Emanate Health
(Formerly Citrus Valley Health Partners)

COMMUNITY BENEFIT REPORT
SB 697

Emanate Health Foothill Presbyterian Hospital
250 S. Grand Ave.
Glendora, CA 91741

Fiscal Year Report Period: 2018

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Emanate Health

Emanate Health Foothill Presbyterian Hospital

2018 Community Benefit Report

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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 Hospital 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 Hospital. 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 Hospital was founded more than 95 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 Hospital 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 **outpatient orthopedic and physical therapy sites** are located in West Covina, Glendora and Chino, California. Our staff of board-certified orthopaedic surgeons practice a variety of orthopedic specialties with a level of experience, skill, and personalized care unmatched in LA and San Bernardino counties. Our comprehensive approach to physical wellness addresses the entire musculoskeletal system. When surgery is necessary, our orthopedic surgeons offer expert arthroscopy and joint replacement and reconstruction procedures, treatment of neck and back disorders, and correction of hand and foot deformities.

Citrus Valley Health Partners **California Diagnostic Imaging Center** is San Gabriel Valley’s premiere outpatient imaging center that offers a wide range of imaging services in a relaxed environment with patient care in mind.

Citrus Valley Health Partners **Foothill Family Practice** functions as a family medicine practice serving patients in the Glendora, San Dimas, La Verne, and Azusa area. The practice was founded in 1972 and consists of several physicians and physician assistants who specialize in internal medicine.

**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 a national VHA Leadership Award for Community Health Improvement.
CHNA 2016 Service Area Demographics

CVHP’s Service Area is characterized by significant disparities in income. An average of 22.2% of people live under the 100% of the Federal Poverty Level (FPL) and 47.2% 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 2016, the estimated total population within CVHP service area was 905,984, making up 8.8% of the population in Los Angeles County (Nielsen Claritas SiteReports, 2016, zip code).

There are slightly more females (50.9%) than males (49.1%). Over one fourth (27.2%) is between the ages of 25 and 44 years in the CVHP service area, nearly one fourth (23%) in the CVHP service area is between the ages of 0 and 17 years.

By ethnicity, over half (56.7%) of the population is Hispanic/Latino. The second largest ethnic group is Asian/Pacific Islander making up nearly a quarter (23.7%) of the population. The third largest ethnic group is Caucasian with 15.7% of the population, smaller than when compared to 26.3% Los Angeles County (Nielsen Claritas SiteReports, 2016, zip code) and 2.0% are African American.

A decreasing percentage, (13.3%) of the population has less than a 9th grade education, and another 24.3% in the CVHP service area have a high school diploma. The service area has lower rates of four year college and graduate degrees than Los Angeles County overall.

By language spoken, a larger portion of the population speaks Spanish (41.0%) at home. Another third speak English only (37.2%) at home; a larger portion of the population speaks an Asian/Pacific Island language (19.5%) at home when compared to Los Angeles County (10.8%).

Based on the Nielsen Claritas SiteReports, 2016, zip codes; 16.8% of the CVHP service area has an annual household income of $25,000 or below, slightly lower than when compared to Los Angeles County report (22.9%). The unemployment rate has decreased in recent years in Los Angeles County (6.7%) and the state (7.6%). No recent data exists to confirm this trend in the Citrus Valley Health Partners service area.
Emanate Health

II

Mission
Vision
Values
Mission Statement

... Emanate Health exists to help people keep well in body, mind and spirit by providing quality health care services in a safe, compassionate environment. ...
Our Vision for the Future

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

Vision Definitions

- Integral Partner – Emanate Health 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 Emanate Health 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.
  - Emanate Health 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.
- Emanate Health 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 Emanate Health 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.
Emanate Health

III

Governance And Management Support
GOVERNANCE AND MANAGEMENT STRUCTURES
TO SUPPORT COMMUNITY BENEFIT ACTIVITY

2018 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 Emanate Health (formerly Citrus Valley Health Partners).

In year 2018 the Community Benefits Department continued its community work under the direction of the Chief Marketing and Communications Officer. The team works with public and private community partners and stakeholders 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 focus on the priority areas identified in the 2016 Community Health Needs Assessment and its implementation plan programs, partnerships and activities. Emanate Health’s community benefit work also focuses on capacity building and service to poor, at-risk, vulnerable populations.

A Committee of the Emanate Health Board continues to provide direction and guidance. A quarterly report is provided to the Strategic Planning, Marketing and Community Benefit Committee of the Board.

Management and Staff Involvement in Community Benefit

During 2018 all Administrative and Operations Managers throughout the corporation contributed to the implementation of the Needs Assessment Implementation Plan activities. Professional staff and volunteers offer support for community health improvement and outreach efforts.

Departmental Community Benefit Projects

A number of departments in the Emanate Health 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 Public Health Department and Emanate Health Emergency Department staff work jointly to ensure that the “residents” of our local winter cold/wet weather shelters get the medical help they need.

Emanate Health Emergency and Pharmacy departments support the ECHO (Every Child’s Health Option) program, providing urgent medical care and orthopedic services for uninsured or underinsured children referred by school nurses. Through this partnership, children are able to access hospital emergency services including radiology, laboratory, and pharmacy.

Emanate Health’s Facilities and Food Service Departments provide free meeting space, AV equipment and refreshments for the monthly meetings of the San Gabriel Valley Consortium on Homelessness.

As a 501(c)3 nonprofit organization, the Emanate Health Foundation provides financial support and serves as a fiscal agent for the ECHO Program.

The Emanate Health Center for Diabetes Education continues to offer free community lectures, information, and support groups for type I and type II adults, seniors, adolescents, parents, and a type II Spanish support group throughout the year. The Outpatient Wound Care Center also provides regularly scheduled free foot screenings for community members suffering from diabetes.

Emanate Health’s Marketing and Communications Department continues to support community partners in writing and distributing press releases and ads for events and programs. In addition, the department assists in the design of outreach materials, such as brochures, invitations, save-the-date notices, maps, etc.

The Auxiliary Department at Emanate Health Inter-Community Hospital gave ten scholarships to students who are furthering their education in the healthcare field. A total of $12,000 was donated in the year 2018.

The Auxiliary at Emanate Health Foothill Presbyterian Hospital also donated seventeen scholarships to community members totaling $23,250 in the year 2018.

Adopt-A-Family Program. The Community Benefit Department (CBD) organizes, coordinates and assists in the implementation of the annual Adopt-A-Family program during the holiday season. The CBD seeks referrals of individuals and families from various community and school partners. The CBD staff connects dozens of families each with a hospital department, who voluntarily comes together to adopt people in need. Staff members go to the homes and personally deliver food and gifts for all family members.
Emanate Health

IV

Charity Care Policies
I. Purpose:

It is Citrus Valley Health Partners’ (CVHP) mission to help people keep well in body, mind and spirit by providing quality health care services in a compassionate environment. CVHP fulfills its mission by providing financial assistance programs to persons who have health care needs and are uninsured or underinsured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. CVHP strives to meet the health care needs of all patients who seek inpatient, outpatient, and emergency services.

It is CVHP’s mission and operational goals to ensure that all of the accounting and patient related transactions are practiced consistently throughout our patient accounting operations. Our Admitting and Patient Financial Services Department staff is responsible for assisting the patient with their financial application and handling of all patient accounting transactions. A designated representative from Patient Financial Services Department will review the individual case to determine the patient’s eligibility for financial assistance and determine the discount for which the patient qualifies.

Our policy includes charity and discounts to patients who financially qualify under the terms and conditions of Citrus Valley Health Partners Financial Assistance Program.

CVHP is committed to providing financial assistance programs when patients are uninsured or underinsured or ineligible and need assistance with their hospital bill. The purpose of this policy is to define charity and discount charity care of which eligibility and financial assistance and qualification for a discount is determined by the patient’s and/or family’s ability to pay.
Title: Charity Care Policy#: A009

CVHP makes every effort to inform our patients of their Hospital’s Financial Assistance Program. We do so by the following:

- Every registered patient receives a written notice of the Hospital’s Financial Assistance Program language per IRC 501(r).
- Upon request, copies of the Financial Assistance Policy, Financial Assistance Application and plain summary language are made available. These documents are also available on the Hospitals website.
- Uninsured patients are screened during the registration process for eligibility with government-sponsored programs and/or the Hospital Financial Assistance Program.
- Public notices are posted throughout CVHP hospitals notifying the public of Financial Assistance Program available for those who qualify.
- CVHP patient billing statements provide information to assist in obtaining government-sponsored coverage and/or financial assistance.
- Community Assistance Outreach program provides assistance to patients seeking for Financial Assistance Program.

II. Financial Assistance/Eligibility for Charity Care

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit programs, and those individuals who are unable to pay for their care as determined by the patient family income relative to the current Federal Poverty Level. The charity award shall be based on an individualized determination of financial need. It shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

1. Include an application process, in which the patient or the patient’s guarantor are required to cooperate and supply personal, financial or other information and documentation relevant to making a determination financial need;
2. Include the use of external publically available data sources that provide information on a patient’s or a patient’s guarantor’s ability to pay such as credit reporting;
3. Include reasonable effort by CVHP to obtain from the patient or patient’s representative information whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered to the patient, including but not limited to:
Title: Charity Care  
Policy#: A009

a. Private health insurance, including coverage offered through the California Health Benefit Exchange;

b. Medicare;

c. Medi-Cal program, the California Children’s Services Program, or other state- or county-funded health coverage programs.

4. Take into account the patient’s available assets and all other financial resources available to the patient.

The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. The need for payment assistance may be evaluated at each subsequent rendering of services, or at any time, additional information relevant to the eligibility of the patient for payment assistance becomes known. The Financial Assistance request must be made within one year of the service date.

Requests for payment assistance shall be processed promptly, and CVHP shall notify the patient or applicant about the financial assessment decision.

III. Eligibility Criteria and Amounts Charged to Patients

AGB is the sum of all amounts of claims that have been allowed by health insurers divided by the sum of the associated gross charges for those claims. Citrus Valley uses the “Look Back” method to determine the AGB for outpatient services. The applicable Med-Cal APR-DRG reimbursement applies to obstetrics, newborns, neonatal intensive care and pediatrics. Medicare DRG applies to all other inpatient services.

\[
AGB \% = \frac{\text{Sum of Claims Allowed Amount \$}}{\text{Sum of Gross Charges \$ for those claims}}
\]

Allowed Amount = Total charges less Contractual Adjustments

If no contractual adjustment is posted then total charges equals the allowed amount.

Denial adjustments are excluded from the calculation as denials do not impact allowed amount.

The AGB is calculated for each hospital on an annual basis.

- Look Back Method is used. A twelve (12) month period is used.

- Includes Medicare fee for service all private health insurers that pay claims to the hospital facility
Title: Charity Care  

Policy#: A009

- Excluded payers: Medicaid, Medicaid pending, uninsured, self-pay case rates, Medicare facility billing, motor vehicle and liability and worker’s compensation claims.

Annual adjustments are made effective February 1 of each calendar year; however, the effective date is also subject to changes.

Services eligible under this policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels in effect at the time of determination.

For the purpose of this policy, Federal Poverty Levels (FPL) is the poverty guideline that is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of section 9902 of Title 42 of the United States Code.

- Patients with monetary assets or income level is at 350% or less of the FPL, the entire hospital bill will be written-off regardless of net worth or size of bill;

- Patients with monetary assets or income level between 350% and 500% of the FPL, a portion of the hospital bill will be subject to write off based upon the sliding scale set forth below regardless of net worth or size of bill:
  - 351% - 400% = 75% write-off
  - 401% - 450% = 50% write-off
  - 451% - 500% = 25% write-off

- Patients with hospital bill that exceeds the patient’s monetary assets or net worth may qualify and be covered under this policy using the guidelines below:
  - Patients will be informed in writing of the financial assistance determination from the Patient Financial Services Department.
  - Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to the Hospital may request a payment plan from the Patient Financial Services Department.
  - In the event of non-payment of a discounted amount due under this financial assistance policy the hospital may engage in further collection activity. The details of the further collection actions can be found in CVHP Billing and Collection policy. A copy of this policy can be obtained by contacting the Patient Financial Services Department.

**NOTE:** For purposes of determining monetary assets or income, the review shall not include the:
Title: Charity Care   Policy#: A009

a. Retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans;

b. First ten thousand dollars ($10,000) of a patient’s monetary assets;

c. Fifty percent (50%) of a patient’s monetary assets over the first $10,000.

• The following conditions must be also satisfied:

  o If the patient is insured, the patient’s liability is NOT a Medicaid share of cost.

  o A pending application for another health coverage program shall not preclude eligibility for financial assistance under this policy, however, final approval of financial assistance may be deferred until the pending application is processed and eligibility is determined.

  o Patient completes and submits a Financial Assistance Application;

  o Patient submits all required and requested documents and responds to any questions that arise from the Financial Assistance Program within 30 days.

IV. Screening Procedure and Documentation Requirement

CVHP, through the assistance and direction of the Patient Registration and Patient Financial Services (PFS) departments shall assist patients who may qualify for charity care.

1. During registration or admission process, the Patient Registration Financial Counselors (FC) shall:

   a. Screen all patients who may qualify for charity care;
   b. Receive requests from patient and/or patient’s representatives for charity care;
   c. Discuss the CVHP charity care policy with the patient and/or patient’s representatives;
   d. Provide the patient the charity application forms – CVHP Hospital Financial Screening Assessment and Income Certification forms.

   i. The Hospital Financial Screening Assessment form requests for patient information, income, monetary assets, debts, disability or injury status, and provides authorization from the patient for CVHP to obtain patient’s credit report.

   ii. The Income Certification form requests family income, number of dependents, and copies of:

       • Completed & signed financial assistance application
Title: Charity Care  
Policy#: A009

- Current pay stubs or if self-employed, current year to date profit & loss statement to determine current income.
- Recent tax returns and W-2 form
- Evidence of any General Relief program benefit, Alimony, Unemployment, Disability, SSI, award letters for social security.
- Last calendar year's filed tax return with all required schedules to determine generating assets including monetary assets;
- Prior year's 1099 for interest income, dividends, capital gains, etc.

e. Guide the patient in completing the forms and provide instruction for submission to PFS department.

2. Upon receipt of the application forms and supporting documents, PFS shall:
   a. Review the contents of the forms and supporting documents for completion;
   b. Review the applications forms and documents, and request additional information from patient;
   c. Obtain information and supporting documentation regarding patient’s application for private and/or public health insurance or sponsorship which may include, but not limited to:
      i. Private health insurance, including coverage offered through the California Health Benefit Exchange;
      ii. Medicare
      iii. Medi-Cal, California Children's Services Program, or other state- or County health programs.
   d. Determine and approve charity care award following the criteria stated on section III, Eligibility Criteria and Amounts Charged to Patient;
   e. Notify the patient of the charity care award decision;

**NOTE:** Patients requesting charity care are expected to complete the application forms and provide supporting documents to CVHP. Submission of incomplete and inaccurate information may result in denial of charity care and discounting request. The hospital retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

The hospital’s designee authorized to approve financial assistance application is based on the Financial assistance requested; larger discounts require a higher level of approval as indicated:

- Discounts from $1,000.00 to $3,999.99: Patient Account Manager
- Discounts from $4,000-$9,999.99: Director of Patient Financial Services Department
Title: Charity Care

- Discounts $10,000- $49,999.99: VP of Revenue Cycle
- Discounts greater than $50,000.00: Executive VP & CFO

V. Physician Independent Contractors Charity Care and Discounting Policy

Citrus Valley is committed to providing care without discrimination, for emergency medical conditions in accordance with the Emergency Medical and Labor Act (EMTALA). CVHP facilities are prohibited from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

All emergency physicians, surgeons and allied health professions furnishing services to the patient, including, but not limited to, the radiologist, pathologist, anesthesiologist and the like, are independent contractors and are not employees or agents of the hospital. Those who provide emergency medical care to patients at acute general hospitals are required by law to provide discounts to uninsured patients or patients with high medical costs whose income is at or below 350% FPL. The law also requires the acute general hospital to notify patients of the emergency physicians’ charity care and discounting program. Those providers not covered by the CVHP policy and there are no providers (other than CVHP) that are covered by this CVHP policy.

The FC and/or the PFS staff shall advise the patient and/or patient’s representatives to contact the emergency physician billing company and request for the emergency physicians’ charity care and discounting program.

VI. Communication of the CVHP Charity Care policy to Patients and the Public

Information about the CVHP’s charity care policy shall be publicized to the Emergency Room and the Patient Registration departments at all CVHP campuses, and other areas that CVHP may elect.

VII. Collection Policy and Procedure

CVHP developed policy and procedures for internal and external collection practices that take account the extent to which the patient qualifies for charity care, a patient’s good faith effort to apply for a governmental program or charity care from CVHP, and the patient’s good faith effort to comply with his or her payment agreements with CVHP.

For patients who qualify for charity care and who are cooperating in good faith to resolve their discounted hospital bills, CVHP may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. CVHP will not impose extra-ordinary
Title: Charity Care
Policy#: A009

collection actions such as wage garnishments, liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this policy.

For patients who do not apply, do not qualify, or do not respond to required documentation requests, CVHP shall continue reasonable efforts to collect the balance owed. This includes but is not limited to statements, phone calls, referrals to outside collection agencies before extra-ordinary collection activity will commence no sooner than 120 days from the service date. The Patient Financial Services Department is responsible for ensuring that reasonable efforts are made to determine an individual's eligibility for financial assistance prior to any extraordinary collection actions being taken against that individual.

All outside collection agencies contracted with CVHP who perform account follow-up and/or bad debt collections will utilize the following criteria to identify a status change from bad debt to charity care:

1. Patient accounts must have no applicable insurance (including government coverage programs or other third party payers)
2. The patient or family representative has not made a payment within 120 days of assignment to the collection agency;
3. The collection agency has determined that the patient/family representative is unable to pay.

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

VIII. Collections Procedure for Uninsured and Underinsured

It shall be the policy of CVHP to provide our uninsured and underinsured patients the same allowances provided to its managed care contractors.

CVHP will follow up on and collect all self pay account balances, as well, where third party benefits exist, all patient copay and deductibles, either at the time of service, or when they become due.

A. Procedure for the collection of self-pay accounts and patient co-pay and deductibles:

1. CVHP patient accounting system is designed to assist the patient business services department, through a series of billing statements and collection notices in the collection of self pay balances as well as co-pay and deductibles from our patients, without regard of their primary source of payment, i.e. Medicare, managed care, commercial coverage, etc.
Title: Charity Care

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2. For co-pay and deductibles for Medicare accounts, a business services representative will not assign to bad debt until a minimum of 120 days from when Medicare payment is received, four statement notices and one phone call is made. Balances after insurances an account will not be assigned to bad debt until a minimum of 90 days from an insurance payment is received, four statement notices and one call is made.

3. Balances remaining unpaid at the end of the statement cycle are subject to further collection notices by the contracted collection agency service. The collection agency will continue, but no limited to send notices, make phone calls, and pursue legal action and report information to credit bureaus no earlier than 180 days from the service.

B. The following adjustments shall be applied to self-pay accounts prior to billing for both Inpatient and Outpatient:

1. All outpatient services, the discounted balance represents the average HMO/PPO collection rate on outpatient services, not to exceed our established AGB (2017-32%)

2. For Inpatient services, the discounted balance represents the Medicare DRG amount and the Medi-Cal APR-DRG amount for pediatric and cosmetic inpatient services, not to exceed our established AGB (2018-32%)

3. For patients who are unable to meet their deductible and/or copay obligation or the full amount of the bill if no third party exists:
   CVHP shall offer the option of an installment contract for payment. Individual plans will be negotiated between the hospital and patient based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months.

4. Patients who are unable to meet any or part of their financial obligation may apply for CVHP's Financial Assistance Program (FAP). The balance shall be adjusted in part or in full based on the financial need and criteria are met.

C. The following coverage options should always be explored in assessing patients’ ability to pay:

1. Linkage to available state aid such as:
   a. Med-Cal
   b. California Children Services
   c. Covered California
Title: Charity Care  

Policy#: A009

d. Other

2. Patients under age of twenty one years, who are self pay, shall be referred to the onsite Medi-Cal eligibility worker or to either of our contracted vendors for completion of a Medi-Cal application and/or the onsite GEM (Get Eligibility Moving) program.

3. All obstetrical patients who are self pay and unable to meet their financial obligation shall be referred to the onsite Medi-Cal eligibility worker or either to

4. Our contracted vendors for completion of a Medi-Cal application and/or the on-site GEM (Get Eligibility Moving) program.

A copy of this Financial Assistance Policy and a plain language summary is available on CVHP’s website. A hardcopy of the policy will be made available to the public upon request at any of CVHP hospital campuses or by mail.

CVHP makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that the information presented by the patient or family representative is complete and accurate.

Financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient and or family representative. In addition, CVHP reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or families representatives who have provided fraudulent or purposely inaccurate information in order to qualify for CVHP Financial Assistance Program.

References

California Assembly Bill 774
California Assembly Bill 1503
California Senate Bill 1276
Charity Care Policy

Attachments

I.  Emanate Health/ CVHP Policy #A009 Attachments

II. Emanate Health/CVHP Policy #PC-300
I. Attachments -
Emanate Health /
CVHP Policy #A009
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

011 (Screening form)
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 utilizara 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_____________________________________

<table>
<thead>
<tr>
<th>Casa/Propiedad</th>
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<tbody>
<tr>
<td>Automóviles</td>
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<td>Inversiones</td>
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<tr>
<td>Retiro (jubilación)</td>
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<tr>
<td>Otros bienes</td>
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</tbody>
</table>

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)

019 (Screening form - Sp)
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

012 (Income certification)
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

019A (Income Certification – Sp)
ELIGIBILITY CRITERIA:
(CHARITY PROGRAM)

DATE: [DATE]

PATIENT NAME : [PATIENT NAME]
DATE OF SERVICE: [ADM/SER DATE]
ACCT NUMBER : [ACCOUNT #]
AMT OF CHARITY WRITE-OFF : $_______

___ UNDOC CHECKED HISTORY: ____________________
___ ON G/R
___ HOMELESS
___ UNEMPLOYED
___ NO M/CAL LINKAGE
___ OTHERS PROVIDE FOOD/SHELTER
___ OTHER _______________________________________

TOTAL INCOME FOR THE LAST 12 MONTHS: $____________________________

# DEPENDENTS (including patient): ________________________________

% OF CHARITY ELIGIBILITY: ______ % PT RESPONSIBILITY: $__________

SUBMITTED BY: ________________________________________________

APPROVAL SIGNATURES:

NATALIE ACOSTA DATE
PATIENT ACCOUNT SUPERVISOR, BUSINESS SVCS

SALLY DE LA O DATE
ASSISTANT DIRECTOR, BUSINESS SVCS

ROGER SHARMA DATE
SENIOR V.P. & CFO
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)
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 RECENTES DE CHEQUE)

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

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

Sinceramente,

Dept. De Contabilidades del Paciente

014 (Cover letter -Sp)
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)
Su aplicación para el programa de asistencia comunitaria está 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 ÚLTIMOS 90 DÍAS
____ FIRMA
____ CARTA EXPLICATORIA DE SU SITUACIÓN FINANCIERA
____ CARTA COMPROBANDO SUS BENEFICIOS DE DESEMPLEO
(MISCELANEO)____________________________________

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

Gracias en adelanto por su cooperación.
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)
Dear [GUARANTOR NAME]:

Basado en la información que usted proporciono a Citrus Valley Health Partners, no califica 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
(8:00 a.m.-4:00 p.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)
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)
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)
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%)
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 complacemos 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%)
II. Supplemental Emanate Health/ CVHP Policy #PC-300
Title: Emergency Medical Treatment and Active Labor Act
Policy #: PC-300

Type: Hospital

Effective: 3/1/99
Revised: 4/30/12, 1/22/14, 3/13/14, 9/28/15
Reviewed: 2/4/01, 5/13/02, 10/11/07, 10/4/13+

+ Template changed

Approved by:

Approved by: [Signature]

Approved by: BOD

10-28-15

Statement of Policy

A medical screening examination will be provided 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 of 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:

GHO-EMTALA
Last saved by Kathleen Hugge RN
9-28-15
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 of 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 stabilize” 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.

GHO-EMTALA
Last saved by Kathleen Hangge RN
9-28-15
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 for 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:

GHO-EMTALA
Last saved by Kathleen Hangge RN
9-28-15
Citrus Valley Health Partners  Policy and Procedures

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. Transfers 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 or 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 transfers 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 subspecialists 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 areas 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

1. CHA Consent Manual
2. EMTALA Statute, US Code, Title 42, Section 395dd
4. Emergency Department Policy A113, Emergency Response to Medical Emergencies Outside of the Hospital (CVMC)
5. Perinatal Services Policy S101, Screening Examination and Evaluation of Maternity Patients (CVMC)
6. Standardized Procedure, Medical Screening Exam/Discharge of the Obstetrical Patient (FPH)
7. Hospital Policy, Transfer of Patients, Interfacility, PC-430.
Emanate Health

V

Financial Valuation Summary And Report
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, Emanate Health 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 Emanate Health provides to vulnerable and at-risk populations. The key elements for the valuation process are: 1. Data Gathering of services offered by different Emanate Health 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. Government program shortfalls are included in this report.
Emanate Health continued in 2018 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 loses. 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.

