2019 COMMUNITY HEALTH NEEDS ASSESSMENT

City of Hope®

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I. Acknowledgments

The City of Hope worked in partnership with the Center for Nonprofit Management to conduct this needs community health needs assessment.

City of Hope

City of Hope is dedicated to making a difference in the lives of people with cancer, diabetes and other serious illnesses. Our mission is to transform the future of health care by turning science into a practical benefit and hope into reality. We accomplish this by providing outstanding care, conducting innovative research, and offering vital education programs focused on eliminating these diseases.

At City of Hope, we're striving to benefit the communities in our service areas by decreasing health disparities in multiple ways. These include creating major institutional shifts in thinking about community benefits, organizing thoughtful community collaborations and partnerships, and addressing the root causes that create barriers to good health.

Designating community benefit programs as an institutional priority has increased our urgency about creating meaningful, impactful programs that meet the needs of the vulnerable populations in our service area. This institutional commitment is fostering collaboration among City of Hope employees participating in community benefit activities. By making community benefit a priority, we're taking a more strategic focus on the needs that are critical to our service area and creating pathways for health and healing.

CHNA Consultants

The Center for Nonprofit Management (CNM) team has extensive experience conducting more than 30 community health needs assessments (CHNAs) for hospitals throughout Los Angeles County and San Diego County since 2004. In 2016, CNM conducted CHNAs for three Kaiser Foundation hospitals (Baldwin Park, Los Angeles and West Los Angeles), Citrus Valley Health Partners (now Emanate Health), the Glendale Hospitals Collaborative (Glendale Adventist Medical Center, Glendale Memorial Hospital and Health Center, and Verdugo Hills Hospital) and the Metro Hospitals Collaborative (California Hospital Medical Center, Good Samaritan Hospital, and St. Vincent Medical Center). In 2014, the CNM team assisted two additional Kaiser Permanente hospitals (Panorama City and San Diego) in community benefit planning based on their needs assessments and conducted a CHNA for Casa Colina Hospital and Centers for Healthcare and the Hope Street Family Center in 2015.

II. Executive Summary

In order to remain responsive to the needs of our multicultural communities, City of Hope undertakes the community health needs assessment (CHNA) every three years as required by state (California Senate Bill 697) and federal law (Affordable Care Act). The 2019 CHNA process allows us to develop a deeper understanding of our community's health care needs, inform our community benefit plan for outreach and services that complement and extend clinical services, and improve disease prevention and overall health status. By doing so and as an added benefit, we maintain our tax exempt status with the Internal Revenue Service.

About Us

Founded in 1913, City of Hope is a world-renowned comprehensive cancer center and independent biomedical research institution near Los Angeles that offers a unique blend of compassionate care and research innovation. City of Hope is recognized by the National Cancer Institute as one of only 51 comprehensive cancer centers in the nation. As a pioneer in patient-centered care, U.S. News & World Report has ranked it as one of the nation's "Best Hospitals" in cancer for the past 13 years.

Each day, we live out our credo: "There is no profit in curing the body if, in the process, we destroy the soul." In our quest to bridge the health disparities gap, we seek opportunities to impact our underserved communities.

We serve our patients in 217 licensed beds and provide the latest medical treatments, particularly in cancer, HIV/AIDS and diabetes. We lead many groundbreaking discoveries in cancer drugs (including Herceptin, Rituxan, Erbitux and Avastin) and synthetic insulin through technologies and research developed at City of Hope. We run one of the largest bone marrow transplantation and stem cell transplant programs in the United States.

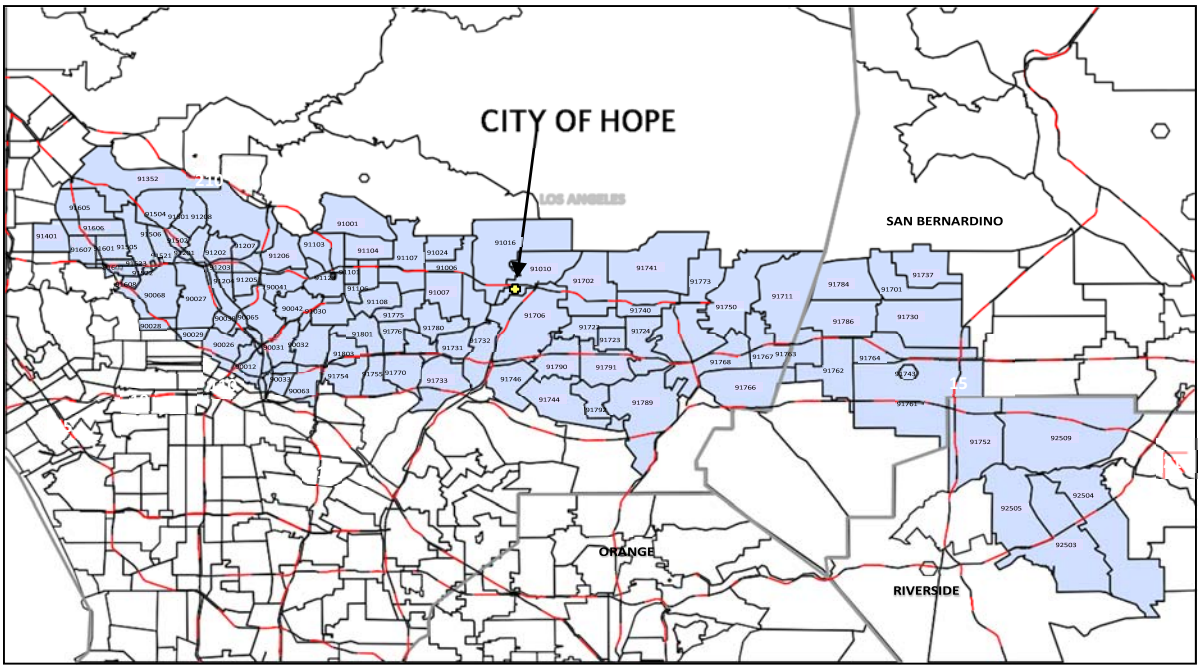
We are committed to creating an infrastructure to support an array of community projects. In fiscal year 2018, these investments yielded $238,411,117 in community benefits.

Our Service Area and Footprint

City of Hope is headquartered in the City of Duarte, situated at the base of the San Gabriel Mountains just 21 miles northeast of Los Angeles. Our services, however, extend far beyond our immediate community and, in fact, impact five major counties (Los Angeles, Orange, Riverside, San Bernardino, and Ventura) where City of Hope operates 30 clinical network locations.

The majority of our patients come from Los Angeles County, specifically from communities within Service Planning Area 3 (SPA 3). City of Hope itself is within SPA 3, which includes 34 cities, such as Alhambra, Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut and West Covina.

City of Hope Primary Service Area



Our Process

To inform the health priorities and needs of the communities that we serve, we collected both primary and secondary data.

Secondary data helps to pinpoint trends at various geographic levels, such as city, county or state, to begin parsing out which populations or groups in an area are affected by which health or social condition. We relied on an array of public data sources to isolate demographics, social and economic factors, health access, leading causes of death, cancer incidence and mortality, chronic disease, health behaviors, mental health and substance abuse. To identify significant health needs, the size (relative portion of population afflicted by the problem) and seriousness of the health need (impact on individuals, families, and communities) were benchmarked against other geographic areas (e.g., state) or against specific state goals (e.g., Healthy People 2020 objectives).

Primary data fleshes out the community picture with color and detail based on these identified health needs. The primary data helps us validate the secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs, and discover gaps in resources. We asked community stakeholders how a particular health or social issue impacts them. To do this, we conducted focus groups to understand the lived experience of residents, a community survey, and interviews with key public health and service providers, members of medically underserved, low-income and minority populations in the community, and individuals or organizations serving or representing the interests of such populations.

Based on a review of all of this information, the following significant health needs were determined.

- Access to Care
- Cancer
- Chronic Disease
- Economic Insecurity
- Housing Insecurity and Homelessness
- Mental Health
- Overweight and Obesity
- Substance Use

Our Priorities

Our Community Benefit Advisory Council (CBAC) met on December 19, 2019, to identify the top health needs that need be prioritized over the next three years. Based on findings from the primary and secondary data collections, participants learned about the identified health needs within City of Hope's community service areas. After the data presentation, everyone was instructed to rate these leading indicators in relationship to seriousness, size of problem (number of people impacted), trends, equity, feasibility, value, consequence of Inaction, social determinants/root causes and effective strategies to address problem. Then they were instructed to represent their priorities by placing colored dots on the charts. Red #1, Blue #2, Green #3 and Yellow #4. People were also invited to elaborate on their prioritized issues with comments that can help us shape the overall strategies for the 2021 Implementation Strategy.

Results were as follows:

2019 Prioritized Health Needs

Rank	Health Needs
1	Access to Care
2	Mental Health and Substance Use
3	Economic and Housing Insecurity
4	Chronic Disease
5	Cancer Prevention

It is important to know that while there were eight identified areas of need, those schooled in public health language will see that the CBAC combined topics because they felt that the root causes and shared risk factors were similar and by addressing them collectively rather than individually we could have a greater impact. Thus, you will see that mental health was combined with substance abuse. In recent years, mental health researchers have found that creating an integrative approach for mental health and substance use disorders made more sense and provided greater support for the patients[1],[2]. The chronic disease was combined with obesity/overweight because the shared risk factors and methods for addressing those risks are similar. While some might say City of Hope is not addressing the eight originally identified needs, we are in fact addressing them all.

[1] Ungar, M., Liebenberg, L., & Ikeda, J. (2014). Young people with complex needs: Designing coordinated interventions to promote resilience across child welfare, juvenile corrections, mental health and education services. *The British Journal of Social Work*, **44**, 675–693.

[2] Clark, H. W., Power, A. K., Le Fauve, C. E., & Lopez, E. I. (2008). Policy and practice implications of epidemiological surveys on co-occurring mental and substance use disorders. *Journal of Substance Abuse Treatment*, **34**(1), 3–13.

Please take time to explore this priority ranking and our CHNA report. We welcome you to share your comments with us or make requests for additional data. Send all comments to communitybenefit@coh.org. This report is available for download at our website: CityofHope.org/about-city-of-hope/community/community-benefit. Use this CHNA report to learn more about your community or to design your own reports or project plans. At City of Hope, we will use this report to help us hone in on the most serious health issues and social disparities that lead to poor health, so we can best allocate our resources toward improving the lives of residents throughout our broad service area.

III. Introduction

City of Hope has undertaken a community hHealth needs assessment (CHNA) as required by state and federal law. California Senate Bill 697 (the Patient Protection and Affordable Care Act) and IRS section 501(r)(3) direct tax-exempt hospitals to conduct a CHNA and develop an implementation strategy every three years. The CHNA is a primary tool used by City of Hope to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the community benefit service area.

What Is a CHNA?

A CHNA is a report on the health status of a community. A CHNA explores the root causes of death and disease and identifies the communities most impacted by these causes. Aside from genetic predispositions, socioeconomic and behavioral factors (such as poverty, educational attainment and substance use), act as important determinants of death and disease. A CHNA helps pinpoint risk factors affecting specific communities/cities. In the process of conducting a CHNA, statistical data are collected from secondary sources to get a better understanding of these communities and the leading causes of death and illness by which they are affected. Secondary data sources often include the major public data banks built by the U.S. Census, the Centers for Disease Control, universities, and national, state and local health departments.

In order to dig deeper, a CHNA may conduct primary data collection by going into local communities and actually asking the people who live there for their thoughts and feelings about health and disease in their community. Data collection happens through phone calls, written or electronic surveys, or small group discussions. It is a perfect opportunity to ask people why they think a certain health issue is more prevalent in their neighborhood. More importantly, they may be able to provide input on possible solutions for improving their health, as well.

How to Use This CHNA

Depending on what you are interested in accomplishing, you may choose to study the entire report, focus on a particular key health indicator or select various characteristics found in a specific area, like San Bernardino. No matter which pathway you choose, this report is organized in a way that will make it easy for you to review the information you seek.

Much of the report provides data on various health indicators at the state and county level. Whenever possible, we gathered data for the specific cities located within the San Gabriel Valley. For example, if you want to learn which cities have the highest percentage of residents graduating from high school, you can simply go to the section on Educational Attainment and locate the table with graduation rates.

Since City of Hope considers Los Angeles, Orange, San Bernardino, Riverside and Ventura as part of our larger service area, we have included data on those counties. You may find it useful to pull from this data and compare geographic areas, so you can track trends or identify issues of significance. Take your time diving into the information provided in this report.

Background and Purpose

City of Hope is a world-renowned comprehensive cancer center and independent biomedical research institution near Los Angeles that offers a unique blend of compassionate care and research innovation. Founded in 1913, City of Hope is a leading research and treatment center for cancer, diabetes and other life-threatening diseases. Our scientists work with doctors to treat both the physical and emotional needs of our patients. By attending to the individual, not just the illness, their life afterward can be fuller and more rewarding.

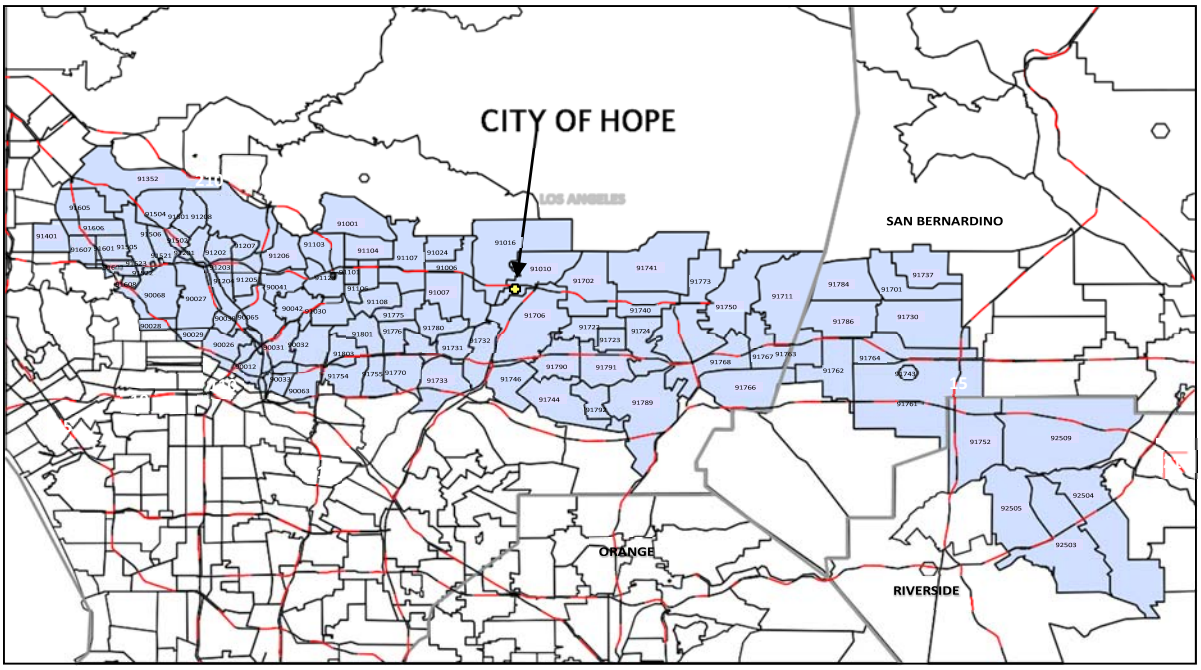
City of Hope continues to be a pioneer of patient-centered care and remains committed to a tradition of exceptional care for patients, families and communities. Each day, we live out our credo: "There is no profit in curing the body if, in the process, we destroy the soul."

Service Area

City of Hope's main campus, located in Duarte, California, has 217 licensed beds and provides the latest treatments for cancer, HIV/AIDS and diabetes.

City of Hope's primary service area includes portions of Los Angeles, Orange, Riverside, San Bernardino and Ventura counties. The majority of our patients come from Los Angeles County, specifically communities within Service Planning Area 3 (SPA 3). City of Hope itself is situated in this Service Planning Area, which is included in its primary service area (please see figure below). SPA 3 includes 34 cities, such as Alhambra, Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, Duarte, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut and West Covina, among others.

City of Hope Primary Service Area



IV. Methods

The CHNA process is designed to (1) develop a deeper understanding of community health care needs, (2) inform each hospital's community benefit plan for outreach and services that complement and extend clinical services, and (3) improve disease prevention and overall health status.

Both primary data via community input and secondary data were collected to inform community health priorities and needs, as well as assets and gaps in resources. This data also helps draw a picture of what life is like for residents of that community.

Secondary Data Collection

Secondary data is a higher level of data that can pinpoint particular diseases and conditions that impact citizens at different geographic levels such as city, county, state, national and world. Knowing secondary data can help an organization target programs and services directly to communities that are impacted the most. However, secondary data can often be impersonal — it will not necessarily tell you why certain health or social conditions exist. Secondary data is like a black-and-white picture. It tells you a lot about a community, but it is two-dimensional. Primary data fleshes out the picture with color and detail.

Secondary data is collected from a variety of local, county and state sources to present community demographics, social and economic factors, health access, leading causes of death, cancer incidence and mortality, chronic disease, health behaviors, mental health and substance abuse. The sources of data we used for this CHNA included U.S. Census American Community Survey, County Health Rankings & Roadmaps, California Health Interview Survey, California Department of Public Health, California Department of Finance, California's Office of Statewide Health Planning and Development, California Department of Justice, California Employment Development Department, Community Commons, California Cancer Registry, California Department of Education and Los Angeles County Department of Public Health, among others. When pertinent, these data sets are presented in the context of the State of California, framing the scope of an issue as it relates to the broader community.

Secondary data for the hospital service area was collected and documented in data tables with narrative explanations. The tables include the data indicator, the geographic area represented, the data measurement (e.g., rate, number, or percent), county and state comparisons (when available), data source, data year and an electronic link to the data source. The report includes benchmark comparison data that measures Mercy data findings with Healthy People 2020 objectives. Healthy People 2020 is a national initiative to improve public health by providing measurable objectives and goals that are applicable at national, state and local levels.

Primary Data Collection

In collecting primary data, you enter a community and ask the residents how a particular health or social issue impacts them. This type of information — which is often more significant than a "leading cause of death" — can help you design a program or services to eliminate barriers decreasing quality of life for that group. You may find language, lack of transportation, poverty, crime and/or location of housing are the reasons why a health issue is more prevalent in a community. Primary data can be gathered directly through focus groups, interviews and targeted surveys. When an organization is able to address the most pressing issues — the root causes of health inequities — the path to preventing or eliminating a leading cause of death becomes clearer. The following sections will introduce you to the types of methods used to

learn more about City of Hope's community and add color to your own picture of health and wellness in the San Gabriel Valley.

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

For this CHNA, we obtained information through focus groups; a community survey; and interviews with key community stakeholders, public health and service providers, members of medically underserved, low-income, and minority populations in the community, and individuals or organizations serving or representing the interests of such populations.

Focus Groups

Representatives of select subpopulations were convened to advance understanding of the lived experience of residents in City of Hope's service area. Subpopulations represented in focus groups included seniors, Spanish-speaking residents, Mandarin-speaking residents, African American residents, homeless residents and LGBTQ residents. **19 focus groups were convened between January and October 2019.**

Interviews

Interviews with key stakeholders provided opportunities to gather in-depth insights from experts in particular subfields of public health and social services in targeted communities. A total of 32 individual interviews were conducted for this community health needs assessment, from February through July 2019.

Data Limitations and Gaps

The secondary data allows for an examination of the broad health needs within a community. However, there are some limitations with regard to this data, as is true with any secondary data:

1. Data were not always available at the ZIP code level, so county level data as well as SPA level data were utilized.
2. Disaggregated data for age, ethnicity, race and gender are not available for all data indicators, which limited the examination of disparities of health issues within the community.
3. At times, a stakeholder-identified health issue may not have been reflected by the secondary data indicators.
4. Data are not always collected on an annual basis, meaning that some data are several years old.

Public Comment

In compliance with IRS regulations 501(r)(3) for charitable hospitals, a hospital CHNA and implementation strategy are to be made widely available to the public, and public comment must be solicited. In compliance with these regulations, the previous City of Hope CHNA and implementation strategy were made available to the public on CityofHope.org/about-city-of-hope/community/community-benefit. Public comment was requested. At the time of completing this report, no public comments had been received.

V. Identification of Significant Health Needs

How to Use This Section

This section highlights the health and social issues with the greatest impact on residents in City of Hope's service area. You can use this information to broaden your understanding of how the needs were identified and prioritized. Pay particular attention to the way that community input was used to validate the data and focus priorities at the local level.

Review of Primary and Secondary Data

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

The following criteria were used to identify significant health needs:

1. Size of the problem (relative portion of population afflicted by the problem)
2. Seriousness of the problem (impact on individuals, families and communities)

To determine size and seriousness, health indicators identified in the secondary data collection were measured against benchmark data, specifically California rates and Healthy People 2020 objectives, whenever available. Health indicators that performed poorly against one or more of these benchmarks were considered to have met the size or seriousness criteria. Additionally, primary data sources (interview, focus group and survey participants) were asked to identify and validate community and health issues. Information gathered from these sources helped determine significant health needs.

Significant Health Needs

The following significant health needs were determined:

- Access to Care
- Cancer
- Chronic Disease
- Economic Insecurity
- Housing Insecurity and Homelessness
- Mental Health
- Overweight and Obesity
- Substance Use

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

Resources to Address Significant Needs

Through the focus groups, surveys and interviews, community stakeholders and residents identified community resources that can help address the significant health needs. These resources are presented in Appendix B.

VI. Priority Health Needs

How to Use This Section

Even when data exposes a health issue as critical, it may not actually be the case on the community level. This section shares the insights that local residents provided on health and social issues that impact them. It is interesting to note how priorities shifted when presented to the community members for ranking. This suggests that even though data may tell us one thing, we must address issues according to residents' priorities. In the end, program and services should be designed to address the most pressing concerns first; building trust and social capital and leading the way toward more sustainable programs and services to be implemented in the future.

Community Input on Significant Health Needs

The identified significant health needs were prioritized with input from the community. The following criteria were used to prioritize the health needs.

- Perceived severity of a health issue or health factor/driver as it affects the health and lives of community residents
- The level of importance City of Hope should place on addressing the issue

Each stakeholder interviewee was sent a link to an electronic survey on Survey Monkey in advance of the interview. They were asked to rank each identified health need in order of importance. The percentage of responses noted for those identified as having severe or very severe impact on the community, having worsened over time, and having a shortage or absence of resources available in the community for addressing the issue. Not all survey respondents answered every question; therefore, the percentages were calculated based on number of responders and not on entire sample size. Mental health and overweight/obesity scored the highest. This indicates a severe impact on the community, a worsening over time, and a shortage or absence of resources available to address these issues. Access to health care also rated high on insufficient resources available.

The survey respondents, focus group attendees, and interviewees were asked to rank the health needs according to highest level of importance in the community. The total score for each significant health need (possible score of 4) was divided by the total number of responses for which data was provided, producing an average score for each health need.

Impact Evaluation of Priorities Identified in the Last Assessment

City of Hope conducted its previous CHNA in 2016. Significant health needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. In developing the hospital's implementation strategy resulting from the 2018-2021 CHNA, City of Hope chose to address access to health care, healthy living (specifically the impact of nutrition and physical activity on cancer and diabetes), mental health and cancer prevention. An evaluation of the impact of the actions City of Hope took to address these significant health needs can be found in Appendix D.

VII. Community Demographics

How to Use This Section

This section introduces you to the people who live in City of Hope's service area. You will learn how many people reside here and their age, ethnicity, gender, citizenship and language spoken in their home. When working with communities, it is necessary to know who the residents are. While reading through this section, think about how language and gender might influence community programs. Would delivering a program in English in a community that mostly speaks Spanish be successful? If the population is older, would it be a good idea to hold classes at night? The data is shared in a broader context of the five counties before further narrowing down to cities of interest to City of Hope.

Population

Based on 2010 census data, the population in the five core counties served by City of Hope is 17,877,006. Population density ranges from the very dense Orange and Los Angeles counties to the more sparsely populated Ventura, Riverside and San Bernardino counties.

Population of City of Hope's Service Area by County (2010 Census)

Report Area	Total Population	Total Land Area (square miles)	Population Density (per square mile)
Los Angeles County	9,818,605	4,057.88	2,419.6
Orange County	3,010,232	790.57	3,807.1
Riverside County	2,189,641	7,206.48	303.8
San Bernardino County	2,035,210	20,056.94	101.5
Ventura County	823,318	1,843.13	446.7
California	17,877,006	33,955.00	7,079.3

Source: U.S. Census Bureau, 2010 Census of Population and Housing

The cities within the Service Planning Area (SPA) 3 of Los Angeles are listed in the table below. They range widely in population from Industry (334 residents) to Pomona (152,366 residents).

Population of SPA 3 Cities

Report Area	Total Population
Alhambra	85,168
Altadena	45,236
Arcadia	58,156
Azusa	49,029
Baldwin Park	76,572
Bradbury	992
Citrus)	11,489
Claremont	35,949
Covina	48,601
Diamond Bar	56,600
Duarte	21,832
El Monte	115,958
Glendora	51,891

Report Area	Total Population
Hacienda Heights	54,155
Industry	334
Irwindale	1,371
La Puente	40,451
La Verne	32,320
Monrovia	37,138
Monterey Park	61,056
Pasadena	141,231
Pomona	152,366
Rosemead	54,615
Rowland Heights	50,572
San Dimas	34,334
San Gabriel	40,315
San Marino	13,331
Sierra Madre	11,061
South El Monte	20,712
South Pasadena	25,974
Temple City	36,214
Valinda	25,080
Walnut	30,062
West Covina	107,786

Source: U.S. Census, American Community Survey, 2013-2017

Between the 2000 and 2010 Census, the population in the state of California grew nearly 10% to 37,253,956. The population is estimated to have grown an additional 6.2% over eight years thereafter. For the counties served by City of Hope's hospital, the overall growth in population within this same period lags slightly behind that of the state by 1.2%. The increase is driven primarily by explosive growth in the Riverside population (11.9%). Los Angeles and Ventura counties are growing at much slower rates (2.9% and 3.4%, respectively). Nevertheless, with over 39 million people in California, one in four residents live in Los Angeles County.[3]

Population Growth by County (2013-2017)

Report Area	Total Population	Current Population Estimate 2018	Total Population Change	Percent Population Change
Los Angeles	9,818,605	10,105,518	286,913	2.9%
Orange	3,010,232	3,185,968	175,736	5.8%
Riverside	2,189,641	2,450,758	261,117	11.9%
San Bernardino	2,035,210	2,171,603	136,393	6.7%
Ventura	823,318	850,967	27,649	3.4%

Source: U.S. Census, 2010 Census & American Fact Finder (2018)

[3] U.S. Bureau of Census, 2017 American Community Survey

Children under 5 make up 5.7% of the population in SPA 3, while 18.4% of residents are 5-19 years of age, 7.0% are 20-24, 27.3% are 25-44, 26.6% are 45-64 and 14.9% are 65 years and older. The senior population has grown by 2.1% in five years. While somewhat similar in size, Pasadena and Pomona have very divergent population profiles: Pasadena has the highest number of residents 25 years and older while Pomona has the highest number of residents below 25 years old.

