ST JOSEPH HOSPITAL OF ORANGE (SJH)
2014 Community Health Assessment Report

St. Joseph Health
St. Joseph Hospital

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act requires hospitals to conduct a needs assessment every three years. This is similar to a requirement that California hospitals have fulfilled for over 15 years. The needs assessment is intended to generate discussions regarding the diverse communities in the hospital's service area and help the hospital design more responsive programs, guide policy and planning efforts, and write funding proposals.

In 2012 and 2013, St. Joseph Hospital (SJH) of Orange, California gathered information to complete its needs assessment. Community input was obtained through a phone survey, five focus groups, and interviews with five leaders in the community. Information about the community also was pulled from the Office of Statewide Health Planning and Development (OSHPD), the 2010 Census and the American Community Survey (ACS).

In preparing the Community Health Needs Assessment, SJH worked with Professional Research Consultants, Inc. (PRC) to conduct and analyze the community survey, and The Olin Group, Inc. to conduct interviews and focus groups and to summarize all the community input.

Community organizations that participated in this process included The Cambodian Family, Delhi Center, Healthy Smiles for Kids - Orange County, Lestonnac Free Clinic, Orange County Health Care Agency, and Valley High School. Interviewees represented organizations that serve low-income, medically underserved residents of SJH's community benefits service area. Focus group participants were all community members and/or patients of the hospital or its clinics as well as Spanish or Khmer speaking individuals.

COMMUNITY NEED

Community Needs Prioritized

Through the CHNA process, fifteen areas of concern were identified. The top eight concerns arose consistently across all avenues for community input - interviews, focus groups and community survey (note – the survey did not ask about access to green space and parks, but it was a high concern among community members in interviews and focus groups). The second list includes seven concerns that were mentioned through just one or two of the data gathering methods and thus appeared less

frequently. The top eight are presented here in alphabetical order followed by the additional seven, also in alphabetical order:

Top Eight Concerns

1. **Access to affordable, healthy food**
2. **Access to health care**
3. **Dental health**
4. **Diabetes**
5. **Lack of green space and parks**
6. **Mental health**
7. **Obesity**
8. **Substance abuse**

Seven Additional Concerns:

9. Affordable and accessible transportation
10. Asthma in adults
11. Chronic Heart Disease
12. Cultural competency
13. Depression
14. Stress
15. Stroke

MISSION, VISION, AND VALUES

Our Mission
To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.

Our Vision
We bring people together to provide compassionate care, promote health improvement, and create healthy communities.

Our Values
The four core values of St. Joseph Health -- Service, Excellence, Dignity, and Justice -- are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

The compassionate spirit of our founding Sisters of St. Joseph of Orange lives on. For over 80 years SJH has been serving the healthcare needs of the Orange County community. From the very beginning, our talented and caring clinicians have worked hard to achieve many milestones in the hospital's rich history. SJH has enjoyed being the first in many medical achievements in Orange County. In addition to being on the cutting edge of medical technology and innovation, SJH has a history of proactive community engagement and collaboration. In 1986, the hospital opened its first community clinic, La Amistad Family Heath Center, in the Buena Clinton neighborhood of Garden Gove. A few years later, La Amistad relocated to the City of Orange and opened a dental clinic alongside the medical clinic. La Amistad's primary goal is to serve the most vulnerable population in our community. In 1996, SJH took the lead on a collaborative project that today is known as Puente a la Salud Mobile Community Clinics. Seventeen years later, Puente has three mobile clinics in operation; a health screening, a dental and a vision mobile clinic. These mobile clinics travel throughout Orange County to partner community sites and provide services in neighborhoods and communities that would otherwise have no access to care.

SJH has the reputation in the community for being a partner as well as taking a lead role in collaborative partnerships. Since 1996, SJH has engaged in multiple, multi-year collaborative partnerships in an effort to respond to identified community needs, i.e., specialty care to the underserved diabetic population in Orange County; dental health services to underserved children 0-18 years of age; cardiac screening, referral and treatment for the at-risk underserved population in central Orange County; and assistance with outreach, enrollment and care coordination for uninsured and

underserved children in Orange County. In each and every one of these collaborative partnerships, SJH provides above and beyond what a grant agreement holds it to. The in-kind support and resources dedicated to each community partnership is essential to accomplish goals and outcome measures, but it is also the right thing to do if we are to truly respond to the needs of those living in poverty and improve community health.

ORGANIZATIONAL COMMITMENT
Community Benefit Governance and Management Structure

The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit in accordance with a Board-approved Charter. The Community Benefit Committee meets six times a year. Two of the hospital's senior Executive Management Team (EMT) members serve on the Community Benefit Committee: The Chief Executive Office/President and the Vice President of Mission Integration. The Community Benefit Committee consists of at least eight (8) members. The Committee includes at least three (3) members of the Board of Trustees. At least a majority of the Committee consists of members from the community who have knowledge and experience with populations who have Disproportionate Unmet Heath Needs. The Board of Trustees and EMT receive regular updates on Community Benefit Programs' progress and outcomes. Per the community Benefit Committee Charter, the Committee's involvement with Community Benefit programs includes overseeing and providing general direction to the Hospital's Community Benefit activities including:

a) Budgeting decisions- Review, approve and recommend the Care for the Poor budget and all community benefit expenditures annually.
b) Program content – Review, approve and recommend new community benefit program content.
c) Program design – Review, approve, and recommend overall program design that will best meet the need of the community(ies) served.
d) Geographic/population targeting – Insure that community benefit programs target communities with disproportionate unmet health needs in the service area of the Corporation.
e) Program continuation/termination – Review and recommend programs for continuation/discontinuation annually.
f) Fund Development support – Identify funding sources and partnerships for community benefit programs. Provide letters of support or introduction as appropriate.

g) Community wide Engagement – Assure effective communication and engagement of diverse stakeholders in community benefit planning and implementation.

COMMUNITY
Description of Community Served

St. Joseph Hospital's Community Benefit Service Area strictly focuses on the most vulnerable members of our community and is comprised of key communities and zip codes where health disparities and socioeconomic indicators demonstrate the highest need and significant barriers to health care access.

Primary Service Area:

City	Zip Codes
Anaheim	92801, 92802, 92804, 92805, 92806, 92807, 92808
Garden Grove	92840, 92841, 92843, 92844, 92845
Midway City	92655
Orange	92865, 92866, 92867, 92868, 92869
Santa Ana	92701, 92703, 92704, 92705, 92706, 92707
Tustin	92780, 92782
Villa Park	92861
Westminster	92683

Secondary Service Area:

City	Zip Codes
Buena Park	90620, 90621
Corona	92879, 92880, 92882, 92883
Costa Mesa	92626, 92627
Cypress	90630
Foothill Ranch	92610
Fountain Valley	92708
Fullerton	92831, 92833
Huntington Beach	92646, 92647, 92648, 92649
Irvine	92602, 92603, 92604, 92605, 92606, 92612, 92614, 92617, 92618, 92620
Lake Forest	92630

City	Zip Codes
Placentia	92870
Silverado	92676
Stanton	90680
Yorba Linda	92886, 92887

Hospital Service Area

The Hospital Total Service Area is comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA), which was established based on the following criteria:

- PSA: 70% of discharges (excluding normal newborns)
- SSA: 71%-85% of discharges (draw rates per ZIP code were considered and PSA/SSA were modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries were considered (i.e., freeways, mountain ranges, etc.)
- Cities were placed in the PSA or SSA, but not both

Community Profile

Over 2 million people live in the primary and secondary community benefit service areas of St. Joseph Hospital. Across the entire service area, there is no racial or ethnic group that constitutes a majority. However, in the primary service area, Hispanics of any race make up over half the population, followed by non-Hispanic Whites at 24% and non-Hispanic Asians at 20%.

Race/Ethnicity	Primary Service Area	Secondary Service Area	Entire Service Area
Hispanic of any race	52.3%	25.0%	39.0%
White	24.3%	49.0%	36.4%
Asian	19.8%	20.3%	20.0%
Black	1.5%	2.2%	1.8%
Two or more races	1.3%	2.7%	2.0%
Native Hawaiian or Pacific Islander	0.4%	0.4%	0.4%
American Indian or Alaska Native	0.2%	0.3%	0.2%
Other	0.2%	0.3%	0.2%
Total number of people	1,152,520	1,101,418	2,253,938

From the 2012 American Community Survey / Demographic and Housing Estimates, http://factfinder2.census.gov/

The primary service area includes the two most populous cities in Orange County - Santa Ana and Anaheim. The four largest cities (by population) in the primary service area (Santa Ana, Anaheim, Garden Grove, and Orange) have more households where the primary language is Spanish and incomes are below the poverty line than the county average. They also have more adults with less than a high school education – in Santa Ana, 45% of adults over age 25 do not have a high school diploma (compared to 17% countywide). The three largest cities have more households with seven or more residents than the county average.

The table below shows how each zip code area in the primary service compares to the County average for five indicators of vulnerability. A red up-arrow (↑) indicates the percentage for the zip code is at or above the county average – meaning more vulnerable. Green down-arrows (↓) indicate the percentage for the zip code area is below the county average – less vulnerable. Half of the 28 zip code areas are above the county average on all five measures and three more are above average on four of five measures. Only four are below the county average on all five measures (92807, 92808, 92845, and 92861).

City	Zip Code	Spanish is primary language at home	Age 25+ with no HS diploma	7+ people per household	Household below poverty	Female-headed household
Anaheim	92801	↑	↑	↑	↑	↑
Anaheim	92802	↑	↑	↑	↑	↑
Anaheim	92804	↑	↑	↑	↑	↑
Anaheim	92805	↑	↑	↑	↑	↑
Anaheim	92806	↑	↑	↑	↑	↑
Anaheim	92807	↓	↓	↓	↓	↓
Anaheim	92808	↓	↓	↓	↓	↓
Garden Grove	92840	↑	↑	↑	↑	↑
Garden Grove	92841	↑	↑	↑	↑	↑
Garden Grove	92843	↑	↑	↑	↑	↑
Garden Grove	92844	↓	↑	↑	↑	↑
Garden Grove	92845	↓	↓	↓	↓	↓
Midway City	92655	↓	↑	↑	↑	↑
Orange	92865	↓	↓	↓	↑	↑
Orange	92866	↑	↑	↓	↑	↑
Orange	92867	↓	↑	↓	↑	↓
Orange	92868	↑	↑	↓	↑	↑
Orange	92869	↑	↓	↑	↑	↓
Santa Ana	92701	↑	↑	↑	↑	↑
Santa Ana	92703	↑	↑	↑	↑	↑
Santa Ana	92704	↑	↑	↑	↑	↑
Santa Ana	92705	↑	↑	↓	↑	↑
Santa Ana	92706	↑	↑	↑	↑	↑
Santa Ana	92707	↑	↑	↑	↑	↑
Tustin	92780	↑	↑	↑	↑	↑
Tustin	92782	↓	↓	↓	↑	↑
Villa Park	92861	↓	↓	↓	↓	↓
Westminster	92683	↓	↑	↑	↑	↑

In 2013, the Orange County Health Care Agency published a report profiling the health of Orange County residents. The report provides breakouts by race/ethnicity for a number of health-related measures. Although this is county-wide data, it provides insights to the health needs of the St. Joseph Hospital service area, especially among its diverse racial and ethnic populations.