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. Emanate Health 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. Emanate Health 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 *Lighten-Up SGV, GEM, Welcome Baby, Diabetes Management, and the Mental Health Initiative.*

5. **Cash and In-Kind Donations Made by the Facility**

   These are cash or non-monetary assets contributed by Emanate Health 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, Emanate Health 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) and durable medical equipment donated.
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. Emanate Health’s primary activity has been the *Neonatal Sleep Apnea Program*, which was the first of its kind 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 2018 the 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 Emanate Health with the value of services given back to the needy. Emanate Health surpassed its Community Benefit Threshold in 2018.
EMANATE HEALTH
Community Benefit Summary
2018

Community Benefit Threshold

Exemption from taxes:
    Property Taxes $ 1,706,679
    Federal Income Tax -
    State Income Tax -

Total Community Benefit Threshold $ 1,706,679

This is the amount which the community invested in Emanate Health through tax preferences in 2018

Program Valuation

Community Assistance Program (Charity Care) $ 2,669,558
Community Outreach and Mission Effectiveness 163,540
Neonatal Apnea Net Costs 9,100
Emergency Department Call Panel 349,682
Foundation Community Benefit 60,489
Community benefit expense - Health Professions Education 1,757,985
Departmental Community Benefit Services Quantification 1,226,643

Total Value of Community Benefit Services Provided $ 6,236,997

This is the value of SB697 services that EH provided to the community in 2018 $ 6,236,997

Measurement excluding Government Program Shortfalls

1 Community Benefit Service Provided by Emanate Health in 2018 $ 6,236,997
Community Benefit Threshold 1,706,679

Surplus of Services Provided Over Threshold $ 4,530,318
## Emanate Health

### Schedule to Estimate Property Taxes

#### 2018

<table>
<thead>
<tr>
<th>Property &amp; Improvements</th>
<th>Adjustments for For-Profit Entities, Rental Properties, &amp; Construction in Progress</th>
<th>Adjusted</th>
<th>Rate</th>
<th>Estimated Property Taxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHMC</td>
<td>$124,178,748 $ (25,617,389) $</td>
<td>$98,561,359</td>
<td>1.2%</td>
<td>$1,182,736</td>
</tr>
<tr>
<td>FPH</td>
<td>33,886,502 $ (1,969,374)</td>
<td>31,917,128</td>
<td>1.2%</td>
<td>383,006</td>
</tr>
<tr>
<td>EH &amp; Other Affiliates</td>
<td>49,570,813 $ (37,826,070)</td>
<td>11,744,744</td>
<td>1.2%</td>
<td>140,937</td>
</tr>
<tr>
<td>EH Total</td>
<td>$207,636,063 $ (65,412,833)</td>
<td>$142,223,231</td>
<td></td>
<td>$1,706,679</td>
</tr>
</tbody>
</table>

*Note: Adjustment represents for-profit and income property on which the organization has already paid taxes.*
## EMANATE HEALTH
### CHARITY CARE BY ENTITY
#### 2018

<table>
<thead>
<tr>
<th>2018</th>
<th>ICH</th>
<th>QVH</th>
<th>EHMC</th>
<th>FPH</th>
<th>HOSPICE/HC</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity Care at cost is computed as follows:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted Gross Revenue per IRS W/S-2</td>
<td>553,849,264</td>
<td>764,388,114</td>
<td>1,318,237,378</td>
<td>366,130,296</td>
<td>11,762,572</td>
<td>1,696,130,246</td>
</tr>
<tr>
<td>Cost to Charge Ratio per IRS W/S-2</td>
<td>29.5%</td>
<td>30.8%</td>
<td>30.2%</td>
<td>26.5%</td>
<td>75.2%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Total Charity at Full Charges (Gross up)</td>
<td>2,902,816</td>
<td>4,226,506</td>
<td>7,129,322</td>
<td>2,294,720</td>
<td>50,275</td>
<td>9,474,317</td>
</tr>
<tr>
<td>Total Traditional Charity Care at Cost</td>
<td>854,633</td>
<td>1,299,980</td>
<td>2,154,613</td>
<td>607,030</td>
<td>37,784</td>
<td>2,799,427</td>
</tr>
<tr>
<td>Partial Payment by charity patients</td>
<td>14,379</td>
<td>90,602</td>
<td>104,981</td>
<td>24,888</td>
<td>-</td>
<td>129,869</td>
</tr>
<tr>
<td>Total Cost of Traditional Charity Care-Net of payments</td>
<td>840,254</td>
<td>1,209,378</td>
<td>2,049,632</td>
<td>582,142</td>
<td>37,784</td>
<td>2,669,558</td>
</tr>
<tr>
<td>Community Benefits</td>
<td>1,373,156</td>
<td>2,059,734</td>
<td>3,432,890</td>
<td>134,549</td>
<td>3,567,439</td>
<td></td>
</tr>
<tr>
<td>Total Charity Care &amp; Unpaid Costs Before Hospital Fees Revenue</td>
<td>2,213,409</td>
<td>3,269,112</td>
<td>5,482,521</td>
<td>716,691</td>
<td>37,784</td>
<td>6,236,997</td>
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</table>
EMANATE HEALTH  
Community Outreach and Mission Effectiveness/Community Education  
2018

**Mission Effect**  
EH  
(40.86120)

<table>
<thead>
<tr>
<th><strong>Department Expenses</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Expenses per 12/31/18 General Ledger</td>
<td><strong>163,540</strong></td>
</tr>
<tr>
<td>Adjustments:</td>
<td></td>
</tr>
<tr>
<td>Adjusted Departmental Expenses</td>
<td><strong>163,540</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Department Income</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Actual Income per 12/31/18 General Ledger</td>
<td>None</td>
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<tr>
<td>Adjustments:</td>
<td></td>
</tr>
<tr>
<td>Adjusted Departmental Income</td>
<td>-</td>
</tr>
<tr>
<td>Net amount spent for Community Benefits</td>
<td><strong>163,540</strong></td>
</tr>
</tbody>
</table>
EMANATE HEALTH
Neonatal Sleep Apnea Department - Costs
2018

**Department Expenses**

- Actual Expenses per 12/31/18 General Ledger: 9,100
- Adjustments:

  - Adjusted Departmental Expenses: 9,100

**Department Income**

- Actual Income per 12/31/18 General Ledger: -
- Adjustments: -

- Adjusted Departmental Income: -

- Net amount spent for Community Benefits: 9,100
EMANATE HEALTH  
ER - On Call Physicians  
2018

<table>
<thead>
<tr>
<th></th>
<th>CVMC</th>
<th>FPH</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td><strong>Department Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual Expenses per 12/31/18 General Ledger</td>
<td>263,204</td>
<td>86,478</td>
<td>349,682</td>
</tr>
<tr>
<td>Adjustments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted Departmental Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>263,204</td>
<td>86,478</td>
<td>349,682</td>
</tr>
<tr>
<td><strong>Department Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual Income per 12/31/18 General Ledger</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adjusted Departmental Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net amount spent for Community Benefits</td>
<td>263,204</td>
<td>86,478</td>
<td>349,682</td>
</tr>
</tbody>
</table>
## EMANATE HEALTH
### Foundations - Net Fundraising Costs
### 2018

<table>
<thead>
<tr>
<th>Contribution Description</th>
<th>At Risk %</th>
<th>Total</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted contribution-current year</td>
<td>5%</td>
<td>3,042,593</td>
<td>152,130</td>
</tr>
<tr>
<td>Restricted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td>20%</td>
<td>5,332</td>
<td>1,066</td>
</tr>
<tr>
<td>Chaplains / Strength Journey</td>
<td>10%</td>
<td>290</td>
<td>29</td>
</tr>
<tr>
<td>Echo</td>
<td>100%</td>
<td>38,131</td>
<td>38,131</td>
</tr>
<tr>
<td>Maternal &amp; Child Health</td>
<td>20%</td>
<td>1,000</td>
<td>200</td>
</tr>
<tr>
<td>NICU</td>
<td>20%</td>
<td>8,323</td>
<td>1,665</td>
</tr>
<tr>
<td>Pediatric</td>
<td>20%</td>
<td>470</td>
<td>94</td>
</tr>
<tr>
<td>All other restricted</td>
<td>5%</td>
<td>714,773</td>
<td>35,739</td>
</tr>
<tr>
<td><strong>Total Restricted</strong></td>
<td></td>
<td>768,319</td>
<td>76,924</td>
</tr>
<tr>
<td>Total Contributions</td>
<td></td>
<td>3,810,912</td>
<td>229,054</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td></td>
<td>1,006,392</td>
<td></td>
</tr>
<tr>
<td>Expenses related to Fundraising for At Risk Population</td>
<td></td>
<td></td>
<td>60,489</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Total Community benefit expense (Health Professions Education)

<table>
<thead>
<tr>
<th>1 Medical students</th>
<th>EHMC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-</td>
</tr>
<tr>
<td>2 Interns, residents, and fellows</td>
<td>Family Medicine</td>
</tr>
<tr>
<td></td>
<td>3,182,395</td>
</tr>
<tr>
<td>3 Nurses (students)</td>
<td>-</td>
</tr>
<tr>
<td>Other Allied Health Professions, students</td>
<td>-</td>
</tr>
<tr>
<td>4 (Pharmacy, OT, dietetics, pastoral care, etc.)</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Continuing health professions education</td>
<td>104,044</td>
</tr>
<tr>
<td>5 (community physicians)</td>
<td>-</td>
</tr>
<tr>
<td>6 Other students</td>
<td>-</td>
</tr>
<tr>
<td>7 Total Community benefit expense</td>
<td>3,286,439</td>
</tr>
</tbody>
</table>

### Direct offsetting revenue

| 8 Medicare reimbursement for Direct GME | 1,500,954 |
| 9 Medicaid reimbursement for Direct GME | - |
| Continuing health professions education | - |
| 10 reimbursement/tuition | - |
| 11 Other revenue (Pharmacy Res Program - Revenue) | Pharmacy-Other Reimb |
|                              | 27,500 |
| 12 Total Direct offsetting revenue | 1,528,454 |

10 Net community benefit expense (income) - Health Professions Education | 1,757,985
## Estimated List of Community Outreach Services by Department 2018

### Radiology
- **Advisory Committee for Mt. SAC Radiology Program--ICH**
  - Resource 852
- **Advisory Committee for Mt. SAC Radiology Program--QVH**
  - Resource 955
- **Student coordinator for Mt. SAC Radiology Program--ICH**
  - Resource 1,910
- **Student coordinator for Mt. SAC Radiology Program--QVH**
  - Resource 2,334
- **Advisory Committee for Cypress College Ultrasound Program**
  - Resource 1,878
- **Student Coordinator for Cypress College Ultrasound Program**
  - Resource 3,713
- **ICH/QVH MR Safety Tours Education**
  - Resource 2,122

**Radiology Subtotal**

<table>
<thead>
<tr>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>13,764</td>
<td>13,764</td>
</tr>
</tbody>
</table>

### Pediatrics/ MBCU- Mother Baby Care Unit
- 12 English language Tours
  - Education 4,800
- 10 Spanish language Tours
  - Education 4,000
- Printing
  - Resource 8,000
- 2 Boris the Bear Preoperative classes
  - Education 500
- 25 Pediatric Teddy Bear Clinics
  - Resource 2,600

**Pediatrics Subtotal**

<table>
<thead>
<tr>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>19,900</td>
<td>19,900</td>
</tr>
</tbody>
</table>

### Food Services - Queen of the Valley Hospital
- **Student Interns (2) Jennifer, Deanna**
  - Education 5,000
- Dieticians speak to community groups on health issues
  - Education 2,500
- **ED Patient Trays**
  - Resource 19,957

**Food Services Subtotal**

<table>
<thead>
<tr>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>27,457</td>
<td>27,457</td>
</tr>
</tbody>
</table>

### Food Services - Inter-Community Hospital
- **Student Interns (3) Terrance, Morel, Brianna**
  - Education 7,500
- Dieticians speak to community groups on health issues
  - Education 1,155
- **Meals on Wheels**
  - Charity 28,934
- **ED Patient Trays**
  - Resource 19,724

**Food Services Subtotal**

<table>
<thead>
<tr>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td>57,313</td>
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</table>

### Volunteers & Auxiliary Department/Patient Relations & Service Recovery
<table>
<thead>
<tr>
<th>Dept.</th>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ten $1,000 scholarships for students in allied healthcare field</td>
<td>Education</td>
<td>12,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chaplain Services-Spiritual Visits</td>
<td>Service</td>
<td>50,861</td>
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<tr>
<td></td>
<td>Scholarship Committee</td>
<td>Education</td>
<td>1,790</td>
<td></td>
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<tr>
<td></td>
<td>Spiritual Tape Distribution</td>
<td>Service</td>
<td>2,123</td>
<td></td>
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<tr>
<td></td>
<td>Telecare (Calls to Home Bound patients 365 days per year)</td>
<td>Resource</td>
<td>9,184</td>
<td></td>
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<tr>
<td></td>
<td>Pet Therapy</td>
<td>Service</td>
<td>6,356</td>
<td></td>
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<tr>
<td></td>
<td>NICU Cuddler</td>
<td>Service</td>
<td>44,392</td>
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<tr>
<td></td>
<td>Music Therapy</td>
<td>Service</td>
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</table>

Volunteers & Auxiliary Department/Patient Relations & Service Recovery

<table>
<thead>
<tr>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>FPH</th>
</tr>
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<tbody>
<tr>
<td>Public Relations Department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lighten Up SGV</td>
<td>Education</td>
<td>8,733</td>
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</tr>
<tr>
<td>Glendora Chamber</td>
<td>Resource</td>
<td>1,500</td>
<td></td>
</tr>
<tr>
<td>Covina Rotary</td>
<td>Resource</td>
<td>5,000</td>
<td></td>
</tr>
<tr>
<td>La Verne Chamber</td>
<td>Resource</td>
<td>183</td>
<td></td>
</tr>
<tr>
<td>San Dimas Chamber</td>
<td>Resource</td>
<td>620</td>
<td></td>
</tr>
<tr>
<td>Foot &amp; Ankle lecture</td>
<td>Education</td>
<td>1,085</td>
<td></td>
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<tr>
<td>Men's Health lecture (ED)</td>
<td>Education</td>
<td>16,326</td>
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</tr>
<tr>
<td>Women's May Day</td>
<td>Education</td>
<td>5,548</td>
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<tr>
<td>Sidewalk CPR</td>
<td>Education</td>
<td>4,890</td>
<td></td>
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<tr>
<td>Flu shot clinic</td>
<td>Resource</td>
<td>11,468</td>
<td></td>
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<tr>
<td>RESTORE Rehab event</td>
<td>Education</td>
<td>8,626</td>
<td></td>
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<tr>
<td>Beryl call center/Stericycle</td>
<td>Resource</td>
<td>160,349</td>
<td></td>
</tr>
<tr>
<td>Health Day web library</td>
<td>Resource</td>
<td>9,270</td>
<td></td>
</tr>
<tr>
<td>Stroke Events</td>
<td>Education</td>
<td>14,227</td>
<td></td>
</tr>
<tr>
<td>Senior Health Fair</td>
<td>Education</td>
<td>9,075</td>
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<tr>
<td>Heart Smarts (3 events)</td>
<td>Education</td>
<td>46,705</td>
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<tr>
<td>Colorectal seminar</td>
<td>Education</td>
<td>7,545</td>
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<tr>
<td>Event advertising (SGV Tribune)</td>
<td>Education</td>
<td>9,284</td>
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</tbody>
</table>

Public Relations Subtotal

<table>
<thead>
<tr>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Relations Subtotal</td>
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<td>320,434</td>
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</table>
### Emanate Health

#### Estimated List of Community Outreach Services by Department

**2018**

<table>
<thead>
<tr>
<th>Dept.</th>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EH Externship</td>
<td>Service</td>
<td>52,200</td>
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<tr>
<td></td>
<td>Onsite Nursing Student Coordination EHMC</td>
<td>Service</td>
<td>81,000</td>
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<tr>
<td></td>
<td>Onsite Nursing Student Coordination FPH</td>
<td>Service</td>
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<td></td>
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<tr>
<td><strong>Laboratory</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>QVH Red Cross Blood Drives</td>
<td>Service</td>
<td>4,900</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>ICH Red Cross Blood Drives</td>
<td>Service</td>
<td>4,450</td>
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<td></td>
<td><strong>Laboratory Subtotal</strong></td>
<td></td>
<td>9,350</td>
<td>9,350</td>
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</tr>
<tr>
<td><strong>Cardiopulmonary Mended Hearts, Breathsavers &amp; Support Groups</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiopulmonary Mended Hearts, Breathsavers &amp; Support Groups</td>
<td>Resource</td>
<td>65,440</td>
<td></td>
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<tr>
<td></td>
<td>Breathsavers Program Scholarship</td>
<td>Education</td>
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<td></td>
<td><strong>Cardiopulmonary Subtotal</strong></td>
<td></td>
<td>71,179</td>
<td>71,179</td>
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<tr>
<td><strong>Health Scholars (formerly Clinical Care Extenders)</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Health Scholar: Annual Expense for Program</td>
<td>Service</td>
<td>174,200</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Health Scholar: Recruit, train, monitor students for service learning projects</td>
<td>Service</td>
<td>7,140</td>
<td></td>
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<tr>
<td></td>
<td><strong>Health Scholar Subtotal</strong></td>
<td></td>
<td>181,340</td>
<td>181,340</td>
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</tr>
<tr>
<td><strong>Population Health: Diabetes &amp; Specialty Care Centers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Lectures: Hours / Supplies</td>
<td>Education</td>
<td>1,200</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support Groups: Hours</td>
<td>Education</td>
<td>9,200</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support Groups: Supplies</td>
<td>Education</td>
<td>700</td>
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<tr>
<td></td>
<td>Inpatient Education - 30 hours per week</td>
<td>Education</td>
<td>78,000</td>
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<td></td>
<td>Interfaith Outreach</td>
<td>Education</td>
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</tr>
<tr>
<td></td>
<td>School Outreach</td>
<td>Education</td>
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</tr>
<tr>
<td></td>
<td>Community Meetings</td>
<td>Planning</td>
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</tr>
<tr>
<td></td>
<td>Health Fairs</td>
<td>Education</td>
<td>1,400</td>
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</tr>
<tr>
<td></td>
<td>MD Office Lectures</td>
<td>Education</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preceptorship MSN Students - APU/ Western Univ.</td>
<td>In-Kind</td>
<td>10,608</td>
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<tr>
<td></td>
<td>Preceptorship KGI Pharmacy Students (Amb DM Pharm)</td>
<td>In-Kind</td>
<td>14,000</td>
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</tr>
<tr>
<td></td>
<td>Write off (No insurance)</td>
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<td>9,116</td>
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<tr>
<td></td>
<td><strong>Diabetes &amp; Specialty Care Centers Subtotal</strong></td>
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<td>125,224</td>
<td>125,224</td>
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<tr>
<td><strong>Population Health: Chronic Disease Management (10/1/18 through 12/31/18)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Note: Some categories and services are grouped or combined for clarity.*
## Emanate Health
### Estimated List of Community Outreach Services by Department
#### 2018

<table>
<thead>
<tr>
<th>Dept.</th>
<th>Description</th>
<th>Category</th>
<th>Totals</th>
<th>Totals</th>
<th>FPH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Interventions</td>
<td>Education/Medication</td>
<td>13,580</td>
<td></td>
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<tr>
<td>Nurse Interventions</td>
<td>Education</td>
<td>23,280</td>
<td></td>
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<td>Social Worker</td>
<td>Mental Health</td>
<td>5,800</td>
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<tr>
<td>Psychologist</td>
<td>Mental Health/Couns</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Health Team Assistant</td>
<td>Assessment/Educatio</td>
<td>800</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Flu Vaccines</td>
<td>Vaccines</td>
<td>2,152</td>
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<tr>
<td>Preceptor MSN Students -APU</td>
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<tr>
<td>Preceptor KGI Pharmacy Students</td>
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<td><strong>Chronic Disease Management Subtotal</strong></td>
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<td>54,963</td>
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<tr>
<td>FPH Nursing - Perinatal</td>
<td>Maternity Tea and Tour</td>
<td>Education</td>
<td>1,930</td>
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<td></td>
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<tr>
<td></td>
<td>Breast Feeding Class</td>
<td>Education</td>
<td>1,700</td>
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<tr>
<td></td>
<td>Sibling Class</td>
<td>Education</td>
<td>576</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Baby Basics</td>
<td>Education</td>
<td>1,600</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prepared Childbirth Series</td>
<td>Education</td>
<td>2,454</td>
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<td></td>
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<tr>
<td></td>
<td>Prepared Childbirth (Lamaze)</td>
<td>Education</td>
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<tr>
<td><strong>Perinatal Subtotal</strong></td>
<td></td>
<td>11,228</td>
<td>11,228</td>
<td>11,228</td>
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</tr>
<tr>
<td>Food Services - Foothill Presbyterian Hospital</td>
<td>Student Interns</td>
<td>Education</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food donated - Fun Run Breakfast</td>
<td>Charity</td>
<td>805</td>
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</tr>
<tr>
<td><strong>Food Services Subtotal</strong></td>
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<td>805</td>
<td>805</td>
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</tr>
<tr>
<td>FPH Volunteer Services &amp; Auxiliary</td>
<td>Spiritual Care Visits</td>
<td></td>
<td>8,542</td>
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<tr>
<td></td>
<td>17 Scholarships</td>
<td>Education</td>
<td>23,250</td>
<td></td>
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<tr>
<td></td>
<td>Scholarship Committee</td>
<td>Education</td>
<td>3,950</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pet Therapy</td>
<td>Service</td>
<td>296</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Volunteer Services and Auxiliary Subtotal</strong></td>
<td></td>
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<td>36,038</td>
<td>36,038</td>
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<tr>
<td><strong>Grand Total--EH Departmental Outreach Services</strong></td>
<td></td>
<td>$1,226,643</td>
<td>$48,071</td>
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</tr>
</tbody>
</table>
Emanate Health
(Formerly Citrus Valley Health Partners)

VI

2016 CHNA Report
Executive Summary
& Selected Data
2016 Community Health Needs Assessment Report


Queen of the Valley • Inter-Community • Foothill Presbyterian

Citrus Valley Health Partners
I. EXECUTIVE SUMMARY

Citrus Valley Health Partners (CVHP) serves the residents of the East San Gabriel Valley 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.

This 2016 report documents the community health needs assessment (CHNA) conducted for Citrus Valley Health Partner in collaboration with Kaiser Foundation Hospital – Baldwin Park. The results of the CHNA will inform the development of implementation strategies developed by CVHP to address the health needs found in the community. This executive summary is intended to provide a high level snapshot of the CHNA regulations governing hospitals, the list of prioritized health needs found in the report, the methodology used to identify those health needs, and a summary of the overall assessment.

A. Community Health Needs Assessment (CHNA Background)

The Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Citrus Valley Health Partners has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

B. Summary of Prioritized Needs

Health outcomes and drivers are interconnected and can negatively or positively impact individual health. Drivers include social and economic factors that often contribute to the ability or inability of certain populations or groups to access the necessary care needed to diagnose, treat and prevent poor health. Therefore, it is important that drivers be taken into consideration when developing health strategies and programs to address health needs.

The following is a list of 19 prioritized health needs (health outcomes and social determinants of health) that resulted from the analysis of primary and secondary data, observations of disparities, and review of the previous 2013 CVHP CHNA findings.

<table>
<thead>
<tr>
<th>Prioritized Health Needs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diabetes</td>
<td>Outcome</td>
</tr>
<tr>
<td>2. Overweight and obesity</td>
<td>Outcome</td>
</tr>
<tr>
<td>3. Economic security</td>
<td>Driver</td>
</tr>
<tr>
<td>4. Mental health</td>
<td>Outcome</td>
</tr>
<tr>
<td>5. Access to health care</td>
<td>Driver</td>
</tr>
<tr>
<td>6. Healthy behaviors</td>
<td>Driver</td>
</tr>
<tr>
<td>7. Cultural and linguistic barriers</td>
<td>Driver</td>
</tr>
<tr>
<td>Prioritized Health Needs</td>
<td>Driver/Outcome</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>8. Housing</td>
<td>Driver</td>
</tr>
<tr>
<td>9. Alcohol abuse, substance abuse, and tobacco use</td>
<td>Outcome</td>
</tr>
<tr>
<td>10. Preventive health care</td>
<td>Driver</td>
</tr>
<tr>
<td>11. Cancer</td>
<td>Outcome</td>
</tr>
<tr>
<td>12. Cardiovascular disease</td>
<td>Outcome</td>
</tr>
<tr>
<td>13. Physical environment</td>
<td>Driver</td>
</tr>
<tr>
<td>14. Violence and injury prevention</td>
<td>Driver</td>
</tr>
<tr>
<td>15. Oral health</td>
<td>Outcome</td>
</tr>
<tr>
<td>16. Respiratory disease</td>
<td>Outcome</td>
</tr>
<tr>
<td>17. Hypertension</td>
<td>Outcome</td>
</tr>
<tr>
<td>18. Alzheimer's disease</td>
<td>Outcome</td>
</tr>
<tr>
<td>19. Access to healthy foods</td>
<td>Driver</td>
</tr>
</tbody>
</table>

C. Summary of Needs Assessment Methodology and Process

Identification

The 2016 CHNA needs assessment methodology and process involved a mixed-methods approach that included the collection of both secondary data and primary data. Over 400 secondary data indicators on a variety of health, social, economic, and environmental topics were collected by ZIP Code, Service Planning Area (SPA)\(^1\), county, and state levels (as available). The consultant team queried data on indicators through the Kaiser Permanente CHNA Data Platform and obtained the data rates for the Citrus Valley Health Partners Area through accessing various additional data sources. In most cases the service area values represent the aggregate of data of smaller geographic units (e.g., ZIP Codes, census tracts) which fall within the service area boundary. When one or more geographic units are not entirely encompassed by a service area, the measure is aggregated proportionally. The options for weighing “small area estimations” are based on total area, total population, and demographic group population. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most affected the health of the community. The CHNA process also included an identification of existing community assets and resources to address the identified health needs.

For the Citrus Valley Health Partners’ CHNA, primary data were collected through six focus groups and ten phone interviews with a total 69 stakeholders, including community representatives, health experts, local government representatives, local business owners, and social and health service providers. These informants assisted in identifying the most severe health outcomes and associated drivers, health disparities, and community assets and resources available in the Citrus Valley Health Partners service area to address the identified health outcomes and drivers identified through secondary data analysis.

In order to be included in the list of identified health needs, a health outcome or driver had to meet two requirements: it had to be mentioned in the primary data collection more than once and a secondary data indicator associated with the health outcome and/or driver needed to perform poorly against a

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\(^{1}\) A Service Planning Area, or SPA, is a specific geographic region within Los Angeles County. SPAs were created to help divide Los Angeles County into distinct areas that allow the Los Angeles County Department of Public Health develop and provide more relevant and targeted public health and clinical services to treat specific health needs of residents in those areas. (Retrieved from [http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm](http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm)).
designated benchmark (County average, state average, or Healthy People 2020 goal).

Prioritization

Prioritization of the identified needs is essential to the community benefit planning process. CNM engaged a total of 41 community stakeholders through a community forum held in December 2015 to assist with the prioritization of 19 health needs. During the community forum, attendees reviewed a summary of the secondary data indicators and responses from stakeholders and participated in a guided group activity to share insights and perspectives with their colleagues. At the end of the community forum, attendees were asked to complete a survey in which they ranked each health outcome and health driver according to five criteria:

- Magnitude: how many community members were affected
- Severity: how much community members were impacted
- Change over time: whether an issue has improved or gotten worse over time
- Resources: amount of resources available in the community to address an issue
- Disparities: the level of impact on a specific vulnerable population group

Those who were not able to attend the community forum could participate in the process by completing an online version of the prioritization survey disseminated at the community forums. In addition, attendees had an opportunity to vote to indicate which health outcomes and health drivers they believed most severely affected the communities within the Citrus Valley Health Partners’ service area. A link to the online survey and supplemental materials shared at the forums were emailed to stakeholders; a total of six people completed the online survey. Overall composite scores were calculated for both in-person and online surveys by averaging the responses to the criteria questions. The resulting scores were put into a matrix where other factors (or considerations) were taken into account, including observed population disparities by ethnicity, age, gender, and geography through secondary or primary data; noted trends from a review of the 2013 Citrus Valley Health Partners CHNA (worsening or improving); and order in priority ranking. The matrix served as a way to centralize all composite scores and considerations, further demonstrating the severity of each health outcome and driver.