Population by Age in SPA 3 Cities

SPA 3	0-4	5-19	20-24	25-44	45-64	65+
Alhambra	4,285	12,279	6,159	24,979	23,242	14,224
Altadena	2,139	7,654	2,605	10,785	14,421	7,632
Arcadia	2,597	10,961	2,943	13,688	17,548	10,419
Azusa	3,085	10,953	6,766	13,235	10,216	4,774
Baldwin Park	4,935	16,098	6,197	22,392	18,437	8,513
Bradbury	55	105	59	257	303	213
Citrus	841	2,272	973	3,451	2,800	1,152
Claremont	1,635	7,991	3,165	7,493	8,960	6,705
Covina	3,421	9,732	3,206	13,258	12,463	6,521
Diamond Bar	2,586	9,791	3.409	14,384	17,616	8,814
Duarte	999	4,095	1,390	5,846	5,575	3,927
El Monte	6,729	23,937	9,177	32,917	28,569	14,629
Glendora	2,764	10,063	2,922	12,686	15,236	8,220
Hacienda Heights	2,492	9,140	3,499	13,840	15,123	10,061
Industry	39	68	34	105	56	32
Irwindale	94	308	100	344	329	196
La Puente	2,703	8,805	3,436	11,628	9,337	4,542
La Verne	1,910	5,890	2,216	6,843	9,365	6,096
Monrovia	1,970	6,906	2,132	11,036	10,235	4,859
Monterey Park	2,591	8,235	3,549	16,375	17,535	12,771
Pasadena	9,009	19,929	9,319	46,371	34,682	21,921
Pomona	11,577	33,886	14,677	43,420	34,444	14,362
Rosemead	2,825	9,440	3,658	13,971	15,992	8,729
Rowland Heights	2,914	7,146	3,487	13,638	14,346	9,041
San Dimas	1,824	6,174	2,457	8,101	9,143	6,635
San Gabriel	2,237	5,937	2,713	11,428	11,739	6,261
San Marino	558	2,793	461	2,541	4,254	2,724
Sierra Madre	633	1,808	339	2,519	3,555	2,207
South El Monte	1,453	4,220	1,732	5,683	5,041	2,583
South Pasadena	1,261	5,368	882	8,038	6,698	3,727
Temple City	1,918	6,639	1,964	8,562	10,906	6,225
Valinda	1,463	5,077	2,132	7,292	6,566	2,550
Walnut	1,371	4,962	2,050	7,047	9,585	5,047
West Covina	6310	20,142	7,888	29,753	28,429	15,264

Source: U.S. Census, American Community Survey, 2013-2017

Relative to their population size, Bradbury (21.5%), Monterey Park (20.9%) and San Marino (20.4%) have highest proportion of seniors compared to peer cities in SPA 3. Meanwhile, the very small town of Industry (11.7%), Pomona (7.6%) and Citrus (7.3%) have the greatest proportion of residents under 5 years of age.

Percent of Population of SPA 3 Cities by Age

SPA 3	0-4	5-19	20-24	25-44	45-64	65+
Alhambra	5.0%	14.4%	7.2%	29.4%	27.3%	16.7%
Altadena	4.7%	16.8%	5.8%	23.9%	31.9%	16.9%
Arcadia	4.5%	18.9%	5.1%	23.6%	30.2%	17.9%
Azusa	6.3%	22.3%	13.8%	27.0%	20.8%	9.7%
Baldwin Park	6.4%	21.0%	8.1%	29.2%	24.1%	11.2%
Bradbury	5.5%	10.5%	5.9%	25.9%	30.6%	21.4%
Citrus	7.3%	19.8%	8.5%	30.0%	24.3%	10.0%
Claremont	4.5%	22.3%	8.8%	20.8%	24.9%	18.6%
Covina	7.0%	20.0%	6.6%	27.2%	25.7%	13.5%
Diamond Bar	4.6%	17.3%	6.0%	25.4%	31.1%	15.6%
Duarte	4.6%	18.8%	6.3%	26.7%	25.6%	18.0%
El Monte	5.8%	20.6%	7.9%	28.3%	24.6%	12.6%
Glendora	5.3%	19.4%	5.6%	24.5%	29.4%	15.9%
Hacienda Heights	4.6%	16.8%	6.5%	25.6%	27.9%	18.6%
Industry	11.7%	20.4%	10.2%	31.5%	16.8%	9.6%
Irwindale	6.9%	22.4%	7.3%	25.1%	22.9%	14.3%
La Puente	6.7%	21.8%	8.5%	28.7%	23.1%	11.2%
La Verne	5.9%	18.2%	6.9%	21.2%	28.9%	18.8%
Monrovia	5.3%	18.6%	5.7%	29.7%	27.6%	13.1%
Monterey Park	4.2%	13.5%	5.8%	26.8%	28.7%	21.0%
Pasadena	6.4%	14.2%	6.6%	32.8%	24.6%	15.5%
Pomona	7.6%	22.3%	9.6%	28.5%	22.6%	9.5%
Rosemead	5.2%	17.3%	6.7%	25.6%	29.3%	16.0%
Rowland Heights	5.8%	14.1%	6.9%	27.0%	28.4%	17.9%
San Dimas	5.3%	18.0%	7.2%	23.6%	26.5%	19.3%
San Gabriel	5.5%	14.8%	6.7%	28.4%	29.1%	15.6%
San Marino	4.2%	20.9%	3.5%	19.1%	32.0%	20.4%
Sierra Madre	5.7%	16.4%	3.1%	22.7%	32.1%	20.0%
South El Monte	7.0%	20.3%	8.4%	27.5%	24.3%	12.5%
South Pasadena	4.9%	20.7%	3.4%	29.9%	25.7%	14.4%
Temple City	5.3%	18.3%	5.4%	23.6%	30.1%	17.2%
Valinda	5.8%	20.3%	8.5%	29.1%	26.2%	10.2%
Walnut	4.6%	16.6%	6.8%	23.4%	31.8%	16.8%
West Covina	5.9%	18.6%	7.3%	27.6%	26.3%	14.2%

Source: U.S. Census, American Community Survey, 2013-2017

At the county level, children and youth ages 0-4 make up 6.4% of the five-county population, while 20% are ages 5-19, 7.5% are 20-24, 28.2% are 25-44, 25.3% are 45-64 and 12.7% are 65 or older.

Population by Age and County

County	0-4	5-19	20-24	25-44	45-64	65+
Los Angeles	621,911	1,915,331	756,629	2,911,750	2,545,117	1,264,984
Orange	188,952	611,146	223,560	869,275	836,438	426,445
Riverside	157,698	525,454	171,312	622,453	561,106	316,979
San Bernardino	154,070	481,945	171,907	585,473	502,651	225,174
Ventura	52,759	172,400	60,289	217,613	225,527	119,246
California	2,493,545	7,678,760	2,859,724	11,002,942	9,799,428	5,148,448

Source: U.S. Census, American Community Survey, 2013-2017

Collectively, the five counties have a population distribution very similar to that of the state. San Bernardino County has the highest proportion of youth under 25, while Los Angeles has a higher proportion of younger working adults aged 25-44. Relative to rest of its population, Ventura County has a slightly higher rate of adults aged 65 and over, while San Bernardino has the lowest rate of these five counties, at 10.6%.

Percentage of Population by Age and County

County	0-4	5-19	20-24	25-44	45-64	65+
Los Angeles	6.3%	18.9%	7.5%	29.6%	25.2%	12.5%
Orange	6.0%	19.4%	7.1%	27.5%	26.5%	13.4%
Riverside	6.7%	22.3%	7.3%	26.5%	23.8%	13.4%
San Bernardino	7.3%	22.7%	8.1%	27.6%	23.8%	10.6%
Ventura	6.2%	20.3%	7.1%	25.7%	26.5%	14.1%
California	6.4%	19.7%	7.3%	28.2%	25.1%	13.3%

Source: U.S. Census, American Community Survey, 2013-2017

Gender

The chart below illustrates gender breakdown by county, each showing a slightly greater female than male population. In the state, 49.7% are male and 50.3% are female.

Population by Gender and County

County	Male	Female
Los Angeles	49.3%	50.7%
Orange	49.4%	50.6%
Riverside	49.8%	50.2%
San Bernardino	49.7%	50.3%
Ventura	49.5%	50.5%
California	49.7%	50.3%

Source: U.S. Census, American Community Survey, 2013-2017

Race/Ethnicity

Within the SPA 3, the highest concentration of Latinos are in Pomona, while Pasadena has the highest concentration of Whites and Blacks. Alhambra has the highest population of Asians. Native Americans and Hawaiian/Pacific Islanders reside in higher numbers within Baldwin Park and El Monte.

Total Population of SPA 3 Cities by Race/Ethnicity

SPA 3	Latino	White	Asian	Black or African-American	Native HI/PI	American Indian/AK Native	Other or Multiple
Alhambra	32,061	7,324	42,754	1,386	223	284	1,136
Altadena	12,297	17,904	2,950	9,831	51	10	2,193
Arcadia	6,809	12,989	35,590	790	90	141	2,005
Azusa	31,265	9,669	5,705	1,186	85	115	1,004
Baldwin Park	56,667	2,723	14,296	1,432	557	595	302
Bradbury	118	404	439	16	0	2	13
Citrus	8,968	1,308	1,003	142	17	30	21
Claremont	9,489	18,013	4,894	1,882	0	188	1,483
Covina	27,223	11,978	6,561	1,713	10	133	983
Diamond Bar	10,427	11,096	30,859	2,172	545	218	1,283
Duarte	10,666	5,272	3,730	1,514	15	64	571
El Monte	75,572	4,655	33,628	622	567	102	812
Glendora	16,483	26,567	5,462	1,116	81	226	1,956
Hacienda Heights	24,918	6,806	21,160	564	64	109	534
Industry	212	75	45	2	0	0	0
Irwindale	1,279	74	13	0	0	0	5
La Puente	34,262	1,378	4,172	364	66	31	129
La Verne	11,741	16,211	2,321	1,227	1	121	698
Monrovia	15,417	13,287	5,186	1,843	75	37	1,293
Monterey Park	16,126	2,395	40,765	195	403	137	1,035
Pasadena	48,617	51,579	22,618	13,743	177	160	3,804
Pomona	107,583	17,891	14,513	9,165	317	397	2,026
Rosemead	18,375	2,081	33,494	82	48	157	378
Rowland Heights	12,885	5,269	30,738	661	206	129	684
San Dimas	11,091	16,043	5,387	823	36	143	811
San Gabriel	10,228	4,822	24,391	219	99	47	509
San Marino	1,304	4,293	7,163	174	41	0	356
Sierra Madre	1,797	7,370	1,230	129	26	17	492
South El Monte	16,986	746	2,935	21	0	2	22
South Pasadena	5,234	10,881	7,529	762	20	56	1,492
Temple City	7,442	5,649	22,175	195	125	76	552
Valinda	19,914	1,455	3,296	213	22	72	108
Walnut	6,171	3,232	19,112	870	0	16	661
West Covina	57,855	12,762	30,645	4,324	102	125	1,973

Source: U.S. Census, American Community Survey, 2013-2017

The population within the SPA 3 is 44.7% Latino, 19.3% White, 29.9% Asian and 3.6% Black/African American. Irwindale, La Puente and South El Monte have the highest concentration of the Latino population, with a rate of 93.3%, 84.7% and 82%, respectively.

Percent of Population in SPA 3 Cities by Race/Ethnicity

SPA 3	Latino	White	Asian	Black or African-American	Native HI/PI	American Indian/AK Native	Other or Multiple
Alhambra	37.6%	8.6%	50.2%	1.6%	0.3%	0.3%	1.3%
Altadena	27.2%	39.6%	6.5%	21.7%	0.1%	0.0%	4.9%
Arcadia	11.7%	22.3%	61.2%	1.4%	0.2%	0.2%	3.0%
Azusa	63.8%	19.7%	11.6%	2.4%	0.2%	0.2%	2.1%
Baldwin Park	74.0%	3.6%	18.7%	1.9%	0.7%	0.8%	0.4%
Bradbury	11.9%	40.7%	44.3%	1.6%	0.0%	0.2%	1.3%
Citrus	78.1%	11.4%	8.7%	1.2%	0.1%	0.3%	0.1%
Claremont	26.4%	50.1%	13.6%	5.2%	0.0%	0.5%	4.1%
Covina	56.0%	24.6%	13.5%	3.5%	0.0%	0.3%	2.1%
Diamond Bar	18.4%	19.6%	54.5%	3.8%	1.0%	0.4%	2.2%
Duarte	48.9%	24.1%	17.1%	6.9%	0.1%	0.3%	2.6%
El Monte	65.2%	4.0%	29.0%	0.5%	0.5%	0.1%	0.7%
Glendora	31.8%	51.2%	10.5%	2.2%	0.2%	0.4%	3.8%
Hacienda Heights	46.0%	12.06%	39.1%	1.0%	0.1%	0.2%	0.9%
Industry	63.5%	22.5%	13.5%	0.5%	0%	0%	0%
Irwindale	93.3%	5.4%	0.9%	0%	0%	0%	0.4%
La Puente	84.7%	3.4%	10.3%	0.9%	0.2%	0.1%	0.4%
La Verne	36.3%	50.2%	7.2%	3.8%	0%	0.4%	2.2%
Monrovia	41.5%	35.8%	14.0%	5.0%	0.2%	0.1%	3.4%
Monterey Park	26.4%	3.9%	66.8%	0.3%	0.7%	0.2%	1.7%
Pasadena	34.4%	36.5%	16.0%	9.7%	0.1%	0.1%	3.1%
Pomona	70.6%	11.7%	9.5%	6.0%	0.2%	0.3%	1.6%
Rosemead	33.6%	3.8%	61.3%	0.2%	0.1%	0.3%	0.7%
Rowland Heights	25.5%	10.4%	60.8%	1.3%	0.4%	0.3%	1.3%
San Dimas	32.3%	46.7%	15.7%	2.4%	0.1%	0.4%	2.4%
San Gabriel	25.4%	12.0%	60.5%	0.5%	0.2%	0.1%	1.3%
San Marino	9.8%	32.2%	53.7%	1.3%	0.3%	0.0%	2.7%
Sierra Madre	16.2%	66.6%	11.1%	1.2%	0.2%	0.2%	4.5%
South El Monte	82.0%	3.6%	14.2%	0.1%	0%	0%	0.1%
South Pasadena	20.2%	41.9%	29.0%	2.9%	0.1%	0.2%	5.7%
Temple City	20.6%	15.6%	61.2%	0.5%	0.3%	0.2%	1.5%
Valinda	79.4%	5.8%	13.1%	0.8%	0.1%	0.3%	0.4%
Walnut	20.5%	10.8%	63.6%	2.9%	0%	0.1%	2.2%
West Covina	53.7%	11.8%	28.4%	4.0%	0.1%	0.1%	1.8%

Source: U.S. Census, American Community Survey, 2013-2017

In addition, Sierra Madre has the highest concentration of Whites (66.6%), though the rate has dropped nearly 3% in five years. Monterey Park and Walnut have the highest percentage of Asians, at 66.8% and 63.6%, respectively. By far, Altadena has the highest concentration of Blacks (21.7%) and one of the lowest percentages of Asians (6.5%).

Within the five-county service area, the Latino population continues to grow to 46.1%, while the White population steadily declines to 31.6%. The Asian and Black populations appear stable at 12.9% and 6.3%, respectively. In comparison to California, these counties have a significantly higher concentration of Latino population — the state rate stands at 38.8% — and a significantly lower concentration of White population — a margin gap of 6.3%, with the state having the higher rate of 37.9%. The state populations consists also of 13.9% Asians and 5.5% Black/African Americans.

Total Population by Race/Ethnicity by County

County	Latino	White	Asian	Black or African-American	Native HI/PI	American Indian/AK Native	Other or Multiple
Los Angeles	4,893,579	2,676,982	1,442,577	799,579	24,950	19,915	248,140
Orange	1,079,172	1,306,398	615,659	49,560	8,714	6,584	89,729
Riverside	1,130,033	861,271	143,855	140,810	6,026	9,584	63,423
San Bernardino	1,108,996	632,557	142,802	168,985	6,057	6,935	54,888
Ventura	358,244	391,128	59,513	13,416	1,212	2,439	21,882
California	15,105,860	14,777,594	5,427,928	2,161,459	138,283	137,813	1,233,910

Source: U.S. Census, American Community Survey, 2013-2017

San Bernardino County has the highest percentage of Latinos (52.3%) and Blacks (8.0%), Ventura County has the highest percentage of Whites (46.1%) and Orange County has the highest concentration of Asians (19.5%).

Percent of Population by Race/Ethnicity by County

County	Latino	White	Asian	Black or African-American	Native HI/PI	American Indian/AK Native	Other or Multiple
Los Angeles	48.4%	26.5%	14.3%	7.9%	0.2%	0.2%	2.5%
Orange	34.2%	41.4%	19.5%	1.65	0.3%	0.2%	2.9%
Riverside	48.0%	36.6%	6.1%	6.0%	0.3%	0.4%	2.7%
San Bernardino	52.3%	29.8%	6.7%	8.0%	0.3%	0.3%	2.6%
Ventura	42.3%	46.1%	7.0%	1.6%	0.1%	0.3%	2.6%
California	38.8%	37.9%	13.9%	5.5%	0.4%	0.4%	3.1%

Source: U.S. Census, American Community Survey, 2013-2017

Demographic Shifts

Projections for the counties in City of Hope's service area suggest that the number of Latino residents will continue to rise, and the number of White residents will continue to fall. Latinos are expected to represent the majority of the population (more than 50%) by 2030 in Los Angeles and San Bernardino counties. The number of Black and Asian residents is expected to remain stable throughout the five counties.

Expected Changes in Race/Ethnicity by County

Race/Ethnicity	2017	2020 (Projected)	2030 (Projected)
Los Angeles			
Latino	49.3%	49.7%	51.2%
White	26.6%	26.3%	25.2%
Black/African American	8.1%	8.1%	8.1%
Asian	13.6%	13.5%	12.8%
Orange			
Latino	35.2%	35.6%	36.9%
White	42.1%	41.6%	40.0%
Black/African American	1.5%	1.5%	1.6%
Asian	18.2%	18.2%	17.9%
Riverside			
Latino	47.1%	47.4%	48.3%
White	38.0%	37.5%	36.2%
Black/African American	6.0%	6.0%	6.2%
Asian	6.0%	6.1%	6.1%
San Bernardino			
Latino	50.8%	51.3%	52.9%
White	31.6%	31.1%	29.45
Black/African American	8.4%	8.4%	8.6%
Asian	6.3%	6.2%	5.9%
Ventura			
Latino	42.5%	43.1%	44.9%
White	46.6%	45.9%	44.0%
Black/African American	1.6%	1.6%	1.6%
Asian	6.7%	6.7%	6.5%

Source: State and County Population Projections by Race/Ethnicity, 2010-2060. State of California, Department of Finance; 2019.

Citizenship

In the five-county service area, the rate of foreign-born citizens has remained steady, as has the state's rate of 27%. Los Angeles County and Orange County have the highest percentage, and San Bernardino County has the lowest percentage of foreign-born and noncitizen residents. The rate of foreign-born residents who are not U.S. citizens is on a moderate decline from 14.3% to 13.5% in the state. The five counties all share a similar decline.

Foreign-born and Noncitizen Residents by County

Report Area	Foreign Born	Not a U.S. Citizen
Los Angeles County	34.4%	16.9%
Orange County	30.3%	14.3%
Riverside County	21.8%	11.5%
San Bernardino County	20.9%	10.8%
Ventura County	22.5%	11.8%
California	27.0%	13.5%

Source: U.S. Census, American Community Survey, 2013-2017

Language

With the exception of Los Angeles County, the remaining counties of interest to City of Hope all have at least half of their respective populations speaking English only in the home. Los Angeles County has the highest rates of foreign-language speakers in Spanish (39.3%) and other Indo-European languages (5.3%). All but Orange County have rates of Spanish speakers in the home greater than the state rate of 28.7%. Los Angeles and Orange have the highest proportion of households speaking Asian languages. Their rates, 10.9% and 14.5%, respectively, are also greater than the state rate of 9.9%

Language Spoken at Home by County

County	English Only	Spanish	Other Indo-European	Asian/PI	Other
Los Angeles	43.4%	39.3%	5.3%	10.9%	1.1%
Orange	54.4%	25.8%	4.1%	14.5%	1.1%
Riverside	59.8%	33.3%	2.0%	4.1%	0.7%
San Bernardino	58.9%	33.8%	1.5%	4.9%	0.9%
Ventura	61.4%	30.5%	2.8%	4.4%	0.9%
California	56.0%	28.7%	4.4%	9.9%	1.9%

Source: U.S. Census, American Community Survey, 2013-2017

Given the distribution of languages spoken, it is perhaps self-evident that Los Angeles County has a higher proportion of the population feeling linguistically isolated compared to California (17.9%).[4] These rates are slightly lower than they were in 2014 when county and state population for linguistic isolation trended at 25.8% for Los Angeles and 19.1% for the state.

When language is examined by city, certain cities disproportionately favor one foreign language over another. More than two-thirds of La Puente (70.4%) and South El Monte (67%) residents speak Spanish at home. On the other hand, less than 10% of households in Sierra Madre (8.5%), San Marino (8.2%), Bradbury (7.7%) and Arcadia (6.6%) speak Spanish. Seven cities had at least half of residents speaking Asian or Pacific Islander in the home: Monterey Park (56.7%), Rosemead (56.2%), San Gabriel (55.4%), Rowland Heights (53.3%), Temple City (52.4%) and Arcadia (51.5%). Altadena (7.1%) and Pasadena (7.1%) have the highest percentage of residents who speak some other Indo-European Language.
Sierra Madre has the highest percentage of residents speaking only English in the home (81.4%), while El Monte has the lowest percentage of only English-speaking residents (16.1%).

[4] Linguistic isolation describes the population over age five who speak English "less than very well."

Language Spoken at Home in SPA 3 Cities

SPA 3	English Only	Spanish	Other Indo-European	Asian/PI	Other
Alhambra	27.2%	25.8%	2.0%	44.7%	0.3%
Altadena	68.4%	21.0%	7.1%	2.7%	0.7%
Arcadia	37.3%	6.6%	4.0%	51.5%	0.6%
Azusa	43.8%	46.1%	1.3%	8.3%	0.5%
Baldwin Park	18.2%	64.2%	0.4%	17.1%	0.1%
Bradbury	51.3%	7.7%	5.3%	31.6%	4.1%
Citrus	33.2%	57.8%	1.7%	7.3%	0%
Claremont	71.8%	13.6%	3.9%	9.5%	1.2%
Covina	54.7%	32.9%	1.1%	10.3%	1.1%
Diamond Bar	41.5%	10.3%	4.7%	41.9%	1.7%
Duarte	45.6%	36.9%	3.9%	13.0%	0.5%
El Monte	16.1%	55.8%	0.3%	27.6%	0.1%
Glendora	71.3%	15.2%	3.1%	7.2%	3.3%
Hacienda Heights	35.6%	28.7%	1.3%	34.0%	0.2%
Industry	64.1%	32.2%	0%	3.7%	0%
Irwindale	39.5%	59.9%	0%	0.6%	0%
La Puente	19.5%	70.4%	0.3%	9.7%	0.2%
La Verne	77.0%	13.7%	2.6%	5.1%	1.6%
Monrovia	56.9%	28.9%	2.8%	10.3%	1.2%
Monterey Park	24.2%	18.2%	0.7%	56.7%	0.2%
Pasadena	54.9%	27.5%	6.9%	9.9%	0.8%
Pomona	34.1%	56.1%	1.1%	7.7%	0.9%
Rosemead	17.0%	26.3%	0.5%	56.2%	0.1%
Rowland Heights	25.8%	18.5%	2.2%	53.3%	0.2%
San Dimas	70.3%	14.4%	2.4%	10.1%	2.8%
San Gabriel	26.8%	16.7%	0.8%	55.4%	0.3%
San Marino	47.6%	8.2%	3.1%	40.5%	0.6%
Sierra Madre	81.4%	8.5%	3.0%	6.5%	0.6%
South El Monte	19.2%	67.0%	0.2%	13.7%	0%
South Pasadena	62.6%	12.1%	3.45	21.4%	0.4%
Temple City	67.1%	12.7%	1.3%	52.4%	0.7%
Valinda	24.8%	62.8%	0.2%	11.9%	0.2%
Walnut	35.4%	12.0%	1.6%	50.6%	0.5%
West Covina	41.1%	33.2%	1.5%	23.8%	0.5%

Source: U.S. Census, American Community Survey, 2013-2017

VIII. Social and Economic Factors

How to Use This Section

The previous section on community demographics was the start of a beautiful black-and-white picture of our communities. This section will now add color in the form of detail on the residents who live in City of Hope's service area. With a deeper understanding of the community, you will begin to realize that many things impact health. Think about the following questions as you explore this section: How does poverty make a person vulnerable? How does unemployment impact housing? What does it mean to be food insecure, and how does that hurt children? Listen to the voices of the community. What do they have to say? How can their opinions impact the way programs are planned?

County Health Ranking: Social and Economic Factors

In the most recent statewide county health rankings on social and economic factors, Orange County (9) and Ventura County (12) are in the top quartile of California counties.[5] In contrast, among the 58 counties ranked, Los Angeles County ranks in the bottom-half of all counties at 30, and San Bernardino at 32.

County Ranking on Socio-economic Factors

County	Ranking
Los Angeles	30
Orange	9
Riverside	23
San Bernardino	32
Ventura	12

Source: County Health Rankings, 2019

Poverty

Poverty thresholds are used for calculating official poverty population statistics. The federal government measures the number of people in poverty with thresholds (aka Federal Poverty Level) established and updated annually by the U.S. Census. In 2017, the Federal Poverty Level for an individual stood at annual income of $12,060, while for a family of four it was $24,600. In California, where the cost of living is high, research indicates that families can earn two or more times the Federal Poverty Level and still struggle to meet their basic needs.[6]

In SPA 3, eight cities have poverty levels greater than the state's rate of 15.1%. They include Pasadena (15.5%), Monterey Park (15.8%), Azusa (16.4%), La Puente (18%), Rosemead (185), South El Monte (18.7%)

[5] The rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. The County Health Rankings list counties according to health factors data. Social and economic indicators are examined as contributors to the health of a county's residents. California's 58 counties are ranked according to social and economic factors, with 1 being the County with the most favorable factors and 58 being the County being the least favorable factors. The ranking includes high school graduation rates, unemployment, children in poverty and need for social support.

[6] "Making Ends Meet: How Much Does It Cost to Support a Family in California?" (December, 2017). California Budget and Policy Center. Available at https://calbudgetcenter.org/wp-content/uploads/Making-Ends-Meet-12072017.pdf Accessed [June 13, 2019].

Pomona (20.7%), and the highest level in El Monte, where almost one out of four (22.6%) of the population lives below the poverty level.

Percent of Population Below the Poverty Level, by County

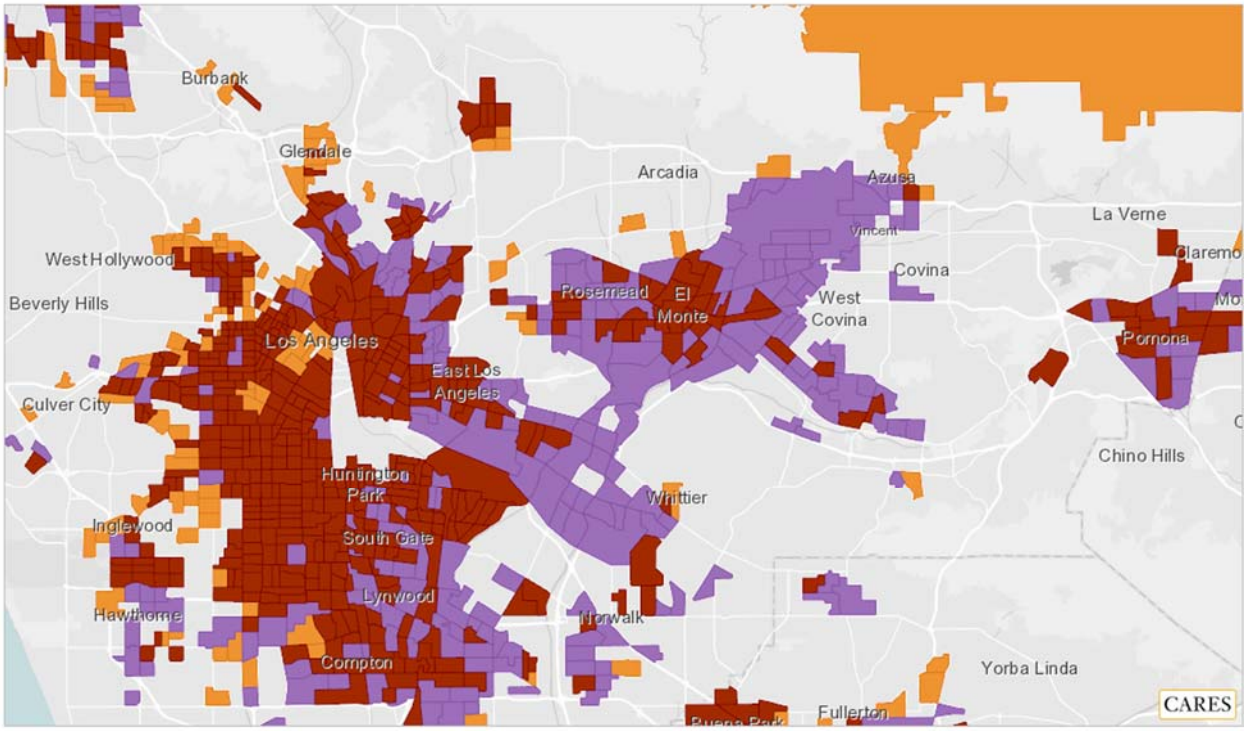
SPA 3	>100 % Below Poverty
Alhambra	15.1%
Altadena	10.6%
Arcadia	8.8%
Azusa	16.4%
Baldwin Park	14.9%
Bradbury	8.1%
Citrus	12.3%
Claremont	8.5%
Covina	9.1%
Diamond Bar	6.2%
Duarte	12.4%
El Monte	22.6%
Glendora	9.1%
Hacienda Heights	8.5%
Industry	6.9%
Irwindale	8.3%
La Puente	18.0%
La Verne	7.7%
Monrovia	8.4%
Monterey Park	15.8%
Pasadena	15.5%
Pomona	20.7%
Rosemead	18.0%
Rowland Heights	12.8%
San Dimas	8.5%
San Gabriel	13.3%
San Marino	6.8%
Sierra Madre	5.1%
South El Monte	18.7%
South Pasadena	8.2%
Temple City	11.7%
Valinda	11.8%
Walnut	8.1%
West Covina	10.0%
CALIFORNIA	15.1%

Source: U.S. Census, American Community Survey, 2013-2017

Vulnerable Populations

Poverty and education attainment are predictive of at-risk or vulnerable populations. As depicted in the figure below,[7] City of Hope, located In Duarte, is surrounded by vulnerable communities. Communities with 30% or more of residents in poverty are shown in orange. Communities in which 25% or more of residents lack a high school education are shown in purple. The overlap of high poverty and low educational attainment is depicted in red and indicate communities with vulnerable populations.

