MASTER CARD  AMERICAN EXPRESS  DISCOVER

PRINT NAME: \_\_\_\_\_

CARD#: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

AUTHORIZED AMOUNT: \$ \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

MAIL PAYMENTS TO: CITRUS VALLEY HEALTH PARTNERS  
DEPT. 0147  
LOS ANGELES, CA 90084-0147

ACCOUNT #: [ACCOUNT #]

061 (Approval ltr – bal due)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

NOMBRE DEL PACIENTE: [PATIENT NAME]  
NUMERO DE CUENTA: [ACCOUNT #]  
FECHA DE SERVICIO: [ADM/SER DATE]  
BALANCE: \$[PT BALANCE]

Querido(a) [GUARANTOR NAME]:

Basado en la información que usted envió nos complace informarle que ha sido aprobado(a) para asistencia financiera con esta cuenta.

La cantidad debida y anotada arriba se determino después de revisar y calcular su información proporcionada basada en nuestras guías de asistencia financiera. Califica por un porcentaje de su factura en total y el balance se debe. Por favor envíe su pago en total o llámenos para hacer un contrato de pagos.

Sinceramente,

Business Services  
(626) 732-3100  
(8:00 A.M. - 4:00 P.M.)

---

AUTORIZO QUE CITRUS VALLEY HEALTH PARTNERS COBRE A MÍ:

\_\_\_\_\_ VISA \_\_\_\_\_ MASTERCARD \_\_\_\_\_ AMERICAN EXPRESS \_\_\_\_\_ DISCOVER  
NOMBRE EN LETRA DE MOLDE: \_\_\_\_\_  
NÚMERO DE TARJETA: \_\_\_\_\_ FECHA DE VENCIMIENTO: \_\_\_\_\_  
CANTIDAD AUTORIZADA: \$ \_\_\_\_\_ FECHA: \_\_\_\_\_  
FIRMA: \_\_\_\_\_

ENVIE SUS PAGOS A: CITRUS VALLEY HEALTH PARTNERS  
DEPT. 0147  
LOS ANGELES, CA 90084-0147

NUMERO DE CUENTA: [ACCOUNT #]

061S (Approval ltr – bal due)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

PATIENT NAME: [PATIENT NAME]  
ACCOUNT #: [ACCOUNT #]  
ADMIT/SVC DATE: [ADM/SER DATE]  
BALANCE: \$[BALANCE]

Dear [GUARANTOR NAME]:

Based on the financial information you submitted, we are pleased to inform you that you have been approved for financial assistance on this account.

Your information provided was reviewed based on our financial assistance guidelines and approved for 100% coverage. Your balance is now zero.

Thank you for making Citrus Valley Health Partners your caregiver of choice.

Sincerely,

Business Services  
(626)732-3100  
(8:00a.m.-4:00p.m.)

061A (Approval letter – 100%)



# CITRUS VALLEY HEALTH PARTNERS

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY,STATE ZIP]

NOMBRE DEL PACIENTE: [PATIENT NAME]  
NUMERO DE CUENTA: [ACCOUNT #]  
FECHA DE SERVICIO: [ADM/SER DATE]  
BALANCE: \$[BALANCE]

Querido(a) [GUARANTOR NAME]:

Basado en la información que nos envió nos comparamos en informarles que usted ha sido aprobado(a) para asistencia financiera en esta cuenta.

Su información proporcionada fue revisada basada en nuestras guías de asistencia financiera y fue aprobada el 100%. Su balance es cero.

Gracias por escoger a Citrus Valley Health Partners como su proveedor de salud.

Sinceramente,

Business Services  
(626)732-3100  
(8:00 a.m. - 4 p.m.)

061A-SP (Approval letter – 100%)

**Policy Type:** GHO Manual  
**Policy #:** PC-300 (Formerly D301)  
**Policy Title:** EMTALA (Emergency Medical Treatment and active labor act)  
**Originating Date:** 3/99  
**Reviewed Date:** 2/04, 5/02, 10/07, 2/28/11(FPH), 10/4/13+  
**Revised Date:** 6/99, 5/02, 1/08\*, 3/23/11, 4/30/12, 1/22/14

+ Template changed

See Nursing Administration office for paper copy of policy.

#### Statement of Policy

It is the policy of Citrus Valley Medical Center and Foothill Presbyterian Hospital to provide a medical screening examination by a qualified medical person to any individual who comes to the Hospital and seeks an examination or medical treatment to determine if the individual has an emergency medical condition, whether or not eligible for insurance benefits and regardless of ability to pay.

If it is determined that the individual has an emergency medical condition, medical examination and treatment will be provided as required to stabilize the emergency medical condition, within the capability of the Hospital, or to arrange for transfer to the individual to another medical facility in accordance with the procedures set forth below.

#### Declarations

- A. The provision of a medical screening examination, stabilizing treatment, or appropriate transfer will not be delayed in order to inquire about the individual's method of payment or insurance status.
- B. The Hospital will not request or allow a health plan to require prior authorization for services before the individual has received a medical screening examination and stabilizing treatment.
- C. The Hospital will provide emergency services and care without regard to an individual's race, ethnicity, religion, national origin, citizenship, age, sex, sexual orientation, preexisting medical condition, physical or mental disability, insurance status, economic status or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the individual.
- D. The policy applies to:
1. All individuals who present anywhere on the Hospital's Campus, even if they present at a location other than the Emergency Department.
  2. All individuals in any ambulance subject to the policies and procedures of the local Emergency Medical Services (EMS) authority that is on Hospital property, even if instructed not to come to the Hospital.
- E. Hospital property means the entire Hospital campus (including parking lots, sidewalks and driveways) defined as:
1. The main facility buildings.
  2. Structures owned and operated by the Hospital that are within 250 yards to the

main buildings.

- F. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
  2. Serious impairment to bodily functions; or
  3. Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is having contractions:
1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  2. That transfer may pose a threat to the health or safety of the woman or her unborn child.
- G. Labor means the process of childbirth beginning with the latent or early phase and continuing through the delivery of the placenta. A woman who is experiencing contractions is in true labor unless a physician or qualified medical person certifies, after a reasonable period of observation, that she is in false labor.
- H. Medical screening examination means the screening process required to determine with reasonable clinical confidence whether an emergency medical condition does or does not exist.
- I. Qualified medical person means an individual other than a licensed physician who is licensed or certified in one of the following professional categories and who has demonstrated current competence in the performance of a medical screening examination:
1. Registered nurses who are credentialed to perform a medical screening examination for patients in labor.
  2. Physician's Assistants or Nurse Practitioners in the Emergency Department under physician supervision.
- J. "To stabilized" or "stabilize" or "stabilized" means:
1. With respect to an emergency medical condition, that the individual is provided with such medical treatment as is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from the Hospital; or
  2. With respect to a pregnant woman who is having contractions and who cannot be transferred before delivery without a threat to the health or safety of the woman or the unborn child, that the woman has delivered the child and the placenta.
- K. Stable for discharge means:
1. The physician has determined, within reasonable clinical confidence, that the patient has reached the point where his/her continued medical treatment, including diagnostic work-up or treatment, could reasonably be performed as an outpatient or later as an inpatient, as long as the patient is given a plan for appropriate follow-up care with discharge instructions; or

2. With respect to an individual with a psychiatric condition, the physician has determined that the patient is no longer considered to be a threat to himself/herself or others.

NOTE: "Stable for discharge" does not require the final resolution of the emergency medical condition. However, the patient is never considered "stable for discharge" if within a reasonable medical probability, the patient's condition would materially deteriorate after discharge.

L. Stable for transfer between medical facilities means:

1. The physician determines within reasonable clinical confidence, that the patient will sustain no material deterioration in his/her medical condition as a result of the transfer, and that the receiving facility has the capability to manage the emergency medical condition and any reasonably foreseeable complication; or
2. With respect to an individual with a psychiatric condition the physician determines that the patient is protected and prevented from injuring himself/herself or others.

NOTE: Stable for transfer does not require the final resolution of the emergency medical condition.

M. Transfer means the movement (including the discharge) of an individual outside the Hospital's facilities at the direction of any person employed or associated, directly or indirectly, with the Hospital, but does not include the movement of an individual who: (1) is being moved from one location in the Hospital to another location in the Hospital; (2) has been declared dead; or (3) leaves the Hospital without permission or against medical advice.

N. Within the capability of the Hospital means those services which the Hospital is required to have as a condition of its license, as well as Hospital ancillary services routinely available to the Emergency Department.

Procedure

A. Medical Screening Examination

1. The Hospital shall provide a medical screening examination for every person who comes to the emergency department and seeks medical treatment or on whose behalf such a request is made, and shall also provide such an examination for every person who comes to another area of the Hospital campus to seek treatment for a potential emergency medical condition.
2. An individual who comes to another (non-emergency department) area of the Hospital campus and seeks treatment for a potential emergency medical condition shall be immediately transported to the Emergency Department of the screening examination and necessary stabilizing treatment. Such transport shall be by the method and with the personnel and equipment deemed appropriate under the circumstances by those who are with the individual.
  - a. Emergency Department staff will respond and provide first aid to any person in need of emergency care who is on Hospital property or in a structure that is owned and operated by the Hospital and is within 250 yards of the Hospital.
  - b. Emergency Medical Services Staff will be utilized for calling 911 for any person outside the designated area.
  - c. If an individual is found down in extremis, 911 and Emergency Department staff will be called simultaneously.

3. Within the capability of the Emergency Department, the medical screening examination shall determine within reasonable medical probability whether or not an emergency medical condition exists. The medical screening examination shall be performed by a physician or by a qualified medical person and must be documented in the medical record.
4. If, after an initial medical screening examination, a physician determines that the individual requires the services of an on-call physician, the on-call physician shall be contacted.

B. Individuals Who Do Not Have An Emergency Medical Condition

1. When a physician determines as a result of a medical screening examination that the individual does not have an emergency medical condition, the individual may be transferred to another medical facility (if in need of further care) or discharged. The transfer or discharge of an individual who does not have an emergency medical condition shall be in accordance with the Hospital's transfer and discharge policies.
2. The hospital may transfer an individual with no emergency medical condition to another hospital for non-medical reason. Before transferring the individual, the hospital shall:
  - a. Ask the individual if he or she has a preferred contact person who should be notified about the transfer;
  - b. Contact the person and alert him or her about the proposed transfer;
  - c. If the individual is unable to respond, the hospital shall:
    - i. Make reasonable effort to ascertain the identity of the preferred contact person, or the next of kin;
    - ii. Alert the preferred contact person or the next of kin about the transfer;
    - iii. Document any attempt to contact a preferred contact person or next of kin in the medical records.
3. The appropriate portions of the Physician Authorization for Transfer form shall be completed if the individual is transferred to another medical facility.

C. Individuals Who Have An Emergency Medical Condition

1. When it is determined that the individual has an emergency medical condition, the Hospital shall:
  - a. Within the capability of the staff and facilities available at the Hospital, stabilize the individual to the point where the individual is either stable for discharge or stable for transfer.
  - b. Provide for an appropriate transfer of the unstabilized individual to another medical facility. Transfer of unstabilized individuals are allowed only pursuant to patient request, or when a physician, or a qualified medical person in consultation with a physician, certifies that the expected benefits to the patient from the transfer outweigh the risks of transfer.
2. If an individual has an emergency medical condition which has not been stabilized, the individual may be transferred only if the transfer is carried out in accordance with the procedures set forth below:
  - a. The individual may be transferred if the individual or the legally responsible person acting on the individual's behalf is first fully informed of the risks of the transfer, the alternatives (if any) to the transfer, and of the Hospital's obligations to provide further examination and treatment sufficient to stabilize the individual's emergency medical condition, and to

provide for an appropriate transfer. The transfer may occur if the individual or legally responsible person: (i) makes a written request for transfer to another medical facility, stating the reasons for the request; and (ii) acknowledges his request and understanding of the risks and benefits of the transfer, by signing the Patient Request for Transfer or Discharge form.

b. The individual may be transferred if a physician has documented in the Physician Authorization for Transfer form that the medical benefits expected from transfer outweigh the risks.

3. The transfer from this Hospital to a receiving medical facility of an individual with an unstabilized emergency medical condition shall be carried out as follows:

a. The Hospital shall, within its capability, provide medical treatment which minimizes the risks to the individual's health and, in the case of a woman who is having contractions, the health of the woman and the unborn child;

b. A representative of the receiving medical facility must have confirmed that the receiving medical facility has available space and qualified personnel to treat the individual and has agreed to accept the transfer and to provide appropriate medical treatment, and a physician at the receiving facility has agreed to accept the transfer;

c. The Hospital shall send the receiving medical facility copies of all pertinent medical records available at the time of transfer, including (1) available history; (2) records related to the individual's emergency medical condition; (3) observations of signs or symptoms; (4) preliminary diagnoses; (5) results of diagnostic studies for telephone reports of the studies; (6) treatment provided; (7) results of any tests; (8) a copy of the Physician Authorization for Transfer form, including if applicable, the certification of risks and benefits by a physician, or the signed Patient Request for Transfer form;

d. The transfer shall be effected through qualified professionals and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer. The physician is responsible for determining the appropriate mode of transport, equipment, and transporting professionals to be used for the transfer.

e. If an on-call physician has refused or failed to appear within a reasonable time after being requested to provide necessary stabilizing treatment thus necessitating a transfer, the emergency physician shall document the on-call physician's name and address in the medical record.

D. Individuals Who Have An Emergency Medical Condition But Refuse to Consent to Treatment Or to Transfer

1. If the Hospital offers examination and treatment and informs the individual or legally responsible person of the risks and benefits to the individual of refusing the examination and treatment, but the individual or legally responsible person refuses to consent to the examination and treatment, the Hospital shall take all reasonable steps to have the individual or legally responsible person sign a Refusal to Permit Further Medical Treatment form. The medical record shall contain a description of the examination, treatment, or both, if applicable, that was proposed but refused by or on behalf of the individual; the risks and benefits of the examination and/or treatment; the reasons for refusal; and if the individual refused to sign the form. The steps taken in effort to secure the written informed refusal. An individual who has refused medical examination and/or treatment may be transferred in accordance with the procedures

set forth for transfer of unstabilized patients.

2. If the Hospital offers an appropriate transfer but the individual or the legally responsible person refuses the transfer, after being informed of the risks and benefits of the transfer, the Hospital shall take all reasonable steps to have the individual or legally responsible person sign Section 4, Transfer is Refused, on the Physician Authorization for Transfer form. In addition, the medical record shall contain a description of the reasons for the proposed transfer.

#### E. On-Call Physicians

The Hospital shall maintain an on-call list of physicians, including specialists and sub-specialists that are available to screen, examine, and treat patients with potential emergency medical conditions. On-call physicians shall respond to Hospital calls for emergency coverage within a reasonable time after receiving communication indicating that their attendance is required. If an on-call specialist or sub-specialist is not available, the Emergency Department physician, or his or her designee, shall attempt to obtain the services of another appropriate specialist or sub-specialist from the Hospital's medical staff through working with the Chief of Staff and the Administrator on-call, as deemed appropriate. If the necessary on-call services remain unavailable despite these efforts, such that the patient requires transfer in order to obtain the necessary services at another medical facility, the emergency physician shall note the name and address of the on-call physician who refused or failed to appear, in the medical record.

#### F. Record-keeping

The Hospital, whether transferring or receiving patients, must maintain the following:

1. Medical and other records related to individuals transferred to or from the Hospital, for a minimum period of five (5) years from the date of the transfer;
2. A list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition, for a period of five (5) years;
3. A central log on each individual who comes to the Emergency Department seeking screening or treatment, for a period of five (5) years. The log must indicate whether the individual refused treatment or transfer, or was transferred prior to stabilization, admitted and treated, stabilized and transferred, or discharged.

#### G. Acceptance of Patient Transfers

The Hospital has the obligation to accept an appropriate transfer of a patient with an unstabilized emergency medical condition who requires specialized capabilities or facilities of the Hospital.

#### H. Reporting the Receipt of Inappropriate Transfers

1. Each Hospital medical staff member, house staff member, nursing supervisor or employee who works in the Emergency, Labor and Delivery or Admitting departments and who has reason to believe that a potential violation of the law has resulted in an inappropriate transfer to the Hospital as a receiving hospital shall report the incident to the Administrator on-call, or Director of Risk management as soon as possible for investigation.

#### I. Signage

1. The Hospital shall post signs in English and in Spanish that specify the rights of individuals under the law with respect to examination and treatment for

emergency medical conditions and of women who are pregnant and are having contractions. These signs shall be posted in the Emergency Department, Perinatal Services Department and where patients wait prior to examination and treatment.

2. The Hospital shall post signs stating whether or not the Hospital participates in the Medi Cal program.

#### **References**

CHA Consent Manual

EMTALA Statute, US Code, Title 42, Section 395dd

California Health and Safety Code, Section 1317.2, All Facilities Letter 13-37.

Emergency Department Policy A113, Emergency Response to Medical Emergencies Outside of the Hospital (CVMC)

Perinatal Services Policy S101, Screening Examination and Evaluation of Maternity Patients (CVMC)

Standardized Procedure, Medical Screening Exam FPH

# Citrus Valley Health Partners

V

2013  
Community Needs  
Assessment



# 2013 Community Health Needs Assessment Report



*Elevating health care. Together.*



Queen of the Valley • Inter-Community • Foothill Presbyterian



## **Authors**

### **The Center for Nonprofit Management**

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## Acknowledgement

East Metro West Collaborative would like to thank the following participating organizations for assisting with the needs assessment for Citrus Valley Health Partners.

211 Los Angeles County  
Alliance for Housing and Healing  
AltaMed Health Services Corporation  
American Heart Association  
American Red Cross  
Asian Pacific Community Fund  
Asian Pacific Women's Center  
Asian Youth Center  
Azusa Pacific University  
Baldwin Park Unified School District  
Bassett Unified School District  
Bike San Gabriel Valley  
Boys & Girls Club of the Foothills  
Boys & Girls Club of West San Gabriel Valley  
Boys & Girls Club San Gabriel Valley  
Buddhist Tzu Chi Free Clinic  
Cal Poly Pomona, Department of Agriculture  
California Center for Public Health Advocacy  
California State Senate, 24th Senate District  
Chinatown Service Center  
Citrus Valley Health Foundation  
Citrus Valley Health Partners  
City of Baldwin Park  
City of Covina  
City of Pasadena Public Health Department  
Community Health Alliance of Pasadena  
Drexel Smith Consulting  
Early Identification and Intervention Collaborative for Los Angeles County  
East San Gabriel Valley Coalition for the Homeless  
East San Gabriel Valley Regional Occupational Program and Technical Center  
East Valley Community Health Center  
El Monte City School District  
El Monte Comprehensive Community Health Center  
Ettie Lee Youth and Family Services  
Foothill Family Service  
Foothill Unity Center  
Girl Scouts of Greater Los Angeles  
Greater West Covina Business Association  
Herald Christian Health Center  
John Wesley Community Health Institute

La Casa de San Gabriel Community Center  
Latino Diabetes Association  
Lincoln Training Center  
Los Angeles County Department of Mental Health  
Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health  
Programs  
Los Angeles County Emergency Medical Services  
Majestic Realty Corporation  
Montebello Unified School District  
Neighborhood Homework House  
New Horizons Caregivers Group  
Options  
Our Saviour Center/Cleaver Family Wellness Center  
Planned Parenthood of Pasadena  
Pueblo que Camina  
Rowland Unified School District  
San Gabriel Children's Center  
San Gabriel Valley Conservation Corps  
San Gabriel Valley Consortium on Homelessness  
San Gabriel Valley Council of Governments  
San Gabriel Valley Economic Partnership  
San Gabriel Valley Foundation for Dental Health  
San Gabriel Valley YMCA  
Service Planning Area 3 - Health Planning Group  
Services Center for Independent Living  
THINK Together  
West Covina Unified School District  
YWCA San Gabriel Valley

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## I. Executive Summary

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

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

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

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

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

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

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

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

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

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

## a. Health needs

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

### 1. Mental Health

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

### 2. Obesity/Overweight

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

### **3. Diabetes**

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

### **4. Oral Health**

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

## **5. Hypertension**

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

## **6. Cardiovascular Disease**

Cardiovascular disease – also called heart disease and coronary heart disease – includes several problems related to plaque buildup in the walls of the arteries, or atherosclerosis. As the plaque builds up, the arteries narrow, restricting blood flow and creating a risk for a heart attack.

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

## **7. Cancer, in General**

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

## **8. Vision**

People with diabetes are at an increased risk of vision problems as diabetes can damage the blood vessels of the eye, potentially leading to blindness. Diabetics are 40% more likely to suffer from glaucoma and 60% more likely to develop cataracts compared to people without diabetes. The percent of diabetic adults who had their vision checked within the last year was higher in the CVHP service area (65.7%) compared to Los Angeles County (63.3%). Vision care providers should expect to see more of these complications among a younger population as more young

children and adolescents are being diagnosed with diabetes. Stakeholders agreed that vision was an issue and attributed it to the lack of available services. They added that vision is not isolated to any group but instead that it is widespread. There is a need for vision screenings, especially for children who experience difficulty in school because they cannot see well. Vision was identified as a major health issue in one out of 19 interviews and three out of five focus groups. Vision was not identified as a need in the 2010 CVHP Community Health Needs Assessment.

## **9. Colorectal Cancer**

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

## **10. Disability**

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

Education Plans) as a particularly impacted population. Disabilities were not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

### **11. Intentional Injury (Homicide)**

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

### **12. Alcohol & Substance Abuse**

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

### **13. Cervical Cancer**

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

the statewide rate of 8.30 per 100,000 and the national rate of 8 per 100,000. Over one-third of the communities in the CVHP service area have cervical cancer mortality rates above Los Angeles County (3.0) and the CVHP service area (2.2) average, including Diamond Bar (8.0), West Covina (5.2), La Puente (4.3), Rowland Heights (3.9), and Walnut (3.6). Within the CVHP service area, cervical cancer related hospital discharge rates are higher among the Hispanic/Latino population (13.2). Cervical cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

#### **14. Chlamydia**

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

#### **15. Asthma**

Asthma is a disease that affects the lungs and is one of the most common long-term diseases of children. Adults also may suffer from asthma and the condition is considered hereditary. Asthma symptoms include wheezing, breathlessness, chest tightness, and coughing. The prevalence of asthma for adults in Los Angeles County and in the CVHP service area is the same at 11.1%. While the average adult asthma hospitalization rate per 100,000 persons in the CVHP service area (89.2) is lower than the statewide average (94.3), it is very high in South El Monte (198.2) and El Monte (171.7) and is also high in Baldwin Park, La Puente, West Covina and Rowland Heights. The asthma hospitalization rate for youth in the CVHP service area is higher with 20.8 youth per 1000 compared to a statewide average of 19.2 youth per 1000. Some asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroach allergens, pet dander, mold, and certain infections known to cause asthma such as the flu, colds, and respiratory related viruses. Other contributing factors include exercising, certain medication, bad weather, high humidity, cold/dry air, certain foods and fragrances. Within the CVHP service area, individuals between the ages of 1 and 19 (4.6%) experienced the most asthma related hospital discharges. Stakeholders indicated that asthma and respiratory illness were on the rise and attributed the prevalence to the inability of people to control their respiratory conditions. Asthma was mentioned as a major health issue in one out of five focus groups and five out of 19 interviews.

Community stakeholders highlighted youth and individuals over the age of 35 as particularly affected populations. Asthma was not identified as a key health need in the 2010 CVHP Community Health Needs Assessment.

## **16. Alzheimer's Disease**

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

## **17. Unintentional Injury (Pedestrian/Motor Vehicle)**

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

## **18. Arthritis**

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

## **19. Chronic Obstructive Pulmonary Disease (COPD)**

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

## **20. HIV/AIDS**

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

## **21. Allergies**

Allergies are an overreaction of the immune system to substances that usually cause no reaction in most individuals. These substances can trigger sneezing, wheezing, coughing and itching. Risk factors associated with allergic reactions include pollen, dust, food, insect stings, animal dander, mold, medications, and latex. Other social and economic factors that can cause or trigger

allergic reactions include poor housing conditions (living with cockroaches, mites, asbestos, mold etc.) and living in an environment or home with smokers. More teens in the CHVP service area had allergies (36.8%) when compared to Los Angeles County (24.9%). Allergies were identified as a major health concern in three out of 19 interviews. Allergies were not indicated among major needs in the 2010 CVHP Community Health Needs Assessment.

## **22. Infant Mortality**

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

### **b. Health drivers**

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

1. Employment
2. Income
3. Homelessness
4. Health Insurance
5. Health Care Access
6. Awareness
7. Dental Care Access
8. Nutritional Access
9. Education

10. Healthy Eating
11. Physical Activity
12. Family and Social Support
13. Preventive Care Services
14. Language Barrier
15. Transportation
16. Cancer Screenings
17. Natural Environment
18. Safety

## **II. Introduction/Background**

### **a. Purpose of the community health needs assessment report**

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

### **b. About Citrus Valley Health Partners**

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

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

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

### **c. About Citrus Valley Health Partners Community Benefit**

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

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

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

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

*About the new federal requirements*

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

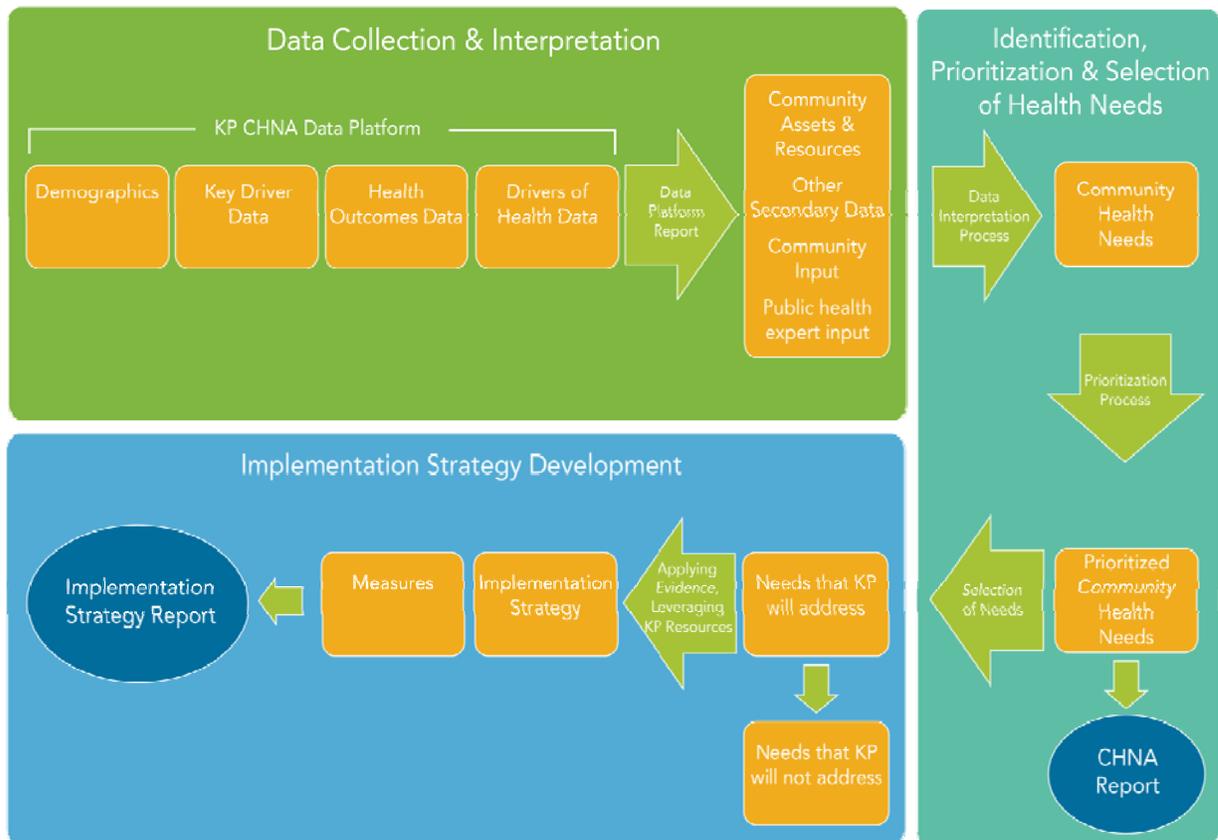
### *SB 697 and California’s history with past assessments*

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

### *Kaiser Permanente’s CHNA framework and process*

Kaiser Permanente Community Benefit staff at the national, regional, and hospital levels worked together to establish an approach for implementing the new federally legislated CHNA. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

## KAISER PERMANENTE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS MAP



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

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

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

Each hospital/collaborative used a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on a second set of criteria. This process resulted in a complete list of prioritized community health. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, Citrus Valley Health Partners will examine the list of prioritized health needs and develop an implementation strategy for those health needs it will address. These strategies will build on Citrus Valley Health Partners assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H.

### **III. Community Served**

#### **a. Definition of community served by hospital facility**

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

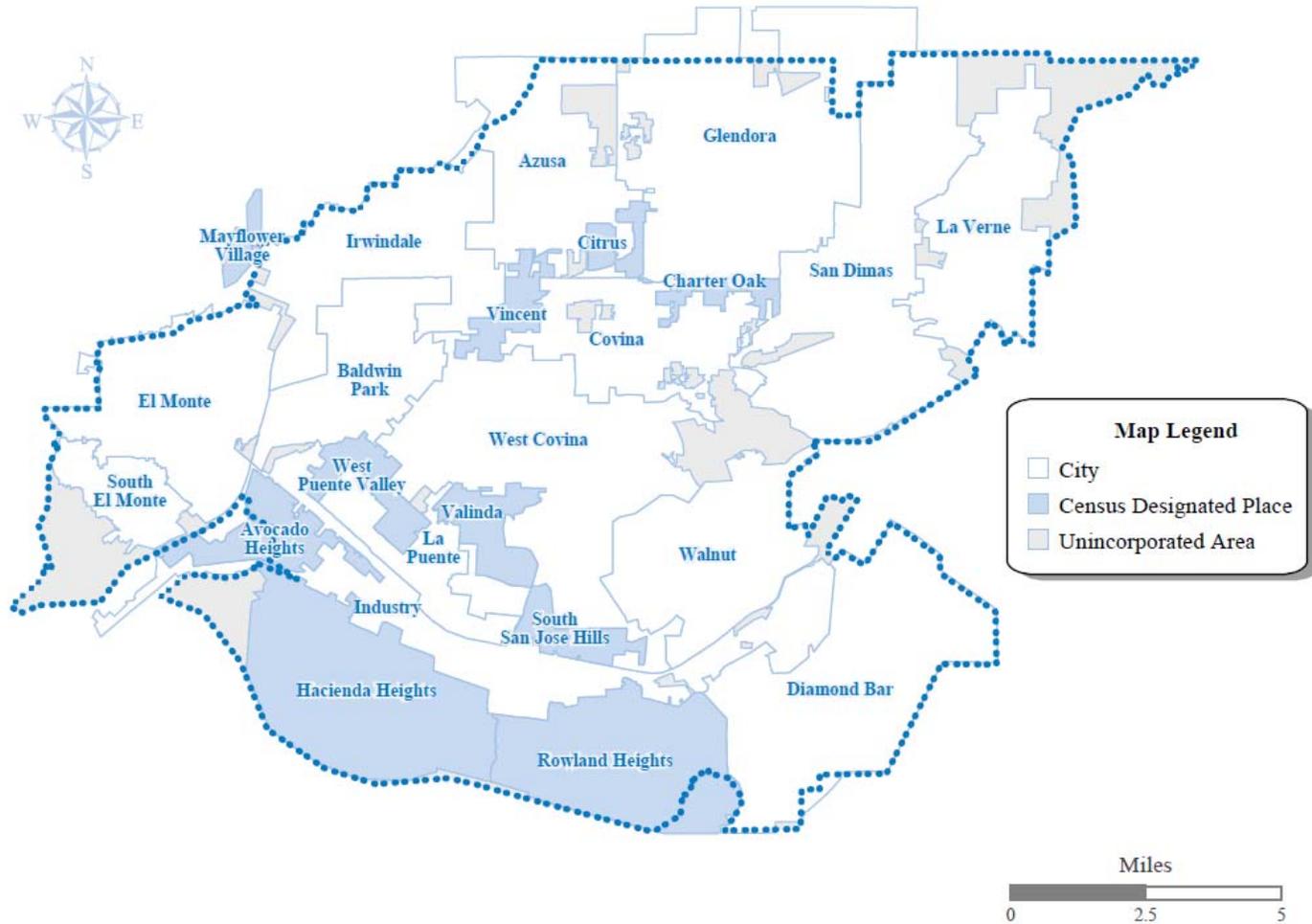
## b. Description and map of community served by hospital facility

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

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



# Citrus Valley Health Partners SERVICE AREA



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

*Demographic profile*

**Population**

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

**Total Population, 2010**

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

Source: U.S. Census Bureau Decennial Census, 2010

Source Geography: Zip Code (each city is aggregated to include only those zip codes in the service area)

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

## Gender, 2010

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

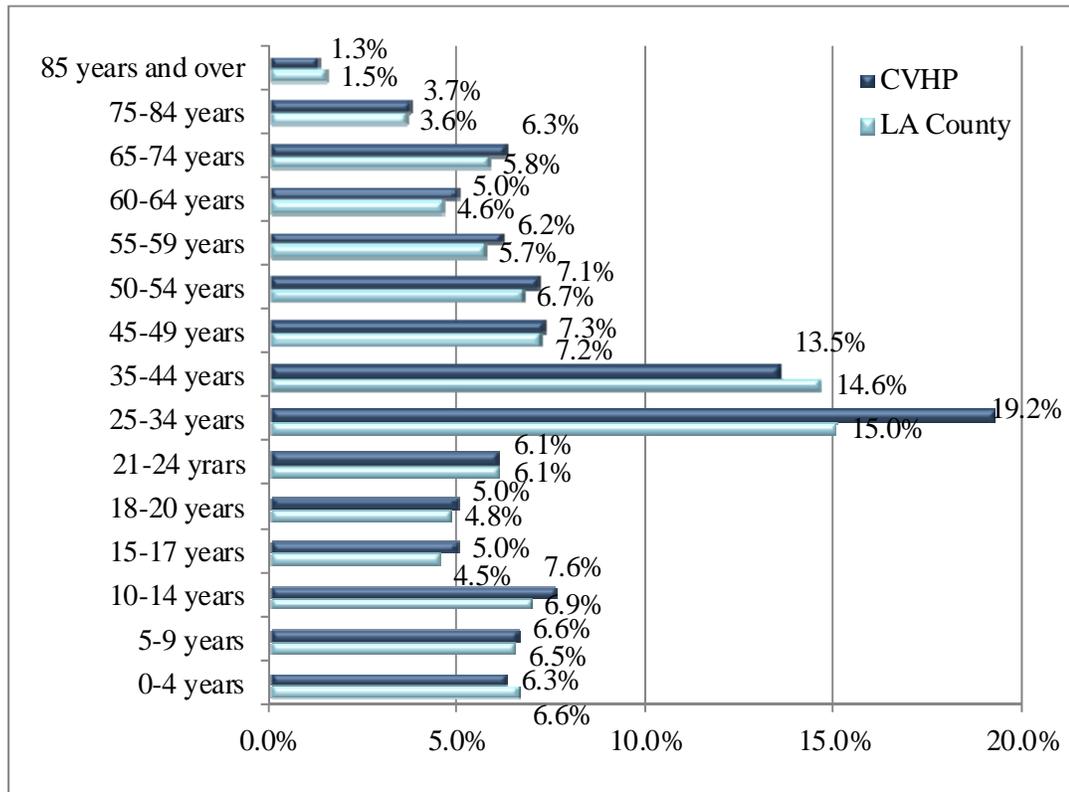
Source: U.S. Census Bureau Decennial Census, 2010

Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

## Age

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

### Age, 2010



Source: U.S. Census Bureau Decennial Census, 2010

Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

### Race and Ethnicity

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

### Race and Ethnicity, 2010

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

Source: U.S. Census Bureau Decennial Census, 2010

Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

### Language Spoken at Home

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

### Language Spoken At Home, 2013

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

Data source: Nielson Claritas, 2013

Source geography: ZIP Code

### Education Attainment

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

### Education Attainment, 2010

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

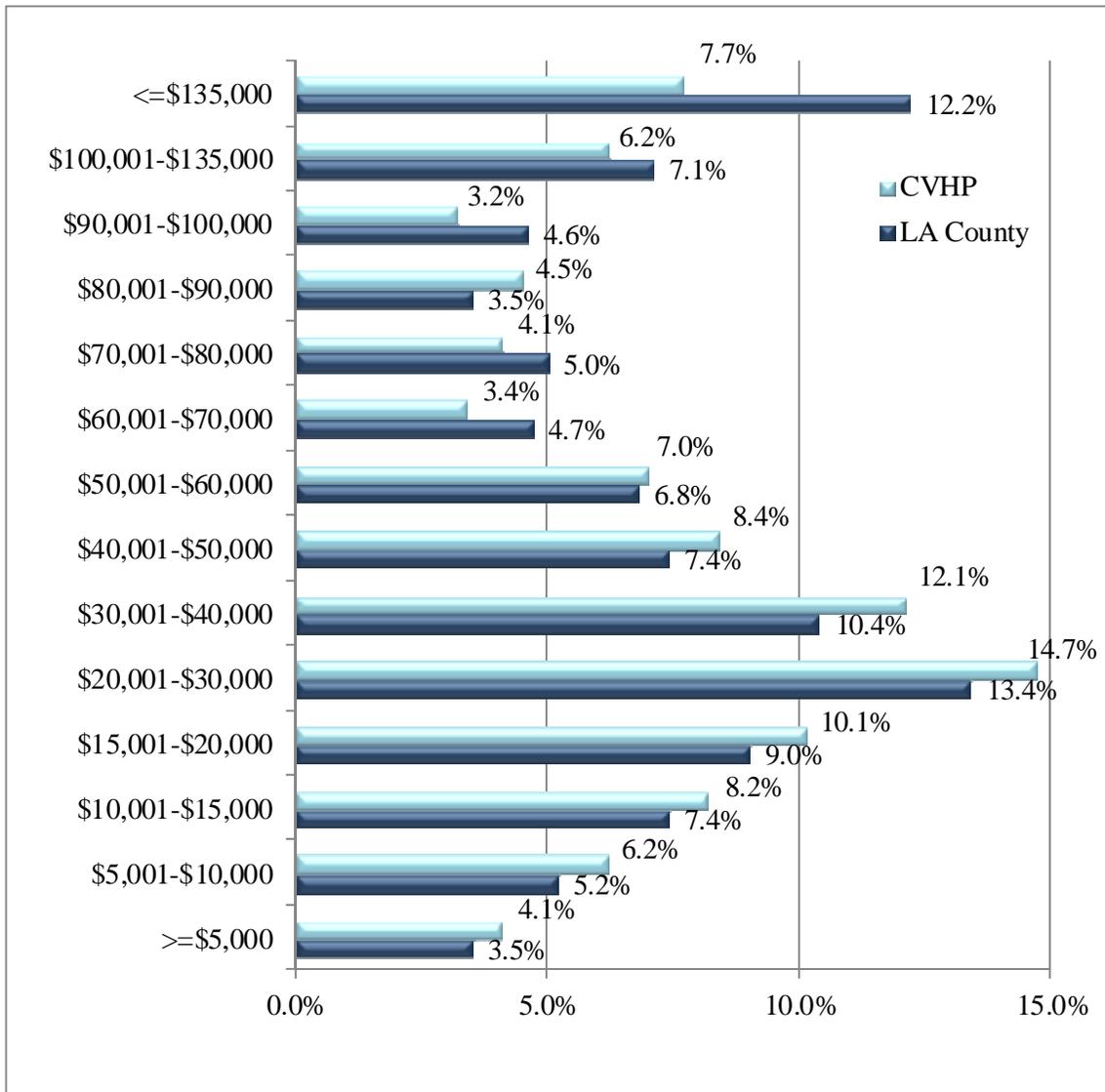
Source: U.S. Census Bureau Public Use Microdata Statistics (PUMS), 2010

Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

### Household Income

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

### Annual Household Income, 2009



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

### Poverty

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

**Poverty Level, 2010**

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

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

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

**Poverty Level, 2010**

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

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

## Homeless Persons

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

### Homeless Persons, 2011

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

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

Source geography: SPA

## Homeless Persons by Age

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

### Homeless Persons by Age, 2011

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

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

## Employment Status

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

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

### Employment Status, 2010

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

Source: American Community Survey 5-Year Estimates, 2006-2010

Source Geography: SPA (data not available at the zip code level)

### Medical Insurance

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

### Insurance Status, 2009 and 2011

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

Source: California Health Interview Survey (CHIS), 2009<sup>1</sup>, California Department of Health Care Services (DHCS), 2011<sup>2</sup>

Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

### Population without a Usual Source of Care

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

#### Population without a Usual Source of Care, 2009

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

Source: California Health Interview Survey (CHIS), 2009

Source Geography: SPA (data not available at the zip code level)

### Health Professional Shortage Areas

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

#### Health Professional Shortage Areas, 2012

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

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

Source geographic: HPSA

### Federally Qualified Health Center (FQHC)

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

#### Federally Qualified Health Center (FQHC), 2011

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

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

Source geographic: Address

*Chronic diseases in the CVHP service area*

**Diabetes Prevalence and Hospitalizations**

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

**Diabetes Prevalence, 2009 and 2010**

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

Source: California Health Interview Survey (CHIS), 2009<sup>1</sup>, Office of Statewide Health and Planning and Development (OSHPD), 2010<sup>2</sup>

Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)<sup>2</sup>

Adults in the CVHP service area experience more diabetes-related hospitalizations per 100,000 population (147.4) compared to youth (26.8). Specifically, in South El Monte where the rate of adults experience nearly double the rate (289.3) of California (145.6) and the CVHP service area (147.4) of diabetes-related hospitalizations. El Monte (211.8) and La Puente (194.7) also

experienced some of the highest rates of diabetes-related hospitalizations by adults. As far as youth, Glendora (66.5) has twice the rate of diabetes-related hospitalizations when to the CVHP service area (26.8) and California (34.9). The cities of Azusa (49.0), El Monte (42.3), Hacienda Heights (42.2), and La Puente (40.0) also experienced higher rates of diabetes-related hospitalizations of youth.

### Diabetes Hospitalizations, 2010

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

Source: Office of Statewide Health Planning and Development (OSHPD), 2010

Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

### Cardiovascular Disease Prevalence

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

### Cardiovascular Disease Prevalence, 2009

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

Source: California Health Interview Survey (CHIS), 2009

Source Geography: SPA data not available at the zip code level)

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

heart disease mortality rate in the CVHP service area (14.4) is lower when compared to California (15.6). However, a large number of cities within the CVHP service area had higher mortality rates than California (15.6) including San Dimas (22.7), La Verne (21.7), and Glendora (20.7).

### Cardiovascular Disease Prevalence, 2009 and 2010

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

Source: Office of Statewide Health and Planning and Development (OSHPD), 2010

Source Geography: Zip Code (each city aggregated to include only those zip codes in the service area)

### Cervical Cancer

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

### Cervical Cancer, 2007

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

Source: Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2007<sup>2</sup>

Source Geography: SPA (data not available at the zip code level)

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

### Cervical Cancer, 2008

	<b>Death Rate (age-adjusted per 100,000 pop.)</b>
Azusa	0.0
Baldwin Park	2.3
Covina	0.0
Diamond Bar	8.0
El Monte	3.0
Glendora	0.0
Hacienda Heights	0.0
La Puente	4.3
La Verne	0.0
Rowland Heights	3.9
San Dimas	0.0
South El Monte	0.0
Walnut	3.6
West Covina	5.2
CVHP Service Area	2.2
Los Angeles County	3.0
California	2.3
HP 2020	<=2.2

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

### Colorectal Cancer

The portion of men over the age of 50 who had a sigmoidoscopy or colonoscopy was on average much lower (28.3%) in the CVHP service area when compared to Los Angeles County (75.7%) and the Healthy People 2020 benchmark of >=70.5%. Men over the age of 50 who had the same tests done in the last five years was higher (61.5%) in CVHP service area when compared to Los Angeles County (65.5%) but did not meet the Healthy People 2020 benchmark >=70.5%.

#### Colorectal Cancer Incidence, 2009

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

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

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

### Colorectal Cancer Incidence, 2008

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

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

### Mental Health

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

### Mental Health, 2010

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

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

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

### Mental Health, 2010

	Alcohol/Drug Induced Mental Disease Hospitalization Rate

CVHP Service Area	91.4
California	109.1

Source: Office of Statewide Health Planning and Development (OSHPD), 2010

Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

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

### Mental Health, 2009

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

Source: California Health Interview Surveys, 2009

Source Geography: SPA (data not available at the zip code level)

### Obesity/Overweight

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

### Obesity/Overweight, 2009

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

Source: California Health Interview Survey (CHIS), 2009

Source Geography: Zip Code (each SPA aggregated to include only those zip codes in the service area)

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

### Obesity/Overweight, 2009

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

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

Source Geography: County

## IV. Who Was Involved In The Assessment

### a. The Center for Nonprofit Management Team

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

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

### b. East Metro West Collaborative

The Collaborative includes the following partners:

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

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

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

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

*East*

**Citrus Valley Health Partners**

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

### **Kaiser Foundation Hospital—Baldwin Park**

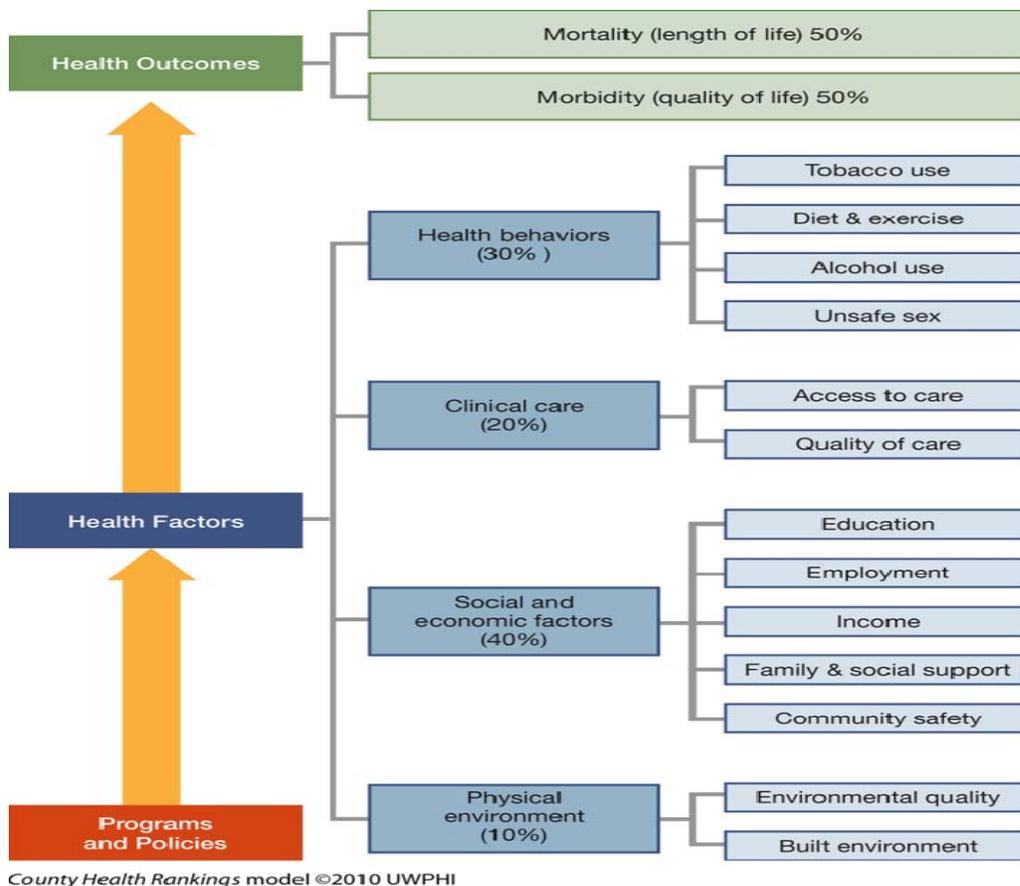
Kaiser Foundation Hospital—Baldwin Park (KFH-BP) is a 272 licensed-bed hospital offering comprehensive services including primary care and specialty services. KFH-BP serves 246,000 members in the San Gabriel Valley through a network of more than 3,300 employees and 498 physicians at its medical center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

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

## V. Process and Methods Used to Conduct the CHNA

### a. Secondary data

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



To promote consistency across the organization, CVHP partnered with Kaiser Permanente to identify a minimum set of required indicators for each of the data categories to be used by all Kaiser Permanente Regions for the Community Health Needs Assessments. Kaiser Permanente partnered with the Center for Applied Research and Environmental Systems (CARES) at the University of Missouri to develop a web-based data platform to provide the common indicators

across service areas. The secondary data for this report was obtained from the Kaiser Permanente CHNA data platform from October 2012 through February 2013. The data platform is undergoing continual enhancements and certain data indicators may have been updated since the data were obtained for this report. As such, the most updated data may not be reflected in the tables, graphs, and/or maps provided in this report. For the most recent data and/or additional health data indicators, please visit [CHNA.org/kp](http://CHNA.org/kp).

The Kaiser Permanente common indicator data were calculated to obtain unique service area rates. In most cases, the service area values represent the aggregate of all data for geographies (ZIP Codes, counties, tracts, etc.), which fall within the service area boundary. When one or more geographic boundaries are not entirely encompassed by a service area, the measure is aggregated proportionally. The options for weighting “small area estimations” are based upon total area, total population, and demographic-group population. The specific methodology for how service area rates are calculated for each indicator can be found on the [CHNA.org/kp](http://CHNA.org/kp) website.

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

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

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

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

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

## b. Community input

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

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

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

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

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

**Individuals with special knowledge of or expertise in public health**

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

**Individuals with special knowledge of or expertise in public health**

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

**Individuals with special knowledge of or expertise in public health**

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

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

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

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

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

**c. Data limitations and information gaps**

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

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

## VI. Identification and Prioritization of Community's Health Needs

### a. Identifying community health needs

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

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

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

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

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

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

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

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

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

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

#### **Health Needs and Drivers Carried Into Prioritization Phase**

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

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

Note: Presented in alphabetical order

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

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

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

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

- To be inclusive of stakeholders

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

### *Community Forums*

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

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

The following questions were addressed in the grid exercise:

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

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

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

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

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

### **Analysis of Survey Scores**

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

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

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

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

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

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

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

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

**c. Description of prioritized community health needs**

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

**1. Mental Health**

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

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

## **2. Obesity/Overweight**

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

### **3. Diabetes**

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

### **4. Oral Health**

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

## **5. Hypertension**

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

## **6. Cardiovascular Disease**

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

## **7. Cancer, in General**

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

## **8. Vision**

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

## **9. Colorectal Cancer**

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

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

## **10. Disability**

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

## **11. Intentional Injury (Homicide)**

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

## **12. Alcohol & Substance Abuse**

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

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

### **13. Cervical Cancer**

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

### **14. Chlamydia**

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

## **15. Asthma**

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

## **16. Alzheimer's Disease**

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

## **17. Unintentional Injury (Pedestrian/Motor Vehicle)**

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

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

### **18. Arthritis**

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

### **19. Chronic Obstructive Pulmonary Disease (COPD)**

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

### **20. HIV/AIDS**

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

## **21. Allergies**

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

## **22. Infant Mortality**

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

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

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

### a. Health Care Facilities

#### *Hospitals*

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

#### *Community Clinics*

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

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

### *Dental Care*

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

### *Mental Health*

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

### **b. Other Community Resources**

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

[www.211LA.org](http://www.211LA.org)

[www.HealthyCity.org](http://www.HealthyCity.org)

<http://www.chna.org/KP/>

### *School Districts*

- Azusa Unified School District
- Baldwin Park Unified School District

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

*Community Organizations and Public Agencies*

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

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

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

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



# Appendix A: Glossary

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

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### **Age-adjusted rate**

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

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### **Benchmark<sup>1</sup>**

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

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### **Community assets**

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

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### **Community Health Needs Assessment<sup>2</sup>**

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

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### **Community served**

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

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### **Consultant**

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

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**Data set**

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

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**Data source**

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

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**Disease burden**

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

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**Drivers of health**

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

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**FQHC<sup>3</sup>**

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

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**Focus group**

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

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**Health disparity**

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Diseases and health problems do not affect all populations in the same way. Health disparity refers to the disproportionate impact of a disease or a health problem on specific populations. Much health disparity research literature focuses on racial and ethnic differences—as to how these communities experience specific diseases—however, health disparity can also be correlated with gender, age, and other factors, such as veteran, disability, and housing status.

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**Health driver**

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Health drivers are behavioral, environmental, social, economic, and clinical-care factors that positively or negatively impact health. For example, smoking (behavioral) is a health driver for lung cancer, and access to safe parks (environmental) is a health driver for obesity/overweight. Some health drivers, such as poverty or lack of insurance, impact multiple health issues.

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**Health indicator<sup>4</sup>**

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A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population. (*Example: Percent of children overweight in Los Angeles County, incidence of breast cancer in Los Angeles County*)

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**Health need**

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

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**Health outcomes<sup>5</sup>**

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

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**Healthy People 2020<sup>6</sup>**

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

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**Implementation strategy<sup>7</sup>**

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

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**Incidence<sup>8</sup> rate**

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

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**Morbidity rate**

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

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**Mortality rate**

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

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**Percent**

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

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**Prevalence<sup>10</sup>**

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

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**Prevalence rate**

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Prevalence rate is the proportion of total population that currently has a given disease or health problem. Prevalence rate is expressed either as a fraction (e.g., percentage) or a density rate (e.g.,  $x$  number of cases per 10,000 people) to allow for comparison between different communities. Prevalence rate is distinct from incidence rate, which focuses on *new* cases. For instance, a community may experience a decrease in new cases of a certain disease (incidence) but an increase in the total number of people suffering that disease (prevalence) because people are living longer as a result of better screening or treatment for that disease.

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**Primary data**

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Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this CHNA, primary data were collected through focus groups and interviews with key stakeholders. Primary data describes what is important to the people who provide the information and is useful in interpreting secondary data (see *qualitative data, quantitative data, secondary data*). (*Example: Focus groups, key informant interviews*)

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**Qualitative data<sup>11</sup>**

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

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**Quantitative data<sup>12</sup>**

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

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**Risk factor<sup>13</sup>**

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

## Secondary data

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

## Stakeholder

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

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<sup>1</sup> Merriam-Webster Dictionary. Retrieved from [<http://www.merriam-webster.com/dictionary/benchmark>]

<sup>2</sup> World Health Organization (WHO). Retrieved from [<http://www.who.int/hia/evidence/doh/en/>]

<sup>3</sup> U.S. Department of Health and Human Services. Rural Health IT Toolbox. Retrieved from [<http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>] Accessed [April 30, 2013].

<sup>4</sup> “Health Promotion Glossary,” World Health Organization, Division of Health Promotion, Education and Communications (HPR), Health Education and Health Promotion Unit (HEP), Geneva, Switzerland, 1998.

<sup>5</sup> “Health Promotion Glossary,” World Health Organization, Division of Health Promotion, Education and Communications (HPR), Health Education and Health Promotion Unit (HEP), Geneva, Switzerland, 1998.

<sup>6</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [<http://healthypeople.gov/2020/default.aspx>] Accessed [April 30, 2013]

<sup>7</sup> Catholic Health Association of the United States (March, 2011). Assessing & addressing community health needs: Discussion Draft. Retrieved from [[http://www.chausa.org/Assessing\\_and\\_Addressing\\_Community\\_Health\\_Needs.aspx](http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx)]

<sup>8</sup> Aschengrau, A. & Seage, G.R. (2008). *Essentials of Epidemiology in Public Health*. Sudbury, Massachusetts: Jones and Barlett Publishers.

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

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

<sup>11</sup> Catholic Health Association of the United States (March, 2011). Assessing & addressing community health needs: Discussion Draft. Retrieved from [[http://www.chausa.org/Assessing\\_and\\_Addressing\\_Community\\_Health\\_Needs.aspx](http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx)]

<sup>12</sup> Ibid.

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

# **Appendix B: CVHP Health Needs Profiles**

## Health Need Profile: Mental Health

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

### **About Mental Health—Why is it important?**

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

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

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

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

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

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- More adults (657.0) experienced mental health–related hospitalizations per 100,000 adults when compared to California (551.7).
- More youth (375.4) experienced mental health–related hospitalizations per 100,000 youth when compared to California (256.4).
- More people in the CVHP service area did not have needed mental health treatment (51.4%) when compared to Los Angeles County (47.3%).
- More people in the CVHP service area experienced serious psychological distress (8.8%) than in Los Angeles County (7.3%).
- High percentages of African-Americans (19.3%), Whites (17.8%), and Hispanics/Latinos (13.0%) in the CVHP service area suffer from poor mental health.

- Adults experiencing the highest mental health–related hospitalization rates per 100,000 persons live in the cities of Covina (1,156.6) and Glendora (1,061.0).
- Youth experiencing the highest mental health–related hospitalization rates per 100,000 persons live in the cities of San Dimas (1,398.0) and La Verne (1,074.0).
- Suicide rates per 100,000 persons were higher in the cities of Glendora (2.4) and Hacienda Heights (1.5).
- Stakeholders<sup>7</sup> identified youth, middle-aged adults, the homeless, and the uninsured as the most severely impacted.
- Stakeholders indicated that mental health was an issue that affects everyone. Mental health services are difficult to access and insurance criteria and requirements are difficult for many to meet. Even when a person qualifies for care, they must often wait a long time to receive services. Stakeholders attributed some of these barriers to a lack of funding for mental health services. Stakeholders also added that the responsibility for providing mental health services for youth is shifting to schools, leading to the need for schools to build school-based health providers’ skills to address mental as well as physical health.
- Mental health issues were identified by stakeholders in four out of 19 interviews and three out of five focus groups.
- Mental health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

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

In the CVHP service area:

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

**Mental Health Indicators**

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

LAC=Los Angeles County

CA=California

<sup>1</sup> Healthy People 2020 = <=10.2

**Sub-populations experiencing greatest impact (disparities)**

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

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

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

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

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

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

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

**Poor-Performing Drivers**

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
<b>HEALTH OUTCOMES</b>				
<b>Cardiovascular Disease</b>				
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons <sup>1</sup>	2010	132.7	LAC	147.1
Stroke mortality per 100,000 persons	2010	38.6	LAC	37.6
<b>Diabetes</b>				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5

<b>Obesity/Overweight</b>				
Youth who are obese	2011	30.6%	CA	29.8%
Adults who are overweight	2010	36.4%	LAC	26.4%
Youth who are overweight	2011	15.1%	CA	14.3%
<b>SOCIAL AND ECONOMIC</b>				
Unemployment rate	2012	10.4	LAC	10.3
<b>ACCESS TO CARE</b>				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC = Los Angeles County

CA = California

<sup>1</sup>Healthy People 2020 = <=100.8

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

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

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

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

#### Sample of mental health-specific community assets:

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

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

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

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

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<sup>1</sup> Centers for Disease Control and Prevention. *10 Leading Causes of Death by Age Group, United States—2010*. Available at [[http://www.cdc.gov/injury/wisqars/pdf/10LCID\\_All\\_Deaths\\_By\\_Age\\_Group\\_2010-a.pdf](http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf)]. Accessed [March 12, 2013].

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

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

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

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

<sup>6</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Available at [<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28>]. Accessed [May 14, 2013].

<sup>7</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

<sup>8</sup> Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

## Health Need Profile: Obesity/Overweight

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

### About Obesity/Overweight—Why is it important?

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

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

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

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

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

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

In the CVHP service area:

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

**Obesity/Overweight Indicators**

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

LAC=Los Angeles County

**Sub-populations experiencing greatest impact (disparities)**

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

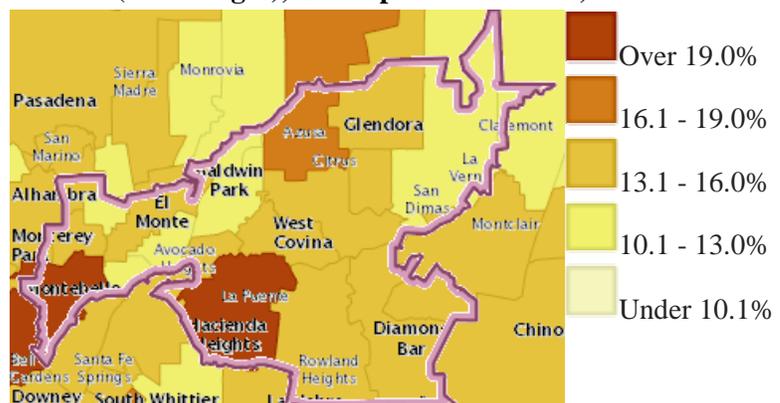
Stakeholders identified youth as being the most severely impacted.

**Geographic areas of greatest impact (disparities)**

Communities experiencing the highest disparities include (see maps):

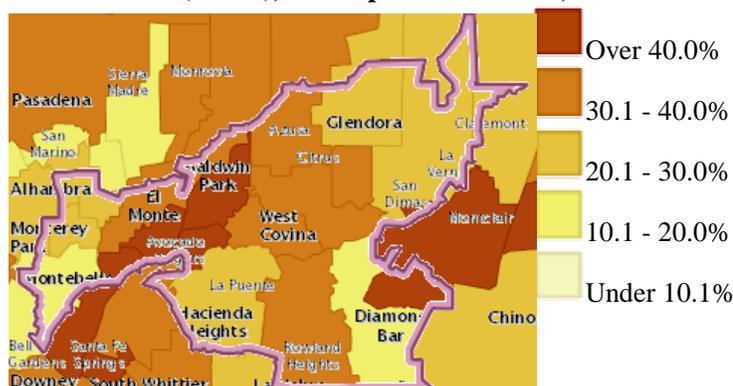
- Baldwin Park (40.7%) and South El Monte (44.6 to 45.3%) had the largest portion of students who were obese.
- La Puente (19.3%) and Hacienda Heights (19.3%) had the largest portions of students who were overweight.

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



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

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



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

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

**Poor-Performing Drivers**

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

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

LAC = Los Angeles County

<sup>1</sup> Healthy People 2020 = <=100.8

<sup>2</sup> Healthy People 2020 = <=38.6

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

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

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

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

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

Sample of Obesity/overweight-specific community assets:

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

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

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

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

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

<sup>2</sup> Ibid.

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

<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

## Health Need Profile: Diabetes

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

### **About Diabetes—Why is it important?**

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

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

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

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

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

betic maintenance, especially as technology (i.e., the glucometer) advances. Stakeholders also indicated that more people are being diagnosed with diabetes at a younger age, where previously the disease appeared to be more prevalent among the middle-aged. Stakeholders also noted the connection between diabetes and other chronic diseases, including high blood pressure, heart disease, arthritis, and certain types of cancer. One stakeholder mentioned positive trends particularly in the Baldwin Park area where people are exercising more, eating less sugar, and making healthier choices overall.

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

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

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In the CVHP service area:

- In 2010, more adults (147.4) experienced diabetes-related hospitalizations per 100,000 adults when compared to Los Angeles County (145.6).
- In 2010, there were more diabetes-related mortalities per 10,000 persons (2.1) when compared to California (1.9).
- In 2010, more uncontrolled diabetes-related hospitalizations occurred per 10,000 persons (12.7) when compared to Los Angeles County (9.5).
- In 2009, more were diagnosed with diabetes (18.5%) when compared to Los Angeles County (10.5%).