Among the county's Hispanic population, there are much lower rates of having health insurance, completing high school, accessing early prenatal care, and exclusively breastfeeding. Hispanics were more likely to live in poverty and crowded housing, and

had higher rates of teen pregnancy, diabetes, and adult obesity. Both the Hispanic and Asian populations have higher rates of gestational diabetes than Whites.

Health Indicators by Race/Ethnicity

Health Indicator	Hispanic	White	Asian / Pacific Islander
Life expectancy (2010)	Men: 80.5 Women: 85.4	Men: 78.7 Women: 83.0	Men: 83.3 Women: 86.5
Percent with health insurance (2011)	68.5%	91.4%	84.9%
Percent living under 100% of Federal poverty level (2009-2011)	Male: 17.8% Female: 20.9%	Male: 6.1% Female: 6.9%	Male: 11.5% Female: 12.2%
% of adults age 25+ with high school diploma (2009-2011)	Male: 57.0% Female: 59.1%	Male: 96.1% Female: 95.4%	Male: 89.4% Female: 83.9%
% of households in crowded conditions (2009-2011)	30.8%	1.5%	8.6%
% of visits to the emergency department that were avoidable (2011)	50.7%	41.0%	51.4%
Birth Rate (# births / 1000 population) (2010)	18.7	8.8	12.1
% received early prenatal care (2010)	86.9%	93.1%	92.0%
% of mothers with gestational diabetes (2010)	7.6%	5.4%	10.7%
% of births with low birth weight (2010)	5.8%	6.3%	7.7%
% of births that were preterm (2010)	8.8%	9.1%	8.3%
Infant mortality – rate per 1000 births (2010)	4.5	3.2	2.0*
% of women with postpartum depression (2010-2011)	13.4%	11.9%	10.3%
% of mothers exclusively breastfeeding for first 3 months (2010)	22.3%	47.6%	48.5%
Births to teens - per 1000 births (2010)	44.3	6.6	3.2
% of adults with diabetes (2011-12)	Male: 9.3% Female: 10.9%	Male: 6.0% Female: 5.7%	Male: 7.1% Female: 4.0%*
% of adults with hypertension (2011-12)	Male: 24.1% Female:24.3%	Male: 28.7% Female: 27.7%	Male: 23.9% Female: 18.7%
% of adults age 20+ who are obese (2011-12)	Male: 30.0% Female: 39.8%	Male: 25.6% Female: 18.7%	Male: 15.4%* Female: 7.6%*
% of 11th graders who used alcohol in the past month (2009/10)	Male: 36.2% Female: 35.9%	Male: 35.1% Female: 37.1%	Male: 16.1% Female: 16.0%

2013 Orange County Health Profile, Public Health Services, Orange County Health Care Agency, http://ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=32217

*estimate unstable due to small sample sizes

The leading causes of hospitalization among the three primary race/ethnic groups were similar except hospitalization for mental diseases or disorders was in the top 10 reasons for Hispanics (#9) and Whites (#6), but not for Asians. Instead, the top 10 for Asians included diseases and disorders of the female reproductive system. Among the leading

causes of death, most touched all three race/ethnic groups. However, suicide and chronic lower respiratory diseases were among the top 10 for Whites and Asians but not Hispanics. Chronic liver disease was among the top 10 for Hispanics and Whites, but not Asians. Nephritis was among the top 10 for Hispanics and Asians but not Whites. Only Hispanics had conditions originating in the perinatal period among their top 10.

Leading Causes of Hospitalization and Death by Race/Ethnicity

Health Indicator	Hispanic	White	Asian / Pacific Islander
Leading causes of hospitalization (2010)	1. Digestive system 2. Circulatory system 3. Respiratory system 4. Nervous system 5. Musculoskeletal system and connective tissue 6. Hepatobiliary system and pancreas 7. Kidney and urinary tract 8. Infectious and parasitic disease 9. Mental diseases and disorders 10. Endocrine, nutritional and metabolic	1. Circulatory system 2. Musculoskeletal system and connective tissue 3. Digestive system 4. Respiratory system 5. Nervous system 6. Mental diseases and disorders 7. Infectious and parasitic disease 8. Kidney and urinary tract 9. Hepatobiliary system and pancreas 10. Endocrine, nutritional, and metabolic	1. Circulatory system 2. Digestive system 3. Respiratory system 4. Nervous system 5. Musculoskeletal system and connective tissue 6. Infectious and parasitic disease 7. Kidney and urinary tract 8. Hepatobiliary system and pancreas 9. Endocrine, nutritional, and metabolic 10. Female reproductive system
Leading causes of death (2010)	1. Cancer 2. Heart disease 3. Cerebrovascular diseases 4. Accidents 5. Diabetes mellitus 6. Chronic liver disease and cirrhosis 7. Alzheimer's disease 8. Nephritis, nephrotic syndrome, and nephrosis 9. Influenza and pneumonia 10. Conditions originating in the perinatal period	1. Heart disease 2. Cancer 3. Alzheimer's disease 4. Chronic lower respiratory diseases 5. Cerebrovascular diseases 6. Accidents 7. Influenza and pneumonia 8. Diabetes mellitus 9. Suicide 10. Chronic liver disease and cirrhosis	1. Cancer 2. Heart disease 3. Cerebrovascular diseases 4. Influenza and pneumonia 5. Alzheimer's disease 6. Diabetes mellitus 7. Chronic lower respiratory diseases 8. Accidents 9. Nephritis, nephrotic syndrome, and nephrosis 10. Suicide

2013 Orange County Health Profile, Public Health Services, Orange County Health Care Agency, http://ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=32217

The Orange County Asian Pacific Islander Community Alliance (OCAPICA) is a nonprofit organization focused on enhancing the well-being of Asians and Pacific Islanders (APIs) in Orange County. They offer both health and mental health programs to Orange County's API community to reduce health disparities, address the stigma associated with mental health, and promote wellness. The API communities in Orange County are very diverse, including Cambodian, Chamorro, Hmong, Lao, Marshallese, Native Hawaiian, Samoan, Thai, Tongan, and Vietnamese communities.

In a review of 400 OCAPICA client records – all low-income and 78% Vietnamese – they found that 70% had undiagnosed mental health needs, which showed up in somatic symptoms over a long period of time. These symptoms included headaches, stomach aches, too little or too much sleep, and extreme stress. About 50% had severe depression, of which 40% had thoughts of suicide and 10% had attempted suicide. About 60% had experienced domestic violence and 80% had witnessed some form of violence; 75% had experienced a severe trauma. All had difficulty accessing health care due to cultural and linguistic barriers and 70% had issues meeting basic needs such as food, clothing, and housing. Thirty percent were homeless.

In addition, OCAPICA reports seeing an increase in incarceration, foster care, and homelessness among youth; overcrowded housing; and an increase in youth with cognitive issues, such as autism. They also see a lot of trauma from refugee and immigration experiences.

In 2013, The Olin Group prepared a report for MOMS Orange County, a community-based provider of services for low-income pregnant women, to help identify the areas in Orange County where babies are born with one or more risk factors. St. Joseph Hospital was granted permission to use information from this report. Eleven of the 19 zip code areas with rates of late or no prenatal care above 12.5% (compared to the county average of 10.3%) are in the St. Joseph Hospital primary service area. Fifteen of the 19 zip code areas with Medi-Cal birth rates above 50.6% (including all 6 areas with Medi-Cal birth rates above 66%), are in the St. Joseph Hospital primary service area. Six zip code areas were identified as having more than 600 births, Medi-Cal birth rates of greater than 50.6%, and a rate of late or no prenatal care greater than 12.5% (the county average is 10.3%). All six zip codes (Santa Ana 92701 and 92703, Anaheim 92801 and 92804, and Garden Grove 92840 and 92843) are in the St. Joseph Hospital primary service area. Only 4 of 19 zip code areas with high rates of low birth weight babies (rates of 8.0% or higher, compared to the county average of 6.7% low birth weight babies) are in the St. Joseph Hospital primary service area.

Orange County zip code areas with late or no prenatal care rates above 12.5% (County average is 10.3%) and total births

Zip Code	City	% Late or No Prenatal Care	Total Births
92655*	Midway City	20.6%	102
92801*	Anaheim	16.5%	1099
92624	Dana Point	16.4%	73
92844*	Garden Grove	16.4%	263
90621	Buena Park	14.9%	524
92675	San Juan Capistrano	14.7%	389
92703*	Santa Ana	14.2%	1243
92804*	Anaheim	13.8%	1250
90620	Buena Park	13.7%	520
90623	La Palma	13.6%	110
92861*	Villa Park	13.6%	44
92683*	Westminster	13.6%	974
92843*	Garden Grove	13.5%	650
92672	San Clemente	13.4%	569
92629	Dana Point	13.0%	262
90680	Stanton	13.0%	448
92841*	Garden Grove	12.9%	410
92701*	Santa Ana	12.7%	961
92840*	Garden Grove	12.7%	709

*indicates zip code area is within the St. Joseph Hospital primary service area

Zip code areas with high rates of Medi-Cal births, the number of births, and the rate of late/no prenatal care (the county average is 10.3%).