Map of City of Hope Service Area Highlighting Vulnerable Populations



Source: American Community Survey 5-Year Estimates, 2013-2017

Food Insecurity

Households that report three or more conditions that indicate food insecurity are classified as "food insecure." That is, they were at times unable to acquire adequate food for one or more household members because they had insufficient money and other resources for food. The three least severe conditions that would result in a household being classified as food insecure are:

- They worried whether their food would run out before they got money to buy more.
- The food they bought didn't last, and they didn't have money to get more.
- They couldn't afford to eat balanced meals.

In California, 4 out of 10 adults whose income is less than 200% of the Federal Poverty Level cannot afford enough food. Three counties, Los Angeles (40.2%), Orange (41.2%) and Ventura (46.6%) have similar or higher rates than that of the state. Measuring at 34.1%, Riverside has the lowest rate of food insecurity among its vulnerable population for the counties of interest to City of Hope.

[7] Map developed by Community Commons, available here: http://www.communitycommons.org/entities/60847319-e438-44be-a5c3-5b8d298845e1.

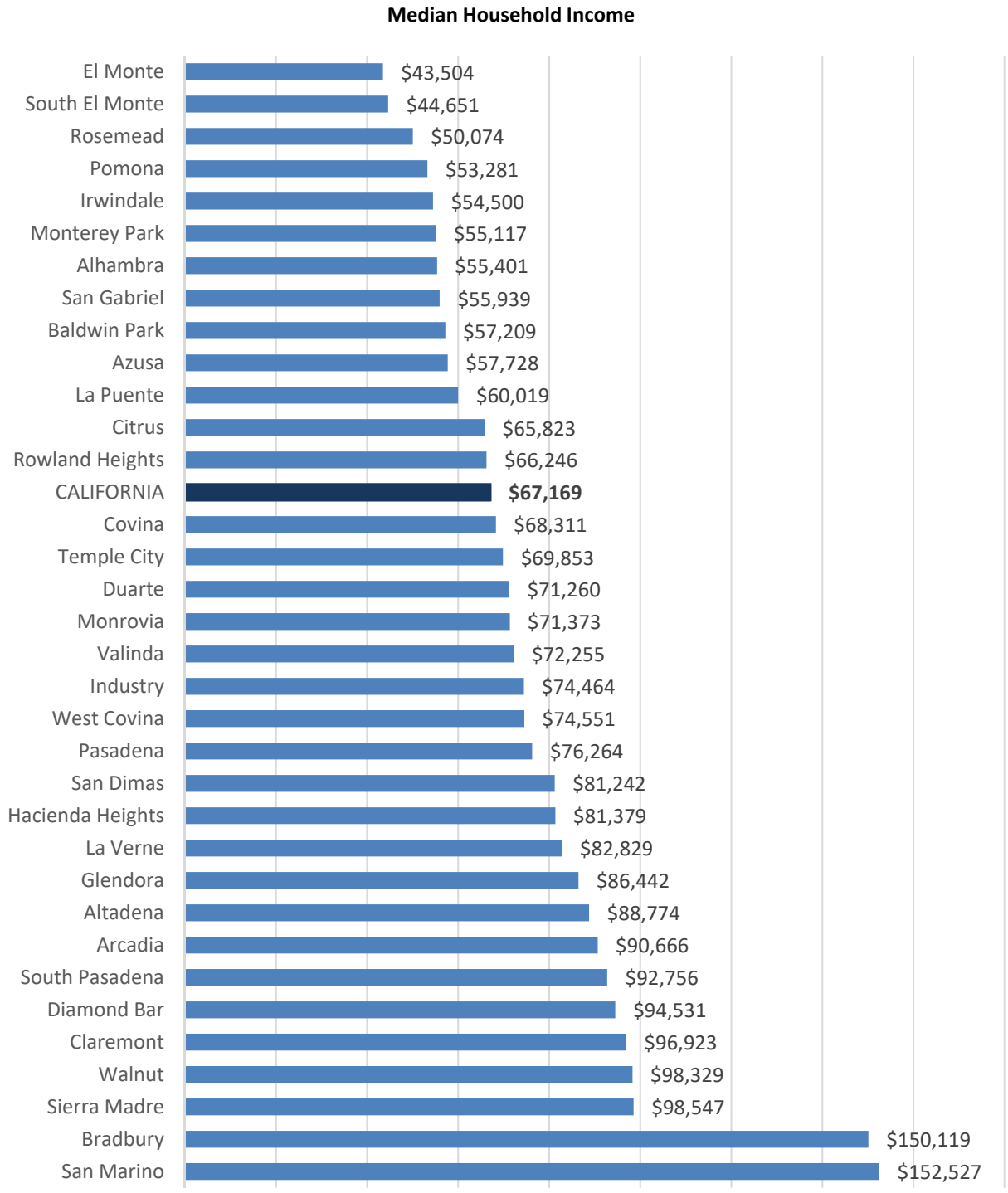
Food Insecurity by County

County	Adults >200 FPL
Los Angeles	40.2%
SPA 3	38.4%
Orange	41.2%
Riverside	34.1%
San Bernardino	36.3%
Ventura	46.6%
California	40.8%

Source: California Health Interview Survey, 2017

Household Income

The median household income in Service Planning Area 3 is highest in San Marino ($152,527), followed by Bradbury ($150,119) and Sierra Madre ($98,329). Among the 34 cities reporting in SPA 3, a third have household incomes below the state median ($67,169), with El Monte ($43,504), South El Monte ($44,651) and Rosemead ($50,074) reporting the lowest medians.



Source: U.S. Census, American Community Survey, 2013-2017

Among the five counties, Ventura and Orange counties have median incomes above the state median of $67,169. In contrast, Riverside, Los Angeles and San Bernardino counties have median incomes below that of the state.

Median Household Income by County

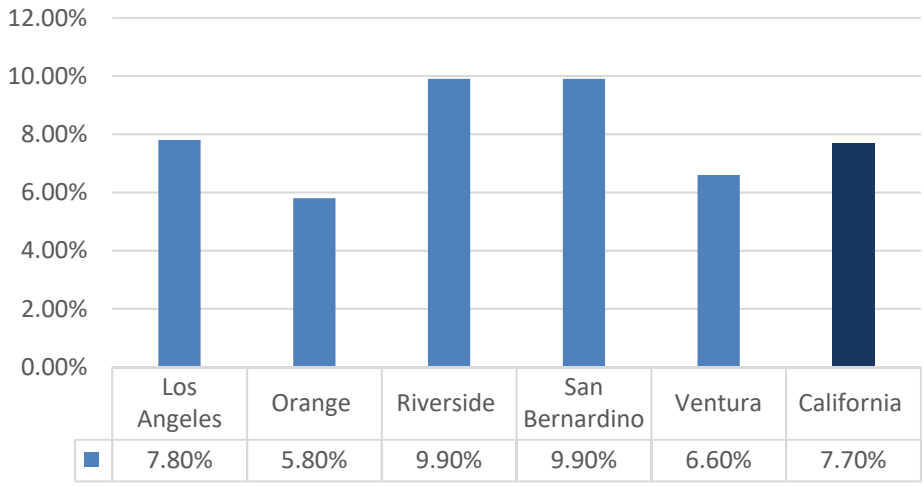
County	Median Household Income
Los Angeles	$61,015
Orange	$81,851
Riverside	$60,807
San Bernardino	$57,156
Ventura	$81,972
California	$67,169

Source: U.S. Census, American Community Survey, 2013-2017

Unemployment

Though unemployment rates have dropped in all five counties over the past eight years, close to 1 in 10 adults remain unemployed in Riverside and San Bernardino. Other counties of interest to City of Hope, in contrast, have significantly lower rates, even from the State's rate of 7.7%. They include Orange at 5.8% and Ventura at 6.6%. The unemployment rate in Los Angeles is at par with the state rate.

Unemployment Rate by County



Source: U.S. Census, American Community Survey, 2013-2017

Homelessness

A homeless individual is defined as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations and an individual who is a resident in transitional housing."[8]

More than 20% of the nation's homeless population now lives in California. According to estimates (as of January 2018) from U.S. Department of Housing and Urban Development (HUD) estimates, approximately

[8] Portland State Univeristy Homelessness Research and Action Collaborative. Available at https://www.pdx.edu/homelessness-collaborative/find-help. Accessed [Dec 1, 2019].

129,972 people in California experience homelessness on any given day. Among these homeless, 6.18%, or 6,702, were family households, 8.3%, or 10,836, were veterans, 9.5%, or 12,396, were unaccompanied young adults (aged 18-24), and 26.4%, or 34,332, were individuals experiencing chronic homelessness. In addition, "public school data reported to the U.S. Department of Education during the 2016-2017 school year shows that an estimated 246,296 public school students experienced homelessness. Of that total, 7,533 students were unsheltered**,** 17,061 were in shelters, 10,095 were in hotels/motels and 211,607 were doubled up."[9]

The Los Angeles Homeless Services Authority conducts the Greater Los Angeles Homeless Count every two years to provide a snapshot of homelessness in a given day. "Homeless individuals" include single adults, adult couples with no children and groups of adults over the age of 18.

In just under four years, the number of homeless individuals in Los Angeles County has risen 43% to 58,936. In Service Planning Area 3, the rate of homelessness has increased by 45%. The majority among them are single adult individuals (81.1%) and unsheltered (75%). In contrast, the homeless in SPA 3 has a better shelter rate (63.3%), though the rate of unsheltered has increased drastically by a 7.2% margin.

Homeless Population Count in Greater Los Angeles

Homeless Population	SPA 3		Los Angeles County	
	2015	2019	2015	2019
Total Homeless	3,093	4,489	41,174	58,936
Sheltered	43.9%	26.7%	29.7%	25.0%
Unsheltered	56.1%	63.3%	70.3%	75.0%
Adult Individuals (not in family units)	81.0%	83.0%	81.1%	85.0%%
Family Members (in family units	18.7%	14.0%	18.2%	15.0%
Unaccompanied Minors	0.4%	0.1%	>1%	0.1%

Source: Los Angeles Homeless Services Authority, 2015 and 2019 Greater Los Angeles Homeless Count Results

Despite the increase in the homeless population, the percentage of chronically homeless has actually decreased between 2014 and 2019. In SPA 3, 28.0% of the homeless population is now chronically homeless in both SPA 3 and Los Angeles County. Both of these areas have seen improvements in the rates of homeless who are mentally ill, veterans or suffering from substance abuse. For instance, the rate of homeless with substance abuse has decreased significantly in SPA 3 and Los Angeles County, by 10.8% and 11.9%, respectively. Perhaps most disturbing though is the outsized increase of homeless with a domestic violence history, particularly in SPA 3 were the rate has jumped from 18.6% to 35%.

[9] California Homelessness Statistics, United States Interagency Council on Homelessness. Available at https://www.usich.gov/homelessness-statistics/ca. [Accessed June 4, 2019].

Homeless Subpopulation Count

Homeless Subpopulation	SPA 3		Los Angeles County	
	2015	2019	2015	2019
Chronically Homeless	32.4%	28.1%	34.4%%	28.0%
Substance Abuse	23.9%	13.1%	25.2%	13.3%
Mental Illness	20.3%	23.5%	29.8%	23.2%
Veterans	7.7%	5.7%	9.8%	6.6%
HIV/AIDS	0.9%	1.3%	0.2%	2.2%
Domestic Violence Experience	18.6%	35.0%	1%	5.3%
Physical Disability	18.5%	18.9%	19.8%	NA

Source: Los Angeles Homeless Services Authority, 2015 and 2019 Greater Los Angeles Homeless Count Results

Educational Attainment

One of the key drivers of health is educational attainment — low levels of education are often linked to poverty and poor health. In Service Planning Area 3, 12 cities rate below the state in the rate of college-educated adults 25 years old or older, including South El Monte and Irwindale, which have the lowest rates, at 6.2%, and 7.5%, respectively. The highest percentage of residents with a high school diploma are Baldwin Park (32.5%), Citrus (31.8%) and Valinda (30.2%). Though La Puente has low rates of college-educated adults (8.3%), it does have a larger portion of residents with no high school education (24%) or a high school diploma (29.7%) than the majority of SPA 3 peer cities. El Monte (26.7%) and South El Monte (29.4%) have the largest proportions of residents with no high school experience.

Educational Attainment Age 25 Years and Older

SPA 3	No HS	Some HS	HS Diploma	Some college, No degree	Assoxiate Degree	Bachelor's Degree	Graduate Degree
Alhambra	11.4%	6.9%	24.4%	16.1%	7.7%	22.8%	10.8%
Altadena	6.7%	3.7%	15.5%	20.5%	8.8%	23.5%	21.3%
Arcadia	5.0%	3.1%	14.9%	15.4%	9.2%	33.1%	19.3%
Azusa	13.6%	8.0%	28.0%	22.0%	8.3%	13.7%	6.3%
Baldwin Park	21.2%	12.0%	32.5%	16.3%	5.8%	10.0%	2.2%
Bradbury	3.6%	3.4%	10.2%	10.5%	11.0%	35.1%	26.3%
Citrus	15.7%	12.8%	31.8%	22.1%	5.5%	9.0%	3.1%
Claremont	2.7%	3.1%	10.7%	20.2%	7.4%	24.0%	31.9%
Covina	6.2%	7.7%	23.7%	26.2%	8.5%	20.4%	7.3%
Diamond Bar	3.4%	3.8%	14.6%	17.8%	8.2%	34.4%	17.7%
Duarte	9.1%	7.7%	22.1%	23.5%	7.7%	17.7%	12.2%
El Monte	26.7%	15.9%	27.3%	13.4%	5.2%	9.2%	2.4%
Glendora	4.0%	5.9%	18.9%	24.7%	10.3%	22.4%	13.7%
Hacienda Heights	6.7%	6.8%	23.1%	20.2%	9.1%	23.4%	10.7%
Industry	8.8%	8.3%	24.9%	33.2%	1.0%	21.2%	2.6%
Irwindale	15.1%	10.0%	29.1%	27.4%	9.3%	7.5%	1.6%
La Puente	24.0%	14.1%	29.7%	17.4%	4.5%	8.3%	2.0%
La Verne	3.2%	5.2%	17.2%	27.2%	9.5%	22.5%	15.2%
Monrovia	6.8%	4.7%	18.5%	22.5%	9.9%	24.3%	13.4%
Monterey Park	6.8%	4.7%	18.5%	22.5%	9.9%	24.3%	13.4%
Pasadena	7.9%	4.5%	13.7%	15.6%	7.2%	27.6%	23.5%
Pomona	18.0%	13.5%	24.7%	19.9%	6.3%	13.1%	4.6%
Rosemead	24.0%	11.2%	25.9%	14.6%	6.3%	14.0%	3.9%
Rowland Heights	8.6%	5.7%	20.5%	17.7%	8.6%	29.6%	9.3%
San Dimas	3.2%	4.0%	18.1%	26.0%	11.6%	24.6%	12.6%
San Gabriel	12.5%	7.8%	26.5%	14.7%	6.3%	24.6%	7.5%
San Marino	2.1%	1.0%	6.3%	13.7%	3.6%	32.3%	41.1%
Sierra Madre	0.1%	0.6%	12.0%	13.6%	10.4%	35.9%	27.4%
South El Monte	29.4%	17.8%	26.9%	13.5%	3.5%	6.2%	2.6%
South Pasadena	2.4%	1.7%	10.4%	15.2%	7.5%	33.3%	29.6%
Temple City	9.8%	5.9%	19.3%	17.1%	9.5%	27.4%	10.9%
Valinda	20.8%	11.3%	30.2%	18.5%	7.1%	10.1%	2.0%
Walnut	5.0%	2.8%	14.1%	16.6%	9.5%	37.4%	14.6%
West Covina	7.8%	7.5%	26.3%	20.9%	8.9%	21.4%	7.1%
California	9.7%	7.8%	20.6%	21.5%	0.9%	20.4%	12.2%

Source: U.S. Census, American Community Survey, 2013-2017

In California, close to 2 out of 5 adults (38.1%) aged 25 years and older have either a high school diploma or even less education. Within counties of interest to City of Hope, the highest rate of residents age 25 and older without a high school diploma is found in San Bernardino County (26.2%). Only Orange and Ventura counties have lower rates (17.3% and 18.9%, respectively) than the state rate of 20.6%. San Bernardino County also has the highest rate of adults 25 years and older who had some high school education but

never graduated (11.5%). Meanwhile, a large portion of Los Angeles County adults 25 years and older (12.9%) have never even attended high school.

Adults in Orange, Ventura and Los Angeles counties are more likely to have graduated from college and graduate school.

Educational Attainment by Southern California County

County	No HS	Some HS	HS Diploma	Some college, No degree	Assoxiate Degree	Bachelor's Degree	Graduate Degree
Los Angeles	12.9%	9.0%	20.7%	19.3%	6.9%	20.4%	10.9%
Orange	8.5%	6.8%	17.3%	20.5%	7.8%	25.2%	13.9%
Riverside	9.3%	9.7%	26.4%	25.2%	8.0%	13.7%	7.8%
San Bernardino	9.3%	11.5%	26.2%	25.0%	8.2%	12.8%	6.9%
Ventura	9.7%	6.3%	18.9%	23.5%	9.0%	20.4%	12.2%
California	9.7%	7.8%	20.6%	21.5%	0.9%	20.4%	12.2%

Source: U.S. Census, American Community Survey, 2013-2017

High school graduation rates, or the number of high school graduates that graduated four years after starting ninth grade, are highest in Orange (89.2%), Riverside (88.9%) and Ventura (86.1%) counties. These rates are also higher than the state rate (83%). San Bernardino and Los Angeles counties are both modestly lower than the state rate.

Four-year Adjusted Cohort Graduation Rate

County	HS Graduation Rate 2017-18
Los Angeles	81.6%
Orange	89.2%
Riverside	88.9%
San Bernardino	83.4%
Ventura	86.1%
California	83.0%

Source: California Department of Education, 2016-2017

Primary Data: Economic Insecurity

Factors Contributing to Economic Insecurity

In the San Gabriel Valley, hikes in housing prices and associated costs of living over the last 10 years — coupled with stagnant wages in blue collar professions — have been two of the the main drivers of economic insecurity. While individuals and families' wages may not be below the federal poverty line, the high costs of housing and goods means that wages earned are no longer enough to cover basic expenses. For many, the response has been to move further away from the San Gabriel Valley, while continuing to commute in for work. This may translate to cost savings, but it also contributes to poorer quality of life and poorer health because of increased commute times, reduced time spent with family and friends, subsequent increased stress and lack of access to services because of the lower density of public services in more peripheral areas of the Valley.

> *"The increase in rent has really killed people. People are starting to qualify for homeless services because they've doubled up, tripled up, in houses. Homeless in schools — it's not the same definition as HUD. In public schools, you can be in a garage, transitional, doubled*

up, and count as homeless — we have 500 kids who are "homeless" now." — Key Stakeholder

"*People who worked a minimum wage job—they were able to pay rent before, but the real estate prices have gone up so much that now they have nowhere to go, so they become homeless."* — Key Stakeholder

"Our families — housing is quite expensive, or families had prior history staying with other relatives or friends. I had a family who told me it took her 12 years to get her section 8 come through. She was a single mom who was living with her mom, too. These are families who are trying to get work, and if they have had a difficult past, it's hard to get to that point of stability or the good job. There are a lot of single parent homes, including single dads taking care of 3-5 kids. They need a lot of support or resources." — Key Stakeholder

"People seem to move further and further east. 15 years ago [it] was a big deal to move out to Duarte, and now they have to move further out, and they are typically moving away from their employment." — Key Stakeholder

Populations Most Vulnerable to Poverty and Economic Insecurity

Immigrants, particularly undocumented immigrants, are vulnerable to poverty because of a number of factors including lack of eligibility to work in the formal economy, lack of knowledge of immigrants' housing rights coupled, and discriminatory housing practices.

"Do I have help paying rent? There are programs but there are no funds left — churches have these programs. It was homeless prevention funds, but it's not for long term. So how do you respond? You might live in with family — this is why we have a lot of people living together. Or you lie and say that your kids are pets to try to get a bigger family into a smaller space. When there are so many requirements to rent here — that you pay first and last deposit — it's a lot. You need someone to cosign with you, so that together you have 3x the rent in the bank. They want someone with a social security number. This is all very difficult. You also have to pay an application fee. They don't give it back even if you don't qualify." — Focus Group Participant

"Do I feel stressed? SICK, not STRESSED. You feel feo*. Alone, like you don't know where to go. I was "homeless" with my friend in Culver City for a while, because we were looking for a cosigner. Many people don't want to be cosigners. It's hard to be without social security. This makes me stressed out, and stresses out my little kid, too, because everything we own is in our car. And it's because the rent went up. It's also racial. I have two jobs, and I do have some money, but people still are not offering me a place.*" — Focus Group Participant

Additionally, seniors on fixed income are vulnerable to poverty and economic and housing insecurity.

"I see the communities with a tremendous financial strain — working class families and seniors on fixed incomes." — Key Stakeholder

Consequences of Economic Insecurity

For individuals and household heads who lack higher levels of education, are not native English speakers, or have disabilities or other factors that limit their ability to seek higher wage employment, there is an increasing feeling of just not being able to get by.

The proportion of the population facing economic and housing insecurity continues to grow as housing prices continue to increase. A majority (over 2/3) of the homeless population are not chronically homeless; rather, they have fallen into homelessness recently or are sporadically homeless. Stakeholders explained it

is all too easy for an economically insecure individual or family to slide into homelessness, and while there are many community resources available to support individuals and families who are housing insecure, many of the preventive or relief services have very stringent qualification criteria that are hard to meet.

Moreover, economic and housing insecurity contribute to stress, anxiety and depression. Stakeholders explained that individuals experiencing high economic stress operate in "fight or flight" mode. Poor mental health may result from or be exacerbated by stressful conditions.

Additionally, the psychological effort it takes to survive in difficult economic circumstances detracts from the time and energy available for preventive self-care.

> *"Being in a stressful situation, you're in fight or flight, you're not thinking down the line, you're thinking "how am I getting food today?" You don't think if the food is healthy or how it will affect your teeth. So preventive care is not a priority."* — Key Stakeholder

Finally, poverty feeds community violence, as the stress related to generational poverty influences behavior.

> *"When people don't have education and jobs they resort to a certain type of lifestyle. A lot of home robberies and burglaries are a result of poverty and people being desperate."* — Key Stakeholder

Importantly, poverty and economic insecurity are very difficult to move out of on one's own. This is particularly true for families with young children. Focus group participants explained that the high costs of child care stand in the way of earning a sufficient income to move out of poverty.

> *"Everyone says there are more job opportunities. Everything is a cycle and everything impacts everything. If I'm a single mom and I don't have free childcare and I can't afford it, I can't go back to work. How do I get myself skills to get back to the workforce?"*— Focus Group Participant

Effective Strategies Proposed by Stakeholders

- Educating the public about the different types of people who fall into housing insecurity and homelessness, to help ameliorate the stigma around "homelessness"
- Progressive communal living spaces
- Increasing availability of short-term, emergency and Section 8 housing
- Providing job training and financial literacy for free to families
- Increasing affordable, quality child care options and availability of affordable, quality early childhood education and development services
- Building relationships between wealthier communities and low-income communities, so there are stronger social ties and greater buy-in around the need to solve these issues collectively
- Building a collective understanding of the factors that make it so difficult to move out of poverty
- Increasing the number of food pantries in communities
- Services and support directed toward foster youth and transitional age youth as a preventive intervention
- Community organizing and community self-advocacy training, plus inclusion of low-income residents at policy decision-making tables
- Providing affordable, integrated health care that connects individuals to providers specializing in mental health care, substance use disorders and physical health care

- Increase understanding of material challenges facing housing insecure or homeless individuals/families: They lack a kitchen or place to store refrigerated foods; lack consistent access to a cell phone or Wi-Fi, and therefore lack access to maps and other online resources; may not be able to afford public transportation; lack access to bathing, toilet, and laundry facilities; lack access to places to store books and toys for kids; lack address required for job applications, etc.

IX. Health Access

How to Use This Section

By now, you should be forming a detailed picture of the residents in City of Hope's service area. Health access is an important issue, because it determines a person's ability to receive care for a health issue before it becomes critical. Even in a time when everyone is supposed to have health insurance, not everyone does. Think back to language, education level and poverty. How does a person with such barriers get health insurance or health care? This section explores how and where residents are obtaining health care. The data is mostly at the county level, and California data is provided for comparison. Data is provided at the SPA level wherever it was available. Remember, SPA stands for special planning area. For City of Hope, that means cities within our local service area. When you see SPA 3, it will include the San Gabriel Valley. You can use this data when writing grants or reporting on your programs.

Health Insurance

Health insurance coverage is considered a key component to accessing health care and improving quality of life. Navigating the health care system, accessing a health care location where needed services are provided, and finding health-care providers with whom the patient can communicate and trust are essential to improving (1) the overall physical, social and mental health status, (2) the prevention of disease and disability, (3) the detection and treatment of health conditions, as well a (4) life expectancy for individuals.[10]

Within the county service areas of interest to City of Hope, at least 9 out of 10 residents are insured, with San Bernardino County lagging its peers marginally. Of the five counties that make up City of Hope's regional service area, only Orange County residents (88.2%) are more likely to be insured, when compared to the state as a whole. In the Service Planning Area 3 of Los Angeles County, where the largest proportion of City of Hope patients come from, 93.2% of residents are insured — a rate that has increased by 7.3% since 2014. In California, as within the counties below, the proportion of insured children under 17 is

Insurance Coverage by County

	Total Population Insured	Adults 18-64	Children 17 and Under
Los Angeles	92.2%	88.5%	98.1%
SPA 3	93.2%	89.1%	100%*
Orange	93.3%	89.9%	98.6%
Riverside	91.5%	87.0%	96.5%
San Bernardino	89.9%	84.3%	99.6%
Ventura	90.3%	88.4%	89.8%
California	92.7%	89.1%	97.8%

Source: California Health Interview Survey, 2017

[10] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov/2020/ . Accessed [August 25, 2019].

significantly higher than insured adults. The exception to the rule is Ventura County where the gap between the two groups is nominal because fewer children under 17 carry insurance compared to peers in other counties by at least a 10% margin in the rate of insured.

Among the insured, the type of insurance coverage varies. The two most popular forms of insurance in both the state and the County are employer-based insurance and Medi-Cal.[11] Together, they make up more than two-thirds of insurance plans in California. Ventura and Orange carry particularly strong employment-based programs, with Orange County having more than half of its insured covered by employers. Medi-Cal rates are highest for San Bernardino (35.0%), Riverside (28.8%), and Los Angeles (29.4%) counties, compared to the state (25.0%). Further analysis would be required to determine whether Medi-Cal's popularity is a result of better access to the program or greater need within the geographic area since different Medicare health coverage programs are available for eligible residents.[12]

Type of Insurance Coverage

	Ventura	San Bernardino	Riverside	Orange	Los Angeles	California
Employment based	51.3%	37.7%	35.6%	51.8%	39.8%	44.4%
Medicaid and Medicare	3.5%	3.8%	4.8%	3.0%	5.7%	4.3%
Medi-Cal	14.6%	35.0%	28.8%	19.1%	29.4%	25.0%
Medicare and Others	10.2%	6.1%	10.5%	10.0%	7.5%	9.3%
Medicare Only	2.0%	2.2%	3.0%	1.2%	1.4%	1.6%
No Insurance	9.7%	10.1%	8.5%	6.7%	7.8%	7.3%
Other Public	0.9%	0.8%	1.4%	0.7%	1.8%	1.5%
Private Purchase	7.8%	4.5%	7.4%	7.5%	6.6%	6.5%

Source: California Health Interview Survey, 2017

For instance, Medicaid and Medicare represented a larger share of the coverage in Los Angeles County (5.7%) than the state (4.3%), while Medicare in combination with other programs was used proportionately more by California residents than Los Angeles County residents.