Summary

The overall CHNA process was rigorous, taking into consideration over 400 secondary health, social and economic data indicators and input from over 70 community stakeholders through in-person meetings and an online survey. All the data and information collected were analyzed and the result of the analysis was a prioritized list of identified health needs. The information collected through the CHNA process will be used by Citrus Valley Health Partners to help inform the development of their 2016 Implementation Strategy Plan for the next three years.

The figure below illustrates the interconnectedness of the health outcomes and drivers identified during this needs assessment. Light green spheres represent the health outcomes and dark green ones (and underlined) represent health drivers. The size of the sphere increases according to the number of connections it has with other nodes. It is important to note that every health outcome and driver prioritized by the community is related to at least one other—there are no isolated outcomes or drivers in this system. When looking at just the health outcomes (light green nodes), a strong relationship is observed between diabetes and overweight and obesity, priorities one and two listed above. They are also strongly related to cardiovascular/heart disease, and hypertension, numbers 12 and 17 on the list. These four outcomes are in turn related to economic security, healthy behaviors, physical environment, and access to healthy food (numbers three, six, 13 and 19, respectively, on the health needs list).
These eight components create a sort of nexus within the Citrus Valley Health Partners system, though four of them fall in the second half of the lists.

Community assets and resources to address the emerging health needs were identified through focus groups and interviews in the identification phase of the process. Stakeholders were asked to share names of community organizations, programs, and other resources they knew of and/or had experience with to address the specific health needs. These included hospitals, clinics, health centers, associations, community-based organizations, faith-based organizations, universities, public initiatives and hotlines. Following the identification of assets, Internet research was conducted to validate each asset and resource and collect up-to-date information for each. To view these community assets and resources please refer to Appendix D. Health Need Profiles.
III. SERVICE AREA

The Citrus Valley Health Partners hospital generally serves residents surrounding the hospital in the East San Gabriel Valley region and does not exclude low-income or underserved populations. The service area is presented in the table below by city/community, ZIP Code and Service Planning Area (SPA).

<table>
<thead>
<tr>
<th>City/Community</th>
<th>ZIP Code</th>
<th>Service Planning Area (SPA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
</tbody>
</table>
IV. DEMOGRAPHIC PROFILE OF COMMUNITY SERVED

Overall, the population in the CVHP service area has increased since the 2013 CHNA and is projected to continue to increase. Many of the demographic numbers remained steady since the previous report, but there have been some positive changes in areas such as homelessness and unemployment, which have decreased since the previous 2013 CHNA according to 2015 US Census data. In education, more youth are finishing high school, and more students entering college are completing their degrees. There is, however, an increase in poverty rates in the service area. The following graphic provides a snapshot of the CVHP service area population.

---

One in five people in the SPA 3 - San Gabriel Valley service area population lives below 100% of the Federal Poverty Level (23% overall and 20% of children), while a larger percentage (38%) lives below 200% of the Federal Poverty Level. There are 2,612 homeless people in SPA 3 - San Gabriel Valley, most of who are mentally ill (30%), suffer from substance abuse problems (25%), or are physically disabled (22%).

In terms of overall health, 28% of SPA 3 - San Gabriel Valley population has been diagnosed with a disability; 6% of infants had a low birthweight (under 2,500 grams); and only 41% of were breastfed for at least six months. In the service area the infant mortality rate was 2.9 per 1,000 births; the births to teen mothers (under the age of 20) was 8.3 per 1,000 births; and 1,032 youth 0 to 17 years old entered foster care in 2013.

In the SPA 3 – San Gabriel Valley service area, the top two leading causes of death were coronary heart disease and stroke, while the top two leading causes of premature death (before the age of 75) were coronary heart disease and liver disease/cirrhosis.

Population

The CVHP service area has a total population of 905,984 representing 8.8% of the total population in

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2 The CVHP service area includes many—but not all—of the communities included in Los Angeles County Service Planning Area (SPA) 3 – San Gabriel Valley. Some of the measures included in this report represent SPA 3 – San Gabriel Valley as a proxy for the CVHP service area.
Los Angeles County (10,237,502) and 2.3% of the total population in California (39,356,473). The total population in the CVHP service area is projected to increase at a slower rate of 3.2% by 2021 than Los Angeles County (4.1%) and California (4.8%).

### CVHP Service Area Population Trends

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>880,220</td>
<td>905,984</td>
<td>934,532</td>
<td>2.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>9,818,605</td>
<td>10,237,502</td>
<td>10,656,104</td>
<td>4.3%</td>
<td>4.1%</td>
</tr>
<tr>
<td>California</td>
<td>37,253,956</td>
<td>39,356,473</td>
<td>41,248,721</td>
<td>5.6%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code

### Gender, 2016

Since the 2013 report, the ratio of females to males has remained steady, and nearly divided in half by females (50.9%) and males (49.1%). This is consistent with Los Angeles County and California (50.7% females and 49.3% males, respectively) and California (50.3% and 49.7%, respectively).

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>CVHP service area</td>
<td>445,120</td>
<td>49.1%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>5,052,683</td>
<td>49.3%</td>
</tr>
<tr>
<td>California</td>
<td>19,563,891</td>
<td>49.7%</td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code
Age

CVHP age distribution is consistent with that of the county and state. Youth between the ages of 0 and 17 comprise 23.0% of the population in the CVHP service area, adults between the age of 18 and 64 comprise 63.7%, and senior adults 65 years and older comprise 13.2% of the population. Similar percentages were noted in Los Angeles County (22.9%, 64.5% and 12.6%, respectively) and California (23.6%, 63.2% and 13.4%, respectively).

### Age in the CVHP Service Area

![Age Distribution Chart]

### Population by Age, 2016

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>CVHP Service Area</th>
<th>Los Angeles County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>0-4 years</td>
<td>55,141</td>
<td>6.1%</td>
<td>638,970</td>
</tr>
<tr>
<td>5-9 years</td>
<td>55,018</td>
<td>6.1%</td>
<td>643,058</td>
</tr>
<tr>
<td>10-14 years</td>
<td>58,079</td>
<td>6.4%</td>
<td>642,211</td>
</tr>
<tr>
<td>15-17 years</td>
<td>39,598</td>
<td>4.4%</td>
<td>414,921</td>
</tr>
<tr>
<td>18-20 years</td>
<td>40,234</td>
<td>4.4%</td>
<td>427,972</td>
</tr>
<tr>
<td>21-24 years</td>
<td>57,113</td>
<td>6.3%</td>
<td>595,034</td>
</tr>
<tr>
<td>25-34 years</td>
<td>131,733</td>
<td>14.5%</td>
<td>1,561,554</td>
</tr>
<tr>
<td>35-44 years</td>
<td>115,361</td>
<td>12.7%</td>
<td>1,434,469</td>
</tr>
<tr>
<td>45-54 years</td>
<td>121,421</td>
<td>13.4%</td>
<td>1,396,531</td>
</tr>
<tr>
<td>55-64 years</td>
<td>112,159</td>
<td>12.4%</td>
<td>1,191,539</td>
</tr>
<tr>
<td>65-74 years</td>
<td>70,883</td>
<td>7.8%</td>
<td>741,361</td>
</tr>
<tr>
<td>75-84 years</td>
<td>35,247</td>
<td>3.9%</td>
<td>378,700</td>
</tr>
<tr>
<td>85 years and older</td>
<td>13,997</td>
<td>1.5%</td>
<td>171,182</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>905,984</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>10,136,509</strong></td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code
Median Age

The average age in the CVHP service area is 37.9 years, slightly higher than Los Angeles County (37.7 years) and California (37.8 years). The median age in the service area is similar (36.4 years) when compared to Los Angeles County (36.4 years) and California (36.4 years).

<table>
<thead>
<tr>
<th>Age</th>
<th>CVHP Service Area</th>
<th>Los Angeles County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>37.9 years</td>
<td>37.7 years</td>
<td>37.8 years</td>
</tr>
<tr>
<td>Median Age</td>
<td>36.4 years</td>
<td>36.4 years</td>
<td>36.4 years</td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code

Race and Ethnicity

The CVHP service area is more heavily Hispanic/Latino and Asian, and less Caucasian/White (as a percentage of the total population), than either Los Angeles County or the state of California. In the CVHP service area in 2015, more than half the population identified as Hispanic/Latino (56.7%), followed by Asian/Pacific Islanders (23.7%), and Caucasian/White (15.7%). Hispanics/Latinos represent 48.4% of the population in Los Angeles County and 38.7% in California. Caucasians/Whites are the second-largest ethnic group in Los Angeles County (26.3%) and California (37.7%) followed by Asians/Pacific Islanders (14.4% and 14.2%, respectively).

Race and Ethnicity in the CVHP Service Area
Race and Ethnicity, 2016

Source: Nielsen Claritas SiteReports, 2016, ZIP Code

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>CVHP Service Area</th>
<th>Los Angeles County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>African-American/Black</td>
<td>18,410</td>
<td>2.0%</td>
<td>818,212</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>1,582</td>
<td>0.2%</td>
<td>19,687</td>
</tr>
<tr>
<td>Asian</td>
<td>214,925</td>
<td>23.7%</td>
<td>1,472,173</td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>142,057</td>
<td>15.7%</td>
<td>2,695,688</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>1,150</td>
<td>0.1%</td>
<td>23,556</td>
</tr>
<tr>
<td>Other</td>
<td>1,345</td>
<td>0.1%</td>
<td>25,952</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>12,626</td>
<td>1.4%</td>
<td>222,850</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>513,889</td>
<td>56.7%</td>
<td>4,959,384</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>905,984</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>10,237,502</strong></td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code
Language

As in 2013, nearly two-thirds (62.8%) of the population over the age of 5 years in the CVHP service area primarily speaks a language other than English in the home. This is significantly higher than in the county and state. The largest percentage of the population 5 years and older in the CVHP service area speak primarily Spanish in the home (41.0%), closely followed by English (37.2%) and an Asian language (19.5%). However, in Los Angeles County and California, English is most often spoken in the home (43.2% and 56.1%, respectively) followed by Spanish (39.5% and 28.8%, respectively). Asian languages represent the third language most often spoken in the home for Los Angeles County and California (10.8% and 9.6%, respectively). There has been no increase in number for primarily English speaking households since 2013, and a very slight decrease of 0.3% for primarily Spanish speaking households.

Language Primarily Spoken in the Home (Age 5+), 2016

<table>
<thead>
<tr>
<th>Language</th>
<th>CVHP Service Area</th>
<th>Los Angeles County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>English</td>
<td>316,640</td>
<td>37.2%</td>
<td>4,148,342</td>
</tr>
<tr>
<td>Asian</td>
<td>165,863</td>
<td>19.5%</td>
<td>1,033,480</td>
</tr>
<tr>
<td>Indo-European</td>
<td>13,828</td>
<td>1.6%</td>
<td>521,493</td>
</tr>
<tr>
<td>Spanish</td>
<td>348,536</td>
<td>41.0%</td>
<td>3,791,978</td>
</tr>
<tr>
<td>Other</td>
<td>5,976</td>
<td>0.7%</td>
<td>103,239</td>
</tr>
<tr>
<td>Total</td>
<td>850,843</td>
<td>100.0%</td>
<td>9,598,532</td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code

1Includes Arabic, Armenian, Yiddish, and other languages with origin in Europe or Asia
Household Income

While the service area’s income distribution is skewed slightly higher than the county and state, a significant number of households have lower income levels. Almost 20 percent of households (18.4%) had household incomes between $50,000 and $74,999, followed by household incomes between $35,000 and $49,999 (12.6%) and $75,000 and $99,999 (14.0%). The service area reflects similar percentages of households in Los Angeles County and California, where most incomes are between $35,000 and $99,999. Slightly fewer households in the service area have incomes less than $35,000 when compared to the county and state (25.8%, 32.3%, and 29.1% respectively). Households with incomes between $35,000 and $74,999 in the service area slightly exceed those in the county and state (31.0%, 28.8%, and 28.5%). Comparisons with the previous CHNA report are not presented because those data are from 2009, which is too long ago to provide any meaningful insights for 2016 numbers. A look at poverty numbers, which follows, will provide more insight.

### Household Income, 2016

<table>
<thead>
<tr>
<th>Income Level</th>
<th>CVHP Service Area</th>
<th>Los Angeles County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>$15,000 and below</td>
<td>20,267</td>
<td>7.9%</td>
<td>417,524</td>
</tr>
<tr>
<td>$15,000-$24,999</td>
<td>22,804</td>
<td>8.9%</td>
<td>360,024</td>
</tr>
<tr>
<td>$25,000-$34,999</td>
<td>22,869</td>
<td>9.0%</td>
<td>319,101</td>
</tr>
<tr>
<td>$35,000-$49,999</td>
<td>32,213</td>
<td>12.6%</td>
<td>419,941</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>46,820</td>
<td>18.4%</td>
<td>554,866</td>
</tr>
<tr>
<td>$75,000-$99,999</td>
<td>35,689</td>
<td>14.0%</td>
<td>391,484</td>
</tr>
<tr>
<td>$100,000-$124,999</td>
<td>25,167</td>
<td>9.9%</td>
<td>282,878</td>
</tr>
<tr>
<td>$125,000-$149,999</td>
<td>16,959</td>
<td>6.7%</td>
<td>184,593</td>
</tr>
<tr>
<td>$150,000-$199,999</td>
<td>17,210</td>
<td>6.8%</td>
<td>198,649</td>
</tr>
<tr>
<td>$200,000-$249,999</td>
<td>6,541</td>
<td>2.6%</td>
<td>86,389</td>
</tr>
<tr>
<td>$250,000-$499,999</td>
<td>6,773</td>
<td>2.7%</td>
<td>113,970</td>
</tr>
<tr>
<td>$500,000 and above</td>
<td>1,789</td>
<td>0.7%</td>
<td>52,850</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>255,101</td>
<td>100.0%</td>
<td>3,382,269</td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code

Poverty

The level of poverty in an area can have an impact on overall health and create barriers to everyday necessities, including healthy and affordable foods, health care, and other basic needs.

A slightly higher percentage of the population in the SPA 3 – San Gabriel Valley (22.2%) lived in households below 100% of the Federal Poverty Levels (FPL) when compared to Los Angeles County (21.0%) and California (18.4%).

The previous CHNA shows that with respect to trends over time, the percentage of service area population living below 100% of federal poverty level rose sharply from 2010, going from 12% to 22.2% in 2014.
Population Living Below 100% Federal Poverty Level, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3-San Gabriel Valley</td>
<td>390,000</td>
<td>22.2%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>2,076,000</td>
<td>21.0%</td>
</tr>
<tr>
<td>California</td>
<td>6,932,000</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey, 2010-14, Tract

Of those households in the CVHP service area living at 100% below the FPL, 19.5% have children between the ages of 0 and 17 years. This is lower than the percentage reported for Los Angeles County (26.0%) and California (22.7%).

Children Living Below 100% Federal Poverty Level, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>41,803</td>
<td>19.5%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>610,376</td>
<td>26.0%</td>
</tr>
<tr>
<td>California</td>
<td>2,091,190</td>
<td>22.7%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey, 2010-14, Tract

The percentage of households (47.2%) in the SPA 3-San Gabriel Valley service area living at 200% below the FPL was lower (in 2014) when compared to Los Angeles County (40.9%) and slightly higher than reported in California (36.4%).

Population Living Below 200% Federal Poverty Level, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3-San Gabriel Valley</td>
<td>830,000</td>
<td>47.2%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>4,460,000</td>
<td>45.1%</td>
</tr>
<tr>
<td>California</td>
<td>15,301,000</td>
<td>40.7%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

Homelessness

Of the estimated 43,854 homeless in Los Angeles County as of 2016, 6.0%—approximately 2,612 homeless people—resided within SPA 3. While the population has critical needs, proportionally the community is a little better off than the overall county.

Total Homeless, 2016

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>2,612</td>
<td>6.0%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>43,854</td>
<td></td>
</tr>
</tbody>
</table>

Source: Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2016, SPA

Of the total homeless population in SPA 3, 36.4% lived in shelters (including emergency shelters and transitional housing programs), a higher percentage than the county’s 25.2%.
### Homeless by Special Population, 2016

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Mentally Ill</th>
<th>With Substance Abuse Issues</th>
<th>With HIV</th>
<th>Physically Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>793</td>
<td>30.4%</td>
<td>653</td>
<td>25.0%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>13,006</td>
<td>29.7%</td>
<td>9,941</td>
<td>22.7%</td>
</tr>
</tbody>
</table>

Source: Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2016, SPA 3 - San Gabriel Valley

### Employment Status

Lack of steady work and income can affect an individual’s health in multiple ways, along with access to insurance and health care. In SPA 3 – San Gabriel Valley, as well as Los Angeles County and California, there has been a steady decrease in the unemployment rate. In 2015, the rate of unemployment for the county was lower (6.7%) relative to the state (7.6%).

#### Unemployment Rate, 2012–2015

<table>
<thead>
<tr>
<th>Report Area</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley¹</td>
<td>8.1%</td>
<td>8.5%</td>
<td>3.9%*</td>
<td>--</td>
</tr>
<tr>
<td>Los Angeles County²</td>
<td>10.9%</td>
<td>9.7%</td>
<td>8.2%</td>
<td>6.7%</td>
</tr>
<tr>
<td>California²</td>
<td>12.1%</td>
<td>10.4%</td>
<td>8.8%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

¹ Source: California Health Interview Survey, 2012-2014, SPA 3 - San Gabriel Valley
² Bureau of Labor Statistics, 2012-2015, County and State
*Statistically Unstable

No data were available for 2015 for SPA 3

### Educational Attainment

Overall, slightly less than a third of the population 25 years old and older in the CVHP service area have graduated college (32.7%) with an associate, bachelor, masters, professional, or doctorate degree. While this percentage is lower when compared to Los Angeles County (36.5%) and California (38.5%), it is an increase of 11.3% from the previous CHNA report. Close to a quarter (23.3%) of the population in the CVHP service area did not complete high school (including completing less than the ninth grade), which is slightly higher than percentages for Los Angeles County (23.2%) and California (18.7%).

#### Educational Attainment, 2016

- Graduated high school only:
  - CVHP: 24.3%
  - Los Angeles County: 20.5%
  - California: 20.8%

- Graduated from college:
  - CVHP: 32.7%
  - Los Angeles County: 36.9%
  - California: 38.8%

Source: Nielsen Claritas SiteReports, 2016, ZIP Code
Educational Attainment (Age 25+), 2016

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>CVHP Service Area</th>
<th>Los Angeles County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Less than 9th grade</td>
<td>80,036</td>
<td>13.3%</td>
<td>932,109</td>
</tr>
<tr>
<td>Some high school</td>
<td>60,013</td>
<td>10.0%</td>
<td>660,103</td>
</tr>
<tr>
<td>High school graduate</td>
<td>146,147</td>
<td>24.3%</td>
<td>1,409,226</td>
</tr>
<tr>
<td>Some college</td>
<td>118,165</td>
<td>19.7%</td>
<td>1,336,128</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>45,556</td>
<td>7.6%</td>
<td>479,703</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>105,893</td>
<td>17.6%</td>
<td>1,349,235</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>32,803</td>
<td>5.5%</td>
<td>461,587</td>
</tr>
<tr>
<td>Professional school degree</td>
<td>7,810</td>
<td>1.3%</td>
<td>159,139</td>
</tr>
<tr>
<td>Doctorate degree</td>
<td>4,378</td>
<td>0.7%</td>
<td>88,106</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>600,801</td>
<td>100.0%</td>
<td>6,875,336</td>
</tr>
</tbody>
</table>

Source: Nielsen Claritas SiteReports, 2016, ZIP Code

Disability

Having a disability can present many complications that would be exacerbated by the absence of appropriate assistance. Having a disability can also lead to other health needs such as poor mental health. In SPA 3, a slightly lower percentage (28.2%) of the population reported having a physical, mental or emotional-associated disability when compared to Los Angeles County (28.6%) and California (28.5%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>383,000</td>
<td>28.2%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>2,169,000</td>
<td>28.6%</td>
</tr>
<tr>
<td>California</td>
<td>8,127,000</td>
<td>28.5%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

Infant and Maternal Health

Infants with low birth weights (under 2,500 grams) are at a higher risk for health problems. In the CVHP service area, 5.9% of births were of babies having a low birth weight (down from 6.4% in 2011). This percentage was lower than that of California (6.7%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area, 2011</td>
<td>973</td>
<td>6.4%</td>
</tr>
<tr>
<td>CVHP service area, 2012</td>
<td>777</td>
<td>5.9%</td>
</tr>
<tr>
<td>California</td>
<td>33,723</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

The following table shows the births with low birth rates as a percentage of all births in each ZIP Code in 2012. The highest percentages of birth weights under 2,500 grams took place in La Puente including Bassett, City of Industry and Valinda (91744), Baldwin Park, Irwindale (91706), and Rowland Heights (including City of Industry, La Puente) (91748), ranging from 10.2% to 10.9% of births.

<table>
<thead>
<tr>
<th>City/Community</th>
<th>ZIP Code</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>54</td>
<td>6.9%</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>79</td>
<td>10.2%</td>
</tr>
<tr>
<td>Covina</td>
<td>91722</td>
<td>25</td>
<td>3.2%</td>
</tr>
<tr>
<td>Covina</td>
<td>91723</td>
<td>13</td>
<td>1.7%</td>
</tr>
<tr>
<td>Covina</td>
<td>91724</td>
<td>22</td>
<td>2.8%</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>37</td>
<td>4.8%</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731</td>
<td>29</td>
<td>3.7%</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91732</td>
<td>65</td>
<td>8.4%</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740</td>
<td>13</td>
<td>1.7%</td>
</tr>
<tr>
<td>Glendora</td>
<td>91741</td>
<td>18</td>
<td>2.3%</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>33</td>
<td>4.2%</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744</td>
<td>85</td>
<td>10.9%</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91746</td>
<td>29</td>
<td>3.7%</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>17</td>
<td>2.2%</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>80</td>
<td>10.3%</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>14</td>
<td>1.8%</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>42</td>
<td>5.4%</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>23</td>
<td>3.0%</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790</td>
<td>38</td>
<td>4.9%</td>
</tr>
<tr>
<td>West Covina</td>
<td>91791</td>
<td>38</td>
<td>4.9%</td>
</tr>
<tr>
<td>West Covina</td>
<td>91792</td>
<td>23</td>
<td>3.0%</td>
</tr>
<tr>
<td>CVHP service area</td>
<td>777</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>California</td>
<td>33,723</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>


The greatest percentages of mothers under age of 20 years at delivery were found in La Puente including Bassett, City of Industry and Valinda (91744), Azusa, Irwindale (91702) and Baldwin Park, Irwindale (91706). The communities of 91744 and 91706 both had the highest percentages of low births and mothers under the age of 20 years of age.
Leading Causes of Death

In the CVHP service area, the top two leading causes of death were coronary heart disease and stroke, just as reported in Los Angeles County overall. However, the service area’s third leading cause of death was chronic obstructive pulmonary disease (COPD), followed by lung cancer and Alzheimer’s disease—similar to Los Angeles County’s where the third leading causes of death is Alzheimer’s disease followed by lung cancer and COPD.

<table>
<thead>
<tr>
<th>SPA 3 – San Gabriel</th>
<th>Ranking #1</th>
<th>Ranking #2</th>
<th>Ranking #3</th>
<th>Ranking #4</th>
<th>Ranking #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>Stroke</td>
<td>COPD</td>
<td>Lung cancer</td>
<td>Alzheimer’s disease</td>
<td></td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>Coronary heart disease</td>
<td>Stroke</td>
<td>Alzheimer’s disease</td>
<td>Lung cancer</td>
<td>COPD</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Department of Public Health, 2012, SPA

Leading Causes of Premature Death

In the CVHP service area, the top two leading causes of premature death (before the age of 75) were coronary heart disease and liver disease/cirrhosis. This is slightly similar to Los Angeles County, whose number one cause of premature death is coronary heart disease but whose second leading cause of premature death is homicide. In the service area, the third leading cause of premature death is suicide, followed by diabetes and lung cancer; in Los Angeles County, the third leading cause of premature death is motor vehicle crashes, followed by liver disease/cirrhosis and suicide.

<table>
<thead>
<tr>
<th>SPA 3 – San Gabriel</th>
<th>Ranking #1</th>
<th>Ranking #2</th>
<th>Ranking #3</th>
<th>Ranking #4</th>
<th>Ranking #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>Liver disease/cirrhosis</td>
<td>Suicide</td>
<td>Diabetes</td>
<td>Lung cancer</td>
<td></td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>Coronary heart disease</td>
<td>Homicide</td>
<td>Motor vehicle crash</td>
<td>Liver disease/cirrhosis</td>
<td>Suicide</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Department of Public Health, 2012, SPA
The following figure illustrates the top prioritized health needs in 2013 and 2016.

<table>
<thead>
<tr>
<th>2013 Health Needs</th>
<th>2016 Health Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental health</td>
<td>1. Diabetes</td>
</tr>
<tr>
<td>2. Obesity</td>
<td>2. Overweight and obesity</td>
</tr>
<tr>
<td>3. Diabetes</td>
<td>3. Economic security</td>
</tr>
<tr>
<td>4. Oral health</td>
<td>4. Mental health</td>
</tr>
<tr>
<td>5. Hypertension</td>
<td>5. Access to health care</td>
</tr>
<tr>
<td>6. Cardiovascular disease</td>
<td>6. Healthy behaviors</td>
</tr>
<tr>
<td>7. Cancers (all)</td>
<td>7. Cultural and linguistic barriers</td>
</tr>
<tr>
<td>8. Vision</td>
<td>8. Housing</td>
</tr>
<tr>
<td>10. Disability</td>
<td>10. Preventive health care</td>
</tr>
<tr>
<td>12. Alcohol/ substance abuse</td>
<td>12. Cardiovascular disease</td>
</tr>
<tr>
<td>15. Asthma</td>
<td>15. Oral health</td>
</tr>
<tr>
<td>17. Unintentional injury (pedestrian/motor vehicle)</td>
<td>17. Hypertension</td>
</tr>
<tr>
<td>19. COPD</td>
<td>19. Access to healthy foods</td>
</tr>
<tr>
<td>20. HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>21. Allergies</td>
<td></td>
</tr>
<tr>
<td>22. Infant mortality</td>
<td></td>
</tr>
</tbody>
</table>

VII. KEY FINDINGS

This section provides key findings for the identified health needs (organized by health outcomes and health drivers) identified for the communities served by CVHP.

A. Health Outcomes (Morbidity and Mortality)

The following section provides descriptions and overviews of the top 10 health needs identified through the secondary and primary data analysis, and prioritized by stakeholders. Alphabetically, the list of health outcomes includes:

- Alcohol abuse, substance abuse, and tobacco use,
- Alzheimer's disease,
- Cancer,
- Cardiovascular/heart disease,
- Diabetes,
Alcohol Abuse, Substance Abuse and Tobacco Use

Alcohol and substance abuse have a major impact on individuals, families, and communities contributing significantly to costly social, physical, mental, and public health problems, including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), violence, crime, homicide, and suicide.3

Alcohol Abuse

Over half (51.5%) the population in SPA 3 reported consuming an alcoholic beverage in the past month, which was slightly lower than Los Angeles County (51.9%). In SPA 3, 15.9% of the population reported binge drinking (five or more drinks for men and four or more drinks for women, in two hours), which was slightly higher than Los Angeles County (15.5%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Alcohol use in past month</th>
<th>Binge drinking in past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>51.5%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>51.9%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Health Survey, 2015, SPA

Substance Abuse

Stakeholders indicated that substance abuse is an important issue in the CVHP service area, and mentioned an increase in substance abuse among youth in middle school between the ages of 10 and 12 years old, adults between the ages of 18 and 40 years old, and the homeless, considered an ongoing issue.