Zip Codes	City	Number of Births (2011)	% Late or No Prenatal Care (2011)
Medi-Cal births >= 66.0% (2008-2010)			
92704*	Santa Ana	1515	12.4
92805*	Anaheim	1278	12.0
92703*	Santa Ana	1243	14.2
92707*	Santa Ana	1120	11.9
92701*	Santa Ana	961	12.7
92706*	Santa Ana	659	11.1
Medi-Cal births 50.6 to <66.0% (2008-2010)			
92804*	Anaheim	1250	13.8
92801*	Anaheim	1099	16.5
92840*	Garden Grove	709	12.7
92802*	Anaheim	700	11.7
92843*	Garden Grove	650	13.5
92806*	Anaheim	590	11.4
90621	Buena Park	524	14.9
90680	Stanton	448	13.0
92841*	Garden Grove	410	12.9
92675	San Juan Capistrano	389	14.6
92832	Fullerton	354	12.4
92844*	Garden Grove	263	16.4
92655*	Midway City	102	20.6

*indicates zip code area is within the St. Joseph Hospital primary service area

Community Need Index

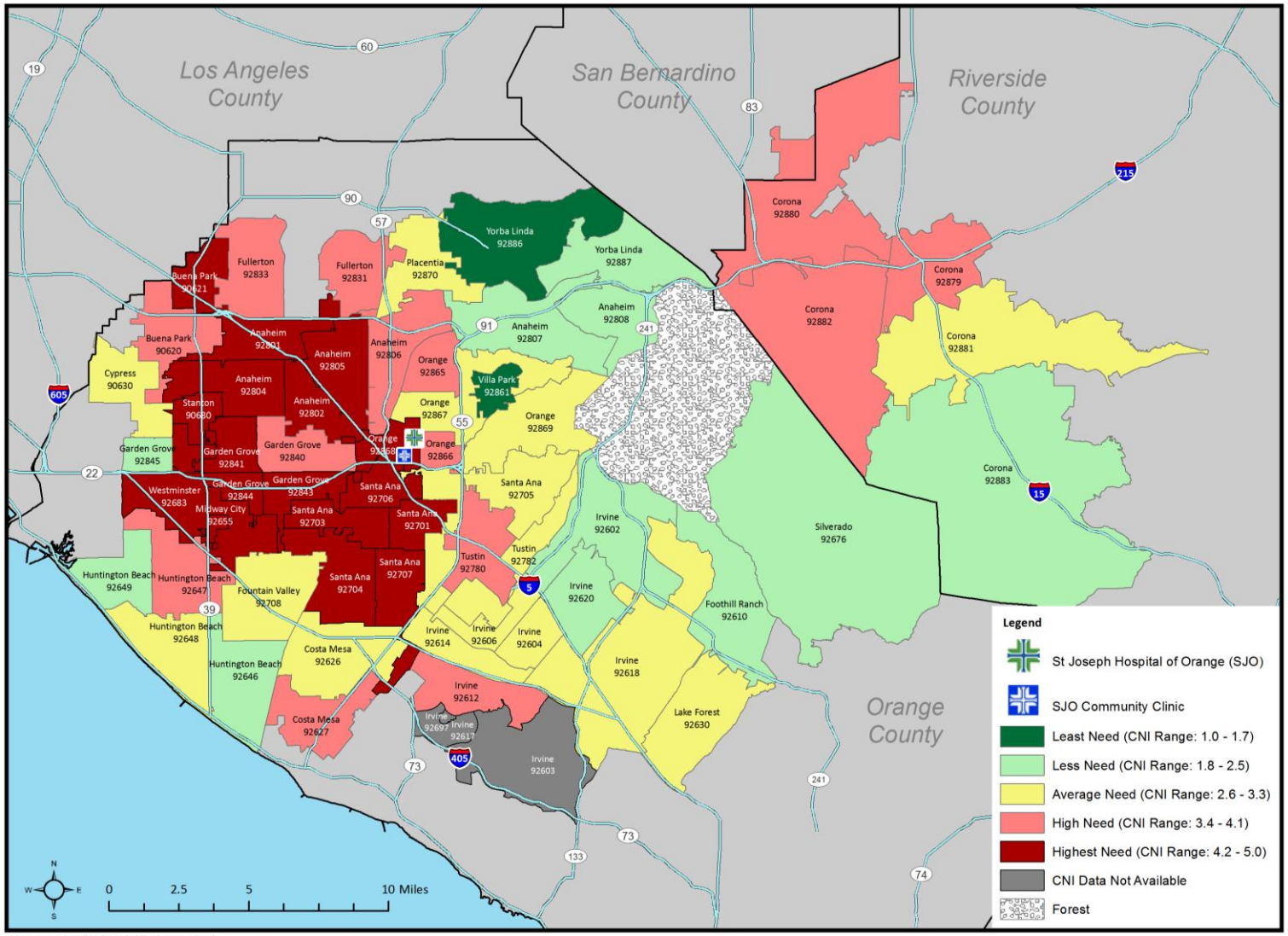
The Community Need Index (CNI) was developed by Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics. The Community Needs Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations. This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalization for manageable conditions such as ear infections, pneumonia or

congestive heart failure compared to communities with the lowest CNI scores. (*Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.)* The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

For example, the zip code 92612 on the CNI map is scored 3.6, making it a High Need community, even though it would appear to be an upper-middle class area. County and hospital health experts would need to conduct an extensive analysis to explain the incongruity.

59 Zip Code CNI Severity Scores in the St. Joseph Hospital CBSA

Severity Scores	No. of Zip Codes in each category	% of Total
Highest Need (4.2-5)	17	28.8%
High Need (3.4-4.1)	14	23.7%
Average Need (2.6-3.3)	15	25.4%
Less Need (1.8-2.5)	11	18.6%
Least Need (1-1.7)	2	3.4%



Map represents HTSA (Hospital Total Service Area).
Prepared by the St Joseph Health Strategic Services Department, September 2013.
Source: Dignity Health.

InterCity Hardship Index

The Intercity Hardship Index (IHI) was developed in 1976 by the Urban and Metropolitan Studies Program of the Nelson A. Rockefeller Institute of Government to reflect the economic condition of cities and allow comparison across cities and across time. The IHI ranges from 0-100, with a higher number indicating greater hardship. In 2000, the city of Santa Ana had the highest IHI in the nation, at 73.7. The IHI was used by St. Joseph Hospital Orange to identify block groups at greatest need.

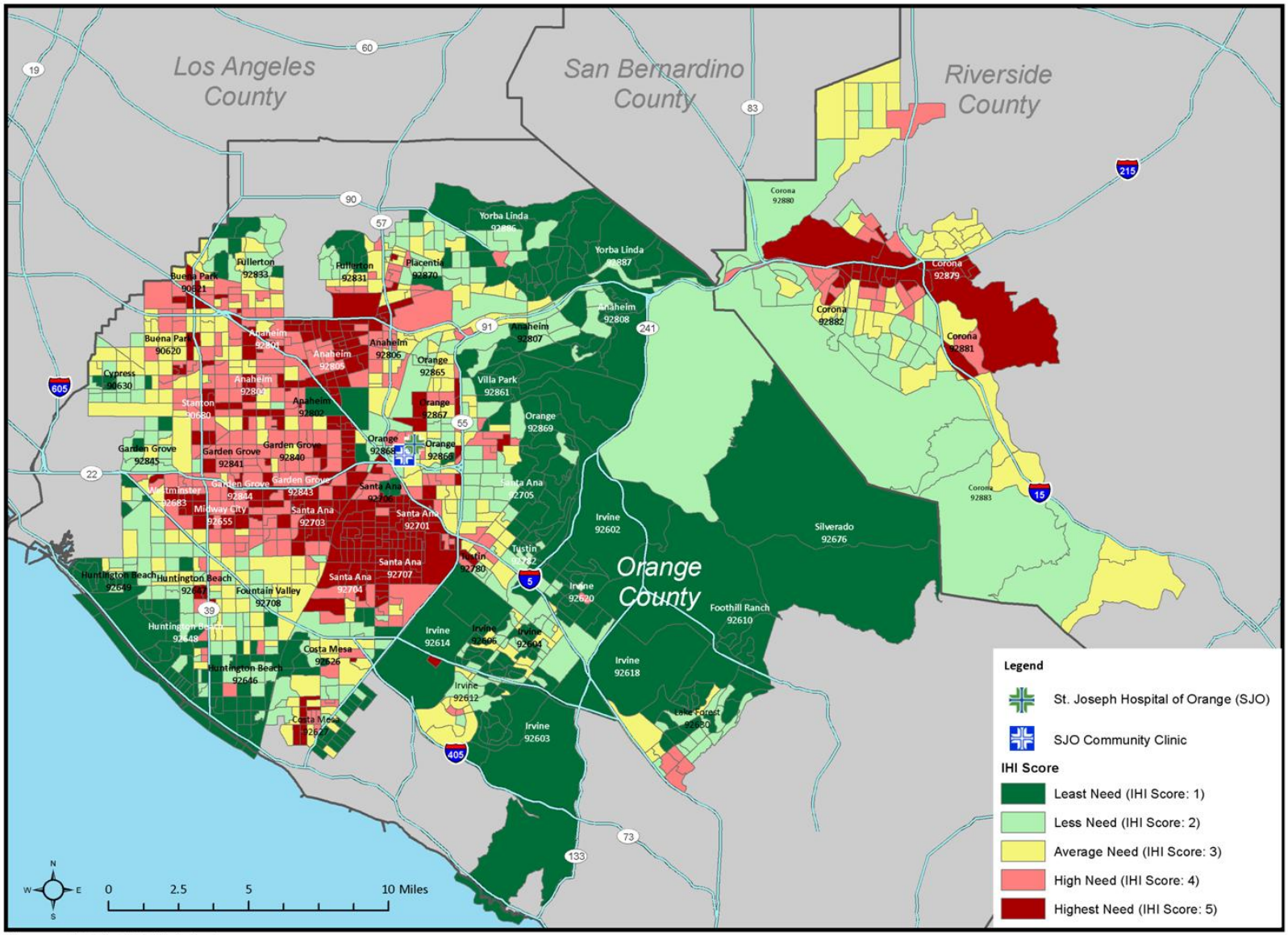
The IHI combines six key social determinants that are often associated with health outcomes:

1) Unemployment (the percent of the population over age 16 that is unemployed)
2) Dependency (the percent of the population under the age of 18 or over the age of 64)
3) Education (the percent of the population over age 25 who have less than a high school education)
4) Income level (per capita income)
5) Crowded housing (percent of households with seven or more people)
6) Poverty (the percent of people living below the federal poverty level)

The relationship between socioeconomic factors and health outcomes has been well documented (*one example is Adler and Newman, Health Affairs, Socioeconomic Disparities in Health: Pathways and Policies, March 2002,* *http://content.healthaffairs.org/content/21/2/60.full*). Although the IHI has not been studied specifically with regard to health, the six components are known individually to be related to health, giving the IHI face validity. Its use as a health indicator has been recommended by the Institute of Medicine as a "reasonably comprehensive, understandable measure."(*Institute of Medicine, Leading Health Indicators for Healthy People 2020, Letter Report, The National Academies Press, 2011*). The IHI also has the advantage of using measures that are available at the block group level, making it possible to see the pockets of higher and lower socioeconomic status within cities and zip codes. This is especially important in Orange County, which has an uneven distribution of poor and wealthy neighborhoods.

Based on the IHI, each block group was assigned a score from 1 (lowest IHI, lowest level of hardship/need) to 5 (highest IHI, highest level of hardship/need). The IHI is based on relative need within a geographic area, allowing for comparison across areas. Similar to what is seen with the Community Need Index, the highest need areas are in

the cities of Santa Ana, Anaheim, Garden Grove, Westminster, Midway City, and Buena Park. There are also pockets of need in Corona, Orange, Fullerton, Huntington Beach, and Costa Mesa.



Map represents HTSA (Hospital Total Service Area)
Prepared by the St Joseph Health Strategic Services Department, September 2013.

METHODOLOGY
ANALYTIC METHODS

A variety of methods and sources were used to gather primary and secondary data for this needs assessment in order to ensure input from across the community. Each approach is summarized below. Full methodologies accompany the respective results.

Primary Data

Survey – Professional Research Consultants, Inc. conducted a survey in 2012 of 1,250 residents in the St. Joseph Hospital service area. The survey instrument was based largely on the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, as well as various other public health surveys and customized questions addressing gaps in indicator data relative to national health promotion and disease prevention objectives targeted by Healthy People 2020. The responses were weighted to match the demographic characteristics of the population and thereby improve the representativeness of the results.