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

LAC=Los Angeles County

**Sub-populations experiencing greatest impact (disparities)**

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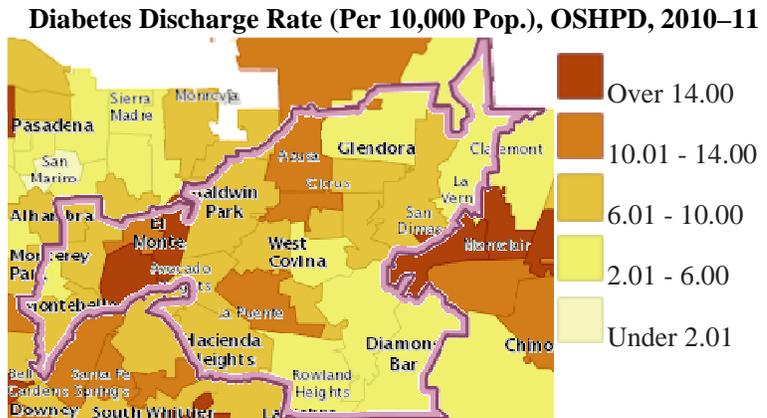
Within the CVHP service area, the following sub-populations are the most severely impacted:

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

**Geographic areas of greatest impact (disparities)**

Communities experiencing the highest disparities include (see map):

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



By communities, the following disparities were found:

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

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

LAC = Los Angeles County

<sup>1</sup> Healthy People 2020 = <=100.8

<sup>2</sup> Healthy People 2020 = <=38.6

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

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

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

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

Sample of Diabetes-specific community assets:

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

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

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

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

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

# Health Need Profile: Oral Health

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

### About Oral Health—Why is it important?

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

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

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

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

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

- Oral health was identified as a health need in the 2010 CVHP Community Health Needs Assessment.

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

In the CVHP service area:

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

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

LAC=Los Angeles County

**Sub-populations experiencing greatest impact (disparities)**

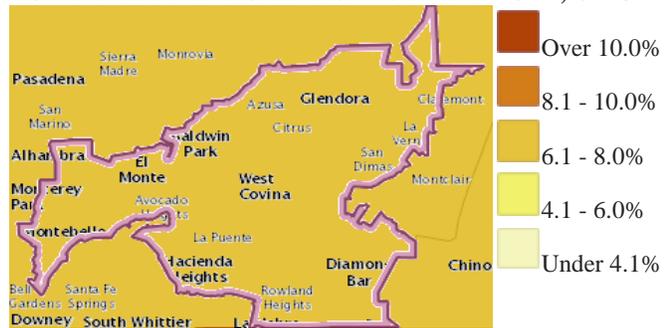
- Within the CVHP service area, the following sub-populations are the most severely impacted:
- More Hispanics/Latinos (43.7%) and Asian/Pacific Islanders (40.6%) did not have dental insurance.
- Hispanic/Latino youth (or children) were more likely (8.3%) among all youth to be unable to afford dental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

**Geographic areas of greatest impact (disparities)**

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

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

**Children and Teens Unable to Afford Dental Care, CHIS 2007**

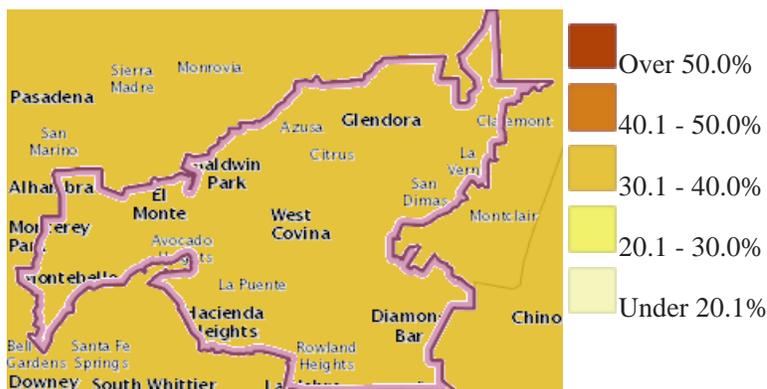


**Adults Without Dental Insurance for Past 1 Year, CHIS 2007**



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

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



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

**Teens Without Dental Exam in Past 1 Year, CHIS 2007**



Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

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

LAC = Los Angeles County

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

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

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

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

Sample of Oral health-specific community assets:

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

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

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

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

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

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

## Health Need Profile: Hypertension

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

### **About Hypertension—Why is it important?**

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

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

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

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

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

In the CVHP service area:

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

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

LAC = Los Angeles County

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

**Sub-populations experiencing greatest impact (disparities)**

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

Stakeholders did not identify disparities among sub-populations.

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

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

LAC = Los Angeles County

<sup>1</sup> Healthy People 2020 = <=100.8

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

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

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

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

**Sample of Hypertension-specific community assets:**

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

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

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

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

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

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

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

<sup>5</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

## Health Need Profile: Cardiovascular Disease

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

### **About Cardiovascular Disease—Why is it important?**

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

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

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

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

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

- Stakeholders<sup>4</sup> identified the homeless, the aging, the uninsured, and adults over the age 35 as the most severely impacted.
- Stakeholders attributed cardiovascular disease to a lack of access to specialty care (such as cardiologists). Stakeholders also linked cardiovascular disease to high blood pressure, diabetes, arthritis, and certain cancers.
- Cardiovascular disease was identified as a major health issue in five of 19 interviews and one of five focus groups. Stroke was also raised as a concern in one of 19 interviews.
- Cardiovascular disease was identified as a health need in the 2010 CVHP Community Health Needs Assessments.

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

In the CVHP service area:

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

**Cardiovascular Disease Indicators**

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

LAC=Los Angeles County

<sup>1</sup> Healthy People 2020 = <=100.8

**Sub-populations experiencing greatest impact (disparities)**

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

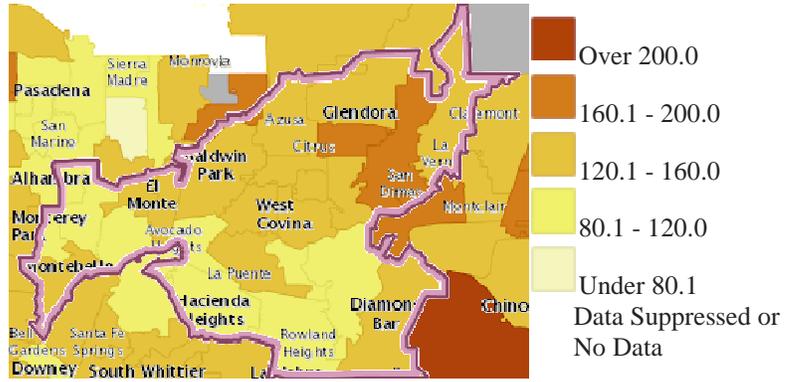
- Those most often diagnosed with heart disease included the White (8.2%) and Hispanic/Latino (5.1%) populations.
- Stakeholders identified the homeless, the aging, the uninsured, and adults over the age 35 as the most severely impacted.

**Geographic areas of greatest impact (disparities)**

Communities experiencing the highest disparities included (see map):

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

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



By communities, the following disparities were found:

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

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

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

**Poor-Performing Drivers**

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
<b>HEALTH OUTCOMES</b>				
<b>Diabetes</b>				
Diabetes hospitalizations per 10,000 adults	2010	10.5	CA	9.7
Diabetes hospitalizations per 100,000 adults	2010	147.4	CA	145.6
Diabetes mortality rate per 10,000 persons	2010	2.1	CA	1.9
Diabetes prevalence	2009	18.5%	LAC	10.5%
Hospitalizations for uncontrolled diabetes per 100,000 persons	2010	12.7	CA	9.5
<b>Obesity/Overweight</b>				
Adults who are obese	2009	21.4%	LAC	21.4%
Adults who are overweight	2010	36.4%	LAC	36.4%

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

LAC = Los Angeles County

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

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

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

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

**Sample of Cardiovascular disease-specific community assets:**

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

Stakeholders did not identify community assets specific to cardiovascular disease.

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

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

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

<sup>5</sup> Ibid.

## Health Need Profile: Cancer

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

### About Cancer—Why is it important?

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

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

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

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- Cancer mortality rates per 10,000 persons were highest in La Verne (23.2), San Dimas (21.7), Hacienda Heights (19.6), Glendora (18.4), Covina (16.9), and West Covina (16.5).
- The lung cancer mortality rate per 100,000 persons was higher (30.2) when compared to Los Angeles County (29.0).
- Lung cancer mortality rates per 100,000 persons were highest in La Verne (63.0), Glendora (62.0), Hacienda Heights (33.2), Baldwin Park<sup>5</sup> (31.6), West Covina (29.8), Walnut (29.6), and San Dimas (29.5).
- The prostate cancer mortality rate per 100,000 men was higher (16.3) when compared to Los Angeles County (15.4).
- Prostate cancer mortality rates per 100,000 men were highest in San Dimas (30.3), Glendora (26.8), Covina (19.5), La Verne (18.6), Walnut (18.8), West Covina (17.9), and La Puente (17.4).
- The breast cancer mortality rates per 100,000 women were highest in La Verne (40.8), San Dimas (34.4), Azusa (28.7), Covina (23.5), and Walnut (21.8).
- Stakeholders<sup>6</sup> identified adults over the age of 35 as the most severely impacted.
- Stakeholders identified cancer as an issue and linked cancer to cardiovascular disease.

- Cancer was identified as a major health issue by community stakeholders in two out of 19 interviews and one out of five focus groups.
- Cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

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

In the CVHP service area:

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

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

LAC=Los Angeles County

<sup>1</sup> Healthy People 2020 = <=160.6

**Sub-populations experiencing greatest impact (disparities)**

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

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

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

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

A primary method of preventing cancer is screening for cervical, colorectal, and breast cancers.<sup>7</sup> The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight exposure, certain chemicals, some viruses and bacteria, a family history of cancer, poor diet, and lack of physical activity.<sup>8</sup> The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

**Poor-Performing Drivers**

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

LAC = Los Angeles County

<sup>1</sup> Healthy People 2020 = >=93%

<sup>2</sup> Healthy People 2020 = >=93%

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

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

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

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have

been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Cancer-specific community assets:

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

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

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

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

<sup>2</sup> Ibid.

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

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

<sup>5</sup> Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

<sup>6</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

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

# Health Need Profile: Vision

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

## About Vision—Why is it important?

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

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

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

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

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

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

In the CVHP service area:

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

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

LAC=Los Angeles County

## Sub-populations experiencing greatest impact (disparities)

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

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

**Geographic areas of greatest impact (disparities)**

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

LAC = Los Angeles County

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

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

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

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

Sample of Vision-specific community assets:

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

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

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

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

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

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

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

## Health Need Profile: Colorectal Cancer

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

### **About Colorectal Cancer**—why is it important?

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

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

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

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

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

- Colorectal cancer was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

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

In the CVHP service area:

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

**Colorectal Indicators**

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

LAC=Los Angeles County

<sup>1</sup> Healthy People 2020 = <=38.6

### Sub-populations experiencing greatest impact (disparities)

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

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

Stakeholders<sup>5</sup> did not identify disparities among sub-populations.

### Geographic areas of greatest impact (disparities)

By communities, the following disparities were found:

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

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

LAC = Los Angeles County

<sup>1</sup>Healthy People 2020 = >=70.5%

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

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

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

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

#### Sample of Colorectal cancer-specific community assets:

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

Stakeholders did not identify community assets specific to colorectal cancer.

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

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

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

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

<sup>4</sup> Ibid.

<sup>5</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

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

# Health Need Profile: Disability

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

## About Disability– Why is it important?

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

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

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

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

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

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In the CVHP service area:

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

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

LAC=Los Angeles County

## Sub-populations experiencing greatest impact (disparities)

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

Stakeholders identified children as the most severely impacted.

**Geographic areas of greatest impact (disparities)**

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

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

LAC = Los Angeles County

<sup>1</sup> Healthy People 2020 = >=70.5%

<sup>2</sup> Healthy People 2020 = >=93%

<sup>3</sup> Healthy People 2020 = >=93%

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

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

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

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

**Sample of Disability-specific community assets:**

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

Stakeholders did not identify community assets specific to disability.

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

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

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

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

<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

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

## Health Need Profile: Intentional Injury

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

### **About Intentional Injury—Why is it important?**

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

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

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

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

In the CVHP service area:

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

**Sub-populations experiencing greatest impact (disparities)**

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

Stakeholders did not identify sub-populations.

**Intentional Injury Indicators**

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

LAC=Los Angeles County

<sup>1</sup> Healthy People 2020: <=5.5

**Geographic areas of greatest impact (disparities)**

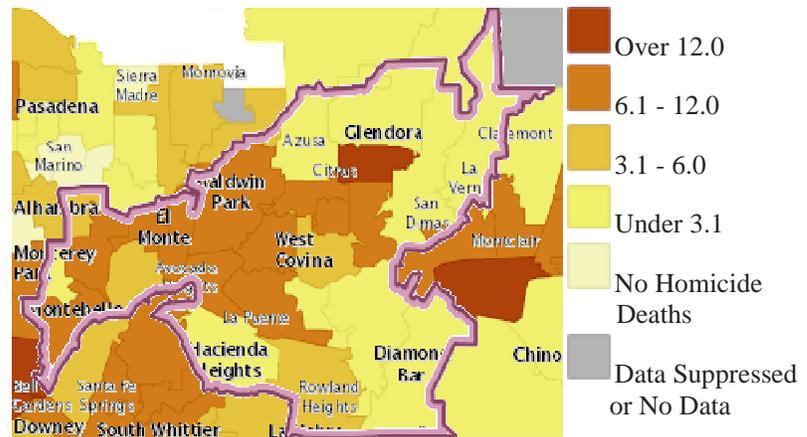
Communities experiencing the highest disparities include (see map):

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

By communities, the following disparities were found:

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

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



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

Factors associated with intentional injuries include high-risk behaviors such as alcohol use, risk-taking, socializing in unsafe and violent physical environments, as well as economic factors including poverty and unemploy-

ment.<sup>5</sup> The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

**Poor-Performing Drivers**

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

LAC = Los Angeles County

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

Stakeholders identified suicide as an issue, specifically among teens.

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

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

Sample of Intentional injury–specific community assets:

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

Stakeholders did not identify community assets specific to intentional injury.

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

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

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

<sup>3</sup> Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

## Health Need Profile: Alcohol and Substance Abuse

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

### **About Alcohol and Substance Abuse—Why is it important?**

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

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

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

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

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

In the CVHP service area:

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

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

LAC=Los Angeles County

**Sub-populations experiencing greatest impact (disparities)**

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

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

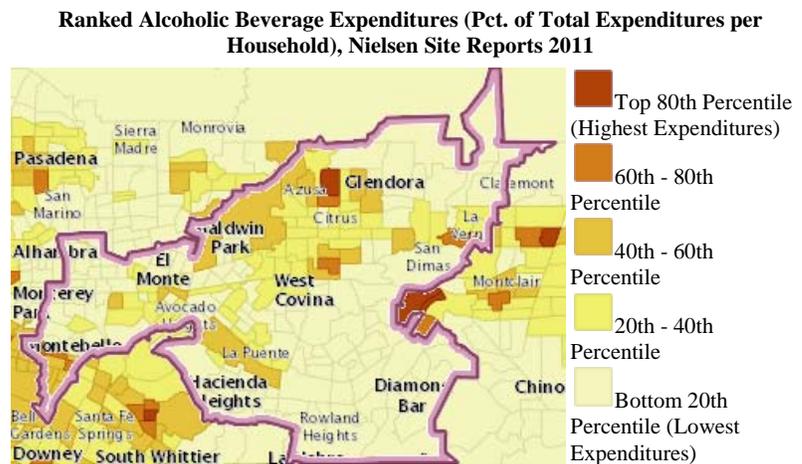
**Geographic areas of greatest impact (disparities)**

Communities experiencing the highest disparities include (see map):

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

By communities, the following disparities were found:

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



Stakeholders did not identify geographic disparities.

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

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

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

**Poor-Performing Drivers**

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

LAC = Los Angeles County

CA = California

<sup>1</sup> Healthy People 2020 = <=5.5

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

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

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

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

**Sample of Alcohol/substance abuse-specific community assets:**

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

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

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

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

<sup>2</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

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

## Health Need Profile: Cervical Cancer

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

### **About Cervical Cancer—*Why is it important?***

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

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

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

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

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

In the CVHP service area:

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

**Cervical Cancer Indicators**

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

LAC=Los Angeles County

No data available for City of Industry and Irwindale.

<sup>1</sup> Healthy People 2020 = <=7.1

<sup>2</sup> Healthy People 2020 = <=2.2

**Sub-populations experiencing greatest impact (disparities)**

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

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

Stakeholders<sup>4</sup> did not identify geographic disparities.

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

LAC = Los Angeles County

<sup>1</sup>Healthy People 2020 = >=93%

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

Stakeholders did not comment on this issue.

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

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

Sample of Cervical cancer-specific community assets:

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

Stakeholders did not identify community assets specific to cervical cancer.

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

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

<sup>2</sup> Ibid.

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

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<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

# Health Need Profile: Chlamydia

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

## About Chlamydia—Why is it important?

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

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

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

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

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

In the CVHP service area:

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

**Chlamydia Indicators**

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

LAC=Los Angeles County

No data available for City of Industry and Irwindale.

## Sub-populations experiencing greatest impact (disparities)

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

Stakeholders<sup>3</sup> did not identify sub-populations.

### **Geographic areas of greatest impact (disparities)**

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

LAC = Los Angeles County

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

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Stakeholders did not comment on the issue.

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

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

#### **Sample of Chlamydia-specific community assets:**

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

Stakeholders did not identify community assets specific to chlamydia.

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

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

<sup>2</sup> Ibid.

<sup>3</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

## Health Need Profile: Asthma

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

### **About Asthma—Why is it important?**

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

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

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

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

In the CVHP service area:

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

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

LAC=Los Angeles County  
CA = California

**Sub-populations experiencing greatest impact (disparities)**

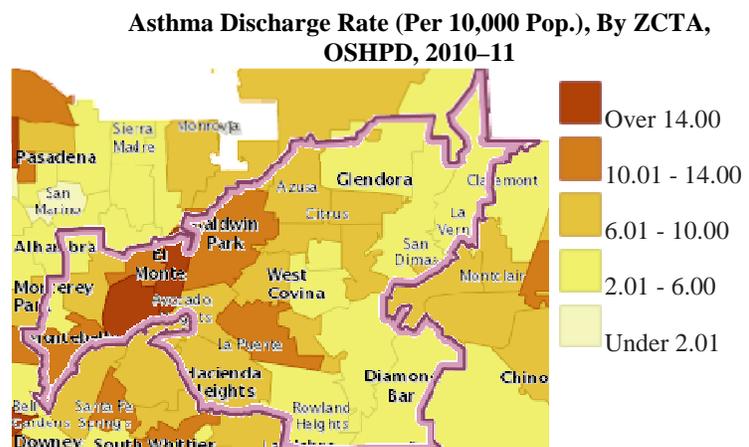
- Multi-racial individuals (1.4%) experienced more asthma-related hospital discharges than other ethnic groups, and individuals between the ages of one and 19 (4.6%) experienced the most asthma-related hospital discharges.

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

**Geographic areas of greatest impact (disparities)**

Communities experiencing the highest disparities include (see map):

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



By communities, the following disparities were found:

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

LAC = Los Angeles County

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

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

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

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

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

Sample of Asthma-specific community assets:

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

Stakeholders did not identify community assets specific to asthma.

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

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

<sup>2</sup> Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

<sup>3</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

## Health Need Profile: Alzheimer’s Disease

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

### **About Alzheimer’s Disease—Why is it important?**

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

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

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

### **Major Findings in the Citrus Valley Health Partner’s Service Area (CVHP)**

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

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

In the CVHP service area:

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

**Alzheimer’s Disease Indicators**

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

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

**Sub-populations experiencing greatest impact (disparities)**

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

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

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

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

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

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

**Poor-Performing Drivers**

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

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

LAC = Los Angeles County

CA = California

<sup>1</sup> Healthy People 2020 = <=100.8

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

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

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

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

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

Sample of Alzheimer’s disease-specific community assets:

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

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

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

<sup>1</sup> Alzheimer’s Association. *2012 Alzheimer’s Disease Facts and Figures*. Available at [http://www.alz.org/downloads/facts\_figures\_2012.pdf]. Accessed [March 6, 2013].

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

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<sup>3</sup> Alzheimer's Association. *2012 Alzheimer's Disease Facts and Figures*. Available at [[http://www.alz.org/downloads/facts\\_figures\\_2012.pdf](http://www.alz.org/downloads/facts_figures_2012.pdf)]. Accessed [March 6, 2013].

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

<sup>5</sup> Alzheimer's Association. *2012 Alzheimer's Disease Facts and Figures*. Available at [[http://www.alz.org/downloads/facts\\_figures\\_2012.pdf](http://www.alz.org/downloads/facts_figures_2012.pdf)]. Accessed [March 6, 2013].

<sup>6</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

<sup>7</sup> Alzheimer's Association. *2012 Alzheimer's Disease Facts and Figures*. Available at [[http://www.alz.org/downloads/facts\\_figures\\_2012.pdf](http://www.alz.org/downloads/facts_figures_2012.pdf)]. Accessed [March 6, 2013].

## Health Need Profile: Unintentional Injury

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

### **About Unintentional Injury—Why is it important?**

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

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

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

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

In the CVHP service area:

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

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

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing greatest impact (disparities)**

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

Stakeholders did not identify disparities among sub-populations.

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

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

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

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

**Poor-Performing Drivers**

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
<b>HEALTH OUTCOMES</b>				
<b>Mental Health</b>				
Mental health treatment not received	2009	51.4%	LAC	47.3%
Mental health–related hospitalizations per 100,000 adults	2010	657.0	CA	551.7

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Mental health–related hospitalizations per 100,000 youth	2010	375.4	CA	256.4
Serious psychological distress	2009	8.8%	LAC	7.3%
<b>SOCIAL AND ECONOMIC</b>				
Unemployed	2012	10.4%	LAC	10.4%
<b>ACCESS TO CARE</b>				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care provider rate per 100,000 persons	2011	80.6	LAC	80.7

LAC—Los Angeles County

CA—California

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

Stakeholders did not comment on the issue.

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

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

**Sample of Unintentional injury–specific community assets:**

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

Stakeholders did not identify community assets specific to unintentional injury.

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

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

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

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

<sup>4</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

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

## Health Need Profile: Arthritis

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

### **About Arthritis—Why is it important?**

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

### **Major Findings in the Citrus Valley Health Partner’s Service Area (CVHP)**

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

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

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

### **Sub-populations experiencing greatest impact (disparities)**

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

Stakeholders<sup>2</sup> did not identify sub-populations.

### **Geographic areas of greatest impact (disparities)**

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

Stakeholders did not identify geographic disparities.

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

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

**Poor-Performing Drivers**

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

LAC = Los Angeles County

CA = California

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

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Stakeholders did not comment on the issue.

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

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

Sample of Arthritis-specific community assets:

Stakeholders did not identify community assets specific to unintentional injury.

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

Stakeholders did not identify community assets specific to arthritis.

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

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

<sup>2</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

<sup>3</sup> Ibid.

# Health Need Profile: Chronic Obstructive Pulmonary Disease

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

## About Chronic Obstructive Pulmonary Disease—Why is it important?

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

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

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

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

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

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

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

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

LAC=Los Angeles County

CA=California

\* Represents Los Angeles County

**Sub-populations experiencing greatest impact (disparities)**

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

Stakeholders<sup>5</sup> did not identify sub-populations.

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

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

Stakeholders did not identify geographic disparities.

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

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

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

LAC = Los Angeles County

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

Stakeholders did not comment on this issue.

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

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

Sample of COPD-specific community assets:

- American Lung Association
- Azusa Pacific University – Neighborhood Wellness Center
- Breath Savers
- Community Clinic Association of Los Angeles County
- Kaiser Foundation Hospital – Baldwin Park
- San Dimas Community Hospital

Stakeholders did not identify community assets specific to chronic obstructive pulmonary disease (COPD).

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

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<sup>1</sup> Centers for Disease Control and Prevention. *Chronic Obstructive Pulmonary Disease (COPD)*. Available at [<http://www.cdc.gov/copd/data.htm>]. Accessed [March 8, 2013].

<sup>2</sup> Mayo Clinic. *COPD Risk Factors*. Available at [<http://www.mayoclinic.com/health/copd/DS00916/DSECTION=risk-factors>]. Accessed [March 8, 2013].

<sup>3</sup> Mayo Clinic. *COPD*. Available at [<http://www.mayoclinic.com/health/copd/DS00916>]. Accessed [March 8, 2013].

<sup>4</sup> UCLA Center for Health Policy Research. *Chronic Obstructive Pulmonary Disease Burden in California and Southern California, 2011*. Available at [<http://healthpolicy.ucla.edu/publications/Documents/PDF/copdpnoct2012.pdf>]. Accessed [April 29, 2012].

<sup>5</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

## Health Need Profile: HIV/AIDS

**\*\*Overall Ranking Resulting from Prioritization: 20 of 22**

### **About HIV/AIDS—Why is it important?**

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More than 1.1 million people in the United States are living with HIV, and almost one in five (18.1%) are unaware of their infection.<sup>1</sup> HIV infection weakens the immune system, making those living with the infection highly susceptible to a variety of illnesses and cancers, including tuberculosis (TB), cytomegalovirus (CMV), cryptococcal meningitis, lymphomas, kidney disease, and cardiovascular disease.<sup>2</sup> Without treatment, almost all people infected with HIV will develop AIDS.<sup>3</sup> While HIV is a chronic medical condition that can be treated, it cannot yet be cured.

The risk of acquiring HIV is increased by engaging in unprotected sex, having another sexually transmitted infection, sharing intravenous drugs, having been diagnosed with hepatitis, tuberculosis, or malaria, exchanging sex for drugs or money, and having been exposed to the virus as a fetus or infant before or during birth, or through breastfeeding from a mother infected with HIV.<sup>4</sup> Racial disparities in HIV prevalence persist; African-Americans and Hispanics/Latinos are disproportionately affected by HIV and experience the most severe burdens compared with other races and ethnicities in the United States. Prevention efforts encompass many components, such as behavioral interventions, HIV testing, and linkage to treatment and care.<sup>5</sup>

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

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- Within the CVHP service area, a larger proportion of African-Americans (0.3%) experienced hospital discharges resulting from HIV than Whites (0.1%) and multi-racial persons (0.1%).
- Those between the ages of 20 and 44 (0.1%) and 45 and 64 (0.2%) experienced the most hospitalizations resulting from HIV compared to other age groups.
- HIV hospitalizations per 100,000 persons was higher in Covina (14.0), El Monte (13.3), Glendora (11.8), La Puente (9.4), Walnut (9.3), and South El Monte (6.8) when compared to the overall CVHP service area (6.6).
- The HIV mortality rate per 100,000 persons, were higher in West Covina (6.1), La Puente (4.7), Covina (3.9), El Monte (3.0), San Dimas (2.4), and Rowland Heights (2.0) than the overall CVHP service area (1.9).
- HIV/AIDS is associated with numerous health factors, including poverty, heavy alcohol consumption, lack of timely HIV screenings, and liquor store access.
- HIV/AIDS was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

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

In the CVHP service area:

- HIV prevalence per 100,000 persons was slightly lower (480.3) when compared to Los Angeles County (480.4).

HIV/AIDS Indicators				
Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
HIV prevalence per 100,000 persons	2008	480.3	LAC	480.4
HIV hospitalizations per 10,000 persons	2011	0.9	LAC	2.2
HIV hospitalizations per 100,000 persons	2010	6.6	CA	11.0

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing greatest impact (disparities)**

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

- A larger proportion of African-Americans (0.3%) experienced hospital discharges resulting from HIV than Whites (0.1%) and multi-racial people (0.1%).
- Those between the ages of 20 and 44 (0.1%) and 45 and 64 (0.2%) experienced the most hospitalizations resulting from HIV compared to other age groups.

Stakeholders did not identify disparities among sub-populations.

**Geographic areas of greatest impact (disparities)**

By communities, the following disparities were found:

- HIV hospitalizations per 100,000 persons was higher in Covina (14.0), El Monte (13.3), Glendora (11.8), La Puente (9.4), Walnut (9.3), and South El Monte (6.8) when compared to the overall CVHP service area (6.6).
- The HIV mortality rate per 100,000 persons, were higher in West Covina (6.1), La Puente (4.7), Covina (3.9), El Monte (3.0), San Dimas (2.4), and Rowland Heights (2.0) than the overall CVHP service area (1.9).

Stakeholders did not identify geographic disparities.

**Associated drivers and risk factors**—What is driving the high rates of HIV/AIDS in the community?

The following factors are associated with HIV/AIDS: injection drug use, risky sexual behaviors,<sup>6</sup> poverty, heavy alcohol consumption, liquor store access, and HIV screenings. HIV prevalence is highest among gay, bisexual, and other men who have sex with men, and among African-Americans.<sup>7</sup>

Untreated HIV infection is associated with many diseases, including cardiovascular disease, kidney disease, liver disease, and cancer.<sup>8</sup> Persons with HIV infections are disproportionately affected by viral hepatitis, and those co-infected with HIV and viral hepatitis experience greater liver-related health problems than those who do not have the HIV infection.<sup>9</sup> The table below includes drivers that did not meet the indicated benchmark, indicating that the

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

**Poor-Performing Drivers**

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
<b>HEALTH OUTCOMES</b>				
<b>Cancers</b>				
Cervical cancer incidence rate per 100,000 persons <sup>1</sup>	2009	9.9	LAC	9.9
Cervical cancer mortality rate per 100,000 persons (age adjusted) <sup>2</sup>	2008	2.2	LAC	3.0
Colorectal cancer incidence rate per 100,000 persons <sup>3</sup>	2009	45.2	LAC	45.2
Lung cancer mortality rate per 100,000 persons	2008	30.2	LAC	29.0
Prostate cancer mortality rate per 100,000 males	2008	16.3	LAC	15.4
<b>Cardiovascular Disease</b>				
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons <sup>4</sup>	2010	132.7	LAC	147.1
Stroke mortality rate per 100,000 persons	2010	38.6	LAC	37.6
Cerebrovascular disease hospitalizations per 100,000 persons	2009	233.6	CA	221.5
<b>ACCESS TO CARE</b>				
Lack of a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC=Los Angeles County

CA=California

<sup>1</sup>Healthy People 2020 = <=7.1

<sup>2</sup>Healthy People 2020 = <=2.2

<sup>3</sup>Healthy People 2020 = <=38.6

<sup>4</sup>Healthy People 2020 = <=100.8

**Community input**—What do community stakeholders think about the issue of HIV/AIDS?

Stakeholders did not comment on the issue.

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

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

Sample of HIV/AIDS-specific community assets:

- AIDS Project Los Angeles
- Alliance for Housing and Healing
- Asian Pacific Health Care Venture
- Community Clinic Association of Los Angeles County
- Foothill AIDS Project
- Los Angeles County Comprehensive Health Center - El Monte

Stakeholders did not identify community assets specific to HIV/AIDS.

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

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<sup>1</sup> Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/idu.htm>]. Accessed [February 28, 2013].

<sup>2</sup> Mayo Clinic. *Complications*. Available at [<http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=complications>]. Accessed [March 1, 2013].

<sup>3</sup> National Institutes of Health, *HIV Infection*. Available at [<http://www.nlm.nih.gov/medlineplus/ency/article/000602.htm>]. Accessed [March 1, 2013].

<sup>4</sup> National Institute of Allergy and Infectious Diseases. *HIV Risk Factors*. Available at [<http://www.niaid.nih.gov/topics/hivaids/understanding/pages/riskfactors.aspx>]. Accessed [March 6, 2013].

<sup>5</sup> Centers for Disease Control and Prevention. *CDC's HIV Prevention Progress in the United States*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/cdcprev.htm>]. Accessed [February 28, 2013].

<sup>6</sup> Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/idu.htm>]. Accessed [February 28, 2013].

<sup>7</sup> Centers for Disease Control and Prevention, *HIV in the United States: At A Glance*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/us.htm>]. Accessed [February 28, 2013].

<sup>8</sup> Centers for Disease Control and Prevention. *Basic Information about HIV and AIDS*. Available at [<http://www.cdc.gov/hiv/topics/basic/index.htm>]. Accessed [March 1, 2013].

<sup>9</sup> Centers for Disease Control and Prevention. *HIV and Viral Hepatitis*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/hepatitis.htm>]. Accessed [March 1, 2013].

## Health Need Profile: Allergies

**\*\*Overall Ranking Resulting from Prioritization: 21 of 22**

### About Allergies—Why is it important?

Allergies are an overreaction of the immune system to substances that usually cause no reaction in most individuals. These substances can trigger sneezing, wheezing, coughing, and itching. Allergies have been linked to a variety of common and serious chronic respiratory illnesses such as sinusitis and asthma. Factors such as a family history with allergies, the types and frequency of symptoms, seasonality, duration, and even location of symptoms (indoors or outdoors, for example) are all taken into consideration in allergy diagnoses. Allergic reactions can be severe and even fatal. With proper management and patient education, allergic diseases can be controlled and people with allergies can lead normal and productive lives.<sup>1</sup> Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Other social and economic factors have been known to cause or trigger allergic reactions, including poor housing conditions (living with cockroaches, mites, asbestos, mold, etc.). Living in an environment or home with smokers has also been known to exacerbate allergies and/or asthma.

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

- Allergies among teens were higher in the CVHP service area (36.8%) compared to Los Angeles County (24.9%).
- Within the CVHP service area, male teens were more often diagnosed with allergies (23.3%) than females (23.0%).
- Stakeholders<sup>2</sup> linked allergies with asthma and other chronic respiratory conditions.
- Allergies were identified as a major health concern in three out of 19 interviews.
- Allergies were not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

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

In the CVHP service area:

- The portion of teens that have allergies was higher (36.8%) when compared to Los Angeles County (24.9%).

Allergy Indicators				
Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Allergies prevalence (teens)	2007	36.8%	LAC	24.9%

LAC=Los Angeles County

### Sub-populations experiencing greatest impact (disparities)

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

- Male teens were more often diagnosed with allergies (23.3%) than females (23.0%).

Stakeholders did not identify sub-populations.

**Geographic areas of greatest impact (disparities)**

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

Stakeholders did not identify geographic disparities.

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

Allergic reactions are known to be caused by pollen, dust, food, insect stings, animal dander, mold, medications, and latex.<sup>3</sup> Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Social and economic factors have been known to cause or trigger allergic reactions, including poverty leading to poor housing conditions (living with cockroaches, mites, asbestos, mold, etc.) and living in an environment or home with smokers. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

Poor-Performing Drivers				
Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
<b>HEALTH OUTCOMES</b>				
<b>Asthma</b>				
Asthma hospitalizations per 10,000 youth	2010	20.8	CA	19.2
Heart disease hospitalizations per 100,000 persons	2010	374.4	CA	367.1
Heart disease mortality rate per 100,000 persons <sup>1</sup>	2010	132.7	LAC	147.1
Stroke mortality per 100,000 persons	2010	38.6	LAC	37.6
<b>SOCIAL AND ECONOMIC</b>				
Free or reduced-price school lunch	2010	61.6%	LAC	58.5%
<b>ACCESS TO CARE</b>				
Lack a consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC—Los Angeles County

CA—California

<sup>1</sup> Healthy People 2020 = <=100.8

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

Stakeholders linked allergies with asthma and other chronic respiratory conditions.

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

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

Sample of Allergy-specific community assets

- American Lung Association

- Asthma & Allergy Foundation of America - California Chapter
- Asthma Coalition of Los Angeles County (ACLAC)
- BREATHE California of Los Angeles County
- Community Clinic Association of Los Angeles County
- Kaiser Foundation Hospital – Baldwin Park
- San Dimas Community Hospital

Stakeholders did not identify community assets specific to allergies.

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

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<sup>1</sup> Asthma and Allergy Foundation of America (AAFA). *Allergies*. Milwaukee, WI. Available at [<http://www.aaaai.org/conditions-and-treatments/allergies.aspx>]. Accessed [March 1, 2013].

<sup>2</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

<sup>3</sup> American Academy of Allergy Asthma and Immunology. *Allergies*. Landover, MD. Available at [<http://www.aafa.org/display.cfm?id=9>]. Accessed [March 1, 2013].

## Health Need Profile: Infant Mortality

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

### **About Infant Mortality—Why is it important?**

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Infant mortality remains a concern in the United States: each year, approximately 25,000 infants die before their first birthday.<sup>1</sup> The leading causes of infant death include congenital abnormalities, pre-term/low birth weight, Sudden Infant Death Syndrome (SIDS), problems related to complications of pregnancy, and respiratory distress syndrome.<sup>2</sup>

Infant mortality is associated with factors such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices. Significant disparities exist among racial and ethnic groups that impact the infant mortality rate. For example, African-Americans had an infant mortality rate of 14.1 deaths per 1,000 live births in the year 2000, which is more than twice the national average of 6.9 deaths per 1,000 live births.<sup>3</sup>

The Centers for Disease Control and Prevention have set the goal of eliminating disparities among racial and ethnic groups with infant mortality rates above the national average. The CDC's prevention strategy focuses on modifying behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness.

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

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- The infant mortality rate per 1,000 live births was much higher among African-Americans (11.5) than Hispanics/Latinos (4.8), Whites (4.5), and Asians (3.3).
- Infant mortality is associated with low birth weight. A higher percentage of infants were born with very low birth weight (less than 1,500 grams) in San Dimas (1.8%), Baldwin Park<sup>4</sup> (1.7%), La Verne (1.7%), South El Monte (1.5%), and El Monte (1.4%) when compared with Los Angeles County (1.3%).
- Very low birth weight can indicate broader issues such as access to health care, maternal and child health, poverty, education rate, teen births, and a lack of insurance and of prenatal care.
- Infant mortality was not identified as a health need in the 2010 CVHP Community Health Needs Assessment.

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

In the CVHP service area:

- The infant mortality rate per 1,000 live births (5.1) was the same as the rate for Los Angeles County.

**Infant Mortality Indicators**

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
Infant mortality rate per 1,000 births <sup>1</sup>	2009	5.1	LAC	5.1
Low-birth-weight infants	2010	6.3%	CA	6.8%
Very-low-birth-weight infants	2010	1.1%	LAC	1.3%

LAC=Los Angeles County

CA = California

<sup>1</sup> Healthy People 2020 = <=6.0

**Sub-populations experiencing greatest impact (disparities)**

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

- The infant mortality rate per 1,000 live births was much higher among African-Americans (11.5) than Hispanics/Latinos (4.8), Whites (4.5), and Asians (3.3).

Stakeholders<sup>5</sup> did not identify disparities among sub-populations.

**Geographic areas of greatest impact (disparities)**

By community, the following disparities were found:

- A higher percentage of infants were born with very low birth weight (less than 1,500 grams) in San Dimas (1.8%), Baldwin Park<sup>6</sup> (1.7%), La Verne (1.7%), South El Monte (1.5%), and El Monte (1.4%) when compared with Los Angeles County (1.3%).

Stakeholders did not identify geographic disparities.

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

Factors that affect birth outcomes include smoking, substance abuse, poor nutrition, medical problems, and chronic illness. Additionally, infant mortality is associated with low birth weight. High rates of infant mortality can indicate broader issues such as access to health care, maternal and child health, poverty, education rate, lack of insurance, teen births, and lack of prenatal care. The table below includes drivers that did not meet the indicated benchmark, indicating that the CVHP service area is performing worse than the comparison area/benchmark. For data on additional indicators, please refer to the CVHP Scorecard in Appendix D.

**Poor-Performing Drivers**

Indicators	Year	CVHP Service Area	Comparison	
			Level	Avg.
<b>SOCIAL AND ECONOMIC</b>				
Lack health insurance	2009	16.2%	CA	16.2%
Soft drink expenditures	2010	0.49%	CA	0.46%
Drink two or more glasses of soda in a day (youth)	2009	18.8%	LAC	18.1%
Frequent fast food restaurants 4 times a week or more	2009	15.5%	LAC	12.5%
<b>ACCESS TO CARE</b>				
Lack of consistent source of primary care	2009	18.2%	LAC	16.2%
Primary care providers per 100,000 persons	2011	80.6	LAC	80.7

LAC=Los Angeles County

CA=California

**Community input—What do community stakeholders think about the issue of infant mortality?**

Stakeholders did not comment on this issue.

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

Numerous assets and resources are available to respond to health needs within a given community, including health care facilities, community organizations, and public agencies. The following list includes assets that have

been identified as specifically addressing this health need and/or key drivers related to this health need through various sources including CVHP community partners. Where available, a sampling of community assets specifically highlighted by stakeholders during interviews and/or focus groups is noted as well.

Sample of Infant mortality–specific community assets:

- Asian Pacific Health Care Venture - El Monte Rosemead Health Center
- Beverly Hospital
- Community Clinic Association of Los Angeles County
- Early Identification and Intervention Collaborative for Los Angeles County
- East Valley Community Health Center, Inc.
- LA Best Babies Network
- Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs
- March of Dimes - California Programs

Stakeholders identified the following community resources available to address infant mortality:

- Women, Infants and Children (WIC) - Community resource for social services

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

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<sup>1</sup> Centers for Disease Control and Prevention. *Infant Mortality*. Available at [<http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm>]. Accessed [March 5, 2013].

<sup>2</sup> Centers for Disease Control and Prevention. *Infant Health*. Available at [[http://www.cdc.gov/nchs/fastats/infant\\_health.htm](http://www.cdc.gov/nchs/fastats/infant_health.htm)]. Accessed [March 5, 2013].

<sup>3</sup> Centers for Disease Control and Prevention. *Eliminate Disparities in Infant Mortality*. Available at [<http://www.cdc.gov/omhd/amh/factsheets/infant.htm#2>]. Accessed [March 5, 2013].

<sup>4</sup> Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

<sup>5</sup> Stakeholders included health care professionals, government officials, social service providers, community residents, and community leaders, among others.

<sup>6</sup> Baldwin Park data includes data for Irwindale, as they share the same ZIP Code, 91706.

# **Appendix C: Secondary Data Sources from Kaiser Permanente CHNA Data Platform and Other Sources**

**Secondary Data Sources from Kaiser Permanente CHNA Data Platform and Other Sources**

<b>Category</b>	<b>Indicator</b>	<b>Data Area</b>	<b>Data Source</b>	<b>Geography</b>	<b>Benchmark</b>	<b>Data Breakout by Groupings (including ethnicity, gender, additional geographies)</b>
Clinical Care	Absence of Dental Insurance Coverage	CA Only	California Health Interview Survey (CHIS), 2007	County (Grouping)	State Average	Yes
Clinical Care	Access to Primary Care	U.S.	U.S. Health Resources and Services Administration Area Resource File, 2011	County	State Average	No
Clinical Care	Adults ages 50 and older ever have a sigmoidoscopy, colonoscopy, or FOBT	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Adults ages 50 and older have a sigmoidoscopy, colonoscopy in the last 5 years	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Breast Cancer Screening (Mammogram)	U.S.	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2003-2007	County	State Average	No
Clinical Care	Cervical Cancer Screening in last 3 years	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Clinical Care	Cervical Cancer Screening in last 3 years	U.S.	Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Health Assessment Unit, Los Angeles County Health Survey, 2007	County	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Children who have never seen a dentist	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Colon Cancer Screening (Sigmoid/Colonoscopy)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Clinical Care	Delayed or didn't get medical care	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Delayed or didn't get prescriptions	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Dental Care Affordability (Youth)	CA Only	California Health Interview Survey (CHIS), 2007	County (Grouping)	State Average	Yes
Clinical Care	Dental Care Utilization (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Clinical Care	Dental Care Utilization (Youth)	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes
Clinical Care	Diabetes Management (Hemoglobin A1c Test)	U.S.	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2010	County	State Average	No
Clinical Care	Do Not Have a Usual Source of Care	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Facilities designated as health professional shortage areas	CA Only	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012	HPSA		No
Clinical Care	Federally Qualified Health Centers	U.S.	U.S. Health Resources and Services Administration, Centers for Medicare & Medicaid Services, Provider of Service File, 2011	Address		No
Clinical Care	Hard Time Understanding Doctor	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Heart Disease Management	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	High Blood Pressure Management	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Clinical Care	HIV Screenings	CA Only	California Health Interview Survey (CHIS), 2005	County (Grouping)	State Average	Yes
Clinical Care	Hospitalizations per 1,000 Pop.	CA Only	Office of Statewide Health Planning and Development (OSHDP), 2010	ZIP Code	State Average	Yes
Clinical Care	Lack of a Consistent Source of Primary Care	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Lack of Prenatal Care	CA Only	California Department of Public Health, Birth Profiles by ZIP Code, 2010	ZIP Code	State Average	No
Clinical Care	Needed help for mental/emotional/alcohol-drug issues but did not receive treatment	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Clinical Care	Pneumonia Vaccinations (Age 65+)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Clinical Care	Population Living in a Health Professional Shortage Area	U.S.	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012	HPSA	State Average	No
Clinical Care	Preventable Hospital Events	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010-2010	ZIP Code	State Average	Yes
Clinical Care	Primary care provider per 100,000 Population	CA Only	U.S. Health Resources and Services Administration Area Resource File, 2011	County	County Average	No
Clinical Care	Received Pap smear in last 3 years	County	Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2007	SPA	Healthy People 2020	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Clinical Care	Received Pap smear in last 3 years	County	Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2010	SPA	Healthy People 2020	No
Clinical Care	Teens who can't afford dental care	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	No
Demographics	Change in Total Population	U.S.	U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1	County		No
Demographics	Linguistically Isolated Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Demographics	Median Age	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Female Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Male Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Demographics	Total Population Age 0-4	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 18-24	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 25-34	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 35-44	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 45-54	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 5-17	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 55-64	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Demographics	Total Population Age 65 or Older	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract		Yes
Health Behaviors	Adequate Fruit/Vegetable Consumption (Youth)	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Behaviors	Alcohol & Substance Use	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010.	County	County Average	No
Health Behaviors	Alcohol Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Breastfeeding (Any)	CA Only	California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011	County	State Average	Yes
Health Behaviors	Breastfeeding (Exclusive)	CA Only	California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011	County	State Average	Yes
Health Behaviors	Children drinking two or more glasses of soda	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Children eating less than 5 servings of Fruit/Vegetable a Day	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Frequent Fast Food Restaurants	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Fruit/Vegetable Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Heavy Alcohol Consumption	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Behaviors	Inadequate Fruit/Vegetable Consumption (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2003-2009	County	State Average	No
Health Behaviors	Physical Inactivity (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Health Behaviors	Physical Inactivity (Youth)	CA Only	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011	School District	State Average	Yes
Health Behaviors	Serious Psychological Distress in Last Year	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Behaviors	Soft Drink Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Tobacco Expenditures	U.S.	Nielsen Claritas Site Reports, Consumer Buying Power, 2011	Tract	State Average	No
Health Behaviors	Tobacco Usage (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Health Outcomes	Adults Taking Medicine to Lower Cholesterol	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	Allergies (teens)	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Alzheimer's mortality age-adjusted	CA Only	Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, 2006	SPA	County Average	Yes
Health Outcomes	Alzheimer's mortality age-adjusted	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	County Average	Yes
Health Outcomes	Arthritis Prevalence	CA Only	Los Angeles County Department of Public Health, Los Angeles County Health Survey, 2011	SPA	County Average	Yes
Health Outcomes	Asthma Hospitalization (Adults)	CA Only	Office of Statewide Health and Planning and Development (OSHDP), 2010.	ZIP Code	State Average	No
Health Outcomes	Asthma Hospitalization (Adults)	CA Only	Office of Statewide Health Planning and Development (OSHDP), 2010	ZIP Code	State Average	Yes
Health Outcomes	Asthma Hospitalizations (Youth)	CA Only	California Office of Statewide Health, Planning and Development (OSHDP), Patient Discharge Data, 2010	ZIP Code	State Average	Yes
Health Outcomes	Asthma Hospitalizations (Youth)	CA Only	Office of Statewide Health Planning and Development (OSHDP), 2010	ZIP Code	State Average	Yes
Health Outcomes	Asthma Prevalence	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Asthma Prevalence	CA Only	California Health Interview Survey (CHIS), 2009	ZIP Code	County Average	Yes
Health Outcomes	Breast Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	State Average	Yes
Health Outcomes	Breast Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes
Health Outcomes	Cancer Mortality per 10,000 Pop.					
Health Outcomes	Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Cardiovascular Disease Mortality	CA only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Cerebrovascular Disease Hospitalization per 100,000 Pop.	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Cerebrovascular Disease Mortality per 10,000 Pop.	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Cervical Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	Healthy People 2020	Yes
Health Outcomes	Cervical Cancer Mortality	CA only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Chlamydia Incidence	U.S.	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2009	County	State Average	No
Health Outcomes	Chronic Lower Respiratory Disease per 10,000 Pop.	CA Only	California Behavioral Risk Factor Surveillance System, CDC, 2011	ZIP Code	State Average	Yes
Health Outcomes	Colon Cancer Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	County Average	Yes
Health Outcomes	Colorectal Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	Healthy People 2020	Yes
Health Outcomes	COPD prevalence	CA Only	California Behavioral Risk Factor Surveillance System, CDC, 2011	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Diabetes Hospitalizations	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Hospitalizations (adult)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Hospitalizations (under 18)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Mortality per 10,000 Pop.	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	State Average	Yes
Health Outcomes	Diabetes Prevalence	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	Diabetes Prevalence	U.S.	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009	County	State Average	Yes
Health Outcomes	Diagnosed with Diabetes	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	Heart Disease Hospitalization	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Heart Disease Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Heart Disease Prevalence	CA Only	California Health Interview Survey (CHIS), 2009	County	State Average	Yes
Health Outcomes	Hepatitis C Prevalence	County	Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report, 2011	SPA	County Average	Yes
Health Outcomes	High Blood Pressure Prevalence	County	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Health Outcomes	HIV Hospitalizations	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010	ZIP Code	State Average	Yes
Health Outcomes	HIV Hospitalizations	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	HIV Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	State Average	Yes
Health Outcomes	HIV Prevalence	U.S.	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	HIV Prevalence	U.S.	Los Angeles County Department of Public Health, Annual HIV Surveillance Report, 2011	County	County Average	Yes
Health Outcomes	Homicide	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Homicide	CA Only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Homicide by Firearms per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2010	ZIP Code	State Average	Yes
Health Outcomes	Hospitalizations for Uncontrolled Diabetes	CA Only	Office of Statewide Health and Planning and Development (OSHDP), 2010	ZIP Code	State Average	Yes
Health Outcomes	Hypertension and Hypertensive Renal Mortality per 10,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2010	ZIP Code	State Average	Yes
Health Outcomes	Infant Mortality	U.S.	Centers for Disease Control and Prevention, National Vital Statistics System, 2003-2009	County	Healthy People 2020	Yes
Health Outcomes	Low Birth Weight	CA Only	California Department of Public Health, Birth Profiles by ZIP Code, 2010	ZIP Code	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Lung Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	State Average	Yes
Health Outcomes	Lung Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes
Health Outcomes	Mental Health Hospitalizations (adults)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	County Average	Yes
Health Outcomes	Mental Health Hospitalizations (under 18)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	County Average	Yes
Health Outcomes	Motor Vehicle Crash Death	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Non-fatal Firearm Hospitalizations per 100,000 Pop.	CA Only	Office of Statewide Health Planning and Development (OSHPD), 2010	ZIP Code	State Average	Yes
Health Outcomes	Obesity (Adult)	LAC Only	California Health Interview Survey (CHIS), 2009	ZIP Code		Yes
Health Outcomes	Obesity (Adult)	U.S.	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009	County	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Obesity (Youth)	CA Only	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011	School District	State Average	Yes
Health Outcomes	Overweight (Adult)	LAC Only	California Health Interview Survey (CHIS), 2009	ZIP Code		Yes
Health Outcomes	Overweight (Adult)	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Health Outcomes	Overweight (Youth)	CA Only	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011	School District	State Average	Yes
Health Outcomes	Pedestrian Motor Vehicle Death	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Pedestrians Killed	CA Only	California Highway Patrol Statewide Integrated Traffic Records System (CHP - SWITRS), 2008	SPA	County Average	Yes
Health Outcomes	Poor Dental Health	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Poor General Health	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010	County	State Average	No
Health Outcomes	Poor Mental Health	CA Only	California Health Interview Survey (CHIS), 2009	County (Grouping)	State Average	Yes
Health Outcomes	Population with Any Disability	U.S.	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates	Tract	State Average	No
Health Outcomes	Prostate Cancer Mortality per 100,000 Pop.	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes
Health Outcomes	Premature Death	U.S.	Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (As Reported in the 2012 County Health Rankings)	County	State Average	No
Health Outcomes	Prostate Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	State Average	Yes
Health Outcomes	Stroke Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Health Outcomes	Suicide	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020	Yes
Health Outcomes	Suicide per 10,000 Pop.	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	State Average	Yes
Health Outcomes	Uncontrolled Diabetes Hospitalizations		Office of Statewide Health and Planning and Development (OSHDP), 2009	ZIP Code	State Average	Yes
Health Outcomes	Unintentional Injuries Mortality per 10,000 Pop.	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	State Average	Yes
Health Outcomes	Very Low Birthweight	CA Only	California Department of Public Health, 2010	ZIP Code	County Average	No
Physical Environment	Fast Food Restaurant Access	CA Only	U.S. Census Bureau, ZIP Code Business Patterns, 2009	ZIP Code	State Average	No
Physical Environment	Grocery Store Access	U.S.	U.S. Census Bureau, County Business Patterns, 2009	County	State Average	No
Physical Environment	Liquor Store Access	CA Only	California Department of Alcoholic Beverage Control, Active License File, April 2012	ZIP Code	State Average	No
Physical Environment	Park Access (Within 1/2 mile of park)	U.S.	U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1; Esri's USA Parks layer (compilation of Esri, National Park Service, and TomTom source data), 2012	Block Group	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Physical Environment	Poor Air Quality (Particulate Matter 2.5)	U.S.	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008	Tract	State Average	No
Physical Environment	Population Living in Food Deserts	U.S.	U.S. Department of Agriculture, Food Desert Locator, 2009	Tract (2000)	State Average	No
Physical Environment	Protected Open Space Areas in Acres per 1,000 People	CA Only	California Health Interview Survey (CHIS), 2009	ZIP Code	County Average	No
Physical Environment	Recreation and Fitness Facility Access	CA Only	U.S. Census Bureau, ZIP Code Business Patterns, 2009	ZIP Code	State Average	No
Physical Environment	Visited park in last month	CA Only	California Health Interview Survey (CHIS), 2009	SPA	County Average	Yes
Physical Environment	Walkability	U.S.	WalkScore.Com (2012)	City		Yes
Physical Environment	WIC-Authorized Food Store Access	U.S.	U.S. Department of Agriculture, Food Environment Atlas, 2012	County	State Average	No
Social & Economic Factors	Adequate Social or Emotional Support	U.S.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010	County	State Average	No
Social & Economic Factors	Children Eligible for Free/Reduced Price Lunch	U.S.	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2010-2011	Address	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Social & Economic Factors	Children in Poverty	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Social & Economic Factors	Families in Poverty in The Past 12 Months	U.S.	American Community Survey 5-Year Estimates, 2007-2011	ZIP Code	County Average	Yes
Social & Economic Factors	High School Graduation Rate	U.S.	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Local Education Agency (School District) Universe Survey Dropout and Completion Data, 2008-2009	School District	HP 2020:On-Time Graduation Rate:>82.4	No
Social & Economic Factors	Homeless by Age	County	Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011	County	County Average	Yes
Social & Economic Factors	Homeless Count	County	Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011	County	County Average	Yes
Social & Economic Factors	Population Below 100% of Poverty Level	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	No
Social & Economic Factors	Population Below 200% of Poverty Level	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	No
Social & Economic Factors	Population in Poverty in The Past 12 Months	U.S.	American Community Survey 5-Year Estimates, 2007-2011	ZIP Code	County Average	Yes

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Social & Economic Factors	Population Receiving Medicaid	U.S.	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates	PUMA	State Average	Yes
Social & Economic Factors	Population with No High School Diploma	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Social & Economic Factors	Poverty Rate	U.S.	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates	Tract	State Average	Yes
Social & Economic Factors	Student Reading Proficiency (4th Grade)	U.S.	States' Department of Education, Student Testing Reports, 2011	School District	Healthy People 2020	No
Social & Economic Factors	Supplemental Nutrition Assistance Program (SNAP) Recipients	U.S.	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009	County	State Average	No
Social & Economic Factors	Teen Births	CA Only	California Department of Public Health, Birth Profiles by ZIP Code, 2010	ZIP Code	State Average	Yes
Social & Economic Factors	Unable to Afford Enough Food (Food Insecurity) (Adults)	CA Only	California Health Interview Survey (CHIS), 2009	County	County Average	Yes
Social & Economic Factors	Unemployed (over 16 years of age)	U.S.	American Community Survey 5-Year Estimates, 2006-2010	City	County Average	Yes
Social & Economic Factors	Unemployment Rate	U.S.	U.S. Bureau of Labor Statistics, December, 2012 Local Area Unemployment Statistics	County	State Average	No

Category	Indicator	Data Area	Data Source	Geography	Benchmark	Data Breakout by Groupings (including ethnicity, gender, additional geographies)
Social & Economic Factors	Uninsured	CA Only	California Health Interview Survey (CHIS), 2009	ZIP Code	County Average	Yes
Social & Economic Factors	Uninsured Population	U.S.	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates	PUMA	State Average	Yes
Social & Economic Factors	Violent Crime	U.S.	U.S. Federal Bureau of Investigation, Uniform Crime Reports, 2010	Place, County	State Average	No

# **Appendix D: CVHP Scorecard**

## Community Health Needs Assessment Health Needs and Health Drivers Data Summary Citrus Valley Health Partners

### Identification of Health Needs and Health Drivers

In 2012, Citrus Valley Health Partners (CVHP) conducted Phase I of the 2013 Community Health Needs Assessment (CHNA). This included review of data from the Kaiser Permanente CHNA data platform and other secondary data sources. Additional information was gathered through five (5) focus groups with providers and residents from across the , Kaiser Foundation Baldwin Park service area and interviews with nineteen (19) key stakeholders including public health experts, community leaders, and public agency officials. In all, the CHNA process has engaged nearly 70 individuals in sharing their insight and expertise to identify key needs in the Baldwin Park service area.

This process highlighted numerous health needs and health drivers in the CVHP service area. The document that follows represents a subset of those needs based on set criteria, which included poor performance against California or Los Angeles County benchmarks or the Healthy People 2020 (HP2020) Target or repeated mentions in stakeholder interviews and focus groups. The identified health needs and drivers are summarized in the attached Health Needs and Drivers Summary Scorecard.

### Reading the Health Needs & Drivers Data Summary Scorecard

The following notes and legend will help you to understand the data presented in the Summary Scorecard.