In SPA 3, a smaller percentage (7.7%) of teens reported using marijuana in the past year as compared to Los Angeles County (11.6%). Additionally, a smaller percentage (4.7%) of adults reported misusing or abusing prescription drugs when compared to Los Angeles County (5.5%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Teens who used marijuana in the past year</th>
<th>Misuse of Prescription Drugs (in last year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>7.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>11.6%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Health Survey, 2015, SPA

---

**Tobacco Use**

In the CVHP service area, 9.4% of the population reported smoking which is slightly lower than Los Angeles County (10.0%) and California (10.8%). Additionally, 10.9% of teens in the service area have smoked electronic cigarettes in the past, a smaller percentage than Los Angeles County (11.3%) and slightly greater than in California (10.3%).

Stakeholders added that smoking among high school youth has become more common and is on the rise.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Currently Smoke</th>
<th>Teens who have ever smoked electronic cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>9.4%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>10.0%</td>
<td>11.3%</td>
</tr>
<tr>
<td>California</td>
<td>10.8%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

**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 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. 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.4

**Mortality**

The average rate of Alzheimer’s mortality per 10,000 persons in the CVHP service area (3.1) is consistent with the statewide average (3.1). The rate is higher in Glendora (7.5), San Dimas (5.6), La Verne (4.5), Covina (4.1), and Walnut (3.5).

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa</td>
<td>91702</td>
<td>2.3</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>1.5</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>4.1</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>2.5</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>2.8</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>7.5</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>2.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>0.9</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>4.5</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>1.3</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>5.6</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>1.4</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>3.5</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>3.0</td>
</tr>
<tr>
<td>CVHP service area</td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td>California</td>
<td></td>
<td>3.1</td>
</tr>
</tbody>
</table>

Source: California Department of Public Health (CDPH), 2012, ZIP Code

**Cancer**

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year\(^5\). In 2009, cancer incidence rates per 100,000 persons indicate that the three most common cancers among men in the United States are prostate cancer (137.7), lung cancer (64.3), and colorectal cancer (42.5). Among women, the leading causes of cancer deaths are breast cancer (123.1), lung cancer (54.1), and colorectal cancer (37.1).\(^6\) Research has shown that early detection through regular cancer screenings can help reduce the number of new cancer cases and, ultimately, deaths.\(^7\) Research has also shown that cancer is associated with certain diseases and behaviors including obesity, tobacco, alcohol, certain chemicals, some viruses and bacteria, a family history of cancer, poor diet, and lack of physical activity.\(^8\) The CVHP priorities systems reflect the two drivers of preventive health care (e.g., cancer screenings) and healthy behaviors (e.g., tobacco use).

**Incidence**

In the CVHP service area, the incidence rate of colorectal incidence per 100,000 population was higher (41.3) than California (40.0) and the Healthy People 2020 goal of <=38.7.

Stakeholders added that colorectal cancer is common among immigrants who do not have access to preventative health care and are often diagnosed in the late stages of colorectal cancer.

---


**Mortality**

The cancer mortality rate per 10,000 population is slightly higher (15.3) in the CVHP service area when compared to California (15.1). Comparison with the 2013 CHNA reveals that the mortality rate of colorectal cancer in the service area doubled from 2008 to 2012, rising from 7.7 per 100,000 to 15.3. Communities with the highest mortality rates in the service area were La Verne (23.2), San Dimas (20.5), and Glendora (20.2).

### Cancer Mortality Rate per 10,000 Populations, 2012

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>13.1</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>11.0</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>14.2</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>13.7</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>12.3</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td><strong>20.2</strong></td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>18.3</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>11.1</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td><strong>23.2</strong></td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>14.7</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td><strong>20.5</strong></td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>11.6</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>15.0</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>14.7</td>
</tr>
<tr>
<td>CVHP service area</td>
<td></td>
<td>15.3</td>
</tr>
<tr>
<td>California</td>
<td></td>
<td>15.1</td>
</tr>
</tbody>
</table>

Source: California Department of Public Health (CDPH), 2012, ZIP Code
Cardiovascular/Heart Disease

Cardiovascular/heart disease —also called heart disease and coronary heart disease—includes several health conditions related to plaque buildup in the walls of the arteries, or atherosclerosis. As plaque builds up, the arteries narrow, restricting blood flow and creating the risk of heart attack. Currently, more than one in three adults (81.1 million) in the United States live with one or more types of cardiovascular/heart disease. In addition to being one of the leading causes of death in the United States, heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. Cardiovascular/heart health is also significantly influenced by physical, social and economic factors including maternal and child health, access to educational opportunities, availability of and access to healthy foods, physical activity, access to safe and walkable communities, and access to affordable, quality health care.

Prevalence

In SPA 3, 7.0% of the population was diagnosed with heart disease, which is higher when compared to Los Angeles County (5.7%) and California (6.1%).

Stakeholders added that those most often impacted by heart disease include African-Americans, Hispanics/Latinos, Asians, the homeless, the middle-aged, and the elderly. However, stakeholders noted an increase in heart disease in younger people. In addition, stakeholders noted that heart disease was common among those who were obese and diabetic (with co-morbidities).

Heart Disease Diagnosis, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>7.0%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>5.7%</td>
</tr>
<tr>
<td>California</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

Hospitalizations

Heart disease hospitalizations may indicate a person’s lack of awareness about having the condition and/or not leading a healthy lifestyle. In the CVHP service area, the heart disease hospitalization rate per 100,000 population was much higher (371.0) than Los Angeles County’s (366.6) and California’s (339.0). Hospitalization rates were even higher within the communities of Glendora (498.1) and Hacienda Heights (487.4).

Comparison with the 2013 CHNA reveals that all service area communities suffered an increase in heart disease hospitalization with the exception of La Verne, Azusa, San Dimas and South El Monte. Communities like Glendora, Hacienda Heights, and Walnut suffered particularly large increases, rising from 408.4 – 498.1, 405.5 – 487.4, and 257.7 – 348, respectively, from 2010 to 2012.


Mortality

The heart disease-related death rate in the service area was slightly lower (15.4 per 10,000 population) when compared to California (15.5), and appears to be on the rise from 14.4 per 10,000 population reported in the 2013 CHNA. The state’s rate, however, has remained about the same (15.6). Rates were even higher in La Verne (27.9) and Glendora (24.0).

Heart Disease Hospitalization Rate per 100,000 Population and Mortality Rate per 10,000 Population, 2012

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Hospitalization Rate</th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>281.2</td>
<td>15.0</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>418.6</td>
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</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>412.6</td>
<td>17.4</td>
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<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>320.1</td>
<td>11.2</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>359.0</td>
<td>12.5</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>498.1</td>
<td>24.0</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>487.4</td>
<td>15.6</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>438.1</td>
<td>10.2</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>258.0</td>
<td>27.9</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>354.9</td>
<td>11.9</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>353.4</td>
<td>21.9</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>311.5</td>
<td>11.1</td>
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<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>348.0</td>
<td>12.3</td>
</tr>
<tr>
<td>West Covina</td>
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<td>352.7</td>
<td>12.6</td>
</tr>
<tr>
<td>CVHP service area</td>
<td></td>
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</tr>
<tr>
<td>Los Angeles County</td>
<td></td>
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</tr>
<tr>
<td>California</td>
<td></td>
<td>339.0</td>
<td>15.5</td>
</tr>
</tbody>
</table>

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code
Source: California Department of Public Health, Death Statistical Master File, 2012, ZIP Code
**Stroke**

Strokes are a leading risk factor for cardiovascular/heart disease and share many of the same risk factors. In the CVHP service area, the stroke mortality rate is slightly higher (3.6) than in California (3.5). Several communities experience much higher rates of strokes, including La Verne (5.4), Hacienda Heights (5.1), San Dimas (5.0), and West Covina (5.0).

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>2.2</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>1.8</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>3.6</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>2.5</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>3.0</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>2.6</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry,</td>
<td>91745</td>
<td>5.1</td>
</tr>
<tr>
<td>La Puente)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry</td>
<td>91744, 91746</td>
<td>3.3</td>
</tr>
<tr>
<td>and Valinda)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>5.4</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry,</td>
<td>91748</td>
<td>3.5</td>
</tr>
<tr>
<td>La Puente)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>5.0</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>3.0</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>3.7</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>5.0</td>
</tr>
<tr>
<td>CVHP service area</td>
<td></td>
<td>3.6</td>
</tr>
<tr>
<td>California</td>
<td></td>
<td>3.5</td>
</tr>
</tbody>
</table>

Source: California Department of Public Health, Death Statistical Master File, 2012, ZIP Code
Diabetes

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.\(^{11}\) A diabetes diagnosis can also indicate an unhealthy lifestyle—a risk factor for further health needs—and is also linked to obesity. Given the steady rise in the number of people with diabetes and the earlier onset of Type 2 diabetes, there is growing concern about substantial increases in diabetes-related complications and the 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. Diabetes is associated with many health needs including heart disease and is also closely linked to social, economic, and environmental factors including access to health care, access to healthy food, and access to green space, exercising, and healthy eating.\(^{12}\)

Prevalence

In the CVHP service area, a larger percentage (11.9\%) of the population self-reported being diagnosed with diabetes when compared to Los Angeles County (10.0\%) and California (8.9\%). However, this number has decreased greatly for the CVHP service area since 2009 when it was at 19.2\% (decrease of 7.3\%), while Los Angeles County has seen a slight decrease (from 10.5\%).

Stakeholders also added that diabetes was common in those living in poverty, youth, the homeless, single parent homes, Hispanic/Latinos, African-Americans, and Asians. Stakeholders shared that youth who attend Title I schools (schools that have a higher percentage of pupils who come from low-income families) were particularly predisposed to being overweight because of the lunches served in Title I schools.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>11.9%</td>
<td>135,631</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>10.0%</td>
<td>759,000</td>
</tr>
<tr>
<td>California</td>
<td>8.9%</td>
<td>2,539,000</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, ZIP

Hospitalizations

Diabetes-related hospitalizations may indicate a lack of awareness of having diabetes, not following an appropriate health management plan, and/or leading an unhealthy lifestyle. In the CVHP service area, the hospitalization rate per 100,000 adults was much higher (187.1) than in California (142.6) and Los Angeles County (171.7). Furthermore, hospitalizations in the CVHP service area have seen a large increase of 39.7 per 100,000 adults since the 2013 report (147.4 per 100,000 adults). In addition, certain communities experienced much higher rates including West Covina (460.5), South El Monte (248.0), and Baldwin Park (240.1). The rates in West Covina are almost twice that of any other city.


Comparison with the 2013 CHNA reveals that while the rate of hospitalization statewide (for adults) decreased from the 2013 to 2016 report (145.6 – 142.6) the rate of hospitalization increased significantly for the service area, up from 147.4 to 167.1.

Youth under the age of 18 in the service area were hospitalized for diabetes at a lower rate (24.8 per 100,000 youth) than in Los Angeles County (27.7) and California (31.2). However, certain communities experience much higher rates, including Covina (41.3) and Azusa (39.7). The communities with higher rates of adult hospitalization are not the same as those with higher rates of youth hospitalization.

### Diabetes Hospitalization Rate per 100,000 Population, 2012

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Adults</th>
<th>Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>156.4</td>
<td>39.7</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>240.1</td>
<td>14.2</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>188.6</td>
<td>41.3</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>88.4</td>
<td>16.5</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>183.9</td>
<td>21.6</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>177.4</td>
<td>25.2</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>154.0</td>
<td>25.6</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>222.9</td>
<td>13.8</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>124.8</td>
<td>27.8</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>108.4</td>
<td>30.8</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>163.1</td>
<td>27.9</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>248.0</td>
<td>24.4</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>103.4</td>
<td>19.2</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>460.5</td>
<td>19.1</td>
</tr>
<tr>
<td>CVHP service area</td>
<td></td>
<td>187.1</td>
<td>24.8</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td></td>
<td>171.7</td>
<td>27.7</td>
</tr>
<tr>
<td>California</td>
<td></td>
<td>142.6</td>
<td>31.2</td>
</tr>
</tbody>
</table>

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code

In the CVHP service area, nearly three times as many people (13.4 per 100,000 population) have been hospitalized with uncontrolled diabetes when compared to Los Angeles County (4.5), a rate that is also significantly higher than California’s (2.8). Even higher rates were reported in Glendora (32.4), South El Monte (29.6), and El Monte (27.5). There has also been a slight increase in this rate for the service area since the 2013 report (from 12.7 per 100,000).

### Uncontrolled Diabetes Hospitalization Rate per 100,000 Population, 2012

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>8.3</td>
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<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>14.1</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>10.7</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>2.1</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>27.5</td>
</tr>
</tbody>
</table>

46
<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>32.4</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>11.0</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>14.0</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>8.9</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>2.2</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>11.9</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>29.6</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>7.4</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>7.2</td>
</tr>
<tr>
<td>CVHP service area</td>
<td></td>
<td>13.4</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td></td>
<td>4.5</td>
</tr>
<tr>
<td>California</td>
<td></td>
<td>2.8</td>
</tr>
</tbody>
</table>

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code

**Hypertension**

Hypertension, defined as a blood pressure reading of 140/90 mmHg or higher, affects one in three adults in the United States. With no symptoms or warning signs and the ability to cause serious damage to the body, the condition has been called a silent killer. If untreated, high blood pressure can lead to blood vessel aneurysms, chronic kidney disease which may lead to kidney failure, cognitive changes including memory loss, difficulty finding words, and losing focus during conversations, eye damage, heart attack, heart failure, peripheral arterial disease, and stroke. High blood pressure can be controlled through medication and lifestyle changes; however, patient adherence to treatment regimens is a significant barrier to controlling the condition.

Changes in the body’s normal functions may cause hypertension, including changes to kidney fluid and salt balances, the renin-angiotensin-aldosterone system (a complex system that uses hormones to control blood pressure and fluid balance), sympathetic nervous system activity, and blood vessel structure and function. Other causes of hypertension include unhealthy lifestyle habits, the use of certain medicines, and other health needs such as being overweight or obese, diabetic or having chronic kidney disease.

**Prevalence**

In SPA 3, close to a third (29.8%) of the population were diagnosed with hypertension, which is slightly down from 30.2% reported in the 2013 CHNA. Despite showing a decrease, that percentage is still higher than Los Angeles County (27.3%), which shows an increase over the previous report (from 2012).

---


25.5%). It is also higher than California (28.5%) and the Healthy People 2020 goal of <=26.9%.

Stakeholders added that hypertension has become common among young adults between 20 and 30 years old.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>29.8%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>27.3%</td>
</tr>
<tr>
<td>California</td>
<td>28.5%</td>
</tr>
<tr>
<td>Healthy People 2020</td>
<td>&lt;=26.9%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

**Mental Health**

Mental illness is a major and complex health need which, if left untreated, may leave individuals at risk for substance abuse, self-destructive behavior, and even suicide. Additionally, mental health disorders can have a serious impact on physical health and can be associated with the prevalence, progression and outcome of chronic diseases.\(^\text{17}\)

Suicide is considered a major preventable public health problem in the United States. 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.\(^\text{18}\) 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, other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders).\(^\text{19}\)

New mental health needs have emerged among some special populations, such as: veterans who have experienced physical and mental trauma; people in communities with psychological trauma caused by natural disasters; and older adults, as the awareness, understanding and treatment of dementia and mood disorders continues to improve.\(^\text{20}\) Stigma associated with mental health results in prejudice, avoidance, rejection and discrimination directed at people believed to have an illness, disorder or other trait perceived to be undesirable. Such stigma causes suffering, potentially causing a person to deny symptoms, delay treatment and refrain from daily activities. Stigma can also exclude people from access to housing, employment, insurance, and appropriate medical care. Thus, stigma can interfere with prevention efforts and examining and combating stigma is a public health priority.\(^\text{21}\)


Prevalence

In SPA 3 - San Gabriel Valley, the average number of mentally unhealthy days among those 18 years old and older was 3.7 (days), slightly higher than the number of days reported in California (3.6). Stakeholders added that poor mental health is most common among certain sub-populations in the service area including the Lesbian, Gay, Bisexual and Transgender (LGBT) community, foster youth, the low income, the homeless, teenagers, and senior citizens.

In addition, 22.8% of teens 14 to 17 years old in the service area were at risk for becoming depressed. This was within the range reported in Los Angeles County (23.1%) and California (21.0%). Also, 11.0% of adults reported being at risk for becoming depressed, slightly less than reported in Los Angeles County (11.8%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Teens</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>22.8%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>23.1%</td>
<td>11.8%</td>
</tr>
<tr>
<td>California</td>
<td>21.0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA¹, Los Angeles County Health Survey, 2015, SPA²

A smaller percentage (10.4%) of adults in SPA 3 was diagnosed with depression when compared to Los Angeles County (13.0%). Similarly, a smaller percentage (9.1%) was diagnosed with anxiety in the service area when compared to Los Angeles County (11.3%). Stakeholders added that it is often difficult to get necessary medical treatment and support to treat existing mental health needs.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Depression</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>10.4%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>13.0%</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Health Survey, 2015¹, 2011, SPA²

Alcohol and drug use can often contribute to the development or worsening of mental health disease. In the CVHP service area, there was a much lower rate (105.4 per 100,000 population) of alcohol and drug induced mental health disease than reported in Los Angeles County (125.8). However, particularly high rates were reported in the communities of San Dimas (219.4), La Verne (213.9) and Glendora (191.5).

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>131.4</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>84.7</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>117.9</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>40.0</td>
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<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>76.8</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>191.5</td>
</tr>
</tbody>
</table>

²² Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12, County.
<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>60.5</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>93.9</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>213.9</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>32.5</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>219.4</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>72.8</td>
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<tr>
<td>Walnut (including City of Industry)</td>
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<td>46.8</td>
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<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>94.0</td>
</tr>
<tr>
<td>CVHP service area</td>
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<td>125.8</td>
</tr>
<tr>
<td>California</td>
<td></td>
<td>102.5</td>
</tr>
</tbody>
</table>

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code

**Hospitalizations**

Mental health hospitalizations can indicate a number of factors including a lack of awareness or health education, leading an unhealthy lifestyle, and a gap in preventative services. In the CVHP service area, mental health hospitalizations are high among youth and adults with youth in the service area experiencing a higher rate (478.7 per 100,000 youth) of mental health hospitalizations when compared to California (294.8) and Los Angeles County (377.1). Much higher rates were reported in La Verne (1,166.2), and San Dimas (1,099.0).

Adults in the service area are experiencing a lower rate (606.2 per 100,000 adults) of mental health hospitalizations when compared to Los Angeles County (677.0) but a higher rate when compared to California (540.9). However, much higher rates were reported in Glendora (1,251.5) and Covina (833.4). This is also a lower rate of mental health hospitalizations compared to the 2010 rate in the service area (657).

**Mental Health Hospitalization Rate per 100,000 Population, 2012**

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Youth</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>452.4</td>
<td>733.7</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>347.3</td>
<td>544.4</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>661.6</td>
<td>833.4</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>224.4</td>
<td>343.2</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>375.6</td>
<td>656.9</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>600.5</td>
<td>1,251.5</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>350.2</td>
<td>403.4</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>315.9</td>
<td>529.5</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>1,166.2</td>
<td>698.3</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>239.8</td>
<td>297.0</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>1,099.0</td>
<td>764.9</td>
</tr>
</tbody>
</table>
Suicide

Suicide is closely linked with depression and other mental health needs. In SPA 3, 5.7% of adults reported having thoughts of suicide at one point in their life, a lower percentage than in Los Angeles County (7.2%) and California (7.8%).

### Suicidal Thoughts, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>5.7%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>7.2%</td>
</tr>
<tr>
<td>California</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Source: California Health interview Survey, 2014, SPA

Additionally, the youth suicide rate was lower (0.8 per 100,000 youth) in the CVHP service area when compared to California (1.0) and the Healthy People 2020 goal of <=1.0. However, youth rates of suicide were higher in Azusa (1.8), Rowland Heights (1.1) and West Covina (1.1). Stakeholders added that suicides were on the rise among youth.

### Suicide Rate per 100,000 Youth, 2012

<table>
<thead>
<tr>
<th>Community</th>
<th>ZIP Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azusa, Irwindale</td>
<td>91702</td>
<td>1.8</td>
</tr>
<tr>
<td>Baldwin Park, Irwindale</td>
<td>91706</td>
<td>0.3</td>
</tr>
<tr>
<td>Covina</td>
<td>91722, 91723, 91724</td>
<td>0.9</td>
</tr>
<tr>
<td>Diamond Bar</td>
<td>91765</td>
<td>0.4</td>
</tr>
<tr>
<td>El Monte (including City of Industry)</td>
<td>91731, 91732</td>
<td>0.9</td>
</tr>
<tr>
<td>Glendora</td>
<td>91740, 91741</td>
<td>1.0</td>
</tr>
<tr>
<td>Hacienda Heights (including City of Industry, La Puente)</td>
<td>91745</td>
<td>0.6</td>
</tr>
<tr>
<td>La Puente (including Bassett, City of Industry and Valinda)</td>
<td>91744, 91746</td>
<td>0.7</td>
</tr>
<tr>
<td>La Verne</td>
<td>91750</td>
<td>0.9</td>
</tr>
<tr>
<td>Rowland Heights (including City of Industry, La Puente)</td>
<td>91748</td>
<td>1.1</td>
</tr>
<tr>
<td>San Dimas</td>
<td>91773</td>
<td>0.9</td>
</tr>
<tr>
<td>South El Monte</td>
<td>91733</td>
<td>0.7</td>
</tr>
<tr>
<td>Walnut (including City of Industry)</td>
<td>91789</td>
<td>0.0</td>
</tr>
<tr>
<td>West Covina</td>
<td>91790, 91791, 91792</td>
<td>1.1</td>
</tr>
<tr>
<td>CVHP service area</td>
<td></td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: Office of Statewide Health and Planning and Development (OSHPD), 2012, ZIP Code
Could Not Afford Dental Care Services, 2011, 2015

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Youth¹</th>
<th>Adults²</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>9.9%</td>
<td>27.7%</td>
</tr>
<tr>
<td>California</td>
<td>11.5%</td>
<td>30.3%</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Health Survey, 2015, SPA ¹, 2011, SPA²

Over a quarter of youth (26.7%) were reported as never having been to see a dentist, which is up from 11.5% in the previous report and significantly higher than for Los Angeles County (16.0%) or California (15.3%). In regards to adults in SPA 3, 6.4% had never been to a dentist—a higher percentage than Los Angeles County (4.1%) and nearly three times as higher than California (2.2%).

Never Seen a Dentist, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Youth</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>26.7%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>16.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>California</td>
<td>15.3%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

Overweight and Obesity

Obesity is defined as having a body mass index (BMI) of 30.0 or higher; being overweight is defined by a BMI between 25.0 and 29.9. Excess weight is a significant national problem and indicates an unhealthy lifestyle that further influences health needs. 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.⁵⁵ Being overweight or obese results from a combination of causes and contributing factors, including behavior and genetics.⁵⁶ Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures. Additional contributing factors include food and physical activity, environment, education and skills, and food marketing and promotion. Some Americans have less access to stores and markets that provide healthy, affordable food such as fruits and vegetables, especially in rural, minority and lower-income neighborhoods.⁵⁷

Obesity, in particular, is a serious concern, associated with a reduced quality of life and many serious diseases and health conditions, including diabetes, heart disease, stroke, high blood pressure (hypertension), high cholesterol, and mental illness such as clinical depression and anxiety.⁵⁸ 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.⁵⁹

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Prevalence

In SPA 3, over a third (34.9%) of adults were overweight, with a body mass index (BMI) between 20.00 and 29.99. This percentage is slightly lower than California (35.5%) and Los Angeles County (36.2%). A quarter (25.7%) of adults were obese, with a BMI of 30 or higher—again lower than percentages reported for Los Angeles County (27.2%), California (27.0%), and the Healthy People 2020 goal of <=30.5%. What’s worse, there appears to be movement of adults going from overweight to obese, as seen by the decrease from 36.4% overweight to an increase from 21.4% obese seen in the previous report.

Stakeholders also noted that being overweight or obese was most common among those living in low income communities.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Overweight (20.00-29.99 BMI)</th>
<th>Obese (30 or higher BMI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>34.9%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>35.9%</td>
<td>23.5%</td>
</tr>
<tr>
<td>California</td>
<td>35.5%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Healthy People 2020</td>
<td></td>
<td>&lt;=30.5%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

The percentage of youth (27.5%) in SPA 3 who were considered overweight was over twice as much as in Los Angeles County (13.1%) and California (13.6%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Gabriel Valley</td>
<td>27.5%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>13.1%</td>
</tr>
<tr>
<td>California</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

In SPA 3, the percentage of obese youth (20.9%) fell within the range of California (19.0%) and Los Angeles County (21.5%). However, unlike the trend in adults, there has been a decrease in obese youth since the last report—from 30.6% down to 20.9%. Similarly, the amount of youth in SPA 3 who were overweight has decreased since the last report—from 36.4% down to 27.5%.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>20.9%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>21.5%</td>
</tr>
<tr>
<td>California</td>
<td>19.0%</td>
</tr>
</tbody>
</table>

Source: California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14, School District

Being overweight or obese seems to be common across the service area regardless of age. A smaller percentage (13.4%) of teens between the ages of 14 and 17 were overweight when compared to Los Angeles County (14.4%) and California (16.3%). However, close to a quarter (22.8%) were obese—a higher percentage than Los Angeles County (14.9%) and California (14.6%). Rates of youth being overweight are higher than those of teens, but obesity rates are higher in teens than in youth.
Respiratory Disease

Respiratory diseases that impair the lungs can have long-term effects on an individual’s overall health. Respiratory diseases can include diseases such as asthma, chronic obstructive pulmonary disease and pneumonia.