Interviews – Five community and health care leaders who are knowledgeable about the health needs of local residents were interviewed in the fall of 2013. One of those interviewed was a representative of the Orange County Health Care Agency (Orange County's public health department). Each interviewee was provided key findings from the survey and then asked to provide their own insights on the needs of the community. A summary report was prepared that presents the main points from all five interviews.

Focus Groups – A total of 54 community members participated in five focus groups about health needs and quality of life issues in the St. Joseph Hospital service area. The transcripts of four focus groups (40 participants) that were conducted in May 2012 for The Cambodian Family, a local nonprofit organization, were analyzed for this assessment. Two of the focus groups were conducted in Spanish, and two in Khmer. All four asked about health and quality of life challenges in the Santa Ana area. A fifth focus group was conducted in October 2013. This focus group consisted of 14 clients of the St. Joseph Hospital Diabetes Management Program and was conducted in Spanish.

Secondary Data

Office of Statewide Health Planning and Development (OSHPD) data from 2009 was used in defining the St. Joseph Hospital service area.

Data from the 2010 US Census and estimates from the 2006-2010 American Community Survey (ACS) and 2005-2009 ACS were used to develop the Community Needs Indices and Intercity Hardship Indices.

Data from the 2012 American Community Survey / Demographic and Housing Estimates, was used to show the race/ethnic breakouts of the SJH service area. The 2013 Orange County Health Profile, Public Health Services, Orange County Health Care Agency, was used to show health differences among the three primary racial/ethnic groups of the SJH service area. Information on the API community was provided in a personal communication from the Executive Director of OCAPICA. An unpublished report prepared for MOMS Orange County by The Olin Group provided information about births in the SJH service area.

PRIORITIZATION PROCESS AND CRITERIA

Through the CHNA process, fifteen areas of concern were identified. The top eight concerns came up consistently across all the community input processes – interviews, focus groups, and survey (note – the survey did not ask about access to green space and parks, but it was a high concern among participants in the interviews and focus groups). An additional seven concerns were mentioned less frequently but arose through at least one, and typically two, of the data gathering methods, but not all three.

These concerns were identified and placed into the two lists by The Olin Group to reflect the frequency at which the concerns were raised through the community input process. Members of the St. Joseph Hospital Community Benefit Committee will weigh the findings of this report along with potential measures for addressing these areas of concern to select three or four priority initiatives for FY15 to FY17.

COLLABORATING ORGANIZATIONS

Organizations that participated in preparing the CHNA include:

- The Cambodian Family
  The Cambodian Family, a nonprofit community based organization, established in 1980 and headquartered in Santa Ana, California helped with the CHNA by conducting primary data collection with 4 focus groups. The Cambodian Family promotes the health and well-being of limited English-speaking refugees and immigrants in the Orange County region.

The Cambodian Family held four focus groups to understand health needs and community concerns, with a specific focus on Santa Ana. Individuals who use programs and services at The Cambodian Family, as well as others in the local community, were invited to participate in focus groups. The focus groups were conducted in Spanish and Khmer; with two groups in Spanish and two groups in Khmer. All participants had lived in the city of Santa Ana for at least one year, and they shared their concerns about health and the community.

The Cambodian Family, as a community partner with the St. Joseph Hospital of Orange, enthusiastically shared the data from these four groups to help present a clearer picture of the community assets and needs, especially surrounding health and wellness. This community input is provided in further detail later in the report.

Consultants:

- Professional Research Consultants, Inc.
- The Olin Group

COMMUNITY NEEDS
Community Needs Prioritized

The top eight are presented here in alphabetical order followed by the additional seven, also in alphabetical order:

Top Eight Concerns:

1. **Access to affordable, healthy food**
2. **Access to health care**
3. **Dental health**
4. **Diabetes**
5. **Lack of green space and parks**
6. **Mental health**
7. **Obesity**
8. **Substance abuse**

Seven Additional Concerns:

9. Affordable and accessible transportation
10. Asthma in adults
11. Chronic Heart Disease
12. Cultural competency
13. Depression
14. Stress
15. Stroke

Disproportionate Unmet Health Need Group (DUHN), Key Community Needs, and Assets Summary

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within the St. Joseph Hospital service area.

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Garden Grove – 92843, 92844	• Higher rates of families where Spanish is the primary language at home • Higher rates of families with someone age 25+ not having a HS diploma • Higher number of Households with more than 7 people • Higher number of Households living below the poverty level • Higher number of female heads of household Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with • Higher rates unemployment • Higher rates of dependency • Lower rates of education attainment • Lower per capita income levels	• County of Orange Health Care Agency • Community-based Organizations o Healthy Smiles o Orange County Asian and Pacific Islander Community Alliance (OCAPICA) o Orange County Korean American Health Information Education Center (OCKAHIEC) o MOMS Orange County

DUHN Population Group or Community	Key Community Needs	Key Community Assets
	• Higher rates of crowded housing (> 7 persons per household) • Higher rates of poverty • Higher rates of limited English proficient individuals • Higher rates of unemployed and uninsured	
Santa Ana – 92701, 92704, 92707	• Higher rates of families where Spanish is the primary language at home • Higher rates of families with someone age 25+ not having a HS diploma • Higher number of households with more than 7 people • Higher number of households living below the poverty level • Higher number of female heads of household Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with • Higher rates Unemployment • Higher rates of dependency • Lower rates of education attainment • Lower per capita Income levels • Higher rates of crowded housing (> 7 persons per household) • Higher rates of poverty • Higher rates of limited English proficient individuals Higher rates of unemployed and uninsured	• County of Orange Health Care Agency • Community-based Organizations o Latino Health Access o Kidworks o MOMS Orange County o The Cambodian Family o Delhi Center o Corbin Family Resource Center o Taller San Jose • Community Clinics/Health Centers o AltaMed (3 clinics) o Birth Choice Health Center o Clinica CHOC Para Ninos o Kaiser Permanente Harbor MacArthur Clinic o Serve the People Health Center o SOS-El Sol Wellness Center o UCI Santa Ana
Midway City - 92655	• Higher rates of families where Spanish is the primary language at home	• County of Orange Health Care Agency • Community-based

DUHN Population Group or Community	Key Community Needs	Key Community Assets
	• Higher rates of families with someone age 25+ not having a HS diploma • Higher number of households with more than 7 people • Higher number of households living below the poverty level • Higher number of Female heads of household Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with • Higher rates unemployment • Higher rates of dependency • Lower rates of education attainment • Lower per capita income levels • Higher rates of crowded housing (> 7 persons per household) • Higher rates of poverty • Higher rates of limited English proficient individuals Higher rates of unemployed and uninsured	Organizations o MOMS Orange County
Anaheim – 92801, 92805	Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with • Higher rates unemployment • Higher rates of dependency • Lower rates of education attainment • Lower per capita income levels • Higher rates of crowded housing (> 7 persons per household) • Higher rates of poverty • Higher rates of limited English	• County of Orange Health Care Agency • Community-based Organizations o Boys and Girls Club o Anaheim Harbor Family Resource Center o MOMS Orange County • Community Clinics/ Health Centers o Alta Med (2 clinics) o UCI Family Health Center-Anaheim

DUHN Population Group or Community	Key Community Needs	Key Community Assets
	proficient individuals Higher rates of unemployed and uninsured	

PRIMARY DATA

Method	Who Participated	When
Community Survey	1250 residents of SJH CBSA	2012
5 Stakeholder Interviews	5 community leaders who are knowledgeable about health and health access in the CBSA	Fall 2013
4 Focus Groups	20 Spanish-speaking and 20 Khmer-speaking residents of Santa Ana	May 2012
1 Focus Group	14 participants in SJH Diabetes Management Program	October 2013

Community Input
Summary of Community Input

For the Community Health Needs Assessment, community input was gathered through a telephone survey, key informant interviews, and focus groups with community members in the hospital service area. The following is a brief overview of issues shared by community members across these data collection methods. The data is not organized in any particular order or priority.

<u>Health Concerns</u>

- Lack of access to preventative care
- Arthritis
- Dental/oral health
- High cholesterol
- Major depression
- Stigmas associated with mental health
- Osteoporosis
- Stroke
- Lack of access to surgeries for low-income and uninsured
- Chronic heart disease
- Diabetes
- Hypertension
- Fair or poor mental health
- Obesity
- Stress

<u>Factors that influence or result from unhealthy behaviors</u>

- Adult and childhood overweight/ obesity
- Binge drinking
- Cultural stigma
- Poverty
- Very/somewhat difficult obtaining fresh, affordable produce
- Low proportion of adults ages 65+ who have received a flu shot
- Low proportion of women aged 50+ who had a mammogram in the past 2 years
- Unhealthy eating and life habits

Health Access

- High proportion of uninsured adults ages 18-64
- Concern about proportion of people with an ongoing source of care
- Access to care – long wait times
- Need support navigating the health care system
- Utilization of services, even once enrolled via ACA
- Prevalence of access difficulties
- Lack of access to care due to cost and eligibility
- Fear of missing or not making the enrollment deadlines
- Needs of undocumented individuals

Community Concerns

- Affordable housing
- Lack of health fairs in the community for education and resources
- Need for bike safety education
- Lack of and cost of transportation
- Lack of parks/open spaces for physical activity and outdoor time
- Lack of time to care for one's self and health
- Safety is an issue especially with regard to homeless in the community

Opportunities

- Be accessible and flexible with the circumstances of patients
- Have more health clinics in the community, especially in Santa Ana and Anaheim
- Increase number of FQHCs
- Provide dental services
- Increase community engagement and visibility
- Build trust through word of mouth
- Understand ER access needs, to prevent ER use
- Provide access and referrals to the undocumented
- Mobile clinics
- Cultural competency education for employees
- Health fairs
- Develop resident-led and promotora-like community-based empowerment programs
- Provide vision services

The data following represents detailed responses from each methodology and highlights health and community needs and trends observed in the community.

PRC Survey - Overview of Community Survey Findings

Professional Research Consultants, Inc. conducted a survey in 2012 of 1250 residents in the St. Joseph Hospital service area. The survey instrument was based largely on the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, as well as various other public health surveys and customized questions addressing gaps in indicator data relative to national health promotion and disease prevention objectives targeted by Healthy People 2020.

Thirty-four percent of the respondents were White, 42% were Hispanic, and 24% were listed as Other, which included Asian respondents. The responses were weighted to match the demographic characteristics of the population and thereby improve the representativeness of the results.

A similar survey was conducted in 2007, making it possible to see which areas are improving and which are getting worse over time. The tables below list the areas of improvement and decline, as compared between 2012 and 2007. A more detailed summary of the survey findings can be found in Appendix 4.