<b>DATA INDICATOR</b>	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	KFH-BP Service Area Average	City A	City B	City C	City D	Interviews (n=#)	Focus Groups (n=#)
<b>Legend:</b> *Data from the Kaiser Permanente CHNA data platform **Data from secondary sources represents the entire City †Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the KFH-BP service area ^KFH-BP service area average aggregated at the City-level as data was not available at the zip code or city-level. An <i>italicized indicator</i> denotes qualitative data collected in a focus group or interview Comparison levels: CA - California LAC - LA County											

### DATA INDICATORS

- Indicators, or standard measures of health, are highlighted in the first column
- Qualitative data collected in focus groups or interviews is indicated by an *italicized indicator*
- Indicators which did not meet a benchmark, including HP2020 Targets, are highlighted by a **black box**
- When health indicator definitions are consistent across comparison levels, and the HP2020 Target is not met, the HP2020 Target is noted
- The Health Needs and Drivers are listed in alphabetical order, NOT by order of importance

### DATA INDICATORS LEGEND

\*Data gathered from the Kaiser Permanente CHNA data platform

\*\*Data from secondary sources represents the entire City

†Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the CVHP service area

^CVHP service area average aggregated at the City-level as data was not available at the zip code or city-level

### COMPARISON LEVEL

- CVHP service area is compared against benchmarks at the State or County-level depending on data available
  - CA: State of California
  - LAC: Los Angeles County
- Where available, data is also presented for individual Service Planning Areas (SPAs) or cities in the CVHP service area

2013 KP CHNA - Citrus Valley Health Partners Health Needs and Drivers Summary Scorecard

DATA INDICATOR		Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Azusa	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)
<b>HEALTH NEEDS</b>																						
<b>Alcohol &amp; Substance Abuse</b>																						
Rate of alcohol/drug induced mental disease hospitalization per 100,000 pop.†		2010	CA	109.1	91.4	77.0	70.5	197.0	84.0	77.4	129.2	72.2	109.8	123.3	41.8	120.8	59.2	30.2	87.4		4	1
<i>Alcoholism</i>																					1	2
<i>Substance abuse</i>																						
<b>Allergies</b>																						
Percent of teens with allergies^		2007	LAC	24.9%	36.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	3	0
<i>Allergies</i>																						
<b>Alzheimer's Disease</b>																						
Rate of Alzheimer's mortality age-adjusted per 100,000 pop.^		2009	LAC	17.6	17.9	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	3	0
Rate of Alzheimer's mortality per 10,000 pop.†		2010	CA	2.9	2.6	2.3	1.0	3.6	1.3	0.4	5.5	1.9	1.5	6.6	1.1	5.7	0.9	2.8	2.3			
<i>Alzheimer's disease</i>																						
<b>Arthritis</b>																						
<i>Arthritis</i>																					3	0
<b>Asthma</b>																						
Percent of adults diagnosed with asthma*		2010	LAC	11.1%	11.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of adult asthma hospitalization per 10,000*		2010	CA	7.7	7.7	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of adult asthma hospitalization per 100,000†		2010	CA	94.3	89.2	87.1	120.1	72.1	25.8	171.7	61.0	55.5	103.2	87.2	46.2	54.3	198.2	58.0	107.9			
Rate of youth asthma hospitalization per 10,000*		2010	CA	19.2	20.8	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
<i>Asthma</i>																					5	1
<b>Cancer</b>																						
Rate of cancer mortality per 100,000 pop.*		2010	<=160.6	LAC	156.5	154.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
<i>Cancer</i>																					2	1
<b>Cardiovascular Disease</b>																						
Percent of heart disease prevalence*		2009	LAC	5.8%	5.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of heart disease hospitalization per 100,000 pop.†		2010	CA	367.1	374.4	323.3	342.2	419.2	318.6	379.4	408.4	405.5	402.5	357.9	303.9	507.3	382.0	257.7	434.0			
Rate of heart disease mortality per 10,000 pop.†		2010	CA	15.6	14.4	10.4	10.5	18.4	13.4	13.9	20.7	13.7	11.0	21.7	10.8	22.7	8.0	10.2	15.9			
Rate of heart disease mortality per 100,000 pop.*		2010	<=100.8	LAC	147.1	132.7	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of stroke mortality per 100,000 pop.*		2010	LAC	37.6	38.6	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
<i>Coronary disease/heart disease</i>																					5	1
<i>Stroke</i>																					1	0
<b>Cervical Cancer</b>																						
Rate of cervical cancer incidence per 100,000 pop.*		2009	<=7.1	LAC	9.9	9.9	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of cervical cancer mortality per 100,000 pop.†		2008	<=2.2	LAC	3.0	2.2	0.0	2.3	0.0	8.0	3.0	0.0	0.0	4.3	0.0	3.9	0.0	0.0	3.6	5.2		
<b>Chlamydia</b>																						
Rate of chlamydia incidence per 100,000 pop.*		2009	LAC	476.3	476.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of chlamydia incidence per 100,000 pop.^		2010	LAC	455.1	309.0	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
<b>Chronic Obstructive Pulmonary Disease (COPD)</b>																						
Percent of COPD prevalence**		2011	CA	4.0%	3.1%^^	3.2	3.1	4.0	2.8	2.3	5.7	1.9	2.2	4.5	2.6	6.3	1.4	1.4	3.2			
Rate of chronic lower respiratory disease per 10,000 pop.†		2010	CA	3.5	3.2	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
<i>Chronic Obstructive Pulmonary Disease (COPD)</i>																					2	0
<b>Colorectal Cancer</b>																						
Rate of colorectal cancer mortality age-adjusted per 100,000 pop.†		2008	LAC	11.2	7.7	11.2	4.7	7.9	8.2	5.2	18.9	7.0	0.0	9.0	9.9	5.8	0.0	9.2	10.3			
Rate of colorectal cancer incidence per 100,000 pop.*		2009	<=38.6	LAC	45.2	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		

2013 KP CHNA - Citrus Valley Health Partners Health Needs and Drivers Summary Scorecard

DATA INDICATOR		Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Actua	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)	
<i>Colon/rectum cancer</i>																					1	1	
<b>Diabetes</b>																							
Percent diagnosed with diabetes†		2009	N/A	N/A	19.2%	22.5%	24.5%	17.6%	15.6%	23.5%	15.3%	17.4%	26.0%	14.0%	16.8%	14.1%	24.8%	16.1%	20.0%				
Percent of diabetes prevalence*		2009	LAC	10.5%	18.5%																		
Percent of diabetes prevalence*		2009	LAC	7.7%	7.7%																		
Rate of adult diabetes hospitalizations per 10,000 pop.*		2010	CA	9.7	10.5																		
Rate of adult diabetes hospitalizations per 100,000 pop.†		2010	CA	145.6	147.4	180.9	181.5	147.3	56.0	211.8	109.7	125.9	194.7	126.3	88.1	138.9	289.3	76.6	137.0				
Rate of diabetes mortality per 10,000 pop.†		2010	CA	1.9	2.1	2.9	2.2	3.1	0.9	1.4	2.2	1.9	3.1	2.7	0.9	2.7	1.4	1.2	2.7				
Rate of hospitalizations for uncontrolled diabetes per 10,000 pop.†		2010	CA	9.5	12.7	11.3	14.9	3.7	8.0	26.2	9.6	7.0	23.1	14.0	6.1	11.4	26.8	2.0	13.5				
Rate of youth diabetes hospitalizations per 10,000 pop.*		2010	CA	4.8	3.5																		
<i>Diabetes (specifically type 1 and 2)</i>																					4	4	
<b>Disability</b>																							
Percent of population with a disability*		2010	LAC	9.4%	9.4%																		
<i>Behavior issues</i>																						2	0
<i>Developmental delays</i>																						0	1
<b>HIV/AIDS</b>																							
Rate of HIV hospitalizations per 10,000 pop.*		2011	LAC	2.2	0.9																		
Rate of HIV hospitalizations per 100,000 pop.†		2010	CA	11.0	6.6	5.0	6.5	14.0	2.2	13.3	11.8	1.9	9.4	3.0	6.6	0.0	6.8	9.3	2.7				
Rate of HIV prevalence per 100,000 pop.*		2008	LAC	480.4	480.3																		
Rate of HIV prevalence per 100,000 pop.†		2010	LAC	14.0	10.0																		
Rate of HIV mortality per 100,000 pop.†		2008	CA	2.5	1.9	1.6	1.2	3.9	0.0	3.0	0.0	1.7	4.7	0	2.0	2.4	0.0	0.0	6.1				
<b>Hypertension</b>																							
Percent of adults ever diagnosed with high blood pressure^		2009	LAC	25.5%	30.2%																		
Rate of hypertension & hypertensive renal mortality per 10,000 Hypertension		2010	CA	1.0	1.3	1.5	0.5	1.4	1.5	0.7	1.2	0.9	1.1	3.0	0.7	2.7	0.5	0.7	1.4			3	1
<b>Infant Mortality</b>																							
Percent of infants, low birth weight (1500-2499 grams)*		2010	CA	6.8%	6.3%																		
Percent of infants, very low birth weight (<1500 grams)†		2010	LAC	1.3%	1.1%	0.9%	1.7%	0.6%	0.7%	1.4%	1.2%	0.5%	1.2%	1.7%	0.3%	1.8%	1.5%	0.6%	1.1%				
Rate of infant mortality per 1,000 births*		2009	<=6.0	LAC	5.1	5.1																	
<b>Intentional Injury</b>																							
Rate of homicide by firearms per 100,000 pop.†		2009	CA	3.9	2.2	1.5	3.5	3.2	0.0	3.0	2.1	0.0	10.6	0.0	3.8	0.0	0.0	0.0	3.5				
Rate of homicide per 100,000 pop.*		2010	<=5.5	LAC	7.0	5.9																	
Rate of homicide per 100,000 pop.†		2008	<=5.5	LAC	8.4	6.1	3.2	9.4	15.7	0.0	7.5	7.3	0.0	10.1	3.0	3.9	2.9	3.9	0.0	17.8			
Rate of non-fatal firearm hospitalizations per 100,000 pop.†		2010	CA	8.8	4.5	6.7	9.1	9.9	4.3	5.9	3.9	0.0	8.0	0.0	0.0	0.0	9.1	0.0	5.8				
<i>Homicide</i>																					1	1	
<b>Mental Health</b>																							
Percent needing help for mental/emotional/alcohol-drug issues but did not receive treatment^		2009	LAC	47.3%	51.4%																		
Percent who had serious psychological distress in the last year^		2009	LAC	7.3%	8.8%																		
Percent with poor mental health*		2009	LAC	14.0%	14.0%																		
Rate of adult hospitalizations per 100,000 pop.†		2010	CA	551.7	657.0	651.5	650.4	1156.6	346.6	548.1	1061.0	340.7	444.7	932.4	235.7	942.1	942.1	325.0	620.4				
Rate of suicide per 100,000 pop.†		2010	<=10.2	LAC	8.0	6.3																	
Rate of suicide per 10,000 pop.†		2010	CA	1.0	0.9	0.5	0.8	0.7	0.7	0.8	2.4	1.5	0.6	0.6	0.9	0.6	0.9	0.7	0.6				
Rate of youth (under 18) hospitalizations per 100,000 pop.†		2010	CA	256.4	375.4																		
<i>ADHD</i>																					4	0	

2013 KP CHNA - Citrus Valley Health Partners Health Needs and Drivers Summary Scorecard

DATA INDICATOR		Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Actua	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)
<p><b>Legend:</b>                      *Data from the Kaiser Permanente CHNA database reflecting the CVHP/KFH-BP service area.                      †Data from secondary sources aggregated at the City-level reflecting only zip codes represented in the MCA                      ^Service area average represents Service Planning Area 3 as data was not available at the zip code or city-level.                      An italicized indicator denotes qualitative data collected in a focus group or interview</p>																						
Aging																					1	0
Anxiety																					2	0
Autism																					2	1
Bipolar																					2	0
Depression																					0	2
Eating disorder																					1	0
Mental health, general																					3	2
Stress																					1	0
Suicide																					0	1
<b>Obesity/Overweight</b>																						
Percent of adults who are obese†		2009	LAC	21.2%	20.0%	24.5%	24.9%	21.8%	14.5%	22.3%	20.5%	16.8%	26.0%	19.5%	13.2%	19.2%	23.7%	13.3%	20.4%			
Percent of adults who are overweight†		2009	LAC	29.7%	28.8%	28.5%	28.8%	29.5%	28.1%	27.8%	28.8%	29.2%	29.4%	30.5%	27.4%	30.3%	28.5%	27.5%	28.3%			
Percent of adults who are obese*		2009	LAC	21.4%	21.4%	---	---	---	---	---	---	---	---	---	---	---	---	---	---			
Percent of adults who are overweight*		2010	LAC	26.4%	36.4%	---	---	---	---	---	---	---	---	---	---	---	---	---	---			
Percent of youth who are obese*		2011	CA	29.8%	30.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---			
Percent of youth who are overweight*		2011	CA	14.3%	15.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---			
Obesity																					7	4
<b>Oral Health</b>																						
Percent with poor dental health*		2010	LAC	11.6%	11.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Oral health																					6	4
<b>Unintentional Injury</b>																						
Percent of pedestrians killed^		2008	LAC	25.7%	21.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of motor vehicle mortality per 100,000 pop.*		2010	<=12.4	LAC	7.1	7.7	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of pedestrian motor vehicle mortality per 100,000 pop.*		2010	<=1.3	LAC	1.5	1.3	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Rate of unintentional injuries mortality per 10,000 pop.†		2010	CA	2.7	1.6	1.5	1.6	1.0	0.7	1.5	2.0	1.7	1.7	0.9	1.8	2.7	2.3	1.2	1.4			
<b>Vision</b>																						
Percent of diabetic adults who had an eye exam in the last year^		2009	LAC	63.3%	65.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Vision																					1	3
<b>DRIVERS OF HEALTH</b>																						
<b>Awareness</b>																						
Lack of general awareness/education																					9	3
Inability to navigate health system																					2	1
Women's health education																					1	1
<b>Cancer Screenings</b>																						
Percent of adult men (50+) screened for colon cancer*		2010	LAC	50.1%	50.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of adults ages 50 and older have a sigmoidoscopy, colonoscopy in the last 5 years^		2009	>=70.5%	LAC	65.5%	61.5%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of adults ages 50 and older have a sigmoidoscopy, colonoscopy, or FOBT^		2009	LAC	75.7%	28.3%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of breast cancer screenings*		2007	LAC	52.5%	53.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent with cervical cancer screenings in last 3 years*		2010	>=93%	LAC	67.6%	67.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent with cervical cancer screenings in last 3 years^		2007	>=93%	LAC	84.4%	84.9%	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
<b>Dental Care Access</b>																						
Percent of adults utilizing dental care*		2010	LAC	34.5%	34.5%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Percent of children who have never seen a dentist^		2009	LAC	10.5%	11.9%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		

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DATA INDICATOR		Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Acton	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)	
Percent of teens who can't afford dental care <sup>^</sup>		2009	LAC	23.8%	<b>53.2%</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of youth (children and teens) can't afford dental care*		2007	LAC	6.2%	<b>6.3%</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of youth (children and teens) utilizing dental care*		2009	LAC	12.2%	12.2%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent without dental insurance coverage*		2007	LAC	37.4%	37.4%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
<b>Education</b>																							
Percent of 4th grade children reading below proficiency*		2011	<=36.3%	CA	35.6%	35.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of population with no high school diploma**		2010	LAC	24.1%	22.3%	<b>25.3%</b>	<b>43.3%</b>	15.9%	7.5%	<b>47.8%</b>	10.6%	15.3%	<b>44.0%</b>	8.1%	14.3%	7.1%	<b>48.3%</b>	7.8%	17.3%	---	---	---	
Rate of high school graduation*		2009	>82.4	CA	82.3	87.2	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
<i>Education level</i>																					8	4	
<b>Employment</b>																							
Rate of unemployment*		2012	LAC	10.3	<b>10.4</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent unemployed (over 16 years of age)**		2010	LAC	5.7%	4.9%	<b>5.9%</b>	<b>6.4%</b>	<b>7.4%</b>	3.4%	<b>5.9%</b>	4.8%	3.9%	5.0%	4.9%	3.7%	3.6%	4.7%	2.9%	<b>5.8%</b>	---	---	1	0
<i>Underemployment</i>																						8	4
<i>Unemployment</i>																							
<b>Family &amp; Social Support</b>																							
Percent who have social/emotional support*		2010	LAC	71.1%	71.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
<b>Health Care Access</b>																							
Lack of a consistent source of primary care		2009	LAC	16.2%	<b>18.2%</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Number of facilities designated as health professional shortage areas*		2012	LAC	137 <sup>1</sup>	6 <sup>2</sup>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Number of federally qualified health centers (FQHC)*		2011	LAC	101	3	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of population living in a health professional shortage areas*		2012	CA	53.2%	48.9%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent who delayed or didn't get medical care <sup>^</sup>		2009	LAC	11.6%	9.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent who delayed or didn't get prescriptions <sup>^</sup>		2009	LAC	7.5%	7.2%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Rate of primary care provider per 100,000 pop.*		2011	LAC	80.7	<b>80.6</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Rate of hospitalizations per 1,000 pop.**		2010	CA	106.6	102.8	97.8	105.5	<b>112.9</b>	75.8	<b>113.1</b>	<b>118.4</b>	96.8	102.3	<b>108.4</b>	97.5	<b>126.0</b>	<b>115.0</b>	67.8	101.7	---	---	---	---
<i>Access to health services</i>																						2	0
<i>Adequate providers</i>																						2	0
<i>Coordinated healthcare</i>																						3	2
<i>Cost of care</i>																						5	3
<b>Health Insurance</b>																							
Percent of population receiving Medicaid*		2010	LAC	19.9%	<b>19.9%</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent who are uninsured*		2010	LAC	22.6%	20.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent who are uninsured <sup>†</sup>		2009	CA	16.2%	16.2%	<b>21.1%</b>	<b>22.2%</b>	15.9%	11.3%	<b>21.0%</b>	13.3%	13.7%	<b>22.8%</b>	11.4%	12.0%	11.4%	<b>22.1%</b>	11.6%	<b>17.5%</b>	---	---	---	---
<i>Medical insurance</i>																						6	2
<b>Healthy Eating</b>																							
Percent of adults who consume inadequate amount of fruit/vegetables*		2010	LAC	72.3%	72.3%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of fruit/vegetable expenditures*		2011	CA	1.6%	1.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of soft drink expenditures*		2010	CA	0.46%	<b>0.49%</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of youth drinking two or more glasses of soda yesterday <sup>^</sup>		2009	LAC	18.1%	<b>18.8%</b>	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of youth eating less than 5 servings of fruit/vegetables a day <sup>^</sup>		2009	LAC	50.8%	49.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

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DATA INDICATOR		Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	MCA Service Area Average	Azusa	Baldwin Park	Covina	Diamond Bar	El Monte	Glendora	Hacienda Heights	La Puente	La Verne	Rowland Heights	San Dimas	South El Monte	Walnut	West Covina	Interviews (n=20)	Focus Groups (n=5)	
Percent of youth who consume adequate amount of fruit/vegetables*	2009	LAC	50.8%	50.8%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
	Percent who frequent fast food restaurants 4 times a week or more <sup>†</sup>	2009	LAC	12.5%	15.5%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	3	1
<b>Homelessness</b>																							
Number of homeless persons <sup>^</sup>	2011	LAC	45,422	17,412	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	6	2
Homelessness Affordability																						2	1
Homelessness Overcrowding																						1	0
<b>Poverty</b>																							
Percent of adults unable to afford enough food (food insecurity)	2009	LAC	38.2%	36.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent eligible for free/reduced price school lunch*	2010	LAC	58.5%	61.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of population living at 100% of Federal Poverty Level (FPL)*	2010	LAC	15.7%	12.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of population living at 200% of Federal Poverty Level (FPL)*	2010	LAC	37.6%	33.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of population receiving Supplemental Nutrition Assistance Program (SNAP) benefits*	2009	LAC	8.7%	8.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of youth in poverty*	2010	LAC	22.4%	16.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	5	2
High cost of living																						5	1
Poverty																							
<b>Language Barrier</b>																							
Percent who have a hard time understanding doctor <sup>^</sup>	2009	LAC	4.7%	6.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	5	2
Language barrier																							
<b>Natural Environment</b>																							
Percent of days with poor air quality (particulate matter 2.5)*	2008	LAC	2.6%	2.0%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	2	2
Air quality																						1	1
Clean water																							
<b>Nutrition Access</b>																							
Percent living in food deserts*	2009	LAC	1.5%	1.5%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of food insecurity <sup>^</sup>	2009	LAC	38.2%	36.3%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Rate of fast food restaurants per 100,000 pop.*	2009	LAC	72.5	76.2	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Rate of grocery stores per 100,000 pop.*	2010	LAC	21.6	21.5	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Rate of WIC-authorized food stores per 100,000 pop.*	2012	LAC	17.0	17.0	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Lifestyle/access (healthy food, food desert, nutrition)																						3	3
<b>Physical Activity</b>																							
Percent in Walk Score Area (walkability)*	2012	CA	84.0%	93.6%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of adults who are not physically active*	2010	LAC	24.7%	24.7%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of youth who are not physically active*	2010	CA	37.5%	38.4%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent who visited a park in the last month <sup>^</sup>	2009	LAC	79.3%	76.3%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent within 1/2 mile of a park*	2010	LAC	63.1%	64.1%	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Rate of protected open space areas in acres per 1,000 pop. <sup>†</sup>	2009	N/A	N/A	168.9	1091.8	16.8	2.29	11.2	2.2	193.5	19.7	4.4	34.51	8.7	942.1	23.3	9.2	4.8					
Rate of recreation and fitness facility establishment per 100,000 pop.*	2009	LAC	7.5	5.7	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Percent of families in poverty in the past 12 months**	2010	LAC	12.6%	8.3%	12.0%	14.0%	8.0%	3.0%	18.3%	3.5%	5.9%	10.3%	5.3%	9.1%	3.5%	12.6%	4.1%	6.1%					

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Percent of population in poverty in the past 12 months** <i>Access to green space</i> <i>Lack of exercise</i>	2010		LAC	15.7%	10.5%	17.4%	15.9%	10.7%	4.6%	20.7%	6.5%	7.7%	12.0%	6.8%	10.5%	5.4%	15.6%	4.9%	8.7%	6	3
<b>Preventative Care Services</b> Rate of preventable hospital admissions (ACSC) per 1,000 total admissions* <i>Preventative healthcare</i> <i>Specialty care</i>	2010		CA	88.5	97.9	---	---	---	---	---	---	---	---	---	---	---	---	---	---	0	1
<b>Safety</b> <i>Domestic violence</i> <i>Safety</i> <i>Violence</i>																				2	1
<b>Transportation</b> <i>Transportation</i>																				3	0
																				1	0
																				11	4

FOOTNOTES

<sup>1</sup>Health Professional Shortage Area Facilities: Los Angeles County - 48 primary, 45 mental health, 44 dental

<sup>2</sup>Health Professional Shortage Area Facilities: Citrus Valley MCA - 2 primary, 2 mental health, 2 dental

N/A=no data available

Zip code assignments by City:

Azusa: 91702

Baldwin Park/Irwindale: 91706\*

Covina: 91722, 91723,

Diamond Bar: 91765

El Monte: 91731, 91732, 91734, 91735

Glendora: 91740, 91741

La Puente: 91744, 91746, 91747, 91749,

La Verne: 91750

Rowland Heights: 91748

San Dimas: 91773

South El Monte: 91733

Walnut: 91788, 91789, 91795

# **Appendix E: Stakeholder Interviews Summary for CVHP**

## Health Trends and Drivers

CHNA interviews with stakeholders were conducted via telephone during September and October 2012. Nineteen interviews representing a broad range of community stakeholders, including health professionals and service providers, were conducted to gather information and opinions directly from persons who represent the broad interests of the community served by the Hospital. The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each. The interview protocol was designed to collect reliable and representative information about health and other needs and challenges faced by the community, access and utilization of health care services, and other relevant topics. A summary of key interview findings is noted below.

Interviewees identified several issues of primary concern that cut across all population groups in the CVHP service area including obesity, and drivers including poor eating habits and a lack of exercise. The most frequently mentioned broader, community-wide issues include:

### Health Needs

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- Asthma, pneumonia, chronic respiratory disease
- Cancer
- Cardiovascular disease
- Diabetes
- High cholesterol
- HIV/AIDS
- Hypertension
- Mental Health
  - Anxiety
  - Autism
  - Bipolar
  - Dementia
  - Depression
  - Post-Traumatic Stress Disorder
  - Schizophrenia
- Obesity
- STDs and women's health issues

### Drivers of Health

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- Community safety
- Cost of healthy food
- Economy / recession
- Education
- Family issues and violence
  - Lack of parental guidance / supervision
- Food deserts (no access to fresh fruits and vegetables)
- Lack of access to primary and specialty care
- Lack of follow-up care

- Lack of green space
  - Lack of open places to exercise
- Lack of knowledge or education
  - Lack of access to information and resources
- Language barriers
- Lifestyle, poor choices, people unmotivated to be active
- Poor air and water quality (pollution)
- Substance abuse
- Transportation
- Uninsured
  - Lack of insurance to get chronic diseases under control
- Unemployment
  - Loss of manufacturing jobs / Obesity

Participants provided further insight into these key issues. One interviewee noted that, “poor immigrants have culturally-based eating patterns that include too many carbs and deep fried foods” which often leads to obesity. In addition, people “don’t exercise, and instead drive everywhere, even if it’s just two blocks away”. Another interviewee added that, “kids don’t play and exercise or participate in athletics.”

## Health-Related Trends in the Community

### Negative Trends

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Recent health-related developments noted by interviewees include increases in chronic diseases including obesity and diabetes in children and poor oral health including greater numbers of tooth extractions and other restorative dental procedures, diagnoses of developmental delays in children between 0 and 5 years of age, increase in depression and suicide cases, dual diagnoses, in co- and tri-morbidity, drug-resistant bacterial infections, , people living in unhealthy conditions due to multiple families living in homes, and unemployment rates. There is also a need for access to preventative medical care including tests and screenings, shelters, affordable housing and employments services.

Other recent developments noted by interviewees include cuts to Head Start and other developmental programs for low-income children, Medi-Cal cuts to vision care services (limited prescription for lenses/glasses) and dental care for adults, reduced coverage for children, loss of community redevelopment funds, increasing financial burdens on community hospitals, and the continuing ripple effects of the recession.

It was noted that Citrus Community College closed the campus childcare center due to inadequate funding: “We’ve lost about 30% of the spaces for children in Head Start and early childhood development.

In addition, interviewees added that “prior to the recession, our community had about the same unemployment rate as the U.S. There are jobs available but they are not good quality jobs and they don’t pay a living wage.” Also, “manufacturing jobs have been reduced by almost half in the last 12 years. We used to produce mostly durable goods, but now it’s mostly food-related products. The recession’s ripple effect and loss of construction jobs has raised the unemployment rate in our area and has changed the materials used for new housing units.”

### Positive Trends

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Interviewees also noted positive health-related trends including people being able to identify links between chronic diseases such as obesity, diabetes and hypertension and behaviors such as healthy eating. There is also an increased awareness about diseases such as HIV/AIDS, with more people accessing screenings and other preventative measures.

One interviewee said that while HIV/AIDS infections are still occurring, the infection rate is slowing down: “A few years ago we found 136 HIV-positive people in one year. Last year, this dropped to 68. I’m not sure if that’s because we just got the motivated ones or there was actually a decrease.”

Interviewees seemed concerned and anxious about the roll out of the Affordable Care Act (ACA), while many commented on the potential benefits expected, including:

- “The Healthy LA program has opened access to many people, and the county is expanding access to specialty care.”
- “The whole health care system is shifting with Affordable Care. The Act indirectly addresses the undocumented issue by paying clinics to care for the uninsured, so we’re moving toward being able to address some of these issues.”

An interviewee commented about California’s role in the changing healthcare landscape. Related observations include:

- California must take a leadership role and draw as many federal dollars as possible
- California needs to control healthcare costs and maintain stability in the system
- Covered California (ACA-mandated health exchange) will benefit all Californians
- With more people on Medi-Cal, the state will have to provide care with fewer resources
- Need to grow overall workforce; 25% of population is over age of 65
- Aging baby boomers will have different health needs to address

In addition to health-related trends, interviewees also noted a shift in the population, economy, and barriers. The following observations were made:

- “The San Gabriel Valley is a fairly strong working class community and has a long history of second and third generation immigrant groups.”
- “People here are resource poor. They don’t have enough food or affordable places to live. Multiple families live in one apartment.”
- “Healthcare is the Valley’s largest and strongest industry. The area has an unusually high number of quality hospitals that other providers (e.g., pharmacies, physical therapists) tend to cluster around.”
- “Our aging population is growing; people stay in the region, others are retiring here.”
- “Enrollment in elementary school and pre-school is declining. People are putting off having children. Sometimes there are small increases, but the numbers decrease again. This may turn around once the economy stabilizes, but the long term trend is fewer young children, even among Latinos, Blacks, and Asians.”
- “On-going immigration will require a new approach to health.”

- “The San Gabriel Valley is mostly Latino, and now 25% of the population is Asian. The number of Asian-owned businesses is growing.”
- “Poverty is the source of chronic disease; it comes from multiple interacting issues, including the economy and family stresses.”

## Barriers to Access

Interviewees were asked to identify the kinds of problems or challenges that people face in obtaining health care and/or social services. The most frequently reported barriers specifically related to delivery of services.

- “There are resources but the public just doesn’t have the knowledge.”
- “The critical issue is the lack of access to specialty care physicians such as cardiologists and gastroenterologists. It can take month or over a year to be seen and is very expensive. Referral to specialty care is complicated. When we refer a patient to neurology, they say the patient needs a CT scan before they can be seen.”
- “There’s very little specialty care through public clinics. Clients usually get referred to the County where there is a long wait or don’t have a way to get there (transportation).”

Additional barriers identified by interviewees include access to care, prevention, treatment, and management of chronic health conditions.

- Economic constraints
- Fear
- Homelessness
- Inadequate capacity (long waits, especially for specialty care)
- Lack of health insurance
- Lack of services on weekends and after working hours
- Lack of transportation
- Language issues and cultural differences
- Limited knowledge / education / understanding
- Noncompliance with advice and recommended treatments
- Preference for alternative, nonmedical treatment

### Insurance /Accessing Available Services

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- “Some have insurance but don’t understand the co-pay. They have a fear of billing. They think they’ll be presented with a huge bill at the end of the doctor visit.”
- “We make a big effort to encourage parents to get medical and dental preventative treatment, but without our intervention, they just don’t use preventative services. Many low-income families have government sponsored or job-based health coverage, but they don’t use it. Most go to county health clinics, or wait until the situation is dire and then go to the ER.”

### Transportation

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- “The bus system is designed to take people to work downtown, so it isn’t easy to navigate. The working poor may have one car someone takes to work so the other person has to walk or take the bus.”

- “The San Gabriel Valley is very spread out. Bus fare is expensive, about \$75 a month. They get some bus tokens from LA Metro and Foothill Transit, but only for the main bus line. Lack of viable transportation is a barrier to getting to a job interview.”
- “Children have access to health insurance through a variety of programs, but aren’t using it. It may be a transportation issue because parents have to get them there, or it may be cultural.”

### **Language, Education, and Cultural Barriers**

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- “Most of our clients won’t go to San Gabriel Valley Medical Center due to discomfort around cultural differences (with the providers).”
- “The cultural issues are complex. Some are very wary around others wearing any kind of uniform; others are uncomfortable traveling through San Marino to get to a clinic in East Pasadena.”
- “Many don’t realize that there are translators available at some clinics.”

### **Psychological Barriers**

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- “The homeless and some of the working poor have a hard time going to large institutions for care. They feel they don’t look presentable; they aren’t clean. They don’t want to sit in a waiting room for hours. They worry they’ll get stuck downtown at night, in a strange neighborhood.”
- “Recent immigrants are afraid to access services, especially if they are undocumented.”
- “The biggest resistance comes from thinking the problem will go away, or from fear of the doctor or dentist.”
- “What has been the practice when you’re ill? Go to the botanicas. They believe in an alternative non-medical system.”
- “Really low-income people have all types of social issues from unemployment, or having a job but not enough to get by, the safety of the area where they live, not knowing where their next meal is coming from. These issues are more important than their health.”

### **Autism**

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An interviewee noted that the “spike” in diagnosed cases of autism, which started twenty years ago, has resulted in a large population of adults, now 25 to 30 years old, who deal with continuing challenges related to autism. It was suggested that Kaiser Permanente take a leadership role in investigating the reason for the rise in autism diagnoses (environmental triggers, genetic issues). Additionally, hospitals can do the following to address autism early when intervention is most effective:

- Focus on early intervention and diagnose children correctly
- Conduct annual developmental screenings with a reliable, effective tool on every child
- Build performance standards into regular pediatric care/clinics to ensure that assessments are being conducted
- Track assessments over time (up to 6 years old)
- Have parents fill out an assessment in the emergency waiting room and keep on file for future use

Suggestions were also offered to help hospitals deal with autism including:

- “Help families coordinate the non-medical pieces that also have implications for the wellbeing of children with autism.”

- “Take the lead in helping families navigate not only the health care system, but other systems. There’s a cost argument for coordination of complimentary services— they end up making people healthier.”
- “If you can’t figure out how to fill out paperwork for your child with a disability because you don’t speak English, you can’t get the child enrolled in early intervention. If the child is chronically absent from school and failing, a system navigator can walk parents through it otherwise they will flounder.”

## **Oral Health**

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Participants discussed challenges faced by those seeking dental services including finding a dentist, getting parental compliance to serve children, and the lack of restorative care services:

- “It’s almost impossible to get free dental care. I’d like to see the dental community come together to organize groups of dentists who will set aside a certain number of visits/services per week/month for low-income families. Dentists fear they will be overwhelmed by the number of requests from low-income clients.”
- “Parents resist getting dental care when cavities are in the child’s baby teeth because those will fall out so it’s not a priority to them. Also parents who have had bad dental experiences don’t want to expose their kids to the pain.”
- “We can’t do restorative work anymore, only extractions and fillings. We don’t have money for dental lab services.”

## **Mental Health**

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Participants described a large gap in the availability of mental health services and how difficult it is to get people with mental illness to come in for treatment:

- “Among the homeless, 50 percent have addiction and mental health issues.”
- “Most don’t seek mental health care. (Our organization) brings mental health providers to school sites because parents won’t go to a counseling office. There’s a big stigma attached to going to a therapist.”
- “The vast majority wouldn’t seek help; those who do, go to their churches or family members. Stigma is huge around mental health.”

## **Most Severely Impacted Sub-Populations**

Interviewees were asked to comment on issues of concern to specific sub-populations within the communities their agencies serve. The following sub-populations were identified as being the most severely impacted:

- Adult males
- Homeless individuals and families
- Least educated
- Mothers
- Newly immigrated
- Seniors
- Undocumented
- Veterans
- Young families

## Homeless

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Interviewees described a “huge need” for recuperative care, year-round shelters, and programs designed to address the issues unique to people without stable homes.

- “The very ill and those discharged from ICU need to get off the streets. They can’t go to the shelters; they need a place to be out of the cold, rest and get well. There are a few recuperative beds, but those are far from San Gabriel Valley. There was a guy who came out of ICU with a drain and dressing on an open gunshot wound. There’s no in-between for people like him.”
- “Respiratory problems can be lethal to the homeless. If they were housed and out-of-the elements, they might not have died, but they have to leave the shelter in the day, when it’s still cold outside.”
- “We have only one winter shelter and funding has been cut, but the number of homeless is increasing. I’ve been affiliated with this (homeless resource) organization since 1997, and I see the need get worse every year.”
- “Services are set-up to meet the needs of low-income clients, not the homeless. Homeless clients don’t know where to go, how to get there. They don’t know they have to line up at 5am for services. This is only doable if there’s some stability in their lives. If they have other appointments or are waiting in another line for food, then they miss the 5am.”
- “The homeless have extra difficulty accessing services (don’t have required documents e.g., ID, insurance cards, legal residency) for county eligibility. They have trouble getting prescriptions filled because they can’t pay the co-pay.”
- “The homeless don’t have a choice about what they eat. They have no way to cook, no refrigeration. They eat food high in sodium, fat, and calories.”
- “A lot of our clients are totally bewildered by their circumstances. They’re dazed and just trying to survive.”

## Seniors

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Interviewees also identified the senior population as the most severely impacted by the lack of available doctors and nurses, and follow-up care for chronic disease.

- “The boomer population is aging and living longer. They will have mobility issues. There are not enough doctors, nurses, caregivers to serve this population.”
- “There’s little follow-up to manage chronic disease. This is a burden on the patient and the caregivers, who often don’t have the skills or wherewithal to care for a condition.”

## Undocumented

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The undocumented were also identified as one of the most severely impacted populations unable to access health care.

- “The undocumented are locked out of access to health care even with the advent of health care reform – they have no way to even buy in to low cost insurance. Either we pay now or we pay later because this population will need care from the system at some point.”

## Veterans

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Veterans were also identified as severely impacted by the lack of transportation..

- “Veterans qualify for services, but they have to get to West LA, Long Beach or Loma Linda, there’s nothing in East San Gabriel Valley. The veterans housing/social services in El Monte, doesn’t have medical care. There’s no viable transportation for veterans.”

### **Other Disparities**

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Concern was also expressed regarding adult women who “tend to put health concerns on the back burner in order to take care of their families” and for adult men who need assistance managing chronic conditions.

Expanding on the issues and challenges of these subgroups, interviewees offered the following:

- “We are seeing a younger population with these health issues compared to before. Now they are in their early 40s with diabetes, compared to being in their 50s in prior years.”
- “One in three of our 3 to 4 year olds are overweight or obese! This will lead to a range of health and psychological problems as the kids go through school and life.”

## **Health Care Utilization**

Interviewees were asked to name places where people go to access services and information to help them deal with mental and physical health care issues, family challenges, and personal concerns. Community members access services, information, and education in varied settings and across many communication platforms. Community resources mentioned during the interviews are included in the compiled list of community assets in Section VII of the Community Health Needs Assessment report.

Interviewees noted that community members were more likely to hear about these resources through word-of-mouth, churches, radio and billboard campaigns, community events including health fairs and farmers markets, community clinics, county hospitals, and phone help lines.

### **Patient Advocacy**

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Several interviewees concurred that utilization of available services would increase and produce more effective outcomes if clients knew how to access and understand what is available to them. They recommended increased training and use of patient advocates and system navigators:

- “It seems more and more that you need an advocate when you go to the hospital or clinic. Someone to come with you, make sure you’re getting what you need.”
- “They need someone to accompany them on medical visits, so two people hear and learn the key points about the condition.”
- “We need more social workers, advocates and discharge planners who can translate preventative care practices into people’s real life needs and capabilities.”
- “Train front line people to provide resources to patients, their caregivers and families.”
- “Provide someone who can help people pursue resources, make calls, and help them figure out how they can do it.”
- “A proactive person can ask for what they think should be monitored, but a less knowledgeable person is at the mercy of the system and the capacity of health care staff on any given day to pay attention and do the appropriate follow up.”

## Gaps in Services

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Interviewees mentioned that the San Gabriel Valley service area had significant service gaps in the following areas:

- Emergency rooms, trauma centers, and urgent care facilities
- Follow-up care
- Nutrition and health education
- Preventative care
- Primary care center designed to address the unique needs of the homeless
  - Year-round shelters for the homeless
- Recuperative care
- Specialty care
- Viable transportation options

## Ideas for Collaboration and Cooperation among Service Providers

Interviewees were asked to reflect on specific actions or initiatives that hospitals could take to help address identified needs. They were also asked to describe potential areas for collaboration and coordination among hospitals and CBOs to better meet the needs of the communities they serve.

- Be more patient-centric and customer service oriented
- Be more specific about referrals (where to go, who to see) after a patient is discharged from the ER
- Create a care coordinating entity to work with private providers
  - Streamline services
- Follow-up with primary care doctor after ER discharge
- Get physicians to provide referrals to social services, not just prescriptions for medications
- Help with recuperative care (pay for motel stays and nurse visits for homeless)
- Partner with family resource centers (e.g., Magnolia Place)
- Partner with farmers markets to promote healthy eating
- Provide practical, hands-on, culturally sensitive cooking and nutrition classes
- Subsidize specialists at community clinics
- Team with churches, YMCAs, schools, and community centers where people congregate

Interviewees also offered cost-based, economic reasons for expanding collaboration with hospitals:

- “Hospital-sponsored off-site recuperative care for the homeless frees up hospital beds.”

- “Hospitals need to increase partnerships with urgent care providers to handle everyday issues, like the flu, for the uninsured. That would shorten ER wait times.”
- “The healthcare sector is a vital part of the San Gabriel Valley economy, with good jobs that pay good wages. Hospitals should make a concerted effort to train and hire local people—train young people, starting in high school, to get them interested in healthcare career.”

Examples of working collaborations among hospitals and community-based organizations include:

- Citrus Valley Hospital and Altamed are sharing information, coordinating Electronic Health Records, and trying to form an efficient system
- Model recuperative program in Orange County (possibly called Illuminate). Hospitals run it, pay for 6- to 10-day stays in motels and nurse visits for recuperating homeless patients
- Kaiser Permanente - Baldwin Park Medical Center provided low risk outpatient surgeries for uninsured patients who couldn't afford the procedures

### **Potential Areas of Collaboration among Service Providers**

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Interviewees suggested the following areas as fertile ground for productive collaboration:

- Conduct proactive educational outreach, class, and programs
- Organize more town hall forums, health fairs, farmers markets
- Partner with comprehensive family resource centers (e.g., Magnolia Place)

Interviewees also offered additional insight into the dynamics of and obstacles to collaboration:

- “Hospitals and health providers need to learn to work together better. The challenge is for health systems to learn to keep people healthy, not just treat them when they are ill.”
- “We need to get more service providers around the table, including the local cities. Trying to get city government involved. Coordinate quite well through Consortium, meeting once a month. Also need to collaborate on a day-to-day basis. Has gotten better, know each other, names, call each other for help. No master plan for this and needs to continue to improve.”
- “A lot of groups across our communities are doing good work, most are small and don't have many resources. Connect with these community services that want to collaborate, but don't come in with a grandiose idea and try to push it on people. Build on the strengths and services that already exist in the community.”

### **Outreach Methods and Message Content**

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Interviewees were asked to share their thoughts about the most effective outreach methods for delivering information to their service populations including:

- Booklet or directory of resources (challenge to keep hard copy version updated)
- Cell phones, online platforms, and social media
- City websites
- Community forums and town hall meetings specific to communities

- Events at schools and libraries
- Faith-based organizations
- Locations where people congregate, local gathering places (e.g., Mexican Consulate)
- Mailings local residents (multilingual text)
- Mobile clinics
- Organizations that serve specific populations
- Promotoras
- Provide information in other languages
- Publications specific to communities (Spanish, and Chinese)
- Radio programs and public service announcements

Interviewees agreed that, to be effective, messaging should have the following attributes:

- Delivery through local service providers and organizations
- Family-centered messaging (“My Kitchen, My Rules” campaign is good)
- Relevant and up-to-date messaging in order to reach young people
- Tailor message according to disease issue and targeted audience

Further suggestions regarding messaging provided by the participants include:

- “Talk about outcomes, but scaring people is not a good idea.”
- “Cost-effective, quality healthcare at a reasonable cost is the message.”
- “Spanish-speaking people prefer visually oriented communication materials.”
- “Approach this by focusing on kids, because many low-income families are child-focused; what little they have is directed to their kids.”
- “Make educational resources available in waiting rooms that are appealing and user-friendly. A good example is, ‘The People’s Guide to Food and Hunger.’”
- “Kaiser Permanente’s public service announcements about health are good.”
- “Mass campaigns around healthy eating and diet really help. We can’t afford to do that on our own, but in partnership we can.”

# **Appendix F: Focus Group Summary for CVHP**

## Health Needs and Drivers

Five focus groups representing a broad range of community stakeholders, including area residents, were convened to gather information and opinions directly from persons who represent the broad interests of the community served by the Hospital. Focus groups took place in a range of locations throughout the service area, with translation and interpretation services provided when appropriate. Focus group sessions were 60 to 90 minutes each. The focus group topics were designed to collect representative information about health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic disease management and other community issues. A summary of key focus group findings is noted below.

### Health needs

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- Alcoholism
- Asthma and other respiratory illnesses
- Birth defects
  - Autism
  - Developmental delays including speech impediments
- Cancer (breast, colon, prostate, pancreas, stomach)
- Coronary disease
- Dental disease
- Diabetes
- High blood pressure
- Homicide
- Mental health
  - Depression
- Obesity
- Teen suicide
- Vision problems

### Drivers of health

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- Cultural
  - Language barriers
- Environmental
  - Lack of clean and fluoride-free water, lack of clean and wholesome food
- Family violence
  - Domestic violence
- Lack of access to health care
  - Lack of insurance

- Long waiting time for appointments – one participant shared how a young woman with breast cancer was afraid her cancer would become more advanced because she had to wait for such a long time to get an appointment with a doctor.
  - Lack of information
  - Lack of trust
- Lack of coordination of healthcare
  - Going from doctor to doctor with no communication between medical service providers
- Lack of dental care
  - Lack of preventative health due to a lack of knowledge
- Lack of green space
  - People feel unsafe going to the park, gym, or walking in the community
- Lack of transportation
  - Public transportation is inadequate, takes too much time (long waits, long lines)
  - Lack of access to bike trails
- Social and Economic
  - High concentration of foster youth and emancipated youth
  - Unemployment, underemployment
  - Immigrant/resident status, lack of legal identification
  - Gyms are not affordable
    - “There are many outdoor and indoor activities such as gyms but everything has a cost and there is not enough money to afford them.”
  - High number of teenage moms with two or three children - need health education
  - Unemployment, lack of work causes stress (unable to pay bills, food and gas costs)
- Unhealthy behaviors and lifestyle
  - Lack of self-management for disease
  - Wait until an illness turns into an emergency
  - Poor nutrition, feeding sugar/sodas to children, no access to fresh vegetables, information gap about healthy foods
    - “People get bombarded with information about health and nutrition but there is no quality information that helps people understand what healthy food and nutrition really is.”
  - Lack of exercise due to time spent watching television or using technology such as video games and computers

## Health-Related Trends in the Community

Focus group participants were asked to discuss negative and positive health-related trends they have noticed in the last five years related to chronic illness, barriers to access, and other factors and issues.

### Negative Trends

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- Decrease in the quality of food
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- Product quality is bad and food goes bad faster than before
- Environmental
  - Air quality has improved, however there is not enough awareness about how to dispose of man-made materials and products composed of toxic materials
- Increase in chronic illnesses
  - Increase in diabetes, insulin dependence
  - Anemia – one person mentioned that their daughter had this condition and did not want to eat because she did not want to become fat
- Increase in unhealthy behaviors
  - Adults continue to consume too much sugar/salt, more obesity, no education about nutrition
- Lack of access
  - Lack of access to qualified specialists
  - Medical reimbursements rates decrease and specialists opt out of the system
  - Lack of information about how to navigate the health care system, which has become more complicated and less user-friendly
  - Reduction in funding for substance abuse treatment
  - Challenges with accessing mental health services, especially for adults
- Lack of access to specialty care
  - Lack of dental and vision especially in adults/seniors
- Poverty
  - Increase in food bank clients
  - Increase in people using donation boxes as a source for clothing for themselves and their children
  - No change in income in conjunction with higher costs for consumer products
  - Public transportation costs – more homeless and working people are now taking public transportation, however, drivers are less lenient if riders are unable to pay the complete fare
  - Increase in homelessness – increased in SPA 3 by 19% despite overall decrease in Los Angeles County – and lack of affordable/accessible housing
  - Cost of gas is “an extreme economic problem” because people use money from other budget areas to pay for gasoline and transportation
- Strict medical insurance guidelines
  - Less medical benefits due to reductions in coverage

Positive trends noted by focus group participants included an increase in a holistic perspective and better understanding of health issues and recognition of community-based needs, of connections between health drivers and health issues and the need to collaborate. Community members are also slowly starting to understand the importance of fresh fruits and vegetables in the diet (i.e. the popularity of farmers markets). Schools have also implemented healthy lunch programs and have become more involved in sharing health care resources.

Healthcare providers talked about health behaviors in the community and stated the following changes occurring in the local communities:

- Changes in policies (and not behavior) were leading to improvement of the health environment
  - Healthier choices were available due to new policies
    - “The healthy choice is the easy choice.”
- Change in attitude and behaviors
  - Decrease of BMI in Baldwin Park
  - More people walking and eating less sugar
- Greater cultural sensitivity towards immigrants
- Moratorium on fast food restaurants

## Sub-Populations most affected by these general health needs

Focus group participants identified the most affected populations as the undocumented, the disabled, seniors, homeless, children and families living below the poverty level, parolees from the prison system, those with special needs, and youth transitioning out of foster care. Many participants felt that these health needs affected “everyone” and that children are impacted as well when they see their parents being affected.

## Barriers to Access

Many participants shared that there is a sense of anxiety about using the health care system. Some immigrants in the community will not use county health services, food banks or churches due to lack of documentation. Others have only emergence insurance and fear that if they see a doctor they will be presented with a large bill. When they do have insurance, they visit the doctor. Otherwise, they self-medicate. When asked about services that were lacking and barriers to access, people’s responses focused on basic needs such as food banks, jobs and affordable housing. The following lists include barriers and services lacking in the community.

### Barriers

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- Immigration status – unsure of consequences when seeking health care and not able to use certain county services
- Eligibility – only those with no income qualify; part-time and self-employed people no longer have access to health care services unless they are 65 years old. If they are under 65 and have assets/income, they cannot get insurance
- Financial barriers – cannot afford insurance co-payments or to take time away from work

- Increase of multiple families in a single residence – causes mental stress, depression, anxiety, lack of privacy, inability to sleep, and family violence
- Lack of motel vouchers for the homeless – Los Angeles County provides help only “one time in lifetime” and once used, the person no longer has access to assistance. One participant described a single mother with four children who could not afford to pay the weekly rate of \$480 at a motel and had no other place to stay. Another participant spoke of a family from Europe that was very stressed because they could not afford any food
- Lack of transportation
- Lack of understanding of the health care system – especially among grandparents who are often taking care of grandchildren and need to be educated about changes in the health care system
- Language/literacy/culture barriers – different cultures have different ways of dealing with health issues; people might have insurance but do not understand co-pays/billing
- Many people have only emergency insurance and fear that if they do see a doctor they will be presented with a large bill
- Need organizations that will “fast-track” and serve as liaisons between people and medical services
- People are losing homes and jobs – if one of the main providers in the family gets laid off they must scramble to pay for other necessities such as gas, utilities and rent and go without food
- Small businesses are choosing not to expand because of the cost of insurance for new employees

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### **Health services that are lacking or difficult to access**

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Participants identified a number of services that were missing the community including mental health resources, youth services, homeless services, recuperative care, computer literacy and access, public transportation, and referrals for the disabled. Health services that are lacking or difficult to access include:

- Affordable health care – a participant shared that her unemployed husband broke his hand and had to see a doctor; the visit was very expensive
  - Ambulance service – can cost almost \$800 without insurance
- Affordable housing – homeless students and families are living in their cars and are not able to take online classes without Internet access
- Better public transportation
- Computer classes for parents – children need help with homework but parents are not able to help because of lack of knowledge
- Computer/Internet access – library use is limited to one hour
- Employment – jobs are being created for skilled workers; need more jobs in manufacturing and other employment opportunities for people with less skills
- Food support services– families needing supportive resources for food are embarrassed because they have not been in this situation before, do not know how to access information and are reluctant to ask for help

- Health education
  - Re-education for diabetic maintenance, due to changes in medical technology (glucometer)
  - Educational resources about nutrition, exercise
  - Information/referrals for the disabled or potentially disabled
- Homeless shelters – especially for families. Sometimes available shelters are far away from a family’s local community.
- Mental health services – no access for those with insurance coverage, language barrier, lack of access for youth, psychologists provide screening but not care, and other difficulties finding mental health care
  - Not enough mental health resources for uninsured people. Difficult to meet eligibility requirements. Even after qualification, can take long time before start of service. More challenges for adults.
  - Depression treatment and care
- Nurses in clinics and at schools (Reduction in nurses within schools)
- Seamless transition from primary care to behavioral health services/treatment
- Specialty care
  - Neurologist, rheumatologist, pediatrician
  - Vision services – students with vision problems having difficulty seeing in the classroom, affecting academic performance
  - Dental care – can take up to a year to get an appointment. Need dental clinics and preventive dental care for students to reduce cavities and other dental issues. Even when dental screenings and basic services are available, restorative dental care is not available for all ages, including seniors
  - Recuperative centers
- Youth services

### **Healthy behaviors most difficult to promote**

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Participants attributed the inability to promote healthy behaviors in the community to a lack of education around healthy behaviors and access to preventative care. In addition, one participant noted that “it’s easier to buy fast food than to cook for ourselves.” Other behaviors that are among the most difficult to promote include:

- Counseling – cultural biases and stigmas attached to mental health
- Smoking cessation
- Engaging in self-medication and using other people’s medications and prescriptions

One participant suggested that connecting with Parent Teacher Associations (PTA) as a means to develop creative ways to teach healthy alternatives for the usual candy and cookie fundraising campaigns. Hospitals can disassociate with fast food restaurants and instead back healthier alternatives.

## Health care utilization

### Preventive healthcare

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Participants noted a 100% participation rate in preventative healthcare programs within the school district. They believed that people use these services because they are being delivered at a trusted site. However, they further note that preventative care is not a priority if basic needs are not being met. In such cases, people will seek medical care only in the case of an emergency. They also commented that adult men and homeless individuals tend not to seek medical care while Latinos seek a more holistic approach to healthcare. Participants also indicated that people do not obtain preventative healthcare due to fear, lack of time, lack of insurance, lack of money, indifference, and a feeling of discomfort or shame.

### Insurance programs available and/or used by community members

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While there are many different programs available in the community, participants reported that requirements keep changing, are inconsistent, and are difficult to understand. Also, many do not have insurance because this is not a priority.

- “Basic needs (paying the rent, bills) are more important than health needs.”

Focus group participants reported using the following insurance programs to access care:

- Blue Cross
- Health Net
- Healthy Families (though this program keeps changing, is hard to understand)
- Healthy Way LA (though there is a lack of low cost clinics for services)
- LA Care (dual eligibility with MediCare/MediCal though overwhelmed with applications)
- MediCal
- MediCare
- PacifiCare

### Community Resources

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Participants were asked to share information about community resources available in their community.

Participants noted that community members mostly went to community clinics to obtain health care, including:

- Cleaver Family Wellness Center
- East Valley Health Center – free clinic
- El Monte Clinic (where you wait all day)
- El Monte Comprehensive Center
- El Monte/South El Monte Resource Services – free glasses for school children
- El Proyecto del Barrio
- Pomona Health Center

In addition to community clinics, community members also go to the following places or resources for care and/or health information:

- Alternative medicine/herbalist
- Boys and Girls Clubs
- Churches
- Community resource centers – La Puente has notebooks full of health information for residents
- Community-based organizations such as Stepping Stones for Women
- Los Angeles County 211 hotline
- Emergency rooms
- Health fairs – organized by hospitals, community centers, veterans’ groups
- Internet/Google/Facebook (some families lack Internet/phone access, but those that do have access use social media, such as Facebook, quite effectively)
- Local pharmacies
- School clinics
- Schools – PTA/School office
- Senior centers
- Social gatherings including job clubs, veteran networking clubs, student councils, booster groups, college career fairs
- Tijuana, Mexico and China (or other native countries)

## **How hospitals can address the health service needs of this community**

Participants discussed the need for hospitals to build partnerships and relationships within the community. While some participants wanted to see additional preventative health services, others wanted more appropriate and accessible programs (e.g., in multiple languages, culturally relevant, located within the community). Specific suggestions included:

- Create marketing/policy/advocacy effort against fast food and bad nutrition
- Encourage doctors to volunteer in community clinics
- Engage in better discharge planning to improve the long term health of patients and prevent hospital re-admissions; make referrals to agencies for recuperative care; make sure people can afford prescription medications
- Form partnerships with corporations such as Macy’s and offer free services/donations

- Hospitals as conveners – facility/staff can create and facilitate partnerships with community groups as well as connect with established community resources. Get to know community-based agencies and collaborate with them.
- Hospitals and motels could collaborate to provide temporary housing for the homeless
- Make educational classes accessible to non-Kaiser members
- Make specialty services accessible to non-Kaiser members
- More health fairs and screenings within the community for local residents
- Partner with large corporations to contribute to the community. A participant shared a story about a large group of Vietnamese refugees/immigrants who received assistance and jobs. Another participant talked about how the store Sephora, where her daughter works, provides food and clothing donations to St. Vincent de Paul, a charity organization in Los Angeles.
- Promote available health services to the community through flyers/brochures
- Provide diabetes screenings and diabetes education in multiple languages for a broader audience
- Provide e-consultation with Kaiser specialists
- Provide free breast screenings and checkups
- Provide information about health, nutrition and obesity
- Provide nutritional education in Spanish to support the healthy lunch program
- Provide vision screenings and make vision services low-cost and affordable
- Provide vouchers for doctor visits to reduce costs
- Reduce medical service costs and/or educate patients about options for paying less than billed amount

# Appendix G: Data Collection Tools and Instruments

## KP CHNA 2012 Provider Focus Group Protocol

### ***Introduction:***

Thank you for participating in this focus group discussion. We are holding discussion groups as part of a community needs assessment for Kaiser Permanente and their medical centers to help them better understand community needs and identify the type of support Kaiser Permanente can provide to its diverse communities. Therefore, we would like get your ideas about the most important health issues facing your community. In addition, we will talk about what community members need to be healthier as well as the availability of services to meet those needs. Please share your honest opinions and experiences and allow other to express theirs freely. Your responses will not be associated with your name in the report and only to ensure your confidentiality and anonymity. Does anyone have any questions before we get started?

***Note to facilitator:*** Review health data for appropriate service area in order to effectively probe where appropriate.

## GENERAL NEEDS (INCLUDING HEALTH AND SOCIAL NEEDS)

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1. What are some of the **major issues** that impact individuals in your service area?
  - a. Why do you think they're the **most important**?
  - b. What **populations are most affected** by these needs? Why?
  - c. What are the **social issues** that contribute to the health problems? (Such as substance use, unemployment, etc.)
2. What **major trends in needs** (positive and negative) are you seeing in your service area?
  - a. How are today's trends **different** from the major trends **5 years ago**? Are there any differences among **different communities/geographic areas**? What are the differences (if any)? Why?
3. Are there **social or environmental factors** that have contributed to these changes? **Other factors**?
4. What kind of **insurance programs** do community members have available to them?
  - a. How does insurance **impact their ability** to get the health care they need? Is it different for their family members by age?
  - b. If they are **uninsured**, why? [*barriers, etc.*]

## BARRIERS TO ACCESS

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5. What health services are **difficult to access** in your service area? [*For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.*]
  - a. Does this affect certain **communities/geographic areas** more than others? Which? **What factors** contribute to this?
6. What health services are **lacking** in your service area? [*For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.*]
  - a. Does this affect certain **communities/geographic areas** more than others? Which? **What factors** contribute to this?
7. What other **challenges** keep individuals from **seeking help**? [*For example, this could be a lack of awareness of available resources, language barriers, lack of bilingual healthcare providers, immigration status/issues, lack of transportation or childcare, cultural values/beliefs, unsafe neighborhood, working multiple jobs/lack of time, etc.*]
8. Which **healthy behavior is the most difficult to promote** in your service area?
  - a. Why?
  - b. Are there any healthy behaviors that are the hardest to promote for a **particular population**? Which? Why?

- c. Based on your knowledge of this community, what are some **possibilities** for addressing this?

## **ASSETS (HEALTH AND SOCIAL)**

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### **Health services**

- 9. What **health-related services are available** to you in the community?
  - a. **Where** do community members go to receive or obtain information on health services?
  - b. How do you prefer to **receive information** about important health issues or available services? [newspaper, radio, community clinic, flyers, billboards]
  - c. Does **access differ** for certain populations or groups?

### **Social services**

- 10. What **social services (non-medical) are available** to you in the community? (*For example, senior services, food/nutrition, family support, disability, employment, environmental, homeless, etc.*)
  - a. **Where** do community members go to receive or obtain information on social services?
  - b. Does **access differ** for certain populations or groups?
  - c. Which social services are **needed** in your community?
- 11. What are the **strengths and resources** available that have had a positive impact health?
  - a. What **populations are more able to access** these resources because of this?

## **HEALTH CARE UTILIZATION**

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- 12. Are individuals in your service area likely to use **preventative healthcare**?
  - a. **If no**, why?
  - b. **Had this changed** in the last 5 years?
  - c. Do **culture or community norms** influence the health behaviors of community member? How?
- 13. If community members are not feeling well [not an emergency], where do they usually **go for care**? [*Prompt for other providers: alternative health care including curanderos, traditional healers, use of herbs and natural medicines*]
  - a. Where are they **located**? How do you **get there**?
  - b. Do you feel that it's getting easier or harder to **obtain healthcare**? Why?

## **HOSPITALS ROLE**

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- 14. What **role could hospitals** play in addressing the service needs of your service area?

**CVHP CHNA 2012  
Resident Focus Group Protocol**

**Introduction:**

Thank you for participating in this focus group discussion. We are holding discussion groups as part of a community needs assessment for Citrus Valley Health Partners and Kaiser Permanente and their medical centers to help them better understand community needs and identify the type of support they can provide to its diverse communities. Therefore, we would like get your ideas about the most important health issues facing your community. In addition, we will talk about what community members need to be healthier as well as the availability of services to meet those needs. Please share your honest opinions and experiences and allow other to express theirs freely. Your responses will not be associated with your name in the report and only to ensure your confidentiality and anonymity. Does anyone have any questions before we get started?

*Note to facilitator: Review health data for appropriate service area in order to effectively probe where appropriate.*

**GENERAL HEALTH NEEDS (i.e. CHRONIC DISEASE, COMMUNICABLE DISEASES, MENTAL HEALTH, ETC.)**

---

1. What are some of the **major health issues** that affect individuals in your community overall?
  - a. Why do you think they're the **most important**?
  - b. What populations are **most affected** by these needs? Why?
  - c. What are the **social/societal issues** that contribute to the health problems? (**DO NOT SAY ALOUD:** Such as substance use, unemployment, etc.)
2. What **major trends** in health needs (positive and negative) are you seeing in your **community**?
  - d. How are health issues **different** from **5 years ago**? Are there any differences among **different communities/geographic areas**? What are the differences (if any)? Why?
  - e. What **factors** have contributed to these changes?
3. Are there **social or environmental factors** that have contributed to health needs or trends? Which? **Other factors**?
4. Do **you or a family member** have a **chronic health condition** such as asthma, diabetes or heart disease?
  - f. If yes, how do you keep your **condition under control**?
  - g. How helpful is the support you receive from your **health care provider**?
  - h. How helpful is the **information** that you receive?
5. What kind of **insurance programs** do you use for yourself? Your spouse? Your children?
  - i. How does insurance **impact/effect your ability** to get the health care you need? Is it different for your other family members?
  - j. What **other kinds** of insurance programs are you aware of?
  - k. If you are **uninsured**, why?

## BARRIERS TO ACCESS

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6. What health **services are difficult to access** in this community? [**DO NOT SAY ALOUD:** *For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.*]
  - l. Does this affect certain **communities/geographic areas** more than others? Which? What **factors** contribute to this?
7. What health **services are lacking** in this community? [**DO NOT SAY ALOUD:** *For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.*]
  - m. Does this affect certain **communities/geographic areas** more than others? Which? What **factors** contribute to this?
8. What other **challenges** keep individuals from **seeking help/care**? [**DO NOT SAY ALOUD:** *For example, this could be a lack of awareness of available resources, language barriers, lack of bilingual healthcare providers, immigration status/issues, lack of transportation or childcare, cultural values/beliefs, unsafe neighborhood, working multiple jobs/lack of time, etc.*]
9. Which **healthy behavior is the most difficult to encourage** in this community? Why?
  - n. Are there any healthy behaviors that are the hardest to promote for **certain communities/geographic areas**? Which? Why?
  - o. Based on your knowledge of this community, what are some **possibilities** for addressing this?

## COMMUNITY ASSETS (HEALTH AND SOCIAL)

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### Health services

10. What **health-related services are available** to you in the community?
  - p. **Where** do community members go to receive or obtain information on health services?
  - q. How do you prefer to **receive information** about important health issues or available services? [newspaper, radio, community clinic, flyers, billboards]
  - r. Does **access differ** for certain populations or groups?

### Social services

11. What **social services (non-medical) are available** to you in the community? (**DO NOT SAY ALOUD:** *For example, senior services, food/nutrition, family support, disability, employment, environmental, homeless, etc.*)
    - s. **Where** do community members go to receive or obtain information on social services?
    - t. Does **access differ** for certain populations or groups?
    - u. Which social services are **needed** in your community?
-

## **HEALTH CARE UTILIZATION**

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12. What does **preventative/preventive healthcare** mean to you?
- a. What do you do to stay healthy?
  - b. Do culture or community norms influence the health behaviors of community member?  
How?
13. If you are not feeling well [not an emergency], where do you usually **go for care**? [*Prompt for other providers: alternative health care including curanderos, traditional healers, use of herbs and natural medicines*]
- a. Where are they **located**? How do you **get there**?
  - b. Do you feel that it's getting easier or harder to **obtain healthcare**? Why?

## **HOSPITALS ROLE**

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14. What **role could hospitals** play in addressing the health service needs of this community?

**CVHP/KP CHNA 2012  
Resident Focus Group Protocol**

***Introducción:***

Gracias por participar en esta plática. Estamos hablando con varios grupos en el Condado de Los Ángeles como parte de un estudio sobre las necesidades de las comunidades en el condado para mejorar los servicios de Citrus Valley Health Partners and Kaiser Permanente y sus centros médicos locales y para identificar los tipos de apoyo que pueden proveer a las diversas comunidades. Por eso es importante que nos digan cuales son los problemas de salud más grandes en su comunidad para poder identificar áreas de necesidad y los servicios disponibles para servir sus necesidades. Por favor sean honestos y respetuosos de los demás. Esto será completamente confidencial. ¿Tienen preguntas antes

*Note to facilitator: Review health data for appropriate service area in order to effectively probe where appropriate.*

**NECESIDADES DE SALUD GENERALES (COMO ENFERMEDADES CRÓNICAS Y TRANSMISIBLES, SALUD MENTAL, ETC.)**

---

1. ¿Cuáles son algunos de los **temas más grandes de salud afectando** la comunidad?
  - a. ¿Porque piensan que estos temas son **más importantes**?
  - b. ¿Quiénes son **los más afectados** por esto? ¿Por qué?
  - c. ¿Hay **problemas sociales** que contribuyen a estos problemas? *[Pueden ser como abuso de la droga, desempleo, etc.]*
  
2. ¿Cuáles **tendencias de salud** (positiva o negativa) ve en su comunidad?
  - d. ¿Esas tendencias **han cambiado** a comparadas a 5 años atrás? ¿Cómo?
  - e. ¿Que ha **contribuido** a estos cambios?
  
3. ¿Existen **factores sociales o ambientales** que han contribuido a las necesidades de salud o cambios? ¿Cuáles? ¿**Otros factores**?
  
4. ¿**Usted o alguien de su familia** tiene una **condición de salud crónica** como asma, diabetes, o problemas del corazón?
  - f. ¿Si contesto si, **como mantiene su condición** bajo control
  - g. ¿Qué tan útil es el **apoyo que recibe** de su proveedor medico?
  - h. ¿Qué tan útil fue la **información que recibió**?
  
5. ¿Qué **tipo de seguro médico** utilizan para usted y su familia?
  - i. ¿Ha podido **utilizar** el cuidado médico necesario con su seguro médico? ¿Sus familiares?
  - j. ¿Cuáles **otros seguros médicos** conoce?
  - k. ¿**Si no tiene** seguro médico, porque?

## LAS BARRERAS AL ACCESO

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6. ¿Ahí **servicios que son difíciles de utilizar** en la comunidad? *[Por ejemplo, puede ser clínicas comunitarias, proveedores de salud para gente con bajos recursos o sin seguro médico, clases de salud, cuidado dental o de visión, servicios para el abuso de sustancias, servicios de salud mental, ferias de salud gratuitas, recursos para mujeres embarazadas]*
  - a. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?
7. ¿Ahí **servicios que faltan** en la comunidad? *[Por ejemplo, puede ser clínicas comunitarias, proveedores de salud para gente con bajos recursos o sin seguro médico, clases de salud, cuidado dental o de visión, servicios para el abuso de sustancias, servicios de salud mental, ferias de salud gratuitas, recursos para mujeres embarazadas]*
  - b. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?
8. ¿Hay otros problemas o **situaciones que impiden** a la gente buscar ayuda? *[Por ejemplo, falta de conocimiento de recursos disponibles, lenguaje, falta e proveedores bilingües, estereotipo inmigratorio, falta de transportación cuidado de niño, valores o crianzas de cultura, falta de seguridad en la comunidad, falta de tiempo, etc.]*
9. ¿Cuál **comportamiento saludable** es más difícil de promover en la comunidad? ¿Por qué?
  - c. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?
  - d. ¿Cuáles son las mejores formas de tratar de cambiar esto?