Asthma 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 only occur 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, certain foods and fragrances.30

Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases, including emphysema and chronic bronchitis, which block airflow and make breathing difficult. Although men (47.6 per 100,000) in the United States had higher COPD death rates than women (36.4 per 100,000) in 2006, the death rates for COPD increased significantly for men (from 57.0 per 100,000) though not for women (from 35.3 per 100,000) between 1999 and 2009.31

Pneumonia is an infection of the lungs that can cause mild to severe illness in people of all ages. Pneumonia can be caused by viruses (such as influenza), bacteria, fungi, and as a result of being on a ventilator. However, these infections can often be prevented with vaccines and can usually be treated with antibiotics, antiviral drugs, or specific drug therapies. Common signs of pneumonia include cough, fever, and difficulty breathing. Smokers and people with underlying medical conditions, such as diabetes or heart disease are at higher risk of contracting pneumonia.32

Asthma

In SPA 3, 11.9% of the population was diagnosed with asthma, a slightly higher percentage than in Los Angeles County (11.4%) yet still lower than California’s (14.2%). The service area and the county saw similar slight increases from 11.1% in the previous report.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Overweight</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>13.4%</td>
<td>22.8%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>14.4%</td>
<td>14.9%</td>
</tr>
<tr>
<td>California</td>
<td>16.3%</td>
<td>14.6%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

Socioeconomic factors
- Cultural & linguistic barriers
- Economic security
- Homelessness and housing
- Violence and injury prevention

Access to Health Care
Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life. The lack of access to health services can lead to unmet health needs, delays in receiving appropriate care, inability to benefit from preventive services, and preventable hospitalizations.33

Health Care Coverage
In the CVHP service area, a slightly smaller percentage (13.7%) of the population does not have health coverage when compared to Los Angeles County (13.3%) though health coverage is slightly higher when compared to California (11.9%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>13.7%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>13.3%</td>
</tr>
<tr>
<td>California</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey, 2010-14, Tract

Most of the population in SPA 3 had a usual source of care (81.2%), which was a slightly higher percentage when compared to Los Angeles County (80.3%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>1,119,000</td>
<td>81.2%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>6,181,000</td>
<td>80.3%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey, 2010-14, Tract

In terms of accessing primary care, in SPA 3, 3.1% of the population reported having a difficult time, which is lower compared to Los Angeles County (4.7%) and California (4.6%).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>3.1%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>4.7%</td>
</tr>
<tr>
<td>California</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

In terms of specialty care, in SPA 3 almost a third of the population (31.9%) needed to see a medical specialist, which was lower than that reported in Los Angeles County (33.9%) and California (36.3%). Access to specialty care is important and may be affected by cost or lack of health coverage for such services. A small percentage (10.0%) of the population in SPA 3 reported having difficulty accessing a medical specialist when compared to Los Angeles County (11.1%) and California (10.8%).

Stakeholders added that Hispanics/Latinos, the homeless, youth under the age of 10 years old, single-parent families, and adults 50 years old and older had the most difficult time accessing specialty care.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Needed to see a medical specialist in past year</th>
<th>Difficult time accessing specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>31.9%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>33.9%</td>
<td>11.1%</td>
</tr>
<tr>
<td>California</td>
<td>36.3%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

One of the barriers to accessing necessary health care services can be lack of health insurance or coverage. In SPA 3, 3.8% of the population reported that their primary care doctor did not accept their insurance in the past year, which is lower when compared to Los Angeles County (4.2%) and California (4.1%). Additionally, 7.9% of those needing to see a medical specialist were not able to because their insurance was not accepted which is similar compared to Los Angeles County (7.9%) but lower than for California (9.0%).

Stakeholders added that most people seem to have a difficult time getting the health care they needed with their existing health insurance. However, they specified that the Lesbian, Gay, Bisexual, and Transgender (LGBT) community had an especially difficulty time obtaining necessary health care with their existing coverage.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Insurance not accepted by general doctor in past year</th>
<th>Insurance not accepted by medical specialist in past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>3.8%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>4.2%</td>
<td>7.9%</td>
</tr>
<tr>
<td>California</td>
<td>4.1%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

**Provider Shortage**

Having sufficient health professionals available to meet the demand is essential to keeping a community healthy. In SPA 3, the primary care physician access rate per 100,000 population was the same (72.0) when compared to Los Angeles County (72.0) and lower than California (77.2).

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>72.0</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>72.0</td>
</tr>
<tr>
<td>California</td>
<td>77.2</td>
</tr>
</tbody>
</table>

Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2012, County
A Health Professional Shortage Area (HPSA) is an area that has a shortage of primary medical care, dental or mental health professionals. In SPA 3, the percentage of the population living in a HPSA area (13.8%) was two or more times lower when compared to Los Angeles County (31.4%) and California (25.4%).

Population Living in a Health Professional Shortage Area (HPSA), 2015

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>13.8%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>31.4%</td>
</tr>
<tr>
<td>California</td>
<td>25.4%</td>
</tr>
</tbody>
</table>

Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration, March 2015, HPSA

Federally Qualified Health Center

Federally Qualified Health Centers (FQHCs) are community assets that provide health care to vulnerable populations. There are 14 FQHCs in the service area which are 10.4% of those located in Los Angeles County. In addition, the rate of FQHCs per 100,000 population is more than two times higher (4.4) in the service area when compared to Los Angeles County (1.4) and California (2.0).

Federally Qualified Health Center per 100,000 Population, September 2015

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>14</td>
<td>4.4</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>134</td>
<td>1.4</td>
</tr>
<tr>
<td>California</td>
<td>735</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, Sept. 2015, Address

Emergency Room Use

There were 6,980 admissions into the CVHP medical center’s emergency department in 2014, making up 0.4% of the emergency room admissions reported in California. The average length of stay for someone admitted into the emergency department at CVHP was 3.7 days. This was lower than the average reported in California (4.7 days).

Emergency Room Use, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>6,980</td>
<td>3.7 Days</td>
</tr>
<tr>
<td>California</td>
<td>1,817,237</td>
<td>4.7 Days</td>
</tr>
</tbody>
</table>

Source: Office of Statewide Health Planning and Development, CVHP Emergency Department Summary Report, 2014, CVHP Medical Center

Affordable Health Care

Another common barrier to accessing health care is cost. In SPA 3, more than a quarter of the population (26.8%) delayed getting necessary care due to the cost of medication or lack of insurance. However, this percentage is significantly lower than for Los Angeles County (44.8%) and California.
A slightly lower percentage (5.6%) of the population in SPA 3 who were eligible for Medi-Cal under the age of 65 years were not registered Medi-Cal recipients when compared to Los Angeles County (5.8%) and California (6.4%). Of those in the CVHP service area under the age of 65 years and eligible for Healthy Families, 13.5% are not recipients. This percentage is three or more times higher than Los Angeles County (3.9%) and California (3.4%).

### Medical and Healthy Families Eligibility, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Eligibility of uninsured under 65 for Medi-Cal (Pre-ACA)</th>
<th>Eligibility of uninsured under 65 for Healthy Families (Pre-ACA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>5.6%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>5.8%</td>
<td>3.9%</td>
</tr>
<tr>
<td>California</td>
<td>6.4%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

**Preventive Health Care**

As with access to health care, preventive practices such as having a regular source of care and timely physical and medical tests are also critical to overall health and healthy living. Adequate primary care can prevent the development of health problems and maintain positive health conditions. In SPA 3, the hospital discharge rate for preventable hospital events was higher (100.4 per 10,000 population) than Los Angeles County’s (92.2) but slightly lower than California’s (102.9).

### Preventable Hospital Events Rate per 10,000 Population, 2011

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
<td>22,242</td>
<td>100.4</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>199,046</td>
<td>92.2</td>
</tr>
<tr>
<td>California</td>
<td>396,260</td>
<td>102.9</td>
</tr>
</tbody>
</table>

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES, 2011, ZIP Code

**Cancer Screenings**

Engaging in preventative behaviors is key to early detection and the treatment of serious illnesses such as cancer. In the CVHP service area, the percentage of women receiving cervical cancer screenings in the prior three years was lower (81.2%) than Los Angeles County (84.4%) and did not meet the Healthy People 2020 goal of >=93.0%. Similarly, a lower percentage of women (76.7%) in the service area had a mammogram within the prior two years when compared to women in Los Angeles County (77.3%), and California (82.2%). The service area did not meet the Healthy People 2020 goal of >=81.1%. Stakeholders added that non-English speaking women living in the San Gabriel Valley were less likely to have an annual pap smear and mammogram exam.
Population Living Below 100% Federal Poverty Level, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>390,000</td>
<td>22.2%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>2,076,000</td>
<td>21.0%</td>
</tr>
<tr>
<td>California</td>
<td>6,932,000</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

Of those households in SPA 3 living 100% below the FPL, 19.5% were children between the ages of 0 and 17 years. This is lower than the percentage reported for Los Angeles County (26.0%) and California (22.7%).

Children Living Below 100% Federal Poverty Level, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>41,803</td>
<td>19.5%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>610,376</td>
<td>26.0%</td>
</tr>
<tr>
<td>California</td>
<td>2,091,190</td>
<td>22.7%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey, 2010-14, Tract

SPA 3 – San Gabriel Valley includes a large percentage of households 47.2% living 200% below the FPL, slightly higher than reported in Los Angeles County (45.1%) but lower than the percentage reported in California (40.7%).

Population Living Below 200% Federal Poverty Level, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPA 3 - San Gabriel Valley</td>
<td>830,000</td>
<td>47.2%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>4,460,000</td>
<td>45.1%</td>
</tr>
<tr>
<td>California</td>
<td>15,301,000</td>
<td>40.7%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

The percentage of youth in the service area eligible to receive a free or reduced price lunch is higher (68.4%) when compared to Los Angeles County (66.9%) and California (58.1%).

Youth Eligible for a Free or Reduced Price Lunch, 2014

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP service area</td>
<td>133,914</td>
<td>68.4%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>1,030,344</td>
<td>66.9%</td>
</tr>
<tr>
<td>California</td>
<td>3,610,385</td>
<td>58.1%</td>
</tr>
</tbody>
</table>

Source: National Center for Education Statistics, (NCES) Common Core of Data, 2013-14, Address

Education Level

Overall, almost a third of the people in the CVHP service area have graduated from college (32.7%) with an Associate, Bachelor, Master’s, Professional, or Doctorate degree. This percentage is lower when compared to Los Angeles County (36.9%) and California (38.8%). Close to a quarter (23.3%) of the population in the service area did not complete high school (including completing less than the 9th grade), a higher percentage than reported in Los Angeles County (23.2%) and California (18.4%).
In SPA 3, the percentage of children in the fourth grade whose reading-skills scores were below proficiency level on the English Language Arts portion of the California Standards Test was (34.0%), less than the Los Angeles County and California percentages (both at 36.0%) and below the Healthy People 2020 goal of <=36.3%.

The rate of Head Start program facilities in SPA 3 was higher (14.5 per 10,000 youth) when compared to Los Angeles County (7.2) and California (6.3). Access to early education is very important to a youth’s development and can indicate future economic success and lifestyle.

Healthy behaviors and overall health are also closely linked. Healthy behaviors include preventative health care, healthy eating, exercising, and other behaviors. Cultural practices and traditions are also important factors in healthy behaviors and overall health. While covered preventative care was part of the ACA, the impact of the change in policy is not yet reflected in the data.

---

Healthy Eating

Following a healthy diet is essential to overall health and longevity. In SPA 3, a third (33.4%) of youth 0 to 17 years old consumed at least one soda or sweetened drink a day, slightly less when compared to Los Angeles County (39.2%). Less than a third (28.3%) of the adults in the service area consumed at least one soda or sweetened drink a day, again lower when compared to Los Angeles County (31.4%) and California (38.6%).

Stakeholders indicated unhealthy habits among youth, Hispanics/Latinos, and Pacific Islanders. In addition, stakeholders indicated that cultural practices often contributed to unhealthy eating habits. Stakeholders attributed unhealthy behaviors to a lack of education around healthy behaviors and practices, most common among those living in poverty, youth, Hispanics/Latinos, immigrants, and multi-family homes. Stakeholders also added that unhealthy behaviors were most often present in Baldwin Park and La Puente.

<table>
<thead>
<tr>
<th>Soda or Sweetened Drink Consumption, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Area</strong></td>
</tr>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Los Angeles County</td>
</tr>
<tr>
<td>California</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Health Survey, 2015, SPA

In SPA 3, over three-quarters (77.5%) of youth 0 to 17 years old consumed fast food at least once a week, slightly lower when compared to Los Angeles County (80.5%). A smaller percentage (65.8%) of adults consumed fast food at least once a week, lower when compared to Los Angeles County (67.0%) but higher than California (62.7%)

<table>
<thead>
<tr>
<th>Fast Food Consumption, 2011, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Area</strong></td>
</tr>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Los Angeles County</td>
</tr>
<tr>
<td>California</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Health Survey, 2011, SPA; California Health Interview Survey, 2014, SPA

In terms of adequate fruit and vegetable consumption, more than half (62.2%) of youth consumed five or more fruits and vegetables a day—more than youth in Los Angeles County (55.4%) and California (50.7%). Similarly, a greater percentage of adults (16.2%) consumed five or more fruits and vegetables a day than in Los Angeles County (14.7%). In the service area, 74.8% reported that they had access to affordable fresh fruits and vegetables. This percentage is slightly lower than Los Angeles County (75.2%) and California (78.0%). Affordability is likely a factor contributing to youth and adults not consuming the recommended number of fruits and vegetables.

<table>
<thead>
<tr>
<th>Fruit and Vegetable Consumption and Affordability, 2011-2012, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Area</strong></td>
</tr>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Los Angeles County</td>
</tr>
<tr>
<td>California</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2011-2012, SPA; California Health Interview Survey, 2014, SPA
**Physical Activity**

Physical activity is also essential to living a healthy lifestyle and longevity. Over half (51.8%) of the youth in SPA 3 participate in daily physical activity. This percentage is twice as high as that reported in Los Angeles County (26.4%) and California (32.8%). However, a slightly smaller percentage (64.2%) of adults participated in aerobic and strengthening activities when compared to Los Angeles County (65.1%).

<table>
<thead>
<tr>
<th>Physical Activity, 2011, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Area</strong></td>
</tr>
<tr>
<td>SPA 3 – San Gabriel Valley</td>
</tr>
<tr>
<td>Los Angeles County</td>
</tr>
<tr>
<td>California</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA¹
Los Angeles County Health Survey, 2015, SPA²

**Vaccinations**

Annual vaccinations such as influenza and pneumonia vaccinations can help prevent sickness, and death for particular age groups such as senior citizens. In SPA 3, over a third (42.0%) of adults 18 years old and older received an influenza vaccination, a slightly higher percentage than reported in Los Angeles County (40.1%). Over two-thirds (74.6%) of senior citizens 65 years old and older in the service area received an influenza vaccination when compared to Los Angeles County (69.0%). However, a smaller percentage (59.5%) of senior citizens in the service area received an annual pneumonia vaccination when compared to Los Angeles County (62.0%). Stakeholders also added that it had become common for youth, particularly those new to the school system, to not have the recommended vaccinations.

<table>
<thead>
<tr>
<th>Vaccinations, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccination</strong></td>
</tr>
<tr>
<td>Influenza vaccinations (adults)</td>
</tr>
<tr>
<td>Influenza vaccinations (seniors)</td>
</tr>
<tr>
<td>Pneumonia vaccinations (seniors)</td>
</tr>
</tbody>
</table>

Source: Los Angeles County Health Survey, 2015, SPA
Diabetes in the CVHP Service Area

Description & Significance

Diabetes affects an estimated 23.6 million people and is the seventh leading cause of death in the United States.

Diabetes decreases 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\textsuperscript{xvi}. A diabetes diagnosis can indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity\textsuperscript{xvii}.

In addition to heart disease, diabetes is also associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis.\textsuperscript{xviii} Gestational (developing diabetes during pregnancy) diabetes occurs more frequently among Black/African-Americans, Hispanic/Latino Americans, American Indians, and people with a family history of diabetes. Women who have had gestational diabetes have a 35% to 60% chance of developing diabetes in the next 10 to 20 years.

Health Outcome Statistics

The CVHP service area is experiencing high rates of diabetes-related hospitalizations. Stakeholders agreed that diabetes is a worsening problem in the community.

**Prevalence.** In the CVHP service area, 12.0% of the population 20 years and older were diagnosed with diabetes, which is higher than in Los Angeles County (10.0%) and California (8.9%).\textsuperscript{xxxix}

**Hospitalizations.** More adults in the CVHP service area were hospitalized for diabetes (200.5 per 100,000 population) when compared to Los Angeles County (171.7) and California (142.6 per 100,000 population). Nearly three times the number of adults in the CVHP service area were hospitalized for uncontrolled diabetes (13.5 per 100,000 population) than in Los Angeles County (4.5), and more than four times the number than in California overall (2.8).

Community Perspective

“Diabetes patients tend to go to the ER for medication. With awareness and proper education, this can be mitigated.”

Social Services Provider
Health Disparities

Health disparities were observed throughout the CVHP service area, particularly in the western and central portions of the service area.

Communities Most Affected (Diabetes Hospitalizations):
- Azusa
- Baldwin Park
- Covina
- El Monte
- Glendora
- Hacienda Heights
- La Puente
- La Verne
- San Dimas
- South El Monte
- Walnut
- West Covina

Community Perspective

Stakeholders added that diabetes is of most concern among Black/African-Americans, Hispanics/Latinos, and Asian-Pacific Islanders, as well as children under 18 years of age and those in low-income communities.
Key Health Drivers/Factors

Diabetes is associated with health outcomes including overweight and obesity, high blood pressure (i.e., hypertension), and high cholesterol. Diabetes is also highly correlated to poor health behaviors such as physical inactivity, smoking, and unhealthy eating. However, age, race, gender, and having a family history of diabetes have also been known to greatly contribute to an individual’s susceptibility to becoming diabetic\textsuperscript{xl}. Stakeholders have observed a link between obesity and heart disease.

**Health Outcome(s)**

**Overweight and Obesity**. Being overweight or obese can contribute to an individual’s likelihood of becoming diabetic. In the CVHP service area, nearly a third of youth (27.5%) are overweight—twice as many as in Los Angeles County (13.1%) and California (13.6%). Similarly, nearly twice as many teens in the service area are obese (22.8%) when compared to Los Angeles County (14.9%) and California (14.6%).

<table>
<thead>
<tr>
<th>Youth Who Are Overweight</th>
<th>CVHP Service Area</th>
<th>LA County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27.5%</td>
<td>13.1%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

(Source: Percent of the teens (12 to 17 years old) who are obese, California Health Interview Survey, 2014, SPA)

<table>
<thead>
<tr>
<th>Teens Who Are Obese</th>
<th>CVHP Service Area</th>
<th>LA County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22.8%</td>
<td>14.9%</td>
<td>14.6%</td>
</tr>
</tbody>
</table>

(Source: Percent of youth who consumed 2 or more fruits in the last day, California Health Interview Survey, 2014, SPA)

**Hypertension**. About 60% of diabetics are very likely to develop heart disease at some point in their lives\textsuperscript{xli}. In the CVHP service area, nearly a third of the population (29.8%) were diagnosed with hypertension which is higher than the Healthy People 2020 goal (<=26.9%) and Los Angeles County (27.3%).

<table>
<thead>
<tr>
<th>Diagnosed with Hypertension</th>
<th>CVHP Service Area</th>
<th>LA County</th>
<th>HP2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29.8%</td>
<td>27.3%</td>
<td>&lt;=26.9%</td>
</tr>
</tbody>
</table>

(Source: Percent diagnosed with hypertension, California Health Interview Survey, 2014, SPA)

**Health Behaviors**

**Healthy Eating**. Not engaging in healthy eating behaviors, such as not consuming fresh fruit on a daily basis, could be indicative of unhealthy behaviors that may lead to health issues like obesity. In the CVHP service area, a slightly lower percentage of youth (54.0%) consumed two or more fruits a day when compared to Los Angeles County (57.3%); the rate is even lower when compared to California (63.3%).

<table>
<thead>
<tr>
<th>Youth Who Consumed Two or More Fruits A Day</th>
<th>CVHP Service Area</th>
<th>LA County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>54.0%</td>
<td>57.3%</td>
<td>63.3%</td>
</tr>
</tbody>
</table>

(Source: Percent of youth who consumed 2 or more fruits in the last day, California Health Interview Survey, 2014, SPA)
Physical Environment

Fast-Food Establishments. Environmental influences such as easy access to fast-food rather than healthy food options is a critical factor that contributes to poor health outcomes such as diabetes. In the CVHP service area, the rate of fast-food establishments per 100,000 population (76.4) was slightly lower when compared to Los Angeles County (77.8) and higher than in California (74.5).

# Social & Economic

Access to Healthy Foods. Access to affordable, healthy, high-quality food—including fresh fruit and vegetables—is essential to an individual’s overall well-being. Lack of access contributes to the development of health issues such as diabetes. In the CVHP service area, a large percentage of the population (40.6%) cannot afford enough food—higher than in Los Angeles County (39.5%) and California (38.4%).

<table>
<thead>
<tr>
<th></th>
<th>CVHP Service Area</th>
<th>LA County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to Afford Enough Food</td>
<td>40.6%</td>
<td>39.5%</td>
<td>38.4%</td>
</tr>
</tbody>
</table>

Source: Unable to afford enough food (food insecurity), California Health Interview Survey, 2014, SPA.

Assets & Opportunities

Stakeholders identified the following diabetes-specific and related assets through phone interviews and focus groups. Diabetes may also be addressed indirectly through programs and assets for obesity and efforts to encourage proper nutrition and physical activity. Additional resources can be found at www.211.org.

**Diabetes-Specific Assets**
- American Diabetes Association
- Asian Pacific Health Care Venture, Inc.
Mental Health in the CVHP Service Area

Description & Significance

Mental illness is a major and complex health issue; if left untreated, it may leave individuals at risk for substance abuse, self-destructive behavior, and suicide.

Mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression, and outcome of chronic diseases. Mental illnesses such as depression and anxiety affect people’s ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery. New mental health issues have emerged among some special populations, such as veterans who have experienced physical and mental trauma; people in communities with psychological trauma caused by natural disasters and exposure to violence; and older adults, as the awareness, understanding and treatment of dementia and mood disorders continues to improve. The stigma associated with mental health causes suffering, potentially leading a person to deny symptoms, delay treatment, and refrain from daily activities.

Health Outcome Statistics

The CVHP service area is experiencing mental health-related issues with youth and adults, as indicated in the Mental Health–Related Hospitalizations chart below. Issues include general mental health status, depression, anxiety, alcohol and drug use, access to mental health providers and services, hospitalizations related to mental health, and suicide.

Prevalence. In the CVHP service area, the population experienced an average of four mentally unhealthy days per month, similar to that reported in Los Angeles County.

Hospitalizations. In the CVHP service area, the mental health hospitalization rate per 100,000 adults was higher (616.8) when compared to California (540.9), and less than the county (677.0). The mental health hospitalization rate per 100,000 youth was much higher (451.6) than Los Angeles County’s (377.1) and twice California’s (294.8).
Health Disparities

Health disparities were observed among youth, the elderly, the low income, the middle class, the uneducated, the homeless, and communities mostly located in the western and central parts of the CVHP service area.

Communities Most Affected (Higher Hospitalization Rates Among Youth and Adults):

- Azusa
- Baldwin Park
- Covina
- El Monte
- Glendora
- La Puente
- La Verne
- San Dimas
- West Covina

Community Perspective

Stakeholders agreed that mental health affects “everyone” such as adolescents, teens, young adults, working-class professionals, low-income populations, non–English speakers, women and single mothers, parents, the elderly, younger members in the LGBT community, foster youth, homeless populations, and members across ethnic groups. The communities mentioned as most affected were Baldwin Park and San Gabriel. Glendora was mentioned for high suicide rates.

Key Health Drivers/Factors

Mental health is associated with factors such as poverty, heavy alcohol consumption, and unemployment.

Stakeholders described drivers of mental health as varied and complex. Everyday stress on working mothers, families, children, and homeless populations was identified as a contributor to mental health issues. Stakeholders agreed on the lack of education regarding mental health. Mental health is seen as unimportant or carrying negative associations, which prevents people from seeking help or recognizing their issues and seeking opportunities for assistance.

Community Perspective

“Mental health affects everyone across the board; some people fall through the cracks because mental illnesses aren’t always very apparent.”

Social Services Provider
Often people will not seek help because of the cultural stigma associated with accessing mental health services, particularly among Asians and Black/African-Americans. Children and adolescents receive care and support at some schools, though participants indicated that current efforts are insufficient. Among homeless populations, substance abuse is an issue commonly associated with degraded mental health. Immigrant and/or non–English speaking populations have a difficult time accessing mental health care because of a lack of multilingual providers or not being aware of available resources.

Stakeholders also identified barriers associated with insurance and funding for mental health services. Insurance does not cover all kinds of treatment for mental health issues; for example, dementia is often not considered a mental health condition. Securing timely appointments is also a concern; patients have to wait a long time to be seen, and there are not enough facilities to access during a crisis (e.g., 5150). Focus group participants highlighted the challenges in properly medicating mental health issues; for example, refill processes are complex and time-consuming. In general, participants stated that there is a lack of funding for mental health programs and care for adults 18 to 59 years of age, low-income populations, and the uninsured.

**Access.** The rate of mental health providers per 100,000 population in the CVHP service area is lower (149.5) than in California (157.0).lv

### Social & Economic

**Poverty.** Financial instability creates barriers to access including to insurance coverage, health services, healthy food, and other necessitieslv. The percent of the population living 200% below the FPL is slightly higher (47.2%) than in the state overall (40.7%).

<table>
<thead>
<tr>
<th>Population below 200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVHP Service Area</td>
</tr>
<tr>
<td>47.2%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014, SPA

### Assets & Opportunities

Many resources are available to respond to health needs within a given community, including health care facilities, community organizations, faith-based organizations and public agencies. The following list includes assets that have been identified as specifically addressing this health need and/or related key drivers and is an abbreviated list of mental health providers and services available, additional resources can be found at www.211.org.

#### Mental Health Providers

- AltaMed Medical and Dental Group  
  [http://www.altamed.org/programs_and_services/dental_services]
- Aurora Charter Oak Hospital
- Azusa Pacific University—Neighborhood Wellness Center
  [http://www.apu.edu/nursing/resources/community/](http://www.apu.edu/nursing/resources/community/)
- Center for Integrated Family and Health Services
- Citrus Valley Health Partners: Inter-Community Hospital and Queen of the Valley Campus
- Community Clinic Association of L.A. County
- East Valley Community Health Center
  [https://www.evchc.org/](https://www.evchc.org/)
- El Proyecto del Barrio, Inc.
  [http://www.elproyecto.us/](http://www.elproyecto.us/)
- Foothill Family Service
  [https://www.foothillfamily.org/index.php](https://www.foothillfamily.org/index.php)
- Hathaway Sycamores—Covina Community-Based Mental Health Services
  Phone: 1-844-222-2377
- Kaiser Permanente Baldwin Park Medical Center (Hospital)
  [www.kp.org/baldwinpark](http://www.kp.org/baldwinpark)
- Pacific Clinics—Family Outreach Services
- San Gabriel Children’s Center, Inc.
  Phone: 626-859-2089

**Alcohol and Drug-Related Services**
- SPIRITT Family Services—Glendora Family Center
Overweight and Obesity in the CVHP Service Area

Description & Significance

Being overweight is defined by maintaining a body mass index (BMI) between 25.0 and 29.9. Obesity is defined as having a BMI of 30.0 or higher.