Even though 7.3% remain uninsured in California, the rate has dropped significantly from the 2014 rate of 11.9%. This downward trend holds true for all five counties, and particulary for Riverside where the uninsured rate dropped from 20.7% to 8.5% in three years.

In SPA 3, insurance coverage rates are as follow: Uninsured — 6.8%, Medicare and Medicaid — 3.2%, Medicare and others — 9.4%, Medicare only — 1.5%, Medical — 28.6%, employment based — 42.1%, privately purchased — 6.3%. They too indicate a strong employer-based insurance plan.

[11] Medi-Cal — California's Medicaid program — is a state-federal program that offers free or low-cost health coverage to Californians with low family incomes. Prior to the Affordable Care Act (ACA), Medi-Cal served low-income families and children, the elderly, and people with disabilities. Under the ACA, California lawmakers expanded the program to include low-income adults without children or a qualifying disability starting in 2014. https://www.ppic.org/publication/the-medi-cal-program/ Accessed (August 25, 2019].

[12] Medicare, a federal program administered by the Centers for Medicare & Medicaid Services (CMS), provides health insurance for people age 65 or older, those under age 65 with certain disabilities or ALS (amyotrophic lateral sclerosis, or Lou Gehrig's disease), and people of any age with End-Stage Renal Disease (kidney failure requiring dialysis or a kidney transplant). Available at https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare. Accessed [May 25, 2019].

Sources of Care

To attend to their medical care needs, most people visit the doctor's office. Indeed, approximately 59.2% of California residents have a doctor's office/HMO or Kaiser Permanente as their source of medical care, though the rate among Los Angeles residents is exactly 5% lower and is the lowest rate among County peers. Orange residents, on the other hand, have the highest rate at 67.1%.

Los Angeles County has some of the highest rates in alternative sources of medical care and no care in the service areas of interest to City of Hope. More so than California residents (25.7%) and county peers, approximately 28% of Los Angeles County residents visit a community clinic, government clinic or community hospital. Another 2.4% rely on emergency room or urgent care. Still, a significant proportion of Los Angeles County residents have no source of care at all (15.1%).

Of the five counties, San Bernardino has the lowest percentage of residents with no usual source of care (16.5%). The ER/urgent care is less likely to be the regular source of care in Orange County, with more than two-thirds of residents relying heavily on doctor's office, HMO or Kaiser Permanente.

Type of Usual Source of Care

	Dr. Office/ HMO/ Kaiser Permanente	Community or Government Clinic/ Community Hostpital	ER/ Urgent Care	Some other place/No one place	No Usual Source of Care
Los Angeles	54.2%	28.0%	2.4%	0.4%	15.1%
SPA 3	58.1%	27.4%	1.2%*	--	13.1%
Orange	67.1%	18.1%	0.7%*	0.7%*	13.4%
Riverside	60.3%	24.1%	2.3%*	0.4%*	12.9%
San Bernardino	59.5%	20.5%	2.7%	0.7%*	16.5%
Ventura	64.65	19.6%	1.8%*	0.6%	13.3%*
California	59.2%	25.7%	1.6%	0.5%	13.0%

Source: California Health Interview Survey, 2017

Within the population itself, differences in consistent source of care by age group do emerge. In all age groups, Los Angeles and San Bernardino County residents appear to lag behind their California counterparts in care. In Orange County, the youth have the higest rate (97.6%) in source of care among peer counties, while adults under 65 have the lowest rate (80.1%). A similar divergent pattern emerges in Riverside County. For residents 65 and over, Ventura County posted the highest rate in the range at 98.1%

Consistent Source of Care by Age

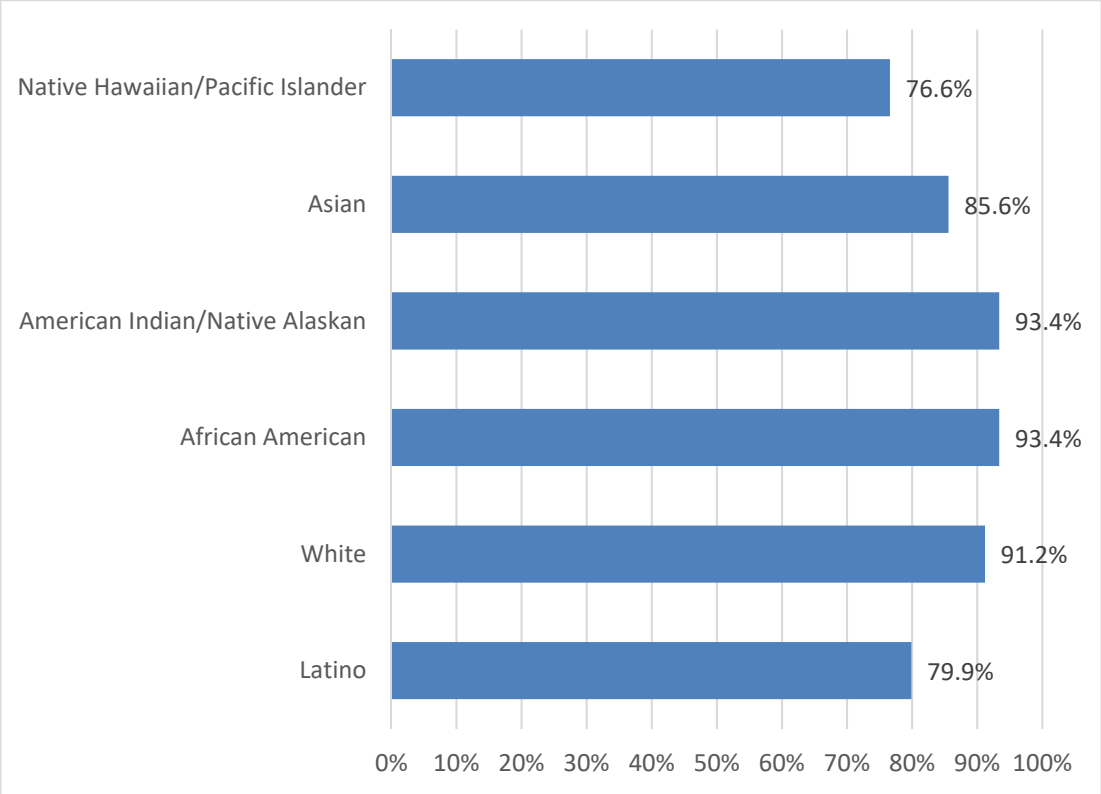
Report Area	Ages 0-17*	Ages 18-64	Ages 65+*
Los Angeles	88.9%*	81.6%	93.9%*
SPA 3	91.3%*	83.3%	95.0%*
Orange	97.6%*	80.1%	97.4%*
Riverside	96.7%*	80.8%	94.2%*
San Bernardino	84.4%*	81.0%	95.4%*
Ventura	89.1%*	83.7%	98.1%*
California	90.5%	83.7%	95.5%

Source: California Health Interview Survey, 2017 *statistically unstable

By reviewing disparities in source of care by ethnicity, hospitals and health care organizations may further develop culturally sensitive strategies in their outreach.

Among all ethnic groups, American-Indian/Alaskan Natives, African Americans, and Whites appear to have the highest access rates to usual care, at 93.4%, 93.4%, and 91.2% respectively. They have a usual source of care, whether it is the doctor's office, community clinic, an emergency room/urgent care or some other place. Native Hawaiian/Pacific Islanders (76.6%) and Latinos (79.4%) had significantly less access to care, with Asians (85.6%) falling closer to the median.

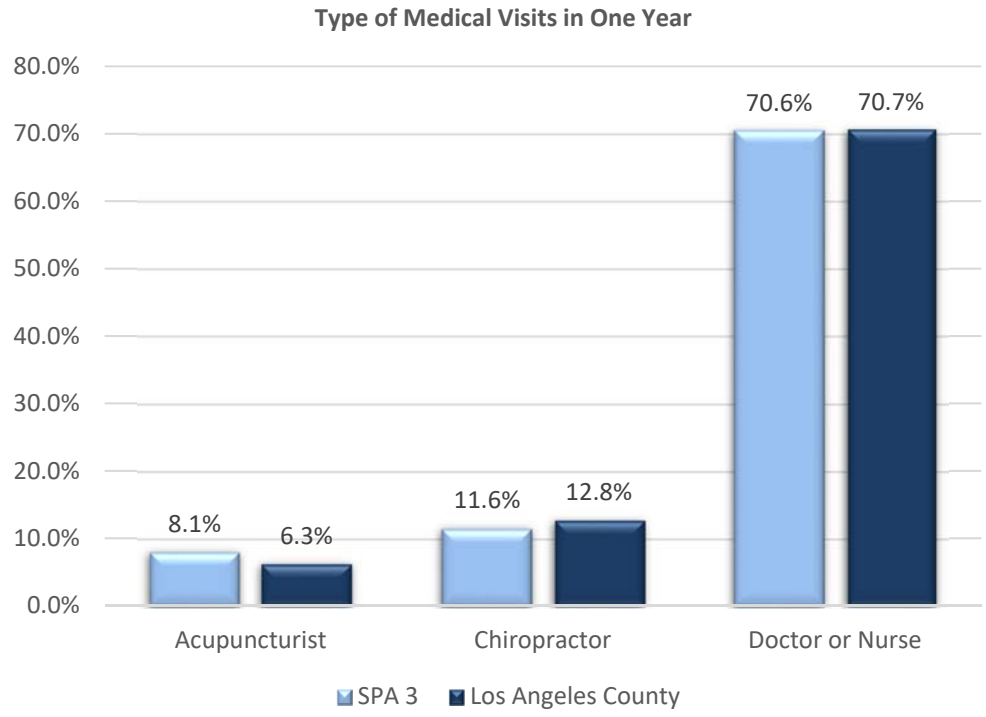
Has Usual Source of Care by Ethnicity in All Counties of Interest



Source: California Health Interview Survey, 2018

COMMUNITY SPOTLIGHT — Type of Care in Los Angeles County

Residents in Los Angeles County sought medical care from a doctor, nurse or other primary care professional, but also from alternative medical care practitioners such as acupuncturists and chiropractors. Over 70% of residents visited a doctor, nurse or primary care professional for any reason within one year. Approximately 12.8% and 6.3% of residents visited a chiropractor or an acupuncturist, respectively. In SPA 3, a slightly higher percentage of residents sought care from an acupuncturist (8.1%) as compared to Los Angeles County (6.3%) as a whole.



Source: Los Angeles County Health Survey, 2015

Barriers to Care

Access to medical care in communities is negatively affected by many factors including narrow supply of medical care professionals, high cost of care, language barriers and even transportation. Some of these barriers are further examined below.

Adequate supply of medical professionals to serve the population in a particular geographic area is critical, particularly in vulnerable communities where resources may be serverely limited. With the exception of Orange County, the other four counties had fewer primary care physicians available to serve their respective residents than California (1,270:1) and the United States (1,050:1). Clearly, in comparison to the nation, California and these City of Hope service area counties have a shortage of primary care physicians. Nowhere is this problem more pronounced than in Riverside County, where the ratio stands at 2,390 residents to 1 primary care physician, a ratio more than double that of the country.

Riverside County also fares worse in the supply of dental providers and mental health providers — 1,980:1 and 530:1, respectively. Only Orange and Ventura counties have ratios of dental providers greater than the state and the country. Ventura County also fares best in the supply of mental health professionals (290:1). Los Angeles County carries no particular advantage in supply of dentists when compared to the rest of the state.

Supply of Health Professionals

County	Primary Care: Population to Primary Care Physician Ratio	Dentist: Population to Dental Provider Ratio	Mental Health: Population to Mental Health Provider Ratio
Los Angeles	1,380:1	1,180:1	320:1
Orange	1,030:1	910:1	410:1
Riverside	2,390:1	1,980:1	530:1
San Bernardino	1,750:1	1,440:1	480:1
Ventura	1,310:1	1,130:1	290:1
California	1,270:1	1,200:1	310:1
United States	1,050:1	1,260:1	310:1

Source: County Health Rankings, 2019

When actually seeking medical care, adult residents in all counties of interest to City of Hope, except for those in Ventura, found it slightly less difficult to find primary care than all residents in the state (5.7%). About 6.4% of adults had difficulty accessing primary care in Ventura.

Like Los Angeles, Orange and San Bernardino counties, more than 1 in 10 adults in California also had difficulty finding specialty care. The rate stood at 12.5% in San Bernardino County; while adults in Ventura had the greatest difficulty finding primary care, they had more access than county peers to finding specialty care.

Challenges to Accessing Medical Care

Report Area	Difficulty Finding Primary Care, Adults	Difficulty Finding Specialty Care, Adults
Los Angeles County	5.0%	11.5%
Orange County	4.6%*	10.2%
Riverside County	4.9%*	9.0%*
San Bernardino County	5.1%*	12.5%*
Ventura County	6.4%*	5.3%*
California	5.7%	11.5%

Source: California Health Interview Survey, 2017 *statistically unstable

Another barrier is the delay of medical care. Approximately, 45.6% of residents in California delay care due to cost or lack of insurance, which speaks directly to the affordability of medical services. Residents in Orange and Ventura counties, in particular, struggled more than their California and county peers by at least a 10% and 5% margin, respectively.

Delaying or not getting medical care in a one year period was higest in Riverside (11.9%) and Ventura (12.0%) counties. The remaining counties were all below the California rate of 10.3%. Ventura County residents also struggled the most (11.8% rate) with delaying and not getting prescription medication within a 12 month period. However, the Service Planning Area 3 of Los Angeles County had a significantly lower rate (5.2%) than all the counties and the state's rate of 8.5%.

Insurance Coverage for Adults, Teens, and Children by County

	Delayed Care Due to Cost or Lack of Insurance	Delayed or Didn't Get Medical Care in Last 12 Months	Delayed or Didn't Get Prescription Medicine in Last 12 Months
Los Angeles	46.0%	9.5%	8.2%
SPA 3	50.9%	9.1%	5.2%*
Orange	56.2%*	8.5%	7.3%
Riverside	43.7%*	11.9%	8.4%
San Bernardino	43.6%	9.8%	8.5%*
Ventura	56.0%*	12.0%	11.8%
California	45.6%	10.3%	8.5%

Source: California Health Interview Survey, 2017

Other barriers that may also impact residents' ability to access care and require further study include language isolation and lack of transportation.

Use of the Emergency Room

A close look at emergency room (ER) use can lead to improvements in providing better community-based primary and preventive care. In close similarity to the state rate (20.6%), over 1 in 5 residents in Los Angeles County visited the emergency department within one year. The rate of ER access was lowest for residents in Orange County (16.4%) and highest for those in San Bernardino County (26.1%).

Residents 65 and older frequented the ER in greater proportions to their younger counterparts in California, though in certain counties (Riverside and San Bernardino) and Service Planning Area 3, the opposite trend held true. More than a quarter of California residents with income 100% below the Federal Poverty Level also frequented the ER, though the rate of visits by residents in San Bernardino County was significantly elevated (39.7%) than that of the state and other counties.

Emergency Department Usage

	Visited ED in Last 12 Months	0-17 Years Old	18-64 Years Old	65 and Older	<100% FPL
Los Angeles	21.7%	18.9%	22.1%	25.0%	25.1%
SPA 3	19.3%	24.1%*	17.3%	19.8%*	27.2%
Orange	16.4%	7.8%*	18.4%	21.9%*	22.5%*
Riverside	23.4%	27.2%	22.3%	21.5%*	20.5%*
San Bernardino	26.1%	31.5%	24.7%	20.9%	39.7%
Ventura	18.2%	12.1%*	19.5%	19.2%*	25.9*
California	20.6%	18.0%	21.0%	23.6%	26.0%

Source: California Health Interview Survey, 2017

Primary Data: Barriers to Health Care Access

Costs of Health Care: Insured and Uninsured

Stakeholders explained that the costs of health care services are not always covered by Medi-Cal or Covered California insurance, and can be prohibitively high. For example, medications, emergency department visits and ambulance rides, and other services may be deemed ineligible for insurance coverage and therefore become out-of-pocket costs. These costs can be prohibitive up front, and can also contribute toward medical debt that over the long term discourages patients from accessing additional medical services.

Stakeholders and focus group participants explained that many individuals and families are not low-income enough to qualify for Medi-Cal, but don't have enough income to afford other insurance options like Covered California. Many individuals are working one or several part-time jobs to get by, and these employers do not offer health care plans to hourly workers.

> "*These days there are a lot of challenges enrolling in Covered California. The young adults age out of their parents insurance, they have a part-time job, trying to be on their own, if they have a part-time job, sometimes they make too much to qualify for Medi-Cal, but they can't afford to purchase Covered California*." — Key Stakeholder

Stakeholders explained that insurance plans and high costs contribute to low rates of dental care access. A very small proportion of costs associated with dental care are covered by most insurance plans (if covered at all). This makes dental care financially inaccessible for a large proportion of the population. Moreover, the Denti-Cal reimbursement rates are so low, providers are disincentivized to provide services to the Denti-Cal population.

There are other associated costs to health care that include wages lost for hourly workers who have to drop shifts for doctor visits.

Effective Strategies Proposed by Stakeholders

- Free mobile clinics that visit workplaces, homeless encampments and areas where people living in cars can access
- Increasing access to free or affordable preventive care, including prenatal care
- Policies affording paid sick time for hourly workers
- Policy changes around Medi-Cal eligibility
- Policy changes around reimbursement rates for providers serving Medi-Cal and Medicare populations
- Providing health literacy/insurance literacy to the community
- Increase availability of affordable dental care services

Geography and Transportation

The San Gabriel Valley (SPA 3) is a very large service area. The intersection of factors including suburban development patterns (large geographic areas filled with housing tracts, lacking walking-accessible shopping areas/business corridors, and planned according to a reliance on private cars as the preferred mode of transportation), the uniform spacial distribution of high-need communities, and the relative lack of affordable health care providers (waitlists for Medi-Cal spots get filled in highest need communities) translates into a situation where geography and access to transportation produce real barriers to access to care and ability to adhere to treatment programs for chronic illness.

> *"We have another challenge — when the client comes and applies for Medi-Cal and is ready to select their primary care physician — there is a big challenge. There are limited providers*

who accept Medi-Cal in the area: if the client tries to pick a doctor who is close to them (they can walk there, don't have a car) we call and find out that the doctor doesn't accept Medi-Cal. In our area, I don't know what is happening, I don't know if the doctors are already booked or have total capacity for the Medi-Cal patients but they are full, and the patients get referred to places ouside of the area, which is very difficult because they don't have transportation. They will refer these clients to Azusa, El Monte, and they can't go there. We have seen this lately more and more." — Key Stakeholder

"What about if the service is far away? Can you get there? What if you are responsible for taking care of kids; it's hard sometimes to find a way to get there." — Focus Group Participant

Immigration Status

The current political climate conveys an anti-immigrant sentiment, and there have been many attempts at the federal level to limit undocumented immigrants' access to public resources and strengthen efforts to deport undocumented immigrants. This has led to fear among immigrant communities, as well as the widespread dissemination of inaccurate information about proposed immigration policies. For these reasons, many residents who are undocumented or have undocumented family members are less likely than in the past to seek and accept any public services, including health care. The concern is that disclosing immigration status to any service provider will facilitate the sharing of that information with law enforcement, and possibly lead to deportation or other legal action.

"We have clients who do not want to apply to Medi-Cal, they actually want to cancel — their lawyers tell them not to apply for these services." — Key Stakeholder

"There aren't many agencies to support undocumented Latin American immigrants here in San Gabriel Valley — the agencies are more in El Monte, Pomona. In La Puente, Azusa, etc., there aren't many places for them to go. But many of the families in these areas don't have transportation, so it is hard for them to go to Pomona, etc. There is a need for those types of agencies here in this area around West Covina." — Key Stakeholder

Cultural Responsiveness, Bias and Discrimination

Stakeholders and focus group participants explained that unconscious bias against the poor, the chronically homeless and seniors, lack of understanding of LGBTQ individuals/communities, lack of linguistic and cultural competency, and unconscious racial bias serve as barriers to health care. Bias and lack of understanding of various cultural groups interferes with the building of trust between practitioners and patients, and for some groups, contributes to generalized distrust in the medical system. Stakeholders and focus group participants offered examples of situations in which bias ultimately translated to what was perceived discrimination in treatment or poor treatment by doctors.

"I went to a mobile clinic. I have diabetes. The doctor was looking at his phone. He told me there was nothing he could do, that I should go to the ED. He didn't ask me any questions." — Focus Group Participant

"We are able to engage in conversations about addressing the health needs of immigrants, Latinos, or other groups, but we don't seem to be as ready or willing to address the health needs of the African-American population in the San Gabriel Valley." — Key Stakeholder

"It's a cultural situation, when you feel the personal service and assistance of the person — you know our parents and grandparents, we are so used to the doctor sitting down and seeing you eye-to-eye, and now these things are so fast and I know that the doctors don't have time to see every single patient. It makes things more difficult for the doctors, and the

patients don't feel they receive the service they were expecting — it has to do a lot with culture." — Focus Group Participant

"First and strongest factor is that there aren't enough providers who are culturally sensitive and offer services that are multilingual. This might be that we have a difficulty recruiting service providers who speak Spanish or are culturally sensitive. There may be competitive salary issues. Given how diverse our SPA is, it's difficult to find practitioners who understand all of the various cultures." — Key Stakeholder

"It is hard to deliver the campaign to improve Black maternal health outcomes but we don't have these moms signed up in our programs—the trust issue makes enrollment and retention very difficult." — Key Stakeholder

Effective Strategies Proposed by Stakeholders

- Integrate patient experience into health/health insurance policy decision-making
- Increase cultural competency and anti-bias training among service providers
- Increase trauma-informed care trainings among service providers
- Increase the number of service providers that share the cultural backgrounds and languages of clients
- Provide services that help patients understand how to best communicate with health care providers
- Provide culturally responsive health literacy training
- Increase use of promatoras
- Increase patient retention in health-care treatment programs by building more services that are rooted in cultural values and traditions (like Herald Cancer Center)
- Improve messaging indicating that providers are safe spaces for immigrants, LGBTQ individuals and other sensitive populations

X. Mortality/Leading Causes of Death

How to Use This Section

People die from many different causes. Use this section as a way of finding out what people are dying from and thinking about what other issues might be putting people at increased risk for one type of disease over another. It is interesting to see that people in Orange County are not dying as early as those living in San Bernardino County. Why is this? How is a premature cause of death different from other causes of death? The most obvious cause of premature death seems to be completely preventable. Learning about what people are dying from is usually a good place to begin exploring solutions for healthier communities. Pinpoint a leading cause of death and begin to consider what puts a person in a particular area at increased risk of death.

Premature Death

The County Health Rankings examine the years of potential life lost (YPL) before age 75 per 100,000 persons. California's 58 counties are ranked from 1 (lowest loss of potential life) to 58 (highest loss of potential life) based on the National Center of Health Statistics' mortality files. Premature death rates in the five counties that make up City of Hope's service area vary widely. Orange County has a ranking of 5 with 4,200 YPL. San Bernardino County has a ranking of 31, which puts it in the bottom 50% of counties statewide. Los Angeles County's ranking has improved from 19 to 15 from 2015 to 2019. Among the five counties of interest, only Ventura County dropped significantly in rankings from 6 in 2015 to 13 in 2019.

Years of Potential Life Lost Before Age 75 per 100,000 Population (age-adjusted)

Report Area	Years of Potentional Life Lost Rate[13]	2019 Ranking (out of 58 counties)	2015 Ranking (out of 58 counties)
Los Angeles County	5,000	15	19
Orange County	4,200	5	5
Riverside County	5,800	24	23
San Bernardino County	6,700	31	30
Ventura County	4,800	13	6

Source: California Health Rankings 2019. Alpine and Sierra counties not ranked.

Mortality Rates

The two leading causes of death in the City of Hope service area are heart disease and cancer. The age-adjusted cancer mortality rate is highest in San Bernardino County (155.1 per 100,000 persons), a rate

[13] "Years of Potential Life Lost (YPLL) is a widely used measure of the rate and distribution of premature mortality. Measuring premature mortality, rather than overall mortality, reflects the County Health Rankings' intent to focus attention on deaths that could have been prevented. YPLL emphasizes deaths of younger persons, whereas statistics that include all mortality are dominated by deaths of the elderly. For example, using YPLL-75, a death at age 55 counts twice as much as a death at age 65, and a death at age 35 counts eight times as much as a death at age 70." Available at https://www.Countyhealthrankings.org/app/california/2019/measure/outcomes/1/data?sort=sc-0 Accessed [August 20, 2019].

lower than the Healthy People 2020 goal of 161.4. Rates in the other four counties also fell below this target. HP2020 target for stroke (34.8) was met by Los Angeles County with a rate of 34.0. All counties have met the target for liver disease set at 8.2.

The following causes of death do not have a HP2020 target: coronary heath disease, chronic lower respiratory disease, Alzheimer's disease, diabete, and pneumonia. Within the last six years, counties have, for the most part, made progress in reducing mortality rates for leading causes of death except for stroke, liver disease, accidents and pneumonia, for which the results have been mixed. In California, the death rate from stroke has increased modestly from 35.9 in 2013 to 36.3 in 2019 as have the death rates from liver disease (11.7 vs 12.2) and drug-induced death (10.2 vs. 12.7).

San Bernardino County had the highest rates of death for coronary heart disease, stroke, chronic lower respiratory disease, diabetes and liver disease. Riverside County had the highest rates of death for coronary heart disease and unintentional injury. Ventura County had the highest rate of death attributed to Alzheimer's disease and drug-induced death. Los Angeles County had the highest rate of death from pneumonia and influenza.

Different Causes of Death by County (age-adjusted mortality rates per 100,000)

Causes of Death	LA	OC	Riverside	SB	Ventura	CA
All Cancers	132.8	129.1	141.1	155.1	140.0	137.4
Coronary Heart Disease	101.7	77.2	106.0	106.5	82.3	87.4
Stroke	34.0	35.9	34.9	42.0	37.6	36.3
Chronic Lower Respiratory Disease	28.2	26.8	40.3	51.5	31.3	32.0
Alzheimer's	35.6	38.6	37.8	38.6	42.6	35.7
Accidents	23.7	26.5	38.0	30.9	34.3	32.2
Diabetes	22.9	13.9	19.1	34.5	19.4	20.8
Influenza and Pneumonia	18.7	15.1	11.3	13.4	8.9	14.2
Chronic Liver Disease or Cirrhosis	13.2	10.7	13.0	15.8	10.7	12.2
Drug-induced Death	8.5	12.1	16.4	12.1	14.7	12.7

Source: County Health Status Profiles 2019

COMMUNITY SPOTLIGHT —

Leading Causes of Death in Ventura County

The 10 leading causes of death in Ventura County from 2012-2014 are as follows: cancer, coronary heart disease, stroke, Alzheimer's disease, chronic lower respiratory disease, accidents, diabetes, drug-induced deaths, suicides, and chronic liver disease and cirrhosis.

Alzheimer's disease is the fourth leading cause of death in Ventura County and ranked higher than in California where it is the fifth leading cause. Drug-induced deaths and suicide rank also higher in Ventura County than in California.

While in the top 10 causes of death in California, influenza and pneumonia do not appear in the Ventura County list. Meanwhile, chronic lower respiratory disease is only the fifth leading cause of death in Ventura County, but is the fourth leading cause of death in California.

	Ventura	California
1	All Cancers	All Cancers
2	Coronary Heart Disease	Coronary Heart Disease
3	Stroke	Stroke
4	Alzheimer's	Chronic Lower Respiratory Disease
5	Chronic Lower Respiratory Disease	Alzheimer's
6	Accidents	Accidents
7	Diabetes	Diabetes
8	Drug-induced Death	Influenza-Pneumonia
9	Suicide	Chronic Liver Disease or Cirrhosis
10	Chronic Liver Disease or Cirrhosis	Drug-induced Dealth

XI. Cancer Incidence and Mortality

How to Use This Section

City of Hope is designated by the National Cancer Institute as a comprehensive cancer center. Unlike many general nonprofit hospitals, City of Hope is a specialty hospital. Because of this, cancer is a big deal. The data in this section will help you understand who has cancer, where they live, whether they are taking preventive measures and what the community thinks about this. Community conversations about cancer are fascinating, because it becomes clear how inequalities in social and economic factors make it hard for people to prevent certain cancers and get help when they need it. Use this section to find information about variation in cancer prevalence by geography and racial/ethnic subpopulation. You can also use this section to compare cancer incidence against cancer mortality by subpopulation — observing that some groups are more likely to have shortened lifespan than others due to cancer.