Health Concerns	
Improving	**Getting Worse**
Asthma in children	Asthma in adults
Cancer (excluding skin cancer)	Diabetes
Skin cancer	Chronic heart disease
Diabetes management	Stroke
Depressed and sought help	Hypertension
High cholesterol	Major depression
Cardiovascular risk factors	Fair or poor mental health
Fair or poor self-rated health among adults	Arthritis
	Osteoporosis
	Activity limitation in adults

Health Behaviors	
Improving	**Getting Worse**
Adults eating 5+ servings of fruits and vegetables per day	Adult obesity
Proportion of adults meeting physical activity guidelines	Adult overweight and obesity
Chronic drinking	Weight loss attempt
Adult current smokers	Childhood obesity
Proportion of homes in which children are exposed to smoking	Childhood overweight and obesity
Proportion of adults ages 65+ who have received a pneumonia shot	Very/somewhat difficult obtaining fresh, affordable produce
Proportion of at-risk adults aged 18-64 who have received a pneumonia shot	Binge drinking
Proportion of women aged 18+ who had a Pap test in the past 3 years	Proportion of adults ages 65+ who have received a flu shot
Proportion of adults aged 50+ who had a colorectal cancer screening	Proportion of women aged 50+ who had a mammogram in the past 2 years
Proportion of children who have had a dental visit in the past year	

Health Access	
Improving	**Getting Worse**
Proportion of adults who have not had a routine checkup in the past year	Proportion of uninsured adults ages 18-64
Proportion of children who have had a routine checkup in the past year	Prevalence of access difficulties
Proportion of adults who visited the emergency department 2 or more times in the past year	Proportion of people with an ongoing source of care

Focus Groups Findings

St. Joseph Hospital Spanish-Language Focus Group
Key Findings

Health Issues

- Diabetes
- Depression
- High cholesterol
- Mental Health
- Stress
- Unhealthy eating/life habits

Health Care Challenges

- Access to care – cost and eligibility
- Access to care – long wait times
- Need support navigating the health care system

Community Issues

- Affordable Housing
- Lack of health fairs in the community for education and resources
- Safety is an issue especially with regard to homeless in the community
- Lack of parks/open spaces for physical activity and outdoor time
- Time to care for one's self and health
- Transportation

Opportunities

- Cultural competency education for employees
- Provide access to the undocumented
- Provide dental services
- Accessible and flexible with circumstances of patients
- Have more clinics, especially in Santa Ana and Anaheim
- Provide vision services

Methodology

The Olin Group conducted one focus group with St. Joseph Hospital patients in October 2013 as part of the Community Health Needs Assessment. The focus group was held with 14 individuals from St. Joseph Hospital's diabetes management program. The focus group provided an opportunity to gather input from clients on the health and community needs in the hospital's service area. It was facilitated by a bi-lingual Spanish facilitator and a bi-lingual note taker, who documented the meeting discussion. A semi-structured interview guide with eight questions was used to facilitate the discussion. The questions were informed by data from the PRC telephone surveys. Participants were recruited from the La Amistad clinic's Diabetes Management program participants. Hospital staff, via the clinic's education and support program, invited participants through in-person or telephone invitations. The focus group took place at the Mother Baby Assessment Center, and lasted approximately 1.5 hours.

Health Issues

When asked about the trends of health issues in their communities, focus group participants agreed in general with the downward (improving) trend of the health issues as shared from the survey. In addition, when the upward (worsening) trends in health issues were shared, the focus group confirmed that diabetes was getting worse in the community, not only among adults but also among children. A participant shared that having diabetes is a stressful disease, as one must constantly check your sugar levels and watch what you eat. Participants added that part of the increase in diabetes is due to ignorance of the consequences of unhealthy eating/life habits. In addition, people's willingness to manage the illness, the emotional dynamics of embracing the condition, and the unrealistic expectation for immediate results, are part of the elements that make diabetes a complex rising condition among adults and children. Participants went on to further discuss how even though people are diagnosed with diabetes, they have a hard time changing their eating habits and taking care of themselves. Some shared the importance of education to help develop good habits. In addition, they talked about the cultural dynamics of life management for people with diabetes, which includes overcoming the denial of having diabetes, and the expectation that once the blood levels go back to normal, people tend to go back to unhealthy eating habits.

Other health conditions that have worsened in the community are high cholesterol, and depression. Patients also shared some of their personal health encounters (e.g. kidney infection and stroke). In addition, they talked about the interconnection between some of the diseases. For example, they noted the correlation between diabetes and depression. Specifically, they talked about how depression may lead to unhealthy eating habits, which in turn worsens the diabetes. Another example was given for the interrelation between stress, depression, and high cholesterol.

Challenges to Health Care

Finally, the participants shared that mental health issues are complex to deal with for many families. Part of the barriers of managing mental health issues include the emotional complexities of accepting the condition and facing the social stigmas associated with having a family member with mental illness. In addition, the lack of knowledge for resources, and the same accessibility issues that are true for other health conditions also play a role when trying to serve the needs of mentally ill patients.

When asked about access to health care, focus group participants identified access to care as a challenge. Some of the barriers to access care include being undocumented and not having access to subsidies to support access to care. Others discussed the challenges with getting access to care and the eligibility requirements that must be met in order to receive low- to no-cost care. Furthermore, navigating the system and meeting the requirements for eligibility seem confusing, intimidating and rigid at times. A participant shared that being asked to provide a lot of personal information (e.g. a reference letter and utility bills), made the process feel inhumane. Added to this is the systematic approach for enrollment and services provision, which at times clashes with the relational nature of the community served by the hospital. A few of the participants referenced a staff person at the hospital who has helped to make the eligibility process much more seamless. However, that was not a consistent experience for all participants. Some participants felt that in their experience, unless their situation was dire, their symptoms were often overlooked and went unaddressed.

Language and long wait times at clinics were also identified as additional barriers to access to care. A focus group participant shared that sometimes patients procrastinate accessing care until they are in dire pain, compounding the previously mentioned challenges to accessing care.

When addressing areas where St. Joseph Hospital had excelled, some participants said that while the eligibility process may be burdensome at times, St. Joseph Hospital has patient advocates or administrative support staff who help with the registration process for patients seeking care. Participants identified the access to caring, available, and responsive staff as one of the strengths of the hospital and its clinics. They praise the value of having caring people available to answer any questions and concerns, and who serve as an educator and coaching resource on their journey toward recovery. In addition, some participants also talked about the fact that St. Joseph Hospital did not deny services to them even though they did not qualify for any subsidy program. While some patients shared some specific situations and challenges with access to care and bad experiences with the health system, three participants also acknowledged the hospital and thanked them for their care and generosity, one stating, “they saved my

life." Finally, the educational and support programs through the clinic were recognized as valuable for the participants.

General Community Conditions

When asked about the general community conditions, focus group participants identified the following as lacking in the community: 1) time (not able to take time to focus on oneself and take care of one's health), 2) health fairs, 3) parks, 4) safety (in particular, homeless in the community) 5) transportation and 6) affordable housing. Focus group participants also shared that there is drug use in the community, particularly at the parks.

St. Joseph Hospital Opportunities

When asked what the hospital can do to address community needs, the following responses were provided: 1) educate employees on cultural competency and patient treatment, 2) be more accessible and flexible, 3) provide access to the undocumented, 4) have more clinics in Santa Ana and Anaheim, and 5) provide dental and vision services.

The information provided from focus group participants was vital in understanding the patient and community member perspective regarding health and community issues. Information shared in this focus group supported data from the PRC telephone surveys and key informant interviews with local community leaders. The focus group data was particularly insightful on the nuanced experiences faced by clients assessing services at St. Joseph Hospital and its affiliated clinics.

Summary of *The Cambodian Family* Focus Groups
Key Findings

Health Issues

- Diabetes
- Obesity
- Drug use
- Drinking
- Depression
- Stress

Health Care Challenges

- Too few community clinics
- Hours of operation
- Too few interpreters
- Need culturally appropriate services

Community Issues

- Transportation
- Lack of open space for physical activity
- Too few exercise opportunities
- Easy access to fast food/ too little access to healthy foods
- Need employment and job training
- Gangs – and association with alcohol and drug use
- Safety
- Environmental health

Opportunities

- Provide classes on nutrition and how to cook healthy foods
- Provide group exercise classes

Methodology

The Cambodian Family, a nonprofit that promotes the health and well-being of limited English-speaking refugees and immigrants, held four focus groups to understand the health needs and other pressing issues in the community. The focus groups also asked where and how individuals found information and resources. The focus groups were conducted in May 2012 at The Cambodian Family office in Santa Ana, and each lasted about 1.5 hours. Two were facilitated by a native Spanish speaker and two were

facilitated by a native Khmer speaker. All of the participants were Latino or Cambodian individuals who had lived in the city of Santa Ana for at least one year. The two ethnic groups represent opposite ends of the spectrum regarding availability of culturally sensitive services in a person's primary language and culture. While services are typically available in Spanish, and often in Vietnamese, Cambodian is one of many languages spoken by residents of Orange County for which services in that language are not routinely provided except through a translation service.

Participants were at least 18 years old and were selected based on their ethnicity and client status (current participant in The Cambodian Family services or had never participated in or accessed The Cambodian Family programs/services); There were two Latino groups (client and non-client), and two Cambodian groups (client and non-client).

Participants were recruited by The Cambodian Family (TCF) staff for four weeks. For the client groups, TCF staff approached potential participants from among current clients in TCF programs. Recruitment for the non-client groups was done through word-of-mouth and flyers that were posted and distributed at various community and partner locations throughout Santa Ana. Approximately 12 to 15 individuals were invited to each focus group and 10 people participated in each group. Participants were re-screened upon their arrival to confirm their eligibility for the focus group.

English-language transcripts of the focus groups, without identifying information, were provided to St. Joseph Hospital for use in this Community Health Needs Assessment. The summary that follows was developed from those transcripts by The Olin Group, which did not conduct or participate in the focus group sessions.

Key Findings

The focus groups at The Cambodian Family revealed some common areas of need, health disparities, and opportunities for the Latino and Cambodian community in the area of Santa Ana. Health concerns mentioned by the participants were diabetes, obesity, drug use, and drinking. Issues affecting health included the lack of community clinics, access to health care services (in terms of hours of operation, information for health behaviors, nutrition and exercise opportunities, open spaces, language interpreters (especially for the Cambodian community) and lack of transportation.

In regards to eating habits, time constraints limit opportunities for cooking healthy meals and promote consumption of fast food, which is affordable and convenient. In addition to safety concerns prohibiting physical activity, the cost of physical activity programs for children was also brought up as a deterrent. Focus group participants

spoke of the need for family members to communicate and interact and that multiple obligations (including work) limited family social interaction. Such dynamics contribute to social isolation, especially among youth/adolescents and the elderly.

Participants wanted classes on healthy eating and healthy food preparation. They suggested group exercise classes (group motivation and social support) and welcomed the opportunity for clean and safe green spaces. Both communities spoke about the role of social support and its importance in health and well-being. While physical health aspects were discussed, the conversation around social support reflected the need for emotional and mental support for community residents. One participant shared how everyone has such fast-paced lives and there is not time to get to know one's own neighbors.