Excess weight is a significant national problem and indicates an unhealthy lifestyle that influences further health issues. Obesity reduces life expectancy and causes devastating and costly health problems, increases the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases.\textsuperscript{lvii} Being overweight and obese may result from a combination of causes and contributing factors that include behavior and genetics.\textsuperscript{lviii} Behaviors can include dietary patterns, physical inactivity, medication use, and other exposures. Additional contributing societal factors may include food and physical activity, education and skills, and food marketing and promotion. Some Americans have less access to stores and markets that provide healthy, affordable food such as fruits and vegetables, especially in rural, minority, and lower-income neighborhoods.\textsuperscript{lix} Obesity is a serious concern and associated with a reduced quality of life and many serious diseases and health conditions including diabetes, heart disease, stroke, high blood pressure (hypertension), high cholesterol, and mental illness such as clinical depression and anxiety.\textsuperscript{lx} 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.\textsuperscript{lxii}

Health Outcome Statistics

The CVHP service area has a greater portion of population classified as overweight and obese when compared to Los Angeles County and California. The issue has become increasingly prevalent among children and youth.

Prevalence. In the CVHP service area, a greater percentage of teens between the ages of 12 and 17 (22.8%) were obese when compared to Los Angeles County (14.9%).

<table>
<thead>
<tr>
<th></th>
<th>CVHP</th>
<th>Los Angeles County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight Youth</td>
<td>19.5%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Obese Youth</td>
<td>19.1%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Overweight Teens</td>
<td>13.4%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Obese Teens</td>
<td>22.8%</td>
<td>14.9%</td>
</tr>
</tbody>
</table>

Source: Percent of youth (2–11 years old) are overweight, California Health Interview Survey, 2014, SPA. Percent of teens (12–17 years old) are obese, California Health Interview Survey, 2014, SPA.
Health Disparities

A greater percentage of Hispanic/Latino (22.5%) as well as Black/African American (21.6%) children in grades 5, 7, and 9 in the CVHP service area are obese relative to other races/ethnic groups. These percentages are also greater than that for the KFH-Baldwin Park service area (19.10%).

Stakeholders recognized health disparities among Hispanics/Latinos, Blacks/African-Americans, Asians, Pacific Islanders, youth as young as two years old, students in low-income communities, the homeless, and residents in the western and central areas of the CVHP service area.

Communities Most Affected (Teens Who Are Obese):

- Azusa
- Baldwin Park
- Covina
- El Monte
- La Puente
- South El Monte
- West Covina

Community Perspective

“We need to educate people so they make intelligent choices about nutrition.”

Social Services Provider

Key Health Drivers/Factors

Obesity is associated with an increased risk of cardiovascular disease, stroke, high blood pressure, diabetes, and a number of other health issues. Obesity is also associated with a lack of physical activity, access to healthy food options and safe green space such as parks, and other social and economic issues. Stakeholders remarked that the increase in access to and the marketing of fast food has contributed greatly to poor nutrition in the area, which is seen as a driver of obesity. Many also noted a lack of exercise and physical activity as a contributing factor, and many recognized the connection between obesity and diabetes, hypertension, and a range of liver diseases.
Health Outcome(s)

**Diabetes.** Diabetes and being overweight or obese often go hand-in-hand. In the CVHP service area, a larger percentage of the population (12.0%) was diagnosed with diabetes when compared to Los Angeles County (10.0%) and California (8.9%).

**Cardiovascular Disease.** Being overweight or obese often leads to health issues including cardiovascular disease. In the CVHP service area, more residents (381.2 per 100,000 population) were hospitalized for heart disease than in Los Angeles County (366.6) or California (339.0).

Health Behaviors

**Physical Activity.** A lack of physical activity is a contributing factor to an individual’s developing health issues, including being overweight or obese. In the CVHP service area, a slightly lower percentage of adults (26.1%) were physically inactive when compared Los Angeles County (29.7%).

**Healthy Eating.** Healthy eating behaviors such as not consuming fresh fruits and vegetables on a daily basis may prevent health issues like obesity. In the CVHP service area, a slightly lower percentage (54.0%) of youth consumed two or more fruits a day than in Los Angeles County (57.3%), and even lower than in California (63.3%).

Social & Economic

**Access to Healthy Foods.** Access to healthy, high-quality, affordable food—including fresh fruit and vegetables—is essential to an individual’s overall well-being. The lack of such access contributes to the development of health issues such as being overweight or obese. In the CVHP service area, a larger percentage of the population (40.6%) could not afford enough food than in Los Angeles County (39.5%) or California (38.4%).
Physical Environment

**Fast-Food Establishments.** Environmental influences such as easy access to fast-food rather than healthy food options is a critical factor that contributes to poor health outcomes such as being overweight or obese. In the CVHP service area, the rate of fast-food establishments per 100,000 population (76.4) was slightly lower than in Los Angeles County (77.8) but higher than in California (74.5).

**Recreation and Fitness Facilities.** Environmental influences such as access to recreation and fitness facilities are important in encouraging physical activity and other healthy behaviors. In the CVHP service area, the rate of recreation and fitness facilities per 100,000 population (4.5) is nearly half that in Los Angeles County (7.6) or California (8.7).

### Fast-Food Establishments

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<td>76.4</td>
<td>77.8</td>
<td>74.5</td>
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Source: Fast-food establishment rate per 100,000 pop., U.S. Census Bureau, County Business Patterns, 2011, Tract.

### Recreation and Fitness Facilities

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<th>CVHP Service Area</th>
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<td>4.5</td>
<td>7.6</td>
<td>8.7</td>
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</table>

Source: Recreation and fitness facilities rate per 100,000 pop., U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012, ZCTA.

**Assets & Opportunities**

Stakeholders provided resources in the community that address obesity indirectly through an increase in physical activity and improving nutrition. There was also mention of a program in the region that addresses barriers to nutrition and exercise in the community. The following list provides the assets that were identified through interviews and focus groups. Additional resources can be found at [www.211.org](http://www.211.org).

**Diabetes-Related Services**

- American Diabetes Association
- American Heart Association
  [http://www.heart.org/](http://www.heart.org/)
- Asian Pacific Health Care Venture, Inc.
  [http://www.aphcv.org/](http://www.aphcv.org/)
- Citrus Valley Health Partners: Inter-Community Hospital and Queen of the Valley Campus
- Kaiser Permanente Baldwin Park Medical Center (Hospital)
  [www.kp.org/baldwinpark](http://www.kp.org/baldwinpark)
Physical Activity-Related Services
- City of Baldwin Park—Healthy Baldwin Park Program
- Bike San Gabriel Valley
  http://www.bikesgv.org/
- Enki Health and Research Systems, Inc.
  http://www.ehrs.com/
- Walking Groups

Nutrition and Wellness-Related Services
- Azusa Pacific University—Neighborhood Wellness Center
  http://www.apu.edu/nursing/resources/community/
- Baldwin Park Unified School District
  http://www.bpusd.net/
- Boys and Girls Club of Baldwin Park
  http://www.evbgc.org/
- Foodbanks
  https://www.lafoodbank.org/get-help/pantry-locator/
- Los Angeles Community Garden Council
  http://lagardencouncil.org/
- New Horizons Caregivers Group
  http://www.nhcg.org/
- THINK Together
  http://www.thinktogether.org/
- West Covina Unified School District
  http://www.wcusd.org/
Appendix E: Glossary of Terms

The following terms are used throughout the Community Health Needs Assessment report. They represent concepts that are important to understanding the findings and analysis in this report.

**Age-adjusted rate.** The incidence or mortality rate of a disease can depend on the age distribution of 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 of some diseases than another community that may have a higher number of younger people. An incidence or mortality rate that is age-adjusted takes into the consideration of the proportions of persons in corresponding age groups, which allows for more meaningful comparison between communities with different age distributions.

**Benchmarks.** A benchmark serves as a standard by which a community can determine how well or not well it is doing in comparison for specific health outcomes. For the purpose of this report, one of two benchmarks is used to make comparison with the medical center area. They are Healthy People 2020 objectives and state (California) averages.

**Death rate.** See *Mortality rate*.

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

**Health condition.** A health condition is a disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

**Health disparity.** 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 of research literature on health disparity focuses on racial and ethnic differences in how these communities experience the diseases, but health disparity can be correlated with gender, age, and other factors, such as veteran, disability, and housing status.

**Health driver.** Health drivers are behavioral, environmental, social, economic and clinical care factors that positively or negatively impact health. For example, smoking (behavior) 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 needs.
**Health indicator.** A health indicator is a characteristic of an individual, population, or environment which 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.

**Health outcome.** A health outcome is a snapshot of a disease in a community that can be described in terms of both morbidity and mortality (e.g. breast cancer prevalence, lung cancer mortality, homicide rate, etc.).

**Health need.** A health need is a poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

**Hospitalization rate.** Hospitalization rate refers to the number of patients being admitted to a hospital and discharged for a disease, as a proportion of total population.

**Incidence rate.** Incidence rate is the number of *new* cases for a specific disease or health problem within a given time period. It is expressed either as a fraction (e.g. percentage) or a density rate (e.g., \( x \) number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with prevalence rate, which measures the proportion of people found to have a specific disease or health problem.

**Morbidity rate.** Morbidity rate refers to the frequency with which a disease appears within a population. It is often expressed as a prevalence rate or incidence rate.

**Mortality rate.** Mortality rate refers to the number of deaths in a population due to a disease. It is usually expressed as a density rate (e.g. \( x \) number of cases per 10,000 people). It is also referred to as “death rate.”

**Prevalence rate.** Prevalence rate is the proportion of total population that currently has a given disease or health problem. It is expressed either as a fraction (e.g. percentage) or a density rate (e.g., \( x \) number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with incidence rate, which focuses only 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 of number suffering that disease (prevalence) because people are living longer due to better screening or treatment for that disease.

**Primary data.** Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this community health needs assessment, primary data were collected through focus groups and interviews with key stakeholders. These primary data describe what is important to the people who provide the information and are useful in interpreting secondary data.

**Secondary data.** Secondary data are data that have been collected and published by another entity. They are typically quantitative (numerical) in nature. Secondary data are
useful in highlighting in an objective manner health outcomes that significantly impact a community.
Focus Group Summary

About the Participants

There were five focus groups conducted in October that included 59 representatives from community representatives, health experts, local government representatives, local business owners, and social and health service providers.

Community Health Needs

Focus group participants identified 17 major health needs including obesity, heart disease, cancer, mental health, alcohol and substance abuse, access to care, and respiratory diseases. The health needs most often mentioned by focus group participants were:

- Access to care
- Alcohol and substance abuse, including tobacco use
- Cancer
- Diabetes
- Mental health
- Oral health

Associated Health Drivers

In addition, to discussing major health needs affecting individuals in the community, focus group participants were also asked to describe the most important socio-economic, behavioral, environmental or clinical factors, or drivers, that are contributing to poor health in the community. A variety of health drivers were mentioned including lack of: health access, education, insurance/care literacy, resources, healthy food and physical activity; to poverty, homelessness, and mental health.

The most frequently mentioned health driver was access to health care issues. They also added that emergency rooms are overburdened and community members turned to alternative medicines and self-diagnosing using internet resources.

Disparities

Focus group participants were also asked to identify areas in the community that were most affected by poor health which included Baldwin Park, La Puente, El Monte, South El Monte, Azusa, Covina and West Covina. They also added that the identified health factors affected the broad population with only a few specific health conditions affecting some sub-populations more than others. For example, culturally sensitive health care greatly affects the undocumented and immigrant sub-populations.

Additionally, most of the health factors identified by participants in the health provider focus group identified youth, young adults and the LGBT youth as the most affected sub-populations. They also added that foster youth are most often involved in homicides, have poor mental health and substance abuse issues. And focus group participants attributed this to low health literacy, and their inability to access health care systems and services.

Services Most Difficult to Access

When asked, what health or social services are most difficult to access or are missing in the community, participants in social service provider focus group shared that holistic care or wrap-around services; dental care; mental health; vision care; services for individuals with special needs; and assistance navigating health care were the most difficult services to access.

Participants from the social service provider’s focus group highlighted dental care as unaffordable and
therefore families traveled to Mexico to receive affordable dental care. In terms of mental health, it is reported there are many mental health services in San Gabriel Valley and Service Planning Area 3; however, mental health services are only available for patients with full medical coverage (non-emergency medical) and mostly for youth sub-populations (less availability for older sub-populations). For vision care, the greatest need is eye glasses. And families with children with disabilities often do not know what a special need is or where to go to receive help.

Participants from the non-traditional service focus group noted the difficulty in accessing culturally competent, trusting and religious sensitivity services. For example, some specific religious sub-populations are opposed to transfusion treatments.

**Suggested Strategies for Addressing Health**

To address the aforementioned health needs, participants suggested several effective program and service delivery models. For example, to deal with obesity issues; access to healthy and affordable food; and increase physical activity, the BUILD Health Challenge model was selected. The program encourages communities to build meaningful partnerships between hospitals, health departments and community-based organizations to improve overall health. The local BUILD chapter is called Healthy Ontario Initiative of Ontario, and is led by Partners for Better Health, County of San Bernardino Department of Public Health and San Antonio Regional Hospital.

The School-Based Health Centers (SBHCs) program was also suggested to address the health of children in grades K-12. The SBHC program allows students to receive immediate assistance at school for acute and chronic conditions, as well as, preventative care. This model allows students to stay in school and teachers to focus only on teaching. A total of five SBHCs are located in El Monte.

In Anaheim, a one-year pilot program was recently created to improve care in response to urgent calls. The $500,000 project is a collaboration with Care Ambulance Service, Citrus Valley Health Partners, local fire fighters and nurse practitioners riding alongside paramedics on non-urgent calls.

When directly asked about KP Baldwin Park and Citrus Valley’s community members’ ability to access care and other services, as a result of the Affordable Care Act (ACA), the majority of the focus group responded negatively.

**Impact of the Affordable Care Act**

Although the Affordable Care Act (ACA) had positively impacted the number of newly insured, those with pre-existing health conditions, those with previous coverage now paying lower deductibles (for some) and those who now obtain prescriptions without a problem. More health coverage is needed and more assistance and education, especially for young adult sub-populations, on how to navigate the ACA’s health system and services (e.g. the hotline “is not very useful;” getting help takes much time and patient; individuals are unaware of alternative care practices like yoga, acupuncture, etc.).

More importantly, because more are insured through the ACA, there is a higher demand on providers and services and thus has lowered the current supply and compounded the pre-existing need of access to health care. Additionally, focus group providers point out, due to lower Medi-Cal reimbursement rates, throughout the service area, there are not enough providers accepting Medi-Cal and they are limited by the number of allowable types of services and patient tests. Additionally, the community is lacking in quality of care and specialty care. Furthermore, special needs patients have difficulty accessing therapy due to the fact families now have to go through their

“We felt very little change – we were expecting more people to qualify and come in, and they never did. But we are seeing people that didn’t have insurance that now do. There are benefits for the poor. If you didn’t have something before, now you do.”

– Mental Health Care Provider
Collaborating with Others

In the last few years, focus group participants perceived changes in the way health and social service providers worked together. Mental health providers now come together to learn how their services intersect and are more willing, and push, themselves to integrate services. For example, the ‘Health Neighborhoods’ model, to facilitate referrals and communication across organizations, was created through the Department of Mental Health. In the city of Azusa, Azusa Pacific University collaborates with Parks and Recreation, local police, non-profits and Wellness Centers to learn about what types of services intersect and to encourage engagement. This model is also in cities of Glendale and Covina.

On the other hand, participants perceived local collaborations as forced because “funding sources have been running dry.” And social service participants point out the difference between “real collaborations” and “paper collaborations” as agreements in written in MOUs. For non-traditional social service agencies, the response was more positive. They have observed and increase in mobile clinics, health fairs and health clinics. For instance, there is a health clinic located across from a hospital in West Covina that offers a convenient health service to quickly access care in a non-emergency setting. CVS, Walmart and Walgreens now offer walk-in community clinics. And employer insurance providers offer incentives for health maintenance. Mt. San Antonio College offers a Wellness Center for faculty and staff.

Participants from the promotora focus group agreed there were not enough partnerships in the region. And many community members (especially undocumented migrants) do not qualify for existing resources. Additionally, community events and workshops are provided; however, many community members work twelve hour shifts, have more than one job, or even a regular job, and are unable to attend and are left without health information. Those who might be able to attend avoid these events out of fear and ask if immigration services and/or the police will be present. In fact, participants highlighted that these are the sub-populations that need the information and the services the most. One participants added that, “we have to try to adapt to people, rather than people adapt to available services, like offer information in times and ways that people can access it.”

Ways of Sharing the CHNA Findings and other information

Participants suggested disseminating available health and social services information in a way that made it relatable to each audience group. They also suggested offering information in a bilingual format and ensuring the material is culturally sensitive.

Other suggestions included:

- Messaging resources should contain infographics and visuals for illiterate sub-populations. For example, with some social groups, messages concerning their children may resonate better, for other groups ‘scare tactic’ messages may be more effective (e.g. homicide rates, colon cancer rates). Note: print versions are not as effective when a large portion of the population cannot read (e.g. illiteracy, English-deficiency).
- Partnering with city and transportation organizations. For example, list the clinics and locations where the information and resources are available and post it on every bus stop and homeless shelter. It is also possible to tap into the school district and distribute information through schools and disseminate information using a peer-to-peer format.
• Presenting at the Baldwin Park Resident Advisory Committee for 20-50 resident members (depending on the topics covered) whom have contact and distribution lists and disseminate post cards; and
• Connecting with faith-based organizations, school nurses, Health Fairs and Farmer’s Markets.

Participants also suggest connecting with churches and faith-based organizations, and also recommend:
• Messaging should include changing diet recommendations for diabetics (e.g. Hispanic/Latino sub-populations). It’s not enough to say “you need to eat differently” but provide the education to go along with the messaging;
• Working with government offices and local elected officials;
• Conducting community outreach – there is a need for more community outreach, before it gets to the emergency room situation;
• Presenting at community events, such as ‘Concerts in the Park’; and using
• Social media.

Level of Severity and Importance by Health Needs and Health Drivers
Focus group participants were specifically asked to rank a pre-identified list of community health needs and health drivers, or factors, on a scale from 1 to 5. The first ranking was a measure of Severity, where 1 is least severe and 5 is most severe, with severity defined as the degree to which a health need or health driver affects the health and lives of individuals in the community.

The second ranking involved Prioritizing each health need or health driver by level of importance for the hospital to address, with 1 representing not important and 5 as very important to address.

The following health needs were ranked as the most severe:
• Diabetes
• Mental health
• Obesity
• Oral care
• Substance abuse

The following health drivers were ranked as the most severe:
• Access to care
• Lack of access to healthy foods
• Unhealthy behaviors including lack of physical activity
• Lack of health literacy
• Lack of preventative care

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ii Percent who could not afford to see a doctor for a health problem, Los Angeles County Health Survey, 2011, SPA.
iii Community Commons. Kaiser Permanente Community Health Needs Assessment, CHNA In-Depth Report, West Los Angeles.
Emanate Health

VII

Citrus Valley Health Partners
Inter-Community Hospital • Queen of the Valley Hospital
Foothill Presbyterian Hospital • Citrus Valley Hospice • Citrus Valley Home Health
www.cvhp.org

Citrus Valley Medical Center, Inc.
Inter-Community Campus – 210 W. San Bernardino Road, Covina, CA 91723-1515
License # 930000131

Queen of the Valley Campus – 1115 S. Sunset Ave., West Covina, CA 91790-3940
License # 930000131

Foothill Presbyterian Hospital – Morris Johnston Memorial
250 S. Grand Ave., Glendora, CA 91741-4218
License # 930000052
# 2016 Community Benefit Needs Assessment

## Implementation Strategy

**2017-2019**

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General Information

Contact Person: Maria Peacock, Director, Community Benefit

Written Plan Effective Date: March 22, 2017

Date Plan was Authorized and Adopted by Authorized Governing Body: March 22, 2017

Written Plan adopted and approved by: CVHP, CVMC, CVH, FPH BOARDS OF DIRECTORS

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 ❌ The new regulations indicate:

(5) When the implementation strategy must be adopted--(i) In general. For purposes of paragraph (a)(2) of this section, an authorized body of the hospital facility must adopt the implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA described in paragraph (b)(1) of this section, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.

Date Facility's Prior Written Plan Was Adopted by Organization's Governing Body: March 2, 2014.

Name and EIN of Hospital Organization Operating Hospital Facility:

Citrus Valley Health Partners, Inc.
Citrus Valley Health Partners - EIN # 95-3885523

Address of Hospital Organization: 140 W. College Street, Covina, CA 91722
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.

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 multiple participating agencies and diverse collaborative relationships 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 and underinsured populations.

CVHP’s vision is to be an integral partner in elevating communities’ health through collaboration and partnerships. This is the principle that guides all community health improvement and community benefit initiatives. Some highlights include CVHP’s Get Enrollment Moving program, also known as GEM, enrollment specialists work in collaboration with community-wide partners to recruit eligible families and enroll them in the different Medi-Cal programs and other health access programs for low-income uninsured and underinsured populations to access health care services. Enrollment is followed by three separate calls to ensure confirmation of coverage, utilization of services, advocacy, problem solving and assistance with renewal. Since conception, Every Child’s Healthy Option (ECHO) has been a collaborative effort 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. CVHP actively engages in community planning in partnership with the Health Consortium of the Greater San Gabriel Valley.

CVHP’s Diabetes and Lighten-Up San Gabriel Valley programs offer culturally competent disease prevention approaches as well as best practices to chronic disease management with the support of CVHP’s clinical and nutrition professionals including community multidisciplinary partnerships. CVHP in partnership with First 5 LA, offer a health and psychosocial maternal/child program through home visitation during the prenatal and postpartum stages. CVHP has been diligent and responsive to the health coverage changes by offering outreach and education in the community on the Affordable Care Act/MediCal Expansion, Covered California market place, and other free and low-cost access programs.
IV Rationale for Implementation Strategy

CVHP’s Community Needs Implementation Strategy is being adopted 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 needs 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 highest needs identified in the 2016 Community Health Needs Assessment.

V Citrus Valley Health Partners Service Area

CVHP’s Service Area is characterized by significant disparities in income. One in five people in the SPA 3 - San Gabriel Valley service area population lives below 100% of the Federal Poverty Level (23% overall and 20% of children), while a larger percentage (47%) lives below 200% of the Federal Poverty Level. There are 2,612 homeless people in SPA 3 - San Gabriel Valley, most of who are mentally ill (30%), suffer from substance abuse problems (25%), or are physically disabled (22%).

The Citrus Valley Health Partners hospital generally serves residents surrounding the hospital in the East San Gabriel Valley region and does not exclude low-income or underserved populations. The cities/communities in CVHP’s service area are Azusa, Irwindale, Baldwin Park, Covina, Diamond Bar, El Monte, Glendora, Hacienda Heights, City of Industry, La Puente, Bassett, Valinda, La Verne, Rowland Heights, San Dimas, South El Monte, Walnut and West Covina. CVHP’s service area is part of the SPA 3 (Service Planning Area 3 of Los Angeles County).
The CVHP service area has a total population of 905,984 representing 8.8% of the total population in Los Angeles County (10,237,502) and 2.3% of the total population in California (39,356,473). The total population in the CVHP service area is projected to increase at a slower rate of 3.2% by 2021 than Los Angeles County (4.1%) and California (4.8%).

In 2010, the total population within CVHP service area 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).

Since the 2013 report, the ratio of females to males has remained steady, and in 2016 nearly divided in half by females (50.9%) and males (49.1%). CVHP age distribution is consistent with that of the county and state. Youth between the ages of 0 and 17 comprise 23.0% of the population in the CVHP service area, adults between the age of 18 and 64 comprise 63.7%, and senior adults 65 years and older comprise 13.2% of the population. 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, and 2.1% are African American. Over a quarter (26.9%) of the population has less than a 9th 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; another significant portion of the population speaks an Asian/Pacific Island language (18.9%) at home. While the service area’s income distribution is skewed slightly higher than the county and state, a significant number of households have lower income levels. Almost 20 percent of households (18.4%) had household incomes between $50,000 and $74,999, followed by household incomes between $35,000 and $49,999 (12.6%) and $75,000 and $99,999 (14.0%). A slightly higher percentage of the population in the SPA 3 – San Gabriel Valley (22.2%) lives in households below 100% of the Federal Poverty Levels (FPL). CHNAs show that the rate has risen sharply over time going from 12% in 2010 to 22.2% in 2014.
## VI List of Identified Community Health Needs

Below is the summary list in alphabetical order of the identified health needs in the CVHP’s 2016 Community Health Needs Assessment:

1. Access to health care
2. Access to healthy foods
3. Alcohol abuse, substance abuse and tobacco use
4. Alzheimer’s disease
5. Cancer
6. Cardiovascular disease
7. Cultural and Linguistic Barriers
8. Diabetes
9. Economic Security
10. Healthy Behaviors
11. Housing
12. Hypertension
13. Mental Health
14. Oral Health
15. Overweight and obesity
15. Physical Environment
16. Preventive Healthcare
17. Respiratory disease
18. Violence and injury prevention

## VII Individuals Involved in the Development of the Implementation Strategy

Tracy Dallarda, Chief Communications and Advocacy Officer  
Maria Peacock, Director, Community Benefit Programs

## VIII Availability of the 2016 Community Health Needs Assessment (CHNA) to the Public

CVHP has implemented several strategies to make the report widely available to the general public within the service area:

1) CVHP’s website [http://www.cvhp.org/Patient_Resources/Community_Needs_Assessment.aspx](http://www.cvhp.org/Patient_Resources/Community_Needs_Assessment.aspx)

2) On November 4th of 2016, Citrus Valley Health Partners and Kaiser Permanente Baldwin Park presented the joint tri-annual community health needs assessment at a breakfast for state and local government representatives, non-profits, community-based organizations, faith communities, school districts, community colleges, public and private agencies, residents, institutions of higher education, public health department, department of health services, mental health department and agencies, etc. It is estimated that 100 community representatives attended this event and were provided with a hard copy and digital copy of the full report. This year, Senator Ed Hernandez, 22nd Senate District provided special remarks at the community presentation.

3) The report findings and hospital priorities are shared with the Health Consortium of the Greater San Gabriel Valley. The group conducts community planning and a coalition of local safety net organizations serving the lower-income populations of the Greater San Gabriel Valley (SGV).

4) The report is available upon request to CVHP’s Community Benefit Department.
IX Health Needs that Citrus Valley Health Partners will address in years 2017-2019

Process and Criteria Utilized in the Selection

Citrus Valley Health Partners Chief Communications and Advocacy Officer and the Director of Community Benefit engaged in an examination and analysis process of the broader list of community health needs identified in the 2016 CHNA. The comprehensive review process was designed with the purpose of identifying the community needs that can best be addressed by the hospital organization taking in consideration assets and expertise and community partnerships. The core factors that drove the process were: 1) High Community Need and 2) Feasibility to create an impact.

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 High 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.