Incidence

California reports 393.6 incidents per 100,000 persons for all types of cancer adjusted for age.

In the City of Hope's service area, the rates ranged between 408.77 in Ventura and 372.85 in Los Angeles. Incidents are highest for female breast cancer (120.9) and male prostate cancer (91.7). Myeloma and Testis are the least frequent forms of cancer reported. Only Ventura has a rate higher than the state in overall cancer incidence, driven by cases in female cancers (breast, uterine and ovarian), skin melanomas, thyroid cancers and non-Hodgkin's lymphoma.

San Bernardino County has the highest rates of prostate, colorectal, uterus, liver, kidney and renal pelvic cancers. Los Angeles County has the highest incidence of cancers of the stomach. Riverside County has the highest rate of lung and bladder cancers, and Orange County has the highest rate of skin melanoma.

Age-adjusted Cancer Incidence per 100,000 Persons, by County

	Los Angeles	Orange	Riverside	San Bernardino	Ventura	California
Cancer, All Sites	372.85	392.03	387.74	386.4	408.77	393.59
Prostate	89.84	89.34	98.02	100.01	93.58	91.72
Breast (female)	115.54	123.45	113.04	111.75	130.05	120.9
Lung and bronchus	36.13	38.72	42.62	40.88	39.31	41.36
Colon and Rectum	35.83	32.91	35.72	39.36	33.61	35.1
In situ Breast (female)	26.52	28.62	26.62	22.86	29.22	28.01
Uterus	25.09	23.59	23.73	26.22	24.14	24.62
Skin Melanoma	13.56	27.66	23.45	15.7	27.66	22.27
Non-Hodgkin's Lymphoma	17.95	18.78	16.32	15.53	18.59	18.3
Bladder (urinary)	15	15.8	18.24	14.96	17.68	16.72
Kidney and Renal Pelvis	13.54	12.72	14.12	15.95	14.1	14.16
Leukemia	11.67	12.09	11.17	11.93	13.65	12.28
Ovary	12.11	12.04	10.73	12.76	12.54	11.52
Thyroid	13.58	15.19	12.11	12.75	17.64	12.99
Pancreas	11.35	11.6	11.06	10.67	11.95	11.53
Liver and Bile Duct	9.56	8.62	7.52	9.63	7.65	9.49
Stomach	9.35	7.16	6.42	7.17	6.28	7.42
Cervix Uteri	7.78	6.44	8.3	8.85	7.29	7.31
Myeloma	5.83	5.82	5.54	534	5.24	5.84
Testis	5.68	6.02	5.15	6.29	6.43	5.91

Source**:** California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

At the state level, Whites and Blacks have higher incidence rates when looking across all types of cancers. In comparison to other ethnic groups, White persons have elevated cancer incidence rates for the following organ types: breast, uterus, skin, bladder, and ovary. Cancer incidence for Black persons is highest for prostate, lung, colon, kidney, pancreas, and myeloma, for which the incidence rates are over double than any other ethnic group. Asians have the least number of incidents, reporting 291.18 cases per 100,000, but they lead in thyroid, liver, and stomach cancer types compared to other ethnicities.

Age-adjusted Cancer Incidence per 100,000 Persons in California, by Race

	Latino	White	Asian/PI	Black	All
Cancer, All Sites	319.36	437.86	294.18	413.5	393.59
Prostate	81.38	92.51	50.67	139.33	91.72
Breast (female)	90.64	138.58	101.42	127.55	120.9
Lung and bronchus	24.01	47.87	35.07	52.41	41.36
Colon and Rectum	31.93	35.75	32.61	42.11	35.1
In situ Breast (female)	20.53	30.12	31.38	30.68	28.01
Uterus	21.98	25.68	20.67	25.02	24.62
Skin Melanoma	4.73	36.29	1.07	1.07	22.27
Non-Hodgkin's Lymphoma	17.08	19.86	14.04	14.5	18.3
Bladder (urinary)	9.48	21.31	8.58	12.72	16.72
Kidney and Renal Pelvis	16.24	14.32	8.26	17.06	14.16
Leukemia	10.05	13.69	7.72	10.64	12.28
Ovary	10.58	12.41	9.92	9.59	11.52
Thyroid	11.93	14.06	14.13	7.59	12.99
Pancreas	10.78	11.96	9.74	14.38	11.53
Liver and Bile Duct	13.09	6.79	13.2	10.96	9.49
Stomach	9.97	5.24	10.24	8.92	7.42
Cervix and Uterus	8.8	6.57	6.57	7.81	7.31
Myeloma	5.83	5.64	3.53	12.34	5.84
Testis	5.62	7.86	2.28	1.56	5.91

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

Within specific counties of interest to City of Hope, White persons report the highest incident ratings in comparison to all groups in all counties and the state, followed by Black persons who have higher ratings in Los Angeles and San Bernardino counties. Latinos and Blacks had had the lowest rates per 100,000 persons among all ethnic groups.

Within ethnic groups, Latinos report elevated incidents in San Bernardino (325.66) when compared to the State (319.36), while White persons have higher cancer rates in Los Angeles (438.56), Orange (442.44) and Ventura (450.15) than the state (437.86). Black cancer rates in these five counties were lower than the state peers, and only in Los Angeles was the rate for Asians slightly more elevated compared to state peers of Asian descent.

Age-adjusted Cancer Rates per 100,000 Persons by Race and County

County	Latino	White	Asian/PI	Black	All
Los Angeles	306.95	438.56	294.87	411.44	372.85
Orange	311.22	442.44	281.97	366.13	392.03
Riverside	306.45	425.64	257.66	384.31	387.74
San Bernardino	325.66	433.98	286.42	413.34	386.4
Ventura	317.68	450.15	281.21	-	408.77
California	319.36	437.86	294.18	413.5	393.59

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

Mortality

The average five-year mortality rate for select cancer types in SPA 3 are listed below:

Age-adjusted Cancer Mortality Rates per 100,000 Persons in SPA 3

	Age-Adjusted Rate
Lung Cancer	28
Breast Cancer	19.4
Cervical Cancer	2.3
Colorectal Cancer	15.5

Source: Los Angeles County Department of Public Health, 2017

The mortality rate per 100,000 cases has improved moderately in California, declining from 154.6 cases per 100,000 persons to 144.6 cases from 2012 to 2017. Rates remain more elevated than the state in Riverside (148.21) and San Bernardino (160.01). These rates are driven by the the highest mortality rates for the following cancerous organs: prostate, female breast, lung, colon and ovary.

Los Angeles County, which is the primary source of patients for City of Hope, has markedly higher mortality rates for female breast cancer, as well as colon, non-Hodgkin's lymphoma, pancreas, liver and stomach than the state.

Age-adjusted Cancer Mortality Rates per 100,000 Persons, by County

	Los Angeles	Orange	Riverside	San Bernardino	Ventura	California
Cancer, All Sites	140.21	135.66	148.21	160.01	142.23	144.6
Prostate	19.22	17.99	20	24.66	19.13	19.68
Breast (female)	20.04	18.72	21.08	23.22	18.65	19.76
Lung and Bronchus	27.3	28.39	33.2	34	27.26	30.65
Colon and Rectum	13.44	11.4	13.84	16.16	12.65	12.89
Uterus	1.83	1.24	1.34	1.75	1.81	1.88
Skin Melanoma	1.59	2.63	2.64	2.6	3.01	2.27
Non-Hodgkin’s Lymphoma	5.38	4.9	5.39	5.08	5.48	5.31
Bladder (urinary)	3.5	3.78	4.45	4.46	3.9	3.93
Kidney and Renal Pelvis	3.19	3.05	3.61	4.41	3.62	3.46
Leukemia	6.04	6.14	5.92	6.1	7.48	6.12
Ovary	7.05	7.12	7.56	8.15	8.12	7.08
Thyroid	0.71	0.56	0.68	0.82	0.82	0.64
Pancreas	10.39	10.43	10.4	9.73	11.22	10.31
Liver and Bile Duct	8.2	7.06	6.61	8.7	6.35	7.73
Stomach	5.25	3.57	3.57	4.32	3.45	3.99
Cervix Uteri	2.62	1.77	2.7	3.11	2.14	2.24
Myeloma	3.05	2.94	3.06	2.86	2.77	3.02
Testis	0.24	0.33	0.41	0.4	-	0.33

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

Among all Californians with cancer, the rate of mortality among Blacks is significantly higher than any other ethnic group and all groups combined. Most notable are the mortality rates for prostate, female breast, lung and colon for this ethnic group when compared to peers. The Latino and Asian populations appear to have a significantly higher mortality rate from liver and bile duct compared to other ethnicities while White persons have elevated rates from skin myeloma.

Age-adjusted Cancer Mortality Rates per 100,000 Persons in California, by Race

	Latino	White	Asian/PI	Black	All
Cancer, All Sites	123.88	155.25	110.09	187.53	144.6
Prostate	17.8	20.62	9.55	43.1	19.68
Breast (female)	15.75	21.74	13.01	31.09	19.76
Lung and Bronchus	17.82	35.51	24.65	41.26	30.65
Colon and Rectum	11.87	13.01	11.25	19.06	12.89
Uterus	1.5	1.92	1.41	3.69	1.88
Skin Melanoma	0.83	3.64	0.31	0.3	2.27
Non-Hodgkin's Lymphoma	5.42	5.54	4.2	4.4	5.31
Bladder (urinary)	2.37	4.94	1.81	4	3.93
Kidney and Renal Pelvis	4.03	3.48	2.22	3.58	3.46
Leukemia	5.21	6.72	4.01	5.74	6.12
Ovary	6.33	7.91	4.82	6.58	7.08
Thyroid	0.87	0.55	0.55	0.55	0.64
Pancreas	9.56	10.74	8.45	13.29	10.31
Liver and Bile Duct	10.68	5.74	10.26	9.1	7.73
Stomach	6.05	2.47	5.74	5.38	3.99
Cervix Uteri	2.78	1.92	2.12	3.01	2.24
Myeloma	3.02	3.06	1.57	6.55	3.02
Testis	0.36	0.33	0.16	0.21	0.33

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

At the county level, White and Black persons have consistently higher mortality rates per 100,000 persons in all counties. In comparison to the state, these five counties do not demonstrate particularly higher rates within ethnic groups. Exceptions to this rule are White persons in Ventura County (180.82) with significantly higher mortality rate than the state rate (155.25), and Black persons in Orange County (149.04) with significantly lower mortality rate than the state rate of 187.5.

Age-adjusted Cancer Mortality Rates per 100,000 Persons by Race and County

	Latino	White	Asian/PI	Black	All
Los Angeles	120.63	152.58	112.52	190.9	140.21
Orange	122.57	146.07	106.48	149.04	135.66
Riverside	122.83	158.23	103.95	182.56	148.21
San Bernardino	131.52	180.82	111.75	181.07	160.01
Ventura	120.96	153.11	100.66	----	142.23
California	123.88	155.25	110.09	187.53	144.6

Source: California Cancer Registry, California Department of Public Health, 2012-2016

Cancer Mortality Versus Incidence

One would expect to see the highest cancer incidence rates paired with the highest mortality rates, however, this is not always the case. For example, the incidence of breast cancer diagnosis is highest among White women, while the mortality rate from breast cancer is highest among Black women. Similarly, while the incidence of cervical cancer is highest among Latino women, the mortality rate is highest among Black women.

Age-adjusted Cancer Mortality and Incidence Rates per 100,000 Persons in California, by Race

	Latino		White		Asian/PI		Black		All	
	Mort.	Incid.	Mort.	Incid.	Mort.	Incid.	Mort.	Incid.	Mort.	Incid.
Cancer, All Sites	123.88	319.36	155.25	437.86	110.09	294.18	187.53	413.5	144.6	393.59
Prostate	17.8	81.38	20.62	92.51	9.55	50.67	43.1	139.33	19.68	91.72
Breast (female)	15.75	90.64	21.74	138.58	13.01	101.42	31.09	127.55	19.76	120.9
Lung and Bronchus	17.82	24.01	35.51	47.87	24.65	35.07	41.26	52.41	30.65	41.36
Colon and Rectum	11.87	31.93	13.01	35.75	11.25	32.61	19.06	42.11	12.89	35.1
Uterus	1.5	21.98	1.92	25.68	1.41	20.67	3.69	25.02	1.88	24.62
Skin Melanoma	0.83	4.73	3.64	36.29	0.31	1.07	0.3	1.07	2.27	22.27
Non-Hodgkin's Lymphoma	5.42	17.08	5.54	19.86	4.2	14.04	4.4	14.5	5.31	18.3
Bladder (urinary)	2.37	9.48	4.94	21.31	1.81	8.58	4	12.72	3.93	16.72
Kidney and renal pelvis	4.03	16.24	3.48	14.32	2.22	8.26	3.58	17.06	3.46	14.16
Leukemia **	5.21	10.05	6.72	13.69	4.01	7.72	5.74	10.64	6.12	12.28
Ovary	6.33	10.58	7.91	12.41	4.82	9.92	6.58	9.59	7.08	11.52
Thyroid	0.87	11.93	0.55	14.06	0.55	14.13	0.55	7.59	0.64	12.99
Pancreas	9.56	10.78	10.74	11.96	8.45	9.74	13.29	14.38	10.31	11.53
Liver and Bile Duct	10.68	13.09	5.74	6.79	10.26	13.2	9.1	10.96	7.73	9.49
Stomach	6.05	9.97	2.47	5.24	5.74	10.24	5.38	8.92	3.99	7.42
Cervix and Uterus	2.78	8.8	1.92	6.57	2.12	6.57	3.01	7.81	2.24	7.31
Myeloma	3.02	5.83	3.06	5.64	1.57	3.53	6.55	12.34	3.02	5.84
Testis	0.36	5.62	0.33	7.86	0.16	2.28	0.21	1.56	0.33	5.91

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

In addition, the ratio of mortality to incidence rates is highest among Black persons for all cancer types at 0.45. Black persons also have the highest ratios for the following cancer types: breast, lung, colon, bladder and testis. The Latino population has the highest ratios for skin melanoma and non-Hodgkin's lymphoma.

Ratios of mortality to incidence suggests cancer outcomes in California tend to be best among Asians and Whites, albeit a few exceptions for various cancers.

Age-adjusted Ratio of Cancer Mortality to Incidence per 100,000 Persons in California by Race

	Latino	White	Asian/PI	Black	All
Cancer, All Sites	39%	35%	37%	45%	37%
Prostate	22%	22%	19%	31%	21%
Breast (female)	17%	16%	13%	24%	16%
Lung and Bronchus	74%	74%	70%	79%	74%
Colon and Rectum	37%	36%	34%	45%	37%
Uterus	7%	7%	7%	15%	8%
Skin Melanoma	18%	10%	29%	28%	10%
Non-Hodgkin's Lymphoma	32%	28%	30%	30%	29%
Bladder (urinary)	25%	23%	21%	31%	24%
Kidney and Renal Pelvis	25%	24%	27%	21%	24%
Leukemia **	52%	49%	52%	54%	50%
Ovary	60%	64%	49%	69%	61%
Pancreas	89%	90%	87%	92%	89%
Liver and Bile Duct	82%	85%	78%	83%	81%
Stomach	61%	47%	56%	60%	54%
Cervix and Uterus	32%	29%	32%	39%	31%
Myeloma	52%	54%	44%	53%	52%

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

When examined at the county level, it is clear that cancer rates and cancer mortality rates tend to be lowest among Asians, and cancer incidence tends to be highest among Whites. Cancer mortality is highest among Blacks.

Age-adjusted Mortality and Incidence Rates for All Cancers per 100,000 Persons, by Race

	Latino		White		Asian/PI		Black		All	
	Mort.	Incid.	Mort.	Incid.	Mort.	Incid.	Mort.	Incid.	Mort.	Incid.
Los Angeles	120.63	306.95	152.58	438.56	112.52	294.87	190.9	411.44	140.21	372.85
Orange	122.57	311.22	146.07	442.44	106.48	281.97	149.04	366.13	135.66	392.03
Riverside	122.83	306.45	158.23	425.64	103.95	257.66	182.56	384.31	148.21	387.74
San Bernardino	131.52	325.66	180.82	433.98	111.75	286.42	181.07	413.34	160.01	386.4
Ventura	120.96	317.68	153.11	450.15	100.66	281.21	-	-	142.23	408.77
California	123.88	319.36	155.25	437.86	110.09	294.18	187.53	413.5	144.6	393.59

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

Based on the ration of mortality to incident rates, Blacks are still disproportionately impacted in every county of interest to City of Hope when compared to peer ethnic groups.

Age-adjusted Ratio of Cancer Mortality to Incidence per 100,000 Persons by Race and County

County	Latino	White	Asian/PI	Black	All
Los Angeles	39.3%	34.8%	38.2%	46.4%	37.6%
Orange	39.4%	33.0%	37.8%	40.7%	34.6%
Riverside	40.1%	37.2%	40.3%	47.5%	38.2%
San Bernardino	40.4%	41.7%	39.0%	43.8%	41.4%
Ventura	38.1%	34.0%	35.8%		34.8%
California	38.8%	35.5%	37.4%	45.4%	36.7%

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

Gender differences also emerge for each ethnic group. Incidences of cancer and its outcomes tend to be generally better among women than men, with the stark exception of Black women, whose rates are only marginally better than those of Black men. Recovery from cancer favors women who are Asian or White, and disfavors Asian and Black men. The disparity between the best and worst ratio of mortality to incidence is a 14.6% margin. Further assessment is necessary to determine the underlying causes for these differences.

Age-adjusted Cancer Mortality and Incidence Rates per 100,000 Persons in California, by Race and Gender

Race and Gender	Mortality	Incidence	Ratio Mortality to Incidence
Asian Women	94.84	300.05	31.6%
White Women	135.57	426.2	31.8%
All Women	126.09	380.76	33.1%
Latina Women	108.89	313.41	34.7%
White Men	181.91	459.66	39.6%
All Mmen	170.37	416.86	40.9%
Black Women	164.68	389.09	42.3%
Latino Men	145.9	336.64	43.3%
Asian Men	131.5	291.92	45.0%
Black Men	223.92	450.59	49.7%

Source: California Cancer Registry, California Department of Public Health, 2012-2016; Age-adjusted to 2000 U.S. Standard

Prevention: Cancer Screenings

New forms of cancer screening gain traction with the rapid pace of technology innovation.

Cervical Cancer Screening: The Healthy People 2020 objective for cervical cancer screening is for 93% of women ages 21 to 65 years to have a Pap smear within three years. In Los Angeles County, women are falling short of that goal, with only 84.4% having been screened. Screening rates are highest among African-American women (89.3%), followed by Whites (86.6%) and Latinas (85.7%). Screening rate among Asians is lower at 73.9%. Within Service Planning Area 3, the screening rate (81.2%) is lower than the state rate.

Women's Cancer Screening

Report Area	Pap Smear Rate (1)	Mammogram Rate (2)
SPA 3	81.2%	74.2%
Los Angeles County	84.4%	78.2%

Source: (1) Los Angeles County Health Survey, 2015 and (2) California Health Interview Survey, 2016

Breast Cancer Screening: The Healthy People 2020 objective calls for 81% of women ages 50 to 74 years to have a mammogram every two years. Mammogram screenings were moderately higher in Los Angeles County (78.2%) than the state (76.1%). The county rate had improved by 17% margin from five years earlier, but still failed to meet the healthy people benchmark.

In SPA 3, women did not exceed the objective, with 74.2% reporting having had a mammogram. Levels in the other counties of interest to City of Hope are lower, however, and range from a high of 80.9% in San Ventura County to a low of 71.6% in San Bernardino County.

Colorectal cancer screening: Screening is benchmarked at 70.5% in the Healthy 2020 Objective. The percent of adults ages 50 to 74 years in Los Angeles County who had a sigmoidoscopy within the past five years or a colonoscopy within the past 10 years was 54.6%. This rate was highest among Whites at 64.4%, followed by Asians at 62.2%, African Americans at 57.7% and Latinos at 42.0%.[14]

[14] Source: Los Angeles County Department of Public Health Health Assessment Unit: http://publichealth.laCounty.gov/ha/LACHSDataTopics2018.htm. Accessed Dec, 2019.

XII. Chronic Disease

How to Use This Section

This section, like the previous one, addresses health status and various chronic diseases, including diabetes, heart disease and high blood pressure. The data describes who gets its, where it occurs most often, and how the community thinks these conditions impact their lives. How could you use both types of data and opinions in building a program or delivering services when funding is lean? Community input can provide rich detail on how best to address barriers and ensure program success.

Health Status

The five counties reporting their population's health status as fair or poor ranged between 14.6% in Orange and 22.1% in San Bernardino. Like San Bernardino, Los Angeles and Riverside counties reported ratings, 19.3% and 19.0%, respectively, that were below the state's rate of 16.6%. The state's rate has remained unchanged in three years. Orange and Ventura counties reports ratings that improved modestly since 2014, while Service Planning Area 3 saw a significant improvement by a 5.7% margin. On the other hand, with a rating of 22.1%, more people in San Bernardino reported their health status worsen since 2014 by a 7% margin.

Health Status by County

Report Area	Fair or Poor Health 2017	Fair or Poor Health 2014	Rate of Change
Los Angeles County	19.3%	19.3%	0%
SPA 3	15.7%	21.4%	-5.7%
Orange County	14.6%	17.4%	-2.8%
Riverside County	19.0%	17.0%	+2.0%
San Bernardino County	22.1%	15.1%	+7.0%
Ventura County	16.0%	17.6%	-1.6%
California	16.6%	17.0%	-0.4%

Source: California Health Interview Survey, 2017

Diabetes

Approximately 10% of adults in California are diagnosed with diabetes, a rate that has increased by 1.8% since 2015. The condition appears to be more prevalent in Los Angeles County (12.1%) and San Bernardino County (14.6%), as well as Riverside County (14.6%) which saw a 6.4% increase in four years.

The rate of adults diagnosed as prediabetic or borderline diabetic stood even higher, at 15.6% in California. This rate has increased by 5.1% since 2015 which seems to suggest that more people are at risk of being fully diabetic. As with adults diagnosed with diabetes, Riverside County has seen the highest increase in pre- to bordline diabetic diagnoses, with a 10.0% increase in four years. This condition also appears to be on a significant rise in Los Angeles and San Bernardino counties, with increases of 8.6% and 8.3% respectively. In Service Planning Area 3, the pre/borderine diabetic rate stands at 15.3% (a 5.7% increase) and the diabetic rate is 9.3%.

Prevalence in Diabetes

Report Area	Diagnosed With Diabetes	Rate of Change 2015-2017	Diagnosed Pre /Borderline Diabetic	Rate of Change 2015-2017
Los Angeles County	12.1%	+2.1	17.4%	+8.6
SPA 3	9.3%*	-2.7	16.3%	+5.7
Orange County	8.8%	+1.7	13.8%	-2.3
Riverside County	11.9%	+6.4	18.1%	+10.9
San Bernardino County	14.6%	+2.1	18.5%	+8.3
Ventura County	9.9%	+2.9	12.7%*	+3.0
California	10.7%	+1.8%	15.6%	+5.1

Source: California Health Interview Survey, 2017

Among diabetic adults in California, approximately 60.1% felt very confident to control their condition and 32.7% felt somewhat confident. Almost 7.2% had no confidence in controlling the condition. Views of adults in counties of interest to City of Hope appear to be split. Ventura residents have a rating of 80.2%, exhibiting significantly more confidence than their peers in controlling the condition. In Riverside County, where diabetes is highly prevalent, fewer adults feel very confident (56.%). Instead, the County had the highest rating of adults feeling somewhat confident to control condition. As a matter of health policy, Riverside residents, perhaps, could benefit from better public education programs to boost their confidence levels in managing the disease.

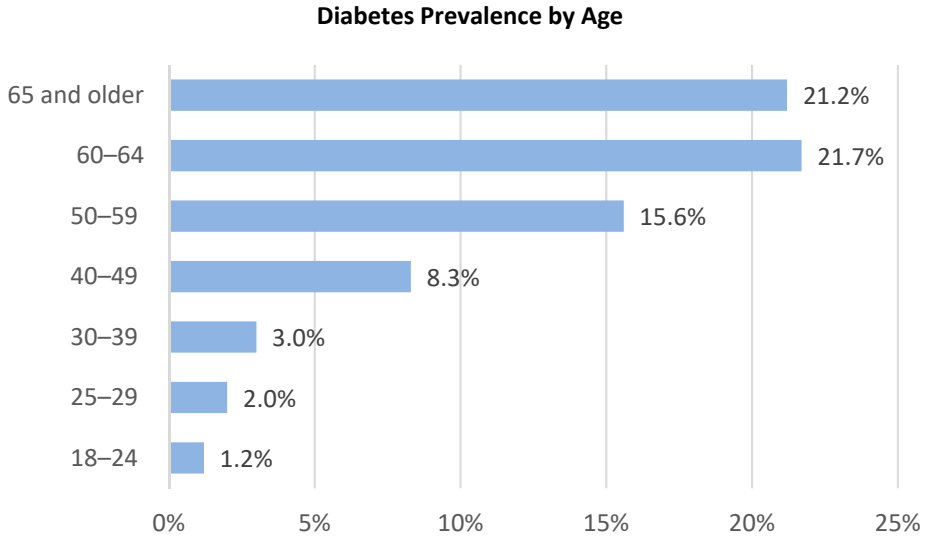
In Service Planning Area 3, the rate of diabetic adults with no confidence to control their condition (14.7%) appeared higher than both Los Angeles County (9.9%) and the state (7.2%).

Confidence Levels to Control Diabetes

Report Area	Very Confident to Control Condition	Somewhat Confident to Control Condition	Not Confident to Control Condition
Los Angeles County	56.7%	33.5%	9.9%*
SPA 3	58.7%*	26.6%*	14.7%*
Orange County	59.0%	37.4%	3.6%*
Riverside County	56.5%*	39.1%*	4.4%*
San Bernardino County	63.0%	28.6%	8.4%*
Ventura County	80.2%*	18.0%*	--
California	60.1%	32.7%	7.2%*

Source: California Health Interview Survey, 2017

Among different age groups in Los Angeles County, older adults are much more affected by diabetes as one would expect. In Los Angeles County, 42.9% or more than 2 out of 5 adults aged 60 and over were identified as diabetic. The percentage of diabetes prevalence drops significantly with each younger age group.



Source: Los Angeles County Health Survey, 2015

Heart Disease

According to the American College of Cardiology, "coronary events, in the United States in 2019, are expected to occur in about 1,055,000 individuals, including 720,000 new and 335,000 recurrent coronary events."[15] 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.[16]

Coronary hearth disease remains one of the leading causes of death in California with 6.6% of adults diagnosed for heart disease. In Los Angeles County, the rate of adults diagnosed with heart disease has increased moderately year after year, from 5.4% in 2015 to 5.6% in 2016 and 6.6% in 2017. This trend is more pronounced in Service Planning Area 3, where the diagnosis rate in 2017 was 7.1%. Within Los Angeles County, almost 1 in 10 White adults (9.5%) had heart disease, compared to 5.6% of Latinos, 8.2% of African Americans and 2.8% of Asians. All counties of interest to City of Hope had heart disease diagnosis rates equal or higher than the state rate, with Orange and San Bernardino counties having the highest rates at 7.7% and 7.6%, respectively.

Over three out of four adults diagnosed with the condition in California has a management plan to control their heart disease. In Ventura County, most diagnosed adults (91.0%) receive assistance from a care provider to manage their disease. The rate is higher than that of the state by 14.7% margin. Riverside County lags its peers in providing a management plan to patients, with less that two-thirds receiving a plan from a medical provider.

Among diagnosed adults managing their condition, more than half in the state (57.4%) appeared confident to control their condition. Almost all adults in San Bernardino County were either confident or somewhat confident to manage their condition whereas in SPA 3-of Los Angeles County, this rate was significantly

[15] Heart Disease and Stroke Statistics, 2019 Update: A Report From the American Heart Association. *Circulation* 2019; Jan 31. Benjamin EJ, Muntner P, Alonso A, et al. Available at https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2019/02/15/14/39/aha-2019-heart-disease-and-stroke-statistics. Accessed [May 26, 2019].
[16] Ibid

lower (86.8%) than peers and skewed more heavily toward those exhibiting modest confidence (53.0%). A full 13.2% in SPA 3 and 9% in Los Angeles County do not feel confident in managing their heart disease diagnosis. This rate is significant given that approximately 512,000 adults in the Los Angeles County are estimated to have heart disease. The rate of no confidence in Los Angeles is 3.2% higher than the state's rate of 5.8%.