## SERVICIOS EXISTENTES (SALUD Y SOCIALES)

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### Servicios de Salud

10. ¿Cuáles **servicios de salud** están disponibles en su comunidad?
  - e. ¿**A dónde van** residentes para obtener información sobre servicios de salud?
  - f. ¿Cómo **prefiere recibir** este tipo de información?
  - g. ¿Hay **diferencias** en acceso para diferentes grupos?

### Servicios Sociales

11. ¿Cuáles **servicios sociales (no de salud)** están disponibles en su comunidad? *[Por ejemplo, servicios para personas mayores, comida/nutrición, apoyo familiar, deshabilitate, empleo, ambiental, vivienda, etc.]*
  - h. ¿**A dónde van** residentes para obtener información sobre servicios de salud?
  - i. ¿Hay **diferencias** en acceso para diferentes grupos?
  - j. ¿Cuáles servicios sociales **faltan** en su comunidad?

## USO DE SERVICIOS DE SALUD

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12. ¿Para usted **que es medicina preventiva**?
  - k. ¿**Qué hace** para mantenerse saludable?
  - l. ¿Hay **algo que afecta** los comportamientos saludables como cultura o costumbres?  
¿Cómo?

13. ¿A dónde van cuando **no se sienten bien**? [*Por ejemplo: curanderos, naturalistas, etc.*]  
m. ¿En **dónde** están localizados? ¿**Cómo llega** a ese lugar?  
n. ¿Siente que se está **facilitando el uso** de servicios médicos? ¿Por qué?

### **PAPEL DE HOSPITALES**

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14. ¿**Qué pueden hacer los hospitales** para corresponder a las necesidades de salud en la comunidad?

**Organization:** \_\_\_\_\_

**CVHP/KP CHNA 2012  
Provider Focus Group Survey**

1. Primary service area: \_\_\_\_\_

2. Primary area of expertise: \_\_\_\_\_

3. Primary service population: \_\_\_\_\_

**This survey is confidential, thank you!**

**Organization:** \_\_\_\_\_

**CVHP/KP CHNA 2012  
Resident Focus Group Survey**

1. What ZIP code do you live in? \_\_\_\_\_
2. How many years have you lived in this ZIP code? \_\_\_\_\_
3. How many children do you have? \_\_\_\_\_
4. What year were you born? \_\_\_\_\_
5. Gender?       Male       Female
6. Ethnicity?  African-American    Hispanic/Latino    Asian/Pacific Islander  
 Caucasian/White    Other \_\_\_\_\_

**This survey is confidential, thank you!**

Organización: \_\_\_\_\_

**CVHP/KP CHNA 2012  
Resident Focus Group Survey**

1. ¿En cuál código postal vive? \_\_\_\_\_
2. ¿Cuántos años ha vivido en este código postal? \_\_\_\_\_
3. ¿Cuántos hijos tiene? \_\_\_\_\_
4. ¿En cuál año nació? \_\_\_\_\_
5. ¿Sexo?  Masculino  Femenino
6. ¿Etnicidad?  Afro-Americano  Hispano/Latino  Asiático  
 Blanco/Americano  Otro \_\_\_\_\_

¡Esta encuesta es confidencial, gracias!

Date:  
Interviewer:  
Interviewee:

CVHP/KP CHNA 2012

## Stakeholder Interview Protocol

### **Introduction:**

The Center for Nonprofit Management is working with Citrus Valley Health Partners and Kaiser Permanente to conduct their 2013 Community Health Needs Assessment. We are talking to health experts to obtain their perspective on the most important health issues facing the local community and to identify areas of need as well as the availability of services to meet those needs. All the information collected will help local medical centers improve and better target their services. The information you provide will not be associated with your name and will only be reported in an aggregated manner.

*For the interviewer: Review health data to help inform appropriate probing where appropriate.*

**Area of expertise:**

**Primary service area:**

**Population served:**

### **GENERAL ISSUES**

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1. What are the **primary issues or challenges** facing your service population? [e.g., health, socio-economic, legal]
  - Have there been any **recent events or developments** that have had an impact or are likely to have an impact on the welfare of the community members you serve? [negative or positive]

### **PRIMARY CONCERNS**

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2. What are the most **significant concerns** among your service population?
  - **Who** do they impact the most?
  - What are the key **drivers** behind the concerns?
  - What **services are available** to address these concerns?
  - Are there any significant **service gaps**?
  - Has there been a significant change in the **availability of services** over the last few years?

### **HEALTH CARE UTILIZATION**

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3. To what extent does your service population **utilize basic health care services** (including preventive care) and **where** do community members **access those services**? What other community **assets are available** to community members?

To what extent do they **utilize dental care** and where do they go?

4. When community members become sick **where do they go to receive care?** (Doctor's office, urgent care, ER, community clinic, etc.)
  - Where do they tend to **obtain information?**
5. Where do **community members go** if they have chronic health issues?
  - Where do they go if they **need specialized care?**
  - Where do they go if they **need mental health care?**

## **BARRIERS TO ACCESS**

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6. What kinds of **challenges** does your service population experience when trying to get the care they need? [e.g., transportation, language barriers, lack of information, no health insurance, economic constraints]
  - Who tends to have the **most difficulty?**
  - How might these **challenges be addressed?**

## **SERVICE PROVISION**

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7. Are there any **growing needs/trends** among your service population? Explain.
  - What **measures** have your organization taken to address this need?
8. What specifically could **hospitals** do to help address these needs?
9. Do you see any potential areas for **collaboration or coordination** among service providers to better meet the needs of your service population? Explain.

## **OUTREACH**

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10. What would be the most effective **way to provide information** to your service population about the availability of health and other services?
  - Is there a **particular message** that would appeal to community members?
11. Is there **anything else** you would like to add?

## Community Health Needs Assessment Prioritization Criteria Scale

### SEVERITY

1 (Not Severe)	2 (Moderately Severe)	3 (Severe)	4 (Very Severe)
The community is slightly impacted and the health need does not generally impact the lives of those affected by it.	The community is slightly impacted and the health need slightly impacts the lives of those affected by it.	The community is greatly impacted but the health need does not generally impact the lives of those affected by it.	The community is severely impacted and the health need significantly impacts the lives of those affected by it.

### CHANGE OVER TIME

1 (Great Improvements)	2 (Moderate Improvements)	3 (No improvements)	4 (Getting worse)
The health need has greatly improved and will likely continue to improve in the future.	The health need has remained the same will either stay the same or improve in the future.	The health need has remained the same but will likely get worse in the future.	The health need has worsened and will likely continue to worsen in the future.

### RESOURCES

1 (Vast Resources)	2 (Moderate Resources)	3 (Gaps in Resources)	4 (Serious Shortages)
There are extensive resources in the community that address this health need and community members are aware of them.	There are moderate resources in the community that address this health need but not many community members are aware of them.	There are few resources in the community to address this health need but there is a potential to leverage existing resources to create interventions.	There are little resources available in the community to address this health need and existing resources are insufficient for interventions.

### COMMUNITY'S READINESS TO SUPPORT

1 (Not Supportive)	2 (Somewhat Supportive)	3 (Supportive)	4 (Extremely Supportive)
Community is not ready to address the issue.	Community is interested in the issue, but unlikely to be able to support efforts.	Community is supportive, but has limited ability to effectively implement programs.	Community is highly supportive and has the ability to effectively implement programs to address this need.

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

The Center for Nonprofit Management is conducting the 2013 Community Health Needs Assessment for the Kaiser Permanente Baldwin Park and Citrus Valley Health Partners Medical Center and we need your help.

In the fall of 2012, we spoke with more than 100 people from the community to obtain their input on important health issues. Through this process we gained valuable insights about the Baldwin Park-Citrus Valley Medical Center service area. After reviewing this input, in conjunction with a wide range of health indicators from public and private data sources, we developed the following list of prominent health needs. The health needs listed below are in alphabetical order, and NOT by order of importance.

We now need your input to help prioritize these identified health needs and determine which represent areas of greatest need. The following confidential survey should take about 15 minutes to complete. When considering your responses, please keep your specific service area and community in mind. If you believe some pertinent issues in your community are not included in the survey, please let us know about these in the final section of the survey.

Please refer to the Community Health Needs Assessment Prioritization Criteria Scale when completing this survey. (In the interest of space, this scale was not included on each page of the survey.)

The results from this survey will inform Kaiser Permanente Baldwin Park-Citrus Valley Medical Center in developing strategies for the next Community Benefits Plan in summer 2013.

Thank you very much for your time and assistance!

Please contact Maura Harrington at [mharrington@cnmsocal.org](mailto:mharrington@cnmsocal.org) with any questions about this survey.

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

Name	<input type="text"/>
Organization	<input type="text"/>
Email	<input type="text"/>

### 2. Please define your service area by selecting from the list below.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Azusa            | <input type="checkbox"/> La Puente       | <input type="checkbox"/> South El Monte     |
| <input type="checkbox"/> Baldwin Park     | <input type="checkbox"/> La Verne        | <input type="checkbox"/> Walnut             |
| <input type="checkbox"/> Covina           | <input type="checkbox"/> Montebello      | <input type="checkbox"/> West Covina        |
| <input type="checkbox"/> Diamond Bar      | <input type="checkbox"/> Rosemead        | <input type="checkbox"/> Monterey Park      |
| <input type="checkbox"/> El Monte         | <input type="checkbox"/> Rowland Heights | <input type="checkbox"/> Los Angeles County |
| <input type="checkbox"/> Glendora         | <input type="checkbox"/> San Dimas       |   |
| <input type="checkbox"/> Hacienda Heights | <input type="checkbox"/> San Gabriel     |   |

## Identified Health Needs

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

Please refer to the Prioritization Criteria Scale when selecting your responses.

### 3. Alcohol and Substance Abuse

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

### 4. Allergies

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

### 5. Alzheimer's Disease

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

### 6. Arthritis

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

# KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

## 7. Asthma

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

## 8. Cancer

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

## 9. Cancer - Cervical Cancer

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

## 10. Cancer - Colon and Rectum Cancer

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

# KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

## 11. Cardiovascular Disease

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

## 12. Chlamydia

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

## 13. Chronic Obstructive Pulmonary Disease (COPD)

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

## 14. Diabetes

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

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

### 15. Disability (i.e. developmental delays, behavioral issues)

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

### 16. HIV/AIDS

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

### 17. Hypertension

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

### 18. Infant Mortality (i.e. low birth weight)

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

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

### 19. Injury - Intentional Injury (i.e. homicide)

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

### 20. Injury - Unintentional Injury (i.e. pedestrians killed by motor vehicles)

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

### 21. Mental Health

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

### 22. Obesity/Overweight

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

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

### 23. Oral Health

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

### 24. Vision

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

## Drivers of Health

Please refer to the Prioritization Criteria Scale when selecting your responses.

### 25. Awareness

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

### 26. Cancer Screenings

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

# KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

## 27. Dental Care Access

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

## 28. Education

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

## 29. Employment

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

## 30. Family and Social Support

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

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

### 31. Health Care Access

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

### 32. Health Insurance

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

### 33. Healthy Eating

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

### 34. Homelessness

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

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

### 35. Income

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

### 36. Language Barrier

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

### 37. Natural Environment (i.e., air and water quality)

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

### 38. Nutrition Access

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

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

### 39. Physical Activity

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

### 40. Preventative Care Services

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

### 41. Safety

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

### 42. Transportation

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

## KP Baldwin Park-Citrus Valley Health Partners - Prioritization Survey

**43. Are there any health needs or drivers you feel have been overlooked that need to be represented?**

**(Please remark on the severity, change over time, resources, and community readiness to support as it relates to this need or driver.)**

Health Need or Driver:

Health Need or Driver:

Thank you for your participation in the 2013 Community Health Needs Assessment.  
(If completing this survey online, please click "Done" to submit your responses.)

# **Appendix H: Tier Results**

The following tables include the list of all identified health needs and drivers. Each health need and driver is presented according to the tier that they fell into during the identification phase, from Tier 1 which was all inclusive to Tier 3 which was the most exclusive. After much discussion between the consultant and the Collaborative, the list in Tier 2 was taken into the prioritization phase. Please note that both tables are presented in alphabetical order and not in any ranking order.

**CVHP Identified Health Issues 2013, by Tier**

	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>
Alcohol and Substance Abuse	X	X	
Allergies	X	X	
Alzheimer's Disease	X	X	
Arthritis	X	X	
Asthma	X	X	X
Brain Cancer	X		
Breast Cancer	X		
Cancer, in General	X	X	
Cardiovascular Disease	X	X	X
Cervical Cancer	X	X	
Cholesterol	X		
Chronic Disease	X		
Chronic Obstructive Pulmonary Disease (COPD)	X	X	
Chronic Pain	X		
Colon Cancer	X	X	
Diabetes	X	X	X
Disability	X	X	
Hepatitis C	X		
Hypertension	X	X	
Infant Mortality	X	X	
Intentional Injury	X	X	
Lung Cancer	X		
Mental Health	X	X	X
Mortality, in General	X		
Obesity/Overweight	X	X	X
Oral Health	X	X	
Overall Health	X		
Pancreatic Cancer	X		
Pneumonia	X		
Prostate Cancer	X		
Respiratory	X		
Sexually Transmitted Diseases	X	X	
Stomach Cancer	X		
Unintentional Injury	X	X	
Vision	X	X	
Allergies	X	X	

**CVHP Identified Drivers 2013, by Tier**

	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>
1. Access - Healthcare	X	X	X
2. Access to Dental Care	X	X	
3. Alcohol and Substance Abuse	X	X	
4. Awareness	X	X	
5. Breastfeeding	X		
6. Cancer Screenings	X	X	
7. Diabetes Management	X		
8. Education	X	X	X
9. Employment	X	X	X
10. Family and Social Support	X	X	
11. Health Insurance	X	X	X
12. Healthy Eating	X	X	
13. HIV Screenings	X		
14. Housing	X	X	
15. Income	X	X	X
16. Language Barrier	X	X	X
17. Natural Environment	X	X	
18. Nutrition Access	X	X	X
19. Physical Activity	X	X	X
20. Pneumonia vaccinations	X		
21. Prenatal Care	X		
22. Preventive Services	X	X	
23. Safety	X	X	
24. Teen Births	X		
25. Transportation	X	X	

Citrus Valley Health Partners

# Service Area Demographics

Appendix Supplement to 2010 Community Health Needs Assessment

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Azusa	9
Baldwin Park	17
Covina	25
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El Monte	41
Glendora	49
Hacienda Heights	57
Irwindale	65
La Puente	73
La Verne	81
Rowland Heights	89
San Dimas	97
South El Monte	105
Valinda	113
Walnut	121
West Covina	129



Area ID: Avocado Heights

Demographic

Place Outlines (Local)



2000 Total Population	15,148
2000 Group Quarters	200
2008 Total Population	16,140
2013 Total Population	16,730
2008-2013 Annual Rate	0.72%



2000 Households	3,758
2000 Average Household Size	3.98
2008 Households	3,886
2008 Average Household Size	4.10
2013 Households	4,001
2013 Average Household Size	4.13
2008-2013 Annual Rate	0.58%
2000 Families	3,275
2000 Average Family Size	4.14
2008 Families	3,390
2008 Average Family Size	4.30
2013 Families	3,482
2013 Average Family Size	4.34
2008-2013 Annual Rate	0.54%



<b>2000 Housing Units</b>	3,839
Owner Occupied Housing Units	74.1%
Renter Occupied Housing Units	23.8%
Vacant Housing Units	2.1%
<b>2008 Housing Units</b>	3,970
Owner Occupied Housing Units	75.2%
Renter Occupied Housing Units	22.7%
Vacant Housing Units	2.1%
<b>2013 Housing Units</b>	4,088
Owner Occupied Housing Units	74.4%
Renter Occupied Housing Units	23.5%
Vacant Housing Units	2.1%

<b>Median Household Income</b>	
2000	\$49,015
2008	\$62,465
2013	\$71,969

<b>Median Home Value</b>	
2000	\$177,489
2008	\$413,884
2013	\$431,303

<b>Per Capita Income</b>	
2000	\$14,574
2008	\$18,189
2013	\$21,129

<b>Median Age</b>	
2000	30.6
2008	30.1
2013	30.6

Data Note: Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Avocado Heights

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	3,789
<15,000	11.5%
\$15,000 - \$24,999	11.1%
\$25,000 - \$34,999	11.2%
\$35,000 - \$49,999	17.0%
\$50,000 - \$74,999	25.2%
\$75,000 - \$99,999	11.0%
\$100,000 - \$149,999	9.2%
\$150,000 - \$199,999	2.1%
\$200,000+	1.7%
Average Household Income	\$57,506

2008 Household by Income

Household Income Base	3,887
<15,000	7.9%
\$15,000 - \$24,999	6.7%
\$25,000 - \$34,999	9.8%
\$35,000 - \$49,999	13.2%
\$50,000 - \$74,999	23.0%
\$75,000 - \$99,999	20.4%
\$100,000 - \$149,999	11.1%
\$150,000 - \$199,999	4.8%
\$200,000+	3.2%
Average Household Income	\$74,714

2013 Household by Income

Household Income Base	4,001
<15,000	6.5%
\$15,000 - \$24,999	5.1%
\$25,000 - \$34,999	7.0%
\$35,000 - \$49,999	10.1%
\$50,000 - \$74,999	23.6%
\$75,000 - \$99,999	18.9%
\$100,000 - \$149,999	18.5%
\$150,000 - \$199,999	4.7%
\$200,000+	5.5%
Average Household Income	\$87,470

2000 Owner Occupied HUs by Value

Total	2,807
<50,000	3.5%
\$50,000 - \$99,999	6.2%
\$100,000 - \$149,999	20.1%
\$150,000 - \$199,999	34.3%
\$200,000 - \$299,999	31.8%
\$300,000 - \$499,999	3.7%
\$500,000 - \$999,999	0.3%
\$1,000,000 +	0.2%
Average Home Value	\$184,730

2000 Specified Renter Occupied HUs by Contract Rent

Total	950
With Cash Rent	96.4%
No Cash Rent	3.6%
Median Rent	\$739
Average Rent	\$734

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Avocado Heights

Demographic

Place Outlines (Local)



2000 Population by Age

Total	15,149
0 - 4	8.1%
5 - 9	9.3%
10 - 14	8.7%
15 - 24	15.5%
25 - 34	15.3%
35 - 44	14.2%
45 - 54	11.8%
55 - 64	8.2%
65 - 74	5.6%
75 - 84	2.6%
85 +	0.7%
18 +	69.3%

2008 Population by Age

Total	16,142
0 - 4	8.4%
5 - 9	8.1%
10 - 14	8.8%
15 - 24	17.0%
25 - 34	15.2%
35 - 44	14.3%
45 - 54	11.9%
55 - 64	8.0%
65 - 74	4.8%
75 - 84	2.7%
85 +	0.9%
18 +	69.2%

2013 Population by Age

Total	16,733
0 - 4	8.7%
5 - 9	8.0%
10 - 14	7.4%
15 - 24	17.4%
25 - 34	14.3%
35 - 44	13.4%
45 - 54	12.4%
55 - 64	9.4%
65 - 74	4.9%
75 - 84	2.9%
85 +	1.1%
18 +	70.8%

2000 Population by Sex

Males	49.9%
Females	50.1%

2008 Population by Sex

Males	50.0%
Females	50.0%

2013 Population by Sex

Males	49.9%
Females	50.1%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	15,149
White Alone	51.8%
Black Alone	1.5%
American Indian Alone	1.2%
Asian or Pacific Islander Alone	9.2%
Some Other Race Alone	32.7%
Two or More Races	3.6%
Hispanic Origin	77.4%
Diversity Index	82.0

2008 Population by Race/Ethnicity

Total	16,141
White Alone	49.5%
Black Alone	1.4%
American Indian Alone	1.0%
Asian or Pacific Islander Alone	8.6%
Some Other Race Alone	35.7%
Two or More Races	3.8%
Hispanic Origin	82.8%
Diversity Index	81.9

2013 Population by Race/Ethnicity

Total	16,730
White Alone	48.6%
Black Alone	1.3%
American Indian Alone	0.9%
Asian or Pacific Islander Alone	8.2%
Some Other Race Alone	37.1%
Two or More Races	3.9%
Hispanic Origin	85.1%
Diversity Index	81.9

2000 Population 3+ by School Enrollment

Total	14,531
Enrolled in Nursery/Preschool	1.8%
Enrolled in Kindergarten	1.7%
Enrolled in Grade 1-8	15.9%
Enrolled in Grade 9-12	7.0%
Enrolled in College	6.2%
Enrolled in Grad/Prof School	0.3%
Not Enrolled in School	67.1%

2008 Population 25+ by Educational Attainment

Total	9,320
Less Than 9th Grade	20.1%
9th to 12th Grade, No Diploma	16.4%
High School Graduate	25.1%
Some College, No Degree	19.7%
Associate Degree	7.3%
Bachelor's Degree	8.3%
Master's/Prof/Doctorate Degree	3.2%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Avocado Heights

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	12,065.0
Married	54.1%
Never Married	35.6%
Widowed	4.6%
Divorced	5.6%



2000 Population 16+ by Employment Status

Total	11,019
In Labor Force	53.2%
Civilian Employed	49.5%
Civilian Unemployed	3.8%
In Armed Forces	0.0%
Not In Labor Force	46.8%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	91.4%
Civilian Unemployed	8.6%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	91.8%
Civilian Unemployed	8.2%

2000 Females 16+ by Employment Status and Age of Children

Total	5,581
Own Children < 6 Only	9.0%
Employed/in Armed Forces	5.2%
Unemployed	0.1%
Not in Labor Force	3.7%
Own Children <6 and 6-17 Only	8.8%
Employed/in Armed Forces	2.0%
Unemployed	0.0%
Not in Labor Force	6.8%
Own Children 6-17 Only	19.7%
Employed/in Armed Forces	9.6%
Unemployed	0.6%
Not in Labor Force	9.5%
No Own Children < 18	62.5%
Employed/in Armed Forces	24.4%
Unemployed	2.2%
Not in Labor Force	35.9%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Avocado Heights

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	5,810
Agriculture/Mining	0.9%
Construction	6.4%
Manufacturing	17.9%
Wholesale Trade	7.9%
Retail Trade	12.8%
Transportation/Utilities	6.3%
Information	2.1%
Finance/Insurance/Real Estate	5.6%
Services	35.2%
Public Administration	4.8%

2008 Employed Population 16+ by Occupation

Total	5,810
White Collar	53.4%
Management/Business/Financial	12.3%
Professional	11.9%
Sales	11.9%
Administrative Support	17.3%
Services	14.2%
Blue Collar	32.4%
Farming/Forestry/Fishing	0.7%
Construction/Extraction	5.6%
Installation/Maintenance/Repair	4.1%
Production	11.2%
Transportation/Material Moving	10.9%



2000 Workers 16+ by Means of Transportation to Work

Total	5,318
Drove Alone - Car, Truck, or Van	70.9%
Carpooled - Car, Truck, or Van	20.6%
Public Transportation	3.3%
Walked	2.0%
Other Means	1.2%
Worked at Home	2.0%

2000 Workers 16+ by Travel Time to Work

Total	5,318
Did not Work at Home	98.0%
Less than 5 minutes	0.6%
5 to 9 minutes	5.1%
10 to 19 minutes	24.2%
20 to 24 minutes	15.3%
25 to 34 minutes	24.8%
35 to 44 minutes	8.7%
45 to 59 minutes	10.2%
60 to 89 minutes	6.6%
90 or more minutes	2.5%
Worked at Home	2.0%
Average Travel Time to Work (in min)	29.4

2000 Households by Vehicles Available

Total	3,757
None	3.9%
1	26.8%
2	39.3%
3	18.3%
4	8.7%
5+	3.0%
Average Number of Vehicles Available	2.1

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Avocado Heights

Demographic

Place Outlines (Local)



2000 Households by Type

Total	3,759
Family Households	87.1%
Married-couple Family	65.9%
With Related Children	41.2%
Other Family (No Spouse)	21.3%
With Related Children	13.0%
Nonfamily Households	12.8%
Householder Living Alone	9.9%
Householder Not Living Alone	3.0%
Households with Related Children	54.2%
Households with Persons 65+	25.7%

2000 Households by Size

Total	3,758
1 Person Household	9.9%
2 Person Household	20.1%
3 Person Household	16.5%
4 Person Household	18.3%
5 Person Household	15.1%
6 Person Household	8.4%
7 + Person Household	11.7%

2000 Households by Year Householder Moved In

Total	3,757
Moved in 1999 to March 2000	10.2%
Moved in 1995 to 1998	24.9%
Moved in 1990 to 1994	18.4%
Moved in 1980 to 1989	20.2%
Moved in 1970 to 1979	15.5%
Moved in 1969 or Earlier	10.8%
Median Year Householder Moved In	1991



2000 Housing Units by Units in Structure

Total	3,832
1, Detached	84.7%
1, Attached	10.9%
2	0.3%
3 or 4	0.5%
5 to 9	0.0%
10 to 19	0.0%
20 +	0.9%
Mobile Home	2.8%
Other	0.0%

2000 Housing Units by Year Structure Built

Total	3,832
1999 to March 2000	0.3%
1995 to 1998	0.9%
1990 to 1994	1.5%
1980 to 1989	6.3%
1970 to 1979	20.3%
1969 or Earlier	70.7%
Median Year Structure Built	1964

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Avocado Heights

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$8,756,732
Average Spent	\$2,253.41
Spending Potential Index	84
Computers & Accessories: Total \$	\$1,070,671
Average Spent	\$275.52
Spending Potential Index	115
Education: Total \$	\$4,702,396
Average Spent	\$1,210.09
Spending Potential Index	88
Entertainment/Recreation: Total \$	\$14,352,195
Average Spent	\$3,693.31
Spending Potential Index	99
Food at Home: Total \$	\$18,544,557
Average Spent	\$4,772.15
Spending Potential Index	98
Food Away from Home: Total \$	\$12,547,806
Average Spent	\$3,228.98
Spending Potential Index	94
Health Care: Total \$	\$13,708,605
Average Spent	\$3,527.69
Spending Potential Index	86
HH Furnishings & Equip: Total \$	\$9,630,431
Average Spent	\$2,478.24
Spending Potential Index	108
Investments: Total \$	\$3,798,025
Average Spent	\$977.36
Spending Potential Index	96
Retail Goods: Total \$	\$106,509,618
Average Spent	\$27,408.55
Spending Potential Index	101
Shelter: Total \$	\$69,660,790
Average Spent	\$17,926.09
Spending Potential Index	115
TV/Video/Sound Equipment: Total \$	\$5,414,854
Average Spent	\$1,393.43
Spending Potential Index	97
Travel: Total \$	\$8,391,210
Average Spent	\$2,159.34
Spending Potential Index	115
Vehicle Maintenance & Repairs: Total \$	\$4,240,602
Average Spent	\$1,091.25
Spending Potential Index	110

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Azusa

**Demographic**

**Market Profile**

**Place Outlines (Local)**

**Place Outlines (Local)**



2000 Total Population	44,712
2000 Group Quarters	1,536
2008 Total Population	48,115
2013 Total Population	52,636
2008-2013 Annual Rate	1.81%



2000 Households	12,549
2000 Average Household Size	3.44
2008 Households	13,122
2008 Average Household Size	3.55
2013 Households	14,377
2013 Average Household Size	3.55
2008-2013 Annual Rate	1.84%
2000 Families	9,540
2000 Average Family Size	3.87
2008 Families	9,969
2008 Average Family Size	4.04
2013 Families	10,778
2013 Average Family Size	4.09
2008-2013 Annual Rate	1.57%



<b>2000 Housing Units</b>	13,013
Owner Occupied Housing Units	52.4%
Renter Occupied Housing Units	44.5%
Vacant Housing Units	3.1%

<b>2008 Housing Units</b>	13,617
Owner Occupied Housing Units	54.8%
Renter Occupied Housing Units	41.6%
Vacant Housing Units	3.6%

<b>2013 Housing Units</b>	14,951
Owner Occupied Housing Units	53.0%
Renter Occupied Housing Units	43.2%
Vacant Housing Units	3.8%

<b>Median Household Income</b>	
2000	\$40,951
2008	\$52,808
2013	\$62,703

<b>Median Home Value</b>	
2000	\$144,186
2008	\$348,376
2013	\$364,136

<b>Per Capita Income</b>	
2000	\$13,866
2008	\$17,457
2013	\$20,658

<b>Median Age</b>	
2000	27.5
2008	28.0
2013	28.5

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Azusa

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	12,460
<15,000	14.6%
\$15,000 - \$24,999	13.1%
\$25,000 - \$34,999	13.8%
\$35,000 - \$49,999	18.1%
\$50,000 - \$74,999	22.4%
\$75,000 - \$99,999	9.0%
\$100,000 - \$149,999	7.3%
\$150,000 - \$199,999	1.3%
\$200,000+	0.5%
Average Household Income	\$49,235

2008 Household by Income

Household Income Base	13,121
<15,000	10.2%
\$15,000 - \$24,999	9.6%
\$25,000 - \$34,999	10.9%
\$35,000 - \$49,999	16.7%
\$50,000 - \$74,999	21.9%
\$75,000 - \$99,999	17.5%
\$100,000 - \$149,999	9.3%
\$150,000 - \$199,999	2.5%
\$200,000+	1.3%
Average Household Income	\$62,637

2013 Household by Income

Household Income Base	14,379
<15,000	8.7%
\$15,000 - \$24,999	8.1%
\$25,000 - \$34,999	8.3%
\$35,000 - \$49,999	11.9%
\$50,000 - \$74,999	23.1%
\$75,000 - \$99,999	17.1%
\$100,000 - \$149,999	16.3%
\$150,000 - \$199,999	3.8%
\$200,000+	2.6%
Average Household Income	\$74,025

2000 Owner Occupied HUs by Value

Total	6,750
<50,000	5.9%
\$50,000 - \$99,999	10.9%
\$100,000 - \$149,999	40.1%
\$150,000 - \$199,999	27.6%
\$200,000 - \$299,999	12.8%
\$300,000 - \$499,999	1.8%
\$500,000 - \$999,999	0.7%
\$1,000,000 +	0.1%
Average Home Value	\$153,313

2000 Specified Renter Occupied HUs by Contract Rent

Total	5,768
With Cash Rent	97.6%
No Cash Rent	2.4%
Median Rent	\$663
Average Rent	\$659

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Azusa

Demographic

Place Outlines (Local)



**2000 Population by Age**

Total	44,710
0 - 4	9.2%
5 - 9	9.5%
10 - 14	8.1%
15 - 24	18.9%
25 - 34	17.1%
35 - 44	14.5%
45 - 54	9.7%
55 - 64	6.0%
65 - 74	4.1%
75 - 84	2.3%
85 +	0.7%
18 +	68.6%

**2008 Population by Age**

Total	48,114
0 - 4	9.4%
5 - 9	8.5%
10 - 14	8.3%
15 - 24	18.7%
25 - 34	16.2%
35 - 44	14.2%
45 - 54	10.9%
55 - 64	7.0%
65 - 74	3.7%
75 - 84	2.2%
85 +	0.8%
18 +	68.8%

**2013 Population by Age**

Total	52,637
0 - 4	9.5%
5 - 9	8.4%
10 - 14	7.4%
15 - 24	19.0%
25 - 34	15.4%
35 - 44	13.4%
45 - 54	11.6%
55 - 64	8.2%
65 - 74	4.0%
75 - 84	2.2%
85 +	0.9%
18 +	70.1%

**2000 Population by Sex**

Males	49.4%
Females	50.6%

**2008 Population by Sex**

Males	49.5%
Females	50.5%

**2013 Population by Sex**

Males	49.6%
Females	50.4%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Azusa

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	44,712
White Alone	52.5%
Black Alone	3.4%
American Indian Alone	1.4%
Asian or Pacific Islander Alone	5.7%
Some Other Race Alone	31.4%
Two or More Races	5.6%
Hispanic Origin	65.3%
Diversity Index	84.7

2008 Population by Race/Ethnicity

Total	48,114
White Alone	48.2%
Black Alone	3.0%
American Indian Alone	1.2%
Asian or Pacific Islander Alone	6.0%
Some Other Race Alone	35.4%
Two or More Races	6.2%
Hispanic Origin	72.6%
Diversity Index	85.7

2013 Population by Race/Ethnicity

Total	52,635
White Alone	46.6%
Black Alone	2.7%
American Indian Alone	1.1%
Asian or Pacific Islander Alone	6.3%
Some Other Race Alone	36.7%
Two or More Races	6.7%
Hispanic Origin	75.2%
Diversity Index	86.1

2000 Population 3+ by School Enrollment

Total	42,109
Enrolled in Nursery/Preschool	1.3%
Enrolled in Kindergarten	2.2%
Enrolled in Grade 1-8	14.7%
Enrolled in Grade 9-12	7.7%
Enrolled in College	9.6%
Enrolled in Grad/Prof School	1.1%
Not Enrolled in School	63.3%

2008 Population 25+ by Educational Attainment

Total	26,522
Less Than 9th Grade	19.3%
9th to 12th Grade, No Diploma	14.0%
High School Graduate	23.2%
Some College, No Degree	20.1%
Associate Degree	6.4%
Bachelor's Degree	11.9%
Master's/Prof/Doctorate Degree	5.1%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Azusa

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	35,498.0
Married	47.8%
Never Married	39.7%
Widowed	4.4%
Divorced	8.1%



2000 Population 16+ by Employment Status

Total	32,065
In Labor Force	61.2%
Civilian Employed	55.9%
Civilian Unemployed	5.2%
In Armed Forces	0.0%
Not In Labor Force	38.8%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	90.1%
Civilian Unemployed	9.9%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	90.6%
Civilian Unemployed	9.4%

2000 Females 16+ by Employment Status and Age of Children

Total	16,483
Own Children < 6 Only	8.5%
Employed/in Armed Forces	4.4%
Unemployed	0.3%
Not in Labor Force	3.8%
Own Children <6 and 6-17 Only	9.7%
Employed/in Armed Forces	4.6%
Unemployed	0.5%
Not in Labor Force	4.7%
Own Children 6-17 Only	16.2%
Employed/in Armed Forces	9.6%
Unemployed	0.9%
Not in Labor Force	5.7%
No Own Children < 18	65.6%
Employed/in Armed Forces	30.5%
Unemployed	3.3%
Not in Labor Force	31.9%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Azusa  
Demographic

Place Outlines (Local)



**2008 Employed Population 16+ by Industry**

Total	19,355
Agriculture/Mining	0.6%
Construction	9.0%
Manufacturing	14.4%
Wholesale Trade	4.7%
Retail Trade	11.6%
Transportation/Utilities	3.8%
Information	1.7%
Finance/Insurance/Real Estate	5.2%
Services	45.8%
Public Administration	3.2%

**2008 Employed Population 16+ by Occupation**

Total	19,357
White Collar	52.4%
Management/Business/Financial	9.9%
Professional	15.8%
Sales	10.8%
Administrative Support	15.9%
Services	19.0%
Blue Collar	28.6%
Farming/Forestry/Fishing	0.4%
Construction/Extraction	7.5%
Installation/Maintenance/Repair	3.8%
Production	9.6%
Transportation/Material Moving	7.3%



**2000 Workers 16+ by Means of Transportation to Work**

Total	17,564
Drove Alone - Car, Truck, or Van	65.9%
Carpooled - Car, Truck, or Van	19.4%
Public Transportation	3.8%
Walked	5.5%
Other Means	3.5%
Worked at Home	1.9%

**2000 Workers 16+ by Travel Time to Work**

Total	17,567
Did not Work at Home	98.1%
Less than 5 minutes	2.3%
5 to 9 minutes	11.1%
10 to 19 minutes	26.6%
20 to 24 minutes	12.9%
25 to 34 minutes	20.7%
35 to 44 minutes	6.4%
45 to 59 minutes	8.8%
60 to 89 minutes	6.8%
90 or more minutes	2.5%
Worked at Home	1.9%
Average Travel Time to Work (in min)	27.0

**2000 Households by Vehicles Available**

Total	12,527
None	10.8%
1	34.6%
2	34.4%
3	14.6%
4	3.8%
5+	1.8%
Average Number of Vehicles Available	1.7

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Azusa

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Households by Type

Total	12,549
Family Households	76.0%
Married-couple Family	51.8%
With Related Children	34.2%
Other Family (No Spouse)	24.2%
With Related Children	16.2%
Nonfamily Households	24.0%
Householder Living Alone	17.5%
Householder Not Living Alone	6.5%
Households with Related Children	50.4%
Households with Persons 65+	19.4%

2000 Households by Size

Total	12,549
1 Person Household	17.5%
2 Person Household	22.3%
3 Person Household	16.1%
4 Person Household	16.5%
5 Person Household	11.7%
6 Person Household	7.1%
7 + Person Household	8.9%

2000 Households by Year Householder Moved In

Total	12,527
Moved in 1999 to March 2000	21.5%
Moved in 1995 to 1998	32.1%
Moved in 1990 to 1994	16.5%
Moved in 1980 to 1989	12.2%
Moved in 1970 to 1979	8.5%
Moved in 1969 or Earlier	9.1%
Median Year Householder Moved In	1995



2000 Housing Units by Units in Structure

Total	12,993
1, Detached	50.4%
1, Attached	13.5%
2	1.6%
3 or 4	9.0%
5 to 9	4.0%
10 to 19	4.4%
20 +	14.1%
Mobile Home	3.0%
Other	0.2%

2000 Housing Units by Year Structure Built

Total	12,993
1999 to March 2000	0.9%
1995 to 1998	3.4%
1990 to 1994	3.7%
1980 to 1989	15.3%
1970 to 1979	19.6%
1969 or Earlier	57.2%
Median Year Structure Built	1966

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Azusa

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$25,965,354
Average Spent	\$1,978.76
Spending Potential Index	74
Computers & Accessories: Total \$	\$2,977,897
Average Spent	\$226.94
Spending Potential Index	95
Education: Total \$	\$14,271,781
Average Spent	\$1,087.62
Spending Potential Index	79
Entertainment/Recreation: Total \$	\$40,078,253
Average Spent	\$3,054.28
Spending Potential Index	82
Food at Home: Total \$	\$55,005,363
Average Spent	\$4,191.84
Spending Potential Index	86
Food Away from Home: Total \$	\$37,239,614
Average Spent	\$2,837.95
Spending Potential Index	83
Health Care: Total \$	\$39,045,579
Average Spent	\$2,975.58
Spending Potential Index	73
HH Furnishings & Equip: Total \$	\$25,784,937
Average Spent	\$1,965.02
Spending Potential Index	85
Investments: Total \$	\$10,153,288
Average Spent	\$773.76
Spending Potential Index	76
Retail Goods: Total \$	\$298,259,634
Average Spent	\$22,729.74
Spending Potential Index	84
Shelter: Total \$	\$194,657,845
Average Spent	\$14,834.46
Spending Potential Index	96
TV/Video/Sound Equipment: Total \$	\$15,750,008
Average Spent	\$1,200.27
Spending Potential Index	84
Travel: Total \$	\$22,182,331
Average Spent	\$1,690.47
Spending Potential Index	90
Vehicle Maintenance & Repairs: Total \$	\$11,756,587
Average Spent	\$895.94
Spending Potential Index	90

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Baldwin Park

Demographic

Place Outlines (Local)



2000 Total Population	75,837
2000 Group Quarters	606
2008 Total Population	79,279
2013 Total Population	81,565
2008-2013 Annual Rate	0.57%



2000 Households	16,961
2000 Average Household Size	4.44
2008 Households	17,381
2008 Average Household Size	4.53
2013 Households	17,809
2013 Average Household Size	4.55
2008-2013 Annual Rate	0.49%
2000 Families	15,069
2000 Average Family Size	4.53
2008 Families	15,439
2008 Average Family Size	4.65
2013 Families	15,790
2013 Average Family Size	4.69
2008-2013 Annual Rate	0.45%



<b>2000 Housing Units</b>	17,430
Owner Occupied Housing Units	60.0%
Renter Occupied Housing Units	37.3%
Vacant Housing Units	2.7%

<b>2008 Housing Units</b>	17,872
Owner Occupied Housing Units	61.8%
Renter Occupied Housing Units	35.5%
Vacant Housing Units	2.7%

<b>2013 Housing Units</b>	18,308
Owner Occupied Housing Units	60.2%
Renter Occupied Housing Units	37.1%
Vacant Housing Units	2.7%

<b>Median Household Income</b>	
2000	\$41,952
2008	\$53,293
2013	\$62,404

<b>Median Home Value</b>	
2000	\$144,280
2008	\$345,142
2013	\$359,619

<b>Per Capita Income</b>	
2000	\$11,615
2008	\$14,217
2013	\$16,366

<b>Median Age</b>	
2000	27.0
2008	27.1
2013	27.5

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Baldwin Park

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	16,926
<15,000	13.6%
\$15,000 - \$24,999	12.6%
\$25,000 - \$34,999	14.6%
\$35,000 - \$49,999	19.1%
\$50,000 - \$74,999	21.5%
\$75,000 - \$99,999	10.5%
\$100,000 - \$149,999	6.2%
\$150,000 - \$199,999	0.9%
\$200,000+	1.1%
Average Household Income	\$51,531

2008 Household by Income

Household Income Base	17,380
<15,000	9.2%
\$15,000 - \$24,999	9.3%
\$25,000 - \$34,999	11.4%
\$35,000 - \$49,999	16.2%
\$50,000 - \$74,999	24.7%
\$75,000 - \$99,999	16.2%
\$100,000 - \$149,999	8.9%
\$150,000 - \$199,999	2.5%
\$200,000+	1.6%
Average Household Income	\$64,216

2013 Household by Income

Household Income Base	17,811
<15,000	7.7%
\$15,000 - \$24,999	7.7%
\$25,000 - \$34,999	8.4%
\$35,000 - \$49,999	13.2%
\$50,000 - \$74,999	25.7%
\$75,000 - \$99,999	17.4%
\$100,000 - \$149,999	14.1%
\$150,000 - \$199,999	3.1%
\$200,000+	2.8%
Average Household Income	\$74,250

2000 Owner Occupied HUs by Value

Total	10,404
<50,000	4.9%
\$50,000 - \$99,999	9.1%
\$100,000 - \$149,999	43.3%
\$150,000 - \$199,999	37.3%
\$200,000 - \$299,999	4.4%
\$300,000 - \$499,999	0.5%
\$500,000 - \$999,999	0.3%
\$1,000,000 +	0.2%
Average Home Value	\$145,048

2000 Specified Renter Occupied HUs by Contract Rent

Total	6,494
With Cash Rent	98.2%
No Cash Rent	1.8%
Median Rent	\$662
Average Rent	\$642

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Baldwin Park

Demographic

Place Outlines (Local)



2000 Population by Age

Total	75,837
0 - 4	9.6%
5 - 9	10.5%
10 - 14	9.5%
15 - 24	17.1%
25 - 34	16.3%
35 - 44	14.2%
45 - 54	10.6%
55 - 64	5.9%
65 - 74	3.7%
75 - 84	2.0%
85 +	0.6%
18 +	65.1%

2008 Population by Age

Total	79,279
0 - 4	9.9%
5 - 9	9.1%
10 - 14	9.2%
15 - 24	18.1%
25 - 34	16.3%
35 - 44	13.8%
45 - 54	11.0%
55 - 64	6.8%
65 - 74	3.3%
75 - 84	1.8%
85 +	0.7%
18 +	66.0%

2013 Population by Age

Total	81,565
0 - 4	10.1%
5 - 9	9.2%
10 - 14	8.0%
15 - 24	18.4%
25 - 34	15.7%
35 - 44	12.9%
45 - 54	11.3%
55 - 64	8.2%
65 - 74	3.7%
75 - 84	1.8%
85 +	0.8%
18 +	67.6%

2000 Population by Sex

Males	50.0%
Females	50.0%

2008 Population by Sex

Males	50.2%
Females	49.8%

2013 Population by Sex

Males	50.2%
Females	49.8%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	75,837
White Alone	40.2%
Black Alone	1.6%
American Indian Alone	1.5%
Asian or Pacific Islander Alone	11.8%
Some Other Race Alone	40.5%
Two or More Races	4.5%
Hispanic Origin	78.6%
Diversity Index	88.4

2008 Population by Race/Ethnicity

Total	79,278
White Alone	38.7%
Black Alone	1.3%
American Indian Alone	1.2%
Asian or Pacific Islander Alone	11.0%
Some Other Race Alone	43.2%
Two or More Races	4.6%
Hispanic Origin	82.7%
Diversity Index	88.4

2013 Population by Race/Ethnicity

Total	81,565
White Alone	38.1%
Black Alone	1.1%
American Indian Alone	1.1%
Asian or Pacific Islander Alone	10.5%
Some Other Race Alone	44.4%
Two or More Races	4.7%
Hispanic Origin	84.5%
Diversity Index	88.5

2000 Population 3+ by School Enrollment

Total	71,562
Enrolled in Nursery/Preschool	1.4%
Enrolled in Kindergarten	2.3%
Enrolled in Grade 1-8	17.6%
Enrolled in Grade 9-12	9.0%
Enrolled in College	5.2%
Enrolled in Grad/Prof School	0.6%
Not Enrolled in School	63.9%

2008 Population 25+ by Educational Attainment

Total	42,463
Less Than 9th Grade	27.5%
9th to 12th Grade, No Diploma	18.4%
High School Graduate	25.1%
Some College, No Degree	13.8%
Associate Degree	3.9%
Bachelor's Degree	9.2%
Master's/Prof/Doctorate Degree	2.0%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Baldwin Park

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	56,835.0
Married	52.5%
Never Married	37.6%
Widowed	4.2%
Divorced	5.6%



2000 Population 16+ by Employment Status

Total	51,994
In Labor Force	55.8%
Civilian Employed	50.3%
Civilian Unemployed	5.5%
In Armed Forces	0.0%
Not In Labor Force	44.2%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	88.2%
Civilian Unemployed	11.8%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	88.8%
Civilian Unemployed	11.2%

2000 Females 16+ by Employment Status and Age of Children

Total	26,347
Own Children < 6 Only	8.5%
Employed/in Armed Forces	4.0%
Unemployed	0.5%
Not in Labor Force	4.0%
Own Children <6 and 6-17 Only	11.2%
Employed/in Armed Forces	4.8%
Unemployed	0.6%
Not in Labor Force	5.8%
Own Children 6-17 Only	19.8%
Employed/in Armed Forces	9.9%
Unemployed	1.0%
Not in Labor Force	9.0%
No Own Children < 18	60.5%
Employed/in Armed Forces	23.0%
Unemployed	3.0%
Not in Labor Force	34.5%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Baldwin Park

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	27,764
Agriculture/Mining	0.3%
Construction	7.7%
Manufacturing	18.1%
Wholesale Trade	5.6%
Retail Trade	10.9%
Transportation/Utilities	5.9%
Information	1.9%
Finance/Insurance/Real Estate	5.6%
Services	41.7%
Public Administration	2.3%

2008 Employed Population 16+ by Occupation

Total	27,765
White Collar	43.5%
Management/Business/Financial	6.9%
Professional	9.8%
Sales	10.7%
Administrative Support	16.1%
Services	20.2%
Blue Collar	36.3%
Farming/Forestry/Fishing	0.2%
Construction/Extraction	7.0%
Installation/Maintenance/Repair	4.6%
Production	13.7%
Transportation/Material Moving	10.8%



2000 Workers 16+ by Means of Transportation to Work

Total	25,238
Drove Alone - Car, Truck, or Van	65.7%
Carpooled - Car, Truck, or Van	23.7%
Public Transportation	4.9%
Walked	1.8%
Other Means	2.0%
Worked at Home	1.9%

2000 Workers 16+ by Travel Time to Work

Total	25,238
Did not Work at Home	98.1%
Less than 5 minutes	1.3%
5 to 9 minutes	6.2%
10 to 19 minutes	25.6%
20 to 24 minutes	14.4%
25 to 34 minutes	21.7%
35 to 44 minutes	7.6%
45 to 59 minutes	10.7%
60 to 89 minutes	7.3%
90 or more minutes	3.3%
Worked at Home	1.9%
Average Travel Time to Work (in min)	30.4

2000 Households by Vehicles Available

Total	16,924
None	7.9%
1	27.6%
2	35.2%
3	17.8%
4	8.1%
5+	3.4%
Average Number of Vehicles Available	2.0

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Households by Type

Total	16,960
Family Households	88.9%
Married-couple Family	62.9%
With Related Children	46.4%
Other Family (No Spouse)	26.0%
With Related Children	18.0%
Nonfamily Households	11.2%
Householder Living Alone	8.1%
Householder Not Living Alone	3.0%
Households with Related Children	64.5%
Households with Persons 65+	20.7%

2000 Households by Size

Total	16,961
1 Person Household	8.1%
2 Person Household	13.6%
3 Person Household	15.6%
4 Person Household	19.0%
5 Person Household	16.7%
6 Person Household	10.9%
7 + Person Household	16.1%

2000 Households by Year Householder Moved In

Total	16,922
Moved in 1999 to March 2000	16.5%
Moved in 1995 to 1998	30.0%
Moved in 1990 to 1994	18.0%
Moved in 1980 to 1989	18.1%
Moved in 1970 to 1979	9.8%
Moved in 1969 or Earlier	7.6%
Median Year Householder Moved In	1994



2000 Housing Units by Units in Structure

Total	17,392
1, Detached	68.2%
1, Attached	10.8%
2	0.8%
3 or 4	2.6%
5 to 9	3.6%
10 to 19	3.5%
20 +	8.5%
Mobile Home	1.9%
Other	0.0%

2000 Housing Units by Year Structure Built

Total	17,393
1999 to March 2000	0.8%
1995 to 1998	1.1%
1990 to 1994	4.4%
1980 to 1989	16.3%
1970 to 1979	15.1%
1969 or Earlier	62.3%
Median Year Structure Built	1964

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$35,044,355
Average Spent	\$2,016.25
Spending Potential Index	75
Computers & Accessories: Total \$	\$4,109,771
Average Spent	\$236.45
Spending Potential Index	99
Education: Total \$	\$18,162,435
Average Spent	\$1,044.96
Spending Potential Index	76
Entertainment/Recreation: Total \$	\$54,095,700
Average Spent	\$3,112.35
Spending Potential Index	84
Food at Home: Total \$	\$74,673,721
Average Spent	\$4,296.28
Spending Potential Index	88
Food Away from Home: Total \$	\$49,458,762
Average Spent	\$2,845.56
Spending Potential Index	83
Health Care: Total \$	\$51,504,655
Average Spent	\$2,963.27
Spending Potential Index	72
HH Furnishings & Equip: Total \$	\$35,961,520
Average Spent	\$2,069.01
Spending Potential Index	90
Investments: Total \$	\$13,080,669
Average Spent	\$752.58
Spending Potential Index	74
Retail Goods: Total \$	\$409,339,139
Average Spent	\$23,550.95
Spending Potential Index	87
Shelter: Total \$	\$269,755,490
Average Spent	\$15,520.14
Spending Potential Index	100
TV/Video/Sound Equipment: Total \$	\$21,092,108
Average Spent	\$1,213.52
Spending Potential Index	84
Travel: Total \$	\$30,617,641
Average Spent	\$1,761.56
Spending Potential Index	93
Vehicle Maintenance & Repairs: Total \$	\$16,322,911
Average Spent	\$939.12
Spending Potential Index	95

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Covina

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	46,837
2000 Group Quarters	598
2008 Total Population	50,308
2013 Total Population	52,270
2008-2013 Annual Rate	0.77%



2000 Households	15,971
2000 Average Household Size	2.90
2008 Households	16,629
2008 Average Household Size	2.99
2013 Households	17,156
2013 Average Household Size	3.01
2008-2013 Annual Rate	0.63%
2000 Families	11,737
2000 Average Family Size	3.36
2008 Families	12,218
2008 Average Family Size	3.50
2013 Families	12,552
2013 Average Family Size	3.55
2008-2013 Annual Rate	0.54%



<b>2000 Housing Units</b>	16,364
Owner Occupied Housing Units	56.8%
Renter Occupied Housing Units	40.9%
Vacant Housing Units	2.4%

<b>2008 Housing Units</b>	17,059
Owner Occupied Housing Units	58.3%
Renter Occupied Housing Units	39.2%
Vacant Housing Units	2.5%

<b>2013 Housing Units</b>	17,604
Owner Occupied Housing Units	56.9%
Renter Occupied Housing Units	40.6%
Vacant Housing Units	2.5%

<b>Median Household Income</b>	
2000	\$48,120
2008	\$61,594
2013	\$70,707

<b>Median Home Value</b>	
2000	\$184,709
2008	\$451,491
2013	\$472,313

<b>Per Capita Income</b>	
2000	\$20,071
2008	\$24,396
2013	\$28,316

<b>Median Age</b>	
2000	33.3
2008	33.5
2013	34.2

Data Note: Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



**2000 Household by Income**

Household Income Base	15,904
<15,000	13.2%
\$15,000 - \$24,999	10.3%
\$25,000 - \$34,999	12.1%
\$35,000 - \$49,999	16.1%
\$50,000 - \$74,999	22.3%
\$75,000 - \$99,999	12.8%
\$100,000 - \$149,999	10.0%
\$150,000 - \$199,999	2.1%
\$200,000+	1.2%
Average Household Income	\$58,492

**2008 Household by Income**

Household Income Base	16,627
<15,000	9.1%
\$15,000 - \$24,999	8.0%
\$25,000 - \$34,999	8.4%
\$35,000 - \$49,999	15.0%
\$50,000 - \$74,999	20.8%
\$75,000 - \$99,999	18.8%
\$100,000 - \$149,999	13.7%
\$150,000 - \$199,999	3.8%
\$200,000+	2.5%
Average Household Income	\$73,611

**2013 Household by Income**

Household Income Base	17,159
<15,000	7.7%
\$15,000 - \$24,999	6.6%
\$25,000 - \$34,999	6.3%
\$35,000 - \$49,999	10.2%
\$50,000 - \$74,999	22.3%
\$75,000 - \$99,999	16.4%
\$100,000 - \$149,999	20.5%
\$150,000 - \$199,999	5.6%
\$200,000+	4.3%
Average Household Income	\$86,084

**2000 Owner Occupied HUs by Value**

Total	9,319
<50,000	6.7%
\$50,000 - \$99,999	1.8%
\$100,000 - \$149,999	13.2%
\$150,000 - \$199,999	43.1%
\$200,000 - \$299,999	28.0%
\$300,000 - \$499,999	6.0%
\$500,000 - \$999,999	0.8%
\$1,000,000 +	0.3%
Average Home Value	\$194,215

**2000 Specified Renter Occupied HUs by Contract Rent**

Total	6,653
With Cash Rent	97.4%
No Cash Rent	2.6%
Median Rent	\$680
Average Rent	\$694

**Data Note:** Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Covina

Demographic

Place Outlines (Local)



2000 Population by Age

Total	46,836
0 - 4	7.5%
5 - 9	8.3%
10 - 14	7.9%
15 - 24	14.2%
25 - 34	14.7%
35 - 44	16.5%
45 - 54	12.5%
55 - 64	7.7%
65 - 74	5.9%
75 - 84	3.7%
85 +	1.1%
18 +	71.9%

2008 Population by Age

Total	50,306
0 - 4	7.6%
5 - 9	7.1%
10 - 14	7.8%
15 - 24	15.3%
25 - 34	14.4%
35 - 44	14.4%
45 - 54	13.9%
55 - 64	9.3%
65 - 74	5.0%
75 - 84	3.8%
85 +	1.5%
18 +	72.6%

2013 Population by Age

Total	52,271
0 - 4	7.7%
5 - 9	6.9%
10 - 14	6.6%
15 - 24	15.3%
25 - 34	14.6%
35 - 44	13.1%
45 - 54	14.1%
55 - 64	10.9%
65 - 74	5.5%
75 - 84	3.5%
85 +	1.7%
18 +	74.4%

2000 Population by Sex

Males	48.0%
Females	52.0%

2008 Population by Sex

Males	48.0%
Females	52.0%

2013 Population by Sex

Males	48.3%
Females	51.7%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Covina

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	46,837
White Alone	62.2%
Black Alone	4.9%
American Indian Alone	1.0%
Asian or Pacific Islander Alone	9.8%
Some Other Race Alone	17.3%
Two or More Races	4.8%
Hispanic Origin	40.7%
Diversity Index	79.4

2008 Population by Race/Ethnicity

Total	50,308
White Alone	56.0%
Black Alone	4.5%
American Indian Alone	0.9%
Asian or Pacific Islander Alone	10.7%
Some Other Race Alone	22.0%
Two or More Races	5.8%
Hispanic Origin	51.2%
Diversity Index	83.7

2013 Population by Race/Ethnicity

Total	52,269
White Alone	52.8%
Black Alone	4.2%
American Indian Alone	0.9%
Asian or Pacific Islander Alone	11.1%
Some Other Race Alone	24.6%
Two or More Races	6.4%
Hispanic Origin	56.7%
Diversity Index	85.1

2000 Population 3+ by School Enrollment

Total	44,682
Enrolled in Nursery/Preschool	1.8%
Enrolled in Kindergarten	1.8%
Enrolled in Grade 1-8	13.9%
Enrolled in Grade 9-12	6.5%
Enrolled in College	7.6%
Enrolled in Grad/Prof School	1.0%
Not Enrolled in School	67.4%

2008 Population 25+ by Educational Attainment

Total	31,323
Less Than 9th Grade	4.9%
9th to 12th Grade, No Diploma	10.4%
High School Graduate	29.6%
Some College, No Degree	25.4%
Associate Degree	8.7%
Bachelor's Degree	14.9%
Master's/Prof/Doctorate Degree	6.1%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Covina

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	39,001.0
Married	51.4%
Never Married	32.0%
Widowed	5.8%
Divorced	10.8%



2000 Population 16+ by Employment Status

Total	35,014
In Labor Force	64.4%
Civilian Employed	60.6%
Civilian Unemployed	3.7%
In Armed Forces	0.0%
Not In Labor Force	35.6%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	93.1%
Civilian Unemployed	6.9%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	93.5%
Civilian Unemployed	6.5%

2000 Females 16+ by Employment Status and Age of Children

Total	18,631
Own Children < 6 Only	7.4%
Employed/in Armed Forces	4.2%
Unemployed	0.2%
Not in Labor Force	2.9%
Own Children <6 and 6-17 Only	7.6%
Employed/in Armed Forces	4.5%
Unemployed	0.4%
Not in Labor Force	2.7%
Own Children 6-17 Only	19.3%
Employed/in Armed Forces	13.6%
Unemployed	0.5%
Not in Labor Force	5.3%
No Own Children < 18	65.7%
Employed/in Armed Forces	32.3%
Unemployed	2.1%
Not in Labor Force	31.2%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



**2008 Employed Population 16+ by Industry**

Total	23,014
Agriculture/Mining	0.2%
Construction	7.1%
Manufacturing	9.9%
Wholesale Trade	4.2%
Retail Trade	12.2%
Transportation/Utilities	5.9%
Information	2.6%
Finance/Insurance/Real Estate	8.7%
Services	44.9%
Public Administration	4.4%

**2008 Employed Population 16+ by Occupation**

Total	23,015
White Collar	62.6%
Management/Business/Financial	13.7%
Professional	18.2%
Sales	11.6%
Administrative Support	18.9%
Services	16.1%
Blue Collar	21.3%
Farming/Forestry/Fishing	0.0%
Construction/Extraction	4.7%
Installation/Maintenance/Repair	4.8%
Production	5.3%
Transportation/Material Moving	6.6%



**2000 Workers 16+ by Means of Transportation to Work**

Total	20,685
Drove Alone - Car, Truck, or Van	77.2%
Carpooled - Car, Truck, or Van	14.1%
Public Transportation	4.3%
Walked	1.4%
Other Means	0.8%
Worked at Home	2.2%

**2000 Workers 16+ by Travel Time to Work**

Total	20,684
Did not Work at Home	97.8%
Less than 5 minutes	2.3%
5 to 9 minutes	8.7%
10 to 19 minutes	24.6%
20 to 24 minutes	11.6%
25 to 34 minutes	17.1%
35 to 44 minutes	8.2%
45 to 59 minutes	12.3%
60 to 89 minutes	9.2%
90 or more minutes	3.6%
Worked at Home	2.2%
Average Travel Time to Work (in min)	30.7

**2000 Households by Vehicles Available**

Total	15,972
None	7.4%
1	32.8%
2	40.9%
3	13.1%
4	3.9%
5+	2.0%
Average Number of Vehicles Available	1.8

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Covina

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Households by Type

Total	15,971
Family Households	73.5%
Married-couple Family	51.5%
With Related Children	28.1%
Other Family (No Spouse)	22.0%
With Related Children	14.4%
Nonfamily Households	26.5%
Householder Living Alone	20.7%
Householder Not Living Alone	5.8%
Households with Related Children	42.5%
Households with Persons 65+	22.5%

2000 Households by Size

Total	15,971
1 Person Household	20.7%
2 Person Household	28.1%
3 Person Household	18.8%
4 Person Household	16.3%
5 Person Household	9.3%
6 Person Household	3.9%
7 + Person Household	2.9%

2000 Households by Year Householder Moved In

Total	15,973
Moved in 1999 to March 2000	21.3%
Moved in 1995 to 1998	29.0%
Moved in 1990 to 1994	14.7%
Moved in 1980 to 1989	15.4%
Moved in 1970 to 1979	9.8%
Moved in 1969 or Earlier	9.9%
Median Year Householder Moved In	1995



2000 Housing Units by Units in Structure

Total	16,372
1, Detached	56.9%
1, Attached	6.7%
2	1.4%
3 or 4	4.5%
5 to 9	6.2%
10 to 19	5.2%
20 +	14.5%
Mobile Home	4.6%
Other	0.1%

2000 Housing Units by Year Structure Built

Total	16,373
1999 to March 2000	0.4%
1995 to 1998	1.4%
1990 to 1994	3.1%
1980 to 1989	11.2%
1970 to 1979	14.3%
1969 or Earlier	69.5%
Median Year Structure Built	1961

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Covina

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$38,643,904
Average Spent	\$2,323.89
Spending Potential Index	87
Computers & Accessories: Total \$	\$4,212,888
Average Spent	\$253.35
Spending Potential Index	106
Education: Total \$	\$24,545,771
Average Spent	\$1,476.08
Spending Potential Index	107
Entertainment/Recreation: Total \$	\$59,712,022
Average Spent	\$3,590.84
Spending Potential Index	97
Food at Home: Total \$	\$81,208,336
Average Spent	\$4,883.54
Spending Potential Index	100
Food Away from Home: Total \$	\$56,556,659
Average Spent	\$3,401.09
Spending Potential Index	99
Health Care: Total \$	\$59,580,947
Average Spent	\$3,582.95
Spending Potential Index	88
HH Furnishings & Equip: Total \$	\$36,756,069
Average Spent	\$2,210.36
Spending Potential Index	96
Investments: Total \$	\$18,304,804
Average Spent	\$1,100.78
Spending Potential Index	109
Retail Goods: Total \$	\$435,452,601
Average Spent	\$26,186.34
Spending Potential Index	96
Shelter: Total \$	\$289,071,442
Average Spent	\$17,383.57
Spending Potential Index	112
TV/Video/Sound Equipment: Total \$	\$23,394,112
Average Spent	\$1,406.83
Spending Potential Index	98
Travel: Total \$	\$33,755,898
Average Spent	\$2,029.94
Spending Potential Index	108
Vehicle Maintenance & Repairs: Total \$	\$16,572,637
Average Spent	\$996.61
Spending Potential Index	100

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Diamond Bar

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	56,287
2000 Group Quarters	118
2008 Total Population	60,473
2013 Total Population	62,927
2008-2013 Annual Rate	0.80%



2000 Households	17,651
2000 Average Household Size	3.18
2008 Households	18,414
2008 Average Household Size	3.28
2013 Households	19,026
2013 Average Household Size	3.30
2008-2013 Annual Rate	0.66%
2000 Families	14,805
2000 Average Family Size	3.47
2008 Families	15,459
2008 Average Family Size	3.59
2013 Families	15,938
2013 Average Family Size	3.63
2008-2013 Annual Rate	0.61%