When discussing the economy, many spoke about the need for employment and better wages. They also spoke about the high rates of the uninsured and the high costs for health care and medications. The financial burden of co-payments was mentioned, especially if more than one family member needed care, or the person needed medications for chronic disease management. A few participants shared that they try to buy over-the-counter medications to resolve issues to avoid accessing health care, but often these remedies do not work and compound the cost of health care access. Participants also spoke about the impact of the economy on food choice and reflected that healthy food options tended to be more expensive and were not always available (e.g., no farmers markets in the area).

In discussing the possible causes of health problems, focus group participants listed stress, lack of exercise, overeating and poor eating habits, limited spaces for physical activity or exercise, cost associated with physical activity opportunities and a lack of affordable health clinics. Participants felt that stress led to physical ailments and bad eating habits. They also shared that the lack of employment opportunities in the community contributed to stress and health issues.

Gangs, drugs, and a lack of safety were discussed by all focus groups. Focus group participants identified that there were gangs in the community and that their presence reflected a lack of safety. Gangs were also associated with alcohol and drug use. One participant spoke about the role of gangs as a source of support for youth; citing that some youth joined gangs for camaraderie. A lack of safety was identified in the community, which limited opportunities for individuals to exercise, take their kids outdoors, and be engaged in activities in the evening hours. They also expressed concern about a lack of law enforcement presence and the opportunity for other unsafe businesses such as prostitution.

Focus group participants also shared community concerns that influenced health and well-being, such as gangs, security and safety in their neighborhood, lack of parks and exercise space, and a lack of education and parent involvement. Domestic violence was mentioned because there is serious concern that victims are not receiving help because of the reluctance to report incidents that might alert immigration authorities. Other concerns included depression among youth and adults, a lack of resources and information to address community needs, affordable health care, environmental health, and an abundance of fast food options.

Participants shared that depression results from a lack of social support for teens and adults. For teens, depression contributed to gang ties that might offer friendship and support. One member mentioned that depression could lead to suicidal tendencies among teenagers. A few focus group participants also spoke about how obesity, bulimia, and anorexia were associated with school bullying. They discussed the pressure and depression that teenagers experience with body weight issues.

The two client and non-client focus groups also spoke about environmental health and safety. They talked about how the community is close to freeways, train tracks, and local factories and that these structures contributed to poor health – bad air or debris in the air and noise pollution. One participant spoke about children's exposure to foul language from local factory workers. The lack of safety in the community contributes to the lack of exercise and physical activity. Many shared that they did not feel safe walking in their neighborhoods. A lack of safety was also associated with a lack of law enforcement presence in the neighborhoods.

When solicited about what can be done to help the community, participants desired more resources and education, transportation assistance, access to care via more local clinics, and a community center with more programs and services, educational opportunities within the community with childcare that are geographically accessible. The Cambodian community also identified The Cambodian Family as a principal source of information and suggested the organization provide additional resources to increase contact with more community members.

When asked what the government could do to help the community, participants overwhelmingly spoke of a need for more programs and services, especially those that are culturally and linguistically appropriate. Several participants said that more money was needed to develop additional programs and services such as clinics, job fairs, educational classes, language classes, and transportation support. When asked how the government could intervene to improve the health of the community, they suggested

accessible places for people to access programs and services, nearby clinics, safe and secure neighborhoods and parks, and an increased law enforcement presence in the community.

Cultural factors affect healthy behaviors. The Latino group spoke about how traditional practices in Mexico allowed for healthier meals and more physical activity. Social support is provided when people gather at meals. The Cambodian focus group participants spoke about concerns with sharing food and passing germs. The Cambodian community also spoke about the importance of gender concordance with health care providers and how a mismatch could prevent people seeking care.

Participants also identified schools, the Internet, newspapers, and magazines, and a few referenced 2-1-1 Orange County as an information source.

Key Informant Interviews

Methodology

The Olin Group conducted five key informant interviews during the fall of 2013. The St. Joseph Hospital's community outreach administrators selected five community and health care leaders who are knowledgeable about the community and could provide a broad perspective on needs (for a list of interviewees, see Appendix 1). The informants were given a brief introduction that explained the purpose of the interview. Most questions began with a description of key findings from the community survey conducted by PRC. The key informants were then asked to impart their own insight into issues affecting the St. Joseph Hospital Service Area. The summary is broken into three sections related to health outcomes, health behaviors, and health care access. Each question **(in bold)** is followed by a summary of the key informant responses.

HEALTH OUTCOMES

Overall, since the last community survey in 2007, *residents report improvements in cancer prevalence, heart disease, high cholesterol, childhood asthma, and low ratings of health.* While there have been these improvements in health outcomes reported, there have also been reported poor outcomes in diabetes, stroke, hypertension, major depression and adult asthma. Amongst these health areas, what do you feel are the top three areas of need for Orange County, especially in the St. Joseph Hospital Service Area?

- Dental/Oral Health
- Diabetes
- Lack of Access to affordable/preventive care
- Mental health and cultural stigmas associated with mental health
- Obesity

All of the respondents noted that dental/oral health and obesity are critical health issues. Diabetes was reported as a major issue by four of the five interviewees. A few respondents also shared that a lack of access to affordable and preventive care will often lead to emergency treatment and health-related problems that further complicate therapy and quality of life.

Mental health and the cultural stigmas associated with it were another concern. Compounding all areas of need is the looming implementation of the Affordable Care Act (ACA). Though not identified in this section, the ACA continually emerged as a source of concern and challenge to providers in the community as to how it will impact undocumented residents and the capacity of providers.

What populations are most affected by these needs?

- Immigrants
- US born Latinos
- Undocumented

Respondents conveyed a sense that these issues transcend group classification and affect all populations, though some groups disproportionately. The populations most affected by these needs include immigrants, U.S. born Latinos, and the undocumented. These groups have more difficulty navigating the system or have a lack of understanding about the services available. Many undocumented persons avoid seeking health care altogether and remain skeptical of free services. As a result, they often seek health care services only when they have a problem that cannot go untreated.

Diabetes and obesity were identified as emerging health concerns in the Vietnamese community, as well. The homeless and uninsured share considerable overlap with the health challenges faced by the undocumented. Respondents believe that although the ACA is meant to reduce the number of uninsured, the undocumented will have no opportunity to purchase health care. In addition, a segment of eligible people will

simply pay the penalty for not having insurance because they perceive it as a less costly option.

HEALTH BEHAVIORS

The survey findings from PRC also suggest that over the last five years, area residents are engaging in healthier behaviors including increases in cancer screening, fruits and vegetables consumption, physical activity, immunization, and lower chronic drinking rates. Furthermore, fewer individuals report visiting the emergency department two or more times in the past year. While these are promising trends, the survey also reports health behaviors that may result in poorer health outcomes in the community. For instance, there is an increase in activity limitation due to physical, emotional or mental problems, increase in obesity, an increase in binge drinking, and increased difficulty with accessing grocery stores for affordable and fresh produce, increased number of individuals who are uninsured, increased difficulty accessing health care, and a decrease in ongoing medical care for residents in the St. Joseph Hospital CBSA. What do you feel may be influencing these changes in the community?

- Lack of affordable healthy food choices
- Poverty
- Cultural stigma

Identified factors influencing these changes in the community were the lack of affordable, healthy food choices, cultural stigma, and poverty. Many parents give their children money to buy high-calorie fast food meals because it is easy, cheap, and efficient. Even though many fast food restaurants are offering healthier meals, such as salads, these remain comparatively expensive and are not likely to be selected by unsupervised children. As two informants commented, when the closest large grocery store is more than a mile away, it is difficult for mothers, who may not have a car, to walk or take the bus with their children in tow while carrying home bags of groceries.

Additionally, there remain stigmas about mental health and domestic violence. Many community members avoid seeking care or finding free alternatives. One respondent stated that the schools could use "an army of therapists" and noted sorrowfully that post-traumatic stress is higher for urban youth than military veterans. Compounding all these issues remains the ever present poverty in Orange County that serves as a barrier to access for many. Lack of transportation has made it increasingly difficult for those without cars to access care or to purchase groceries. Though bus transit exists, there are

often many stops and the cost can rise as people trek to services far from home. Adding to the worries of providers is a lack of coverage for those ineligible or unwilling to enroll in any of the new plans offered by health insurers.

Does the built environment (such as open space/parks, roads without sidewalks for pedestrians, etc.) have an effect on these health behaviors? Are some of these health conditions attributing to other health conditions or behavior?

- Lack of green space
- Need for bike safety education
- Lack and cost of transportation

Interviewees noted that there is a dearth of green space available to the largely urban areas of Orange, Santa Ana and Anaheim. Even where parks exist, there are issues with their use. Schools provide large open areas but these are frequently closed when unstaffed and parking lots are rarely sanctioned for biking or skateboarding. Residents are often unwilling to use the spaces in the evening due to concerns about gang violence. Biking is a common mode of transport for those unable to afford a car, though this often leads to unsafe use because bikers are uneducated about bike safety rules. Some of the respondents doubted that providing more space would ensure their usage given these barriers. However, another noted that where there is open green space in their area, it is widely used, at least during the day. The lack and cost of transportation prevents residents from traveling to large green spaces available at the far edges of the county. One informant noted that the city has less park space per capita than Manhattan. Many working parents prevent their children from leaving home to visit parks when they get home from school. This sedentary lifestyle contributes to stress and depression, and increases the risk of obesity, diabetes and other illnesses.

What existing health programs or models are effective or might be effective in promoting health in this community? Which models are not or no longer working? What health promotion models do you think would work well given your experience and knowledge of this community? Are there certain models that would work better in certain communities/geographic areas? Are there certain models that would work better for certain age groups? Races/ethnicities? Other groups? (i.e. immigrants, undocumented) What are the most effective ways to provide information to your service populations about the availability of health services? How might these differ for the various populations within your service areas?

- Resident led and promotora like community-based empowerment programs
- Health fairs
- Mobile clinics
- Trust building through word of mouth

For the uninsured or underinsured, mobile clinics, resident-led programs, promotoras, and community-based empowerment remain invaluable bulwarks against poor health. The availability of mobile clinics can impact when and how low-income populations receive care. This is doubly true for the undocumented, who seek out these types of low-profile offerings for their basic health needs.

Health fairs and community agencies are also of essential value to local residents. As with most of the responses, interviewees noted that where services were successful, such as mobile clinics, there were still considerable unmet needs. Promotora programs were highly regarded as a means of providing affordable care to English language learners that honors their cultural customs. Despite these efforts, word of mouth remains the primary method for informing potential patients about provider services. When residents develop and lead fitness programs, they are more likely to be successful and have participation from fellow community members.

HEALTH CARE ACCESS

Health Insurance coverage for CBSA residents appears to be decreasing, are there ways to help cover this community? Do you feel that Health Care Reform – Covered California – will help to increase coverage for individuals in the service area? Are there ways that the St. Joseph Hospital of Orange can work collaboratively with others to increase the number of insured?