Following is the conceptual criteria utilized for this process:

High 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:

- Consider CVHP’s relevant capacities and initiatives within the integrated health system.
- Ability to leverage: opportunities to collaborate with existing and new community partners working to address the need, to build on current programs and efforts, identify and support emerging innovative opportunities, and other assets.
**SELECTED COMMUNITY NEEDS TO BE ADDRESSED**

Health outcomes and drivers were taken into account because of their interconnection with community needs considering that they can negatively or positively impact individual health.

**CVHP PRIORITY HEALTH FOCUS AREAS**

**Area of Focus I:**

Increase Diabetes Prevention Strategies and Disease Management Best Practices.

**Area of Focus II:**

Increase access to Mental Health and Behavioral Health services and enhance service capacity through provider collaboration.

**Area of Focus III:**

Increase Awareness and Improve Access to education and resources focusing on the reduction of Obesity and Overweight.

**Area of Focus IV:**

Improve Access to Health Care.
Area of Focus I: Increase Diabetes Prevention Strategies and Disease Management Best Practices

Diabetes decreases 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 indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity. In addition to heart disease, diabetes is also associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis. Gestational (developing diabetes during pregnancy) diabetes occurs more frequently among Black/African-Americans, Hispanic/Latino Americans, American Indians, and people with a family history of diabetes. Women who have had gestational diabetes have a 35% to 60% chance of developing diabetes in the next 10 to 20 years.

Prevalence: In the CVHP service area, 12.0% of the population 20 years and older were diagnosed with diabetes, which is higher than in Los Angeles County (10.0%) and California (8.9%). Hospitalizations: More adults in the CVHP service area were hospitalized for diabetes (200.5 per 100,000 population) when compared to Los Angeles County and California. Nearly three times the number of adults in the CVHP service area were hospitalized for uncontrolled diabetes (13.5 per 100,000 population) than in Los Angeles County (4.5), and more than four times the number than in California overall (2.8).

Goal: Increase awareness of diabetes education and services and create greater access points for better chronic disease management.

Strategy I: DECREASE INADEQUATE HEALTHCARE ACCESS

Partners: CVHP physicians & staff; community physicians, local pharmacies, Welcome Baby Program, etc.

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<tr>
<th>Objective</th>
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<tbody>
<tr>
<td>Provide Ambulatory Care Services</td>
<td>1) Preventative education by ADA-recognized educators 2) Pharmacist-driven medication management for chronic disease states (diabetes, hypertension, hyperlipidemia) and function as a resource to the patient and multidisciplinary team. o Improve patient satisfaction—pts are already verbalizing they can reach the team, easier and appreciate the extra time spent with them. o Achieve measurable outcomes to enhancing patient’s quality of life.</td>
<td>1. A1c reduction 2. Hospital re-admission rate 3. Participant satisfaction 4. Medication adherence 5. Continue ADA-required data collection, including behaviour modification results.</td>
</tr>
</tbody>
</table>
- Reduce re-admissions to the hospital and utilization of EDs. Patient can call the team with questions, rather than go to Urgent Care/EDs.
- Utilize Pharmacist as "middle man" between Retail Pharmacist/Patient and Physician/Patient. Physicians can focus more on other concerns, rather than the chronic diseases.
- Accessibility and availability of pharmacists help patients to feel less alone in new diagnosis of chronic disease state, provides great deal of emotional support.
- Educate patient so that they identify problems early and receive expedited treatment rather than wait before a problem becomes more severe. For example, how to recognize early signs of eye and foot disease so that they seek additional preventative services.
- Improved access to medications. Turn-around time for refills is high. The Pharmacist can help obtain the medications they need or offer appropriate substitutions.
- Identify women in our Sweet Success program that want to prepare for the next pregnancy and get them medically cleared for pregnancy.
- Bridge gap between medication efficacy/safety and medication adherence. Meds will not work if patients decide not to take it.
- Provide continuous DM management in ambulatory care setting, deterring high-risk patients from "falling through the cracks" upon d/c or upon new diagnosis post-PCP visit.

3) Monitor medication side-effects/adverse effects associated with chronic disease state management.
**Strategy II:** DISPARITIES FOR WOMEN OF CHILDBEARING AGE

Objectives and Activities

**Partners:** CVHP Medical Staff, East Valley Community Health Center (FQHC).

<table>
<thead>
<tr>
<th>Objective</th>
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<tbody>
<tr>
<td>1 Support optimal health and planning for the next pregnancy</td>
<td>• Utilize existing outpatient diabetes services to help women achieve their pre-pregnancy goals</td>
<td>• Evaluate all Sweet Success patients for pre-conception care</td>
</tr>
<tr>
<td>2. Reduce the risk of miscarriage and malformations</td>
<td>• Partnership with East Valley Community Health Center to provide a medical home so that the women are screened and provided preventative health maintenance to assure optimal health for the woman planning the next pregnancy.</td>
<td>• Evaluate outcomes for those women who received pre-conception care</td>
</tr>
</tbody>
</table>
Area of Focus II: Increase access to Mental Health and Behavioral Health services

The CVHP service area is experiencing mental health–related issues with youth and adults. Mental Health disparities were observed among youth, the elderly, the low income, the middle class, the uneducated, the homeless, and communities mostly located in the western and central parts of the CVHP service area.

Prevalence. In the CVHP service area, the population experienced an average of four mentally unhealthy days per month, similar to that reported in Los Angeles County.

Hospitalizations. In the CVHP service area, the mental health hospitalization rate per 100,000 adults was higher (616.8) when compared to California (540.9), and less than the county (677.0). The mental health hospitalization rate per 100,000 youth was much higher (451.6) than Los Angeles County's (377.1) and twice California’s (294.8).

Goal: Expansion of Mental Health Services and Provider Coordination

Strategy I: BUILD PROVIDER CAPACITY THROUGH COLLABORATION

Build capacity among the local physical health, mental health and substance use disorder (SUD) providers to better serve patients and community, including primarily the lower-income, vulnerable and immigrant populations residing in Citrus Valley Health Partners service area. Community Partner: Greater San Gabriel Valley Physical & Behavioral Health Integration Committee.

Objectives & Activities

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<tr>
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</table>
| 1. Convene the network on a regular basis to facilitate implementation of purpose. | • Plan meeting schedule and agendas.  
• Submit meeting notices.  
• Complete meeting notes to document discussion items and decisions. | • Meeting agendas will document the plan/focus of each meeting.  
• Meeting notes documenting discussion.  
• Presentation slides and/or hand outs.  
• Evidence of sharing mental health assessment tools |
| 2. Facilitate and support shared learning, capacity building and coordination of care with focus on 3 topics: [1] Emerging best practices; [2] Shared assessments & screening tools; and 3) accessing Los Angeles County mental health services. | • Hold meetings and/or forums focused on the three topics including expert speakers/presenters. | • Meeting agendas will document the plan/focus of each meeting.  
• Meeting notes documenting discussion.  
• Presentation slides and/or hand outs |
Strategy II: **ASSESS THE NEEDS FOR COMMUNITY-BASED FOLLOW-UP SUPPORT.**

Support would be provided by a professional Psychiatric Pharmacist that will focus on this specific condition.

**Objectives and Activities**

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<thead>
<tr>
<th>Objective</th>
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</table>
| 1. Partner with Western University to bring on board a qualified psychiatric pharmacist on a part-time base. | • Develop MOU with Western University  
• Bring on a psychiatric pharmacist 3 times a week.  
• Develop and conduct assessment  
• Review findings and determine priority needs  
• Research resources to respond to the findings/needs. | • Partnership documentation  
• Psychiatric Pharmacist on board.  
• Assessment tool.  
• Determine priority needs  
• Proposal and budget  
• Implementation |
| 2. Conduct needs assessment. | | |
| 3. Determine priorities to design a psychiatric specific pharmacy program to respond to needs. | | |

**Strategy III:** **ADDRESS BEHAVIORAL HEALTH DRIVES FOR OBESITY AND OVERWEIGHT.**

**Objectives and Activities**

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</table>
| 1. Collaborate with other mental health programs on improving the individual overall health by addressing “drivers” (i.e. obesity, overweight, diabetes, cardiovascular disease, etc.). | 1. Weigh-In Events  
2. Inclusion in community education and presentations.  
3. Welcome Baby/maternal depression component.  
4. Diabetes programs | 1. Included mental health education and resources in all activities. |

**Strategy IV:** **INCREASE ACCESS TO OUTPATIENT MENTAL HEALTH SERVICES.**

**Objectives and Activities**

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<tr>
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</table>
| Partner with East Valley Community Health Center, an FQHC clinic, to enhance access to outpatient mental health services by a Psychiatric Nurse Practitioner and Licensed Social Workers. | Work collaboratively with the Clinic to support improving access to outpatient mental health services to low-income uninsured and underinsured individuals and children. | • Number of mental health professionals providing services  
• Decrease in the wait time for appointments |
**Strategy V:**

**DEPRESSION AND RISK ASSESSMENTS FOR PRENATAL AND POST PARTUM WOMEN.**

**Partners:** Welcome Baby Program, Los Angeles Best Babies Collaborative; Perinatal Mental Health Program and Health Consortium of the San Gabriel Valley’s Behavioral Health Committee.

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</table>
| Partner with the San Gabriel Valley area Welcome Baby Program to conduct assessments to pregnant and post partum women. Referrals for mental health services. | • Administer the PHQ9 Assessment.  
• Administer the Bridges for Newborns Assessment.  
• Provide meaningful referrals for mental health services.  
• Follow-up to ensure that the participant successfully receives services. | • Number of mental health professionals providing services  
• Decrease in the wait time for appointments |
**Area of Focus III: Increase Awareness and Improve Access to education and resources focusing on the reduction of Obesity and Overweight.**

Associated health needs consist of hypertension, diabetes, cardiovascular disease, obesity and overweight. The CVHP service area has a greater portion of population classified as overweight and obese when compared to Los Angeles County and California. The issue has become increasingly prevalent among children and youth. **Prevalence.** In the CVHP service area, a greater percentage of teens between the ages of 12 and 17 (22.8%) were obese when compared to Los Angeles County (14.9%).

Greater percentages of Hispanic/Latino (22.5%) as well as Black/African American (21.6%) children in grades 5, 7, and 9 in the CVHP service area are obese relative to other races/ethnic groups.

**Goal:** Increase awareness and access to the Lighten-Up SGV program, resources and services.

CVHP’s innovative weight loss support program Lighten-Up SGV will continue in years 2017-2019. This is a free program which offers the community and 3,000 CVHP employees monthly workshops in a wide variety of health improvement, healthy life styles, prevention, meal preparation, and wellness topics as well as resources to help participants lose weight through awareness and by using any plan they choose. For more information, please see the attached flier. A cadre of community partners is an intricate part of this program from design.

**Strategy I: BI-ANNUAL COMMUNITY WEIGHT LOSS CHALLENGE**

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<th>Objective</th>
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| 1. Weight loss challenge. | • Conduct community “weigh-in” events annually.  
• Professional health providers and volunteers conduct health screenings including weight, blood pressure, etc. The information is documented to compare at the subsequent weigh-in event in June.  
• Special event includes information tables of a variety of community partners who offer nutrition and fitness information. Including exercise modalities such as Yoga, Zumba, etc.  
• L.A. Fitness offers discounted registration prices for interested participants.  
• Monthly series of FREE classes featuring presentations by CVHP experts and community partners  
• 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  
• CVHP will award cash prizes to community and CVHP employee winners. The first place for indivudal and team categories will receive $250 cash.  
• Participant will receive a design bag with information and resources to help them continue to lose weight and be entered into a drawing for a door prize. | • Personal and/or team screening results are shared with participant.  
• Record of Educational Workshops and Presentations.  
• Records of participants  
• 6-month evaluation of improvement.  
• Number of participants  
• Number of pounds lost by individuals and teams.  
• Record of Awards and Recognition provided.  
• Anecdotal stories |
| 2. Dedicated program website at [www.lightenupsgv.com](http://www.lightenupsgv.com) | • Provides social networking features to encourage discussion. Message boards such as Weight Watchers, seniors and new moms.  
• Access to a significant number of health, weight loss and wellness articles.  
• Links to Healthy Partners groups and businesses providing health services. | • Number of hits and interactive participation. |
|---|---|---|
| 3. Dedicated Facebook Page | • Facebook page with a focus on youth.  
• Free profile page, regular blog posts on weight loss and fitness tips.  
• Seek partnerships with school districts and/or youth organizations. | • Will monitor friends of the facebook page and interactions.  
• Partnerships with youth organizations. |
| 4. Focus on becoming more active and health educated vs. Weight loss. | • Focus messaging and promotion on resources and education to maintain healthy lives. | • Flyers, social media messaging, Elevations publication, etc. |
Area of Focus IV: IMPROVE ACCESS TO HEALTH CARE.

Access to health care is a driving factor that affects various aspects of maintaining good health, including: people’s overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy. Financial instability creates barriers to access, including insurance coverage and health services. Furthermore, cultural and linguistic barriers can create inequities.

In the CVHP service area, 21.3% of the population does not have health insurance and 16.7% does not have a usual place to go for medical advice or to receive treatment when sick. Further, a greater percentage (27.7%) could not afford to see a doctor than in Los Angeles County (16.0%). The southeast portion of the CVHP service area seemed most affected by a lack of health coverage according to U.S. Census statistics. In particular, 20.7% of Hispanic/Latino populations lack a consistent source of primary care, and 21.8% non-Hispanic white populations needed access to mental health care.

Goal: Outreach, Screen, Enroll and Follow-up Assistance for the uninsured and/or underinsured in CVHP’s service area.

Strategy I: CONDUCT COMMUNITY OUTREACH

Objectives and Activities

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<th>Objective</th>
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</table>
| 1. Conduct outreach, education, presentations, promotion and information in target areas working in partnership with community agencies, school districts, WIC, etc. | 1. Identify data of service areas with higher number of uninsured.  
2. Schedule outreach activities including community events.  
3. Conduct phone outreach to respond to referrals and inquiries.  
4. Analyze outcomes to strategize as needed. | 1. Enter outreach reports in the data entry system.  
2. Identify trends and results. |

Strategy II: ENROLLMENT ASSISTANCE

Objectives and Activities

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<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Tracking Method</th>
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</table>
| 1. Provide health insurance enrollment assistance to uninsured individuals and families for Medi-Cal, Covered California, and any other low cost health access programs. | 1. Enrollment counsellors screen and complete application for free and/or low-cost health insurance. | 1. Number of applications completed.  
2. Compare statistics of uninsured with the 2019 CHNA data. |
**Strategy III: ENROLLMENT VERIFICATION**

**Objectives and Activities**

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<tbody>
<tr>
<td>1. Conduct follow-up contact to confirm successful enrollment with at least 80% of applications assisted.</td>
<td>1. Call participants to ask if they have received their insurance card/approval. If unable to reach client, check the Meds system to verify enrollment outcomes.</td>
<td>1. Enrollment verification reports.</td>
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**Strategy IV: ASSISTANCE WITH PROBLEM SOLVING AND SYSTEM NAVIGATION**

**Objectives and Activities**

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<tr>
<td>1. Provide ongoing assistance to people experiencing problems with enrollment, utilizing benefits, or retention of health insurance. 2. Offer system navigation support.</td>
<td>1. Conduct troubleshooting/problem solving and advocacy services. 2. Offer utilization of services assistance to ensure that the person is accessing health, dental and vision services. 3. Educate participants on how to navigate the health system. 4. Assist with completing the Medi-Cal packet including plan and physician selection.</td>
<td>1. Completed forms with assistance documented. 2. Data records of number of people contacted and assisted.</td>
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**Strategy V: INSURANCE RETENTION ASSISTANCE**

**Objectives and Activities**

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<tr>
<td>1. Offer assistance with redetermination and/or renewal of health insurance. 2. Achieve rate of retention at least 80%.</td>
<td>1. Contact participants by telephone to determine if they have completed the redetermination forms or if they need assistance. 2. Provide determination assistance as needed.</td>
<td>1. Completed retention verification forms. 2. Completed renewal assistance forms. 3. Data report of success.</td>
</tr>
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</table>
## Strategy VI: INCREASE ACCESSIBILITY TO OUTPATIENT SERVICES AT COMMUNITY SITES.

**Goal:** Increase access to health care services at community-based locations.

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<th>Objectives</th>
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</table>
| 1. Increase accessibility to needed outpatient services through expansion of community-based service capacity. | • Seek community partnerships to increase accessibility to outpatient services in CVHP’s service area.  
• Focus partnerships in specialty care services to increase access at the community level rather than travelling to the hospital. | 1. Number of Partnerships.  
2. List of specialties available at community locations.  
3. Other outcomes |
| 2. Increase and enhance access to emergency services to meet community needs. | • Expansion of the Inter-Community Hospital emergency room services.  
• InQuicker online appointment scheduling for non-emergencies. | • Report on additional capacity of services as a result of the expansion. |
| 3. Increase capacity of hospital physician services to the community through a Partnership with East Valley Community Health Center (FQHC) and University of Southern California Keck School of Medicine to add a Family Residency Program. | • Complete administrative processes.  
• Interview candidates  
• Start residency program | • Completed administrative and contractual activities.  
• # of Candidates Interviewed  
• # of Residents selected  
• Start Date. |

## Strategy VII: INFORMATION DISSEMINATION ON GOVERNMENT CHANGES FOR ACCESSING HEALTH INSURANCE

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<th>Objectives</th>
<th>Activities</th>
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</table>
| 1. Information campaign on repeal and replace the Affordable Care Act. | • Information dissemination on updates and health access changes as a result of the new federal government administration’s mandate to “repeal and replace.”  
• GEM Project will communicate changes and will support community members in maintaining health coverage and access to health services as much as possible.  
• CVHP’s Elevations publication will provide information and updates. | • Report on strategies and information disseminated.  
• Report on barriers and challenges experienced by the community. |
1. 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.

2. Monitoring activities will include the collection and documentation of tracking measures, such as the number of grants made, accounting of financial resources spent and number of people reached and assisted.

3. CVHP will conduct research on best practices to be able to measure community impact.

4. 2016 CHNA Implementation Plan programmatic and financial updates will be provided via the annual SB-697 Community Benefit Report.
Emanate Health

VIII

2016 SB-697 CHNA Implementation Plan Update
Emanate Health
(Formerly Citrus Valley Health Partners)

Emanate Health
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

2018 CHNA Update Report - Implementation Strategies

Citrus Valley Health Partners (CVHP)

As the largest, nonprofit health care provider for the residents of the East San Gabriel Valley, Emanate Health 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, Emanate Hospice and Emanate Home Health in West Covina. Nearly one million residents in the East San Gabriel Valley rely on CVHP for their health care needs.

While Emanate Health 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.

Citrus Valley Health Partners Community Benefit

Emanate Health 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, Emanate Health has a charity care policy in place to respond to the needs of low-income uninsured populations.

Emanate Health’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.

**Community Benefit Implementation Strategy**

Emanate Health’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 2016 Community Health Needs Assessment.

**CITRUS VALLEY HEALTH PARTNERS**

*Update on Implementation Strategies to Address Health Needs*

*2017 - 2019*

**Priority Health Needs**

**Area of Focus 1**

**INCREASE AWARENESS AND ACCESS TO MENTAL HEALTH PROGRAMS AND SERVICES.**

**Goal: Improve Access**

- **Construction of a Federally Qualified Health Center (FQHC) to meet community health access needs.**

1. The Federally Qualified Health Center opened its doors as East Valley Community Health Center (EVCHC) in March of 2015. CVHP’s partner clinic is located across the street from Inter-Community Hospital in the city of Covina, CA. In four years, the new health center has been providing medical care and mental health services for children and adults; women's health services, including prenatal and family planning; diabetes; hypertension and asthma treatment. The health center also cares for homeless individuals and families as well as the remaining uninsured in Emanate Health’s service area. CVHP continues to partner and provide support to the FQHC.
East Valley Community Health Center employs a multidisciplinary mental health staff that provides an array of services to improve the quality of life for each patient and their families. The FQHC offers integrated mental health services ensuring our patient’s mental health and medical needs are met. The mental health team provides unique treatment plans to serve each client or family’s specific needs, including individual therapy for children or adults, couples’ therapy, prenatal support groups, anxiety/depression support groups, and referrals and other resources. The Health Center has put in place a coordinated and effective referral system for at-risk individuals in need to access outpatient mental health services on a timely manner. EVCHC’s Behavioral Health Director the Emanate Health Inter-Community ER Director are joining efforts in program development and grant writing to increase much needed behavioral health resources for the communities we serve.

**Emanate Health Family Residency Program Partnership with FQHC.**

“Emanate Health’s partnership with EVCHC has strengthened with the development and implementation of our Emanate Health Family Medicine Residency Program (FMRP). Our charter class of ten residents joined the program in 2017. In 2018, we additionally recruited our second class of ten residents and recruitment efforts for our third class were underway with the goal of having our full complement of 30 residents by July 1, 2019. The residency program aspires to provide care in a family-oriented, community-focused and evidence-based manner. We incorporate prevention and health promotion as well as comprehensive culturally-sensitive care to the diverse populations served by the EVCHC and Emanate Health. The FMRP continues to focus on developing innovative curriculum emphasizing community collaboration, leadership development in community outreach and education, and expertise in community health needs assessment and in population health strategies. In 2018, our residents’ educational experience included the development of a resident-led, longitudinal community project wherein a partnership was formed with a local vendor to provide free vegetables to EVCHC patients. Residents have also integrated into community outreach efforts through participation in health fairs and mobile HIV screening. The Emanate Health FMRP is committed to robust training in evaluation of process and outcomes via resident participation in both outpatient and inpatient Quality Improvement efforts as well and by resident training and certification in Lean Six Sigma. Our residents have been trail blazers and integral to the continued development and success of the FMRP.”

- **Increased awareness, collaboration and community capacity.**

Emanate Health continues to support and partner with The San Gabriel Valley Health Consortium to strengthen the local health care network by building capacity among the local physical health, mental health and substance use disorder providers to better serve their patients and clients, including primarily the lower-income, vulnerable and immigrant populations residing within Service Planning Area (SPA) 3; i.e., the Greater San Gabriel Valley. Capacity building activities address ongoing and emerging issues and changes that impact service delivery, including:
• Creating a forum that promotes strategic thinking, coordinated planning and sharing of opportunities and lessons learned. Providing and sharing information and updates on Los Angeles County services, data, state initiatives, etc.;

The Consortium partners include local Federally Qualified Health Centers (FQHCs); community clinics; hospitals; the Los Angeles County Departments of Health Services, Public Health and Mental Health; and other nonprofits including community-based organizations.

Emanate Health in partnership with the Health Consortium strengthens the local health care and mental health care network by building bridges and capacity among a variety of stakeholders that translates in improved access to services and increased efficiency for the communities we serve.

Based on CVHP’S 2016 CHNA, Emanate Health’s financial and collaborative partnership address the following priority areas.

4: Mental health (Outcome)
5: Access to health care (Driver)
9: Alcohol abuse, substance abuse and tobacco use (Outcome)

INTEGRATION COMMITTEE OF HEALTH AND MENTAL HEALTH PROVIDERS

1) Emanate Health Community Benefit leadership continued to be an active participant and supporter of the Integration Committee as a group of provider partners who presented and shared education and tools to enhance services through best practices. The group worked together in 2018 to collaborate and identify gaps in services. Committee members include physical health, mental health and Substance Use Disorder (SUD) public and private providers who work together to advice on and participate in planning activities. Committee members continued to collaborate and support each other.

2) In 2018, the CEO of Community Clinic Association of Los Angeles County (CCALAC), shared with The Consortium Integration Committee partners background information about countywide Integration Summits that CCALAC spearheaded in Los Angeles over the past year with the overall goal of improving integration between physical health, mental health and substance use services. Key integration issues identified at those Summits were (1) Referral relationships; (2) Co-management and coordination of care; and (3) Data sharing. People also expressed a desire for similar events at local/regional levels, which led to planning follow-up Summits in other areas in Los Angeles County. CCALAC approached the Health Consortium of Greater SGV about providing leadership for the Summits in Service Planning Area 3 (San Gabriel Valley).

San Gabriel Valley Health & Mental Health Summits I & II

The SGV Consortium Integration Committee took strong interest in holding two Summits and committed to working as a planning committee to help develop the events. Emanate Health jointly with the Integration Committee engaged in summit planning from October-December of
2018. The summits are scheduled for March 5, 2019 and May 7, 2019. The summit reports will be included in Emanate Health’s community benefit update for YR 2019.

Primary target constituency:

Entities located in or that serve the San Gabriel Valley, including Department of Mental Health and its provider network, Substance Abuse Program and its provider network, Community Health Centers/Clinics, hospitals, and other organizations that are involved in the Health Consortium of Greater SGV. If feasible within the space constraints, there is also interest in inviting law enforcement, clergy and community/education members, and staffers from L.A. County Supervisors Solis, Hahn and Barger’s office.

Planning:

- Reviewed/finalized Summit goals.
- Reviewed/discussed invite list.
- Set agenda for Integration Summit #1.
- Identified potential panelists/speakers.
- Identified a group/speaker that can present an existing integrative model or a “glimmer of hope” story (where two branches are working together but other areas of integration are still being worked on).
- Discussed the facilitation of attendees’ break-out groups.

Community Partner Planning Agencies:

Azusa Pacific University School of Nursing and Counseling Center; L.A. County Department of Public Health; San Gabriel Valley Economic Partnership; Beacon Health; Options; L.A. County Department of Mental Health; Community Clinic Association; Emanate Health; L.A. County DHS Whole Person Care; YWCA San Gabriel Chapter; American Cancer Association; and Chinatown Service Center.

Integration Summit Content:

1. In order to determine focus for the Summits, a brief survey for attendees was implemented to help prioritize possible discussion topics when they register. Survey topics will build off the priority list from the previous summits and will added additional topics identified by the Integration Summit Committee. For example, understanding benefits and staying enrolled).
2. A kickoff panel for each summit was identified to highlight a model of integration, preferably in the San Gabriel Valley.
3. Identify future follow-up steps from the two Summits and a plan for continuing to move forward with both the people’s ideas and recommendations.
4. Identifying any support that attendees may need to expand their program capacity (grant writing, applications for programs, etc.).
ACCESS TO HEALTH AND MENTAL HEALTH SERVICES
STRATEGY: COMMUNITY OUTREACH, HEALTH INSURANCE ENROLLMENT AND COVERAGE RETENTION SERVICES.

- Education on how to access services, enrollment verification, troubleshooting and retention services are provided to ensure continued coverage for at-risk communities in Emanate Health’s service area through the GEM (Get Enrollment Moving) outreach program co-sponsored by Emanate Health and a grant from the Los Angeles County Department of Public Health.

2018 Update:

1) Enrollment:
GEM completed a total of 2,240 applications for health insurance for low-income uninsured children, families, pregnant women, and seniors. The programs include MediCal, Covered California, and Medical Access Program (former AIM). People who do not qualify for the programs are referred to the Safety Net Programs such as My Health L.A. to access physical, behavioral and substance abuse health services.