<b>2000 Housing Units</b>	17,959
Owner Occupied Housing Units	81.1%
Renter Occupied Housing Units	17.2%
Vacant Housing Units	1.7%

<b>2008 Housing Units</b>	18,742
Owner Occupied Housing Units	82.2%
Renter Occupied Housing Units	16.0%
Vacant Housing Units	1.8%

<b>2013 Housing Units</b>	19,380
Owner Occupied Housing Units	81.2%
Renter Occupied Housing Units	16.9%
Vacant Housing Units	1.8%

<b>Median Household Income</b>	
2000	\$68,282
2008	\$84,538
2013	\$101,359

<b>Median Home Value</b>	
2000	\$238,252
2008	\$628,683
2013	\$641,369

<b>Per Capita Income</b>	
2000	\$25,463
2008	\$33,189
2013	\$39,890

<b>Median Age</b>	
2000	36.4
2008	39.1
2013	40.3

Data Note: Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Diamond Bar

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	17,731
<15,000	6.9%
\$15,000 - \$24,999	5.6%
\$25,000 - \$34,999	6.8%
\$35,000 - \$49,999	14.1%
\$50,000 - \$74,999	21.8%
\$75,000 - \$99,999	17.0%
\$100,000 - \$149,999	18.9%
\$150,000 - \$199,999	4.6%
\$200,000+	4.4%
Average Household Income	\$80,351

2008 Household by Income

Household Income Base	18,416
<15,000	4.9%
\$15,000 - \$24,999	3.0%
\$25,000 - \$34,999	4.5%
\$35,000 - \$49,999	7.8%
\$50,000 - \$74,999	20.6%
\$75,000 - \$99,999	19.8%
\$100,000 - \$149,999	21.5%
\$150,000 - \$199,999	9.9%
\$200,000+	8.1%
Average Household Income	\$108,924

2013 Household by Income

Household Income Base	19,024
<15,000	4.1%
\$15,000 - \$24,999	2.4%
\$25,000 - \$34,999	2.9%
\$35,000 - \$49,999	5.0%
\$50,000 - \$74,999	17.5%
\$75,000 - \$99,999	17.0%
\$100,000 - \$149,999	25.0%
\$150,000 - \$199,999	11.1%
\$200,000+	15.0%
Average Household Income	\$131,888

2000 Owner Occupied HUs by Value

Total	14,582
<50,000	5.5%
\$50,000 - \$99,999	3.3%
\$100,000 - \$149,999	9.7%
\$150,000 - \$199,999	13.9%
\$200,000 - \$299,999	41.4%
\$300,000 - \$499,999	22.1%
\$500,000 - \$999,999	3.0%
\$1,000,000 +	1.0%
Average Home Value	\$258,892

2000 Specified Renter Occupied HUs by Contract Rent

Total	3,060
With Cash Rent	96.8%
No Cash Rent	3.2%
Median Rent	\$957
Average Rent	\$978

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Diamond Bar

Demographic

Place Outlines (Local)



2000 Population by Age

Total	56,286
0 - 4	5.7%
5 - 9	7.3%
10 - 14	8.6%
15 - 24	14.1%
25 - 34	11.9%
35 - 44	17.7%
45 - 54	17.7%
55 - 64	9.5%
65 - 74	4.7%
75 - 84	2.3%
85 +	0.5%
18 +	73.0%

2008 Population by Age

Total	60,472
0 - 4	5.5%
5 - 9	5.9%
10 - 14	6.9%
15 - 24	13.9%
25 - 34	12.3%
35 - 44	14.4%
45 - 54	17.4%
55 - 64	13.8%
65 - 74	6.2%
75 - 84	2.9%
85 +	0.9%
18 +	77.1%

2013 Population by Age

Total	62,927
0 - 4	5.5%
5 - 9	5.7%
10 - 14	6.3%
15 - 24	12.7%
25 - 34	12.4%
35 - 44	14.4%
45 - 54	16.4%
55 - 64	14.5%
65 - 74	7.5%
75 - 84	3.4%
85 +	1.2%
18 +	78.3%

2000 Population by Sex

Males	49.0%
Females	51.0%

2008 Population by Sex

Males	48.9%
Females	51.1%

2013 Population by Sex

Males	49.0%
Females	51.0%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	56,287
White Alone	40.8%
Black Alone	4.7%
American Indian Alone	0.3%
Asian or Pacific Islander Alone	43.1%
Some Other Race Alone	6.7%
Two or More Races	4.2%
Hispanic Origin	18.4%
Diversity Index	75.2

2008 Population by Race/Ethnicity

Total	60,475
White Alone	34.4%
Black Alone	4.4%
American Indian Alone	0.3%
Asian or Pacific Islander Alone	47.4%
Some Other Race Alone	8.5%
Two or More Races	5.0%
Hispanic Origin	22.8%
Diversity Index	77.7

2013 Population by Race/Ethnicity

Total	62,928
White Alone	31.5%
Black Alone	4.1%
American Indian Alone	0.3%
Asian or Pacific Islander Alone	49.2%
Some Other Race Alone	9.5%
Two or More Races	5.5%
Hispanic Origin	25.4%
Diversity Index	78.8

2000 Population 3+ by School Enrollment

Total	54,523
Enrolled in Nursery/Preschool	1.6%
Enrolled in Kindergarten	1.6%
Enrolled in Grade 1-8	14.1%
Enrolled in Grade 9-12	7.1%
Enrolled in College	9.1%
Enrolled in Grad/Prof School	2.2%
Not Enrolled in School	64.2%

2008 Population 25+ by Educational Attainment

Total	41,048
Less Than 9th Grade	2.2%
9th to 12th Grade, No Diploma	4.8%
High School Graduate	17.6%
Some College, No Degree	19.1%
Associate Degree	9.7%
Bachelor's Degree	32.2%
Master's/Prof/Doctorate Degree	14.4%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Diamond Bar

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	49,461.0
Married	61.0%
Never Married	28.6%
Widowed	3.7%
Divorced	6.6%



2000 Population 16+ by Employment Status

Total	42,994
In Labor Force	66.0%
Civilian Employed	62.2%
Civilian Unemployed	3.7%
In Armed Forces	0.0%
Not In Labor Force	34.0%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	93.5%
Civilian Unemployed	6.5%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	93.9%
Civilian Unemployed	6.1%

2000 Females 16+ by Employment Status and Age of Children

Total	22,284
Own Children < 6 Only	6.8%
Employed/in Armed Forces	3.6%
Unemployed	0.1%
Not in Labor Force	3.1%
Own Children <6 and 6-17 Only	6.9%
Employed/in Armed Forces	3.0%
Unemployed	0.5%
Not in Labor Force	3.4%
Own Children 6-17 Only	23.2%
Employed/in Armed Forces	15.5%
Unemployed	0.7%
Not in Labor Force	6.9%
No Own Children < 18	63.0%
Employed/in Armed Forces	32.6%
Unemployed	1.7%
Not in Labor Force	28.7%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Diamond Bar

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	30,184
Agriculture/Mining	0.4%
Construction	4.8%
Manufacturing	10.1%
Wholesale Trade	7.5%
Retail Trade	12.1%
Transportation/Utilities	4.8%
Information	2.3%
Finance/Insurance/Real Estate	10.4%
Services	43.2%
Public Administration	4.5%

2008 Employed Population 16+ by Occupation

Total	30,186
White Collar	80.9%
Management/Business/Financial	21.9%
Professional	27.8%
Sales	16.4%
Administrative Support	14.8%
Services	8.2%
Blue Collar	11.0%
Farming/Forestry/Fishing	0.1%
Construction/Extraction	2.5%
Installation/Maintenance/Repair	2.6%
Production	3.0%
Transportation/Material Moving	2.8%



2000 Workers 16+ by Means of Transportation to Work

Total	26,265
Drove Alone - Car, Truck, or Van	81.2%
Carpooled - Car, Truck, or Van	12.5%
Public Transportation	2.4%
Walked	0.4%
Other Means	0.4%
Worked at Home	3.1%

2000 Workers 16+ by Travel Time to Work

Total	26,264
Did not Work at Home	96.9%
Less than 5 minutes	0.8%
5 to 9 minutes	5.4%
10 to 19 minutes	21.5%
20 to 24 minutes	10.7%
25 to 34 minutes	20.0%
35 to 44 minutes	7.5%
45 to 59 minutes	13.8%
60 to 89 minutes	13.0%
90 or more minutes	4.2%
Worked at Home	3.1%
Average Travel Time to Work (in min)	34.7

2000 Households by Vehicles Available

Total	17,650
None	3.3%
1	21.3%
2	45.3%
3	22.3%
4	5.2%
5+	2.7%
Average Number of Vehicles Available	2.1

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Diamond Bar

Demographic

Place Outlines (Local)



2000 Households by Type

Total	17,651
Family Households	83.9%
Married-couple Family	68.3%
With Related Children	38.9%
Other Family (No Spouse)	15.6%
With Related Children	8.8%
Nonfamily Households	16.1%
Householder Living Alone	12.4%
Householder Not Living Alone	3.7%
Households with Related Children	47.7%
Households with Persons 65+	17.6%

2000 Households by Size

Total	17,651
1 Person Household	12.4%
2 Person Household	26.3%
3 Person Household	20.4%
4 Person Household	23.1%
5 Person Household	10.9%
6 Person Household	4.6%
7 + Person Household	2.3%

2000 Households by Year Householder Moved In

Total	17,650
Moved in 1999 to March 2000	16.0%
Moved in 1995 to 1998	27.6%
Moved in 1990 to 1994	16.1%
Moved in 1980 to 1989	26.8%
Moved in 1970 to 1979	10.3%
Moved in 1969 or Earlier	3.2%
Median Year Householder Moved In	1993



2000 Housing Units by Units in Structure

Total	17,961
1, Detached	70.4%
1, Attached	14.0%
2	0.4%
3 or 4	4.2%
5 to 9	3.2%
10 to 19	2.0%
20 +	4.3%
Mobile Home	1.6%
Other	0.0%

2000 Housing Units by Year Structure Built

Total	17,961
1999 to March 2000	0.8%
1995 to 1998	1.6%
1990 to 1994	3.8%
1980 to 1989	43.0%
1970 to 1979	31.0%
1969 or Earlier	19.8%
Median Year Structure Built	1980

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Diamond Bar

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$59,519,373
Average Spent	\$3,232.29
Spending Potential Index	120
Computers & Accessories: Total \$	\$7,050,011
Average Spent	\$382.86
Spending Potential Index	160
Education: Total \$	\$39,049,631
Average Spent	\$2,120.65
Spending Potential Index	154
Entertainment/Recreation: Total \$	\$101,808,223
Average Spent	\$5,528.85
Spending Potential Index	149
Food at Home: Total \$	\$121,909,182
Average Spent	\$6,620.46
Spending Potential Index	136
Food Away from Home: Total \$	\$87,781,647
Average Spent	\$4,767.11
Spending Potential Index	139
Health Care: Total \$	\$98,824,241
Average Spent	\$5,366.80
Spending Potential Index	131
HH Furnishings & Equip: Total \$	\$64,941,191
Average Spent	\$3,526.73
Spending Potential Index	153
Investments: Total \$	\$35,096,768
Average Spent	\$1,905.98
Spending Potential Index	188
Retail Goods: Total \$	\$714,968,146
Average Spent	\$38,827.42
Spending Potential Index	143
Shelter: Total \$	\$455,560,870
Average Spent	\$24,739.92
Spending Potential Index	159
TV/Video/Sound Equipment: Total \$	\$37,068,252
Average Spent	\$2,013.05
Spending Potential Index	140
Travel: Total \$	\$59,121,312
Average Spent	\$3,210.67
Spending Potential Index	170
Vehicle Maintenance & Repairs: Total \$	\$27,388,552
Average Spent	\$1,487.38
Spending Potential Index	150

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: El Monte

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	115,965
2000 Group Quarters	1,238
2008 Total Population	122,556
2013 Total Population	126,679
2008-2013 Annual Rate	0.66%



2000 Households	27,034
2000 Average Household Size	4.24
2008 Households	27,907
2008 Average Household Size	4.35
2013 Households	28,703
2013 Average Household Size	4.37
2008-2013 Annual Rate	0.56%
2000 Families	23,029
2000 Average Family Size	4.42
2008 Families	23,752
2008 Average Family Size	4.57
2013 Families	24,362
2013 Average Family Size	4.62
2008-2013 Annual Rate	0.51%



<b>2000 Housing Units</b>	27,758
Owner Occupied Housing Units	39.9%
Renter Occupied Housing Units	57.6%
Vacant Housing Units	2.6%

<b>2008 Housing Units</b>	28,674
Owner Occupied Housing Units	41.5%
Renter Occupied Housing Units	55.9%
Vacant Housing Units	2.7%

<b>2013 Housing Units</b>	29,487
Owner Occupied Housing Units	39.9%
Renter Occupied Housing Units	57.5%
Vacant Housing Units	2.7%

<b>Median Household Income</b>	
2000	\$32,759
2008	\$41,240
2013	\$48,737

<b>Median Home Value</b>	
2000	\$153,758
2008	\$359,964
2013	\$375,648

<b>Per Capita Income</b>	
2000	\$10,292
2008	\$12,429
2013	\$14,129

<b>Median Age</b>	
2000	27.1
2008	27.4
2013	27.4

Data Note: Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: El Monte

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	27,099
<15,000	19.9%
\$15,000 - \$24,999	17.2%
\$25,000 - \$34,999	16.3%
\$35,000 - \$49,999	17.2%
\$50,000 - \$74,999	15.9%
\$75,000 - \$99,999	7.3%
\$100,000 - \$149,999	4.8%
\$150,000 - \$199,999	0.8%
\$200,000+	0.6%
Average Household Income	\$43,907

2008 Household by Income

Household Income Base	27,905
<15,000	14.4%
\$15,000 - \$24,999	12.8%
\$25,000 - \$34,999	15.0%
\$35,000 - \$49,999	17.4%
\$50,000 - \$74,999	19.5%
\$75,000 - \$99,999	11.4%
\$100,000 - \$149,999	6.3%
\$150,000 - \$199,999	1.9%
\$200,000+	1.1%
Average Household Income	\$53,689

2013 Household by Income

Household Income Base	28,700
<15,000	12.8%
\$15,000 - \$24,999	11.0%
\$25,000 - \$34,999	12.2%
\$35,000 - \$49,999	15.1%
\$50,000 - \$74,999	22.1%
\$75,000 - \$99,999	13.0%
\$100,000 - \$149,999	9.6%
\$150,000 - \$199,999	2.3%
\$200,000+	1.9%
Average Household Income	\$61,377

2000 Owner Occupied HUs by Value

Total	11,110
<50,000	11.2%
\$50,000 - \$99,999	4.9%
\$100,000 - \$149,999	30.2%
\$150,000 - \$199,999	39.4%
\$200,000 - \$299,999	11.7%
\$300,000 - \$499,999	1.9%
\$500,000 - \$999,999	0.7%
\$1,000,000 +	0.1%
Average Home Value	\$152,725

2000 Specified Renter Occupied HUs by Contract Rent

Total	15,836
With Cash Rent	98.5%
No Cash Rent	1.5%
Median Rent	\$619
Average Rent	\$606

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: El Monte

Demographic

Place Outlines (Local)



2000 Population by Age

Total	115,965
0 - 4	10.0%
5 - 9	10.3%
10 - 14	8.8%
15 - 24	17.2%
25 - 34	17.4%
35 - 44	14.1%
45 - 54	9.7%
55 - 64	5.7%
65 - 74	3.9%
75 - 84	2.2%
85 +	0.7%
18 +	65.9%

2008 Population by Age

Total	122,552
0 - 4	10.3%
5 - 9	9.1%
10 - 14	9.0%
15 - 24	17.6%
25 - 34	16.6%
35 - 44	14.1%
45 - 54	10.8%
55 - 64	6.5%
65 - 74	3.3%
75 - 84	2.0%
85 +	0.8%
18 +	66.0%

2013 Population by Age

Total	126,678
0 - 4	10.5%
5 - 9	9.3%
10 - 14	7.9%
15 - 24	18.3%
25 - 34	15.4%
35 - 44	13.0%
45 - 54	11.4%
55 - 64	7.9%
65 - 74	3.5%
75 - 84	2.0%
85 +	0.9%
18 +	67.2%

2000 Population by Sex

Males	50.5%
Females	49.5%

2008 Population by Sex

Males	50.5%
Females	49.5%

2013 Population by Sex

Males	50.5%
Females	49.5%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: El Monte

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	115,964
White Alone	35.7%
Black Alone	0.8%
American Indian Alone	1.4%
Asian or Pacific Islander Alone	18.5%
Some Other Race Alone	39.3%
Two or More Races	4.3%
Hispanic Origin	72.5%
Diversity Index	90.3

2008 Population by Race/Ethnicity

Total	122,556
White Alone	34.2%
Black Alone	0.7%
American Indian Alone	1.1%
Asian or Pacific Islander Alone	17.5%
Some Other Race Alone	42.0%
Two or More Races	4.5%
Hispanic Origin	76.5%
Diversity Index	90.5

2013 Population by Race/Ethnicity

Total	126,677
White Alone	33.7%
Black Alone	0.6%
American Indian Alone	1.0%
Asian or Pacific Islander Alone	16.8%
Some Other Race Alone	43.3%
Two or More Races	4.6%
Hispanic Origin	78.4%
Diversity Index	90.6

2000 Population 3+ by School Enrollment

Total	109,452
Enrolled in Nursery/Preschool	1.2%
Enrolled in Kindergarten	2.1%
Enrolled in Grade 1-8	17.0%
Enrolled in Grade 9-12	7.9%
Enrolled in College	5.6%
Enrolled in Grad/Prof School	0.6%
Not Enrolled in School	65.6%

2008 Population 25+ by Educational Attainment

Total	66,248
Less Than 9th Grade	30.6%
9th to 12th Grade, No Diploma	19.5%
High School Graduate	23.7%
Some College, No Degree	12.9%
Associate Degree	4.5%
Bachelor's Degree	6.3%
Master's/Prof/Doctorate Degree	2.5%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: El Monte

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	87,767.0
Married	51.0%
Never Married	39.0%
Widowed	4.3%
Divorced	5.6%



2000 Population 16+ by Employment Status

Total	80,497
In Labor Force	56.1%
Civilian Employed	50.5%
Civilian Unemployed	5.6%
In Armed Forces	0.0%
Not In Labor Force	43.9%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	87.9%
Civilian Unemployed	12.1%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	88.6%
Civilian Unemployed	11.4%

2000 Females 16+ by Employment Status and Age of Children

Total	40,130
Own Children < 6 Only	7.6%
Employed/in Armed Forces	3.4%
Unemployed	0.5%
Not in Labor Force	3.6%
Own Children <6 and 6-17 Only	11.3%
Employed/in Armed Forces	4.4%
Unemployed	0.6%
Not in Labor Force	6.3%
Own Children 6-17 Only	18.2%
Employed/in Armed Forces	9.3%
Unemployed	0.9%
Not in Labor Force	8.0%
No Own Children < 18	62.9%
Employed/in Armed Forces	24.4%
Unemployed	3.4%
Not in Labor Force	35.1%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



**2008 Employed Population 16+ by Industry**

Total	43,032
Agriculture/Mining	0.6%
Construction	8.7%
Manufacturing	22.8%
Wholesale Trade	5.0%
Retail Trade	11.5%
Transportation/Utilities	4.7%
Information	1.5%
Finance/Insurance/Real Estate	4.9%
Services	38.0%
Public Administration	2.3%

**2008 Employed Population 16+ by Occupation**

Total	43,032
White Collar	40.4%
Management/Business/Financial	6.8%
Professional	10.6%
Sales	9.4%
Administrative Support	13.6%
Services	18.6%
Blue Collar	40.9%
Farming/Forestry/Fishing	0.5%
Construction/Extraction	7.7%
Installation/Maintenance/Repair	4.6%
Production	17.8%
Transportation/Material Moving	10.3%



**2000 Workers 16+ by Means of Transportation to Work**

Total	39,276
Drove Alone - Car, Truck, or Van	61.0%
Carpooled - Car, Truck, or Van	22.4%
Public Transportation	7.2%
Walked	4.4%
Other Means	3.3%
Worked at Home	1.7%

**2000 Workers 16+ by Travel Time to Work**

Total	39,277
Did not Work at Home	98.3%
Less than 5 minutes	1.0%
5 to 9 minutes	7.6%
10 to 19 minutes	31.5%
20 to 24 minutes	14.5%
25 to 34 minutes	20.9%
35 to 44 minutes	6.2%
45 to 59 minutes	7.9%
60 to 89 minutes	5.8%
90 or more minutes	2.8%
Worked at Home	1.7%
Average Travel Time to Work (in min)	27.0

**2000 Households by Vehicles Available**

Total	27,038
None	15.2%
1	33.3%
2	31.2%
3	13.6%
4	4.2%
5+	2.4%
Average Number of Vehicles Available	1.7

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: El Monte

Demographic

Place Outlines (Local)



2000 Households by Type

Total	27,034
Family Households	85.2%
Married-couple Family	57.0%
With Related Children	41.1%
Other Family (No Spouse)	28.1%
With Related Children	19.4%
Nonfamily Households	14.8%
Householder Living Alone	10.8%
Householder Not Living Alone	4.0%
Households with Related Children	60.5%
Households with Persons 65+	21.3%

2000 Households by Size

Total	27,034
1 Person Household	10.8%
2 Person Household	15.1%
3 Person Household	15.3%
4 Person Household	18.2%
5 Person Household	15.5%
6 Person Household	10.3%
7 + Person Household	14.8%

2000 Households by Year Householder Moved In

Total	27,039
Moved in 1999 to March 2000	22.1%
Moved in 1995 to 1998	33.2%
Moved in 1990 to 1994	16.5%
Moved in 1980 to 1989	14.2%
Moved in 1970 to 1979	7.7%
Moved in 1969 or Earlier	6.2%
Median Year Householder Moved In	1995



2000 Housing Units by Units in Structure

Total	27,760
1, Detached	53.3%
1, Attached	12.3%
2	2.4%
3 or 4	4.7%
5 to 9	6.0%
10 to 19	6.0%
20 +	10.4%
Mobile Home	4.9%
Other	0.1%

2000 Housing Units by Year Structure Built

Total	27,760
1999 to March 2000	1.0%
1995 to 1998	2.2%
1990 to 1994	4.3%
1980 to 1989	12.8%
1970 to 1979	14.5%
1969 or Earlier	65.2%
Median Year Structure Built	1963

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: El Monte

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$48,289,627
Average Spent	\$1,730.38
Spending Potential Index	64
Computers & Accessories: Total \$	\$5,464,905
Average Spent	\$195.83
Spending Potential Index	82
Education: Total \$	\$24,521,348
Average Spent	\$878.68
Spending Potential Index	64
Entertainment/Recreation: Total \$	\$71,716,820
Average Spent	\$2,569.85
Spending Potential Index	69
Food at Home: Total \$	\$103,390,101
Average Spent	\$3,704.81
Spending Potential Index	76
Food Away from Home: Total \$	\$67,785,283
Average Spent	\$2,428.97
Spending Potential Index	71
Health Care: Total \$	\$68,963,349
Average Spent	\$2,471.18
Spending Potential Index	60
HH Furnishings & Equip: Total \$	\$47,059,448
Average Spent	\$1,686.30
Spending Potential Index	73
Investments: Total \$	\$16,321,397
Average Spent	\$584.85
Spending Potential Index	58
Retail Goods: Total \$	\$549,461,930
Average Spent	\$19,689.04
Spending Potential Index	73
Shelter: Total \$	\$361,326,734
Average Spent	\$12,947.53
Spending Potential Index	83
TV/Video/Sound Equipment: Total \$	\$28,686,604
Average Spent	\$1,027.94
Spending Potential Index	72
Travel: Total \$	\$39,448,441
Average Spent	\$1,413.57
Spending Potential Index	75
Vehicle Maintenance & Repairs: Total \$	\$21,839,600
Average Spent	\$782.59
Spending Potential Index	79

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Glendora

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	49,451
2000 Group Quarters	1,285
2008 Total Population	51,783
2013 Total Population	53,520
2008-2013 Annual Rate	0.66%



2000 Households	16,832
2000 Average Household Size	2.86
2008 Households	17,172
2008 Average Household Size	2.94
2013 Households	17,713
2013 Average Household Size	2.95
2008-2013 Annual Rate	0.62%
2000 Families	12,802
2000 Average Family Size	3.29
2008 Families	13,062
2008 Average Family Size	3.42
2013 Families	13,381
2013 Average Family Size	3.45
2008-2013 Annual Rate	0.48%



<b>2000 Housing Units</b>	17,159
Owner Occupied Housing Units	71.7%
Renter Occupied Housing Units	26.3%
Vacant Housing Units	2.0%

<b>2008 Housing Units</b>	17,533
Owner Occupied Housing Units	72.9%
Renter Occupied Housing Units	25.1%
Vacant Housing Units	2.1%

<b>2013 Housing Units</b>	18,086
Owner Occupied Housing Units	71.7%
Renter Occupied Housing Units	26.3%
Vacant Housing Units	2.1%

<b>Median Household Income</b>	
2000	\$59,577
2008	\$76,303
2013	\$88,915

<b>Median Home Value</b>	
2000	\$217,918
2008	\$578,407
2013	\$611,557

<b>Per Capita Income</b>	
2000	\$25,806
2008	\$33,237
2013	\$39,988

<b>Median Age</b>	
2000	36.6
2008	38.3
2013	39.6

Data Note: Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Glendora

Demographic

Place Outlines (Local)



**2000 Household by Income**

Household Income Base	16,931
<15,000	8.4%
\$15,000 - \$24,999	8.6%
\$25,000 - \$34,999	9.2%
\$35,000 - \$49,999	15.0%
\$50,000 - \$74,999	22.6%
\$75,000 - \$99,999	15.4%
\$100,000 - \$149,999	13.0%
\$150,000 - \$199,999	3.5%
\$200,000+	4.2%
Average Household Income	\$75,056

**2008 Household by Income**

Household Income Base	17,170
<15,000	5.6%
\$15,000 - \$24,999	5.4%
\$25,000 - \$34,999	7.0%
\$35,000 - \$49,999	11.0%
\$50,000 - \$74,999	19.4%
\$75,000 - \$99,999	21.2%
\$100,000 - \$149,999	17.1%
\$150,000 - \$199,999	6.4%
\$200,000+	6.9%
Average Household Income	\$99,035

**2013 Household by Income**

Household Income Base	17,714
<15,000	4.7%
\$15,000 - \$24,999	4.0%
\$25,000 - \$34,999	5.3%
\$35,000 - \$49,999	7.9%
\$50,000 - \$74,999	17.9%
\$75,000 - \$99,999	16.2%
\$100,000 - \$149,999	25.9%
\$150,000 - \$199,999	7.7%
\$200,000+	10.5%
Average Household Income	\$119,723

**2000 Owner Occupied HUs by Value**

Total	12,342
<50,000	5.5%
\$50,000 - \$99,999	1.7%
\$100,000 - \$149,999	5.4%
\$150,000 - \$199,999	30.0%
\$200,000 - \$299,999	34.5%
\$300,000 - \$499,999	17.2%
\$500,000 - \$999,999	5.0%
\$1,000,000 +	0.8%
Average Home Value	\$255,510

**2000 Specified Renter Occupied HUs by Contract Rent**

Total	4,510
With Cash Rent	97.1%
No Cash Rent	2.9%
Median Rent	\$757
Average Rent	\$756

**Data Note:** Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Glendora

Demographic

Place Outlines (Local)



**2000 Population by Age**

Total	49,453
0 - 4	6.2%
5 - 9	7.8%
10 - 14	8.6%
15 - 24	12.9%
25 - 34	11.9%
35 - 44	17.0%
45 - 54	14.0%
55 - 64	9.0%
65 - 74	6.6%
75 - 84	4.4%
85 +	1.5%
18 +	72.6%

**2008 Population by Age**

Total	51,785
0 - 4	6.3%
5 - 9	6.5%
10 - 14	7.2%
15 - 24	14.6%
25 - 34	11.2%
35 - 44	14.1%
45 - 54	16.0%
55 - 64	11.2%
65 - 74	6.3%
75 - 84	4.6%
85 +	2.0%
18 +	75.1%

**2013 Population by Age**

Total	53,523
0 - 4	6.4%
5 - 9	6.1%
10 - 14	6.4%
15 - 24	13.7%
25 - 34	12.2%
35 - 44	12.4%
45 - 54	15.9%
55 - 64	13.2%
65 - 74	6.9%
75 - 84	4.6%
85 +	2.3%
18 +	76.8%

**2000 Population by Sex**

Males	48.2%
Females	51.8%

**2008 Population by Sex**

Males	48.3%
Females	51.7%

**2013 Population by Sex**

Males	48.4%
Females	51.6%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Glendora

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	49,451
White Alone	80.2%
Black Alone	1.5%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	6.3%
Some Other Race Alone	7.3%
Two or More Races	4.1%
Hispanic Origin	21.7%
Diversity Index	57.3

2008 Population by Race/Ethnicity

Total	51,782
White Alone	74.0%
Black Alone	1.6%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	7.9%
Some Other Race Alone	10.3%
Two or More Races	5.6%
Hispanic Origin	30.6%
Diversity Index	68.1

2013 Population by Race/Ethnicity

Total	53,519
White Alone	70.2%
Black Alone	1.6%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	8.8%
Some Other Race Alone	12.2%
Two or More Races	6.6%
Hispanic Origin	36.1%
Diversity Index	73.0

2000 Population 3+ by School Enrollment

Total	47,918
Enrolled in Nursery/Preschool	1.8%
Enrolled in Kindergarten	1.6%
Enrolled in Grade 1-8	14.0%
Enrolled in Grade 9-12	6.5%
Enrolled in College	7.7%
Enrolled in Grad/Prof School	1.6%
Not Enrolled in School	66.8%

2008 Population 25+ by Educational Attainment

Total	33,872
Less Than 9th Grade	3.4%
9th to 12th Grade, No Diploma	6.9%
High School Graduate	23.9%
Some College, No Degree	26.9%
Associate Degree	10.4%
Bachelor's Degree	18.6%
Master's/Prof/Doctorate Degree	9.8%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Glendora

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	41,426.0
Married	58.2%
Never Married	26.2%
Widowed	6.0%
Divorced	9.6%



2000 Population 16+ by Employment Status

Total	37,828
In Labor Force	65.4%
Civilian Employed	62.5%
Civilian Unemployed	2.8%
In Armed Forces	0.0%
Not In Labor Force	34.6%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	94.8%
Civilian Unemployed	5.2%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	95.1%
Civilian Unemployed	4.9%

2000 Females 16+ by Employment Status and Age of Children

Total	20,113
Own Children < 6 Only	5.8%
Employed/in Armed Forces	3.5%
Unemployed	0.1%
Not in Labor Force	2.2%
Own Children <6 and 6-17 Only	7.2%
Employed/in Armed Forces	3.5%
Unemployed	0.2%
Not in Labor Force	3.5%
Own Children 6-17 Only	19.3%
Employed/in Armed Forces	13.8%
Unemployed	0.3%
Not in Labor Force	5.2%
No Own Children < 18	67.6%
Employed/in Armed Forces	34.2%
Unemployed	1.7%
Not in Labor Force	31.7%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Glendora

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	25,373
Agriculture/Mining	0.2%
Construction	8.0%
Manufacturing	10.1%
Wholesale Trade	3.8%
Retail Trade	11.4%
Transportation/Utilities	4.3%
Information	2.4%
Finance/Insurance/Real Estate	8.0%
Services	47.5%
Public Administration	4.3%

2008 Employed Population 16+ by Occupation

Total	25,371
White Collar	69.3%
Management/Business/Financial	17.1%
Professional	24.3%
Sales	12.2%
Administrative Support	15.6%
Services	13.5%
Blue Collar	17.2%
Farming/Forestry/Fishing	0.2%
Construction/Extraction	5.5%
Installation/Maintenance/Repair	3.5%
Production	4.1%
Transportation/Material Moving	3.8%



2000 Workers 16+ by Means of Transportation to Work

Total	23,310
Drove Alone - Car, Truck, or Van	79.9%
Carpooled - Car, Truck, or Van	12.5%
Public Transportation	2.0%
Walked	1.7%
Other Means	0.9%
Worked at Home	3.0%

2000 Workers 16+ by Travel Time to Work

Total	23,313
Did not Work at Home	97.0%
Less than 5 minutes	3.0%
5 to 9 minutes	11.2%
10 to 19 minutes	22.4%
20 to 24 minutes	10.5%
25 to 34 minutes	18.8%
35 to 44 minutes	8.1%
45 to 59 minutes	10.7%
60 to 89 minutes	9.8%
90 or more minutes	2.5%
Worked at Home	3.0%
Average Travel Time to Work (in min)	29.2

2000 Households by Vehicles Available

Total	16,854
None	4.3%
1	28.9%
2	41.8%
3	17.9%
4	5.1%
5+	2.0%
Average Number of Vehicles Available	2.0

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Glendora

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Households by Type

Total	16,832
Family Households	76.1%
Married-couple Family	59.8%
With Related Children	31.5%
Other Family (No Spouse)	16.3%
With Related Children	9.9%
Nonfamily Households	23.9%
Householder Living Alone	19.2%
Householder Not Living Alone	4.7%
Households with Related Children	41.4%
Households with Persons 65+	24.7%

2000 Households by Size

Total	16,832
1 Person Household	19.2%
2 Person Household	30.5%
3 Person Household	17.4%
4 Person Household	18.7%
5 Person Household	8.8%
6 Person Household	3.4%
7 + Person Household	1.9%

2000 Households by Year Householder Moved In

Total	16,853
Moved in 1999 to March 2000	13.2%
Moved in 1995 to 1998	26.9%
Moved in 1990 to 1994	17.2%
Moved in 1980 to 1989	19.0%
Moved in 1970 to 1979	12.8%
Moved in 1969 or Earlier	11.0%
Median Year Householder Moved In	1992



2000 Housing Units by Units in Structure

Total	17,173
1, Detached	72.0%
1, Attached	6.3%
2	1.5%
3 or 4	2.6%
5 to 9	3.2%
10 to 19	2.9%
20 +	6.1%
Mobile Home	5.4%
Other	0.1%

2000 Housing Units by Year Structure Built

Total	17,173
1999 to March 2000	0.4%
1995 to 1998	1.0%
1990 to 1994	3.5%
1980 to 1989	11.5%
1970 to 1979	16.0%
1969 or Earlier	67.5%
Median Year Structure Built	1963

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Glendora

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$51,563,579
Average Spent	\$3,002.77
Spending Potential Index	112
Computers & Accessories: Total \$	\$5,700,548
Average Spent	\$331.97
Spending Potential Index	139
Education: Total \$	\$35,561,224
Average Spent	\$2,070.88
Spending Potential Index	151
Entertainment/Recreation: Total \$	\$84,556,315
Average Spent	\$4,924.08
Spending Potential Index	133
Food at Home: Total \$	\$108,180,667
Average Spent	\$6,299.83
Spending Potential Index	129
Food Away from Home: Total \$	\$76,981,776
Average Spent	\$4,482.98
Spending Potential Index	131
Health Care: Total \$	\$86,426,300
Average Spent	\$5,032.98
Spending Potential Index	123
HH Furnishings & Equip: Total \$	\$51,999,504
Average Spent	\$3,028.16
Spending Potential Index	132
Investments: Total \$	\$29,713,023
Average Spent	\$1,730.32
Spending Potential Index	171
Retail Goods: Total \$	\$603,023,701
Average Spent	\$35,116.68
Spending Potential Index	129
Shelter: Total \$	\$389,935,314
Average Spent	\$22,707.62
Spending Potential Index	146
TV/Video/Sound Equipment: Total \$	\$31,882,401
Average Spent	\$1,856.65
Spending Potential Index	129
Travel: Total \$	\$48,816,137
Average Spent	\$2,842.78
Spending Potential Index	151
Vehicle Maintenance & Repairs: Total \$	\$22,652,315
Average Spent	\$1,319.14
Spending Potential Index	133

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2000 Total Population	53,122
2000 Group Quarters	82
2008 Total Population	55,452
2013 Total Population	56,976
2008-2013 Annual Rate	0.54%



2000 Households	15,993
2000 Average Household Size	3.32
2008 Households	16,216
2008 Average Household Size	3.41
2013 Households	16,539
2013 Average Household Size	3.44
2008-2013 Annual Rate	0.40%
2000 Families	13,422
2000 Average Family Size	3.58
2008 Families	13,612
2008 Average Family Size	3.71
2013 Families	13,849
2013 Average Family Size	3.75
2008-2013 Annual Rate	0.35%



<b>2000 Housing Units</b>	16,358
Owner Occupied Housing Units	77.7%
Renter Occupied Housing Units	20.1%
Vacant Housing Units	2.2%

<b>2008 Housing Units</b>	16,596
Owner Occupied Housing Units	78.8%
Renter Occupied Housing Units	18.9%
Vacant Housing Units	2.3%

<b>2013 Housing Units</b>	16,926
Owner Occupied Housing Units	77.8%
Renter Occupied Housing Units	19.9%
Vacant Housing Units	2.3%

**Median Household Income**

2000	\$59,562
2008	\$74,484
2013	\$83,403

**Median Home Value**

2000	\$221,803
2008	\$573,482
2013	\$589,488

**Per Capita Income**

2000	\$21,892
2008	\$26,790
2013	\$30,945

**Median Age**

2000	36.9
2008	37.7
2013	38.5

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	15,983
<15,000	9.9%
\$15,000 - \$24,999	7.9%
\$25,000 - \$34,999	10.0%
\$35,000 - \$49,999	13.4%
\$50,000 - \$74,999	22.5%
\$75,000 - \$99,999	16.0%
\$100,000 - \$149,999	12.7%
\$150,000 - \$199,999	4.5%
\$200,000+	3.1%
Average Household Income	\$72,036

2008 Household by Income

Household Income Base	16,215
<15,000	6.8%
\$15,000 - \$24,999	4.8%
\$25,000 - \$34,999	6.9%
\$35,000 - \$49,999	12.3%
\$50,000 - \$74,999	19.7%
\$75,000 - \$99,999	20.5%
\$100,000 - \$149,999	17.5%
\$150,000 - \$199,999	5.8%
\$200,000+	5.8%
Average Household Income	\$91,526

2013 Household by Income

Household Income Base	16,538
<15,000	5.7%
\$15,000 - \$24,999	4.0%
\$25,000 - \$34,999	4.3%
\$35,000 - \$49,999	9.1%
\$50,000 - \$74,999	19.6%
\$75,000 - \$99,999	17.5%
\$100,000 - \$149,999	24.1%
\$150,000 - \$199,999	7.4%
\$200,000+	8.2%
Average Household Income	\$106,509

2000 Owner Occupied HUs by Value

Total	12,720
<50,000	8.0%
\$50,000 - \$99,999	2.1%
\$100,000 - \$149,999	11.2%
\$150,000 - \$199,999	21.5%
\$200,000 - \$299,999	37.2%
\$300,000 - \$499,999	17.6%
\$500,000 - \$999,999	2.0%
\$1,000,000 +	0.5%
Average Home Value	\$234,291

2000 Specified Renter Occupied HUs by Contract Rent

Total	3,274
With Cash Rent	95.0%
No Cash Rent	5.0%
Median Rent	\$864
Average Rent	\$881

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2000 Population by Age

Total	53,121
0 - 4	5.7%
5 - 9	7.1%
10 - 14	7.7%
15 - 24	14.1%
25 - 34	12.6%
35 - 44	15.3%
45 - 54	14.6%
55 - 64	11.0%
65 - 74	7.5%
75 - 84	3.6%
85 +	0.8%
18 +	74.7%

2008 Population by Age

Total	55,454
0 - 4	5.8%
5 - 9	5.6%
10 - 14	6.3%
15 - 24	14.5%
25 - 34	14.2%
35 - 44	13.1%
45 - 54	14.4%
55 - 64	12.4%
65 - 74	7.7%
75 - 84	4.5%
85 +	1.3%
18 +	77.7%

2013 Population by Age

Total	56,977
0 - 4	6.1%
5 - 9	5.7%
10 - 14	5.6%
15 - 24	13.6%
25 - 34	14.5%
35 - 44	12.7%
45 - 54	13.9%
55 - 64	13.3%
65 - 74	8.0%
75 - 84	4.7%
85 +	1.8%
18 +	78.8%

2000 Population by Sex

Males	49.0%
Females	51.0%

2008 Population by Sex

Males	48.7%
Females	51.3%

2013 Population by Sex

Males	48.6%
Females	51.4%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	53,122
White Alone	41.0%
Black Alone	1.6%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	36.2%
Some Other Race Alone	16.6%
Two or More Races	3.9%
Hispanic Origin	38.2%
Diversity Index	84.2

2008 Population by Race/Ethnicity

Total	55,453
White Alone	36.7%
Black Alone	1.4%
American Indian Alone	0.6%
Asian or Pacific Islander Alone	37.6%
Some Other Race Alone	19.4%
Two or More Races	4.4%
Hispanic Origin	44.1%
Diversity Index	86.1

2013 Population by Race/Ethnicity

Total	56,976
White Alone	34.9%
Black Alone	1.2%
American Indian Alone	0.6%
Asian or Pacific Islander Alone	37.9%
Some Other Race Alone	20.8%
Two or More Races	4.7%
Hispanic Origin	47.1%
Diversity Index	86.7

2000 Population 3+ by School Enrollment

Total	51,305
Enrolled in Nursery/Preschool	1.4%
Enrolled in Kindergarten	1.3%
Enrolled in Grade 1-8	12.4%
Enrolled in Grade 9-12	7.6%
Enrolled in College	7.7%
Enrolled in Grad/Prof School	2.1%
Not Enrolled in School	67.6%

2008 Population 25+ by Educational Attainment

Total	37,507
Less Than 9th Grade	6.4%
9th to 12th Grade, No Diploma	8.5%
High School Graduate	23.8%
Some College, No Degree	18.1%
Associate Degree	9.1%
Bachelor's Degree	23.4%
Master's/Prof/Doctorate Degree	10.7%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	45,567.0
Married	57.8%
Never Married	30.5%
Widowed	4.8%
Divorced	6.9%



2000 Population 16+ by Employment Status

Total	41,486
In Labor Force	57.7%
Civilian Employed	54.4%
Civilian Unemployed	3.3%
In Armed Forces	0.0%
Not In Labor Force	42.3%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	93.0%
Civilian Unemployed	7.0%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	93.3%
Civilian Unemployed	6.7%

2000 Females 16+ by Employment Status and Age of Children

Total	21,546
Own Children < 6 Only	5.7%
Employed/in Armed Forces	3.1%
Unemployed	0.2%
Not in Labor Force	2.4%
Own Children <6 and 6-17 Only	5.2%
Employed/in Armed Forces	2.7%
Unemployed	0.1%
Not in Labor Force	2.4%
Own Children 6-17 Only	18.7%
Employed/in Armed Forces	11.8%
Unemployed	0.3%
Not in Labor Force	6.7%
No Own Children < 18	70.3%
Employed/in Armed Forces	30.8%
Unemployed	1.9%
Not in Labor Force	37.7%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	24,331
Agriculture/Mining	0.1%
Construction	4.8%
Manufacturing	12.4%
Wholesale Trade	8.5%
Retail Trade	12.7%
Transportation/Utilities	5.3%
Information	1.8%
Finance/Insurance/Real Estate	9.8%
Services	40.3%
Public Administration	4.1%

2008 Employed Population 16+ by Occupation

Total	24,329
White Collar	72.6%
Management/Business/Financial	18.9%
Professional	21.4%
Sales	15.7%
Administrative Support	16.6%
Services	11.3%
Blue Collar	16.1%
Farming/Forestry/Fishing	0.0%
Construction/Extraction	2.4%
Installation/Maintenance/Repair	3.0%
Production	5.2%
Transportation/Material Moving	5.5%



2000 Workers 16+ by Means of Transportation to Work

Total	21,982
Drove Alone - Car, Truck, or Van	80.1%
Carpooled - Car, Truck, or Van	13.1%
Public Transportation	2.0%
Walked	0.9%
Other Means	1.1%
Worked at Home	2.8%

2000 Workers 16+ by Travel Time to Work

Total	21,981
Did not Work at Home	97.2%
Less than 5 minutes	0.8%
5 to 9 minutes	5.3%
10 to 19 minutes	19.3%
20 to 24 minutes	12.4%
25 to 34 minutes	24.8%
35 to 44 minutes	10.2%
45 to 59 minutes	12.5%
60 to 89 minutes	8.9%
90 or more minutes	3.1%
Worked at Home	2.8%
Average Travel Time to Work (in min)	32.6

2000 Households by Vehicles Available

Total	15,996
None	4.3%
1	22.5%
2	43.0%
3	20.3%
4	7.1%
5+	2.8%
Average Number of Vehicles Available	2.1

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2000 Households by Type

Total	15,993
Family Households	83.9%
Married-couple Family	65.8%
With Related Children	33.3%
Other Family (No Spouse)	18.1%
With Related Children	9.2%
Nonfamily Households	16.1%
Householder Living Alone	12.6%
Householder Not Living Alone	3.5%
Households with Related Children	42.5%
Households with Persons 65+	28.6%

2000 Households by Size

Total	15,993
1 Person Household	12.6%
2 Person Household	27.8%
3 Person Household	18.4%
4 Person Household	19.4%
5 Person Household	11.2%
6 Person Household	5.6%
7 + Person Household	5.0%

2000 Households by Year Householder Moved In

Total	15,995
Moved in 1999 to March 2000	13.1%
Moved in 1995 to 1998	23.5%
Moved in 1990 to 1994	15.2%
Moved in 1980 to 1989	20.1%
Moved in 1970 to 1979	17.9%
Moved in 1969 or Earlier	10.2%
Median Year Householder Moved In	1991



2000 Housing Units by Units in Structure

Total	16,359
1, Detached	79.4%
1, Attached	7.5%
2	0.5%
3 or 4	2.9%
5 to 9	1.5%
10 to 19	0.4%
20 +	4.7%
Mobile Home	3.1%
Other	0.0%

2000 Housing Units by Year Structure Built

Total	16,361
1999 to March 2000	0.7%
1995 to 1998	0.6%
1990 to 1994	2.3%
1980 to 1989	11.9%
1970 to 1979	30.6%
1969 or Earlier	53.9%
Median Year Structure Built	1969

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Hacienda Heights

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$43,587,631
Average Spent	\$2,687.94
Spending Potential Index	100
Computers & Accessories: Total \$	\$5,533,964
Average Spent	\$341.27
Spending Potential Index	143
Education: Total \$	\$26,144,471
Average Spent	\$1,612.26
Spending Potential Index	117
Entertainment/Recreation: Total \$	\$74,891,849
Average Spent	\$4,618.39
Spending Potential Index	124
Food at Home: Total \$	\$92,007,843
Average Spent	\$5,673.89
Spending Potential Index	116
Food Away from Home: Total \$	\$63,840,376
Average Spent	\$3,936.88
Spending Potential Index	115
Health Care: Total \$	\$71,635,734
Average Spent	\$4,417.60
Spending Potential Index	108
HH Furnishings & Equip: Total \$	\$49,195,807
Average Spent	\$3,033.78
Spending Potential Index	132
Investments: Total \$	\$22,263,322
Average Spent	\$1,372.92
Spending Potential Index	135
Retail Goods: Total \$	\$536,901,156
Average Spent	\$33,109.35
Spending Potential Index	122
Shelter: Total \$	\$352,391,670
Average Spent	\$21,731.11
Spending Potential Index	140
TV/Video/Sound Equipment: Total \$	\$27,616,402
Average Spent	\$1,703.03
Spending Potential Index	119
Travel: Total \$	\$45,204,728
Average Spent	\$2,787.66
Spending Potential Index	148
Vehicle Maintenance & Repairs: Total \$	\$21,457,677
Average Spent	\$1,323.24
Spending Potential Index	133

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Irwindale

Demographic

Place Outlines (Local)



2000 Total Population	1,430
2000 Group Quarters	2
2008 Total Population	1,521
2013 Total Population	1,570
2008-2013 Annual Rate	0.64%



2000 Households	362
2000 Average Household Size	3.94
2008 Households	375
2008 Average Household Size	4.05
2013 Households	385
2013 Average Household Size	4.07
2008-2013 Annual Rate	0.53%
2000 Families	291
2000 Average Family Size	4.34
2008 Families	300
2008 Average Family Size	4.50
2013 Families	307
2013 Average Family Size	4.55
2008-2013 Annual Rate	0.46%



<b>2000 Housing Units</b>	375
Owner Occupied Housing Units	61.1%
Renter Occupied Housing Units	35.5%
Vacant Housing Units	3.5%

<b>2008 Housing Units</b>	389
Owner Occupied Housing Units	62.7%
Renter Occupied Housing Units	33.7%
Vacant Housing Units	3.6%

<b>2013 Housing Units</b>	399
Owner Occupied Housing Units	63.7%
Renter Occupied Housing Units	32.8%
Vacant Housing Units	3.5%

<b>Median Household Income</b>	
2000	\$45,000
2008	\$59,632
2013	\$67,361

<b>Median Home Value</b>	
2000	\$176,709
2008	\$417,949
2013	\$431,500

<b>Per Capita Income</b>	
2000	\$13,144
2008	\$15,370
2013	\$18,194

<b>Median Age</b>	
2000	28.8
2008	28.5
2013	28.7

Data Note: Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Irwindale

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	412
<15,000	13.3%
\$15,000 - \$24,999	17.5%
\$25,000 - \$34,999	8.0%
\$35,000 - \$49,999	22.6%
\$50,000 - \$74,999	23.1%
\$75,000 - \$99,999	6.8%
\$100,000 - \$149,999	7.0%
\$150,000 - \$199,999	1.2%
\$200,000+	0.5%
Average Household Income	\$46,553

2008 Household by Income

Household Income Base	376
<15,000	10.6%
\$15,000 - \$24,999	15.2%
\$25,000 - \$34,999	6.1%
\$35,000 - \$49,999	9.8%
\$50,000 - \$74,999	31.1%
\$75,000 - \$99,999	15.2%
\$100,000 - \$149,999	5.9%
\$150,000 - \$199,999	4.8%
\$200,000+	1.3%
Average Household Income	\$62,250

2013 Household by Income

Household Income Base	386
<15,000	9.1%
\$15,000 - \$24,999	6.7%
\$25,000 - \$34,999	10.4%
\$35,000 - \$49,999	7.3%
\$50,000 - \$74,999	24.1%
\$75,000 - \$99,999	24.1%
\$100,000 - \$149,999	11.7%
\$150,000 - \$199,999	3.1%
\$200,000+	3.6%
Average Household Income	\$74,116

2000 Owner Occupied HUs by Value

Total	275
<50,000	2.9%
\$50,000 - \$99,999	7.3%
\$100,000 - \$149,999	28.4%
\$150,000 - \$199,999	58.5%
\$200,000 - \$299,999	0.0%
\$300,000 - \$499,999	2.9%
\$500,000 - \$999,999	0.0%
\$1,000,000 +	0.0%
Average Home Value	\$160,865

2000 Specified Renter Occupied HUs by Contract Rent

Total	127
With Cash Rent	85.0%
No Cash Rent	15.0%
Median Rent	\$539
Average Rent	\$511

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Irwindale

Demographic

Place Outlines (Local)



**2000 Population by Age**

Total	1,427
0 - 4	8.5%
5 - 9	10.2%
10 - 14	10.0%
15 - 24	14.6%
25 - 34	16.1%
35 - 44	15.7%
45 - 54	9.6%
55 - 64	7.1%
65 - 74	5.0%
75 - 84	2.5%
85 +	0.7%
18 +	66.6%

**2008 Population by Age**

Total	1,518
0 - 4	9.4%
5 - 9	8.9%
10 - 14	9.2%
15 - 24	17.5%
25 - 34	14.4%
35 - 44	15.5%
45 - 54	11.9%
55 - 64	5.9%
65 - 74	4.3%
75 - 84	2.2%
85 +	0.9%
18 +	67.1%

**2013 Population by Age**

Total	1,566
0 - 4	9.8%
5 - 9	9.1%
10 - 14	8.0%
15 - 24	17.2%
25 - 34	14.0%
35 - 44	14.3%
45 - 54	12.1%
55 - 64	7.9%
65 - 74	4.1%
75 - 84	2.4%
85 +	1.0%
18 +	68.2%

**2000 Population by Sex**

Males	47.8%
Females	52.2%

**2008 Population by Sex**

Males	47.0%
Females	53.0%

**2013 Population by Sex**

Males	46.7%
Females	53.3%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Irwindale

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	1,430
White Alone	47.0%
Black Alone	0.4%
American Indian Alone	1.9%
Asian or Pacific Islander Alone	1.8%
Some Other Race Alone	44.5%
Two or More Races	4.3%
Hispanic Origin	88.3%
Diversity Index	82.4

2008 Population by Race/Ethnicity

Total	1,521
White Alone	44.9%
Black Alone	0.3%
American Indian Alone	1.5%
Asian or Pacific Islander Alone	1.6%
Some Other Race Alone	47.1%
Two or More Races	4.5%
Hispanic Origin	92.4%
Diversity Index	82.6

2013 Population by Race/Ethnicity

Total	1,571
White Alone	44.0%
Black Alone	0.3%
American Indian Alone	1.3%
Asian or Pacific Islander Alone	1.5%
Some Other Race Alone	48.3%
Two or More Races	4.6%
Hispanic Origin	94.1%
Diversity Index	82.8

2000 Population 3+ by School Enrollment

Total	1,352
Enrolled in Nursery/Preschool	1.8%
Enrolled in Kindergarten	1.6%
Enrolled in Grade 1-8	11.9%
Enrolled in Grade 9-12	8.8%
Enrolled in College	5.8%
Enrolled in Grad/Prof School	3.8%
Not Enrolled in School	66.3%

2008 Population 25+ by Educational Attainment

Total	834
Less Than 9th Grade	18.1%
9th to 12th Grade, No Diploma	15.0%
High School Graduate	30.6%
Some College, No Degree	19.2%
Associate Degree	8.5%
Bachelor's Degree	6.0%
Master's/Prof/Doctorate Degree	2.6%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Irwindale

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	1,102.0
Married	48.9%
Never Married	38.3%
Widowed	6.5%
Divorced	6.3%



2000 Population 16+ by Employment Status

Total	1,108
In Labor Force	56.8%
Civilian Employed	51.3%
Civilian Unemployed	4.5%
In Armed Forces	1.0%
Not In Labor Force	43.2%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	90.4%
Civilian Unemployed	9.6%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	91.0%
Civilian Unemployed	9.0%

2000 Females 16+ by Employment Status and Age of Children

Total	583
Own Children < 6 Only	12.7%
Employed/in Armed Forces	8.1%
Unemployed	0.0%
Not in Labor Force	4.6%
Own Children <6 and 6-17 Only	3.9%
Employed/in Armed Forces	0.0%
Unemployed	0.0%
Not in Labor Force	3.9%
Own Children 6-17 Only	14.1%
Employed/in Armed Forces	8.4%
Unemployed	1.0%
Not in Labor Force	4.6%
No Own Children < 18	69.3%
Employed/in Armed Forces	29.3%
Unemployed	4.6%
Not in Labor Force	35.3%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Irwindale

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	558
Agriculture/Mining	1.1%
Construction	9.1%
Manufacturing	8.1%
Wholesale Trade	1.8%
Retail Trade	14.0%
Transportation/Utilities	3.6%
Information	3.2%
Finance/Insurance/Real Estate	5.4%
Services	42.5%
Public Administration	11.3%

2008 Employed Population 16+ by Occupation

Total	556
White Collar	57.4%
Management/Business/Financial	11.5%
Professional	17.1%
Sales	12.1%
Administrative Support	16.7%
Services	21.8%
Blue Collar	20.9%
Farming/Forestry/Fishing	0.9%
Construction/Extraction	4.9%
Installation/Maintenance/Repair	2.5%
Production	2.7%
Transportation/Material Moving	9.9%



2000 Workers 16+ by Means of Transportation to Work

Total	565
Drove Alone - Car, Truck, or Van	68.8%
Carpooled - Car, Truck, or Van	14.2%
Public Transportation	8.3%
Walked	6.7%
Other Means	1.8%
Worked at Home	0.2%

2000 Workers 16+ by Travel Time to Work

Total	565
Did not Work at Home	99.8%
Less than 5 minutes	8.1%
5 to 9 minutes	15.8%
10 to 19 minutes	33.1%
20 to 24 minutes	8.8%
25 to 34 minutes	16.8%
35 to 44 minutes	7.8%
45 to 59 minutes	3.4%
60 to 89 minutes	6.0%
90 or more minutes	0.0%
Worked at Home	0.2%
Average Travel Time to Work (in min)	20.3

2000 Households by Vehicles Available

Total	402
None	10.0%
1	36.1%
2	37.3%
3	13.7%
4	1.7%
5+	1.2%
Average Number of Vehicles Available	1.6

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Irwindale

Demographic

Place Outlines (Local)



2000 Households by Type

Total	362
Family Households	80.4%
Married-couple Family	54.1%
With Related Children	37.6%
Other Family (No Spouse)	26.0%
With Related Children	20.4%
Nonfamily Households	19.6%
Householder Living Alone	15.7%
Householder Not Living Alone	4.1%
Households with Related Children	58.0%
Households with Persons 65+	25.7%

2000 Households by Size

Total	362
1 Person Household	15.7%
2 Person Household	16.2%
3 Person Household	15.1%
4 Person Household	15.4%
5 Person Household	15.1%
6 Person Household	9.6%
7 + Person Household	12.9%

2000 Households by Year Householder Moved In

Total	401
Moved in 1999 to March 2000	6.7%
Moved in 1995 to 1998	24.4%
Moved in 1990 to 1994	12.2%
Moved in 1980 to 1989	28.9%
Moved in 1970 to 1979	17.2%
Moved in 1969 or Earlier	10.5%
Median Year Householder Moved In	1988



2000 Housing Units by Units in Structure

Total	414
1, Detached	84.1%
1, Attached	4.1%
2	3.4%
3 or 4	0.0%
5 to 9	2.7%
10 to 19	3.6%
20 +	0.0%
Mobile Home	2.2%
Other	0.0%

2000 Housing Units by Year Structure Built

Total	413
1999 to March 2000	3.1%
1995 to 1998	14.8%
1990 to 1994	2.4%
1980 to 1989	15.7%
1970 to 1979	5.8%
1969 or Earlier	58.1%
Median Year Structure Built	1966

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Irwindale

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$701,918
Average Spent	\$1,871.78
Spending Potential Index	70
Computers & Accessories: Total \$	\$86,461
Average Spent	\$230.56
Spending Potential Index	96
Education: Total \$	\$379,197
Average Spent	\$1,011.19
Spending Potential Index	74
Entertainment/Recreation: Total \$	\$1,159,751
Average Spent	\$3,092.67
Spending Potential Index	83
Food at Home: Total \$	\$1,484,183
Average Spent	\$3,957.82
Spending Potential Index	81
Food Away from Home: Total \$	\$1,007,547
Average Spent	\$2,686.79
Spending Potential Index	78
Health Care: Total \$	\$1,105,478
Average Spent	\$2,947.94
Spending Potential Index	72
HH Furnishings & Equip: Total \$	\$779,554
Average Spent	\$2,078.81
Spending Potential Index	90
Investments: Total \$	\$310,478
Average Spent	\$827.94
Spending Potential Index	82
Retail Goods: Total \$	\$8,581,257
Average Spent	\$22,883.35
Spending Potential Index	84
Shelter: Total \$	\$5,616,659
Average Spent	\$14,977.76
Spending Potential Index	96
TV/Video/Sound Equipment: Total \$	\$435,418
Average Spent	\$1,161.11
Spending Potential Index	81
Travel: Total \$	\$681,715
Average Spent	\$1,817.91
Spending Potential Index	96
Vehicle Maintenance & Repairs: Total \$	\$341,843
Average Spent	\$911.58
Spending Potential Index	92

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: La Puente

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	41,063
2000 Group Quarters	42
2008 Total Population	42,807
2013 Total Population	44,000
2008-2013 Annual Rate	0.55%



2000 Households	9,461
2000 Average Household Size	4.34
2008 Households	9,671
2008 Average Household Size	4.42
2013 Households	9,894
2013 Average Household Size	4.44
2008-2013 Annual Rate	0.46%
2000 Families	8,243
2000 Average Family Size	4.46
2008 Families	8,427
2008 Average Family Size	4.58
2013 Families	8,603
2013 Average Family Size	4.62
2008-2013 Annual Rate	0.41%



<b>2000 Housing Units</b>	9,660
Owner Occupied Housing Units	61.8%
Renter Occupied Housing Units	36.1%
Vacant Housing Units	2.0%

<b>2008 Housing Units</b>	9,880
Owner Occupied Housing Units	63.5%
Renter Occupied Housing Units	34.4%
Vacant Housing Units	2.1%

<b>2013 Housing Units</b>	10,112
Owner Occupied Housing Units	62.2%
Renter Occupied Housing Units	35.7%
Vacant Housing Units	2.2%

<b>Median Household Income</b>	
2000	\$42,272
2008	\$54,319
2013	\$63,745

<b>Median Home Value</b>	
2000	\$146,090
2008	\$353,106
2013	\$368,437

<b>Per Capita Income</b>	
2000	\$11,363
2008	\$13,980
2013	\$16,254

<b>Median Age</b>	
2000	27.7
2008	28.0
2013	28.6

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



2000 Household by Income

Household Income Base	9,444
<15,000	13.2%
\$15,000 - \$24,999	15.2%
\$25,000 - \$34,999	12.9%
\$35,000 - \$49,999	16.6%
\$50,000 - \$74,999	23.4%
\$75,000 - \$99,999	10.7%
\$100,000 - \$149,999	6.5%
\$150,000 - \$199,999	1.1%
\$200,000+	0.4%
Average Household Income	\$49,471

2008 Household by Income

Household Income Base	9,673
<15,000	9.1%
\$15,000 - \$24,999	8.9%
\$25,000 - \$34,999	13.4%
\$35,000 - \$49,999	14.6%
\$50,000 - \$74,999	22.0%
\$75,000 - \$99,999	18.9%
\$100,000 - \$149,999	9.7%
\$150,000 - \$199,999	2.4%
\$200,000+	1.1%
Average Household Income	\$62,563

2013 Household by Income

Household Income Base	9,895
<15,000	7.8%
\$15,000 - \$24,999	6.9%
\$25,000 - \$34,999	10.1%
\$35,000 - \$49,999	12.2%
\$50,000 - \$74,999	22.7%
\$75,000 - \$99,999	18.5%
\$100,000 - \$149,999	16.1%
\$150,000 - \$199,999	3.4%
\$200,000+	2.2%
Average Household Income	\$73,090

2000 Owner Occupied HUs by Value

Total	5,983
<50,000	3.5%
\$50,000 - \$99,999	3.7%
\$100,000 - \$149,999	48.9%
\$150,000 - \$199,999	40.0%
\$200,000 - \$299,999	3.4%
\$300,000 - \$499,999	0.4%
\$500,000 - \$999,999	0.1%
\$1,000,000 +	0.0%
Average Home Value	\$146,301

2000 Specified Renter Occupied HUs by Contract Rent

Total	3,480
With Cash Rent	97.8%
No Cash Rent	2.2%
Median Rent	\$628
Average Rent	\$603

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Puente

Demographic

Place Outlines (Local)



2000 Population by Age

Total	41,063
0 - 4	8.9%
5 - 9	10.4%
10 - 14	9.3%
15 - 24	16.8%
25 - 34	16.5%
35 - 44	14.4%
45 - 54	9.8%
55 - 64	6.3%
65 - 74	4.7%
75 - 84	2.3%
85 +	0.6%
18 +	66.1%