Heart Disease Indicators

Report Area	Heart Disease Diagnosis	Heart Disease Management Plan*	Confidence Level to Control Condition (1)*		
	Percentage	Percentage	Very Confident	Somewhat Confident	Not Confident
Los Angeles County	6.6%	76.8%	53.5%	37.5%	9.0%
SPA 3	7.1%*	72,2%	33.8%	53.0%	13.2%
Orange County	7.7%	71.3%	70.1%	22.4%	7.5%
Riverside County	7.2%	64.6%	63.3%	31.8%	4.9%
San Bernardino County	7.6%*	76.6%	66.5%	33.5%	--
Ventura County	6.1%*	91.0%	54.8%	38.7%	--
California	6.6%	76.3%	57.4%	36.8%	5.8%

Source: California Health Interview Survey (CHIS), 2017 and (1) 2016 * statistically unstable

Mortality From Heart Disease

The rate of heart disease mortality per 100,000 persons among Californians is 87.4 which exceeds and is significantly better than the Healthy People 2020 national target of 103.4. Three counties, Los Angeles (101.7), Riverside (106) and San Bernardino (106.5) fail to meet the national target and lag significantly behind other California counties. Orange County, for instance, has a rate of 77.2. Its rate is better than that of San Bernardino County by a 29.3% margin.

Age-adjusted Heart Disease Death Rate per 100,000 Persons

Report Area	Rate
Los Angeles County	101.7
Orange County	77.2
Riverside County	106.0
San Bernardino County	106.5
Ventura County	82.3
California	87.4

Data source: California Department of Public Health (CDPH), 2016

COMMUNITY SPOTLIGHT —

Cholesterol Prevalence and Management in SPA 3

Some health conditions, as well as lifestyle and genetic factors, can put people at a higher risk for developing high cholesterol. Age is a contributing factor; as people get older, cholesterol level tends to rise. Diabetes can also lead to the development of high cholesterol.

Certain behaviors can also lead to high cholesterol, including a diet high in saturated fats, trans-fatty acids (trans fats), dietary cholesterol or triglycerides. Being overweight and physical inactive can also contribute to high cholesterol levels.

In Service Planning Area 3, the primary patient source for City of Hope, 23.7% of the adult population is diagnosed with high cholesterol which is lower than Los Angeles County's rate (25.2%). In the past, significant proprotions of residents (8 out of 10 patients) in SPA 3 diagnosed with cholesterol were provided with a disease management plan.

Cholesterol Indicators

Report Area	Cholesterol Diagnosis Percentage	Cholesterol Management Percentage (1)
SPA 3	23.7%	81.4%
Los Angeles County	25.2%	68.7%
California	--	64.8%

Data source: Los Angeles County Health Survey, 2015 and (1) California Health Interview Survey, 2009

Hypertension Prevalence and Management

High blood pressure is a leading risk factor for cardiovascular disease. Risk factors for hypertension include moking, obesity, the regular consumption of salt and fat, excessive drinking and physical inactivity. The population living in Orange County and Service Planning Area 3 is less prone to hypertension (22.4% and 23.5%) than its respective counterparts, such has those living Ventura County where the hypertension diagnosis rate (35.3%) is significantly higher that the state rate of 28.4%.

Only two-thirds of California adults with high blood pressure took medication to control their high blood pressure. In some areas like Orange County and Riverside County, fewer proportion of adults took medication, with rates at 60.6% and 61.8% respectively. This suggests that 4 out of 10 adults that could control their condition with medication do not. Nowhere is this more prevalent than in San Bernardino County. Slightly more than half of diagnosed residents (56.4%) there take medication for hypertension despite the elvetated diagnosis rate (31.1%) of this medical condition compared to county peers.

Hypertension Diagnosis and Medication Rates

Report Area	Hypertension Diagnosis Percentage	Hypertension Medication Percentage
Los Angeles County	28.1%	67.3%
SPA 3	23.5%	67.8%
Orange County	22.4%	60.6%
Riverside County	28.4%	61.8%
San Bernardino County	31.1%	56.4%
Ventura County	35.3%	73.9%*
California	28.4%	65.1%

Source: California Health Interview Survey (CHIS), 2017

Primary Data: Factors Contributing to Chronic Illness

Nutrition and Physical Activity

Stakeholders explained that proper nutrition and physical activity are key to preventing chronic illness or supporting the maintenance of chronic illness. They recognized, however, that good nutrition and physical activity are difficult to attain in the context of economic stress.

> *"It's hard to manage sugar and eating healthy even when you have access and means to afford it. Disproportionally lower income populations are more impacted as they have less money and are managing multiple jobs. They have less time to make healthy meals and less income to afford health options. For the same reasons, homeless people have a huge difficulty staying healthy."* — Key Stakeholder

> *"It's hard to eat well even when you know the health consequences of not doing so. It's also difficult to have the discipline to say no. It also takes time for healthy meals. Many lack access to food on a regular basis that's healthy and affordable."* — Key Stakeholder

> *"With my particular population, we have children who are in group homes for examples — all these services and resources we have are available to them, and we reach out to these group homes regularly with very little participation from them. I would say that no, I don't think that nutrition is something they are properly exposed to. We have families who are new to a homeless situation, and now we have to eat frozen meals, etc.; we can't cook anymore."* — Key Stakeholder

Economic and Housing Insecurity

Stakeholders explained that for many with unmanaged chronic conditions, lack of economic resources is a primary underlying factor.

> *"They don't have money to purchase good food. They don't have money to purchase medications that are recommended."* — Key Stakeholder

> *"They are using so much of their funds to sustain housing that they don't comply with what the doctors are asking them to do. The conditions don't get better or they reach a crisis and ended up in emergency room, which is more expensive. This contributes to a cycle of not being able to sustain themselves and their health."* — Key Stakeholder

"Our clients — when they are sick with cancer, they have to quit their jobs to receive treatment. The lose the source of income. That's another thing that we have to do for them — help find resources. There are very few resources available for financial assistance during their treatment. As soon as they recover, they immediately go back to work because they have to survive." — Key Stakeholder

Chronic Illness Among the Homeless

The homeless population has the poorest access to resources needed to diagnose, treat and manage chronic illness. For example, both temporarily and chronically homeless individuals with diabetes lack access to refrigeration to store insulin. Moreover, the day-to-day challenges of homelessness require a high amount of vigilance and resourcefulness directed toward protecting personal safety, finding food and maintaining a warm, dry place to sleep. Additionally, many chronically homeless are co-morbid or tri-morbid, meaning they have been diagnosed with two or three chronic conditions (including mental or behavioral health diagnoses). In this context, managing chronic illness is extremely difficult, as most chronic disease management requires consistent contact with health care providers and sustained engagement in treatment.

Effective Strategies Proposed by Stakeholders

- Build chronic disease prevention services and support groups into spaces where people already go, including churches and schools, and build the services with the input of the people who would receive them
- Policies to increase the number of affordable healthy food vendors in low-income communities

XIII. Health Behaviors

How to Use This Section

Many of our health problems exist because of lifestyle or health habits that increase the risk of death and chronic disease. Below you will explore such behaviors that increase risk for residents of our five local counties and the San Gabriel Valley. At City of Hope, we know that obesity increases the risk for chronic disease like diabetes and cancer. We also know that if you have diabetes, your ability to fight cancer is weaker than if you did not have diabetes. Using health behavior data related to obesity can help us design programs that get to the root causes of obesity and, ultimately, address risk factors for diabetes and cancer.

Health Behaviors

County Health Rankings ranks counties according to health behaviors. California's 58 counties are ranked from 1 (healthiest) to 58 (least healthy) based on a number of indicators that include adult smoking, obesity, physical inactivity, excessive drinking, sexually transmitted infections, and others. The five counties that make up City of Hope's service area vary widely in their health behavior rankings, from Orange County, which is in the top 25% of California counties for healthy factors and health outcomes, to San Bernardino, which is in the bottom 25%.

Health Behaviors Ranked, by County[17]

County	Health Factors	Health Outcomes
Los Angeles County	35	25
Orange County	8	7
Riverside County	40	28
San Bernardino County	45	46
Ventura County	11	10

Source: 2017 County Health Rankings [18]

HIV/AIDS

The diagnosis of HIV infection is declining steadily in the United States from 41,180 to 38,281 cases, a 7% change, with Black/African Americans (41.1%) disproportionately representing the largest share of cases compared to any other ethnic group.

The rate of new cases of HIV are higher for the Los Angeles/Long Beach/Anaheim Metropolitan Statistical Area (MSA) than for the state (11.4), and lower for the Riverside/San Bernardino/Ontario MSA (10.7) than for the state. In all three areas reported, however, the rate has dropped since 2012. In that time, LA/Long

[17] Ranking for health factors is based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Rankings for health outcomes is based on an equal weighting of length and quality of life.
[18] Available at https://www.Countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_CA.pdf Accessed [August 22, 2019].

Beach/Anaheim MSA has declined at a faster rate than its peer MSA or the state, from 18.1 to 13.7 with a rate of change a 4.4%.

The rate of persons living with diagnosed HIV infection remains unchanged from 2012 except for the Riverside/San Bernardino/Ontario MSA where the rate has increased from 186.2 to 252.3. Among those living with AIDS (stage 3), LA/Long Beach/Anaheim MSA has a rate (220.3) significantly greater than its counterpart (152.4) below. However, as with person living with diagnosed HIV infection, the rate for persons living with AIDS has increased from 120.3 to 152.4 per 100,000 persons in seven years while the rate for comparison groups has remained farily stable.

HIV/AIDS per 100,00 persons, by Metropolitan Statistical Area, in 2012

County	LA/Long Beach /Anaheim MSA		Riverside/San Bernardino /Ontario MSA		California	
	Number	Est. Rate	Number	Est Rate	Number	Est Rate
New HIV cases	1,832	13.7	490	10.7	4,500	11.4
Living with diagnosed HIV Infection	54,845	411.5	11,412	252.3	126,129	385.1
Living with AIDS (stage 3)	29,368	220.3	6,893	152.4	70,547	215.4

Source: Center for Disease Control, 2017[19]

Sexually Transmitted Disease

Sexually transmitted diseases are important at City of Hope because they represent preventable risk factors for cancer. Rates of sexually transmitted diseases (STD) vary widely among the five counties that make up the hospital service area. Los Angeles County has the highest rates in all classes of sexually transmitted diseases (STD) among peer counties of interest to City of Hope. Only Los Angeles has STD rates higher than California in all categories, except for chlamydia for which San Bernardino also has an elevated rate (607.9 vs. 552.2 in California).

Rates are generally lowest in Ventura County. For instance, chlamydia varies from a low of 332.7 cases per 100,000 persons in Ventura County to the 626.2 cases per 100,000 in Los Angeles County. Rates of gonorrhea vary from 83.5 per 100,000 persons in Ventura County to 254.2 per 100,000 in Los Angeles County. Similar patters emerge for syphilis cases.

[19] Diagnoses of HIV Infection in the United States and Dependent Areas, 2017. HIV Surveillance Report. Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. Available at https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2017-vol-29.pdf Accessed [August 15, 2019].

Rate of Sexually Transmitted Diseases per 100,000 Persons, by County

County	Chlamydia	Gonorrhea	Primary and Secondary Syphilis	Early Latent Syphilis
Los Angeles County	626.2	254.2	19.5	27.3
Orange County	438.2	111.7	11.5	10.0
Riverside County	467.3	140.6	10.8	12.0
San Bernardino County	607.9	184.5	11.2	10.7
Ventura County	332.7	83.5	6.1	4.9
California	552.2	190.3	16.8	17.8

Source: California Department of Public Health, Incidence Rates 2013-2017[20]

Overweight and Obesity

Obesity reduces life expectancy and causes devastating and costly health problems. Eventual complications include coronary heart disease, stroke, high blood pressure, diabetes and a number of other chronic diseases. Obesity may also increase the risk of cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder and possibly other cancer types.[21]

Data trends for the adult population reveal a decrease in the rate of overweight people between 2015 and 2017 in Los Angeles County by 4.6% and California by 2.3%. The rate remains unchanged for obese adults in Los Angeles County, while the California rate has also decreased by 5.7%. Nevertheless, in California, more than a quarter of adults have reported being obese. Rates of obesity are significantly higher in Riverside (33.2%), San Bernardino (29.2%) and Los Angeles (28.2%) counties. Ventura and Orange reported rates lower than the State, at 23.8% and 20.1% respectively. Service Planning Area 3 diverges from the rest of Los Angeles County reporting a the lower rate of 22%. In addition, a third of California adults are overweight with nearly all states reporting rates similar or higher to the State. San Bernardino County tops at 38.3% of adults as overweight.

In contrast, trends within the youth population reveal a mixed picture: In California, the rate for overweight children (14.5%) has stagnated with a moderate 3.3% reduction over three years. In Los Angeles County, the rate is 11.4% in 2017, an increase of 12.5% over the same longitudinal period. Perhaps most disturbing are the obesity rates among teens with California reporting 14.9% as obese. Though the reported values are unstable at the county level, they do raise questions about the nutritional habits of teens, especially in Riverside where the rate is nearly triple that of the state. Riverside County also reports a disproportionately higher rate of overweight children (23.9%), who are at greater risk of becoming obese.

In many counties reported below, the rate of overweight persons appears to increase with age. This may suggest that any intervention may require screening and training youth early on nutrition.

[20] Available at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx. Accessed [August 15, 2019].

[21] National Cancer Institute. *Obesity and Cancer Risk*. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed [August 2, 2019].

Obesity and Overweight Rate, by Population Type

Report Area	Obese Adults	Obese Teens	Overweight		
			Adults	Teens	Children
Los Angeles County	28.2%	14.0%*	32.9%	12.5%*	11.4%
SPA 3	22.0%	--	37.5%	12.3%*	5.8%*
Orange County	20.1%	22.4%*	33.5%	18.4%*	11.9%*
Riverside County	33.2%	43.7%*	30.8%	9.3%*	23.1%*
San Bernardino County	29.2%	12.7%*	38.3%	--	17.9%*
Ventura County	23.8%	--	36.4%	--	18.1%*
California	26.4%	14.9%	33.9%	15.1%	14.5%

Source: California Healthy Kids Survey, 2017

Ethnic disparities do emerge in overweight and obese adults. The Asian population has the lowest combined rate for both overweight and obese (39.5%) adults, while the African American population has the highest rate (71.9%) in the state even though the statistical distribution from county to county is quite significant. For instance, in Orange and San Bernardino counties, the rates are 61.7% and 61.3%, respectively, while in Service Planning Area 3 and Ventura County, the rates are drastically higher, 89.6% and 84.8%, respectively.

Rate of the Latino population (70.4%) is similar to that of the African American population, as shown in the chart below. It is interesting to note the inverse trend of the Latino rate to the African American rate when reviewing specific geographic areas: the highest rates for African Americans in a given county are the lowest rates for the Latino population.

Also, more than half of the White population is overweight or obese (57.2%) in California with four of the six areas of interest skewing towards higher rates than the state. Latino and African-American populations in Los Angeles County are slightly above the California rate for overweight or obesity, while the White and Asian populations in the county have a moderately lower rate than the state.

Overweight and Obese Adults by Ethnicity

Report Area	Latino	White	African American	Asian
Los Angeles County	70.7%	55.0%	74.5%	36.9%
SPA 3	63.7%*	63.1%	89.6%*	31.4%*
Orange County	68.6%	53.4%	61.7%*	29.3%
Riverside County	67.3%	61.5%	76.1%*	46.7%*
San Bernardino County	73.2%	66.5%	61.3%*	47.3%*
Ventura County	58.7%	58.1%	84.8%*	63.4%*
California	70.4%	57.2%	71.9%	39.5%

Source: California Health Interview Survey, 2018

Fast Food

Many research studies, including a recent metastudy, have shown that frequent fast food consumption lead to "overweight and abdominal fat gain, impaired insulin and glucose homeostasis, lipid and lipoprotein disorders, induction of systemic inflammation and oxidative stress. Higher fast food consumption also increases the risk of developmental diabetes, metabolic syndrome and cardiovascular disease." [22] These adverse effects from poor dietary patterns remain a tremendous burden on public health.

In California, nearly 1 in 4 children and adults consume, on average, three or more fast food meals per week. The population in San Bernardino County faces a rate that is significantly higher with 42.4% of children consuming as much. Oddly, Ventura County has a significantly high proportion of children (38.5%) consuming frequent fast food per week. It is, however, the only county of interest to City of Hope that, in comparison to its youth, has a disproportionately lower rate of frequent fast food consumers among the adult population (20.2%). This rate is also lower than the state rate by 5.2%. Meanwhile, the rate for children ages 2 to 17 in SPA 3 stands at 9.0%, while the rate among adults in the same geographic area is 32.7%.

Average Consumption of Fast Food Three or More Times a Week

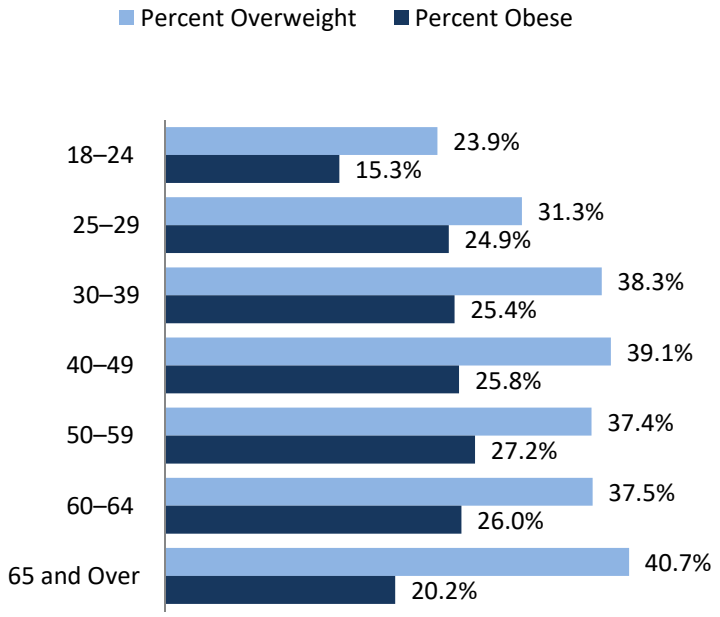
County	Children 2-17	Adults 18+
Los Angeles County	22.4%	29.4%
SPA 3	9.0%*	32.7%
Orange County	21.7%*	29.1%
Riverside County	33.4%*	28.3%
San Bernardino County	42.4%*	40.0%
Ventura County	38.5%*	20.2%
California	23.4%	25.4%

Source: California Healthy Kids Survey, 2016

[22] Bahadoran Z, Mirmiran P, Azizi F. Fast Food Pattern and Cardiometabolic Disorders: A Review of Current Studies. Health Promot Perspect 2015; 5(4): 231-240. doi:10.15171/hpp.2015.028. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772793/. Accessed [August 30, 2019].

COMMUNITY SPOTLIGHT — Adult Overweight and Obesity Prevalence by Age in Los Angeles County

Two-fifths of adults 65 years old and older (40.7%) were overweight, and adults between 50-59 years of age had the highest obesity rate (27.7%). While adults 18-24 had the lowest rates among the different age groups, close to one in four were overweight and over 1 in 6 were obese.



Source: Los Angeles County Health Survey, 2015

Fruit Consumption

More than two thirds of California children consume at least two fruits per day. Only Riverside County children, at 60.7%, consume less than their state counterparts. Orange County (85.1%) and Ventura County (77.0%) have the highest rates among children.

Only teens in San Bernardino County consume two or more servings of fruit per day than their younger counterpart. As in the entire state, teens typically consume less fruit per week than children do. The state posts a rate of 62.5%.

Fruit Consumption: 2 or More Servings per Day

Report Area	Children (2-12)	Teens 13-17
Los Angeles County	73.1%	61.6%
SPA 3	71.5%*	72.9%*
Orange County	85.1%*	66.5%*
Riverside County	60.7%	53.5%*
San Bernardino County	74.2%*	86.6%*
Ventura County	77.0%*	--
California	68.9%	62.5%

Source: California Healthy Kids, 2017

Soda Consumption

More than 1 in 10 adults consume four or more sodas per week, a rate not too dissimilar from that of Los Angeles County (12.0%), Service Planning Areas 3 (11.2%), Orange County (11.7%) and Ventura County (13.9%). On the other hand, a significantly greater proportion San Bernardino County (15.6%) and Riverside County (13.9%) adults consume soda. Among teens in California, approximately 10.4% consume two or more sugary drinks per day. The rate was moderately lower among reporting counties. Compared to sugary drinks, soda drinks appear less popular with all youth. Only 4.1% of California youth consume it regularly at least twice per day.

Soda Consumption Rates by Age Group

Report Area	Soda 4+ per week Adult	Soda 2+ previous day >18 years	Sugary Drink 2+ previous day Teen
Los Angeles County	12.9%	4.3%*	9.2%
SPA 3	11.2%	--	--
Orange County	11.7%	--	7.7%*
Riverside County	14.2%	5.3%*	9.6%*
San Bernardino County	15.6%	--	7.2%*
Ventura County	13.9%	--	--
California	12.8%	4.1%	10.4%

Source: California Health Interview Survey, 2017

Physical Activity

In areas of interest to City of Hope, three counties have more children engaging in one hour of physical activity at least three days per week than all California children: rates of Orange, San Bernardino and Ventura counties are 87.0%, 84.4%, and 81.6% respectively. The same counties have higher rates of engagement from teens, with 96.6% of Ventura County teens engaged the most. Among youth in SPA 3, 62.3% of children engage in physical activity three or more days per week, while 78.1% of teens are equally active.

Similarly, more than 8 out of 10 youth age 17 and under visit a park, playground or open space in all reported geographic areas. The proportional differences among these areas were nominal except in San Bernardino and Ventura counties where visiting rates are 93.1% and 92.2%, respectively. 88.3% of SPA 3 youth visited a park, playground or open space in the past month. At the County level, Orange County children have the lowest rate of physical activity (80.2%).

Physical Activity in Children and Teens

Report Area	Child Engaged in at Least 1 Hour of Physical Activity 3-7 Days of the Previous Week (1)	Teen Engaged in at Least 1 Hour of Physical Activity 3-7 Days in a Typical Week (2)	Youth Visited Park, Playground or Open Space in the Last Month (1)
Los Angeles County	77.2%	65.6%	84.7%
SPA 3	62.3%*	78.1%*	88.3%*
Orange County	87.0%*	77.4%*	80.2%*
Riverside County	75.1%*	63.2%*	86.7%*
San Bernardino County	84.4%*	72.0%*	93.1%*
Ventura County	81.6%*	96.6%*	92.2%*
California	78.3%	72.3%	84.4%

Report Area	Child Engaged in at Least 1 Hour of Physical Activity 3-7 Days of the Previous Week (1)	Teen Engaged in at Least 1 Hour of Physical Activity 3-7 Days in a Typical Week (2)	Youth Visited Park, Playground or Open Space in the Last Month (1)

Source: California Healthy Kids Survey, (1) 2017 and (2) 2016

Substance Abuse

Tobacco Smoking

Tobacco use is known to cause cancer, heart disease, lung disease (such as emphysema, bronchitis and chronic airway obstruction), premature birth, low birth weight, stillbirth and infant death.[23] Smokeless tobacco use such as chewing tobacco or vaping, which has made national healdlines, can also cause a variety of oral health problems, like cancer of the mouth and gums, tooth loss, periodontitis, and even death.

Despite all the public health warnings and risks of further disease, 1 in 10 adults in Calfornia still smoke and another one out of five (21.8%) are former smokers. In SPA 3, 9.1% of adults smoke cigarettes, which is lower than the state's rate. In Riverside County, 12.0% of adults smoke, and in San Bernardino County, 14.2% of adults smoke. These levels exceeds the Healthy People 2020 objective of 12%.

The percent of self-reported persons who never smoked in counties below ranges from 63.1% in Riverside County to 71.5% in Los Angeles. In California, the rate of these nonsmokers is 68% and has marginally improved by 2% over five years.

Cigarette Smoking Among Adults

Report Area	Current Smoker	Former Smoker	Never Smoked
Los Angeles County	8.9%	19.6%	71.5%
SPA 3	9.1%	19.5%	71.4%
Orange County	8.5%	22.3%	69.2%
Riverside County	12.0%	24.9%	63.1%
San Bernardino County	14.2%	20.2%	65.6%
Ventura County	6.5%*	22.2%	71.3%
California	10.0%	21.8%	68.2%

Source: California Health Interview Survey, 2017

Further, as shown in the table below, counties report nearly all or all teens have never smoked cigarettes. Only teens in Service Planning Area 3 report smoking, with 9.1% having smoked a cigarette. The rates increase, however, when teens are asked if they ever smoked electronic cigarettes, also know as e-

[23] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41. Accessed [June 4, 2019].

cigarettes or vaporizer cigarettes. Over 9% of California teens have tried e-cigarettes with Riverside County and San Bernardino reporting rates over 23%.

Teen Smoking Rate

Report Area	Not a current smoker	Ever smoke an e-cigarette
Los Angeles County	98.4%*	8.8%*
SPA 3	90.9%	--
Orange County	100.0%*	--
Riverside County	100.0%*	23.0%*
San Bernardino County	100.0%*	23.9%*
Ventura County	100.0%*	--
California	89.8%	9.1%

Source: California Healthy Kids Survey, 2017

Alcohol and Drug Use

There is a strong scientific consensus that alcohol drinking can cause several types of cancer. In its Report on Carcinogens, the National Toxicology Program of the U.S. Department of Health and Human Services lists alcoholic beverages as a known human carcinogen. Based on data from 2009, an estimated 3.5% of cancer deaths in the United States (about 19,500 deaths) were alcohol related.[24]

In California, 22.6% of teens have tried an alcoholic drink. All counties of interest to City of Hope have rates below the state's rate. The lowest rate reported is from Orange County at 13.3%.

Binge drinking is defined as consuming large quantities of alcohol within a set period of time. For males, this is five or more drinks per occasion; for females, four or more drinks. 27% of SPA 3 adults have engaged in binge drinking within one year, a rate significantly lower than California's rate of 34.7%. While most counties fall in line with the state rate, Ventura County reports an elevetated rate of 41.3%.

Alcohol Consumption Rates

Report Area	Teen Ever Had an Alcoholic Drink	Adult Binge Drinking in the Past Year
Los Angeles County	21.2%*	33.8%
SPA 3	--	27.0%
Orange County	13.3%*	35.5%
Riverside County	20.9%^	34.7%
San Bernardino County	15.9%*	33.6%
Ventura County	--	41.3%
California	22.6%	34.7%

Source: California Healthy Kids Survey, 2017

[24] National Institute on Alcohol Abuse and Alcoholism. Available at https://www.niaaa.nih.gov/alcohols-effects-body. Accessed [Dec 2019].

XIV. Mental Health

How to Use This Section

Oftentimes, we think of physical health, mental health and dental health as separate entities. In reality, they are interconnected and need to be strong in order for a person to be in optimal health. While this section of the assessment is short, it is rich in information about how serious mental health issues are in the San Gabriel Valley. If community programs were designed with mental health challenges in mind, barriers could be addressed up front to ensure future program success.

For example, if you know that you want to start a program to get community members walking, but you notice that people in your community suffer from stress or depression, you could use that information to design promotional materials that reinforce how regular walking can help decrease stress and depression. You can also prepare your program to provide local resources that address these issues as they are presented by participants. Ultimately, this data can help your organizations better serve residents by being aware of and ready for any potential mental health issues that might impede your efforts to do good work.

Mental Health Locally

Mental illness is a prevailing health crisis in America as evident with these sobering facts:[25]

1. 1 out of 5 adults suffer mental illness in a given year.
2. 10 million adults in the United States have a serious mental illness.
3. 1 out of 5 youth live with a serious mental health condition.

Individuals risk substance abuse, self-destructive behavior, and suicide if left untreated. In California, 1 out of 10 adults experiences psychological distress in a given year. San Bernardino County and Service Planning Area 3 of Los Angeles County have distress levels that exceed the state rate at 11.4% and 11%, respectively.