- Utilization concerns, despite coverage through ACA
- Fear of not meeting enrollment deadlines
- Undocumented have needs

Respondents doubted the ability of initiatives to effectively address the gaps in health care coverage, though they acknowledged Covered CA and the ACA may increase the number of actual insured. However, undocumented people will remain uninsured. Insurance alone does not affect lifestyle habits, choices or the location and affordability

of healthy food, nor does it impact the density of housing. Additionally, there is concern that many residents will not meet enrollment deadlines. Often low-income families are preoccupied with work, school, and family and do not have the time to learn about the insurance options or navigate the enrollment system. Because of these barriers and the cost of insurance (even with subsidies), many will likely take the penalty instead of acquiring coverage. As a result, there will still be many people without access to preventive care, at least for the next few years. One informant said, "there should be open access to health care regardless of ability to pay…I should not have to know all this stuff."

What health services are lacking or difficult to access in this community? Does this affect certain communities more than others? Which? How? Why? Are there any health services that are lacking or difficult to access in this community for youth in particular? Which? What factors contribute to this? Are there any health services that are lacking or difficult to access in this community for the elderly in particular? Which? What factors contribute to this?

- Dental Care/Oral Health
- Mental Health
- Access to surgeries

Unanimously agreed upon by the five interviewees was the direct need for dental care. Few insurers will provide coverage and it is not included in the ACA. Orange County is already grappling with the issue, and there is a persistent concern that ACA may exacerbate the problem of dental coverage. Oral health is often at the low end of priorities for the poverty-stricken and the providers interviewed have noted that patients seek dental care only when their problems affect their ability to function. Respondents also noted that there was a need for adult dental care that preserves teeth rather than pulling them.

Access to surgeries of all types also remains extremely difficult for the poor to access. Three informants mentioned a need for more mental health services, especially mentioning loneliness and isolation among the aging, mental health stigma among Latinos and Vietnamese, and a need for assessments and medications in general. As well, depression and suicide were concerns that could present from loneliness and isolation. And stigma is often associated with publically acknowledging mental health issues and therefore some Latino and Vietnamese community members will not seek care for mental health.

Of the various issues that you discussed today, what specifically could hospital organizations like St. Joseph Hospital of Orange do to address these needs? In addition to funding, how can St. Joseph Hospital be more collaborative to make your work more effective?

- Referral resources for the undocumented
- Health clinics in the community
- Increase community engagement and visibility
- Understanding ER access needs, to prevent ER use
- Increase number of FQHCs

Many suggested that St. Joseph Hospital should serve or provide referrals for the undocumented. Additionally some suggested that St. Joseph Hospital should inform local organizations about which services are available to undocumented persons. One recommended monitoring the health concerns that cause people to go to the emergency room and develop services to meet those needs. St. Joseph Hospital should create health clinics in the community it intends to serve or fund ones that already exist. It was also suggested St. Joseph Hospital work to increase the number of Federally Qualified Health Centers.

Providers noted that St. Joseph Hospital did not appear to be as engaged in the collaborative efforts in Santa Ana as they could be. Locally, St. Joseph Hospital could benefit from being more involved in the community. Specifically St. Joseph Hospital Community Benefit staff should spend more time out in the community. Within the three mile radius of the hospital it was noted that "the homeless population has no idea about access and can't get to a pharmacy." Along with the undocumented, the local homeless population in Santa Ana and Orange remains an issue with providers and interviewees noted the opportunity St. Joseph Hospital has to address these local issues. In terms of funding, providers expressed a desire to receive multi-year funding and complimented the follow-up and responsiveness of St. Joseph Hospital as a funder. Despite the criticism and suggestions, one respondent positively noted: "what St. Joseph Hospital does saves lives."

Do you have any last questions or comments? Anything else that you would like to add or share?

Providers reiterated in closing the need for St. Joseph to engage partners and collaboratives and build a referral network. Leveraging these resources will be essential

to closing the gaps in services that exist. The Affordable Care Act is a challenge and an opportunity to better address the systemic issues facing Orange County health care.

Potential Measures Identified through Community Input

Fifteen areas of concern arose consistently across the various forms of community input; they are presented here. Potential strategies and interventions were also identified via community input and are reported below in items #1-9. Items #10-15 were identified as areas of concern via the telephone survey, interviews and focus groups. However, potential strategies and interventions were not discussed and recommendations shared below are provided from The Olin Group.

1. Access to affordable healthy food
    a. Support and/or develop farmers markets or community gardens. Focus access to local geographic locations convenient for the community.
    b. Provide education on nutrition.
    c. Provide cooking classes to help prepare healthy meals.
2. Access to health care
    a. Develop available and accessible health clinics to serve the community, with a focus on low cost, quality care that is available beyond the usual 9am-5pm hours.
    b. Ensure access to coverage through the Affordable Care Act with outreach, education, and application assistance.
    c. Minimize or reduce long wait time at some of the clinics, which is a current deterrent to seeking care.
    d. Provide culturally and linguistically appropriate access to care to all individuals.
    e. Reduce the confusion of eligibility requirements in accessing health care and services.
    f. Provide assistance and support in navigating the health care system.
    g. Reduce and minimize the high cost of co-pays and medications.
    h. Have policy discussions to address the limited access concerns for undocumented individuals.
3. Dental health
    a. Provide low cost quality access to comprehensive dental health care.
4. Diabetes
    a. Provide diabetes outreach and education.

   b. Increase awareness of the association between diabetes and dietary habits and healthy lifestyles.
   c. Increase awareness of the co-morbidities associated with diabetes such as depression.
   d. Monitor prevalence of diabetes in Vietnamese community and develop services as needed
5. Lack of green space and parks
   a. Identify and develop safe and accessible green spaces, such as parks, for community members to exercise.
   b. Identify opportunities for shared use spaces – for example with schools and school playgrounds, such that these open spaces are accessible outside of regular school hours.
   c. Reduce gang and drug use in parks so that open spaces are safe for community use.
6. Mental health
   a. Increase awareness and provide education about mental health issues in the community.
   b. Raise awareness about mental health and address stigmas around mental health so that those who need care have access to care.
7. Obesity
   a. Raise awareness and provide education about obesity.
   b. Provide education about the connection of obesity to other health problems – heart disease, high cholesterol, arthritis, diabetes, depression
   c. Provide nutrition and healthy lifestyles education.
   d. Monitor prevalence of obesity in all populations and develop services as needed.
8. Substance abuse
   a. Identify and address substance abuse issues in the community.
   b. Address gang-related drug and alcohol abuse issues.
9. Depression
   a. Increase awareness and provide education about depression.
   b. Address depression at various age groups – for example focus on body image and a lack of social support as linked to depression among youth.
   c. Raise awareness about mental health and address stigmas around mental health so that those who need care have access to care.

The following priority areas were identified by the PRC Survey and during the primary data gathering process by the Olin Group. However, potential strategies and interventions were not recommended and are presented here as recommendations from the Olin Group.

10. Affordable and accessible transportation
    a. Identify transportation needs among patients.
    b. Develop a transportation plan to reduce transportation barriers. This may include a free pick up/drop off van for services at the hospital or vouchers for public transportation.
11. Asthma in Adults
    a. Reduce asthma rates.
    b. Identify causes and factors for asthma and develop risk reduction strategies.
12. Chronic Heart Disease
    a. Reduce rates of chronic heart disease.
    b. Develop education programs for healthy lifestyles and dietary habits.
    c. Reduce cardiac risk factors.
13. Cultural Competency
    a. Identify populations served by the hospital.
    b. Develop educational and referral resources in the hospital to culturally and linguistically serve all patients.
    c. Increase awareness of availability of language services within the hospital and encourage utilization by providers to ensure quality health care delivery.
14. Stress
    a. Provide education about the physical health implications of stress.
    b. Provide stress management education classes and stress management options for patients.
15. Stroke
    a. Reduce rates of stroke.
    b. Develop education programs for healthy lifestyles and dietary habits.
    c. Reduce cardiac risk factors.

Secondary Data Analysis

Office of Statewide Health Planning and Development (OSHPD) data from 2009 was used in defining the St. Joseph Hospital service area.

Data from the 2010 US Census and estimates from the 2006-2010 American Community Survey (ACS) and 2005-2009 ACS were used to develop the Community Needs Indices and Intercity Hardship Indices.

Data from the 2012 American Community Survey / Demographic and Housing Estimates, was used to show the race/ethnic breakouts of the SJH service area. The 2013 Orange County Health Profile, Public Health Services, Orange County Health Care Agency, was used to show health differences among the three primary racial/ethnic groups of the SJH service area. A personal communication from the Executive Director of OCAPICA provided information about the API community. An unpublished report prepared for MOMS Orange County by The Olin Group provided information about births in the SJH service area.

SOURCES

Dignity Health. (n.d.). Community Needs Index. Retrieved 2012, from http://cni.chw-interactive.org/

Professional Research Consultants. St. Joseph Hospital (SJH) -2012 Community Health Needs Assessment

U.S. Census Bureau. (n.d.). Retrieved 2012, from http://www.census.gov/

2012 American Community Survey / Demographic and Housing Estimates

2013 Orange County Health Profile, Public Health Services, Orange County Health Care Agency

Orange County Birth Data Report: An analysis to identify low-income births and prenatal service providers in Orange County, prepared for MOMS Orange County

ATTACHMENTS:

Appendix 1: Community Input

Appendix 2: Healthcare Facilities within Service Area

Appendix 3: Ministry Community Benefit Committee

Appendix 4: PRC CHNA Data

Appendix 5: Hospital Total Service Area Indicators

Appendix 1: Community Input: Interviewees:

Public Health or Other Departments or Agencies

Organization	Nature of Community Input
OC Health Care Agency	*Shared secondary data, provided input on analyzing secondary data. Shared observations of needs of local community through interviews.*

Community Leaders and Representatives

These leaders represent organizations that provide direct services (health and education) to low income communities of need in Orange County.

Organization	Nature of Community Input
Healthy Smiles for Kids OC 10602 Chapman Ave Garden Grove, CA 92840	*Shared observations of needs of local community through interviews.*
Lestonnac Free Clinic 1215 E Chapman Ave Orange, CA 92866	*Shared observations of needs of local community through interviews.*
Valley High School 1801 S Greenville St Santa Ana, CA 92704	*Shared observations of needs of local community through interviews.*
Delhi Center 505 E Central Ave Santa Ana, CA 92707	*Shared observations of needs of local community through interviews.*

Appendix 1: Community Input (continued): Focus Groups

Others that Represent the Broad Interests of the Community

Focus group participants represent the Cambodian and Latino population of Santa Ana, a high need area in the SJH CBSA. These two ethnic groups represent opposite ends of the spectrum regarding availability of culturally sensitive services in a person's primary language and culture. While services are typically available in Spanish, and often in Vietnamese, Cambodian is one of many languages spoken by residents of Orange County for which services in that language are not routinely provided except through a translation service.