2008 Population by Age

Total	42,810
0 - 4	9.4%
5 - 9	8.8%
10 - 14	9.0%
15 - 24	17.8%
25 - 34	16.1%
35 - 44	14.1%
45 - 54	11.2%
55 - 64	6.8%
65 - 74	3.8%
75 - 84	2.3%
85 +	0.7%
18 +	67.1%

2013 Population by Age

Total	43,999
0 - 4	9.6%
5 - 9	8.9%
10 - 14	7.8%
15 - 24	17.9%
25 - 34	15.3%
35 - 44	13.2%
45 - 54	11.7%
55 - 64	8.4%
65 - 74	4.0%
75 - 84	2.3%
85 +	0.9%
18 +	68.6%

2000 Population by Sex

Males	50.2%
Females	49.8%

2008 Population by Sex

Males	50.1%
Females	49.9%

2013 Population by Sex

Males	49.9%
Females	50.1%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



**2000 Population by Race/Ethnicity**

Total	41,063
White Alone	39.3%
Black Alone	2.0%
American Indian Alone	1.3%
Asian or Pacific Islander Alone	7.1%
Some Other Race Alone	45.3%
Two or More Races	5.1%
Hispanic Origin	83.3%
Diversity Index	88.5

**2008 Population by Race/Ethnicity**

Total	42,807
White Alone	37.7%
Black Alone	1.6%
American Indian Alone	1.0%
Asian or Pacific Islander Alone	6.5%
Some Other Race Alone	47.9%
Two or More Races	5.3%
Hispanic Origin	87.0%
Diversity Index	88.7

**2013 Population by Race/Ethnicity**

Total	44,001
White Alone	37.0%
Black Alone	1.4%
American Indian Alone	0.9%
Asian or Pacific Islander Alone	6.2%
Some Other Race Alone	49.1%
Two or More Races	5.4%
Hispanic Origin	88.7%
Diversity Index	88.7

**2000 Population 3+ by School Enrollment**

Total	38,894
Enrolled in Nursery/Preschool	1.5%
Enrolled in Kindergarten	2.1%
Enrolled in Grade 1-8	17.3%
Enrolled in Grade 9-12	8.6%
Enrolled in College	5.1%
Enrolled in Grad/Prof School	0.7%
Not Enrolled in School	64.7%

**2008 Population 25+ by Educational Attainment**

Total	23,557
Less Than 9th Grade	26.2%
9th to 12th Grade, No Diploma	18.1%
High School Graduate	27.1%
Some College, No Degree	14.4%
Associate Degree	4.7%
Bachelor's Degree	7.0%
Master's/Prof/Doctorate Degree	2.6%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Puente

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	31,156.0
Married	51.9%
Never Married	37.0%
Widowed	4.2%
Divorced	6.9%



2000 Population 16+ by Employment Status

Total	28,680
In Labor Force	58.3%
Civilian Employed	52.8%
Civilian Unemployed	5.4%
In Armed Forces	0.1%
Not In Labor Force	41.7%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	88.9%
Civilian Unemployed	11.1%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	89.5%
Civilian Unemployed	10.5%

2000 Females 16+ by Employment Status and Age of Children

Total	14,342
Own Children < 6 Only	6.7%
Employed/in Armed Forces	2.8%
Unemployed	0.3%
Not in Labor Force	3.7%
Own Children <6 and 6-17 Only	11.2%
Employed/in Armed Forces	5.3%
Unemployed	0.6%
Not in Labor Force	5.3%
Own Children 6-17 Only	19.3%
Employed/in Armed Forces	10.4%
Unemployed	1.1%
Not in Labor Force	7.7%
No Own Children < 18	62.8%
Employed/in Armed Forces	25.9%
Unemployed	3.6%
Not in Labor Force	33.2%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



**2008 Employed Population 16+ by Industry**

Total	16,018
Agriculture/Mining	0.1%
Construction	7.0%
Manufacturing	19.7%
Wholesale Trade	6.3%
Retail Trade	11.7%
Transportation/Utilities	5.8%
Information	1.7%
Finance/Insurance/Real Estate	5.0%
Services	40.7%
Public Administration	2.0%

**2008 Employed Population 16+ by Occupation**

Total	16,019
White Collar	41.3%
Management/Business/Financial	6.2%
Professional	10.8%
Sales	9.2%
Administrative Support	15.1%
Services	18.8%
Blue Collar	39.9%
Farming/Forestry/Fishing	0.1%
Construction/Extraction	6.8%
Installation/Maintenance/Repair	5.4%
Production	14.9%
Transportation/Material Moving	12.8%



**2000 Workers 16+ by Means of Transportation to Work**

Total	14,752
Drove Alone - Car, Truck, or Van	65.2%
Carpooled - Car, Truck, or Van	25.0%
Public Transportation	5.1%
Walked	1.4%
Other Means	1.9%
Worked at Home	1.5%

**2000 Workers 16+ by Travel Time to Work**

Total	14,751
Did not Work at Home	98.5%
Less than 5 minutes	1.0%
5 to 9 minutes	6.9%
10 to 19 minutes	25.5%
20 to 24 minutes	11.7%
25 to 34 minutes	23.8%
35 to 44 minutes	7.5%
45 to 59 minutes	10.4%
60 to 89 minutes	8.3%
90 or more minutes	3.5%
Worked at Home	1.5%
Average Travel Time to Work (in min)	30.0

**2000 Households by Vehicles Available**

Total	9,466
None	10.6%
1	28.6%
2	34.8%
3	16.0%
4	7.6%
5+	2.4%
Average Number of Vehicles Available	1.9

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



2000 Households by Type

Total	9,462
Family Households	87.1%
Married-couple Family	61.0%
With Related Children	43.3%
Other Family (No Spouse)	26.1%
With Related Children	17.1%
Nonfamily Households	12.9%
Householder Living Alone	9.6%
Householder Not Living Alone	3.3%
Households with Related Children	60.4%
Households with Persons 65+	25.1%

2000 Households by Size

Total	9,461
1 Person Household	9.6%
2 Person Household	16.5%
3 Person Household	15.0%
4 Person Household	17.3%
5 Person Household	14.4%
6 Person Household	10.2%
7 + Person Household	17.1%

2000 Households by Year Householder Moved In

Total	9,467
Moved in 1999 to March 2000	15.9%
Moved in 1995 to 1998	26.2%
Moved in 1990 to 1994	15.7%
Moved in 1980 to 1989	16.2%
Moved in 1970 to 1979	11.6%
Moved in 1969 or Earlier	14.4%
Median Year Householder Moved In	1992



2000 Housing Units by Units in Structure

Total	9,666
1, Detached	68.3%
1, Attached	6.4%
2	0.8%
3 or 4	2.6%
5 to 9	3.1%
10 to 19	3.5%
20 +	14.1%
Mobile Home	1.1%
Other	0.1%

2000 Housing Units by Year Structure Built

Total	9,665
1999 to March 2000	0.5%
1995 to 1998	1.3%
1990 to 1994	2.7%
1980 to 1989	7.3%
1970 to 1979	13.0%
1969 or Earlier	75.1%
Median Year Structure Built	1958

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$18,752,202
Average Spent	\$1,939.01
Spending Potential Index	72
Computers & Accessories: Total \$	\$2,231,234
Average Spent	\$230.71
Spending Potential Index	96
Education: Total \$	\$9,804,001
Average Spent	\$1,013.75
Spending Potential Index	74
Entertainment/Recreation: Total \$	\$29,510,351
Average Spent	\$3,051.43
Spending Potential Index	82
Food at Home: Total \$	\$39,901,163
Average Spent	\$4,125.86
Spending Potential Index	84
Food Away from Home: Total \$	\$26,576,415
Average Spent	\$2,748.05
Spending Potential Index	80
Health Care: Total \$	\$28,101,617
Average Spent	\$2,905.76
Spending Potential Index	71
HH Furnishings & Equip: Total \$	\$19,707,064
Average Spent	\$2,037.75
Spending Potential Index	89
Investments: Total \$	\$7,336,320
Average Spent	\$758.59
Spending Potential Index	75
Retail Goods: Total \$	\$222,074,580
Average Spent	\$22,962.94
Spending Potential Index	85
Shelter: Total \$	\$145,988,398
Average Spent	\$15,095.48
Spending Potential Index	97
TV/Video/Sound Equipment: Total \$	\$11,379,902
Average Spent	\$1,176.70
Spending Potential Index	82
Travel: Total \$	\$16,888,334
Average Spent	\$1,746.29
Spending Potential Index	93
Vehicle Maintenance & Repairs: Total \$	\$8,857,681
Average Spent	\$915.90
Spending Potential Index	92

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: La Verne

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	31,638
2000 Group Quarters	820
2008 Total Population	32,551
2013 Total Population	33,109
2008-2013 Annual Rate	0.34%



2000 Households	11,070
2000 Average Household Size	2.78
2008 Households	11,092
2008 Average Household Size	2.86
2013 Households	11,214
2013 Average Household Size	2.88
2008-2013 Annual Rate	0.22%
2000 Families	8,273
2000 Average Family Size	3.23
2008 Families	8,295
2008 Average Family Size	3.35
2013 Families	8,358
2013 Average Family Size	3.39
2008-2013 Annual Rate	0.15%



<b>2000 Housing Units</b>	11,286
Owner Occupied Housing Units	75.4%
Renter Occupied Housing Units	22.6%
Vacant Housing Units	2.0%

<b>2008 Housing Units</b>	11,346
Owner Occupied Housing Units	76.4%
Renter Occupied Housing Units	21.3%
Vacant Housing Units	2.2%

<b>2013 Housing Units</b>	11,463
Owner Occupied Housing Units	75.4%
Renter Occupied Housing Units	22.4%
Vacant Housing Units	2.2%

<b>Median Household Income</b>	
2000	\$60,655
2008	\$75,950
2013	\$87,941

<b>Median Home Value</b>	
2000	\$217,386
2008	\$563,148
2013	\$583,624

<b>Per Capita Income</b>	
2000	\$26,605
2008	\$35,415
2013	\$43,539

<b>Median Age</b>	
2000	37.7
2008	40.2
2013	41.1

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Verne

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Household by Income

Household Income Base	11,041
<15,000	9.7%
\$15,000 - \$24,999	7.8%
\$25,000 - \$34,999	9.9%
\$35,000 - \$49,999	13.1%
\$50,000 - \$74,999	20.8%
\$75,000 - \$99,999	16.5%
\$100,000 - \$149,999	14.3%
\$150,000 - \$199,999	4.1%
\$200,000+	3.7%
Average Household Income	\$74,830

2008 Household by Income

Household Income Base	11,093
<15,000	6.8%
\$15,000 - \$24,999	5.7%
\$25,000 - \$34,999	7.3%
\$35,000 - \$49,999	10.6%
\$50,000 - \$74,999	18.7%
\$75,000 - \$99,999	18.1%
\$100,000 - \$149,999	17.0%
\$150,000 - \$199,999	8.1%
\$200,000+	7.7%
Average Household Income	\$101,228

2013 Household by Income

Household Income Base	11,213
<15,000	5.8%
\$15,000 - \$24,999	4.7%
\$25,000 - \$34,999	5.3%
\$35,000 - \$49,999	8.3%
\$50,000 - \$74,999	16.2%
\$75,000 - \$99,999	16.3%
\$100,000 - \$149,999	21.1%
\$150,000 - \$199,999	8.7%
\$200,000+	13.6%
Average Household Income	\$125,300

2000 Owner Occupied HUs by Value

Total	8,531
<50,000	13.1%
\$50,000 - \$99,999	9.0%
\$100,000 - \$149,999	4.9%
\$150,000 - \$199,999	15.3%
\$200,000 - \$299,999	34.5%
\$300,000 - \$499,999	19.3%
\$500,000 - \$999,999	3.6%
\$1,000,000 +	0.4%
Average Home Value	\$226,268

2000 Specified Renter Occupied HUs by Contract Rent

Total	2,514
With Cash Rent	96.6%
No Cash Rent	3.4%
Median Rent	\$776
Average Rent	\$771

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Verne

Demographic

Place Outlines (Local)



2000 Population by Age

Total	31,640
0 - 4	5.7%
5 - 9	7.0%
10 - 14	7.7%
15 - 24	14.4%
25 - 34	11.2%
35 - 44	16.1%
45 - 54	15.0%
55 - 64	9.4%
65 - 74	6.7%
75 - 84	4.9%
85 +	1.8%
18 +	74.9%

2008 Population by Age

Total	32,554
0 - 4	5.6%
5 - 9	5.9%
10 - 14	6.6%
15 - 24	13.9%
25 - 34	11.6%
35 - 44	13.2%
45 - 54	15.4%
55 - 64	13.5%
65 - 74	7.4%
75 - 84	4.8%
85 +	2.2%
18 +	77.6%

2013 Population by Age

Total	33,105
0 - 4	5.6%
5 - 9	5.7%
10 - 14	6.1%
15 - 24	13.0%
25 - 34	11.7%
35 - 44	12.9%
45 - 54	14.7%
55 - 64	14.6%
65 - 74	8.6%
75 - 84	4.7%
85 +	2.4%
18 +	78.6%

2000 Population by Sex

Males	48.2%
Females	51.8%

2008 Population by Sex

Males	48.3%
Females	51.7%

2013 Population by Sex

Males	48.3%
Females	51.7%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Verne

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	31,638
White Alone	77.2%
Black Alone	3.2%
American Indian Alone	0.6%
Asian or Pacific Islander Alone	7.1%
Some Other Race Alone	7.6%
Two or More Races	4.3%
Hispanic Origin	23.2%
Diversity Index	61.2

2008 Population by Race/Ethnicity

Total	32,551
White Alone	70.9%
Black Alone	3.3%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	8.8%
Some Other Race Alone	10.4%
Two or More Races	5.9%
Hispanic Origin	32.1%
Diversity Index	71.2

2013 Population by Race/Ethnicity

Total	33,110
White Alone	67.1%
Black Alone	3.3%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	9.8%
Some Other Race Alone	12.3%
Two or More Races	6.8%
Hispanic Origin	37.6%
Diversity Index	75.5

2000 Population 3+ by School Enrollment

Total	30,695
Enrolled in Nursery/Preschool	1.7%
Enrolled in Kindergarten	1.5%
Enrolled in Grade 1-8	12.7%
Enrolled in Grade 9-12	7.2%
Enrolled in College	8.1%
Enrolled in Grad/Prof School	1.5%
Not Enrolled in School	67.2%

2008 Population 25+ by Educational Attainment

Total	22,158
Less Than 9th Grade	3.1%
9th to 12th Grade, No Diploma	5.9%
High School Graduate	21.4%
Some College, No Degree	25.2%
Associate Degree	9.5%
Bachelor's Degree	21.9%
Master's/Prof/Doctorate Degree	13.1%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Verne

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	26,687.0
Married	57.5%
Never Married	28.6%
Widowed	5.5%
Divorced	8.5%



2000 Population 16+ by Employment Status

Total	24,617
In Labor Force	66.3%
Civilian Employed	62.9%
Civilian Unemployed	3.4%
In Armed Forces	0.0%
Not In Labor Force	33.7%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	94.4%
Civilian Unemployed	5.6%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	94.7%
Civilian Unemployed	5.3%

2000 Females 16+ by Employment Status and Age of Children

Total	13,001
Own Children < 6 Only	5.6%
Employed/in Armed Forces	3.6%
Unemployed	0.1%
Not in Labor Force	1.9%
Own Children <6 and 6-17 Only	5.2%
Employed/in Armed Forces	3.1%
Unemployed	0.1%
Not in Labor Force	2.0%
Own Children 6-17 Only	19.7%
Employed/in Armed Forces	15.1%
Unemployed	0.6%
Not in Labor Force	4.0%
No Own Children < 18	69.4%
Employed/in Armed Forces	35.5%
Unemployed	1.8%
Not in Labor Force	32.1%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Verne

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	16,500
Agriculture/Mining	0.4%
Construction	6.7%
Manufacturing	9.1%
Wholesale Trade	3.9%
Retail Trade	11.0%
Transportation/Utilities	4.3%
Information	2.5%
Finance/Insurance/Real Estate	9.2%
Services	47.7%
Public Administration	5.1%

2008 Employed Population 16+ by Occupation

Total	16,502
White Collar	71.4%
Management/Business/Financial	18.5%
Professional	26.3%
Sales	12.1%
Administrative Support	14.5%
Services	13.6%
Blue Collar	15.1%
Farming/Forestry/Fishing	0.0%
Construction/Extraction	4.3%
Installation/Maintenance/Repair	3.1%
Production	3.7%
Transportation/Material Moving	3.9%



2000 Workers 16+ by Means of Transportation to Work

Total	15,127
Drove Alone - Car, Truck, or Van	78.5%
Carpooled - Car, Truck, or Van	13.4%
Public Transportation	2.9%
Walked	2.1%
Other Means	0.8%
Worked at Home	2.3%

2000 Workers 16+ by Travel Time to Work

Total	15,127
Did not Work at Home	97.7%
Less than 5 minutes	2.1%
5 to 9 minutes	8.4%
10 to 19 minutes	25.3%
20 to 24 minutes	12.1%
25 to 34 minutes	17.4%
35 to 44 minutes	6.8%
45 to 59 minutes	11.9%
60 to 89 minutes	9.9%
90 or more minutes	3.7%
Worked at Home	2.3%
Average Travel Time to Work (in min)	30.4

2000 Households by Vehicles Available

Total	11,061
None	5.3%
1	26.9%
2	41.7%
3	17.6%
4	5.7%
5+	2.7%
Average Number of Vehicles Available	2.0

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: La Verne

Demographic

Place Outlines (Local)



2000 Households by Type

Total	11,070
Family Households	74.7%
Married-couple Family	59.3%
With Related Children	29.0%
Other Family (No Spouse)	15.4%
With Related Children	8.8%
Nonfamily Households	25.3%
Householder Living Alone	20.2%
Householder Not Living Alone	5.0%
Households with Related Children	37.7%
Households with Persons 65+	27.5%

2000 Households by Size

Total	11,070
1 Person Household	20.2%
2 Person Household	32.4%
3 Person Household	17.3%
4 Person Household	17.0%
5 Person Household	8.9%
6 Person Household	2.7%
7 + Person Household	1.5%

2000 Households by Year Householder Moved In

Total	11,060
Moved in 1999 to March 2000	11.7%
Moved in 1995 to 1998	30.8%
Moved in 1990 to 1994	14.8%
Moved in 1980 to 1989	25.0%
Moved in 1970 to 1979	12.6%
Moved in 1969 or Earlier	5.2%
Median Year Householder Moved In	1992



2000 Housing Units by Units in Structure

Total	11,272
1, Detached	66.1%
1, Attached	5.3%
2	0.6%
3 or 4	5.7%
5 to 9	1.9%
10 to 19	0.9%
20 +	3.9%
Mobile Home	15.4%
Other	0.2%

2000 Housing Units by Year Structure Built

Total	11,274
1999 to March 2000	0.7%
1995 to 1998	3.4%
1990 to 1994	2.1%
1980 to 1989	19.9%
1970 to 1979	38.9%
1969 or Earlier	35.0%
Median Year Structure Built	1974

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: La Verne

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$33,845,564
Average Spent	\$3,051.35
Spending Potential Index	114
Computers & Accessories: Total \$	\$3,691,597
Average Spent	\$332.82
Spending Potential Index	139
Education: Total \$	\$22,261,729
Average Spent	\$2,007.01
Spending Potential Index	146
Entertainment/Recreation: Total \$	\$56,706,639
Average Spent	\$5,112.39
Spending Potential Index	138
Food at Home: Total \$	\$71,001,220
Average Spent	\$6,401.12
Spending Potential Index	131
Food Away from Home: Total \$	\$50,654,935
Average Spent	\$4,566.80
Spending Potential Index	133
Health Care: Total \$	\$60,107,440
Average Spent	\$5,418.99
Spending Potential Index	132
HH Furnishings & Equip: Total \$	\$34,632,367
Average Spent	\$3,122.28
Spending Potential Index	136
Investments: Total \$	\$19,362,634
Average Spent	\$1,745.64
Spending Potential Index	172
Retail Goods: Total \$	\$401,385,344
Average Spent	\$36,186.92
Spending Potential Index	133
Shelter: Total \$	\$245,617,020
Average Spent	\$22,143.62
Spending Potential Index	143
TV/Video/Sound Equipment: Total \$	\$21,120,058
Average Spent	\$1,904.08
Spending Potential Index	133
Travel: Total \$	\$31,180,370
Average Spent	\$2,811.07
Spending Potential Index	149
Vehicle Maintenance & Repairs: Total \$	\$14,963,159
Average Spent	\$1,349.00
Spending Potential Index	136

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Rowland Heights

Demographic

Place Outlines (Local)



2000 Total Population	48,553
2000 Group Quarters	157
2008 Total Population	50,738
2013 Total Population	52,158
2008-2013 Annual Rate	0.55%



2000 Households	14,175
2000 Average Household Size	3.41
2008 Households	14,380
2008 Average Household Size	3.52
2013 Households	14,681
2013 Average Household Size	3.54
2008-2013 Annual Rate	0.42%
2000 Families	11,963
2000 Average Family Size	3.64
2008 Families	12,142
2008 Average Family Size	3.77
2013 Families	12,367
2013 Average Family Size	3.82
2008-2013 Annual Rate	0.37%



<b>2000 Housing Units</b>	14,543
Owner Occupied Housing Units	64.1%
Renter Occupied Housing Units	33.3%
Vacant Housing Units	2.5%

<b>2008 Housing Units</b>	14,771
Owner Occupied Housing Units	65.6%
Renter Occupied Housing Units	31.7%
Vacant Housing Units	2.6%

<b>2013 Housing Units</b>	15,075
Owner Occupied Housing Units	64.8%
Renter Occupied Housing Units	32.6%
Vacant Housing Units	2.6%

<b>Median Household Income</b>	
2000	\$52,951
2008	\$66,748
2013	\$76,227

<b>Median Home Value</b>	
2000	\$208,555
2008	\$567,662
2013	\$599,319

<b>Per Capita Income</b>	
2000	\$19,292
2008	\$24,429
2013	\$28,911

<b>Median Age</b>	
2000	34.6
2008	36.0
2013	37.2

Data Note: Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	14,183
<15,000	12.0%
\$15,000 - \$24,999	11.0%
\$25,000 - \$34,999	9.5%
\$35,000 - \$49,999	14.7%
\$50,000 - \$74,999	20.5%
\$75,000 - \$99,999	12.6%
\$100,000 - \$149,999	13.4%
\$150,000 - \$199,999	3.9%
\$200,000+	2.4%
Average Household Income	\$65,818

2008 Household by Income

Household Income Base	14,379
<15,000	8.1%
\$15,000 - \$24,999	7.4%
\$25,000 - \$34,999	8.8%
\$35,000 - \$49,999	12.6%
\$50,000 - \$74,999	18.4%
\$75,000 - \$99,999	17.9%
\$100,000 - \$149,999	14.9%
\$150,000 - \$199,999	6.3%
\$200,000+	5.5%
Average Household Income	\$85,935

2013 Household by Income

Household Income Base	14,680
<15,000	6.9%
\$15,000 - \$24,999	5.7%
\$25,000 - \$34,999	7.3%
\$35,000 - \$49,999	8.9%
\$50,000 - \$74,999	20.1%
\$75,000 - \$99,999	15.6%
\$100,000 - \$149,999	19.2%
\$150,000 - \$199,999	6.9%
\$200,000+	9.4%
Average Household Income	\$102,421

2000 Owner Occupied HUs by Value

Total	9,379
<50,000	9.3%
\$50,000 - \$99,999	2.9%
\$100,000 - \$149,999	7.6%
\$150,000 - \$199,999	27.9%
\$200,000 - \$299,999	23.4%
\$300,000 - \$499,999	23.9%
\$500,000 - \$999,999	5.0%
\$1,000,000 +	0.0%
Average Home Value	\$244,166

2000 Specified Renter Occupied HUs by Contract Rent

Total	4,800
With Cash Rent	96.5%
No Cash Rent	3.5%
Median Rent	\$791
Average Rent	\$824

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Rowland Heights

Demographic

Place Outlines (Local)



2000 Population by Age

Total	48,553
0 - 4	6.5%
5 - 9	7.3%
10 - 14	7.4%
15 - 24	14.9%
25 - 34	14.4%
35 - 44	16.0%
45 - 54	15.1%
55 - 64	9.5%
65 - 74	5.2%
75 - 84	2.9%
85 +	0.8%
18 +	74.0%

2008 Population by Age

Total	50,739
0 - 4	6.6%
5 - 9	6.1%
10 - 14	6.6%
15 - 24	14.2%
25 - 34	15.1%
35 - 44	14.2%
45 - 54	14.5%
55 - 64	12.0%
65 - 74	6.3%
75 - 84	3.2%
85 +	1.2%
18 +	76.4%

2013 Population by Age

Total	52,158
0 - 4	6.7%
5 - 9	6.2%
10 - 14	5.9%
15 - 24	13.6%
25 - 34	14.5%
35 - 44	14.3%
45 - 54	14.1%
55 - 64	12.5%
65 - 74	7.1%
75 - 84	3.6%
85 +	1.5%
18 +	77.3%

2000 Population by Sex

Males	49.2%
Females	50.8%

2008 Population by Sex

Males	49.2%
Females	50.8%

2013 Population by Sex

Males	49.3%
Females	50.7%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Rowland Heights

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	48,554
White Alone	29.5%
Black Alone	2.7%
American Indian Alone	0.5%
Asian or Pacific Islander Alone	50.2%
Some Other Race Alone	13.0%
Two or More Races	4.2%
Hispanic Origin	28.5%
Diversity Index	80.1

2008 Population by Race/Ethnicity

Total	50,738
White Alone	26.1%
Black Alone	2.3%
American Indian Alone	0.4%
Asian or Pacific Islander Alone	51.4%
Some Other Race Alone	15.1%
Two or More Races	4.7%
Hispanic Origin	32.9%
Diversity Index	81.6

2013 Population by Race/Ethnicity

Total	52,158
White Alone	24.7%
Black Alone	2.1%
American Indian Alone	0.4%
Asian or Pacific Islander Alone	51.5%
Some Other Race Alone	16.3%
Two or More Races	5.0%
Hispanic Origin	35.2%
Diversity Index	82.4

2000 Population 3+ by School Enrollment

Total	46,601
Enrolled in Nursery/Preschool	1.8%
Enrolled in Kindergarten	1.9%
Enrolled in Grade 1-8	11.7%
Enrolled in Grade 9-12	7.7%
Enrolled in College	9.0%
Enrolled in Grad/Prof School	2.3%
Not Enrolled in School	65.7%

2008 Population 25+ by Educational Attainment

Total	33,761
Less Than 9th Grade	6.3%
9th to 12th Grade, No Diploma	7.8%
High School Graduate	23.3%
Some College, No Degree	17.0%
Associate Degree	8.5%
Bachelor's Degree	25.3%
Master's/Prof/Doctorate Degree	11.7%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Rowland Heights

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	40,940.0
Married	58.8%
Never Married	30.4%
Widowed	4.0%
Divorced	6.7%



2000 Population 16+ by Employment Status

Total	37,389
In Labor Force	59.6%
Civilian Employed	56.4%
Civilian Unemployed	3.2%
In Armed Forces	0.0%
Not In Labor Force	40.4%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	93.5%
Civilian Unemployed	6.5%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	93.9%
Civilian Unemployed	6.1%

2000 Females 16+ by Employment Status and Age of Children

Total	19,296
Own Children < 6 Only	6.9%
Employed/in Armed Forces	3.0%
Unemployed	0.2%
Not in Labor Force	3.8%
Own Children <6 and 6-17 Only	6.4%
Employed/in Armed Forces	3.3%
Unemployed	0.4%
Not in Labor Force	2.7%
Own Children 6-17 Only	18.6%
Employed/in Armed Forces	12.3%
Unemployed	0.6%
Not in Labor Force	5.7%
No Own Children < 18	68.1%
Employed/in Armed Forces	30.8%
Unemployed	1.6%
Not in Labor Force	35.7%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Rowland Heights

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	22,633
Agriculture/Mining	0.1%
Construction	4.0%
Manufacturing	12.1%
Wholesale Trade	9.8%
Retail Trade	11.5%
Transportation/Utilities	5.4%
Information	2.5%
Finance/Insurance/Real Estate	8.5%
Services	42.4%
Public Administration	3.7%

2008 Employed Population 16+ by Occupation

Total	22,633
White Collar	70.6%
Management/Business/Financial	18.3%
Professional	21.9%
Sales	15.0%
Administrative Support	15.3%
Services	12.9%
Blue Collar	16.5%
Farming/Forestry/Fishing	0.1%
Construction/Extraction	3.2%
Installation/Maintenance/Repair	3.0%
Production	5.2%
Transportation/Material Moving	5.0%



2000 Workers 16+ by Means of Transportation to Work

Total	20,705
Drove Alone - Car, Truck, or Van	76.3%
Carpooled - Car, Truck, or Van	14.2%
Public Transportation	2.8%
Walked	1.9%
Other Means	1.8%
Worked at Home	3.1%

2000 Workers 16+ by Travel Time to Work

Total	20,704
Did not Work at Home	96.9%
Less than 5 minutes	0.8%
5 to 9 minutes	4.8%
10 to 19 minutes	21.3%
20 to 24 minutes	10.8%
25 to 34 minutes	22.6%
35 to 44 minutes	9.2%
45 to 59 minutes	12.0%
60 to 89 minutes	11.5%
90 or more minutes	4.0%
Worked at Home	3.1%
Average Travel Time to Work (in min)	34.2

2000 Households by Vehicles Available

Total	14,178
None	7.3%
1	24.6%
2	39.4%
3	19.0%
4	6.9%
5+	2.9%
Average Number of Vehicles Available	2.0

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Households by Type

Total	14,176
Family Households	84.4%
Married-couple Family	64.3%
With Related Children	35.3%
Other Family (No Spouse)	20.1%
With Related Children	11.0%
Nonfamily Households	15.6%
Householder Living Alone	11.5%
Householder Not Living Alone	4.1%
Households with Related Children	46.3%
Households with Persons 65+	22.0%

2000 Households by Size

Total	14,175
1 Person Household	11.5%
2 Person Household	23.7%
3 Person Household	20.3%
4 Person Household	21.5%
5 Person Household	12.2%
6 Person Household	6.1%
7 + Person Household	4.7%

2000 Households by Year Householder Moved In

Total	14,177
Moved in 1999 to March 2000	20.6%
Moved in 1995 to 1998	30.4%
Moved in 1990 to 1994	15.9%
Moved in 1980 to 1989	20.2%
Moved in 1970 to 1979	9.2%
Moved in 1969 or Earlier	3.6%
Median Year Householder Moved In	1995



2000 Housing Units by Units in Structure

Total	14,545
1, Detached	69.2%
1, Attached	3.1%
2	0.7%
3 or 4	6.3%
5 to 9	2.5%
10 to 19	1.9%
20 +	12.3%
Mobile Home	3.9%
Other	0.0%

2000 Housing Units by Year Structure Built

Total	14,544
1999 to March 2000	0.8%
1995 to 1998	5.7%
1990 to 1994	4.5%
1980 to 1989	24.1%
1970 to 1979	32.3%
1969 or Earlier	32.6%
Median Year Structure Built	1975

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$37,527,333
Average Spent	\$2,609.69
Spending Potential Index	97
Computers & Accessories: Total \$	\$4,456,645
Average Spent	\$309.92
Spending Potential Index	130
Education: Total \$	\$23,275,553
Average Spent	\$1,618.61
Spending Potential Index	118
Entertainment/Recreation: Total \$	\$62,008,597
Average Spent	\$4,312.14
Spending Potential Index	116
Food at Home: Total \$	\$77,705,741
Average Spent	\$5,403.74
Spending Potential Index	111
Food Away from Home: Total \$	\$54,706,478
Average Spent	\$3,804.34
Spending Potential Index	111
Health Care: Total \$	\$59,673,915
Average Spent	\$4,149.79
Spending Potential Index	101
HH Furnishings & Equip: Total \$	\$39,544,604
Average Spent	\$2,749.97
Spending Potential Index	120
Investments: Total \$	\$19,450,768
Average Spent	\$1,352.63
Spending Potential Index	133
Retail Goods: Total \$	\$441,252,639
Average Spent	\$30,685.16
Spending Potential Index	113
Shelter: Total \$	\$288,978,879
Average Spent	\$20,095.89
Spending Potential Index	129
TV/Video/Sound Equipment: Total \$	\$23,187,751
Average Spent	\$1,612.50
Spending Potential Index	112
Travel: Total \$	\$36,194,418
Average Spent	\$2,517.00
Spending Potential Index	134
Vehicle Maintenance & Repairs: Total \$	\$17,186,197
Average Spent	\$1,195.15
Spending Potential Index	120

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: San Dimas

Demographic

Place Outlines (Local)



2000 Total Population	34,944
2000 Group Quarters	1,147
2008 Total Population	36,853
2013 Total Population	37,994
2008-2013 Annual Rate	0.61%



2000 Households	12,150
2000 Average Household Size	2.78
2008 Households	12,501
2008 Average Household Size	2.85
2013 Households	12,824
2013 Average Household Size	2.87
2008-2013 Annual Rate	0.51%
2000 Families	9,098
2000 Average Family Size	3.21
2008 Families	9,371
2008 Average Family Size	3.33
2013 Families	9,581
2013 Average Family Size	3.37
2008-2013 Annual Rate	0.44%



<b>2000 Housing Units</b>	12,489
Owner Occupied Housing Units	72.3%
Renter Occupied Housing Units	25.1%
Vacant Housing Units	2.6%

<b>2008 Housing Units</b>	12,877
Owner Occupied Housing Units	73.3%
Renter Occupied Housing Units	23.8%
Vacant Housing Units	2.9%

<b>2013 Housing Units</b>	13,203
Owner Occupied Housing Units	72.4%
Renter Occupied Housing Units	24.7%
Vacant Housing Units	2.9%

<b>Median Household Income</b>	
2000	\$63,490
2008	\$80,164
2013	\$97,027

<b>Median Home Value</b>	
2000	\$219,698
2008	\$580,909
2013	\$597,659

<b>Per Capita Income</b>	
2000	\$28,504
2008	\$36,320
2013	\$44,298

<b>Median Age</b>	
2000	37.0
2008	38.9
2013	39.9

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



**2000 Household by Income**

Household Income Base	12,163
<15,000	7.1%
\$15,000 - \$24,999	7.8%
\$25,000 - \$34,999	8.1%
\$35,000 - \$49,999	14.0%
\$50,000 - \$74,999	22.0%
\$75,000 - \$99,999	15.7%
\$100,000 - \$149,999	15.8%
\$150,000 - \$199,999	4.9%
\$200,000+	4.4%
Average Household Income	\$81,572

**2008 Household by Income**

Household Income Base	12,500
<15,000	4.9%
\$15,000 - \$24,999	4.0%
\$25,000 - \$34,999	6.7%
\$35,000 - \$49,999	9.5%
\$50,000 - \$74,999	19.5%
\$75,000 - \$99,999	20.1%
\$100,000 - \$149,999	18.9%
\$150,000 - \$199,999	8.1%
\$200,000+	8.4%
Average Household Income	\$106,560

**2013 Household by Income**

Household Income Base	12,823
<15,000	4.1%
\$15,000 - \$24,999	3.2%
\$25,000 - \$34,999	4.2%
\$35,000 - \$49,999	7.5%
\$50,000 - \$74,999	15.4%
\$75,000 - \$99,999	17.1%
\$100,000 - \$149,999	24.5%
\$150,000 - \$199,999	9.3%
\$200,000+	14.6%
Average Household Income	\$130,919

**2000 Owner Occupied HUs by Value**

Total	9,032
<50,000	7.6%
\$50,000 - \$99,999	2.7%
\$100,000 - \$149,999	10.0%
\$150,000 - \$199,999	21.6%
\$200,000 - \$299,999	35.9%
\$300,000 - \$499,999	18.2%
\$500,000 - \$999,999	3.7%
\$1,000,000 +	0.3%
Average Home Value	\$241,286

**2000 Specified Renter Occupied HUs by Contract Rent**

Total	3,117
With Cash Rent	95.6%
No Cash Rent	4.4%
Median Rent	\$824
Average Rent	\$825

**Data Note:** Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: San Dimas

Demographic

Place Outlines (Local)



2000 Population by Age

Total	34,945
0 - 4	5.9%
5 - 9	7.3%
10 - 14	7.8%
15 - 24	13.8%
25 - 34	12.0%
35 - 44	16.2%
45 - 54	15.7%
55 - 64	9.8%
65 - 74	5.7%
75 - 84	4.1%
85 +	1.5%
18 +	74.1%

2008 Population by Age

Total	36,853
0 - 4	5.8%
5 - 9	6.0%
10 - 14	6.8%
15 - 24	14.1%
25 - 34	12.2%
35 - 44	13.5%
45 - 54	15.6%
55 - 64	12.8%
65 - 74	6.7%
75 - 84	4.4%
85 +	2.0%
18 +	76.7%

2013 Population by Age

Total	37,994
0 - 4	6.0%
5 - 9	5.8%
10 - 14	6.1%
15 - 24	13.2%
25 - 34	12.7%
35 - 44	13.1%
45 - 54	15.0%
55 - 64	13.8%
65 - 74	7.6%
75 - 84	4.4%
85 +	2.3%
18 +	77.9%

2000 Population by Sex

Males	48.2%
Females	51.8%

2008 Population by Sex

Males	47.9%
Females	52.1%

2013 Population by Sex

Males	47.8%
Females	52.2%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	34,943
White Alone	74.5%
Black Alone	3.4%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	9.5%
Some Other Race Alone	7.5%
Two or More Races	4.4%
Hispanic Origin	23.7%
Diversity Index	63.9

2008 Population by Race/Ethnicity

Total	36,853
White Alone	67.7%
Black Alone	3.5%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	11.6%
Some Other Race Alone	10.6%
Two or More Races	6.0%
Hispanic Origin	32.8%
Diversity Index	73.6

2013 Population by Race/Ethnicity

Total	37,994
White Alone	63.8%
Black Alone	3.4%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	12.7%
Some Other Race Alone	12.5%
Two or More Races	7.0%
Hispanic Origin	38.4%
Diversity Index	77.7

2000 Population 3+ by School Enrollment

Total	33,754
Enrolled in Nursery/Preschool	1.7%
Enrolled in Kindergarten	1.4%
Enrolled in Grade 1-8	13.0%
Enrolled in Grade 9-12	6.8%
Enrolled in College	7.7%
Enrolled in Grad/Prof School	1.4%
Not Enrolled in School	68.1%

2008 Population 25+ by Educational Attainment

Total	24,796
Less Than 9th Grade	2.7%
9th to 12th Grade, No Diploma	6.6%
High School Graduate	19.7%
Some College, No Degree	28.4%
Associate Degree	10.5%
Bachelor's Degree	21.9%
Master's/Prof/Doctorate Degree	10.2%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: San Dimas

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	30,009.0
Married	56.5%
Never Married	27.3%
Widowed	5.8%
Divorced	10.4%



2000 Population 16+ by Employment Status

Total	27,068
In Labor Force	66.7%
Civilian Employed	63.1%
Civilian Unemployed	3.7%
In Armed Forces	0.0%
Not In Labor Force	33.3%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	94.3%
Civilian Unemployed	5.7%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	94.6%
Civilian Unemployed	5.4%

2000 Females 16+ by Employment Status and Age of Children

Total	14,294
Own Children < 6 Only	6.4%
Employed/in Armed Forces	3.5%
Unemployed	0.2%
Not in Labor Force	2.8%
Own Children <6 and 6-17 Only	6.9%
Employed/in Armed Forces	3.8%
Unemployed	0.1%
Not in Labor Force	3.0%
Own Children 6-17 Only	17.0%
Employed/in Armed Forces	12.0%
Unemployed	0.3%
Not in Labor Force	4.7%
No Own Children < 18	69.7%
Employed/in Armed Forces	36.6%
Unemployed	2.5%
Not in Labor Force	30.5%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: San Dimas

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	18,699
Agriculture/Mining	0.3%
Construction	5.8%
Manufacturing	9.7%
Wholesale Trade	4.1%
Retail Trade	11.5%
Transportation/Utilities	3.8%
Information	2.5%
Finance/Insurance/Real Estate	8.4%
Services	49.0%
Public Administration	4.9%

2008 Employed Population 16+ by Occupation

Total	18,698
White Collar	72.6%
Management/Business/Financial	19.3%
Professional	24.8%
Sales	13.2%
Administrative Support	15.3%
Services	13.3%
Blue Collar	14.1%
Farming/Forestry/Fishing	0.1%
Construction/Extraction	3.9%
Installation/Maintenance/Repair	3.1%
Production	3.4%
Transportation/Material Moving	3.6%



2000 Workers 16+ by Means of Transportation to Work

Total	16,701
Drove Alone - Car, Truck, or Van	79.3%
Carpooled - Car, Truck, or Van	12.5%
Public Transportation	1.7%
Walked	2.0%
Other Means	1.1%
Worked at Home	3.3%

2000 Workers 16+ by Travel Time to Work

Total	16,704
Did not Work at Home	96.7%
Less than 5 minutes	2.3%
5 to 9 minutes	9.7%
10 to 19 minutes	23.5%
20 to 24 minutes	12.2%
25 to 34 minutes	16.4%
35 to 44 minutes	7.1%
45 to 59 minutes	12.4%
60 to 89 minutes	10.3%
90 or more minutes	2.8%
Worked at Home	3.3%
Average Travel Time to Work (in min)	30.0

2000 Households by Vehicles Available

Total	12,164
None	5.1%
1	27.4%
2	41.0%
3	18.6%
4	5.9%
5+	2.0%
Average Number of Vehicles Available	2.0

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Households by Type

Total	12,150
Family Households	74.9%
Married-couple Family	58.5%
With Related Children	29.2%
Other Family (No Spouse)	16.4%
With Related Children	10.1%
Nonfamily Households	25.1%
Householder Living Alone	20.0%
Householder Not Living Alone	5.2%
Households with Related Children	39.3%
Households with Persons 65+	22.0%

2000 Households by Size

Total	12,150
1 Person Household	20.0%
2 Person Household	31.0%
3 Person Household	18.5%
4 Person Household	17.4%
5 Person Household	8.3%
6 Person Household	3.1%
7 + Person Household	1.7%

2000 Households by Year Householder Moved In

Total	12,164
Moved in 1999 to March 2000	18.3%
Moved in 1995 to 1998	27.3%
Moved in 1990 to 1994	16.1%
Moved in 1980 to 1989	22.0%
Moved in 1970 to 1979	10.9%
Moved in 1969 or Earlier	5.4%
Median Year Householder Moved In	1994



2000 Housing Units by Units in Structure

Total	12,498
1, Detached	61.1%
1, Attached	17.2%
2	0.9%
3 or 4	2.0%
5 to 9	2.8%
10 to 19	1.1%
20 +	8.4%
Mobile Home	6.0%
Other	0.4%

2000 Housing Units by Year Structure Built

Total	12,498
1999 to March 2000	2.3%
1995 to 1998	3.8%
1990 to 1994	4.3%
1980 to 1989	23.7%
1970 to 1979	32.8%
1969 or Earlier	33.1%
Median Year Structure Built	1975

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: San Dimas

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$40,317,174
Average Spent	\$3,225.12
Spending Potential Index	120
Computers & Accessories: Total \$	\$4,460,731
Average Spent	\$356.83
Spending Potential Index	149
Education: Total \$	\$27,821,443
Average Spent	\$2,225.54
Spending Potential Index	162
Entertainment/Recreation: Total \$	\$66,647,494
Average Spent	\$5,331.37
Spending Potential Index	143
Food at Home: Total \$	\$83,777,442
Average Spent	\$6,701.66
Spending Potential Index	137
Food Away from Home: Total \$	\$60,306,172
Average Spent	\$4,824.11
Spending Potential Index	141
Health Care: Total \$	\$67,748,849
Average Spent	\$5,419.47
Spending Potential Index	132
HH Furnishings & Equip: Total \$	\$40,983,526
Average Spent	\$3,278.42
Spending Potential Index	143
Investments: Total \$	\$23,515,510
Average Spent	\$1,881.09
Spending Potential Index	185
Retail Goods: Total \$	\$472,241,316
Average Spent	\$37,776.28
Spending Potential Index	139
Shelter: Total \$	\$300,406,844
Average Spent	\$24,030.63
Spending Potential Index	155
TV/Video/Sound Equipment: Total \$	\$24,998,399
Average Spent	\$1,999.71
Spending Potential Index	139
Travel: Total \$	\$37,784,047
Average Spent	\$3,022.48
Spending Potential Index	160
Vehicle Maintenance & Repairs: Total \$	\$17,672,009
Average Spent	\$1,413.65
Spending Potential Index	142

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: South El Monte

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	21,144
2000 Group Quarters	45
2008 Total Population	21,568
2013 Total Population	21,993
2008-2013 Annual Rate	0.39%



2000 Households	4,620
2000 Average Household Size	4.57
2008 Households	4,679
2008 Average Household Size	4.60
2013 Households	4,763
2013 Average Household Size	4.61
2008-2013 Annual Rate	0.36%
2000 Families	4,091
2000 Average Family Size	4.61
2008 Families	4,146
2008 Average Family Size	4.68
2013 Families	4,215
2013 Average Family Size	4.70
2008-2013 Annual Rate	0.33%



<b>2000 Housing Units</b>	4,724
Owner Occupied Housing Units	48.9%
Renter Occupied Housing Units	48.8%
Vacant Housing Units	2.3%

<b>2008 Housing Units</b>	4,793
Owner Occupied Housing Units	50.3%
Renter Occupied Housing Units	47.3%
Vacant Housing Units	2.4%

<b>2013 Housing Units</b>	4,881
Owner Occupied Housing Units	49.1%
Renter Occupied Housing Units	48.5%
Vacant Housing Units	2.4%

<b>Median Household Income</b>	
2000	\$35,223
2008	\$44,811
2013	\$53,127

<b>Median Home Value</b>	
2000	\$152,659
2008	\$361,217
2013	\$377,400

<b>Per Capita Income</b>	
2000	\$10,344
2008	\$12,329
2013	\$14,271

<b>Median Age</b>	
2000	27.0
2008	27.8
2013	28.0

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: South El Monte

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	4,529
<15,000	13.8%
\$15,000 - \$24,999	19.4%
\$25,000 - \$34,999	16.4%
\$35,000 - \$49,999	18.2%
\$50,000 - \$74,999	17.2%
\$75,000 - \$99,999	8.7%
\$100,000 - \$149,999	4.7%
\$150,000 - \$199,999	0.9%
\$200,000+	0.6%
Average Household Income	\$46,170

2008 Household by Income

Household Income Base	4,678
<15,000	8.9%
\$15,000 - \$24,999	12.3%
\$25,000 - \$34,999	17.8%
\$35,000 - \$49,999	17.1%
\$50,000 - \$74,999	20.1%
\$75,000 - \$99,999	13.6%
\$100,000 - \$149,999	7.0%
\$150,000 - \$199,999	1.9%
\$200,000+	1.2%
Average Household Income	\$56,778

2013 Household by Income

Household Income Base	4,762
<15,000	7.5%
\$15,000 - \$24,999	10.0%
\$25,000 - \$34,999	13.5%
\$35,000 - \$49,999	15.3%
\$50,000 - \$74,999	23.6%
\$75,000 - \$99,999	14.0%
\$100,000 - \$149,999	11.7%
\$150,000 - \$199,999	2.4%
\$200,000+	2.0%
Average Household Income	\$65,846

2000 Owner Occupied HUs by Value

Total	2,328
<50,000	10.5%
\$50,000 - \$99,999	5.3%
\$100,000 - \$149,999	30.9%
\$150,000 - \$199,999	41.3%
\$200,000 - \$299,999	10.4%
\$300,000 - \$499,999	0.9%
\$500,000 - \$999,999	0.4%
\$1,000,000 +	0.2%
Average Home Value	\$149,402

2000 Specified Renter Occupied HUs by Contract Rent

Total	2,280
With Cash Rent	98.5%
No Cash Rent	1.5%
Median Rent	\$617
Average Rent	\$605

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: South El Monte

Demographic

Place Outlines (Local)



2000 Population by Age

Total	21,144
0 - 4	9.6%
5 - 9	10.2%
10 - 14	8.7%
15 - 24	17.8%
25 - 34	17.7%
35 - 44	13.5%
45 - 54	9.2%
55 - 64	6.1%
65 - 74	4.5%
75 - 84	2.1%
85 +	0.6%
18 +	66.4%

2008 Population by Age

Total	21,567
0 - 4	9.9%
5 - 9	9.2%
10 - 14	9.1%
15 - 24	17.0%
25 - 34	16.8%
35 - 44	14.6%
45 - 54	10.2%
55 - 64	6.7%
65 - 74	3.7%
75 - 84	2.1%
85 +	0.7%
18 +	66.2%

2013 Population by Age

Total	21,993
0 - 4	10.1%
5 - 9	9.3%
10 - 14	8.1%
15 - 24	18.0%
25 - 34	14.5%
35 - 44	14.2%
45 - 54	11.0%
55 - 64	8.0%
65 - 74	3.9%
75 - 84	2.1%
85 +	0.8%
18 +	67.2%

2000 Population by Sex

Males	51.0%
Females	49.0%

2008 Population by Sex

Males	51.0%
Females	49.0%

2013 Population by Sex

Males	50.9%
Females	49.1%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	21,145
White Alone	40.5%
Black Alone	0.4%
American Indian Alone	1.5%
Asian or Pacific Islander Alone	9.8%
Some Other Race Alone	43.2%
Two or More Races	4.6%
Hispanic Origin	84.7%
Diversity Index	87.1

2008 Population by Race/Ethnicity

Total	21,566
White Alone	39.4%
Black Alone	0.3%
American Indian Alone	1.2%
Asian or Pacific Islander Alone	8.9%
Some Other Race Alone	45.3%
Two or More Races	4.7%
Hispanic Origin	87.6%
Diversity Index	87.2

2013 Population by Race/Ethnicity

Total	21,993
White Alone	39.0%
Black Alone	0.3%
American Indian Alone	1.1%
Asian or Pacific Islander Alone	8.5%
Some Other Race Alone	46.4%
Two or More Races	4.8%
Hispanic Origin	88.9%
Diversity Index	87.3

2000 Population 3+ by School Enrollment

Total	19,875
Enrolled in Nursery/Preschool	1.5%
Enrolled in Kindergarten	1.8%
Enrolled in Grade 1-8	17.3%
Enrolled in Grade 9-12	8.1%
Enrolled in College	4.4%
Enrolled in Grad/Prof School	0.3%
Not Enrolled in School	66.6%

2008 Population 25+ by Educational Attainment

Total	11,802
Less Than 9th Grade	35.4%
9th to 12th Grade, No Diploma	21.6%
High School Graduate	22.1%
Some College, No Degree	11.9%
Associate Degree	4.6%
Bachelor's Degree	3.0%
Master's/Prof/Doctorate Degree	1.4%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: South El Monte

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	15,475.0
Married	51.8%
Never Married	37.4%
Widowed	4.8%
Divorced	5.9%



2000 Population 16+ by Employment Status

Total	14,593
In Labor Force	55.8%
Civilian Employed	50.7%
Civilian Unemployed	5.1%
In Armed Forces	0.0%
Not In Labor Force	44.2%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	88.8%
Civilian Unemployed	11.2%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	89.5%
Civilian Unemployed	10.5%

2000 Females 16+ by Employment Status and Age of Children

Total	7,397
Own Children < 6 Only	6.5%
Employed/in Armed Forces	2.4%
Unemployed	0.6%
Not in Labor Force	3.4%
Own Children <6 and 6-17 Only	13.0%
Employed/in Armed Forces	5.2%
Unemployed	0.7%
Not in Labor Force	7.2%
Own Children 6-17 Only	15.7%
Employed/in Armed Forces	8.3%
Unemployed	1.1%
Not in Labor Force	6.3%
No Own Children < 18	64.8%
Employed/in Armed Forces	26.8%
Unemployed	3.4%
Not in Labor Force	34.6%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: South El Monte

Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	7,617
Agriculture/Mining	1.0%
Construction	7.6%
Manufacturing	29.1%
Wholesale Trade	4.4%
Retail Trade	11.3%
Transportation/Utilities	4.5%
Information	1.7%
Finance/Insurance/Real Estate	3.6%
Services	33.5%
Public Administration	3.3%

2008 Employed Population 16+ by Occupation

Total	7,617
White Collar	37.5%
Management/Business/Financial	4.8%
Professional	8.6%
Sales	9.6%
Administrative Support	14.6%
Services	17.0%
Blue Collar	45.5%
Farming/Forestry/Fishing	0.5%
Construction/Extraction	6.5%
Installation/Maintenance/Repair	4.3%
Production	23.7%
Transportation/Material Moving	10.5%



2000 Workers 16+ by Means of Transportation to Work

Total	7,111
Drove Alone - Car, Truck, or Van	53.4%
Carpooled - Car, Truck, or Van	22.9%
Public Transportation	4.7%
Walked	12.0%
Other Means	5.7%
Worked at Home	1.4%

2000 Workers 16+ by Travel Time to Work

Total	7,110
Did not Work at Home	98.6%
Less than 5 minutes	1.8%
5 to 9 minutes	10.2%
10 to 19 minutes	31.9%
20 to 24 minutes	12.9%
25 to 34 minutes	22.6%
35 to 44 minutes	5.0%
45 to 59 minutes	6.5%
60 to 89 minutes	5.0%
90 or more minutes	2.8%
Worked at Home	1.4%
Average Travel Time to Work (in min)	25.6

2000 Households by Vehicles Available

Total	4,624
None	13.7%
1	29.6%
2	31.9%
3	15.7%
4	6.4%
5+	2.6%
Average Number of Vehicles Available	1.8

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Households by Type

Total	4,621
Family Households	88.5%
Married-couple Family	61.6%
With Related Children	44.3%
Other Family (No Spouse)	26.9%
With Related Children	17.8%
Nonfamily Households	11.4%
Householder Living Alone	7.8%
Householder Not Living Alone	3.6%
Households with Related Children	62.1%
Households with Persons 65+	24.5%

2000 Households by Size

Total	4,620
1 Person Household	7.8%
2 Person Household	14.3%
3 Person Household	13.7%
4 Person Household	17.1%
5 Person Household	16.8%
6 Person Household	12.1%
7 + Person Household	18.1%

2000 Households by Year Householder Moved In

Total	4,623
Moved in 1999 to March 2000	15.1%
Moved in 1995 to 1998	28.7%
Moved in 1990 to 1994	16.9%
Moved in 1980 to 1989	15.5%
Moved in 1970 to 1979	11.1%
Moved in 1969 or Earlier	12.7%
Median Year Householder Moved In	1993



2000 Housing Units by Units in Structure

Total	4,729
1, Detached	62.3%
1, Attached	9.0%
2	1.8%
3 or 4	4.8%
5 to 9	5.2%
10 to 19	5.2%
20 +	2.5%
Mobile Home	9.2%
Other	0.2%

2000 Housing Units by Year Structure Built

Total	4,729
1999 to March 2000	0.9%
1995 to 1998	1.2%
1990 to 1994	2.6%
1980 to 1989	7.5%
1970 to 1979	15.1%
1969 or Earlier	72.7%
Median Year Structure Built	1960

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$8,373,284
Average Spent	\$1,789.55
Spending Potential Index	67
Computers & Accessories: Total \$	\$967,743
Average Spent	\$206.83
Spending Potential Index	86
Education: Total \$	\$4,287,842
Average Spent	\$916.40
Spending Potential Index	67
Entertainment/Recreation: Total \$	\$12,838,358
Average Spent	\$2,743.83
Spending Potential Index	74
Food at Home: Total \$	\$17,927,204
Average Spent	\$3,831.42
Spending Potential Index	78
Food Away from Home: Total \$	\$11,818,750
Average Spent	\$2,525.91
Spending Potential Index	74
Health Care: Total \$	\$12,398,761
Average Spent	\$2,649.87
Spending Potential Index	65
HH Furnishings & Equip: Total \$	\$8,503,757
Average Spent	\$1,817.43
Spending Potential Index	79
Investments: Total \$	\$3,057,479
Average Spent	\$653.45
Spending Potential Index	64
Retail Goods: Total \$	\$97,636,531
Average Spent	\$20,866.97
Spending Potential Index	77
Shelter: Total \$	\$63,725,045
Average Spent	\$13,619.37
Spending Potential Index	88
TV/Video/Sound Equipment: Total \$	\$5,039,663
Average Spent	\$1,077.08
Spending Potential Index	75
Travel: Total \$	\$7,183,235
Average Spent	\$1,535.21
Spending Potential Index	81
Vehicle Maintenance & Repairs: Total \$	\$3,878,125
Average Spent	\$828.84
Spending Potential Index	84

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Valinda

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	21,571
2000 Group Quarters	50
2008 Total Population	22,627
2013 Total Population	23,313
2008-2013 Annual Rate	0.60%



2000 Households	4,707
2000 Average Household Size	4.57
2008 Households	4,808
2008 Average Household Size	4.70
2013 Households	4,927
2013 Average Household Size	4.72
2008-2013 Annual Rate	0.49%
2000 Families	4,191
2000 Average Family Size	4.66
2008 Families	4,283
2008 Average Family Size	4.82
2013 Families	4,379
2013 Average Family Size	4.86
2008-2013 Annual Rate	0.44%



<b>2000 Housing Units</b>	4,804
Owner Occupied Housing Units	78.5%
Renter Occupied Housing Units	19.6%
Vacant Housing Units	1.9%

<b>2008 Housing Units</b>	4,907
Owner Occupied Housing Units	79.7%
Renter Occupied Housing Units	18.3%
Vacant Housing Units	2.0%

<b>2013 Housing Units</b>	5,031
Owner Occupied Housing Units	78.6%
Renter Occupied Housing Units	19.3%
Vacant Housing Units	2.1%

<b>Median Household Income</b>	
2000	\$50,854
2008	\$65,927
2013	\$76,193

<b>Median Home Value</b>	
2000	\$159,588
2008	\$377,801
2013	\$397,334

<b>Per Capita Income</b>	
2000	\$13,729
2008	\$16,574
2013	\$19,287

<b>Median Age</b>	
2000	28.7
2008	28.3
2013	29.0

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Valinda

Demographic

Place Outlines (Local)



2000 Household by Income

Household Income Base	4,788
<15,000	7.1%
\$15,000 - \$24,999	8.4%
\$25,000 - \$34,999	13.1%
\$35,000 - \$49,999	20.1%
\$50,000 - \$74,999	28.1%
\$75,000 - \$99,999	13.9%
\$100,000 - \$149,999	7.3%
\$150,000 - \$199,999	0.7%
\$200,000+	1.3%
Average Household Income	\$60,186

2008 Household by Income

Household Income Base	4,808
<15,000	4.3%
\$15,000 - \$24,999	5.3%
\$25,000 - \$34,999	7.9%
\$35,000 - \$49,999	14.2%
\$50,000 - \$74,999	27.6%
\$75,000 - \$99,999	23.8%
\$100,000 - \$149,999	11.8%
\$150,000 - \$199,999	3.3%
\$200,000+	1.8%
Average Household Income	\$75,815

2013 Household by Income

Household Income Base	4,926
<15,000	3.5%
\$15,000 - \$24,999	3.9%
\$25,000 - \$34,999	4.9%
\$35,000 - \$49,999	10.5%
\$50,000 - \$74,999	25.5%
\$75,000 - \$99,999	22.8%
\$100,000 - \$149,999	21.8%
\$150,000 - \$199,999	3.7%
\$200,000+	3.4%
Average Household Income	\$88,730

2000 Owner Occupied HUs by Value

Total	3,751
<50,000	2.2%
\$50,000 - \$99,999	2.6%
\$100,000 - \$149,999	29.5%
\$150,000 - \$199,999	57.9%
\$200,000 - \$299,999	7.3%
\$300,000 - \$499,999	0.3%
\$500,000 - \$999,999	0.2%
\$1,000,000 +	0.0%
Average Home Value	\$159,899

2000 Specified Renter Occupied HUs by Contract Rent

Total	995
With Cash Rent	92.8%
No Cash Rent	7.2%
Median Rent	\$754
Average Rent	\$762

Data Note: Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Valinda

Demographic

Place Outlines (Local)



**2000 Population by Age**

Total	21,570
0 - 4	8.9%
5 - 9	10.1%
10 - 14	9.1%
15 - 24	16.3%
25 - 34	15.4%
35 - 44	14.7%
45 - 54	11.5%
55 - 64	6.7%
65 - 74	4.6%
75 - 84	2.2%
85 +	0.5%
18 +	66.5%

**2008 Population by Age**

Total	22,628
0 - 4	9.2%
5 - 9	8.8%
10 - 14	9.3%
15 - 24	17.4%
25 - 34	15.1%
35 - 44	14.0%
45 - 54	11.9%
55 - 64	7.5%
65 - 74	3.8%
75 - 84	2.2%
85 +	0.7%
18 +	66.7%

**2013 Population by Age**

Total	23,314
0 - 4	9.4%
5 - 9	8.7%
10 - 14	8.1%
15 - 24	17.7%
25 - 34	14.4%
35 - 44	13.0%
45 - 54	12.2%
55 - 64	9.2%
65 - 74	4.2%
75 - 84	2.3%
85 +	0.9%
18 +	68.3%

**2000 Population by Sex**

Males	49.5%
Females	50.5%

**2008 Population by Sex**

Males	49.8%
Females	50.2%

**2013 Population by Sex**

Males	49.8%
Females	50.2%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Valinda

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	21,570
White Alone	40.1%
Black Alone	3.0%
American Indian Alone	1.2%
Asian or Pacific Islander Alone	11.2%
Some Other Race Alone	39.3%
Two or More Races	5.2%
Hispanic Origin	72.1%
Diversity Index	89.6

2008 Population by Race/Ethnicity

Total	22,628
White Alone	37.4%
Black Alone	2.4%
American Indian Alone	1.0%
Asian or Pacific Islander Alone	10.7%
Some Other Race Alone	43.0%
Two or More Races	5.5%
Hispanic Origin	77.8%
Diversity Index	90.1

2013 Population by Race/Ethnicity

Total	23,314
White Alone	36.3%
Black Alone	2.1%
American Indian Alone	0.9%
Asian or Pacific Islander Alone	10.3%
Some Other Race Alone	44.7%
Two or More Races	5.6%
Hispanic Origin	80.4%
Diversity Index	90.2

2000 Population 3+ by School Enrollment

Total	20,649
Enrolled in Nursery/Preschool	1.6%
Enrolled in Kindergarten	2.1%
Enrolled in Grade 1-8	16.6%
Enrolled in Grade 9-12	8.7%
Enrolled in College	6.7%
Enrolled in Grad/Prof School	0.5%
Not Enrolled in School	63.8%

2008 Population 25+ by Educational Attainment

Total	12,484
Less Than 9th Grade	17.5%
9th to 12th Grade, No Diploma	16.1%
High School Graduate	30.6%
Some College, No Degree	17.2%
Associate Degree	6.6%
Bachelor's Degree	9.6%
Master's/Prof/Doctorate Degree	2.4%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Valinda

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	16,429.0
Married	53.6%
Never Married	36.2%
Widowed	3.6%
Divorced	6.7%



2000 Population 16+ by Employment Status

Total	15,250
In Labor Force	59.8%
Civilian Employed	53.4%
Civilian Unemployed	6.3%
In Armed Forces	0.1%
Not In Labor Force	40.2%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	87.4%
Civilian Unemployed	12.6%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	88.1%
Civilian Unemployed	11.9%

2000 Females 16+ by Employment Status and Age of Children

Total	7,852
Own Children < 6 Only	6.4%
Employed/in Armed Forces	2.8%
Unemployed	0.7%
Not in Labor Force	3.0%
Own Children <6 and 6-17 Only	9.3%
Employed/in Armed Forces	3.6%
Unemployed	0.6%
Not in Labor Force	5.1%
Own Children 6-17 Only	19.8%
Employed/in Armed Forces	12.0%
Unemployed	0.4%
Not in Labor Force	7.3%
No Own Children < 18	64.6%
Employed/in Armed Forces	28.5%
Unemployed	3.8%
Not in Labor Force	32.2%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