Mental Health Indicators in Adults

Report Area	Had Serious Psychological Distress in the Last Year[1]	Needed Help, but Did Not Receive Treatment (1)
Los Angeles County	9.7%	42.7%
SPA 3	11.0%	38.6*
Orange County	10.0%	27.2%*
Riverside County	10.8%	48.4%
San Bernardino County	11.4%	48.8%
Ventura County	8.0%*	36.5%*
California	10.0%	38.4%

Source: California Health Interview Survey 2017

Some adults report that their mental health state has impaired their work, family life and/or social life within a year. Orange County appears to have the highest proportion of adults sufferering from impairment

[25] National Alliance on Mental Illness. Available at https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers. Accessed [May 22, 2019].

that affected all three major areas of their lives — the rates are higher than those of other counties and the state. Adults in this county also take prescription medication to address their emotion or mental health issue in greater numbers — 11.7% versus the 10.4% state rate.

In contrast, Ventura and Riverside counties have self-reported work, family life and social life impairment rates that fall below the state rates — 14.4%, 15.7% and 16.5% respectively. In comparison to their impairment rates, fewer adults in both Los Angeles and Ventura counties reach for prescription medication to cope with their impairment: only 8.8% and 7%, respectively. Adults in SPA 3 also have limited prescription usage for emotional and mental health issues.

Impairment Due to Poor Mental Health in the Past 12 Months

Report Area	Impaired Work	Impaired Family Life	Impaired Social Life	Has Taken Prescription Medicine for Emotional/Mental Health Issue in Past Year
Los Angeles County	14.6%	15.3%	16.0%	8.8%
SPA 3	16.8%	16.1%	16.7%	7.6%
Orange County	17.3%	17.4%	17.9%	11.7%
Riverside County	11.0%	14.3%	15.0%	11.5%
San Bernardino County	13.5%*	15.6%	18.0%	10.7%*
Ventura County	11.5%*	10.0%*	11.4%*	7.0%*
California	14.4%	15.7%	16.5%	10.4%

Source: California Health Interview Survey, 2017, County * statistically unstable

Feeling despaired, some adults contemplate suicide. Suicide is the 10th leading cause of death among Americans of all ages, and is more prevalent among males than females by 3.54 times. Whites and American Indians and Alaska Natives are more likely to commit suicide than other ethnic groups at 15.85% and 13.42% respectively.[26] Nine out of 10 who commit suicide suffer from depression or substance abuse and often in combination with other mental disorders.[27]

Adults Who Seriously Thought About Committing Suicide

Los Angeles	SPA 3	California
11.3%	8.9%	13.4%

Source: California Health Interview Survey, 2018

The rate of adults who report considering committing suicide is lower in Los Angeles County (11.3%) and Service Planning Area 3 (8.9%) than the rates of the state (13.4%) and three other counties. The age-

[26] American Foundation for Suicide Prevention. Available at https://afsp.org/about-suicide/suicide-statistics/ Accessed [May 29, 2019].

[27] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed [May 29, 2019].

adjusted death rate due to suicide is 8 per 100,000 population in Los Angeles County, lower than the rate of 10.4 per 100,000 in California.[28]

Adults Who Visited Mental or Behavioral Health Care Professional vs. Adults Who Needed Mental or Behavioral Health Care

Report Area	Saw Any Health Care Provider for Emotional-Mental and/or Alcohol/Drug Issues in Past Year	Needed Help for Emotional/Mental Health Problems or Use of Alcohol/Drug
Los Angeles County	17.0%	21.1%
SPA 3	15.3%	17%
Orange County	14.9%	20.7%
Riverside County	13.5%	18.9%
San Bernardino County	12.3%	15.1%

Source: California Health Interview Survey, 2018

There is a service gap with respect to mental and behavioral health care in Southern California. In Orange County, for example, while nearly 1 in 5 individuals indicated a need for emotional/mental health or alcohol/drug use help, fewer than 1 in 6 individuals actually saw a health care provider for these needs. Factors underlying this gap may include lack of available health care providers or open appointments during needed days and times. The gap may also be explained by more complex factors, including lack of social support needed to access mental and behavioral health care, lack of culturally responsive mental and behavioral health care services, the out-of-pocket cost of these services and lack of access to resources like paid time off from work necessary to take advantage of these services.

Primary Data: Mental and Behavioral Health, Including Substance Use Disorders

Stress and Social Isolation

Stakeholders explained that many factors are contributing to an increasing need for mental and behavioral health services, but they isolated two main factors: stress related to economic security and social isolation.

> *"This country gives you many opportunities, but it consumes you."* — Focus Group Participant

> *"Another really upstream issue is trauma due to toxic stress, as a result of nuclear family stress, stress around affordable housing, lack of child care, it all adds up."* — Key Stakeholder

Accessibility and Affordability of Services

Stakeholders explained that in many cases, mental health services are not sufficiently covered by insurance plans and the out-of-pocket costs are prohibitively expensive.

> *"Even the parents, they are experiencing so much. Unless they have a certified diagnosis, getting the parents therapy is nearly impossible. Even moms who screen for PPD, if they have emergency Medi-Cal, there's no coverage there at all for PPD."* — Key Stakeholder

[28] California Department of Public Health, 2019. Accessed through ThinkHealthLa.org.

"However, children who would benefit from mental health services may not qualify for Medi-Cal due to their parents making too much or they may have private insurance that does not cover the scope of work that we are able to provide. Typically, you would think that children who qualify for Medi-Cal are at poverty level. From the mental health perspective, they have more resources available to them than their peers whose families are maybe above the poverty line and who may have private insurance. However, the private insurance they have does not have the right support that Medi-Cal programs have. For instance, we have intensive programs for Medi-Cal youth that are at high risk of school expulsion or entering the juvenile justice system. We work within the home and at the school; we provide psychiatric support and have big team approach. However, for the child who has private insurance, they do not obtain this level of support and they may need to pay out of pocket." — Key Stakeholder

Not Seeking Treatment: Preferred Coping Mechanisms and Stigma

Stakeholders and focus group participants explained that there is a mismatch between the current mental health services provided and the ways in which many people think about mental health care and/or respond to feelings like depression and anxiety. Some subpopulations, including LGBTQ communities and African American communities, have, historically, had negative experiences with mental health care systems and providers, and therefore lack trust in these services. In many families, the ability to deal with anxiety, depression or other emotional and behavioral health issues alone is valued as a sign of strength and independence, and mental health services are perceived as those needed only in the case of severe psychiatric disorder. For these reasons, individuals and families may not turn to mental health care providers for support with mental health issues.

"Some of us adults, we don't know if we are experiencing depression, anxiety, or stress. Or we may know, but we don't want to accept it, we might think it's a weakness. My husband eats a lot of ice cream, for example, when he is stressed." — Focus Group Participant

"We don't see a lot of parents who have a lot of trauma, but we do see a lot of parents with young adults who have mental health issues, and the parents can't exactly help because their kids are already young adults. The young adults don't want to consent to treatment. It's very sad to see this. Some of them have things more serious, like being into drugs, alcohol, they don't work, they have those issues that are affecting them a lot. It is very hard to navigate this medical system and figure out how to help your young adult children." — Key Stakeholder

"I think people feel that going to mental health means you have "psychological problems." We have moved some of the mental health practitioners to our primary care clinic and that has helped. People don't want to be labeled a "psychiatric" case, so they stay away from those practitioners. It may be something that follows them through their employment. It may be something that changes the way your family thinks of you. It may have to do with how you think of yourself." — Key Stakeholder

Effective Strategies Proposed by Stakeholders

- Increase access to integrated care
- Increase cultural competency training and anti-bias training among mental and behavioral health care providers
- Form parent/client advisory councils for mental/behavioral health care providers
- Provide trauma-informed care, and particularly care informed by an understanding of racial trauma

- Provide training for youth/adults around how to prevent and respond to violence (including relationship violence)
- Incorporate social emotional literacy into youth development programs
- Work through schools to destigmatize mental health issues and mental health care services
- Train mental health and behavioral health care providers to recognize the signs of homelessness, and provide resources to respond
- Promatoras and peer-to-peer training
- Bring services to workplaces, schools, and make them available in the evenings and on weekends

Appendix A – Primary Data Collection Participants

Key Stakeholder Interview Participants
Emanate Health Foundation Board
West Covina Unified School District
Pasadena Unified School District
Foothill Unity Center
San Gabriel Valley Economic Partnership
Citrus Valley Association of Realtors
United Methodist Church
Herald Christian Health Center
Day One
Majestic Realty
Foothill Family Services
Health Consortium of the Greater San Gabriel Valley
Pasadena Public Health Department
El Monte Comprehensive Health Center
Los Angeles County Department of Mental Health
Altadena Baptist Church
Our Saviour Center
Baldwin Park Adult and Community Education
All Saints Church
Duarte Unified School District
ChapCare
Asian Youth Center
Pacific Clinics
Los Angeles County Department of Public Health, SPA 3
GEM Fellowship Program
American Cancer Society, Inc. - California Division
Seeds of Hope Episcopal Diocese
Antelope Valley Partners for Health
Young & Healthy
Focus Groups and Listening Session Participants
East San Gabriel Valley Coalition for the Homeless
LGBTQ Seniors
African-American Residents in Monrovia, Pasadena, Covina, and Lancaster
Spanish-speaking Latina Moms in Pasadena

San Gabriel Valley Health Consortium
Chinese Cancer Patients
Huntington Hospital Community Benefit Committee

Appendix B – Community Resources

Significant Health Needs	Community Resources
Access to Care	• Clinica Ramona in El Monte provides one year of health coverage for free • Community Health Alliance of Pasadena (ChapCare) • Set for Life hosts health expos with health screenings • Senior Advocacy Program, a County program for seniors primarily in nursing homes • CVS and Rite Aid offer flu shots and screenings • Foothill Transit offers bus service from Duarte to Pasadena • Duarte Senior Center publishes a newsletter that identifies resources • City of Hope Health Fair • Herald Christian Health Center • Tzu Chi Foundation • Cleaver Family Wellness Clinic and food pantry • Good Samaritan Hospital • Parish Nurses offer screenings with referrals for more services • El Monte School District developed a Family Center in El Monte, which includes a number of services and community organizations. • AltaMed • Western University provides dental services at two dental clinics at schools • Duarte School District's Health Services Center focuses on getting kids access to health insurance. • Foothill Unity Center food bank • Department of Health Services clinic in El Monte • CCARE • Latinos for Hope (City of Hope group) goes out into the community and inform/educate about what's available • Certified Enrollment Counselors at El Proyecto del Barrio help patients understand eligibility and enrollment and to keep them on their programs to maintain their benefits • East Valley Community Health Center • Antelope Valley Community Clinic • Antelope Valley Children's Center • Antelope Valley Partners for Health • Palmdale Regional Medical Center • Antelope Valley Hospital • Garfield Health Center • Asian Community Center • Kaiser Permanente • Huntington Hospital • City of Pasadena Public Health Department • Chinatown Service Center

Cancer	• Clínica Médica Familiár (Family Medical Clinic) has clinics twice a year • Brotherhood Labor League Annual Men's Conference • City of Hope offers cancer screenings at health fairs • Set for Life offers mammograms • Children's Hospital Los Angeles • Southern California Health Conference at Pasadena Civic Center • Cleaver Clinic • American Cancer Society has resources that can help with transportation and navigation assistance • Susan B. Komen • My Health LA patients provides emergency Medi-Cal for women 40+ with breast cancer, and for women of any age with cervical cancer through the Every Woman Counts program • Prostate Cancer Research Institute annual conference • MEMAH (Men Educating Men About Health) annual conference Partners with City of Hope to do digital rectal exams • Garfield Health Center provides mammograms and colorectal cancer screening • Herald Cancer Association offers support, consultation, answers questions, written information, links to websites
Heart Disease	• American Heart Association • Set for Life • Labor Union Conference • Curbside CPR classes offered by the Fire Department • Tzu Chi Foundation • Children's Hospital Los Angeles • Los Angeles County Department of Public Health Service • City of Azusa has a Wellness Center • El Proyecto Del Barrio does medication management and assistance • Clinic pharmacy dispensary provides some additional medications • Los Angeles County Department of Health Services, Healthy Choice the Easy Choice. Working to have healthier options more accessible, including exercise breaks in meetings, etc. • Foothill Unity Center offers a walking program and checks blood pressure • Health plans provide educational materials about foods to eat and foods to avoid. Some have been translated by health plans.
Mental Health	• Alma Services • Spirit Family Services • Enki Mental Health Center • Foothill Unity Center provides referrals and services for families and homeless • National Association for the Mentally Ill • Tri-Cities Mental Health serves Pomona, La Verne and Claremont • Los Angeles County Department of Mental Health

	• Foothill Family Service offers some group services • Libraries provide information on where to access services • Whittier Hospital has a lot of free classes • El Monte School district added a district social worker and school counselor • Pacific Clinics/Asian Pacific Family Center • Foothill Family Services • D'Veal Family & Youth Services • District Homeless Coordinator has information about referrals for kids • Duarte School District has partnerships with providers (Foothill Family Services and D'Veal) to come into the schools and provide services • Asian Coalition helps people find resources • Each Mind Matters, the California Mental Health movement • Mental Health Services Act • Asian Youth Center hosts a mental health day • Health Consortium of Greater San Gabriel Valley is looking to build more connections between physical and behavioral health providers • Healthy Neighborhoods initiative from Department of Mental Health pilot site in El Monte. Department of Mental Health Service Area Advisory Committee includes consumers and tries to deal with issues of access • Santa Anita Family Services • Foothill Family Services • Arcadia Mental Heath • Aurora Clinic • Pacific Clinics • Asian Pacific Health Care Venture has Chinese language mental health services
Overweight and Obesity	• San Gabriel Valley Service Center has free zumba, yoga, line dancing, and aerobics classes • Women, Infant and Children offers nutrition classes • Our Saviour Center has nutrition and cooking classes • Community centers offer exercise programs such as zumba and walking • Senior centers • Each city has some exercise programs • Swim programs for school-age children • Some nonprofits organize physical education and/or nutrition education/healthy snacks, such as Boys & Girls Clubs • City of Duarte hosts a Biggest Loser contest and sponsors city walks • Duarte Senior Center offers referrals and some free services, including a hiking club
Drugs, Alcohol, Tobacco	• Alcoholics Anonymous • Azteca • California's anti-tobacco campaign • Policies that prevent tobacco use in public settings and more enforcement of laws that prevent tobacco sales to minors

	• American Cancer Society • Unity One • Los Angeles County Sherriff's drug and alcohol prevention programs • Parent University • Narcotics Anonymous • Asian Youth Center program helping cities create smoke-free parks

Appendix C – Primary Stakeholder Interview Questions

Interview Questions and Notes

Please tell me about your organization and your programs/services? Tell me about the community or communities you serve? (The demographic of the community they serve, e.g. immigrant (from where?), languages spoken, types of jobs they have, are they renters or home owners, do they have free and reduced price lunch rates, etc.).

What are the most significant health issues or needs in the community (communities) you serve? How do these health issues or needs affect people's daily lives?

Which of these are the top three priority needs/issues, considering both their importance and urgency?

What factors or conditions contribute to these health issues? (e.g., social, cultural, behavioral, environmental, or medical) *[Note: Ask for up to three issues.]*

Who or what groups in the community are most affected by these issues? (e.g., youth, older residents, racial/ethnic groups, specific neighborhoods) *[Note: Ask for up to three issues.]*

What are some major barriers or challenges to addressing these issues? *[Note: Ask for up to three issues.]*

1. In general, for the community?
2. Specifically, what challenges does your organization face in serving your target populations and addressing these issues (besides funding)?

What do you think are effective strategies for addressing these issues?

What resources exist in the community to help address these health issues? (e.g., people, organizations or agencies, programs, or other community resources)

What else is important for us to know about significant health needs in the community?

1. What are the needs that your programs/services are trying to meet?

2. From your experience, what are the factors that have the greatest impact on their health?

3. What inhibits or promotes the secure, consistent access to and use of health care for residents of the service area?

4. What are the difference in health-care needs and health-care outcomes between first and second generation Latinos. First generation being foreign born and second being U.S. born.

5. Would you like to add any additional information?

Appendix D – Community Benefit Advisory Council

American Association for Retired People
American Cancer Society
Arcadia Methodist Hospital
Cancer Detection Program – Cecilia G. De La Hoya Cancer Center – White Memorial Medical Center
City of Azusa – Recreation and Family Services
City of Duarte – Senior Services
City of Pasadena Public Health Department
Duarte Unified School District
Foothill Unity Center
Los Angeles County Department of Health Services Region SPA 3
Our Savior Center
Planned Parenthood Pasadena and San Gabriel Valley
Set for Life
Walden University – Public Health Data Expert
Young Women's Christian Association (YWCA)

Appendix E – Community Benefit Evaluation

It has been three years since the completion of the 2016 Community Health Needs Assessment. City of Hope has just completed the second year in addressing significant needs identified in that CHNA. Below is the update on City of Hope's progress in relationship to the 2018 Implementation Strategy.

Overview of Fiscal Year 2019 Programs/Services

	Core Principles				Strategic Priorities			
Program Activity *Beckman Research Center	Vulnerable Populations	Primary Prevention	Seamless Continuum of Care	Community Capacity Building	Access to Care	Healthy Living	Mental Health	Cancer Prevention
Workforce Development								
• Student Mentoring/Interns • Train, Educate and Accelerate Careers in Healthcare • Science Education Partnership Award Program* • Job Shadowing	x	x		x	x		x	x
Community Health Awareness/Healthy Living (Screening, Lectures/Classes Support Groups)								
• Cooking Classes • Community Nutrition, Diabetes and Cancer Prevention Classes • Community Health Fairs • Healthy Living Grants • Kindness Grants • Community Gardens • Prostate Cancer Awareness • Hopeful.org – Online Cancer Support • Mental Health Integration Summits	x	x	x	x	x	x	x	x
Diversity Initiatives								
• CA Diversity Council • Diversity Resource Groups (Asian American Community, Connecting People of African Descent for Hope, Latinos for Hope, Pride in the City, Women's Professional Network, Young Professionals Network)	x	x	x	x	x	x	x	x
Health Care Support Services								
• Patient Resources Coordination • Transportation • Village Stays	x	x	x				x	
Seamless Continuum of Care								
• Bereavement Support Grp	x	x	x	x		x	x	
Medical Professional Education								
• Pharmacy • Rehabilitation • Nursing • Nutrition • Social Work • Continuing Medical Educ. • Child Life • Health Education	x	x	x	x	x		x	x

Fiscal Year 2019 Community Benefit Program and Services

City of Hope currently offers a wide variety of initiatives to meet a large number of diverse needs. Each initiative has specific goals that benefit the community. Some of the initiatives have been thriving for years, others are new based on latest CHNA. Some are organization-wide, while others are conducted by a specific department. This figure provides a quick overview of our 2019 programs and services.

Key Community Benefit Initiatives

Many programs are created and provided to the community on an annual basis, while others are created to address needs or requests as they arise. As the City of Hope team continues its exploration into community benefit investments throughout the institution, we may find that some programs no longer make sense or should be redesigned to ensure impacts are focused on the needs of our local community. Conversly, new programs may be created to address the emerging needs and integrate strategies that engage City of Hope teams in more community-based collaborations. What follows is a status report on the main focus areas of our 2019 Fiscal Year community benefit programs and services: **Healthy Living and Kindness Grants, Mental Health Integration Summits and Community Garden-Nutritionprograms.** The colorful boxes in each section are meant to provide a snapshot of the programs. **At a glance, the reader will be able to identify what core principle and strategic priorities are addressed through each focus area.**

	Impacts	
Core Principle	Vulnerable Populations	☑
	Primary Prevention	☑
	Seamless Continuum of Care	☑
	Community Capacity Building	☑
Strategic Priorities	Access to Care	☑
	Healthy Living	☑
	Mental Health	☑
	Cancer Prevention Early Detection	☑

Healthy Living – Building Community Capacity Through Healthy Living and Kindness Grants

City of Hope, does not conduct population health interventions on a regular basis as there are organizations in our community which are experts in this area, and we believe they are best equipped to design programs and services that help their own communities. The Healthy Living Community Grant Program is the vehicle that we use to identify organizations that can deliver innovative programs designed to address one or more of our strategic priorities around cancer prevention, healthy living or smoking cessation. In addition to the Healthy Living grant, in Fiscal Year 2018 we created a special grant category to encourage our employees, who have good ideas, to do something great for their community, called Kindness Grants. Our CBAC members review all the applications and make the selections for the Healthy Living grant program.

Members also conduct site visits of Healthy Living grantees. Not only is it rewarding to help local organizations, these groups provide City of Hope more insight into the needs of vulnerable local populations. They also teach City of Hope about ways to support community efforts that tackle health disparities in culturally appropriate and specific ways. Through out the funding period, City of Hope continues to support these organizations by providing technical assistance and networking opportunities. (CityofHope.org/about-city-of-hope/community/community-benefit/healthy-living-grant-program)

Healthy Living Grant

	Impacts	
Core Principle	Vulnerable Populations	☑
	Primary Prevention	☑
	Seamless Continuum of Care	
	Community Capacity Building	☑
Strategic Priorities	Access to Care	☑
	Healthy Living	☑
	Mental Health	☑
	Cancer Prevention Early Detection	☑

During Fiscal Year 2019, the **Healthy Living Community Grant** Program dispensed $45,000 to nine groups and organizations that demonstrated a creative, yet sustainable, approach to promoting healthy living through good nutrition, physical activity, cancer or diabetes prevention, or smoking cessation. The 2019 Healthy Living Cohort included: Walk With Sally, Foothill Unity Center, Set for Life, Asian Pacific Health Care Venture Inc., Los Angeles Brotherhood Crusade, Big Brothers and Big Sisters of Orange County and the Inland Empire, Azusa Pacific University and Hope through Housing Foundation. Their programs are described below:

Walk With Sally
Friendship Activity Days

Walk With Sally believes no child should walk alone through a loved one's cancer, they promote hope through individualized mentoring and community support services that empower children traumatized by a parent, guardian or sibling's cancer journey. **Friendship Activity Days** will address the emotional well-being of the child and guides them on healthier lifestyle choices.

Foothill Unity Center
Fresh Food Workshops and Health Screening

Fresh Food Workshops and Health Screening, is a "one-stop shopping" strategy to effectively deliver multiple services needed by the low-income population in the community. This program meets clients where they are to provide a variety of health, wellness, financial literacy and advocacy support that help's the center's low income clients to begin to take control of their health.

Set for Life Inc.
Our Bodies, A Living Sacrifice

The initiative, **Our Bodies, A Living Sacrifice,** is a pilot program with the goal of convening local African American church leadership in Monrovia and Duarte around a short-term strategic plan focusing on specific activities to increase congregant's knowledge about health living practices, resources and reduce the incidents of preventable chronic disease and cancers in African Americans.

Asian Pacific Health Care Venture Inc.
Managing Diabetes and Cardiovascular Workshops

Managing Diabetes and Cardiovascular Workshops are two-hour interactive workshops held in Chinese (Mandarin). Each series consists of three weekly workshops culturally tailored to the population. APHCV will reach 100 participants.

Los Angeles Brotherhood Crusade
Healthy Kids Zones

The **Healthy Kids Zones** will combat childhood obesity, promote healthy eating and exercise habits and foster youth development among children in grades K-8 living in the economically disadvantaged urban communities of South Los Angeles.

Big Brothers, Big Sisters of Orange County and the Inland Empire
Wellness Through Mentoring Project

Wellness Through Mentoring Project will address the social and economic challenges that are largely responsible for mental and behavioral health programs for low income children and youth. This project will support health and wellness training and development for 21 BBBSOCIE staff specifically addressing mental and behavioral health challenges of mentees.

Azusa Pacific University
Baldwin Park Neighborhood Wellness Center

Baldwin Park Neighborhood Wellness Center will use home visits, conduct individual health education classes and presentations to education 200 Baldwin Park residents to empower them to incorporate daily healthy living practices that changes lives.

Hope Through Housing Foundation **Healthy Choices—Let's Grow Promenade**	**Healthy Choices—Let's Grow Promenade** will promote the harvesting and consumption of home-grown fruits and vegetables for low income residents within an affordable housing community in West Covina. Residents will select, till and manage their own plots in an effort to combat food deserts, poor nutrition, childhood obesity and sedentary lifestyles.

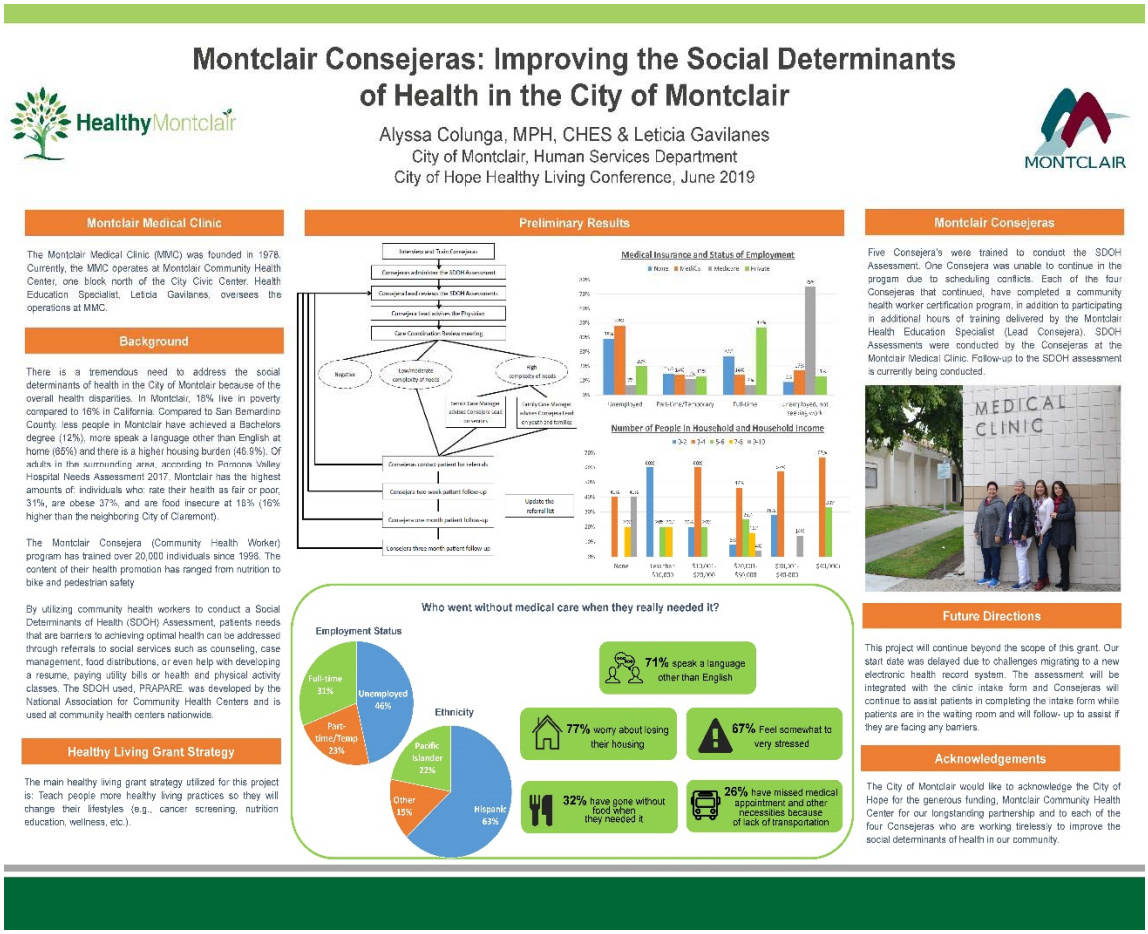
We Build Community Capacity

In order to build capacity, all grantees are being provided with ongoing technical assistance and mentoring support to ensure evaluation data is collected and the programs align with their funded outcomes.

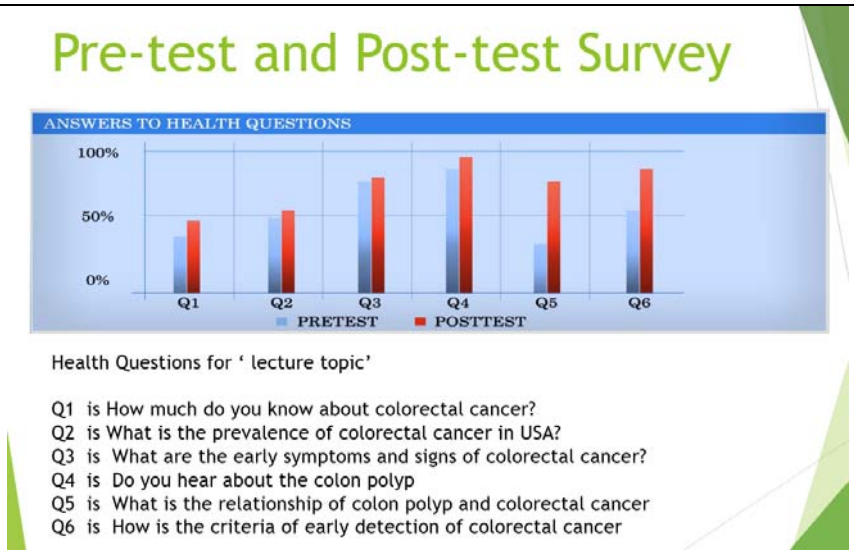
City of Hope's CBAC members will conduct site visits later in the year for each grantee and provide feedback where necessary. Ultimately this grant program is about building community and capacity around efforts that support health and wellness in our service area.