2) Troubleshooting/Advocacy Assistance:
GEM assisted 2,679 residents with troubleshooting and advocacy as well as teaching (educating) community how to navigate the complex healthcare system keep their coverage and access services. It is important to mention that the trend of a high number of participants were seeking assistance to fix complex and time consuming Medi-Cal and Covered California insurance coverage issues. This support is provided to ensure that people do not lose their coverage.

3) Verification of Enrollment:
45 to 60 days after the insurance application is submitted, GEM contacts all clients to confirm enrollment and assists with completing “my medical choice” packet to select a health plan and the providers of their choosing. If the person has additional questions or experiences barriers, the GEM staff provides technical assistance. Enrollment verification efforts have shown excellent results with a 90% of applicants being confirmed enrolled in the insurance program.

4) Utilization Assistance:
Once the enrollment verification is completed, the GEM specialist has a follow-up procedure to contact each client at the six (6) month post-enrollment mark to confirm that the client(s) is (are) utilizing their health, mental health, dental and other benefits. This is another opportunity to identify any access issues that arise with access, quality, and utilization. The results in the CHOI data system indicate that 88% of confirmed enrolled participants were reached and received appropriate utilization assistance services.
5) Redetermination and Retention:
   Eleven months after enrollment all participants are contacted once more to ensure that participants have received and completed their renewal/redetermination form. Often, participants with low literacy level, utilize GEM in-person support services to complete and upload the required documents to maintain coverage and thus, remain insured. In 2018, the program reached 90.78% of enrollees who completed their redetermination (renewal) process for the following year.

6) Community Referrals:
   Program participants received referral services to other health access programs such as My Health LA; California Children’s Services, Department of Public Health Personal Health and Mental Health Services, Early Detection Programs, etc. In addition, the GEM staff provides information on where to obtain low cost Legal Services, Food Access, Housing, Homeless Shelters, Rent Assistance, etc.

- Food access is an important determinant of health and the GEM (Get Enrollment Moving) program staff extended its services to offer assistance in food access programs. The GEM program completed 85 Cal-Fresh applications. The majority of the time the beneficiaries are more than one, particularly if it is a family, therefore, it is reasonable to conclude that the number of adults and children that benefited from this resource is higher than 85.

ACCESS TO HEALTH AND MENTAL HEALTH SERVICES THROUGH HOME VISITATION - WELCOME BABY PROGRAM

Introduction:
Welcome Baby is a voluntary, universal home visitation program offered at no cost to all mothers giving birth, or planning to give birth, at participating Welcome Baby hospitals in Los Angeles County. Program eligibility is based on the families’ needs and not driven by income. Welcome Baby is a First 5 LA funded program that works with families to maximize the health, safety and security of the baby and parent-child relationship as well as to facilitate access to support and services when needed. Emanate Health– Queen of the Valley Hospital is a participating hospital and in partnership with First 5 LA.

Key Community Partners
In addition to First 5 LA, the key collaborative and oversite partner agencies are Los Angeles Best Babies Network (LABBN); Maternal Child Health Access (MCHA); and Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PACLAC) who provide technical assistance, training and supports in the implementation and success of the program.

Emanate Health Queen of the Valley Hospital as a participating hospital, serves the San Gabriel Valley communities with a specific focus on two identified high need/risk cities, El Monte and South El Monte. Through a combination of engagements in the home, at the hospital following delivery, and one-on-one in-home or phone visits. Welcome Baby Public Health Nurses, Parent
Coaches and Hospital Liaisons provide mothers with personalized support at each stage of pregnancy, after delivery, and through the child’s first nine months of age.

“The Welcome Baby (WB) program at Emanate Health – Queen of the Valley Hospital continued to provide services to families in the San Gabriel Valley. In 2018, WB served 1,923 pregnant and postpartum women and provided 1,291 psychosocial full assessments to identify the risk level and the need for services. Fathers are welcome to co-participate.”

The program’s objective is to support and provide information and resources to pregnant and postpartum mothers in an effort to 1) Enhance mother-infant attachment. 2) Increase parental understanding of child development. 3) Increase exclusive breastfeeding rates. 4) Screen for perinatal depression and link moms to mental health resources. 5) Increase dental screening during pregnancy. 6) Ensure access to prenatal, postpartum and ongoing health and behavioral health care for mothers. 7) Increase the receipt of timely postpartum care.

In 2018 Welcome Baby (WB) program at Emanate Health– Queen of the Valley Hospital served 1,923 pregnant and postpartum women and of those women, 1,291 received a full assessment to identify the psychosocial risk level and eligibility for participant. Welcome Baby is part of a Family Strengthening Network of programs that work together to provide supportive services to families with newborns. The assessment, Bridges for Newborn is used to identify risk levels in three main areas: 1) basic needs, 2) physical health, and 3) psychosocial needs. Mothers are screened for maternal depression using the Patient Health Questionnaire (PHQ2/9) which is conducted at each engagement. In July 2018, the WB began utilizing the Generalized Anxiety Disorder Assessment (GAD-7) tool at specific timeframes during the postpartum period. WB Hospital Liaisons approached 1,936 mothers at bedside after delivery. In addition, 1,291-women received an assessment to find that 1,031 women scored 50+ points which is considered high risk. The results indicate that 80% of assessed participants had high risk factors. A total of 61 patients were referred for more intensive services to agencies within our Family Strengthening Network.
Community Resources

WB program completed 2,404 engagements in the home and by phone in efforts to support these women and their families and made over 1,549 referrals to community resources for food, housing, mental health services, Medi-Cal coverage assistance, immigration, education, vocational programs, etc. The largest numbers of referrals at 45% are in Basic Needs such as diapers and baby essentials. The second largest percentage of referrals at 22% was to assist families to secure healthcare insurance. The third highest number of referrals 11% at nutrition/infant feeding. The remaining 514 referrals include: a) Mental/Behavioral Health; b) Benefit Services; c) Crisis Intervention; d) Education and Employment; e) Developmental Concerns/Prevention; f) Family Recreation and Enriched Activities; g) Legal Services;

Area of Focus 2:

INCREASE AWARENESS AND IMPROVE ACCESS TO PROGRAMS, EDUCATION AND SERVICES FOCUSING ON THE REDUCTION ON OBESITY AND OVERWEIGHT CONDITIONS.

Priority Health # 2

Goal: Increase awareness and access to Lighten Up SGV program, resources and services.

CVHP has made a commitment to address obesity reduction and prevention as a key component for the next three years.

Lighten Up SGV (San Gabriel Valley)

In 2018, Emanate Health implemented its ongoing campaign to increase community awareness about overweight and obesity in our communities and offer a comprehensive support program for community members who want to lose weight and become healthier.

Strategy I: Weigh-in Event

In 2018 Emanate Health offered the bi-annual weight loss contest with the purpose of increasing awareness and to improve access to programs, education and services focusing on the reduction of Obesity and Overweight conditions as well as promoting healthy lifestyles.

The program model offers two (2) Weigh-In events/Weight loss contests.

- January-June of 2017 and
- Total event attendees: 265
1) Community residents were widely invited to attend and register at the Weigh-In events. During the health screening process, participants create a record of their individual results of their weight, blood pressure, body fat and body measurements.

2) Emanate Health employees were also invited to participate in this program. A special weigh in session was added for those who could not attend the days of the event.

3) CVHP’s Nutritionists offered formal presentations such as the “Heart Healthy Eating”.

4) The events featured a variety of partner agencies/programs in attendance. They provided resources, education and information on nutrition, exercise and healthy life style opportunities. Participant partners included: Elements Natural Foods, Fitness 19; LA Fitness; Nutrishop Glendora; Take Shape for Life and others.

CVHP conducts a special ceremony to acknowledge every one’s accomplishments and to give special prizes to the individuals who lost the most weight. The prizes include:

**HIGHEST PERCENTAGE OF WEIGHT LOST - INDIVIDUAL**

- Grand Prize (Community Member) $250 cash
- Second Place (Community Member) $100 cash
- Third Place (Community Member) $50 cash

- Grand Prize (Emanate Health Employee) $250 cash
- Second Place (CVHP Employee) $100 cash
- Third Place (CVHP Employee) $50 cash

**HIGHEST PERCENTAGE OF WEIGHT LOST - TEAM**

- Grand Prize (Community Members) $250 cash
- Grand Prize (CVHP Employees) $250 cash

**Outcomes:**

*The 2018 outcome for Lighten-up SGV program accounts for 236 participants and a total joint weight loss of 730.8 pounds jointly.*
Strategy II:  FREE Educational Classes:

*Featuring education presentations by CVHP experts and community partners:*

Heart Healthy Eating  2/08/18  
Healthy Food Ideas  3/08/18  
Ins and Outs of FAD Dieting  4/12/18  
Mediterranean Diet  5/10/18  
Rethink your Drink  7/12/18  
Healthy Summer Fair  8/09/18  
Understanding Gut Health  9/13/18  
Fact or Fiction about Miracle Foods  10/11/18

Strategy III: Dedicated Lighten Up SGV Program Website

The “Lighten Up SGV (LUSGV) program includes social networking features to encourage discussions on the topic.

- The URL to access the website is [www.lightenupsgv.com](http://www.lightenupsgv.com)
  Social networking features to encourage discussion: Message boards (for example: Weight Watchers, Seniors, New Moms, etc.), free user profile page and regular blog posts on weight loss and fitness tips.
- Access to more than 100 health and weight loss articles.
- Links to healthy living Partners, groups and businesses providing health services.
- Dedicated FACEBOOK page.

The LUSGV Program promotes healthy living and awareness that obesity and overweight compromise a person’s current and future health and quality of life.
Area of Focus I: Increase Diabetes Prevention Strategies and Disease Management Best Practices

2018 Update

Diabetes decreases 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 indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity. In addition to heart disease, diabetes is also associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis. Gestational (developing diabetes during pregnancy) diabetes occurs more frequently among Black/African-Americans, Hispanic/Latino Americans, American Indians, and people with a family history of diabetes. Women who have had gestational diabetes have a 35% to 60% chance of developing diabetes in the next 10 to 20 years.

Prevalence: In the CVHP service area, 12.0% of the population 20 years and older were diagnosed with diabetes, which is higher than in Los Angeles County (10.0%) and California (8.9%). Hospitalizations: More adults in the CVHP service area were hospitalized for diabetes (200.5 per 100,000 population) when compared to Los Angeles County and California. Nearly three times the number of adults in the CVHP service area were hospitalized for uncontrolled diabetes (13.5 per 100,000 population) than in Los Angeles County (4.5), and more than four times the number than in California overall (2.8).

Goal: Increase awareness of diabetes education and services and create greater access points for better chronic disease management.

Strategy I: DECREASE INADEQUATE HEALTHCARE ACCESS

Partners: CVHP Physicians and Staff; Community Physicians; Local Pharmacies and the Welcome Baby Program.
## Objective

- Provide Ambulatory Care Services
- Plan is to see 8 patients per day—Monday through Thursday

## Activities

1. Preventative education by ADA-recognized educators
2. Pharmacist-driven medication management for chronic disease states (diabetes, hypertension, hyperlipidemia) and function as a resource to the patient and multidisciplinary team.
   - Improve patient satisfaction—patients are already verbalizing they can reach the team, easier and appreciate the extra time spent with them.
   - Achieve measurable outcomes to enhance patient’s quality of life.
   - Reduce re-admissions to the hospital and utilization of EDs. Patient can call the team with questions, rather than go to Urgent Care/EDs.
   - Utilize Pharmacist as “middle man” between Retail Pharmacist/Patient and Physician/Patient. Physicians can focus more on other concerns, rather than the chronic diseases.
   - Accessibility and availability of pharmacists help patients to feel less alone in new diagnosis of chronic disease state, provides great deal of emotional support.

## Tracking Method

1. A1c reduction
2. Hospital re-admission rate
3. Participant satisfaction
4. Medication adherence
5. Continue ADA required data collection, including behavior modification

## Qualitative/Quantitative Data

**Is this strategy working? 2018 Update**

1. A1c: 5.8% reduction with enrolled patients with < 0.1% hypoglycemia.
2. Re-admission rate = None due to diabetes issues.
3. Patient Satisfaction
   a. “You saved my life!”
   b. “Why did it take so long for someone to help me like this?”
   c. “I want to keep seeing you because of the care I get!”
   d. “I have a new referral from my physician so I can see you! My diabetes got worse when I was just seeing my physician.”
4. Medication adherence > 95%, secondary to greater access to a provider and medications.
5. ADA data collection ongoing with most behavior modifications at 90% or greater.
Educate patient so that they identify problems early and receive expedited treatment rather than wait before a problem becomes more severe. For example, how to recognize early signs of eye and foot disease so that they seek additional preventative services.

- Improved access to medications. Turnaround time for refills is high. The Pharmacist can help obtain the medications they need or offer appropriate substitutions.

- Identify women in our Sweet Success program that want to prepare for the next pregnancy and get them medically cleared for pregnancy.

- Bridge gap between medication efficacy/safety and medication adherence. Meds will not work if patients decide not to take it.

- Provide continuous DM management in ambulatory care setting, deterring high risk patients from “falling through the cracks” upon d/c or upon new diagnosis Post-PCP visit.

2) Monitor medication side-effects/adverse effects associated with chronic disease
## Strategy II: DISPARITIES: WOMEN OF CHILDBEARING AGE

### Objectives and Activities

**Partners:** CVHP Medical Staff, East Valley Community Health Center (FQHC) and Welcome Baby Program.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Tracking Method</th>
<th>Qualitative/Quantitative Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support optimal health and planning for the next pregnancy</td>
<td>o Utilize existing outpatient diabetes services to help women achieve their pre-pregnancy goals</td>
<td>o Evaluate all Sweet Success patients for pre-conception care.</td>
<td>Currently working on a grant related to nutrition to prevent the onset of diabetes in those with previous history of diabetes during pregnancy.</td>
</tr>
<tr>
<td>2. Reduce the risk of miscarriage and malformations</td>
<td>o Partnership with East Valley Community Health Center (FQHC) to provide a medical home so that the women are screened and provided preventative health maintenance and mental health services to assure optimal health for the woman planning the next pregnancy.</td>
<td>o Evaluate outcomes for those women who received preconception care.</td>
<td></td>
</tr>
</tbody>
</table>
## Strategy II: Prevent Re-admission in Chronic Disease States Specific to CHF, COPD, Pneumonia and Diabetes

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Tracking Method</th>
<th>Qualitative/Quantitative Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce risk of adverse events, including re-admission</td>
<td>o Nutrition modification specific to disease state</td>
<td>o Medication Reconciliation with each contact</td>
<td>Chronic Disease Management clinic opened in October, 2018. Data is currently being collected.</td>
</tr>
<tr>
<td></td>
<td>o Medication management</td>
<td>o Attendance to scheduled appointments.</td>
<td></td>
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<tr>
<td></td>
<td>o Equipment access</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Life Coach</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Free Pap smears</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Free mammograms</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Free flu shots</td>
<td></td>
<td></td>
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<tr>
<td>Enhance appropriate utilization of health care resources</td>
<td>o Medication Reconciliation with each contact</td>
<td></td>
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<tr>
<td>Increase access for wellness</td>
<td>o Attendance to scheduled appointments.</td>
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</tbody>
</table>
### Breakdown of Enrollment by Health Insurance Program
**Period:** January 2018-December 2018

<table>
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<tr>
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<td><strong>MCAP</strong></td>
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<td>0</td>
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<td><strong>Emergency Medi-Cal</strong></td>
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<td>13</td>
<td>8</td>
<td>5</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>11</td>
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<td><strong>Medi-Cal</strong></td>
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<td>179</td>
<td>165</td>
<td>178</td>
<td>174</td>
<td>166</td>
<td>194</td>
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<td>136</td>
<td>178</td>
<td>168</td>
<td>136</td>
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<td><strong>Medi-Cal Share of Cost</strong></td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td><strong>MC-TLIP</strong></td>
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<td>1</td>
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<td>3</td>
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<td><strong>COV-CA</strong></td>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>19</td>
<td>19</td>
<td></td>
<td>82</td>
</tr>
</tbody>
</table>

**Total Applications:** 2,240

Exhibit 1
# Community Outreach, Insurance Enrollment, Retention, and Utilization Report

Period: January 2018-December 2018

<table>
<thead>
<tr>
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<tr>
<td><strong>Community Outreach</strong></td>
<td>338</td>
<td>326</td>
<td>312</td>
<td>597</td>
<td>332</td>
<td>479</td>
<td>449</td>
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<td>535</td>
<td>1173</td>
<td>373</td>
<td>328</td>
<td>5,592</td>
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<td><strong>Applications</strong></td>
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<td>190</td>
<td>183</td>
<td>191</td>
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<td>182</td>
<td>203</td>
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<td>143</td>
<td>185</td>
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<td><strong>Referrals</strong></td>
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<td>171</td>
<td>164</td>
<td>151</td>
<td>139</td>
<td>178</td>
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<td>125</td>
<td>179</td>
<td>174</td>
<td>123</td>
<td>1,884</td>
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<tr>
<td><strong>Investigated Enrollment</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Enrollment Confirmed</strong></td>
<td>90.22%</td>
<td>84.02%</td>
<td>88.41%</td>
<td>87.20%</td>
<td>86.32%</td>
<td>86.89%</td>
<td>94.24%</td>
<td>91.35%</td>
<td>86.26%</td>
<td>90.15%</td>
<td>95.63%</td>
<td>96.50%</td>
<td>89.74%</td>
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<tr>
<td><strong>Troubleshooting / Advocacy Assistance</strong></td>
<td>215</td>
<td>217</td>
<td>192</td>
<td>218</td>
<td>248</td>
<td>230</td>
<td>233</td>
<td>262</td>
<td>213</td>
<td>252</td>
<td>202</td>
<td>197</td>
<td>2,679</td>
</tr>
<tr>
<td><strong>Utilization Assistance</strong></td>
<td>91%</td>
<td>89%</td>
<td>87%</td>
<td>86%</td>
<td>86%</td>
<td>92%</td>
<td>89%</td>
<td>80%</td>
<td>88%</td>
<td>97%</td>
<td>87%</td>
<td>89%</td>
<td>88.24%</td>
</tr>
<tr>
<td><strong>Redetermination Assistance</strong></td>
<td>90.23%</td>
<td>94.05%</td>
<td>91.08%</td>
<td>92.59%</td>
<td>89.16%</td>
<td>92.00%</td>
<td>86.33%</td>
<td>91.03%</td>
<td>90.48%</td>
<td>90.98%</td>
<td>86.89%</td>
<td>85.53%</td>
<td>90.16%</td>
</tr>
<tr>
<td><strong>Other Assistance</strong></td>
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<td>71</td>
<td>80</td>
<td>73</td>
<td>91</td>
<td>96</td>
<td>55</td>
<td>67</td>
<td>49</td>
<td>74</td>
<td>43</td>
<td>69</td>
<td>840</td>
</tr>
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updated 05/24/19
Exhibit 3

Lighten Up SGV
Community Weigh-In Event!
Saturday, June 23, 2018
Queen of the Valley Hospital
Oakwood Room
115 S. Sunset Ave.
West Covina, CA

→ NEW Weight Loss Challengers register and weigh in for the Lighten Up SGV! challenge
→ RETURNING Weight Loss Challengers re-weigh for prizes (appointments necessary)
→ FREE giveaways & door prizes
→ Lighten Up SGV! Awards Ceremony

To RSVP call (888) 456-2847
www.lightenupsgv.com for more information

Individuals (ages 12 and up) and teams of 5 are eligible. A $250 cash prize will be awarded for highest percentage of weight lost at the next weigh-in event on Saturday, November 3, 2018. Program sponsored by Citrus Valley Health Partners.
Emanate Health

IX

Free Community Health Improvement, Education, and Wellness Programs
Community Education & Outreach

Emanate Health (formerly Citrus Valley Health Partners or “CVHP”) 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

Emanate Health 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 Emanate Health 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
   - A Healthier You
   - Childbirth Education
   - Diabetes Education

   - Cancer Resources & Programs
   - Hospice & Bereavement Services
   - Lighten Up SGV

   Multiple departments coordinate all activities, classes and programs.

3. Emanate Health/CVHP Resource Center – located in the Professional Plaza building of the Inter-Community Campus, 315 N. Third St., Ste. 307, Covina, CA 91723. The center offers the community an opportunity to check out books, review reference books and find nearby support groups.

4. 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.

5. 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
   - Medical Groups

   Documentation of Public Education – Programs, events and classes are listed on the organization’s website and may be also advertised in the local media and with special fliers and mailings.
2018 EMANATE HEALTH PROGRAMS AND GOALS

Emanate Health 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 2018, Emanate Health continued to follow Community Outreach Goals.

In 2019, Emanate Health will continue to work with community partners to offer preventative education and resources

In 2019, Emanate Health will continue to provide programs and services to enhance awareness of clinical services.

In 2019, Emanate Health will maintain the number of events offering free health screenings.

The eight (8) operational program categories are:

A Healthier You that provide monthly evening and luncheon programs on physical or mental health topics, programming specific to seniors, 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, Breastfeeding Basics, Sibling Classes, Infant Massage, and Maternity open house and tours are available.

Diabetes Education counseling and support groups to help patients learn how to live with and manage diabetes.

Emanate Health Resources & Programs that include multiple, bi-lingual support groups, programs for free or low cost wigs and programs to help women cope with the physical changes of cancer treatments.

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.

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)
Look Good, Feel Better (partnership with American Cancer Association)
Mended Hearts (partnership with American Heart Association)
Programs & services to enhance Emanate Health’s services

Breast-Feeding Educational Classes
Breastfeeding Support Groups
Lamaze – Childbirth Education Class
Sibling Class
Adults con Diabetes Grupo de Apoyo
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
Stroke support group
Yoga for the Cancer Patient
CVHP Resource Center
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
Understanding Stroke
A FREE community stroke awareness and screening event

Thursday, January 18, 2018 • 5-7:30 p.m.
Screenings/Resource booths: 5-6:30 p.m.
Dr. Cheung physician lecture: 6:30-7:30 p.m.

Geleris Family Education Center
427 W. Carroll Ave. • Glendora, CA 91741
- Physician lecture on stroke symptoms & treatment
- Blood pressure screenings
- Carotid artery and glucose screening*
- Resource booths and giveaways

To RSVP, call (888) 456-2847.

* Free carotid artery and glucose screenings to first 75 people who register.
Attendees must keep their appointment time or lose forfeit their test.

Foothill Presbyterian Hospital
An Affiliate of Conejo Valley Health Partners
Citrus Valley Heart Center
An Affiliate of Citrus Valley Health Partners

LOVE YOUR Heart

Women’s Heart Tea
Thursday, February 15, 2018
6-7:30 p.m.

Join us for high tea and dinner and enjoy a lecture educating women on the risks of heart disease.

To RSVP, please call (888) 456-2847. For more information, visit www.cvhp.org.

Glendora Country Club
Grille Room
12400 Country Club Dr., Glendora, CA 91741
LOVE YOUR Heart

Women's Heart Tea
Thursday, February 15, 2018
6-7:30 p.m.

Join us for high tea and dinner and enjoy a lecture educating women on the risks of heart disease.

Glendora Country Club
Grille Room
12400 Country Club Dr., Glendora, CA 91741
Join us for a seminar on Atrial Fibrillation and the signs, symptoms and treatment modalities led by Dr. Srikant Duggirala.

Tuesday, February 20, 2018  
5-7:30 p.m.

To register by phone please call (888) 456-2847.

Queen of the Valley Hospital  
Oakwood Room  
1115 S. Sunset Ave., West Covina, CA 91790
Tuesday, February 20, 2018
5-7:30 p.m.
SWEET HEART HEALTH FAIR

Join us for APU Nursing Student lectures and presentations on Diabetes and Heart Care.

MARCH 29, 2018 - 1 to 5 p.m.
OAKWOOD ROOMS
QUEEN OF THE VALLEY HOSPITAL
1115 S. SUNSET AVE.
WEST COVINA, CA 91790

FOR MORE INFORMATION OR TO RSVP, CALL (888) 456-2847.

Citrus Valley Health Partners
Inter-Community Hospitals • Queen of the Valley Hospital
Foothill Presbyterian Hospital • Citrus Valley Hospice • Citrus Valley Home Health
Did you know there is a strong correlation between cardiovascular disease?
Erectile dysfunction can be an early warning sign of heart problems. Join us to get the facts about treatment options.

Presented by Jonathan Warner, MD
City of Hope Urology/Citrus Valley Health Partners

Attend a FREE Men’s Health Seminar
Tuesday, April 10, 2018 • 6-7:30 p.m.

Geleris Education Center
427 W. Carroll Ave., Glendora, CA 91741

Guests and partners welcome. Refreshments will be served.
Space is limited, call to register (888) 456-CVHP.
Reserve your space now for this FREE community event to learn more about gynecologic conditions and treatments presented by Sean Begley, MD and Zaid Choudhrey, MD.

Tuesday, May 15, 2018
6-7:30 p.m.

Geleris Family Education Center
427 W. Carroll Ave.
Glendora, CA 91741

RSVP by calling (888) 456-CVHP
or online at www.cvhp.org
Stop Stroke F.A.S.T.
Join Our FREE Community Stroke Awareness and Screening Event

Wednesday, May 23, 2018
Screenings/Resource booths: 4:30-6 p.m.
Physician lecture: 6:30-7:30 p.m.

Queen of the Valley Hospital
Oakwood Room
1115 S. Sunset Ave., West Covina, CA 91790

- Physician lecture on stroke symptoms & treatment
- Carotid artery screening and more*
- Resource booths and giveaways

To RSVP, call (888) 456-2847

* Only registered attendees arriving before 6 p.m. will be eligible for screenings. Walk-ins are not eligible.
Men's Health Seminar

Join us and learn everything you need to know about treating erectile dysfunction, male stress incontinence, enlarged prostate and prostate cancer.

Tuesday,
September 11, 2018
6 to 7:30 p.m.
Geleris Family Education Center
427 W. Carroll Ave.
Glendora, CA 91741

RSVP
888.456.2847

Presented by
Jonathan Warner, MD

www.cvhp.org
R.E.S.T.O.R.E.
Rehabilitation Event Supporting Therapy Outcomes, Recovery & Education

Tuesday, September 18, 2018
4-5:30 p.m. Screening and Resource Booths
5:30-6:30 p.m. Physician Lecture

Queen of the Valley Hospital
1115 S. Sunset Ave., West Covina, CA 91790
Dr. Lindberg presents an in-depth discussion on Balance Impairment – Modern Approach in Rehabilitation

• Balance and grip strength screenings
• Walker and cane screenings for proper fit and function
• Health education resource booths
• Door prize drawings

RSVP by calling
(888) 456-2847
Life After Stroke: Education and Support Group

Join our FREE After Stroke Support Group
Sponsored by Citrus Valley Medical Center

- Learn about your stroke
- Learn about prevention
- Learn about how to improve your life after a stroke

First Wednesday of every month • 3-4:30 p.m.

QUEEN OF THE VALLEY HOSPITAL
1115 S. Sunset Ave, West Covina, CA 91790
Room: Meeting Room 4

Please contact Stroke Coordinator at (626) 813-2931 or Social Worker at (626) 814-2475 for more information.