**2008 Employed Population 16+ by Industry**

Total	8,525
Agriculture/Mining	0.2%
Construction	7.0%
Manufacturing	16.5%
Wholesale Trade	5.3%
Retail Trade	11.8%
Transportation/Utilities	6.0%
Information	1.3%
Finance/Insurance/Real Estate	8.3%
Services	40.6%
Public Administration	3.2%

**2008 Employed Population 16+ by Occupation**

Total	8,524
White Collar	51.4%
Management/Business/Financial	9.6%
Professional	12.9%
Sales	10.5%
Administrative Support	18.4%
Services	16.5%
Blue Collar	32.1%
Farming/Forestry/Fishing	0.1%
Construction/Extraction	7.0%
Installation/Maintenance/Repair	4.4%
Production	10.2%
Transportation/Material Moving	10.4%



**2000 Workers 16+ by Means of Transportation to Work**

Total	7,936
Drove Alone - Car, Truck, or Van	74.6%
Carpooled - Car, Truck, or Van	17.9%
Public Transportation	4.1%
Walked	0.7%
Other Means	1.0%
Worked at Home	1.7%

**2000 Workers 16+ by Travel Time to Work**

Total	7,937
Did not Work at Home	98.3%
Less than 5 minutes	1.0%
5 to 9 minutes	5.3%
10 to 19 minutes	23.9%
20 to 24 minutes	12.5%
25 to 34 minutes	23.4%
35 to 44 minutes	6.7%
45 to 59 minutes	13.8%
60 to 89 minutes	7.7%
90 or more minutes	4.0%
Worked at Home	1.7%
Average Travel Time to Work (in min)	31.5

**2000 Households by Vehicles Available**

Total	4,750
None	4.9%
1	21.9%
2	37.4%
3	21.5%
4	10.1%
5+	4.2%
Average Number of Vehicles Available	2.2

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Valinda

Demographic

Place Outlines (Local)



2000 Households by Type

Total	4,707
Family Households	89.0%
Married-couple Family	66.0%
With Related Children	46.5%
Other Family (No Spouse)	23.0%
With Related Children	14.7%
Nonfamily Households	10.9%
Householder Living Alone	7.5%
Householder Not Living Alone	3.4%
Households with Related Children	61.2%
Households with Persons 65+	24.5%

2000 Households by Size

Total	4,707
1 Person Household	7.5%
2 Person Household	16.0%
3 Person Household	13.9%
4 Person Household	18.6%
5 Person Household	16.0%
6 Person Household	10.7%
7 + Person Household	17.2%

2000 Households by Year Householder Moved In

Total	4,752
Moved in 1999 to March 2000	11.8%
Moved in 1995 to 1998	24.8%
Moved in 1990 to 1994	16.0%
Moved in 1980 to 1989	23.4%
Moved in 1970 to 1979	12.3%
Moved in 1969 or Earlier	11.7%
Median Year Householder Moved In	1991



2000 Housing Units by Units in Structure

Total	4,843
1, Detached	91.5%
1, Attached	5.4%
2	0.1%
3 or 4	0.7%
5 to 9	0.2%
10 to 19	0.5%
20 +	1.3%
Mobile Home	0.0%
Other	0.2%

2000 Housing Units by Year Structure Built

Total	4,845
1999 to March 2000	0.0%
1995 to 1998	0.9%
1990 to 1994	1.2%
1980 to 1989	3.2%
1970 to 1979	12.6%
1969 or Earlier	82.1%
Median Year Structure Built	1958

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Valinda

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$10,924,129
Average Spent	\$2,272.07
Spending Potential Index	85
Computers & Accessories: Total \$	\$1,347,339
Average Spent	\$280.23
Spending Potential Index	117
Education: Total \$	\$5,912,375
Average Spent	\$1,229.70
Spending Potential Index	89
Entertainment/Recreation: Total \$	\$18,071,141
Average Spent	\$3,758.56
Spending Potential Index	101
Food at Home: Total \$	\$23,098,052
Average Spent	\$4,804.09
Spending Potential Index	98
Food Away from Home: Total \$	\$15,686,809
Average Spent	\$3,262.65
Spending Potential Index	95
Health Care: Total \$	\$17,222,411
Average Spent	\$3,582.03
Spending Potential Index	87
HH Furnishings & Equip: Total \$	\$12,143,917
Average Spent	\$2,525.77
Spending Potential Index	110
Investments: Total \$	\$4,847,403
Average Spent	\$1,008.20
Spending Potential Index	99
Retail Goods: Total \$	\$133,614,510
Average Spent	\$27,790.04
Spending Potential Index	102
Shelter: Total \$	\$87,456,792
Average Spent	\$18,189.85
Spending Potential Index	117
TV/Video/Sound Equipment: Total \$	\$6,780,637
Average Spent	\$1,410.28
Spending Potential Index	98
Travel: Total \$	\$10,630,924
Average Spent	\$2,211.09
Spending Potential Index	117
Vehicle Maintenance & Repairs: Total \$	\$5,324,258
Average Spent	\$1,107.37
Spending Potential Index	112

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: Walnut

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	29,791
2000 Group Quarters	40
2008 Total Population	31,578
2013 Total Population	32,643
2008-2013 Annual Rate	0.67%



2000 Households	8,200
2000 Average Household Size	3.63
2008 Households	8,440
2008 Average Household Size	3.74
2013 Households	8,666
2013 Average Household Size	3.76
2008-2013 Annual Rate	0.53%
2000 Families	7,525
2000 Average Family Size	3.75
2008 Families	7,747
2008 Average Family Size	3.87
2013 Families	7,947
2013 Average Family Size	3.91
2008-2013 Annual Rate	0.51%



<b>2000 Housing Units</b>	8,334
Owner Occupied Housing Units	87.4%
Renter Occupied Housing Units	11.0%
Vacant Housing Units	1.6%

<b>2008 Housing Units</b>	8,580
Owner Occupied Housing Units	88.2%
Renter Occupied Housing Units	10.2%
Vacant Housing Units	1.6%

<b>2013 Housing Units</b>	8,813
Owner Occupied Housing Units	87.4%
Renter Occupied Housing Units	10.9%
Vacant Housing Units	1.7%

**Median Household Income**

2000	\$78,948
2008	\$97,874
2013	\$115,278

**Median Home Value**

2000	\$280,601
2008	\$761,782
2013	\$782,185

**Per Capita Income**

2000	\$25,211
2008	\$33,384
2013	\$40,762

**Median Age**

2000	36.9
2008	39.2
2013	40.3

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Walnut

Demographic

Place Outlines (Local)



**2000 Household by Income**

Household Income Base	8,202
<15,000	5.9%
\$15,000 - \$24,999	6.0%
\$25,000 - \$34,999	4.9%
\$35,000 - \$49,999	8.4%
\$50,000 - \$74,999	20.7%
\$75,000 - \$99,999	19.4%
\$100,000 - \$149,999	23.0%
\$150,000 - \$199,999	6.2%
\$200,000+	5.6%
Average Household Income	\$91,016

**2008 Household by Income**

Household Income Base	8,441
<15,000	5.2%
\$15,000 - \$24,999	1.9%
\$25,000 - \$34,999	4.7%
\$35,000 - \$49,999	5.6%
\$50,000 - \$74,999	13.4%
\$75,000 - \$99,999	20.5%
\$100,000 - \$149,999	23.4%
\$150,000 - \$199,999	14.0%
\$200,000+	11.4%
Average Household Income	\$124,785

**2013 Household by Income**

Household Income Base	8,669
<15,000	4.4%
\$15,000 - \$24,999	1.6%
\$25,000 - \$34,999	2.8%
\$35,000 - \$49,999	5.1%
\$50,000 - \$74,999	10.5%
\$75,000 - \$99,999	14.7%
\$100,000 - \$149,999	26.6%
\$150,000 - \$199,999	12.2%
\$200,000+	22.2%
Average Household Income	\$153,370

**2000 Owner Occupied HUs by Value**

Total	7,286
<50,000	5.8%
\$50,000 - \$99,999	0.7%
\$100,000 - \$149,999	2.3%
\$150,000 - \$199,999	8.7%
\$200,000 - \$299,999	41.5%
\$300,000 - \$499,999	34.9%
\$500,000 - \$999,999	5.8%
\$1,000,000 +	0.5%
Average Home Value	\$305,116

**2000 Specified Renter Occupied HUs by Contract Rent**

Total	909
With Cash Rent	93.7%
No Cash Rent	6.3%
Median Rent	\$1,099
Average Rent	\$1,163

**Data Note:** Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Walnut

Demographic

Place Outlines (Local)



2000 Population by Age

Total	29,791
0 - 4	4.9%
5 - 9	7.4%
10 - 14	9.4%
15 - 24	15.8%
25 - 34	9.8%
35 - 44	17.4%
45 - 54	19.5%
55 - 64	8.9%
65 - 74	4.3%
75 - 84	2.1%
85 +	0.5%
18 +	72.2%

2008 Population by Age

Total	31,581
0 - 4	4.8%
5 - 9	5.4%
10 - 14	7.0%
15 - 24	15.4%
25 - 34	12.5%
35 - 44	12.9%
45 - 54	19.0%
55 - 64	14.0%
65 - 74	5.6%
75 - 84	2.6%
85 +	0.8%
18 +	77.7%

2013 Population by Age

Total	32,643
0 - 4	5.0%
5 - 9	5.4%
10 - 14	6.2%
15 - 24	13.5%
25 - 34	13.0%
35 - 44	13.4%
45 - 54	16.7%
55 - 64	15.5%
65 - 74	7.1%
75 - 84	3.1%
85 +	1.1%
18 +	79.2%

2000 Population by Sex

Males	49.2%
Females	50.8%

2008 Population by Sex

Males	49.0%
Females	51.0%

2013 Population by Sex

Males	48.9%
Females	51.1%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Walnut

Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	29,790
White Alone	28.4%
Black Alone	4.2%
American Indian Alone	0.2%
Asian or Pacific Islander Alone	55.8%
Some Other Race Alone	7.7%
Two or More Races	3.7%
Hispanic Origin	19.3%
Diversity Index	73.0

2008 Population by Race/Ethnicity

Total	31,578
White Alone	24.4%
Black Alone	3.7%
American Indian Alone	0.2%
Asian or Pacific Islander Alone	58.4%
Some Other Race Alone	9.1%
Two or More Races	4.2%
Hispanic Origin	22.8%
Diversity Index	74.0

2013 Population by Race/Ethnicity

Total	32,644
White Alone	22.7%
Black Alone	3.3%
American Indian Alone	0.2%
Asian or Pacific Islander Alone	59.3%
Some Other Race Alone	10.0%
Two or More Races	4.5%
Hispanic Origin	24.8%
Diversity Index	74.7

2000 Population 3+ by School Enrollment

Total	29,070
Enrolled in Nursery/Preschool	1.8%
Enrolled in Kindergarten	1.4%
Enrolled in Grade 1-8	13.6%
Enrolled in Grade 9-12	9.0%
Enrolled in College	10.1%
Enrolled in Grad/Prof School	1.9%
Not Enrolled in School	62.0%

2008 Population 25+ by Educational Attainment

Total	21,268
Less Than 9th Grade	4.1%
9th to 12th Grade, No Diploma	4.5%
High School Graduate	15.1%
Some College, No Degree	19.6%
Associate Degree	10.5%
Bachelor's Degree	33.0%
Master's/Prof/Doctorate Degree	13.2%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Walnut

Demographic

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	26,133.0
Married	61.3%
Never Married	31.0%
Widowed	3.5%
Divorced	4.2%



2000 Population 16+ by Employment Status

Total	22,828
In Labor Force	63.4%
Civilian Employed	61.0%
Civilian Unemployed	2.4%
In Armed Forces	0.1%
Not In Labor Force	36.6%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	95.5%
Civilian Unemployed	4.5%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	95.8%
Civilian Unemployed	4.2%

2000 Females 16+ by Employment Status and Age of Children

Total	11,713
Own Children < 6 Only	6.4%
Employed/in Armed Forces	3.8%
Unemployed	0.0%
Not in Labor Force	2.6%
Own Children <6 and 6-17 Only	5.6%
Employed/in Armed Forces	3.3%
Unemployed	0.3%
Not in Labor Force	2.0%
Own Children 6-17 Only	26.4%
Employed/in Armed Forces	18.0%
Unemployed	0.6%
Not in Labor Force	7.7%
No Own Children < 18	61.6%
Employed/in Armed Forces	29.4%
Unemployed	1.4%
Not in Labor Force	30.8%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Walnut  
Demographic

Place Outlines (Local)



2008 Employed Population 16+ by Industry

Total	15,588
Agriculture/Mining	0.0%
Construction	3.8%
Manufacturing	10.5%
Wholesale Trade	8.1%
Retail Trade	10.4%
Transportation/Utilities	6.0%
Information	2.5%
Finance/Insurance/Real Estate	10.3%
Services	43.4%
Public Administration	5.0%

2008 Employed Population 16+ by Occupation

Total	15,586
White Collar	79.7%
Management/Business/Financial	23.8%
Professional	26.2%
Sales	14.2%
Administrative Support	15.4%
Services	8.8%
Blue Collar	11.5%
Farming/Forestry/Fishing	0.0%
Construction/Extraction	2.3%
Installation/Maintenance/Repair	2.6%
Production	3.8%
Transportation/Material Moving	2.8%



2000 Workers 16+ by Means of Transportation to Work

Total	13,796
Drove Alone - Car, Truck, or Van	76.4%
Carpooled - Car, Truck, or Van	17.6%
Public Transportation	2.0%
Walked	0.4%
Other Means	0.9%
Worked at Home	2.8%

2000 Workers 16+ by Travel Time to Work

Total	13,796
Did not Work at Home	97.2%
Less than 5 minutes	0.4%
5 to 9 minutes	5.0%
10 to 19 minutes	19.7%
20 to 24 minutes	10.4%
25 to 34 minutes	18.2%
35 to 44 minutes	9.7%
45 to 59 minutes	15.9%
60 to 89 minutes	14.6%
90 or more minutes	3.4%
Worked at Home	2.8%
Average Travel Time to Work (in min)	35.5

2000 Households by Vehicles Available

Total	8,199
None	1.9%
1	12.0%
2	43.9%
3	28.3%
4	9.6%
5+	4.4%
Average Number of Vehicles Available	2.5

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: Walnut

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Households by Type

Total	8,201
Family Households	91.8%
Married-couple Family	77.1%
With Related Children	47.4%
Other Family (No Spouse)	14.7%
With Related Children	7.6%
Nonfamily Households	8.2%
Householder Living Alone	5.8%
Householder Not Living Alone	2.5%
Households with Related Children	55.0%
Households with Persons 65+	18.5%

2000 Households by Size

Total	8,200
1 Person Household	5.8%
2 Person Household	20.5%
3 Person Household	21.2%
4 Person Household	28.4%
5 Person Household	13.7%
6 Person Household	6.5%
7 + Person Household	4.0%

2000 Households by Year Householder Moved In

Total	8,199
Moved in 1999 to March 2000	9.3%
Moved in 1995 to 1998	24.0%
Moved in 1990 to 1994	18.4%
Moved in 1980 to 1989	34.6%
Moved in 1970 to 1979	10.7%
Moved in 1969 or Earlier	2.9%
Median Year Householder Moved In	1990



2000 Housing Units by Units in Structure

Total	8,334
1, Detached	95.7%
1, Attached	1.4%
2	0.2%
3 or 4	0.3%
5 to 9	0.1%
10 to 19	0.4%
20 +	1.8%
Mobile Home	0.0%
Other	0.0%

2000 Housing Units by Year Structure Built

Total	8,335
1999 to March 2000	0.1%
1995 to 1998	3.3%
1990 to 1994	6.6%
1980 to 1989	49.2%
1970 to 1979	21.9%
1969 or Earlier	18.8%
Median Year Structure Built	1982

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Area ID: Walnut

Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$31,081,218
Average Spent	\$3,682.61
Spending Potential Index	137
Computers & Accessories: Total \$	\$3,740,180
Average Spent	\$443.15
Spending Potential Index	185
Education: Total \$	\$20,130,624
Average Spent	\$2,385.15
Spending Potential Index	174
Entertainment/Recreation: Total \$	\$53,580,837
Average Spent	\$6,348.44
Spending Potential Index	171
Food at Home: Total \$	\$63,575,427
Average Spent	\$7,532.63
Spending Potential Index	154
Food Away from Home: Total \$	\$45,675,180
Average Spent	\$5,411.75
Spending Potential Index	158
Health Care: Total \$	\$51,472,715
Average Spent	\$6,098.66
Spending Potential Index	149
HH Furnishings & Equip: Total \$	\$34,493,654
Average Spent	\$4,086.93
Spending Potential Index	178
Investments: Total \$	\$18,331,155
Average Spent	\$2,171.94
Spending Potential Index	214
Retail Goods: Total \$	\$376,003,958
Average Spent	\$44,550.23
Spending Potential Index	164
Shelter: Total \$	\$240,480,657
Average Spent	\$28,492.97
Spending Potential Index	183
TV/Video/Sound Equipment: Total \$	\$19,375,002
Average Spent	\$2,295.62
Spending Potential Index	160
Travel: Total \$	\$31,398,212
Average Spent	\$3,720.17
Spending Potential Index	197
Vehicle Maintenance & Repairs: Total \$	\$14,485,290
Average Spent	\$1,716.27
Spending Potential Index	173

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



Area ID: West Covina

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2000 Total Population	105,335
2000 Group Quarters	715
2008 Total Population	114,942
2013 Total Population	120,338
2008-2013 Annual Rate	0.92%



2000 Households	31,463
2000 Average Household Size	3.33
2008 Households	33,370
2008 Average Household Size	3.42
2013 Households	34,698
2013 Average Household Size	3.45
2008-2013 Annual Rate	0.78%
2000 Families	25,469
2000 Average Family Size	3.66
2008 Families	27,011
2008 Average Family Size	3.80
2013 Families	27,995
2013 Average Family Size	3.84
2008-2013 Annual Rate	0.72%



<b>2000 Housing Units</b>	32,110
Owner Occupied Housing Units	66.4%
Renter Occupied Housing Units	31.6%
Vacant Housing Units	2.1%

<b>2008 Housing Units</b>	34,079
Owner Occupied Housing Units	68.0%
Renter Occupied Housing Units	29.9%
Vacant Housing Units	2.1%

<b>2013 Housing Units</b>	35,472
Owner Occupied Housing Units	67.0%
Renter Occupied Housing Units	30.8%
Vacant Housing Units	2.2%

<b>Median Household Income</b>	
2000	\$53,396
2008	\$67,850
2013	\$78,021

<b>Median Home Value</b>	
2000	\$188,271
2008	\$466,151
2013	\$491,923

<b>Per Capita Income</b>	
2000	\$19,332
2008	\$23,823
2013	\$27,736

<b>Median Age</b>	
2000	32.8
2008	33.6
2013	34.8

**Data Note:** Household population includes persons not residing in group quarters. Average Household Size is the household population divided by total households. Persons in families include the householder and persons related to the householder by birth, marriage, or adoption. Per Capita Income represents the income received by all persons aged 15 years and over divided by total population. Detail may not sum to totals due to rounding.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: West Covina

Demographic

Place Outlines (Local)



**2000 Household by Income**

Household Income Base	31,375
<15,000	9.0%
\$15,000 - \$24,999	9.4%
\$25,000 - \$34,999	11.8%
\$35,000 - \$49,999	15.8%
\$50,000 - \$74,999	23.7%
\$75,000 - \$99,999	14.8%
\$100,000 - \$149,999	10.9%
\$150,000 - \$199,999	2.5%
\$200,000+	2.0%
Average Household Income	\$64,443

**2008 Household by Income**

Household Income Base	33,371
<15,000	6.1%
\$15,000 - \$24,999	5.4%
\$25,000 - \$34,999	8.2%
\$35,000 - \$49,999	14.2%
\$50,000 - \$74,999	21.6%
\$75,000 - \$99,999	20.9%
\$100,000 - \$149,999	15.5%
\$150,000 - \$199,999	4.5%
\$200,000+	3.7%
Average Household Income	\$82,267

**2013 Household by Income**

Household Income Base	34,699
<15,000	5.2%
\$15,000 - \$24,999	4.3%
\$25,000 - \$34,999	5.5%
\$35,000 - \$49,999	10.2%
\$50,000 - \$74,999	21.9%
\$75,000 - \$99,999	18.2%
\$100,000 - \$149,999	23.2%
\$150,000 - \$199,999	5.8%
\$200,000+	5.8%
Average Household Income	\$96,486

**2000 Owner Occupied HUs by Value**

Total	21,265
<50,000	3.1%
\$50,000 - \$99,999	2.7%
\$100,000 - \$149,999	12.2%
\$150,000 - \$199,999	43.9%
\$200,000 - \$299,999	28.3%
\$300,000 - \$499,999	7.9%
\$500,000 - \$999,999	1.9%
\$1,000,000 +	0.1%
Average Home Value	\$207,704

**2000 Specified Renter Occupied HUs by Contract Rent**

Total	10,082
With Cash Rent	97.9%
No Cash Rent	2.1%
Median Rent	\$771
Average Rent	\$759

**Data Note:** Income represents the preceding year, expressed in current dollars. Household income includes wage and salary earnings, interest, dividends, net rents, pensions, SSI and welfare payments, child support and alimony. Specified Renter Occupied HUs exclude houses on 10+ acres. Average Rent excludes units paying no cash rent.

**Source:** U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: West Covina

Demographic

Place Outlines (Local)



2000 Population by Age

Total	105,335
0 - 4	7.7%
5 - 9	8.4%
10 - 14	8.0%
15 - 24	14.5%
25 - 34	14.8%
35 - 44	15.6%
45 - 54	12.8%
55 - 64	7.9%
65 - 74	5.9%
75 - 84	3.6%
85 +	0.9%
18 +	71.3%

2008 Population by Age

Total	114,941
0 - 4	7.7%
5 - 9	7.3%
10 - 14	7.6%
15 - 24	15.0%
25 - 34	14.3%
35 - 44	14.4%
45 - 54	13.5%
55 - 64	9.8%
65 - 74	5.3%
75 - 84	3.7%
85 +	1.3%
18 +	72.5%

2013 Population by Age

Total	120,340
0 - 4	7.7%
5 - 9	7.1%
10 - 14	6.7%
15 - 24	14.9%
25 - 34	13.9%
35 - 44	13.3%
45 - 54	13.8%
55 - 64	11.4%
65 - 74	6.1%
75 - 84	3.6%
85 +	1.6%
18 +	74.1%

2000 Population by Sex

Males	48.6%
Females	51.4%

2008 Population by Sex

Males	48.6%
Females	51.4%

2013 Population by Sex

Males	48.7%
Females	51.3%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Population by Race/Ethnicity

Total	105,337
White Alone	43.9%
Black Alone	6.1%
American Indian Alone	0.8%
Asian or Pacific Islander Alone	22.7%
Some Other Race Alone	21.6%
Two or More Races	4.9%
Hispanic Origin	46.1%
Diversity Index	87.5

2008 Population by Race/Ethnicity

Total	114,942
White Alone	39.7%
Black Alone	5.3%
American Indian Alone	0.7%
Asian or Pacific Islander Alone	23.6%
Some Other Race Alone	25.2%
Two or More Races	5.6%
Hispanic Origin	53.3%
Diversity Index	89.2

2013 Population by Race/Ethnicity

Total	120,339
White Alone	37.8%
Black Alone	4.8%
American Indian Alone	0.6%
Asian or Pacific Islander Alone	23.8%
Some Other Race Alone	27.1%
Two or More Races	5.9%
Hispanic Origin	57.0%
Diversity Index	89.7

2000 Population 3+ by School Enrollment

Total	100,269
Enrolled in Nursery/Preschool	1.5%
Enrolled in Kindergarten	1.7%
Enrolled in Grade 1-8	14.0%
Enrolled in Grade 9-12	7.3%
Enrolled in College	8.0%
Enrolled in Grad/Prof School	1.3%
Not Enrolled in School	66.1%

2008 Population 25+ by Educational Attainment

Total	71,701
Less Than 9th Grade	7.6%
9th to 12th Grade, No Diploma	10.1%
High School Graduate	24.8%
Some College, No Degree	22.8%
Associate Degree	9.1%
Bachelor's Degree	19.2%
Master's/Prof/Doctorate Degree	6.4%

Data Note: Persons of Hispanic Origin may be of any race. The Diversity Index measures the probability that two people from the same area will be from different race/ethnic groups.

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Area ID: West Covina

Demographic

Market Profile

Place Outlines (Local)

Place Outlines (Local)



2008 Population 15+ Marital Status

Total	88,990.0
Married	55.3%
Never Married	31.4%
Widowed	5.3%
Divorced	7.9%



2000 Population 16+ by Employment Status

Total	78,191
In Labor Force	61.6%
Civilian Employed	57.3%
Civilian Unemployed	4.3%
In Armed Forces	0.0%
Not In Labor Force	38.4%

2008 Civilian Population 16+ in Labor Force

Civilian Employed	92.1%
Civilian Unemployed	7.9%

2013 Civilian Population 16+ in Labor Force

Civilian Employed	92.5%
Civilian Unemployed	7.5%

2000 Females 16+ by Employment Status and Age of Children

Total	41,080
Own Children < 6 Only	7.0%
Employed/in Armed Forces	3.8%
Unemployed	0.5%
Not in Labor Force	2.8%
Own Children <6 and 6-17 Only	8.4%
Employed/in Armed Forces	4.9%
Unemployed	0.3%
Not in Labor Force	3.2%
Own Children 6-17 Only	18.6%
Employed/in Armed Forces	12.6%
Unemployed	0.7%
Not in Labor Force	5.4%
No Own Children < 18	65.9%
Employed/in Armed Forces	29.8%
Unemployed	2.2%
Not in Labor Force	34.0%

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Place Outlines (Local)



**2008 Employed Population 16+ by Industry**

Total	49,904
Agriculture/Mining	0.2%
Construction	6.1%
Manufacturing	11.2%
Wholesale Trade	5.6%
Retail Trade	11.4%
Transportation/Utilities	6.3%
Information	2.6%
Finance/Insurance/Real Estate	9.2%
Services	42.8%
Public Administration	4.5%

**2008 Employed Population 16+ by Occupation**

Total	49,903
White Collar	66.0%
Management/Business/Financial	14.1%
Professional	19.9%
Sales	13.1%
Administrative Support	18.9%
Services	13.3%
Blue Collar	20.7%
Farming/Forestry/Fishing	0.0%
Construction/Extraction	4.4%
Installation/Maintenance/Repair	4.3%
Production	5.6%
Transportation/Material Moving	6.3%



**2000 Workers 16+ by Means of Transportation to Work**

Total	43,756
Drove Alone - Car, Truck, or Van	75.6%
Carpooled - Car, Truck, or Van	16.1%
Public Transportation	4.4%
Walked	1.1%
Other Means	1.0%
Worked at Home	1.8%

**2000 Workers 16+ by Travel Time to Work**

Total	43,759
Did not Work at Home	98.2%
Less than 5 minutes	1.0%
5 to 9 minutes	5.1%
10 to 19 minutes	23.2%
20 to 24 minutes	12.3%
25 to 34 minutes	19.6%
35 to 44 minutes	8.2%
45 to 59 minutes	13.7%
60 to 89 minutes	10.5%
90 or more minutes	4.6%
Worked at Home	1.8%
Average Travel Time to Work (in min)	33.7

**2000 Households by Vehicles Available**

Total	31,383
None	6.2%
1	26.2%
2	41.2%
3	17.3%
4	6.3%
5+	2.6%
Average Number of Vehicles Available	2.0

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing. ESRI forecasts for 2008 and 2013.



Demographic

Place Outlines (Local)



2000 Households by Type

Total	31,463
Family Households	80.9%
Married-couple Family	58.9%
With Related Children	34.6%
Other Family (No Spouse)	22.0%
With Related Children	13.2%
Nonfamily Households	19.0%
Householder Living Alone	14.4%
Householder Not Living Alone	4.6%
Households with Related Children	47.8%
Households with Persons 65+	24.9%

2000 Households by Size

Total	31,463
1 Person Household	14.4%
2 Person Household	24.7%
3 Person Household	18.5%
4 Person Household	18.9%
5 Person Household	11.9%
6 Person Household	6.4%
7 + Person Household	5.3%

2000 Households by Year Householder Moved In

Total	31,384
Moved in 1999 to March 2000	16.5%
Moved in 1995 to 1998	28.1%
Moved in 1990 to 1994	16.2%
Moved in 1980 to 1989	16.2%
Moved in 1970 to 1979	11.7%
Moved in 1969 or Earlier	11.3%
Median Year Householder Moved In	1993



2000 Housing Units by Units in Structure

Total	32,044
1, Detached	67.2%
1, Attached	8.6%
2	1.0%
3 or 4	3.8%
5 to 9	2.0%
10 to 19	1.6%
20 +	14.8%
Mobile Home	1.0%
Other	0.1%

2000 Housing Units by Year Structure Built

Total	32,044
1999 to March 2000	0.5%
1995 to 1998	2.1%
1990 to 1994	2.5%
1980 to 1989	10.8%
1970 to 1979	24.8%
1969 or Earlier	59.3%
Median Year Structure Built	1965

Source: U.S. Bureau of the Census, 2000 Census of Population and Housing.



Demographic

Place Outlines (Local)



2008 Consumer Spending shows the amount spent on a variety of goods and services by households that reside in the market area. Expenditures are shown by broad budget categories that are not mutually exclusive. Consumer spending does not equal business revenue.

Apparel & Services: Total \$	\$82,007,323
Average Spent	\$2,457.52
Spending Potential Index	92
Computers & Accessories: Total \$	\$10,000,305
Average Spent	\$299.68
Spending Potential Index	125
Education: Total \$	\$49,029,976
Average Spent	\$1,469.28
Spending Potential Index	107
Entertainment/Recreation: Total \$	\$137,125,836
Average Spent	\$4,109.25
Spending Potential Index	111
Food at Home: Total \$	\$172,959,345
Average Spent	\$5,183.08
Spending Potential Index	106
Food Away from Home: Total \$	\$119,695,845
Average Spent	\$3,586.93
Spending Potential Index	105
Health Care: Total \$	\$132,777,824
Average Spent	\$3,978.96
Spending Potential Index	97
HH Furnishings & Equip: Total \$	\$89,469,595
Average Spent	\$2,681.14
Spending Potential Index	117
Investments: Total \$	\$40,713,135
Average Spent	\$1,220.05
Spending Potential Index	120
Retail Goods: Total \$	\$993,441,267
Average Spent	\$29,770.49
Spending Potential Index	110
Shelter: Total \$	\$649,754,739
Average Spent	\$19,471.22
Spending Potential Index	125
TV/Video/Sound Equipment: Total \$	\$51,262,561
Average Spent	\$1,536.19
Spending Potential Index	107
Travel: Total \$	\$81,100,974
Average Spent	\$2,430.36
Spending Potential Index	129
Vehicle Maintenance & Repairs: Total \$	\$39,193,518
Average Spent	\$1,174.51
Spending Potential Index	118

Data Note: The Spending Potential Index represents the amount spent in the area relative to a national average of 100.

Source: Expenditure data are derived from the 2004 and 2005 Consumer Expenditure Surveys, Bureau of Labor Statistics. ESRI forecasts for 2008 and 2013



# Citrus Valley Health Partners

VI

## Financial Valuation Summary And Report



## **Citrus Valley Health Partners Financial Valuation Summary 2013**

This section of the SB697 Report presents the economic valuation of both the non-profit organization's tax exempt status and the services it provides to vulnerable and at-risk populations. This valuation summary represents the services that can be reasonably quantified; however, CVHP continues its role as servant leader, advocate and facilitator for community leaders to continue the efforts to create and sustain a healthier community.

### **Community Benefit Threshold**

The Community Benefit Threshold measures the value of the organization's tax exempt status. This amount represents the community's investment in the non-profit organization.

The benefit threshold is the sum of tax exempt savings that a non-profit organization enjoys. For this report, we have valued the property and income tax exemptions. All other savings were deemed to be immaterial. The calculation of the Community Benefit Threshold is instrumental in order to measure the organization's SB 697 performance.

### **Program Valuation**

The Program Valuation section quantifies the dollar value of services CVHP provides to vulnerable and at-risk populations. The key elements for the valuation process are: 1. **Data Gathering** of services offered by different CVMC's departments. 2. **Inclusion Test** which is met if (1) the service would not be provided in the absence of the non-profit organization, and (2) the service is directed at vulnerable and at-risk populations. 3. **Project Weighting** is calculated when only a portion of the program or service is intended for vulnerable and at-risk populations. 4. **Cost to Charge Ratio** is the calculation of total operating expenses divided by gross charges. This method converts the charges into costs. It is a hospital-wide average that is intended to approximate costs in the aggregate. 5. Although *government program shortfalls* are included in this report, they are not included in the valuation and threshold comparison because they do not meet the inclusion criteria established above.

## VALUATION SECTIONS

CVHP continued in 2012 the same criteria in the selection of the SB 697 valuation categories:

1. **Operations that Lose Money**

These are services that the organization continues to provide in the face of operating losses. To the extent that these services pass the Inclusion Test, the costs are includable in the SB 697 Report.

2. **Unpaid Costs of Public Programs**

These shortfalls are program costs minus payments received. They are not the same as “contractual allowances.” Examples may include Medi-Cal and other state or local indigent care programs. For CVHP, this category fails the first question of the **Inclusion Test**. In their absence, other providers would compete for CVHP’s Medi-Cal business. We therefore have excluded these shortfalls from the valuation.

3. **Educational Programs**

These activities include (1) direct community benefit provided through public health education; (2) wellness programs; and (3) net costs for training health professionals. CVHP is involved in all three areas. For the SB 697 report, we calculated the value of staff time, salaries and benefits, for hours devoted to these efforts.

4. **Programs that Meet Unmet Needs**

These programs include healthcare services provided without charge and many of the Mission Effectiveness and Community Care projects. CVHP has computed the cost of its **Community Assistance Program** (Charity Care) as direct measure of charity care provided to vulnerable and at-risk populations. Other significant projects include *ECHO*, *GEM*, *Welcome Baby*, *Seamless System of Care*, and *the Clinical Care Extenders*.

5. **Cash and In-Kind Donations Made by the Facility**

These are cash or non-monetary assets contributed by CVHP directly to other programs or efforts for vulnerable and at-risk populations. These services are valued by determining the staff time involved and applying an average rate for salaries and benefits. In addition to out-right grants, CVHP donates cash, in-kind assets, and services through (1) meals-on-wheels program in which the food and preparation costs are donated; (2) staff leadership of rehabilitation support groups; and (3) durable medical equipment provided without charge to patients unable to pay.

6. **Health-Related Research**

This section covers health-related research for studies on alternative health delivery methods, testing of medical equipment, and controlled studies of therapeutic protocols. CVHP's primary activity has been the *Neonatal Sleep Apnea Program*, which is the only one provided in Southern California. The costs for this unmet need, net of any payments received, are included in the SB 697 report. It is considered research because the treatment incorporates studies that further science's understanding of the illness.

7. **Fund-Raising Costs**

The costs to raise funds for programs that serve vulnerable and at-risk populations are includable in the SB 697 report. Foundation operating costs have been weighed so that only those portions that support vulnerable populations are included.

In preparing the valuation of departmental services, we learned that many functions fell under more than one of the categories listed above. To simplify this report, we have listed services by department. The reader of our SB 697 report may assume that all items included (1) have passed the *Inclusion Test*; (2) have been weighed and discounted appropriately; and (3) fall into one or more of the seven categories.

## MEASUREMENT

The 2013 community benefit summary includes (1) a valuation of the Community Benefit Threshold; (2) a valuation of the services provided to vulnerable and at-risk populations; and (3) a summary page that compares the two values. The report compares what the community invested in CVHP with the value of services given back to the needy. CVHP surpassed its Community Benefit Threshold in 2013.

**Citrus Valley Health Partners, Inc.  
Community Benefit Summary  
2013**

**Community Benefit Threshold**

Exemption from taxes:	
Property Taxes	\$ 1,407,801
<b>Total Community Benefit Threshold</b>	<b>\$ 1,407,801</b>

*This is the amount which the community invested in CVHP through tax preferences in 2011*

**Program Valuation**

Community Assistance Program (Charity Care)	\$ 4,353,000
Community Outreach and Mission Effectiveness	84,808
Neonatal Apnea Net Costs	5,894
Ed Call Panel	3,489,897
Foundation Community Benefit	58,771
Departmental Community Benefit Services Quantification	1,484,143
<b>Total Value of Community Benefit Services Provided</b>	<b>\$ 9,476,513</b>

*This is the value of SB697 services that CVHP provided to the community in 2013*

**Measurement excluding Government Program Shortfalls**

<sup>1</sup> Community Benefit Service Provided by CVHP in 2013	\$ 9,476,513
Community Benefit Threshold	1,407,801
<b>Surplus of Services Provided Over Threshold</b>	<b>\$ 8,068,712</b>

-

**Citrus Valley Health Partners**  
**Schedule to Estimate Property Taxes**  
**2013**

	<u>Net Property Plant and Equipment</u>				<u>Rate</u>	<u>Estimated</u> <u>Property Taxes</u>
	<u>Property</u> Land, Buildings & Improvements	<u>Adjustments for</u> For-Profit & Rental Properties		<u>As</u> <u>Adjusted</u>		
CVMC	\$ 71,785,976			\$ 71,785,976	1.2%	\$ 861,432
Foothill	31,720,654			31,720,654	1.2%	380,648
CVHP & Other Affiliates	<u>14,817,929</u>	<u>(1,007,817)</u>		<u>13,810,112</u>	1.2%	<u>165,721</u>
CVHP Total	<u>\$ 118,324,559</u>	<u>(1,007,817)</u>		<u>\$ 117,316,742</u>		<u>\$ 1,407,801</u>

*Note: Adjustment represents income property on which the organization is already paying taxes.*

CITRUS VALLEY HEALTH PARTNERS  
 CHARITY CARE BY ENTITY

2013

2013				
	CVMC	FPH	HOSPICE/HH	TOTAL
Charity Care at cost is computed as follows:				
Adjusted Gross Revenue per IRS W/S-2	1,150,391,630	267,102,942	14,692,699	1,432,187,271
Adjusted Gross Costs per IRS W/S-2	305,901,431	65,127,697	8,499,474	379,528,602
Cost to Charge Ratio per IRS W/S-2	26.6%	24.4%	57.8%	26.5%
Charity Write-off per G/L at Gross	13,410,663	3,204,467	9,522	16,624,652
Total Traditional Charity Care at Cost - rounded	3,566,000	781,000	6,000	4,353,000
Unpaid cost of public programs (Excl HFP)	30,448,000	6,560,000	68,000	37,077,000
Hospital Fee Program Net Revenue	(32,271,000)	(1,163,000)	-	(33,434,000)
Community Benefits	4,728,000	309,000		5,037,000
Total Charity Care & Unpaid Costs	6,471,000	6,487,000	74,000	13,033,000

**CITRUS VALLEY HEALTH PARTNERS**  
**Community Outreach and Mission Effectiveness/Community Education**  
**2013**

	Mission Effect CVHP (40.86120)	Terminated FPH (12.87430)	TOTAL
<b><u>Department Expenses</u></b>			
Actual Expenses per 12/31/13 General Ledger Adjustments:	113,507	-	113,507
Adjusted Departmental Expenses	<u>113,507</u>	<u>-</u>	<u>113,507</u>
<b><u>Department Income</u></b>			
Actual Income per 12/31/13 General Ledger Adjustments:	28,699	-	28,699
Adjusted Departmental Income	<u>28,699</u>	<u>-</u>	<u>28,699</u>
Net amount spent for Community Benefits	<u>84,808</u>	<u>-</u>	<u>84,808</u>

**CITRUS VALLEY HEALTH PARTNERS**  
**Neonatal Sleep Apnea Department - Net Costs**  
**2013**

**Department Expenses**

Actual Expenses per 12/31/13 General Ledger	24,800
Adjustments:	
Adjusted Departmental Expenses	<u>24,800</u>

**Department Income**

Actual Income per 12/31/13 General Ledger	85,008
Adjustments:	
Revenue Deductions 77.76%	(66,102)
(2013 QVC CCS ALL IP W/O%)	
Adjusted Departmental Income	<u>18,906</u>
Net amount spent for Community Benefits	<u>5,894</u>

**CITRUS VALLEY HEALTH PARTNERS**  
**ER - On Call Physicians**  
**2013**

	CVMC	FPH	TOTAL
<b><u>Department Expenses</u></b>			
Actual Expenses per 12/31/13 General Ledger	3,284,303	220,069	3,504,373
Adjustments:			
Adjusted Departmental Expenses	3,284,303	220,069	3,504,373
<b><u>Department Income</u></b>			
Actual Income per 12/31/13 General Ledger	14,476	-	14,476
	-	-	-
Adjusted Departmental Income	14,476	-	14,476
Net amount spent for Community Benefits	3,269,827	220,069	3,489,897

**CITRUS VALLEY HEALTH PARTNERS**  
**Foundations - Net Fundraising Costs**  
**2013**

	At Risk %	CVH Foundation (CVMC/Hosp/FPH)	
		Total	At Risk
<b><u>Contributions</u></b>			
Unrestricted contribution-curr yr	5%	845,952	42,298
Restricted			
Cardiac	20%	80	16
Chaplains / Strength Journey	10%	600	60
Echo	100%	12,500	12,500
Maternal & Child Health	20%	2,000	400
NICU	20%	30,256	6,051
Pediatric	20%	25	5
All other restricted	5%	745,557	37,278
Total Restricted		791,018	56,310
Total Contributions		1,636,970	98,608
		-	6.0%
<b>Total Expenses, Excl transfers</b>		975,651	
Expenses related to Fundraising for At Risk Population			58,771
Total		-	

**Citrus Valley Health Partners, Inc.**  
**List of Community Outreach Services by Department**  
**2013**

<u>Dep:</u>	<u>Description</u>	<u>Category</u>	<u>Department Totals</u>	<u>Totals</u>
<b>Radiology</b>				
	Advisory Committee for Mt. SAC Radiology Program--ICC	Resource	780	
	Advisory Committee for Mt. SAC Radiology Program--QVC	Resource	875	
	Student coordinator for Mt. SAC Radiology Program--ICC	Resource	1,750	
	Student coordinator for Mt. SAC Radiology Program--QVC	Resource	2,266	
	Advisory Committee for Cypress College Untrasound Program	Resource	1,770	
	Student Coordinator for Cypress College Ultrasound Program	Resource	3,708	
	QVC Donation - Free Mammograms - Support ofr Breast Cancer Awareness	Charity	1,100	
	ICC/QVC MR Safety Tours	Education	1500	
	<b>Radiology Subtotal</b>		<b>13,749</b>	<b>13,749</b>
<b>Pediatrics/ MBCU- Mother Baby Care Unit</b>				
	5 English language Tours	Education	1,062	
	5 Spanish language Tours	Education	3,120	
	Printing	Resource	200	
	5 Boris the Bear Preoperative classes	Education	31,367	
	33 Pediatric Teddy Bear Clinics	Resource	3,215	
	<b>Pediatrics Subtotal</b>		<b>38,964</b>	<b>38,964</b>
<b>Food Services</b>				
	Cal Poly Pomona Student Interns/Chaffee College	Education	5,000	
	Dieticians speak to community groups on health issues	Education	1,200	
	Food donated - Muscular Dysterphy Assoc. picnic	Charity	1,500	
	<b>Food Services Subtotal</b>		<b>7,700</b>	<b>7,700</b>
<b>Emergency Department</b>				
	Base Station Program/QVC Emergency Dept.	Base Unit	307,903	
	ICC Emergency Dept.	Charity	71,694	
	<b>Emergency Department Subtotal</b>		<b>379,597</b>	<b>379,597</b>
<b>Volunteers &amp; Auxiliary Department/Patient Relations &amp; Service Recovery</b>				
	Five \$1,000 scholarships for students in allied healthcare field	Education	5,000	
	Community Outreach Van (pick up/delivery of oncology & cardiac patient)	Service	33,500	
	Chaplain Services-Spiritual Visits	Service	33,500	
	Scholarship Committee	Education	2,250	
	Spiritual Tape Distribution	Service	3,725	
	Telecare (Calls to Home Bound patients 365 days per year)	Resource	21,150	
	Pet Therapy	Service	12,000	
	<b>Volunteers &amp; Auxiliary Department/Patient Relations &amp; Service Recovery</b>		<b>111,125</b>	<b>111,125</b>
<b>Public Relations Department</b>				
	Brian Clay Foundation	Resource	6,000	
	Elevations Community Newsletter	Education	41,490	
	Glendora Kiwanis and Chamber	Resource	1,250	
	Covina Rotary	Resource	2,500	
	La Verne Chamber	Resource	222	
	West Covina Chamber Sponsorships	Resource	2,500	
	San Dimas Chamber Events	Resource	85	
	Puente Hills Family YMCA	Resource	300	
	Lighten Up SGV (5 events, classes, online)	Education	17,239	
	Flu shot clinic	Resource	4,000	
	Know Your Stats	Education	9,954	

**Citrus Valley Health Partners, Inc.**  
**List of Community Outreach Services by Department**  
**2013**

<u>Dep:</u>	<u>Description</u>	<u>Category</u>	<u>Department Totals</u>	<u>Totals</u>
	Women's May Day (1 event in 2013)	Education	7,867	
	Beryl call center	Resource	130,825	
	Health Day web library	Resource	9,270	
	Family Health Fair	Education	4,138	
	Stop Stroke FAST	Education	8,289	
	Women's Heart Event	Education	6,487	
	Heart Smarts	Education	5512	
	Colorectal seminar	Education	5465	
	<b>Public Relations Subtotal</b>		<b>263,392</b>	<b>263,392</b>
<b>Pharmacy</b>				
	CMP Charity Meds	Charity	6,500	
	QVC/ ICC Charity Assistance Program	Charity	5,335	
	<b>Pharmacy Subtotal</b>		<b>11,835</b>	<b>11,835</b>
<b>Education</b>				
	CVHP Scholarship	Resource	46,000	
	CVHP Externship	Service	61,384	
	Onsite Nursing Student Coordination CVMC	Service	70,000	
	Onsite Nursing Student Coordination FPH	Service	15,000	
	<b>Education Subtotal</b>		<b>192,384</b>	<b>192,384</b>
<b>Laboratory</b>				
	Red Cross Blood Drives	Service	5,560	
	<b>Laboratory Subtotal</b>		<b>5,560</b>	<b>5,560</b>
<b>Other Departments</b>				
	Cardiopulmonary Mended Hearts, Breathsavers & Support Groups	Resource	55,980	
	Breathsavers Program Scholarship	Education	5,265	
	Clinical Care Extenders: Annual Expense for Program	Service	150,000	
	Clinical Care Extenders (CCE's): Sponsorship of Student Volunteers-T-S	Service	7,760	
	CCE's : Recruit, train, monitor students for service learning projects	Service	7,140	
	<b>Other Departments Subtotal</b>		<b>226,145</b>	<b>226,145</b>
<b>Center for Diabetes Education</b>				
	Community Lectures (10)	Education	1,500	
	Support Groups: Hours	Education	7200	
	Support Groups: Supplies	Education	700	
	Inpatient Education - 10 hours per week	Education	26,000	
	Interfaith Outreach	Education	1,800	
	School Outreach	Education	450	
	Community Meetings	Planning	420	
	Health Fairs	Education	1,400	
	MD Office Lectures	Education	125	
	Preceptorship MSN Students - APU/ Western Univ.	In-Kind	18,000	
	<b>Diabetes Education Program Subtotal</b>		<b>57,595</b>	<b>57,595</b>
<b>CVHP Business Development</b>				
	Diabetic testing strips purchased for diabetic patients	Resources	86,399	
	<b>CVHP Business Development Subtotal</b>		<b>86,399</b>	<b>86,399</b>
<b>FPH Nursing</b>				
<b>Perinatal</b>				
	Maternity Tea and Tour	Education	1,620	

**Citrus Valley Health Partners, Inc.**  
**List of Community Outreach Services by Department**  
**2013**

<u>Dep:</u>	<u>Description</u>	<u>Category</u>	<u>Department Totals</u>	<u>Totals</u>
	Breast Feeding Class	Education	1,275	
	Sibling Class	Education	540	
	Baby Basics	Education	1,305	
	Prepared Childbirth Series	Education	2,125	
	Prepared Childbirth (Lamaze)	Education	2,610	
	<b>Perinatal Subtotal</b>		<b>9,475</b>	<b>9,475</b>
	<b>FPH Food Services</b>			
	Preceptor to Intern	Resources	14,040	
	Food Outdated	Resources	500	
	ED Patient Trays	Resources	14,400	
	Guests	Resources	300	
	Food donated to funerals	Resources	100	
	Glendora Public Library Trivial Challenge	Resources	100	
	<b>Food Services Department Subtotal</b>		<b>29,440</b>	<b>29,440</b>
	<b>FPH Volunteer Services &amp; Auxiliary</b>			
	Telecare (Calls to Home Bound patients)	Resource	21,150	
	19 Scholarships	Education	28,500	
	<b>Volunteer Services and Auxiliary Subtotal</b>		<b>49,650</b>	<b>49,650</b>
	<b>FPH Other Departments</b>			
	Engineering			
	Set up/ tear down for events	In-Kind	1,133	
	<b>Engineering Services Subtotal</b>		<b>1,133</b>	<b>1,133</b>
	<b>Grand Total--CVHP Departmental Outreach Services</b>			<b>\$ 1,484,143</b>



# Citrus Valley Health Partners

VII

## Community Benefit Plan Update



**Citrus Valley Health Partners (CVHP)**  
**CVMC: Inter-Community; Queen of the Valley Campus and**  
**Foothill Presbyterian Hospital**  
**Community Benefit Activities 2013**

**2013 Community Health Needs Assessment (CHNA)**

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included the requirement, under Section 501©, that nonprofit hospitals must conduct a Community Health Needs Assessment (CHNA) every three years following passage of California Senate Bill 697 (SB697) in 1994. The new legislation guiding the CHNA for nonprofit hospitals requires a greater emphasis on structured and standardized methodologies on how community needs are identified and prioritized engaging a range of stakeholders and consideration of the diverse needs of the communities served.

In accordance to the new provisions in the IRS Notice 2011-52, Citrus Valley Health Partners conducted the state-mandated 2013 Community Health Needs Assessment in partnership with Kaiser Foundation Hospital-Baldwin Park.

Citrus Valley Health Partners comprises four campuses: Inter-Community in Covina, Queen of the Valley in West Covina, Foothill Presbyterian in Glendora, and Citrus Valley Hospice in West Covina. The service area for CVHP encompasses 13 cities and 4 census designated places (CDPs).

The complete report of the 2013 Community Health Needs Assessment (CHNA) is included in this reporting system.

Citrus Valley Health Partners adhered to all the new regulations and mandates stipulated for not-for-profit hospitals. The 2013 CHNA was disseminated in the community in a threefold: community presentation, free printed report, and electronic format at the CVHP's website.

Even though, the CHNA was conducted and finalized in 2013, it is important to highlight that this community benefit update is still based on the identified needs in the previous needs assessment report in 2010.

## Access to free and affordable health care services for low income uninsured children and families

### Insurance Enrollment for Low-Income Populations

- **As a result of extensive outreach efforts in the community, a total of 3,782 applications for health insurance were completed in 2013 for low-income uninsured children, families, pregnant women, childless adults, and seniors.**

*The programs include MediCal, Covered California, Healthy Kids, AIM, KPCHP, Healthy Way LA, and other Safety Net Programs.*

#### Ongoing Efforts :

Since 2001, CVHP's GEM (Get Enrollment Moving Project) has been a leader in connecting families and individuals with access to free or low-cost health insurance as well as referrals to other health access and social services programs for the uninsured and low income residents. The GEM project partners with promotoras, schools; child care agencies; places of worship; family resource centers; clinics; community based organizations, businesses, universities, etc., to identify uninsured children and families and provide them with enrollment services in the GEM office and at strategic community-site locations to bring the services in the various neighborhoods. The GEM Project partners with various public and private community organizations to place enrollment specialists at their locations, particularly those in low-income at-risk communities.

During its twelve (12) years of experience as the hub for uninsured and underinsured low-income individuals in the San Gabriel Valley, the challenge of engaging hard to reach populations continues to be significant. There is still a gap between the available services and the residents who qualify for them. The GEM Project offers cultural and linguistic appropriate outreach and enrollment services.

#### Additional Access to Health Care Services:

**In 2013 we provided 3,229 referrals to access care via other healthcare/safety net options available for individuals who did not qualify for the free or low-cost public insurance programs.**

As a result of the weak economy and loss of employment, the need to access free and/or low-cost health insurance programs has increased. Children and families need one-on-one assistance to access the health insurance programs and to maintain their coverage.

### **ACCESS TO CARE/HEALTH INSURANCE: OUTCOMES**

Based on data from the CVHP's 2010 Community Health Needs Assessment, the percentage of uninsured children was 28%. New updated research shows that the number of children without insurance in CVHP'S catchment area has decreased steadily. This outcome is quite significant considering that an additional number of children became uninsured in the last few years due to parents and/or caregivers becoming unemployed. Conversely, the number of additional individuals who now qualify for the new Affordable Care Act Market Place (Exchange) has significantly increased the need for education and assistance to access coverage through Covered California.

#### **Troubleshooting and Assistance to Overcome Barriers to Health Access**

- **In 2013 CVHP's GEM Project assisted 3,962 clients with troubleshooting and advocacy as well as teaching (educating) community how to navigate the complex healthcare system and keep their coverage.**

Insurance/ Health Access Programs	Focus of Program
Full Scope Medi-Cal	Children, parents and disabled who are legal, permanent residents
Medi-Cal Targeted Low-Income Children's Program	Expanded Medi-Cal and former Healthy Families Program for children.
Restricted Medi-Cal	Children and pregnant women who are not legal, permanent residents
Non-MAGI Medically Needy Medi-Cal	Maintenance Need Level determines if family members can get no-cost Medi-Cal at no cost or with a Share-of-Cost (SOC)
ACA - MAGI Medi-Cal Expansion	19-64 Single Childless Adults; Parents and Caretaker Relatives; Pregnant Women and Children
ACA - Covered California: Online Market Place	People can shop for health insurance and find out if they qualify for financial help to make insurance more affordable.
Healthy Kids	Children 0 - 5 who are not eligible for Full Scope Medi-Cal or Healthy Families
AIM	Access for Infants and Mothers (AIM)
Kaiser Permanente Child Health Plan	Uninsured children from birth thru age 18 who are not eligible for other public/private programs, such as Medi-Cal or Healthy Families (this program opens and closes enrollment dates throughout the year)
CHDP, CCS, EBCDP,	Specialized (non-insurance) programs for specific populations
Ability to Pay (ATP) & Pre-Payment Healthy Way LA (HWLA)	Safety Net programs available at the Department of Healthcare Services (Comprehensive Health Centers and the LA County Hospital) and Community Clinics for families who are not eligible for insurance.
Access to Care Referrals	Programs that provide free health care and dental services: Our Savior Center/Cleaver Clinic; East Valley Community Health Center; El Monte Comprehensive Health Center; San Gabriel Valley Foundation for Dental Health, Fairgrove Dental Clinic, Tzu-Chi Clinic, ECHO (Every Child's Health Option), Western University, etc.

## Enrollment Verification, Utilization and Redetermination of Insurance Coverage for Health, Dental and Mental Health Services

- **Enrollment verification:** Once the enrollment is completed, the retention/utilization specialist contacts all clients to confirm enrollment in the insurance program and to provide assistance with any possible barriers or questions that may result in the process of finding an accessible and acceptable health care, dental and vision care provider to receive timely preventive services. Enrollment verification efforts have shown that 82% of participants who received enrollment services were confirmed enrolled in the programs.
- **Utilization assistance:** Once the enrollment verification is completed, the retention/utilization specialist has a follow-up procedure to contact each client at the six month post-enrollment mark to confirm that the client is utilizing the health benefits, advocate and trouble-shoot any issues that arise with access, quality, and utilization, and to maintain contact to facilitate re-enrollment. Based on information provided by enrolled individuals, we have found that at least 74% of them have utilized medical services while only 47% reported to have utilized dental services. It is pertinent to mention that the difference is due to the fact that some individuals qualify only for “Emergency MediCal “ and they can only utilize services in case of an emergency.
- **Retention and re-enrollment:** Eleven months after enrollment all clients are contacted again to ensure that they have received and completed their redetermination form. Many clients, particularly those with low literacy level, utilize support services from CVHP/GEM staff to complete the required process to remain enrolled and maintain coverage. In 2013, the program was able to reach 82.19% of enrollees that reported continued coverage for one full year and completed their redetermination (renewal) form for the following year.

Note: *Experts in this field rate these percentages as highly successful.*

**Provide Community Outreach to low income vulnerable populations via door-to-door, school, faith-based and community events.**

### **Community Outreach:**

In 2013 the total community outreach contacts through community events and/or door-to-door encounters were 16,481.

It is important to highlight that community members received individualized outreach services in their homes. The Door-to-Door *Promotora (Health Promoter)* Program alone provided one-on-one information to 12,140 individuals (already included in the total number of encounters above) in targeted high need neighborhoods on how to access low-cost local healthcare services and referrals for other health and social services such as food; legal; rental assistance; employment fairs; immigration; free or low cost mammograms; etc. The *Promotoras* focus on reaching out to uninsured residents; these community-based leaders become a bridge between the neighborhood residents and the services available to them. Promotoras provide assistance in completing reduced utility applications and inform families about health access opportunities. They represent the community in language and ethnicity.

### **Promotoras “A Community-based leadership and capacity building model”**

*“Building Communities from the Inside Out”*

**Pueblo que Camina Promotoras - Background**

The GEM Project Works in partnership with *“Pueblo que Camina”* (*“Village that Walks”*) Promotora Group. This group was developed in collaboration and support from CVHP’s GEM Project. *Pueblo que Camina* is comprised of women from different neighborhoods whose purpose is to improve the quality of life for families in their communities. For the most part they are Hispanic women who volunteer some of their time to inform low-income families regarding opportunities to access health care services and other community resources. This program is an example of *“community helping community”* in the most vulnerable cities in the San Gabriel Valley. The Promotoras also receive training, empowerment, and personal growth opportunities.

It has been found that Promotoras who are affiliated with faith communities seem to demonstrate a higher level of commitment and consistency in their community involvement.

### **Ongoing Education and Training Opportunities/Capacity Building**

Promotoras are influential leaders in the neighborhoods as “community voices”. As such, it is very important to provide them with continuing education and tailored trainings so that they can become role models and promoters for good health behaviors and a resource to the community residents as it relates to health promotion.

Some of the trainings that the GEM Project provides for them is ongoing updates and training in the various health insurance and access to care programs. Other trainings include Maternal/Child health; Breastfeeding; Mental Health; Nutrition; Access to Preventive Services; Stress Management; Healthcare Reform; Perinatal Depression; Self-Esteem, Communication Skills; Wellness Practices, etc. CVHP/GEM offers an annual recognition holiday event where elected officials thank them for their contributions and give them individual certificates of recognition.

### **Promotoras as Agents of Change and Community Educators in the Affordable Care Act (ACA)**

In preparation to the significant changes that are fast approaching in 2014, *Promotoras* receive ongoing updates on the Health Insurance Exchange/Covered California Market Place as well as the Medi-Cal Expansion. Through these efforts, the Promotoras stay up to date and are

able to talk and guide people to get further education on the programs and for enrollment through the GEM Certified Enrollment Counselors and other enrollment agencies.

## **CVHP Service Area Community Planning and Community Capacity Building**

In 2013, Citrus Valley Health Partners continued to be an active and voting partner of the Steering Committee of the Los Angeles County SPA3 (San Gabriel Valley) Health Planning Group. CVHP participates in ongoing community planning and strategies to respond to ongoing and emerging needs in the community. CVHP also has provided financial support to sustain the facilitation and organizational activities of this important community planning and action group.

### **SPA3 HPG: Overview, Accomplishments and Ongoing Activities**

The Service Planning Area (SPA) 3 Health Planning Group (HPG) is a coalition of community health advocates and local health organizations serving the low-income and uninsured population of the San Gabriel and Pomona Valleys. SPA 3 HPG participants include, but are not limited to, hospitals, community health centers and clinics, other community-based organizations and health providers, non-for-profit hospitals, private practice providers, faith-based organizations, Los Angeles County (LAC) Departments of Health Services (DHS) and Public Health (DPH), Pasadena Public Health Department, school district health programs, advocates, and programs offering services for children, seniors and disabled populations.

The SPA3 Steering Committee agency partners are: Durfee Family Care Medical Center; Tzu Chi Foundation; East Valley Community Health Center; Heal Christian Health Center; LA County Department of Public Health; El Monte Comprehensive Health Center; Pomona Community Health Center; Bill Moore Community Health Clinic; **Citrus Valley Health Partners**; Pomona Valley Hospital Medical Center; Foothill Unity Center; Los Angeles County Department of Mental Health; El Proyecto del Barrio; Kaiser Permanente Baldwin Park; Community Health Alliance of Pasadena; and Garfield Health Center.

Vision: *A healthy community, with optimal quality of life and wellbeing for all.*

Mission: *To improve the health and wellbeing of the SPA 3 community by increasing access to care and promoting healthy lifestyles.*

## SPA 3 HPG Review and Goal Update - 2013

### Goals & Strategies

1. *Increase access to care* through addressing issues such as enrollment and participation in health coverage programs, access to specialty care, access to affordable dental care, linking people to medical homes, and increasing system capacity to provide needed care.
  - a) Support and inform on public policies that will improve access to care and the provision of health care services for underserved populations, particularly with respect to healthcare reform, Healthy Way LA, the Mental Health Services Act, etc.
  - b) Develop collaborative strategies and share information on opportunities, best practices and lessons learned to facilitate access to services.
  - c) Implement programs or projects that will serve to accomplish this goal. Current programs include the Colorectal Cancer Screening and Treatment program, Retinal Telehealth, and Teledermatology.
  
2. *Promote healthy lifestyles* through implementation of health promotion and disease prevention activities and programs that a) identify and reduce health disparities and b) address the priority issues of chronic disease prevention and management among children and adults as well as lifestyle behaviors that impact health.
  - a) Access and monitor relevant information and data through partnerships with public health departments and other groups.
  - b) Support and inform on public policies that will improve community health status.
  - c) Promote healthier places through the integration of social, economic and environmental policy issues into city and community planning processes.
  - d) Respond to priority and emerging needs through identifying opportunities for evidence-based programs that are feasible for the SPA 3 HPG.
  
3. *Increase capacity of HPG participants to serve the SPA 3 community* through relationship building, collaboration, HPG support, resource sharing and information.
  - a) Increase awareness and effective utilization of resources within the HPG and the SPA.
  - b) Promote community awareness of health concerns and available resources through strategies such as hosting forums and disseminating information.
  - c) Outreach to expand HPG participation by new partners who support our mission (e.g., in the areas of dental health, mental health, social services, and representation from municipalities and school districts).

Evaluate and document the outcomes and success of all SPA 3 HPG activities and programs.

**CVHP provided meeting room, lunch and AV equipment every three months for the big group meetings.**

### **SPA3 HPG Specialty Care Initiative**

- In 2013, the Health Planning Group developed a master list of free and/or low cost of dental health services in the San Gabriel Valley. The list was distributed with all partners to be disseminated to other social service agencies and to consumers.
- Through a three year grant, SCI implementation grant to increase early detection of colorectal cancer (CRC) by increasing access to CRC screenings and prioritizing access to colonoscopies; and (2) Provide timely and appropriate dermatological diagnosis and treatment by improving access and services for adults and children through a teledermatology program.
- The SPA 3 Health Planning Group was awarded an additional Specialty Care Continuation grant. This is a one-year grant for \$150,000 that commenced October 1 2013. The goal is to pilot test a viable operational and financial model for implementation of specialty care services at two Hub clinics in Service Planning Area 3 that will create timely and geographic access to specialty care services within the San Gabriel Valley.