At the end of the funding cycle when new grants were awarded, the 2018 grantees participated in a half-day conference, where they shared their program results with the community and acted as mentors to the new round of Health Living Grant recipients. In June 2019, in a room filled with City of Hope staff, community members and the new cohort of healthy living grantees, the nine 2018 healthy living grantees shared their findings after a year of implementing programs that City of Hope funded. All 2018 grantees made 15-minute presentations and held a poster session. While the programs varied from cooking and health education classes to mammograms and health care careers for high school students, all shared a common theme: to improve the lives of the vulnerable living in the San Gabriel Valley. You can access them via our Community Benefit webpage, CityofHope.org/about-city-of-hope/community/community-benefit/healthy-living-grant-program/healthy-living-conference

Fiscal Year 2018 Healthy Living Grantees sharing program results at the 2019 Healthy Living Conference.



City of Montclair 2019 Healthy Living Grant Conference poster presentation



Tzu Chi Medical Foundation 2019 Health Living Grant Conference presentation

The important take-home message from the Healthy Living Grant Program is that "small is beautiful." Meaning, you can do a lot of good with not a lot of money. Local organizations can benefit from smaller grants that increase their productivity, increase the scale of a previous effort or launch a pilot program without making a large investment.

Community Capacity Building Grants

During the 2018 grant review process, the CBAC members found proposals did not fit in with the critiera for a one year project. Yet, there are programs that are worthy because they meet the specific needs of the local vulnerable community. To address this, the CBAC decided to create a new funding category called, "Community Capacity Building Grants." The recipient of the 2019 Healthy Living Community Capacity Building Grants are:

Maternal Outreach Management Teams (MOMs) Orange County. MOMs OC serves women who experience a sense of isolation in an urban environment. Relatives may not live nearby and unsafe neighborhoods keep them indoors. Knowing the value of community, MOMs OC encourages every mother in their program to participate in group health education classes, as well as their Mommy and Me groups. Groups serve a dual purpose as they offer an opportunity for mothers to share their struggles, ask questions, and to gain positive

reinforcement and new insights about motherhood and infant development. Funding will ensure that a projected 2,100 mothers in their program receive regular depression and domestic violence screenings as well as case management to connect those in need to professional services and interventions.

Kindness Grants

The Kindness Grants were created in 2018 to support City of Hope employees who want to do good in their community. During Fiscal Year 2019, seven programs were funded totaling $20,000. These employee driven projects are described below:

1. ***Be the Match Event*** – Submitted by Victoria Taylor McKinney

The Women's Professional Network and the Asian American Community will be partnering with Southern California Edison to host our "Be the Match" event, a one day educational program. This will be aimed to educate the community of Southern California Edison about City of Hope's Bone Marrow Transplant program, focusing on providing access to care for multi-cultural blood donor disparities.

2. ***Hope for the Breast*** – Submitted by Alissa Peralez

The Women's Professional Network hosted their third annual "Hope for Breast and Health" event. This is a one day educational symposium educates women and men on the importance of breast health.

3. ***Sickle Cell Disease Forum*** – Submitted by Jazma Tapia

Connecting People of African American Descent diversity resource group promoted sickle cell disease awareness at both the scientific and layman levels. The goal for the event was to bring awareness to SCD and to City of Hope's new sickle cell disease program roll-out. Also important, is the need to highlight the danger of implicit bias and encourage Cultural Competence for the purpose of improving adult Sickle Cell patient experiences and interactions with healthcare professionals.

CPAD members who organized and volunteered at the Sickle Cell Disease forum.

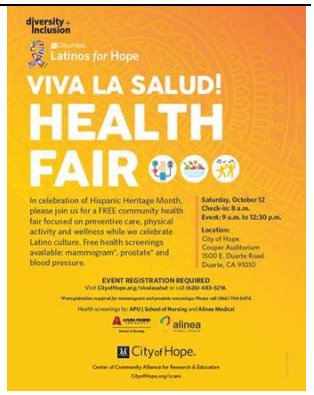
4. ***Mixed Marrow*** – Submitted by: Amanda Fulton

Mixed Marrow is an organization that is dedicated to finding matched unrelated donors for patients of multiethnic descent. This grant will fund care packages for patients and their families.

5. ***Couple Coping With Cancer Together Spanish Language Support Group Retreat*** – Submitted by: Jenny Rodriguez

Funding will support a one day couple's retreat for Spanish-speaking breast cancer patients and their partners. The retreat will provides multiple culturally competent intervention modalities for patients and their partners, including education on gender strengths and differences in stress and coping styles, identifying and reducing gender-role conflict, teaching communication, problem solving skills and psychosocial coping, developing and practicing bonding, positive role modeling behaviors for their family.

6. *Hispanic Heritage Month Celebration* – Submitted by: Brenda Corona
Latinos4Hope addressed the different health disparities affecting the Hispanic/Latino community, such as cancer and diabetes, due to chronic health disease and lack of access to care. They partnered with CCARE and other medical professionals to raise awareness on the importance of Hispanic participation in research studies to improve the health of Hispanic and Latino populations. Participation in such research studies can help reduce health disparities among racial and ethnic minority communities by identifying new ways to treat diseases to achieve better health. The intent of the community event was to engage community members and have an interactive session on various health screenings, BMI, blood pressure check and breast screenings.



7. Cessation4Hope – Filling the Gaps for Successful Cessation – Submitted by: Sophia Yeung
Will address barriers related to smoking cessation. Smoking cessation should be an integral part of the treatment plan, our social worker department, American Cancer Society, and some of the health insurance plans only offer limited free transportation for patients who attend active cancer treatment; there is no existing transportation grants for patients to attend the cessation clinic or the cessation support group. Some patients and support group participants have no coverage or limited coverage to cessation support and/or medication, such as nicotine replacement therapy (NRT). The support group will be open to the community and patients without insurance as a part of the community benefit. Transportation and NRT assistance will be provided for needed patients who commit to participate at least four support group sessions. We will initiate a Rapid Action Plan for lapses and relapses.

Through the Kindness Grants we were able to demonstrate that a "little goes a long way" in encouraging employees to do good in the community. Seven important community-based programs were delivered to a diverse audience within the San Gabriel Valley. Through the Kindness Grant program we learned about the creativity and desire of our employees to do good work in the community.

Addressing Mental Health through Integration With Primary Care

In the 2018-2021 Implementation Strategy, our CBAC prioritized Mental Health as City of Hope's third most important area to address over the next three years. Fiscal Year 2018 initiated the mental health programming through the one day Mental Healthy Symposium. During Fiscal Year 2019, City of Hope partnered with the Health Consortium of San Gabriel Valley to deliver two mental health integration summits. The first of two Health Integration Summits were held on March 5, 2019, in Irwindale.

	Impacts	
Core Principle	Vulnerable Populations	☑
	Primary Prevention	☑
	Seamless Continuum of Care	☑
	Community Capacity Building	☑
Strategic Priorities	Access to Care	☑
	Healthy Living	
	Mental Health	☑
	Cancer Prevention Early Detection	

The overall goal of the Health Integration Summits is to forge new collaborations, partnerships and opportunities for networking that will further enhance integration of physical health, mental health and substance use services in the Greater San Gabriel Valley.

The Health Integration Summits are targeted to representatives from physical health, mental health and substance use service organizations who are in leadership positions and who have an understanding of program implementation, operations and/or clinical services.

Agenda highlights for Summit I:

- Panel presentation on Integration Issues & Challenges in SPA 3 from the L.A. County Perspective
- Panel presentation on Health Neighborhoods as a Best Practice Model of Integration in SPA 3
- Opportunity for networking and strategizing in small groups on how to best serve clients/patients with multiple, cross-system needs and how issues of referral relationships, co-management/coordination of care and data sharing impact integrated care

The second Health Integration Summit was held on May 7, 2019 from 1 to 4 p.m. at City of Hope. The day's objectives were for providers to forge new collaborations for networking to further enhance integration of physical health, mental health and substance use services in the Greater San Gabriel Valley; learn about existing models for integrating services; identify actions they can take to better integrate services; and learn about new ways to access community resources. Target audience members were representatives from service organizations who have an understanding of program implementation, operations and/or clinical services, and who can make decisions and share ideas and suggestions with their organizational leadership. Providers were able to display organizational materials, and network with other providers. The day's presentations covered the following topics:

- Social Determinants, Sectors & Systems: Creating a Healthy SGV
- Behavioral Health Integration in Primary Care, LA County
- Expanding Access to Treatment for Opioid Use Disorders
- One Degree Resources

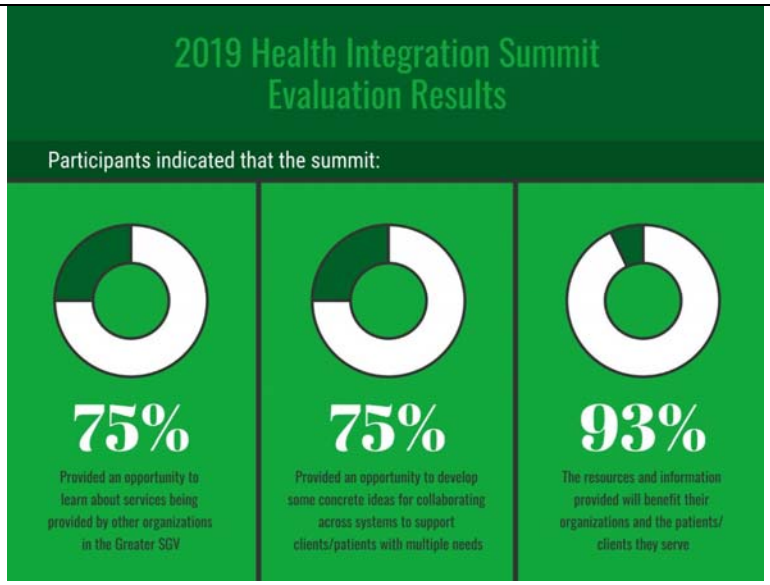


Figure 8. Evaluation Results from Health Integration Summits

In the next fiscal year, will be looking at a collaborative approach to addressing mental health through our SPA 3 Hospital Collaborative. Within the context of the challenging emergency department burden for providing care to those in mental health crisis, the hospital collaborative will explore models for reducing the strength of the burden and connecting patients to the care and resources they deserve.

Enterprisewide Collaborations – Community Garden and Nutrition Programs

City of Hope is proud of the accomplishments of the programs across the enterprise. The Department of Community Benefit has worked collaboratively and in partnership with the Conrad N. Hilton Foundation and internal partners throughout the institution from diabetes/endocrinology to Enterprise Support Services and Beckman Research Institute of City of Hope. This partnership is part of a larger five-year initiative to reduce the incidence of cancer and diabetes.

Savoring Hope Cooking Classes

	Impacts	
Core Principle	Vulnerable Populations	☑
	Primary Prevention	☑
	Seamless Continuum of Care	
	Community Capacity Building	☑
Strategic Priorities	Access to Care	☑
	Healthy Living	☑
	Mental Health	
	Cancer Prevention Early Detection	☑

One such collaboration is the Savoring Hope cooking classes. These interactive classes are led by one of City of Hope's executive chefs and a health educator. During the Fiscal Year 2019, over 150 community members (both City of Hope staff and members of our local community) participated in 18 different cooking demonstration classes. Throughout the year students learned to make a variety of healthy food items from chicken tortilla soup to lettuce wraps. To learn more about Savoring Hope cooking classes, go to: https://www.CityofHope.org/about-city-of-hope/community/hilton-partnership/savoring-hope-cooking-classes.

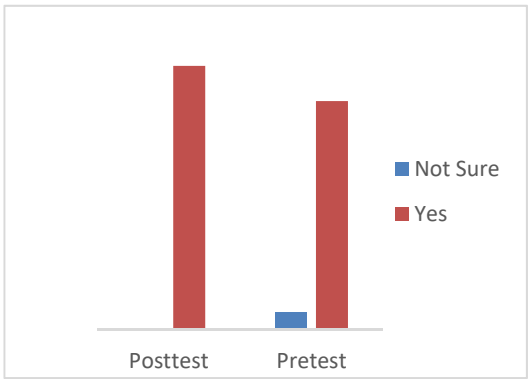


Figure *9*. 100% of *Savoring Hope Cooking* class *participants* indicate they can re-create the grilled shrimp and pineapple meal at home.

As health educators, we know that the best way to share new information is to hide it inside a fun activity. During the Savoring Hope cooking classes, students also learn about the rich nutritient dense ingredients and their roles in promoting good health. Additionally, there are three objectives meant to increase participant skills and confidence in re-creating healthy meals (Figure 9). Ultimately resulting in reduction of barriers to cooking more nutritious meals.

Kid Run Farmer's Market and School Wellness

While City of Hope continued the partnership with the Arroyo Highschool and Eco Urban Gardens to build the farm program there, we also expanded efforts to support wellness at other schools in the San Gabriel Valley. We started off with the implementation of a farmers market at Beardslee Academy in Duarte. Sixth, seventh and eighth graders from the school leadership program were trained to run the market. City of Hope procured the produce from a local community supported agricultural nonprofit called Food Roots. They acquire their produce from local farmers who grow certified organic foods. The team from City of Hope (including our AmeriCorps volunteer) trained the students and adults in the skills necessary to run a farm stand a the school. Training topics included: inventory, setting up the stand, how to determine costs and profits and produce storage.

Beardlsee Academy farmer's market

The goal of the market was not to make a profit. Rather, it was to discover a model that would help a school start and sustain a market at the their school. City of Hope purchased the produce, display and marketing materials. Beardslee provided the scale, petty cash, cash box and students/leadership to run the market. At the end of the school year, the student leaders were asked what they learned and whether or not they felt that it was a good idea to have a farmers market at their school (figure 10 and figure 11). Overall they felt (62%) that having a farmers market is a good idea. Many identified relevant and important skills needed to run a market. Based on this experience, City of Hope will look at expanding farmer's market program in another school district during the next fiscal year.

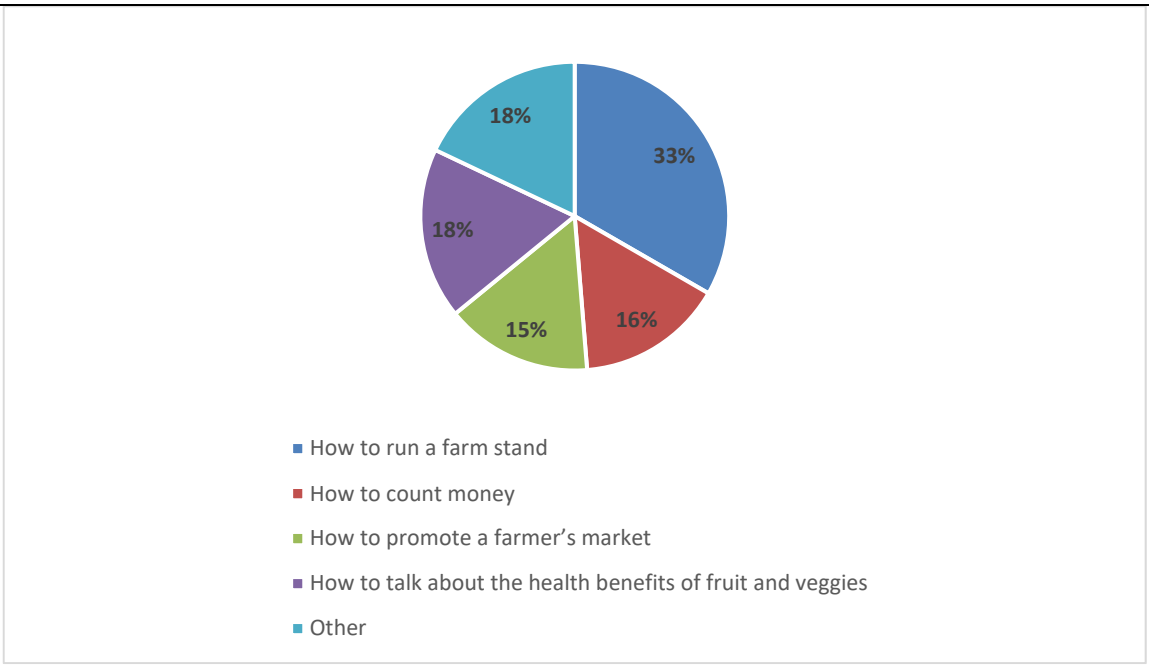


Figure 10. Beardslee Academy students identify skills learned

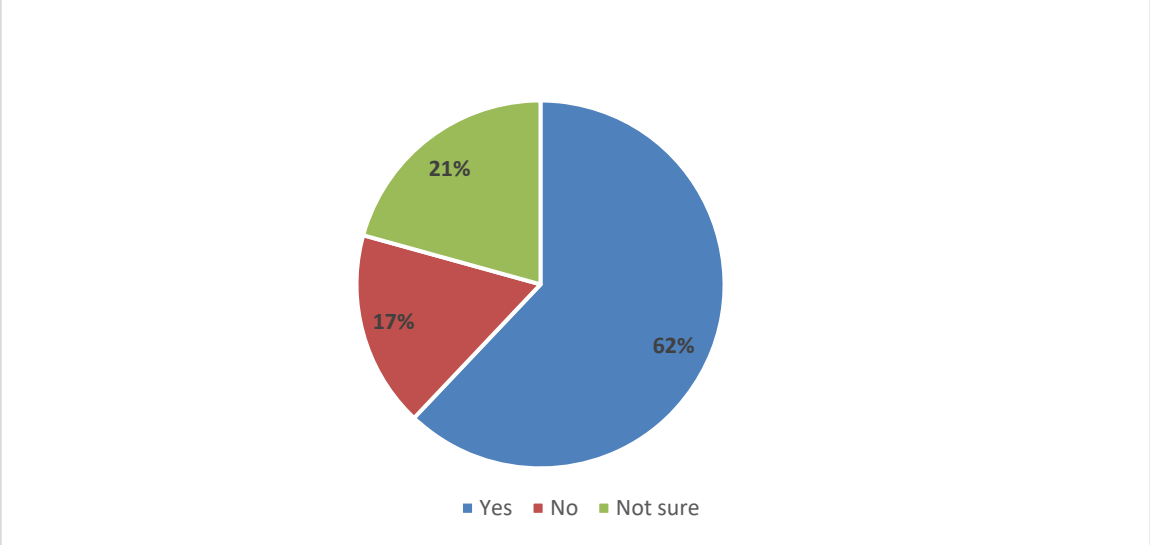
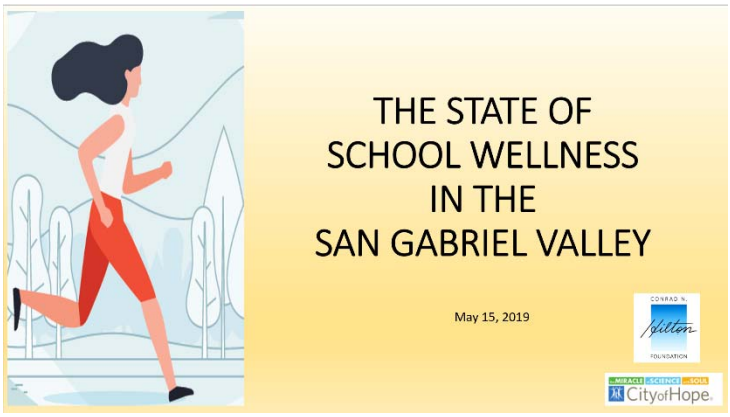


Figure 11. Beardslee Academy students who believe having a farmer's market is a good idea

In May 2019, with the support of the Conrad N. Hilton Foundation, City of Hope hosted a school wellness symposium for schools districts in the San Gabriel Valley. The purpose of this day was to provide encouragement to our local school districts with the knowledge and information necessary to build strong sustainable school wellness programs in their districts. Guest speakers shared the latest polcies and tools that support schools and

best practices needed to design, implement and sustain programming at the levels where the districts are the most receptive. At the end of the event, City of Hope announced the ability to award small grants to support school wellness programs for the districts that attended the event. A number of school districts applied and ultimately three were chosen. Here are the programs that were selected for grants during the past fiscal year: Pasadena



Unified School District – School Kids Yoga and Mindfulness program, El Monte Unified High School District – Freestanding Vegetables for Enhanced Healthy Lunch pilot project and Mountain View School District – Healthy Food Choices bookmark contest. In the selection process, each district needed to demonstrate how the funding would impact their district's school wellness policies. Pasadena says that this grant will allow them to "address the toxic impact of childhood trauma on a student's ability to learn." El Monte Unified suggested that their school district prescribes to the **Smarter Lunchroom Movement** this grant will, "support bringing in a creative solution that increases access to more culturally relevant vegetables options to students choosing to have pho for lunch." Finally, Mountain View will be "increasing the awareness of the Whole School, Whole Community and Whole Child model in their district." Throughout the next fiscal year, the City of Hope community benefit team will be checking in on the districts to document the impact of these grants on the school wellness policies.

Garden of Hope

There is something special about sharing the farm/garden experience with others. Without any scientific research behind this thought, we feel that it makes people really happy. It breaks down barriers and allows us to develop relationships surrounded in trust with our most vulnerable communities. Our Garden of Hope has become a local gathering place for community, both internal and external to City of Hope. Patients come out to the garden between doctor visits and often pick fresh produce to incorporate into their next meal. City of Hope and community volunteers, Garden Sprouts, dedicate hours to help maintain the garden. There was an Earth Day

celebration sharing information on urban gardening, pest management and handed out seeds.

Beardslee Academy kindergarten field trip to the Garden of Hope

During May 2019, kindergarteners from Bearslee Academy walked over to experience the Garden of Hope and learned about soil conservation and composting, creepy crawly insects, tested water, painted rocks, planted seeds and tasted fresh veggies from the garden. The team of volunteers who worked at this event represented staff members from the City of Hope K-12 program, Department of Supportive Care Medicine, Enterprise Support Services and several community members. A summer garden party was held to encourage community members to participate in the garden and to sample a plant-based menu inspired by produce grown in the Garden of Hope. During the garden party, guests learned about hydroponics and composting, tasted and watered produce, and learned about the accessibility of gardening to everyone regardless of housing circumstance. This party blurred the lines between City of Hope and our local community. These blurred lines demonstrate true integration of the Garden of Hope with our community – with a sense of shared ownership for its success. More importantly, the Garden of Hope provided City of Hope with the opportunity to transition urban farming intern and

Community members enjoying the summer garden party

recent Cal State Poly – Pomona (CPP) graduate into a newly created AmeriCorps volunteer. With this linkage, the garden has deepened our ties not only with CPP, but also with the City of Duarte and their AmeriCorps program.

Produce from the garden harvested and shared with all of the volunteers, City of Hope staff, food services (chef integrates the produce into the salad bar and cooking classes) and community members who need it. Funding from the Conrad N. Hilton Foundation has helped us protect the garden by funding the construction of a fence around it. The Pasadena Men's Rugby Club helped to install the fence. All these things demonstrate the strength of community that comes from the Garden of Hope. We look forward to growing the programming and outreach of this garden during the next fiscal year.

Roots of Hope

There are other programs being delivered to the community via the Conrad N. Hilton City of Hope Partnership. One includes a collaboration with the Episcopal Church's Seeds of Hope program in the Los Angeles region. They have spent this last fiscal year certifying community educators in the Center for Disease Control's Diabetes Prevention Program. This churchbased model has seen results that are even more impressive than the CDC's traditional model (figure 12). Not only are there significant weight losses, the progressive decrease in the A1c across 12 months is impressive too. This past year, the program implementors created their strategic plan and an infrastructure that will expand the program to other church denominations within the Asian Pacific Islander communities. The Roots of Hope goal is to impact 88,000 congregants in 144 churches across Los Angeles county and expand into Asian Pacific Islander communities in the continental United States and territories in the South Pacific.

Figure 12. Results of Roots of Hope Diabetes Prevention Program church-based model

Nutrition Science and Food Policy Summit

In May 2019, City of Hope, with support from the Conrad N. Hilton Foundation/City of Hope partnership, hosted a day long Nutrition Science and Food Policy Summit. Over 500 community members registered to attend this event. Topics addressed the science behind nutrition and the practical application of good nutrition to an average person's life. There were cooking demonstrations and breakout sessions that focused on the Asian Pacific Islander community. A keynote was delivered by Most Reverand Bishop Ryan Jimenez from the Roman Catholic Diocese of Chalan Kanoa in the Northern Mariana Islands. His talk focused on the church as a promoter of change that can improve the health of congregants.

Participants reflect the diversity of in the San Gabriel Valley and represent the communities of color in this region. Knowledge transfer was impressive given the complexity of the topics presented. For each category we have between 58% and 75% of participants who Strongly Agree that they recognize the need for culturally appropriate interventions, that they understand the effect of plant-based diets on chronic disease and that they understand how diet affects chronic disease. It is interesting to see these results and allows us to surmise that "people get it" and we need to focus future efforts on behavioral supports once the knowledge has been adopted. Results from the church related pull out session demonstrates that particpants understand how the church can be a support for a program that works towards a healthier community.

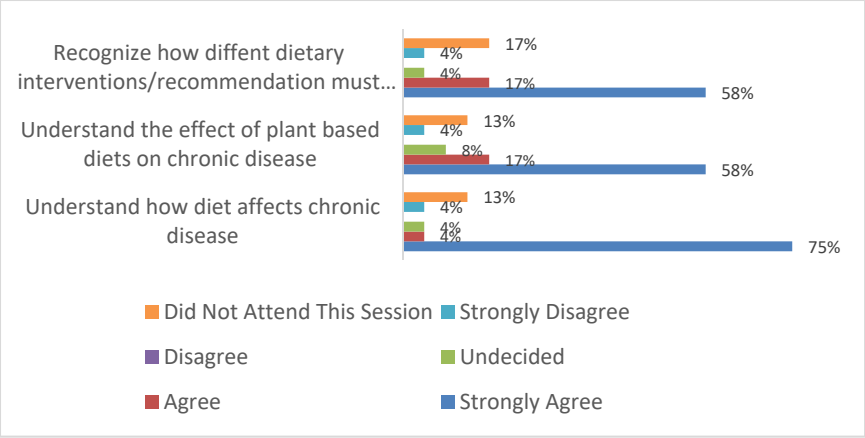


Figure 13. 2019 Nutrition Summit participant survey responses

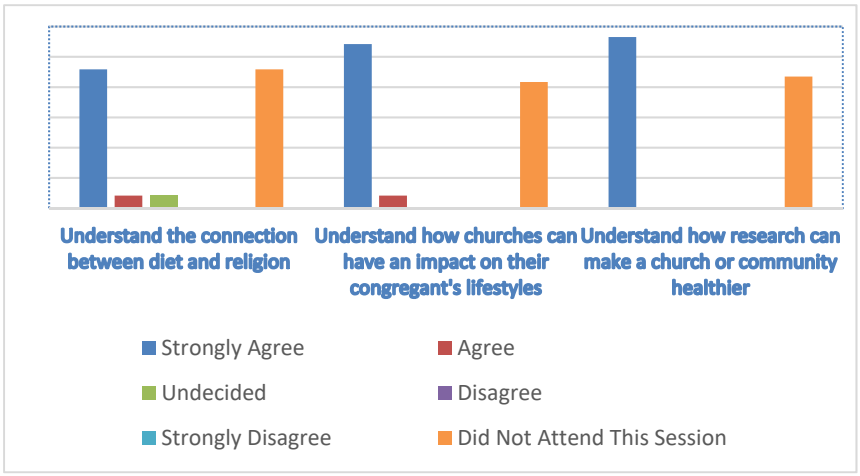


Figure 14. 2019 Nutrition Summit participant agreement with the role of the church and healthy lifestyles

Cross Institution Collaborations

It is important to recognize the participation of the hardworking individuals who contributed to over 212 community education events across this institution and in the vulnerable communities City of Hope serves. Multi-ethnic Marketing contributed to a significant number of programs that were held in our communities of color. There has been an obvious thought shift that has moved from exclusively increasing patients toward getting critical cancer prevention awareness information into our most underrepresented communities that is both culturally and linguistically appropriate. This year we saw significant increases in these type of programs in the African American, Chinese and Hispanic communities, where trust building is critical to the success of reducing health inequities.

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