## **Community Health Improvement and Disease Prevention Programs:**

### **Maternal and Child Health**

#### **San Gabriel Valley Best Babies Collaborative Program Update**

**Background:** Since 2009, Citrus Valley Health Partners in partnership with the Best Babies Network and First 5 L.A., has formed the San Gabriel Valley Best Babies Collaborative (SGVBBC). The SGVBBC seeks to improve the birth outcomes and increase the breast feeding rates among childbearing age women in high risk areas in the San Gabriel Valley and Pomona Areas. We provide *Case Management* services to support and assist high-risk women to ensure access to healthcare and mental health services as well as personalized support for access food, shelter, and other services to improve their quality of life and achieve a healthy birth in a present and future pregnancy. CVHP is the leader agency of the collaborative. Other partners are: Catholic Charities; East Valley Community Health Center; Asian Youth Center; Foothill Family Service; and PHFE WIC. The relationship centered approach has always been a key value and practice for Citrus Valley Health Partners.

San Gabriel Valley Best Babies Collaborative - Comprised of culturally diverse health and community-based organizations committed to serving and empowering women.

- The Purpose is to optimize birth and maternal outcomes through comprehensive and integrated health and wellness services and to increase breastfeeding rates.
- 5 Years of Service - September 2008- June 2013.
- High risk pregnant teens and women receive health and psychosocial services through an intense home visitation program provided by CVHP and partner agency case managers.
- Pregnant moms receive month-by-month guidance to a healthy pregnancy.
- Group and individual Health Education and Social Support services
- Referrals to community services including food, housing, legal, mental health services, particularly counseling for depression.
- Post partum home visitation care.
- Free diapers, baby clothes and toys.
- 

Outcomes:

- 280 participants received perinatal comprehensive services.

➤ Considering the level of risk and complexity of the population being served, the program optimized efforts to decrease poor birth outcomes. The percentage decreased from 19.23% from previous years to 4.35% in 2013.

➤ The program has already attained the breast feeding initiation rates for Healthy People 2020. The actual program achievement shows a 96.3% achievement compared to the Healthy People 2020 at 81.9%.

➤ The six month breast feeding rate has shown an increase in 2013 from 17.86% to 38.46%. The SGVBBC continues to exceed the Healthy People 2020 Goal of 25.5 %.

## Assistance with Transportation Barriers to Access Care

A total of 72 free taxi transportation services and 734 free bus tokens were provided in 2013 for low-income pregnant teens and women to ensure access medical and mental health services.

## SPA3 (Service Area Planning 3) Healthy Births Learning Collaborative (HBLC) - Community Capacity Building

CVHP and the *Best Babies Collaborative* have successfully established a multidisciplinary community group named “Healthy Births Learning Collaborative” in the San Gabriel Valley (SPA3 - LA County Service Planning Area 3).

### **Purpose:**

Convene a SPA3 Healthy Births Learning Collaborative to increase awareness, capacity and coordination of services to improve birth outcomes in the San Gabriel Valley.

The HBLC’s created to promote healthy birth outcomes through a holistic approach that incorporates community involvement, education, social support, access to services and strengthening families.

### **Background/Prioritization and Planning:**

The HBLC went through a comprehensive review and prioritization process through a value voting system.

The top three identified priorities are: 1) Family Shelters (for pregnant women); 2) Advocacy; 3) Reaching out to the Medical Community; and Teen Pregnancy support and prevention.

The HBLC participants agreed to focus on what they can do as individuals, agency, or other disciplinarians to contribute to the identified need related to the priority issues.

Outcome: The HBLC group has continued to meet to learn and collaborate in different ways to support pregnant women.

## **San Gabriel Valley Disabilities Collaborative (SGVDC)**

### **Background**

In 2009, fourteen representatives of various community public and private organizations met at Citrus Valley Health Partners - Queen of the Valley Campus - to consider developing a collaborative made up of representatives of community based organizations, healthcare facilities, and governmental agencies, as well as interested individuals that would look at ways to improve programs and services for persons with disabilities and partner in efforts to obtain more resources for such efforts in the San Gabriel and Pomona Valleys.

**Update:** In 2013, the SGVDC met every month. Currently, it has approximately 200 individuals interested in these efforts. This group meets monthly at Citrus Valley Medical Center-Queen of the Valley Campus.

## **San Gabriel Valley Homeless Coalition**

Citrus Valley Health Partners continues to be the hub where the homeless consortium meets monthly to advance the work related to increasing support and bringing resources to respond to the needs of the homeless population in the San Gabriel Valley. CVHP provides free of charge a meeting room, AV equipment, and refreshments every month of the year.

Outcome: The coalition continued to collaborate and combine programs and resources to assist the homeless population. The leadership and the coalition members are preparing to apply for the new round of funding made available with an RFP that is being published by LAHSA Los Angeles Homeless Services Authority.

## **Citrus Valley Health Partners (CVHP)**

### **La Puente Multidisciplinary Diabetes Collaborative**

**2013**

CVHP called community partners to join in the efforts to improve the health status of people with diabetes. As a result, the La Puente Diabetes Collaborative was formed to address the high incidence of diabetes in the La Puente community.

#### **Collaborative Partners**

CareMore Health System; Bassett Unified School District; YWCA San Gabriel Valley; AltaMed; Pasadena Youth Center; Rowland Unified School District; Bassett Community Member; East Valley Community Health Center; Assembly member Roger Hernandez; Bike SGV; St. Stephen's Church; City of La Puente; La Puente City Council; UCLA; CA Center for Public Health Advocacy; State Senator Ed Hernandez; Diabetes Care Pharmacy & Health Program Centers; and GEM (Get Enrollment Moving) Project.

#### **Collaborative Accomplishments:**

- The University Of California Los Angeles Fielding School Of Public Health in partnership with the collaborative members developed and implemented a community survey/assessment of Diabetic Patients' Behavioral Health and Care Management Needs. The survey results identified demographic information such as age, gender, race and ethnicity, zip code, county of origin, language, level of information about Diabetes as well as health behaviors that could impact their health status. Eighty five (85%) percent of the participants reported that a nurse or a doctor has told them that they have diabetes.
- As a collaborative partner, CVHP provided funding to East Valley Community Health Center (clinic) to offer free diabetic testing strips to hundreds of patients to measure and control their sugar levels on a daily basis. This strategy is beginning to show a positive impact in patient's lab results. Data will be collected for future reporting.

#### **Diabetes Collaborative: Next Steps.**

- Based on the results of the community assessment, the collaborative partners will explore strategies, resources and opportunities to address: 1) the major behavioral health and care management challenges of local diabetic patients; 2) improve their well-being; and 3) support them in their health improvement goals.

- Currently, CVHP's Health Foundation is leading the efforts in seeking grant funding to offer a peer education program for disease management known as the *Stanford Model*. The program is available in various languages and it is rated as "*best practice*".

### **CVHP Physician Leadership**

- Additional diabetes health improvement efforts are being spearheaded by the Chief Medical Officer, Pavelijt Bindra, MD and Dr. Ed Jari. They are developing a process for a *care continuum* project to monitor, educate and support individuals with diabetes inside and outside the hospital walls.

# Free Support Groups

to help you with your concerns, achievements and challenges in

## Managing Your Diabetes



**Now in  
TWO locations**  
(Beginning June 2013)

<b>Foothill Education Center</b> 427 West Carroll Avenue, Glendora, CA 91741		<b>CVHP Resource Center</b> 315 N. Third Ave., Suite 303B, Covina, CA 91723	
<b>Adults with diabetes</b>	<b>1<sup>st</sup> Monday of each month from 10:30 AM - 12:00 PM</b>  <b>3<sup>rd</sup> Wednesday of each month from 7:00 – 8:30 PM</b>	<b>Spanish-speaking adults with diabetes *</b>	<b>1<sup>st</sup> Wednesday from 10:00 – 11:30 AM</b>
<b>Parents of Children with Diabetes</b>	<b>1<sup>st</sup> Wednesday of each month from 7:00 – 8:30 PM</b>	<b>Adults with diabetes</b>	<b>4<sup>th</sup> Thursday from 10:00 – 11:30 AM</b>
<b>Adolescents</b>	<b>4<sup>th</sup> Wednesday of each month from 7:00 - 8:30 PM</b>		

Groups are led by Tammy Yamashita, MS, MFT; Counselor for the Center for Diabetes Education

\* Spanish language groups led by Sandy Ramirez, RN, CDE; Certified Diabetes Educator for the Center for Diabetes Education



**CITRUS VALLEY HEALTH PARTNERS**  
*Citrus Valley Medical Center – Inter-Community Campus & Queen of the Valley Campus,  
Foothill Presbyterian Hospital and Citrus Valley Hospice*

**Call (888) 456-2847 or visit us online at [www.cvhp.org](http://www.cvhp.org) for more information.**

# Interfaith Diabetes Outreach

- 24 million people in the US have diabetes
- Diabetes education helps those with diabetes know how to take care of themselves, prevent problems and live healthy lives

**The Citrus Valley Health Partners Center for Diabetes Education** will come to your place of worship and provide 2 hours of free education.

*If you would you like to host a diabetes educational event or receive more information, contact:*

Ann Kuns, MSN, RN, CNS, CDE  
Clinical Nurse Specialist  
Program Coordinator  
626.857.3476



## **Citrus Valley Health Partners (CVHP)**

### **Outpatient Wound Center Diabetic Foot Screenings**

**2013**

Since August 2012, Citrus Valley Outpatient Wound Center (at InterCommunity Campus) has held free monthly community diabetic foot screenings. The monthly screenings happen on the third Wednesday of each month. In 2013, the Outpatient Wound Center has held at least fifteen screenings and has served approximately 108 people with diabetes.

#### **Attendance at Monthly Foot Screenings and Community Health Fairs**

Attendance has varied from 1-10 participants per screening, with an average of 4 per month, or approximately 48 individuals screened per year. In addition to these regularly scheduled events, the Wound Center has performed foot screenings for diabetics in several community events hosted by Citrus Valley Health Partners. In 2013 we participated in the following health fairs performing approximately 20 screens at each:

June 13, 2013: Diabetes Education and Screenings at La Puente Senior Center  
September 14, 2013: Community Healthy Fair at Foothill Presbyterian Hospital  
November 23, 2013: Chinese Health Fair at Queen of the Valley Campus

#### **Diabetic Foot Education Booklets**

Also, supplementary educational booklets on the self care of the diabetic foot were given out at other community health fairs including: Stroke Awareness event in May 2013, and the Covina Senior Fair in September 2013.

The English language booklet has been included on the following pages.

#### **Summary**

- Total # of diabetic foot screenings = 15
- Total # of people served = 108
- Total # of educational booklets provided = 148

# Diabetic Foot Screen

**FREE** TO THE SAN GABRIEL VALLEY COMMUNITY

**Third Wednesday  
of the month  
3-6 p.m.**

210 W. San Bernardino Road  
Covina, CA

PROVIDED BY THE  
Out Patient Wound Care Center

AT  
Citrus Valley Medical Center –  
Inter-Community Campus

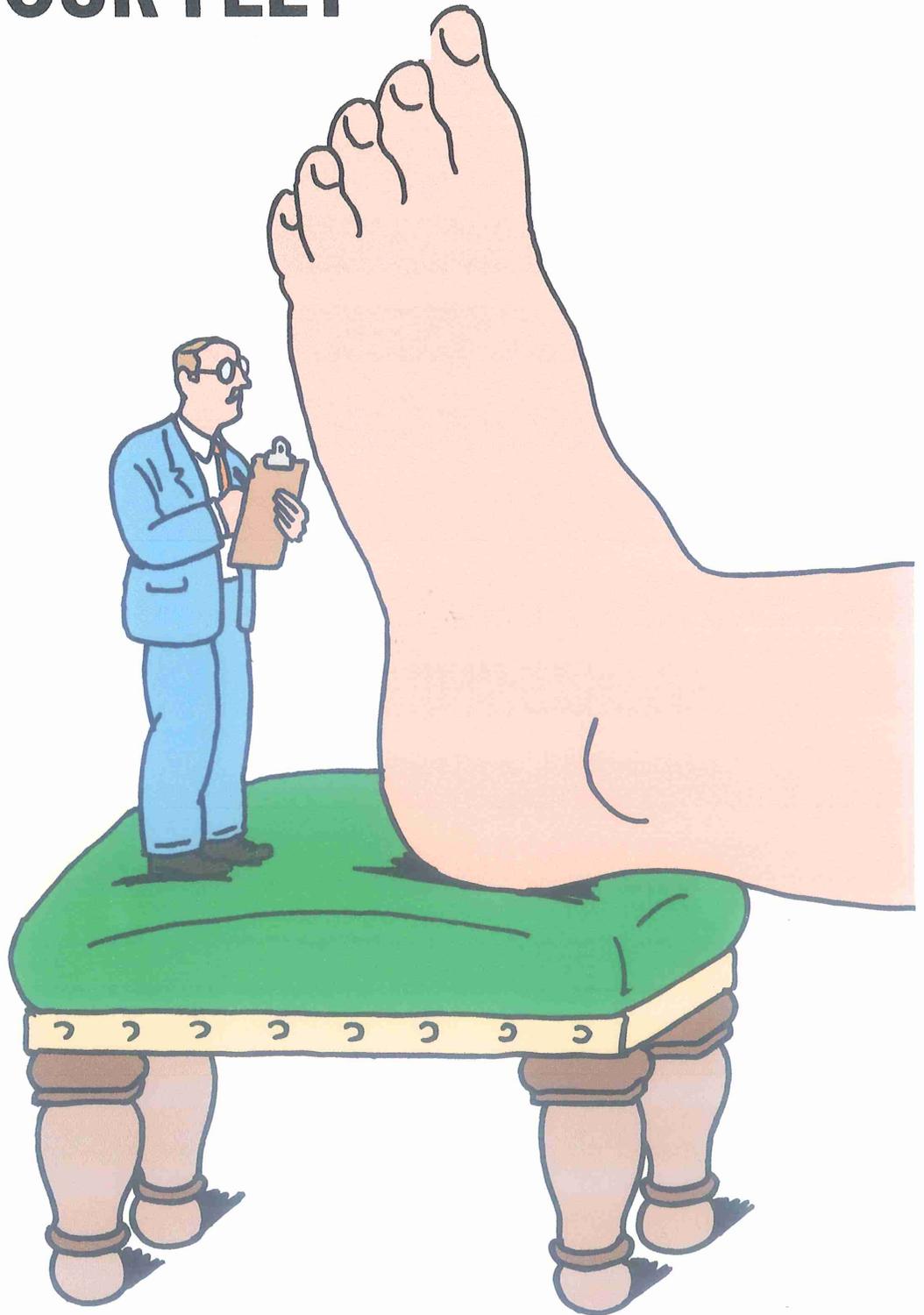
PLEASE CALL TO REGISTER:  
**(626) 915-6261**



CITRUS VALLEY MEDICAL CENTER  
*Wound Care*

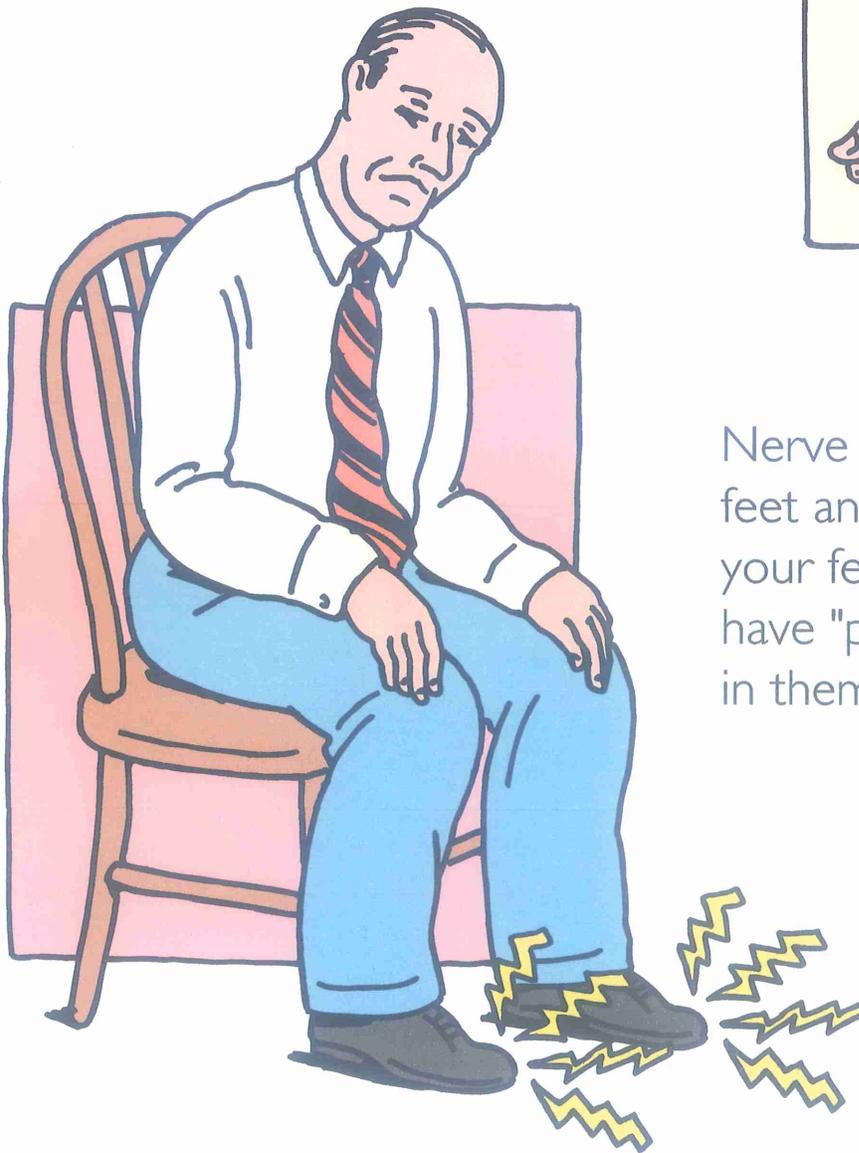
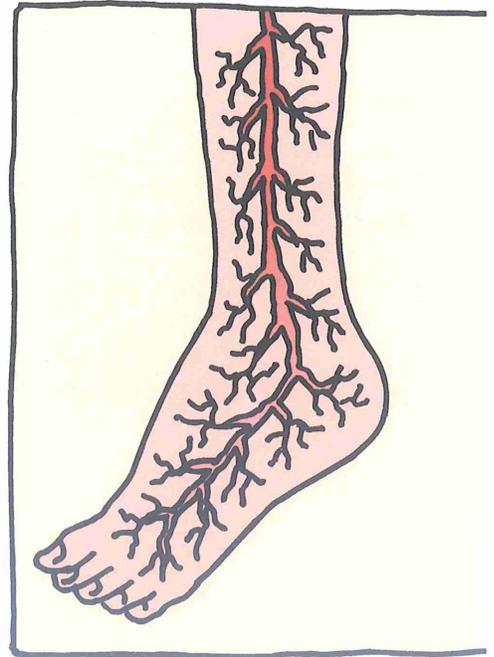


# DIABETES AND YOUR FEET



**W**hen you have diabetes, it is important to take care of your feet.

High blood sugar can damage the nerves in your feet and cause blood flow problems.



Nerve damage in your feet and legs can make your feet feel like they have "pins and needles" in them.

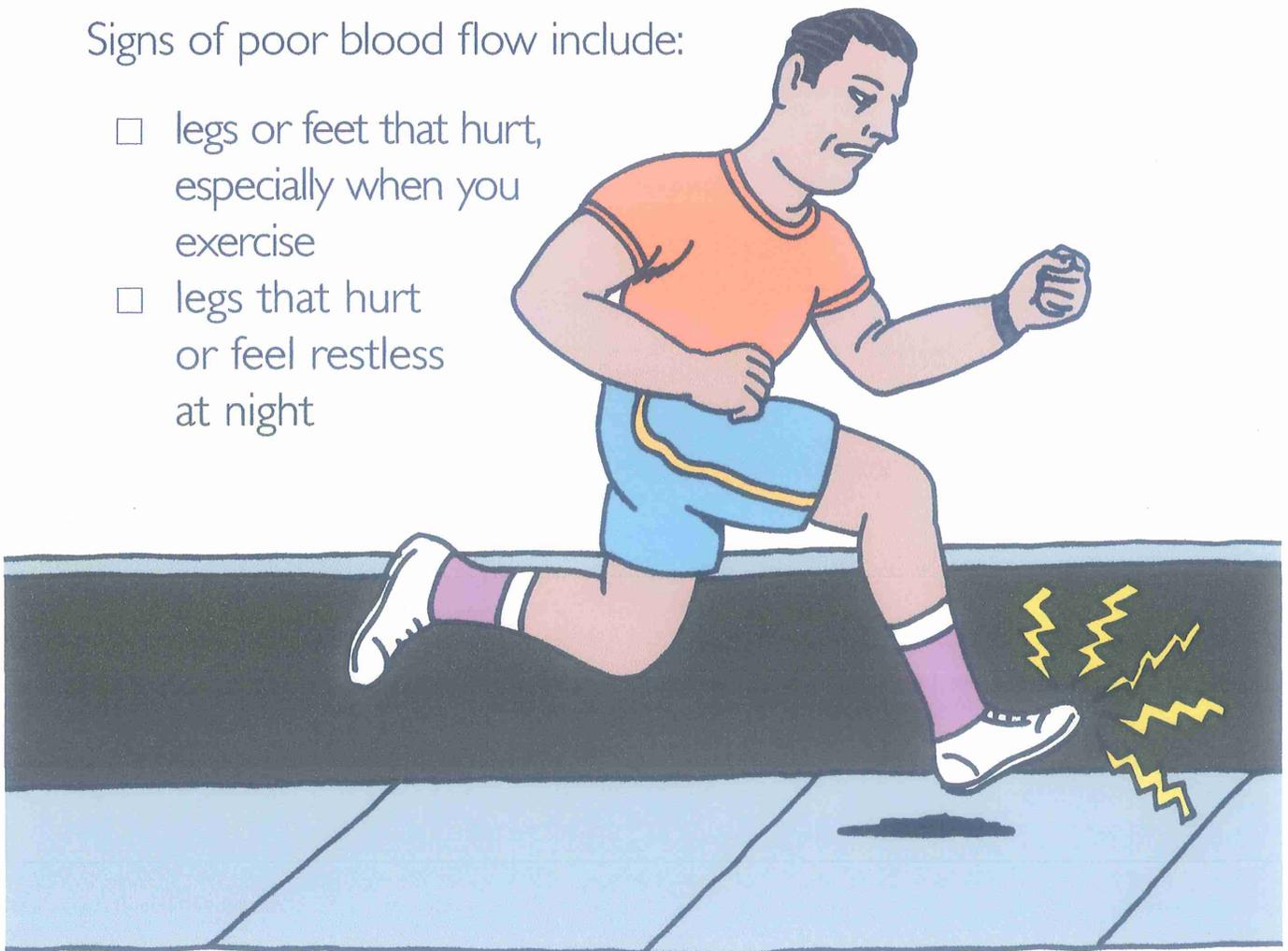
You may also lose feeling in your feet and not be able to feel pain, pressure, heat or cold. Then if you have a sore, blister, or injury, you may not know it right away. The sore can become infected.

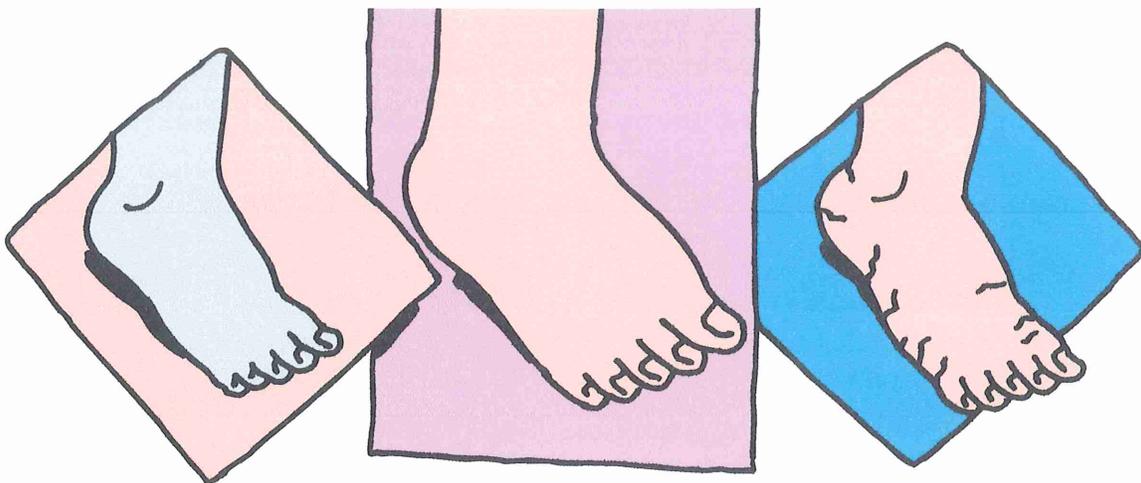


Infection and poor blood flow can lead to losing your toes, foot, or leg.

Signs of poor blood flow include:

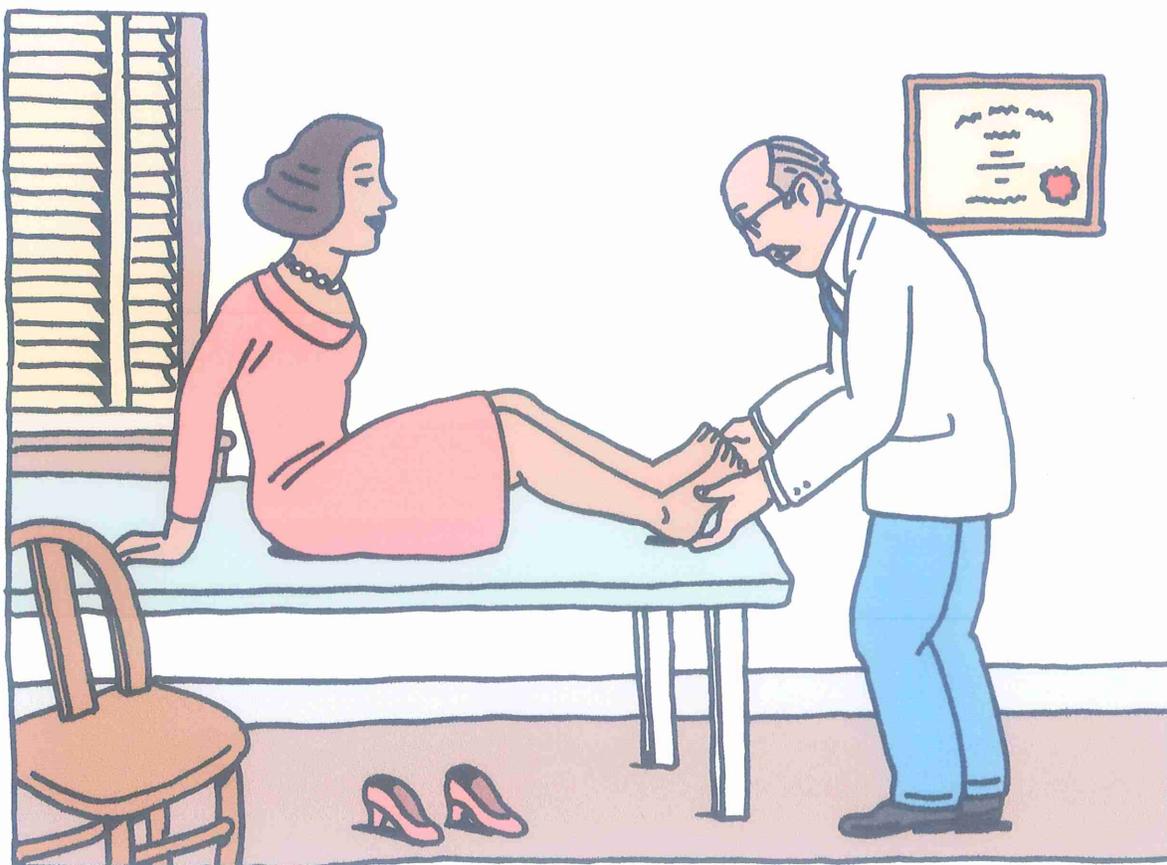
- legs or feet that hurt, especially when you exercise
- legs that hurt or feel restless at night





You may also have sores that won't heal, feet that are swollen or blue, or skin on your feet that is very dry and cracked.

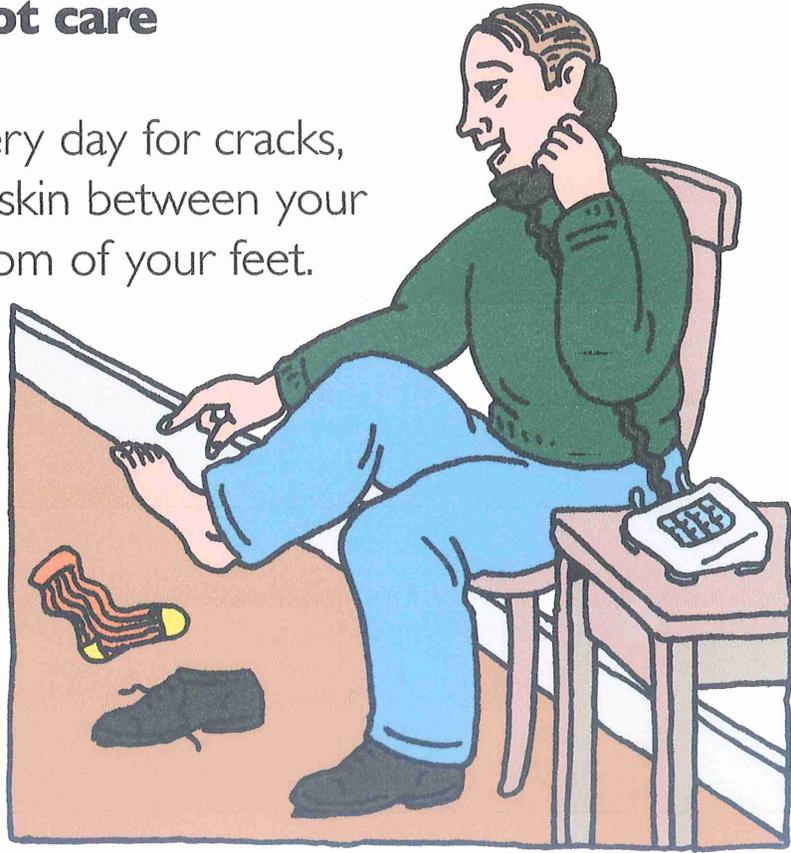
If you have diabetes, it is important to have your feet checked often by your doctor or health clinic. Each time you visit your doctor or health clinic, make sure you take your shoes and socks off to have your feet checked.



## Tips for good foot care

Check your feet every day for cracks, blisters, cuts, or dry skin between your toes or on the bottom of your feet.

Use a mirror or get someone to help if you have trouble seeing your feet. Call your doctor right away if you see a sore on your foot. Don't wait.



Wash your feet every day with mild soap and warm (not hot) water. Always test the water first against your wrist or elbow to make sure it is not too hot. Dry your feet well, including between your toes.

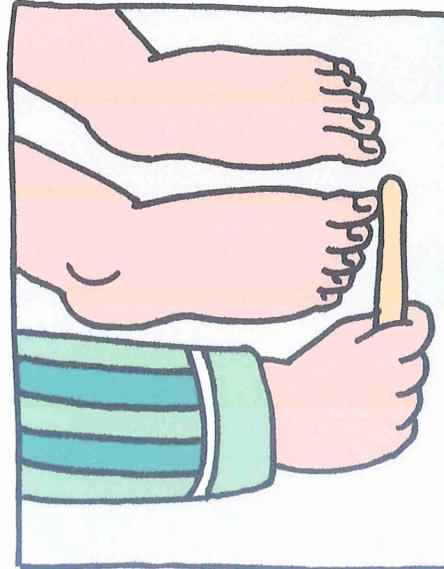
Don't soak your feet. It may dry your skin too much.



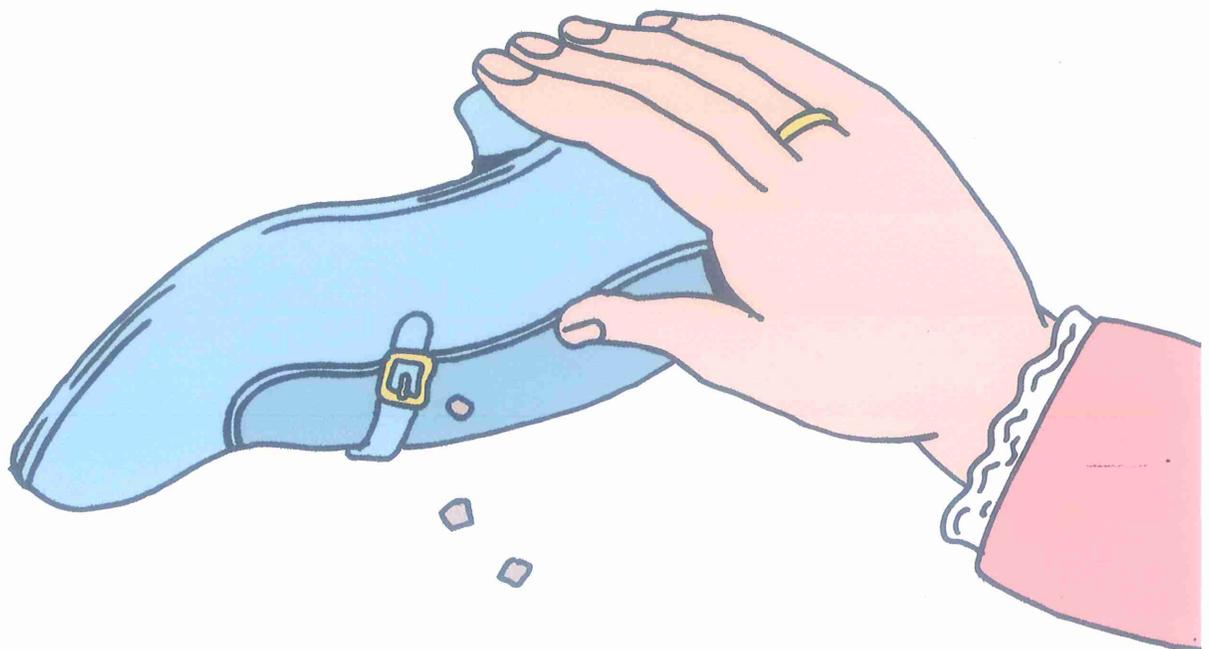
Use lotion or cream on the tops and bottoms of your feet (not between toes) and especially on any dry skin areas.



Trim your toenails straight across with an emery board or file. Do not use scissors or clippers.



Look inside and shake out your shoes and socks before you put them on. This will help you remove small objects that could hurt your feet.





Wear shoes that fit well, are comfortable, and don't cause blisters. Shoes that fully cover and protect your feet should be worn year-round.

Never go barefoot, even indoors.

Cotton or wool socks will help keep your feet dry. If your feet are cold, wear warmer socks.



Don't use heating pads or hot water bottles to warm your feet.



See your doctor for care of corns, calluses, and warts. Never cut or treat corns and calluses yourself. Razor blades, corn plasters, liquid callus removers, and wart compounds can damage your skin and cause infection.



Foot care is an important part of managing your diabetes. Your doctor will help you develop a foot care plan that's right for you.



Always talk to your doctor or diabetes educator before making any changes in your diabetes treatment plan.

# 2013 Community Benefit Plan Update

## ATTACHMENTS

- III. GEM Project  
Community Outreach, Insurance  
Enrollment, Retention, and Utilization  
Report January 2013 – December 2013



**Citrus Valley Health Partners  
GEM Project  
Breakdown of Enrollment by Health Insurance Program  
Period: January 2013-December 2013**

<b>2013 PROGRAM TOTALS</b>	<b>Jan-13</b>	<b>Feb-13</b>	<b>Mar-13</b>	<b>Apr-13</b>	<b>May-13</b>	<b>Jun-13</b>	<b>Jul-13</b>	<b>Aug-13</b>	<b>Sep-13</b>	<b>Oct-13</b>	<b>Nov-13</b>	<b>Dec-13</b>	<b>TOTAL</b>
AIM	1	1	1	1	1	0	0	2	2	0	2	0	11
CK-CA Kids	0	0	0	0	0	0	0	0	0	0	0	0	0
Emergency Medi-Cal	40	22	30	28	24	9	21	20	31	32	15	27	299
Healthy Families	53	29	12	0	0	0	0	0	0	0	0	0	94
Healthy Kids	2	3	2	0	3	2	3	1	3	1	2	1	23
KP-CHP Kaiser Perm. Child. Hlth. Plan	124	98	2	1	0	0	0	0	0	1	0	16	242
Medi-Cal	182	232	240	225	171	143	233	211	246	319	209	252	2663
Medi-Cal Share of Cost	13	6	2	6	6	2	8	12	4	16	4	4	83
MC-TLIP	0	0	12	42	34	29	36	54	41	31	18	42	339
HWLA	0	0	0	0	0	0	0	0	0	0	1	27	28

**Total Applications      3,782**

**Citrus Valley Partners  
GEM Project  
Breakdown of Enrollment by Health Insurance Program  
Period: January 2013-December 2013**

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**Total Applications      3,782**

# Citrus Valley Health Partners

## VIII

Foothill Presbyterian  
Hospital

Supplementary List of  
Community Benefit  
Contributions



**Foothill Presbyterian Hospital  
Supplementary List of Community Benefit Contributions  
2013**

<u>Department</u>	<u>Description</u>	<u>Category</u>	<u>Dept. Total</u>
FPH Perinatal	Monthly Maternity Tea and Tour	Education	1,620
	Breast Feeding Class	Education	1,275
	Sibling Class	Education	540
	Baby Basics	Education	1,305
	Prepared Childbirth Series	Education	2,125
	Prepared Childbirth (Lamaze)	Education	2,610
		<b>TOTAL:</b>	<b>9,475</b>
FPH Volunteer Services & Auxiliary	Telecare (Calls to Home Boun	Service	21,150
	19 Scholarships	Education	28,500
		<b>TOTAL:</b>	<b>49,650</b>
FPH Engineering	Set up/tear down for events	In-Kind*	1,133
		<b>TOTAL:</b>	<b>1,133</b>
FPH Food Service	Preceptor to Intern	Resources	14,040
	Food Outdated	Resources	500
	ED Patient Trays	Resources	14,400
	Guests	Resources	300
	Food donated to funerals	Resources	100
	Glendora Public Library Trivial Challenge	Resources	100
		<b>TOTAL:</b>	<b>29,440</b>
		<b>Grand Total:</b>	<b>\$89,698</b>

In-Kind – (definition): paid or given in goods, commodities, or services instead of money



# Citrus Valley Health Partners

IX

Community Education/  
Wellness Program



Community Education & Outreach

Citrus Valley Health Partners' takes existing valuable services, in conjunction with business partners, and makes them available in ways that will improve the health of the community at low or no cost.

The programs differ somewhat from those previously described under Community Benefit, which represents partnership programs initiated in the community, designed by the community and implemented collaboratively. Rather than services, the community benefit programs are community built responses to community needs.

Executive Summary

Citrus Valley Health Partners (CVHP) advocates for the health needs of the East San Gabriel Valley and coordinates community education over the full continuum of care.

1. *Community Ambassadors* – Employee volunteers committed to improving the physical, mental, social, and spiritual health status of the East San Gabriel Valley and to conserve and enhance the resources of CVHP.
2. *Health Education and Support Groups* – Education and Support Groups are offered on all CVHP campuses as well as multiple community locations. Sessions are usually provided free; occasionally there is a minimal charge for material. All programs fall under one of the following categories:

- |                      |                                |
|----------------------|--------------------------------|
| Special Events       | Cancer Resources & Programs    |
| A Healthier You      | Hospice & Bereavement Services |
| Childbirth Education | Lighten Up SGV                 |
| Diabetes Education   |                                |

Multiple departments coordinate all activities, classes and programs.

4. *CVHP Resource Center/Library* – located in the Medical Arts Building of the Inter-Community Campus, 315 N. Third St., Ste. 303B, Covina, CA 91723. The center offers the community an opportunity to check out books, review reference books, videos, tapes, and have access to the internet with a directory of sites related to cancer education and information. The focus of the resources center is cancer but resources on other topics such as nutrition and relaxation techniques are offered. Diabetes support groups are also held here.

5. *Methodology for Selecting Activities* – 1. Review of community needs assessment; 2. Review of health information data; 3. Review of feedback from previous program participants regarding types of programs they are interested in.

7. *Program Coordination with Community Agencies* – Services and programs are developed and implemented in collaboration with the following entities:

- American Cancer Society
- Local Physicians
- Senior Centers
- Medical Groups

**Documentation of Public Education** – Three times a year, all services and programs are advertised in the community magazine “Elevations in Health.” Programs, events and classes are also advertised in the local media and with special fliers and mailings.

**Overall Outcome of all CVHP community education programs – In 2013, nearly 4,000 community members attended CVHP community education programs and events.**

**2013 CITRUS VALLEY HEALTH PARTNERS PROGRAMS AND GOALS**

CVHP is committed to elevating the physical, mental, social and spiritual health status of our communities. This is accomplished through a variety of classes, community programs, support groups, health fairs, screenings, educational programs within our schools, churches, libraries, senior centers as well as the use of telephone referrals. Most programs are offered at no charge. If there is a charge for the class it is minimal and would be waived if the client, verbally states that the fee may be a hindrance to them accessing the important health education information. All programming is open to every member of our community and surrounding communities. Participants are never screened to determine whom their payer is, ability to pay or any other criteria. Education is frequently available in English and Spanish. In 2013, Citrus Valley Health Partners adopted the following Community Outreach Goals.

In 2013, CVHP will work with more community partners to offer more preventative education and resources

In 2013, CVHP will continue to provide programs and services to enhance awareness of clinical services.

The seven (7) operational program categories are:

**A Healthier You** that provide monthly evening and luncheon programs on physical or mental health topics, programming specific to seniors, a daily walking program for adults, programs geared to change health habits, as well as early detection. Support groups helping the community to deal with chronic conditions, new diagnosis, move through chronic pain or life changing experiences and a program to prepare children ages 3-12 for surgery.

**Childbirth Education** programs designed to provide the expectant family with information, resources, guidance and support in preparation for the new baby. Lamaze, Newborn Necessities, Breastfeeding Basics, Sibling Classes, Infant Massage, and Maternity open house and tours are available. A low cost breast pump rental program is also available. (see Mother Baby Specialty Shoppe)

**Diabetes Education** counseling and support groups to help patients learn how to live with and manage diabetes.

**CVHP Resources & Programs** that include multiple, bi-lingual support groups, programs for free or low cost wigs, breast prosthesis, programs to help women cope with the physical changes of cancer treatments, and treatment/instruction of therapies that compliment western medical treatments for cancer at no or low cost to the patient.

**Hospice & Bereavement Services** provide class series, individualized to adults, to deal with the loss of a loved one as well as training for volunteer opportunities to help someone else in need. Attendance varies from Class to class but averages about 20 participants per program.

**Special Events** provide various types of health screenings and informational events. This is a time to share valuable health education information, in addition to providing referrals.

**Mother Baby Specialty Shoppe** provides free lactation support/services and low cost breast pump rentals and breastfeeding supplies for new moms. Approximately 99 breast pumps are being used in the community on a monthly basis.

**Lighten Up SGV** provides monthly classes on weight loss support and community weight loss challenge and a online community for those looking for free resources to help them lose weight.

## **Partnership with Other Public, Private and Community Agencies to offer preventative health care and education**

Breath Savers Club (partnership with American Lung Association)  
Mother Baby Specialty Shoppe  
Diabetes - Parents Support Group  
Diabetes Education – Managing your Diabetes  
Yoga for the Cancer Patient  
Clinical Trials  
Look Good, Feel Better  
Reiki Therapy For Cancer Patients

## **Programs & services to enhance Citrus Valley Health Partners' services**

Nutrition Counseling  
Partners in Your Progress – Cardiac Education Series  
FBNC – Breast-Feeding Educational Classes  
MOM-2-MOM – Breastfeeding Support Group  
Mother Baby Specialty Shoppe  
Lamaze – Childbirth Education Class  
FBNC - Newborn Necessities Educational Class  
Newborn Inn - Sibling Class  
Adultos con Diabetes Grupo de Apoyo  
Boris the Bear  
Managing Your Diabetes  
Parents Support Group – Diabetes  
Adults with Diabetes Support Group  
Type 1 Support Group - Diabetes  
Adolescent Support Group – Diabetes  
Sweet Success – Gestational Diabetes  
Mended Hearts  
Yoga for the Cancer Patient  
Cancer Resource Center  
Clinical Trials  
Group De Apoyo Para Personas Con Cancer  
Look Good, Feel Better  
Reiki Energy Healing Sessions for Cancer Patients  
Become a Volunteer for Hospice  
Grief Outreach  
Road to Survival  
Getting Through the Holidays After the Loss Of A Loved One  
Sweet Success  
Breath Savers Club  
Inter-Faith Diabetes Outreach



# Citrus Valley Health Partners

X

2014  
Community Benefit  
Plan





# CITRUS VALLEY HEALTH PARTNERS

**Citrus Valley Medical Center, Inc.**  
**Inter-Community Campus 210 W. San Bernardino Rd., Covina, CA 91723-1516**  
**License # 930000131**

**Queen of the Valley Campus - 1115 S. Sunset Avenue, West Covina, CA 91790-3940**  
**License # 930000131**

**Foothill Presbyterian Hospital-Johnston Memorial**  
**250 S. Grand Avenue - Glendora, CA 91741-4218**  
**License # 930000052**

## **2013 Community Health Needs Assessment (CHNA) Implementation Strategy Report**

### ***I. General Information***

**Contact Person:** Maria Peacock, Director, Community Benefit

**Written Plan Effective Date:** December 31, 2013

**Date Plan was Authorized and Adopted by**

**Authorized Governing Body:** March 26, 2014

**Written Plan adopted and approved by:** Strategic Planning, Marketing and Community Benefit Committee of the Board.

**Was the written plan written and Adopted by the Authorized Governing Body by End of Tax Year in Which CHNA was**

**made available to the Public?** Yes  No

**Date Facility's Prior Written Plan Was Adopted by Organization's Governing Body:**

**Name and EIN of Hospital Organization Operating Hospital Facility:**

Citrus Valley Health Partners - EIN # 95-3885523

**Address of Hospital Organization:** 140 W. College Street, Covina, CA 91722

## ***II Citrus Valley Health Partners (CVHP)***

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

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

## ***III Citrus Valley Health Partners Community Benefit***

CVHP is an organization recognized for its outstanding community outreach efforts and accomplishments. An organization dedicated to creating innovative partnerships among the numerous health and social service organizations in our valley, with close to 100 participating agencies in diverse collaborative relationship devoted to promoting community health and well-being. In addition, CVHP has a charity care policy in place to respond to the needs of low-income uninsured populations.

CVHP's vision is to be an integral partner in elevating communities' health through partnerships. This is principle that guides all community health improvement and community benefit initiatives. Some highlights include CVHP's Get Enrollment Moving program, also known as GEM, volunteers and CVHP staff members work together and in collaboration with community-wide partners to recruit eligible families and enroll them in the different Medi-Cal programs, Covered California, and other health access programs for low-income uninsured and underinsured populations. Enrollment is followed by three separate calls to ensure enrollment confirmation, utilization of services, as well as trouble shoot and provide assistance at renewal time. GEM works in partnership with Promotoras de Salud/Health Promoters, a peer outreach and education neighborhood-based initiative with the purpose of teaching and connects community residents with health insurance options. CVHP's Diabetes and Lighten Up San Gabriel Valley programs offer a culturally competent disease prevention approaches as well as best practices to disease management with the support of CVHP's clinical professionals and through community multidisciplinary partnerships. CVHP's maternal/child program offers home visitation during the prenatal and postpartum stages. CVHP has been diligent and responsive to the health coverage changes by offering outreach and education throughout the community in the Affordable Care Act/MediCal Expansion, Market Place, and other. Since conception, Every Child's Healthy Option (ECHO) is a collaborative effort involving CVHP, coordinated and lead by local school districts. The program offers free urgent care services in various specialties regardless of income level and provides enrollment for the child in the adequate health insurance program.

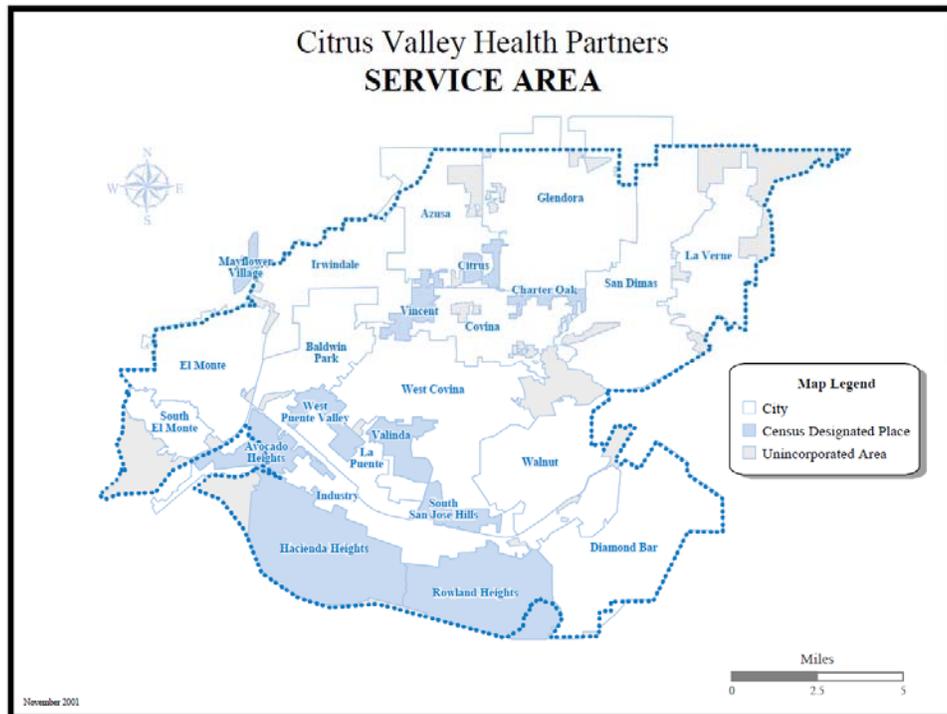
## ***IV Rationale for Implementation Strategy***

The Community Needs Implementation Strategy is being adapted to comply with federal tax law requirements set forth in Internal Revenue Code section 501r requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community health need identified through the community health needs assessment.

CVHP's implementation strategy is the means to satisfy all applicable requirements outlined in the proposed regulations released in April of 2013. This implementation strategy focuses on the needs identified in the 2013 Community Health Needs Assessment.

## ***V Citrus Valley Health Partners Service Area***

CVHP's Service Area is characterized by significant disparities in income. An average of 14.3% of people live under the 100% of the Federal Poverty Level (FPL) and 33.7% live below the 200% of the FPL while, by contrast, one city accounts for only 4.6% of people living below 100% of the FPL. The cities and non incorporated areas that CVHP serves are Avocado Heights, Azusa, Baldwin Park (including Irwindale), Bassett, Covina, Diamond Bar, El Monte, Glendora, Hacienda Heights, La Puente, La Verne, Rowland Heights, San Dimas, South El Monte, Valinda, Walnut and West Covina. CVHP's service area is part of the SPA 3 (Service Planning Area 3 of Los Angeles County).



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

There are slightly more females (50.1%) than males (49.9%). Over a third (32.7%) is between the ages of 25 and 44 years in the CVHP service area, one fourth (25.5%) in the CVHP service area is between the ages of 0 and 17 years. By ethnicity, over half (55.7%) of the population is Hispanic/ Latino. The second largest ethnic group is Asian/Pacific Islander making up over a quarter (22.5%) of the population. The third largest ethnic group is Caucasian with 18.0% of the population, smaller when compared to 27.8% in Los Angeles County (U.S. Census Bureau Decennial Census, 2010) and 2.1% are African American. Over a quarter (26.9%) of the population has less than a 9<sup>th</sup> grade education, another 20.1% in the CVHP service have a high school diploma. The service area has lower rates of four year college and graduate degrees in Los Angeles County. By language spoken, a larger portion of the population speaks Spanish (41.3%) at home another third speak English only (37.2%) at home; a larger portion of the population speaks an Asian/Pacific Island language (18.9%) at home when compared to Los Angeles County (10.9%).

Based on the 2009 California Health Interview survey, over one fourth (28.6%) of the CVHP service area has an annual household income of \$20,000 or below, slightly higher when compared to Los Angeles County report (23.8%). In

addition, over one third (33.7%) of the population served by CVHP is lives below the FPL. The larger portions of families are living in poverty in the cities of El Monte (18.3%), Baldwin Park (14.0%), and South El Monte (12.6%) when compared to Los Angeles County overall (12.6%). The unemployment rate in the CVHP service area is 10.2, slightly higher when compared to Los Angeles County (9.7).

## ***VI List of Identified Community Health Needs***

Below is the summary list in alphabetical order of the health needs identified in the CVHP's 2013 Community Health Needs Assessment:

- |   |                          |
|---|--------------------------|
| 1. Alcohol and Substance Abuse            | 11. Colorectal Cancer    |
| 2. Allergies                              | 12. Diabetes             |
| 3. Alzheimer's Disease                    | 13. Disability           |
| 4. Arthritis                              | 14. HIV/AIDS             |
| 5. Asthma                                 | 15. Hypertension         |
| 6. Cancer, in General                     | 16. Infant Mortality     |
| 7. Cardiovascular Disease                 | 17. Intentional Injury   |
| 8. Cervical Cancer                        | 18. Mental Health        |
| 9. Chlamydia                              | 19. Obesity/Overweight   |
| 10. Chronic Obstructive Pulmonary Disease | 20. Oral Health          |
|   | 21. Unintentional Injury |
|   | 22. Vision               |

## ***VII Individuals Involved in the Development of the Implementation Strategy***

Maria Peacock, Director, Community Benefit Programs  
Tracy Dallarda, Chief Communications Officer

## ***VIII Availability of the 2013 Community Health Needs Assessment (CHNA) to the Public***

CVHP's has implemented a variety of strategies to make the report widely available to the general public within the service area.

- 1) The full report was made available at CVHP's website [http://www.cvhp.org/documents/CVHP\\_CHNA\\_Report\\_2013.pdf](http://www.cvhp.org/documents/CVHP_CHNA_Report_2013.pdf)
- 2) CVHP and Kaiser Permanente Baldwin Park presented their joint tri-annual community needs assessment at a breakfast for local governments, non-profits, community based organizations, faith communities, school districts, community colleges, public and private agencies, institutions of higher education, public health department, department of health services, mental health agencies, etc. It is estimated that 80 community representatives attended this event and received a hard copy and digital copy of the full report.
- 3) The San Gabriel Valley Tribune covered the event and published a newspaper article informing the general public in the geographic service area about the findings and availability of the assessment It can be found at: <http://www.sgvtribune.com/health/20140207/mental-health-obesity-top-list-of-san-gabriel-valley-health-problems>
- 4) The report findings and hospital priorities were presented to the Health Consortium of the Greater San Gabriel Valley.

## ***IX Health Needs that Citrus Valley Health Partners will Address***

### **a. Process and Criteria Utilized in the Selection**

Citrus Valley Health Partners Community Benefit Director and Chief Communications Operating Officer engaged in a review process to identify which needs the hospital will address from the broader list of community health needs identified in the 2013 CHNA. The systematic process was based on two factors: 1) Community Need and 2) Feasibility. The methodology used for the selection included a scale of 1 to 5 from least to most for each of the health needs listed in section VI. The resulting scores were translated to a four section grid (vertical and horizontal axes from Low to High) according to Need and Feasibility for review by the Implementation Strategy Team. The health needs receiving the highest scores for Need and Feasibility were selected as needs that Citrus Valley Health Partners will address as outlined and described in the Priority Areas listed below in section IX.b.

Following is the conceptual criteria utilized for this process:

#### **Need:**

- Magnitude/Scale of the Problem: the health need affects a large number of people within the community
- Severity of Problem: the health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected
- Disparities: the health need disproportionately impacts the health status of one or more vulnerable population groups

#### **Feasibility:**

- Citrus Valley Health Partners Assets: CVHP has relevant expertise and/or unique assets as an integrated health system to make successful contributions
- Ability to leverage: opportunity to collaborate with existing community partners working to address the need, to build on current programs and efforts, identify and support emerging innovative opportunities, and other assets.

### **b. CVHP will address the following health needs:**

#### **Area of Focus 1: Increase Awareness and Access to Mental Health Programs and Services.**

Mental Health Needs are associated with many other health factors, including poverty, alcohol consumption, unemployment, suicide, chronic medical diseases, and lack of a consistent source of primary care.

Mental health services are difficult to access and insurance criteria and requirements are difficult for many to meet. In the CVHP service area more adults (657.0) experience mental health-related hospitalizations per 100,000 adults when compared to California (551.7). More youth (375.4) experienced mental health-related hospitalizations per 100,000 youth when compared to California (256.4). Furthermore, more people went without needed mental health treatment (51.4%) when compared to Los Angeles County (47.3%). The sub-populations experiencing greatest impact are African Americans (19.3%), Whites (17.8%), and Hispanic Latinos (13.0%). Stakeholders identified youth, middle-aged adults, homeless persons, and the uninsured are the most severely impacted. Six cities in the service area accounted for more mental health adult hospitalizations per 100,000 persons and 11 cities accounted for the highest youth mental health-related hospitalizations per 100,000 persons; however, stakeholders indicated that the entire service area is impacted by disparities.

#### **Area of Focus 2: Increase Awareness and Improve Access to Programs, Education and Services focusing on the reduction on Obesity and Overweight conditions.**

Associated health needs consist of hypertension, diabetes, cardiovascular disease, and obesity and overweight.

The prevalence of obesity/overweight and diabetes was identified as a key need in the CVHP service area specifically related to youth (under the age of 18). Obesity reduces life expectancy and causes devastating and costly health problems, increasing the risk of coronary heart disease, stroke, high blood pressure, diabetes, and other chronic diseases. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness. A diabetes diagnosis can also indicate an unhealthy lifestyle—a risk factor for further health issues.

Healthy lifestyles including nutrition and physical activity need to be incorporated early in life to avoid future health problems. In the Citrus Valley Health Partners service area more youth (30.6%) are obese when compared to California (29.8%). A higher number of youth is overweight (15.1%) when compared to California (14.3%). A slightly higher percentage of youth in the CVHP'S service area are physically inactive (38.4%) when compared to California (37.5%). A significant rate of diabetes in the service area is 18.5% compared to Los Angeles County rate of 10.5%. Moreover, the uncontrolled diabetes hospitalization rate of 12.9 adults per 100,000 persons is higher compared to California at 9.5 per 100,000 persons. Additionally, a significant portion of the population in CVHP's service area was diagnosed with hi blood pressure (30.2%) compared to Los Angeles County (25.5%) and more people die of hypertension and hypertensive renal failure at a rate of 1.3 compared to California at 1.0. at last, more people were hospitalized for heart disease (374.4 per 100,000 persons) when compared to Los Angeles County (367.1 per 100,000 persons) as well as a higher number of cerebrovascular disease hospitalizations (233.6) when compared to California (221.5).

### **Area of Focus 3: Increase Diabetes Prevention Strategies and Disease Management Best Practices**

Associated drivers for the high rates of diabetes in CVHP's service area include being overweight, having high blood pressure, high cholesterol, high blood sugar (or glucose), lack of physical inactivity, smoking, unhealthy eating habits, age, race, gender, having a family history of diabetes, lack of consistent source of primary care.

There is a clear need to take advantage of recent discoveries about the individual and societal benefits to improved diabetes management and prevention by bringing life-savings results and complementing the efforts of primary prevention among those at risk for developing diabetes. More people were diagnosed with diabetes in the CVHP service area (18.5%) than in Los Angeles County (10.5%). Also, more adults (147.4) experienced diabetes-related hospitalizations per 100,000 adults when compared to Los Angeles County; furthermore, more uncontrolled diabetes-related hospitalizations occurred per 100,000 persons (12.7) when compared to Los Angeles County (9.5). More people died of diabetes related conditions at a rate of (2.1) when compared to California (1.9) per 10,000 persons. People between the ages of 45 and 64 (1.5%) and over the age of 65 (1.0%) experienced the most hospital incidents resulting from diabetes compared to other age groups. Stakeholders indicated that more people are being diagnosed with diabetes at a younger age.

## ***X Citrus Valley Health Partners Implementation Strategies***

### **Priority Health Need 1: Increase Awareness and Access to Mental Health Programs and Services.**

#### **Goal: Expansion of Mental Health Services:**

##### **Strategies:**

- Exploring possibility of partial hospitalization facility providing individual and group therapy in extended outpatient setting
- Developing joint grant proposals with community clinics to enhance mental health services in our community
- Expand access points:
- Developing outpatient mental health services in collaboration with new FQHC and staffed by psychiatric NP and licensed social workers

- Collaborate with other mental health programs on improving overall health to address “drivers” (obesity/overweight, diabetes, CV disease)

## **Goal: Improve Access**

### **Strategies:**

- Construction of new Community Health Clinic (FQHC) across from Inter-Community Hospital Campus
- Existing FQHC management team will operate; expected completion Summer 2014
- 12 exam rooms
- Health care teams
- Retail pharmacy
- GEM (Get Enrollment Moving) outreach and enrollment program

## **Priority Health Need 2: Increase Awareness and Improve Access to Programs, Education and Services focusing on the reduction on Obesity and Overweight conditions.**

## **Goal: Increase awareness and access to Lighten Up SGV program, resources and services.**

### **Strategies:**

- Lighten Up SGV program is not a diet or meal plan, but a program utilizing community resources and our health care experts to provide education and support for health living
- Three components:
  1. Education, Web, Weigh-in Event
  2. Monthly series of FREE classes featuring presentations by CVHP experts and community partners
  3. Topics include: weight loss myths, ideas for shopping and cooking healthier, tips to start a fitness routine, how to deal with emotional eating and more
- Also includes special events and activities like Yoga, Zumba, Supermarket Tour and more
- Majority of classes held at Queen of the Valley in West Covina
- Dedicated program Web site found at [www.lightenupsgv.com](http://www.lightenupsgv.com)
- Social networking features to encourage discussion: Message boards (Weight Watchers, seniors, new moms), FREE user profile page, regular blog posts on weight loss and fitness tips
- Access to more than 100 health and weight loss articles
- Links to Healthy Partners – groups and businesses providing health services
- Dedicated FACEBOOK page

- Focus on youth:
  - Partnership with Bonita USD and cities of La Verne & San Dimas in 2012
  - Partnership with West Covina USD in 2013
  - Lower age requirement to encourage entire families to join
  - Create special classes aimed at educating children and their parents on healthy eating and healthy living
  - Focus more on becoming active and health education, rather than weight loss

**Priority Health Need 3: Increase Diabetes Prevention Strategies and Disease Management Best Practices**

**Goal: Increase awareness of diabetes education and services and create greater access points for better chronic disease management.**

Strategies:

- Preventable hospital admissions
- Access to care
  - Through chronic disease management
- Seeking grant funding for Diabetes Clinic on site at QVC campus
  - Recruitment of primary care physicians
  - Recruitment of specialty physicians
  - Manage patients outside hospital through new FQHC and partnerships with existing clinics and communities
  - Continue to seek partnerships

***XI Citrus Valley Health Partners Evaluation Plans***

Citrus Valley Health Partners will monitor and evaluate the strategies listed above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of financial resources spent, number of people reached/served, number and role of volunteers, and volunteer hours as an example.