Organization	Nature of Community Input
The Cambodian Family 1626 E Fourth St Santa Ana, CA 92701	*Shared observations of needs of local community through focus groups*

The Focus Groups conducted by The Cambodian Family
Detailed Discussion Summary
Identify the Biggest Threats to Health and Well-Being in the Community

<u>Key Concerns:</u>

- Obesity (heart problems, diabetes)
- Drugs and alcohol
- Lack of nutrition and exercise courses
- Lack of transportation
- Lack of open spaces
- Need for affordable healthy food, cooking classes
- Need for cultural and language appropriate services
- Stress

Focus group participants shared comments about health concerns in the community. They were, in no particular order, diabetes, obesity, drug use, and drinking. Participants spoke of a lack of access to affordable health care and focused on the additional costs of a medical visit, such as lab work and medications. These associated costs are what make medical visits so expensive, particularly medications. Participants spoke about not having local community clinics or a local hospital, and that transportation was a key barrier to accessing these services. In other cases, families depended on their children to provide transportation for medical visits and since they worked, they could not access services with regular (daytime) operating hours.

In regards to community issues, participants shared that there were gangs, a lack of security, lack of green spaces, need for improved communication between parents and

their children, social isolation, and accessible and affordable fast food options that undermines healthy living. Gangs were addressed by both Latino and Cambodian communities and were associated with drugs and violence. Participants expressed concern for their own safety within their own neighborhoods and feared for the safety of their family members who were involved in gangs.

The issue of safety was also associated with the lack of open and green spaces for the community to exercise or merely walk. In addition, most did not feel comfortable exercising or taking their families outdoors for fear of criminal activity. A few participants also spoke about programs to promote physical activity, but often there were associated costs, especially for youth programs. Community gardening, a feature especially embraced by the Cambodian focus group participants, is limited by the lack of green spaces.

A few participants talked about the importance of communication between parents and children and the need to be more engaged in the activities of their children's lives. They expressed a need to create time to engage and dialogue, though many admitted that working parents come home tired and hungry and do not make time to interact with their children. This time constraint also attributed to the lack of physical activity and exercise in the community.

Lastly, both sets of focus group participants shared that unhealthy eating habits were a result of easily accessible and affordable fast food options in the local community.

How are Threats Affecting the Community?

<u>Key concerns:</u>

- Cost of living
- Lack of medical clinics
- Unhealthy environments (freeways, factories)
- Teenage depression (bullying, anorexia, suicide)
- Expensive healthcare costs
- Parenting education
- Lack of communication between family members

Both client and non-client focus groups shared important information about various issues in the community that affect the health and well-being of their respective communities. Depression was an issue that was discussed by both client and non-client groups, though from different perspectives. The Latino focus group spoke about the role of depression among teens and the lack of resources and support for teens. Some mentioned that because of depression, teens joined gangs to find social support. Participants also spoke of a lack of communication between parents and their children,

contributing to the depression among teens; feeling isolated and not supported. As a result, some felt that suicide among teenagers was high in the community because they could not identify sources of support. Other issues associated with teen depression were anorexia and bulimia, a fear of becoming obese, and bullying. Teen parenting education was mentioned as a need.

The Cambodian focus group participants spoke more about the frustration that community members felt in seeking out resources. The inability to find culturally and linguistically sensitive services would lead to depression and an unwillingness to seek out further assistance. Often the depression arose from seeing other ethnic communities have resources and support.

In terms of community safety, participants mentioned a lack of safety in the community and a need for more law enforcement presence. Many participants did not exercise or walk in their neighborhoods, especially in the evenings. They also noted a lack of parks or open space.

In regards to healthy food options, participants spoke about the wealth of fast food options available in the community and the low cost of the unhealthy food options. Community members were aware of the importance of healthier choices, but noted that this often meant purchasing more expensive food items. Participants spoke about the desire for organic food options, but that cost was often a barrier. Some participants also spoke about a desire for a community garden, but identified a lack of space for such options. Many participants acknowledged farmers markets as a good option, however, they were often too expensive or few if any were in the local neighborhoods, and transportation was an issue to accessing these food options.

Focus group participants also spoke of environmental health. In particular, foul air because of being close to freeways, train tracks, and local factories. Participants spoke of debris in the air, which they felt was not conducive to good health. In addition, participants shared that the local factories also had negative impacts on the community because of the inappropriate and vulgar language used by factory workers, which local children could hear.

Access to affordable health care was an issue that came up in both client and non-client focus groups. Participants felt that a lack of affordable health care influenced and affected health and well-being. Identified issues were a lack of clinics in the community (as well as being full or far away), the cost of care (co-payments could become burdensome, as well as the cost associated with needed medications), and a lack of

clinical providers who spoke their language, which meant they did not fully understand what was said at their medical visits.

Most focus group participants were uninsured and have trouble accessing health care due to cost. Insurance or sliding scale co-payments are burdensome, especially when more than one family member needs care; costs add up quickly. When someone is ill or has a chronic disease, the cost of care is not limited just to the medical visit but also includes the lab work and medications. The cost of medications was mentioned multiple times as a challenge for community members. Some shared that they would buy drugs at the local market and self-medicate in the hopes that it would be the cure for the problem; however, often it would not, which compounded the medical costs. Others spoke about not knowing where to find services and feeling that there were no local options.

Participants spoke in depth about the lack of time spent with their children because of work and family obligations. There is not enough time to engage their children or to motivate them to be physically active. One participant said that it is important to model healthy behaviors for her children and to carve out time in the evenings to encourage her children to participate in physical activity, such as going for neighborhood walks.

What are the Causes of the Health Problems?

Key concerns:

- Obesity causes diabetes, high blood pressure, high cholesterol
- Overeating and diseases caused by stress
- Lack of exercise locations
- Expensive exercise classes
- Expensive clinics

In discussing possible causes of the health problems or problems in the community, participants listed stress, lack of exercise, overeating and poor eating habits, limited spaces for physical activity or exercise, cost associated with physical activity opportunities and a lack of affordable health clinics.

Stress was identified as a key cause of health problems in the community. People felt that stress led to physical ailments and bad eating habits. The lack of employment opportunities and lack of work permits contributed to the stress in communities and therefore additional health issues. Participants spoke at great length about the need to eat more fruits and vegetables and to exercise, but community opportunities are limited.

In regards to the lack of exercise, in addition to the safety concerns and a lack of green and open spaces mentioned earlier, one participant noted that parents have to motivate kids and limit television and video game time. Participants also shared that some exercise classes are provided in the community, but few, if any, are free. Participants lacked the motivation to exercise at home, emphasizing the need for group exercise forums. Participants shared again the lack of access to affordable community health care services.

Families, Drugs, and Lack of Safety

Key concerns:

- Lack of communication between parents
- Kids join gangs for support
- Peer pressure (drug use)
- Prostitution
- Lack of law enforcement

The topic of drugs, lack of safety, and families were discussed in multiple focus group segments. Participants expressed that gangs were present in the community and alcohol and drug use was associated with gangs. Some parents felt that drug use was also a result of peer pressure from gangs. Some participants spoke about the need for parents to talk with their children to understand their needs, and to know if they are involved with gangs.

What Else is Needed to Promote Health and Well-Being in the Community?

Key concerns:

- Affordable (or free) places to exercise
- Education cooking classes
- Open spaces
- Group exercise
- Employment opportunities
- Visiting a doctor too late
- Need a low-income clinic
- Need dental clinic
- Affordable healthy food options
- Community events – education and information, health fairs
- Culturally and language-appropriate services
- Lower-stress lives

Most participants stated that healthy eating habits and exercise would improve the community's health, but confessed to not practicing these healthy behaviors. Healthy foods are expensive and stores do not sell low priced organic goods. Fast food and unhealthy foods are more accessible and cheaper. One participant recommended providing low cost healthy recipes to help residents identify what to buy for low cost healthy meals. Providing examples of what to eat would prove helpful for many. In regards to exercise, many expressed a desire to have exercise programs, especially group programs. Individuals stated that they lacked motivation and group settings

would encourage them to participate and be active. In addition to the need for exercise classes, participants spoke of the need for more green spaces.

The lack of community clinics and access to affordable health care was brought up again in terms of needs to help make the community healthier. Many do not seek care until they are very sick, increasing the cost of treatment and the risk of chronic illness. While this increases the financial burden, it is also the impetus, at times, for life style changes.

Participants also spoke at great length of the importance of socialization and social support. They attribute poor eating habits and binge eating to isolation. Healthier eating habits may prevail if individuals are engaged with their communities. One rationale was if they were busy engaging with others, they could not eat, especially easily accessible bad foods. Socializing with other residents might give them a chance to mirror healthy eating habits. Participants felt having healthy relationships with others might provide social support and that, in and of itself, would improve health.

What Can the Health Department Do to Help the Community?

Key concerns:

- More clinical services
- Provide low-cost services
- Job fairs
- English classes
- Spanish classes
- Transportation to clinics

When asked what the health department or local government can do to help the community, respondents talked about more funds, more clinical services, more low cost services, job fairs, English language classes, Spanish language classes, and transportation to clinics.

Overwhelmingly, participants spoke of a need for more services and programs that are affordable and accessible. Participants were also interested in healthy eating and nutrition classes, exercise classes, and language classes. Not only did participants want English language classes, but also some participants shared that they had never learned to read and write in Spanish and these basic skills were necessary for employment. While many health issues were discussed, employment and financial stability were a concern for the Latino focus groups. Overall, both Latino and Khmer communities needed transportation support to access local programs and services.

Participants provided some suggestions on opportunities to support the community in making healthier choices. Participants welcomed information and resources such as brochures and educational classes. In particular, they focused on classes in the

community that would not require transportation support. In addition to classes, childcare would be nice to have so that participants in attendance could focus on the information and discussion, without having to tend to their children.

Transportation was identified as an issue for community members. One participant shared the idea of peceros, which are transport buses that come every 10-15 minutes and help community members get to local gathering sites. Both focus groups shared the need for a local hospital to address health issues in the community.

Key concerns:

- Transportation (e.g. peceros)
- Local hospital
- Parental models
- Classes where parents and children can participate
- Offer child care
- Use ethnic media (e.g. TV, radio or newspaper – all of which do not currently exist)
- The Cambodian Family is the main source of information
- Provide information and materials (by mail, schools, temples)
- Need cultural competence
- Community center with activities for socialization

Cultural factors

Key concerns

- Family is support
- Cultural practices of shared eating (e.g. eating out of the same bowl)
- Gender concordance
- Cultural understanding trumps language competence, but both are important
- A high tolerance of pain
    - Disciplined not to complain
    - Go to doctor but do not disclose pain
    - Culturally do not want to intrude

Both focus groups spoke about cultural/traditional factors that may influence healthy eating and physical activity behaviors. In the Latino focus group, the conversation was about helping families to cook healthier traditional meals and adapting recipes. Some focus group participants also shared how it was easier and cheaper to eat healthier in Mexico (fresh organic fruits and vegetables were more readily available and accessible) and that people walked more and were therefore skinnier in Mexico. The Latino focus group also spoke about meals as an opportunity to bring people, especially family, together and that the concept of family as an important source of social support.

The Cambodian focus group participants spoke at length about cultural practices of serving food and shared containers and eating out of shared bowls and plates. They

expressed concern of passing germs by using utensils in shared serving bowls and plates. The Cambodian focus group participants also spoke about cultural beliefs that influence health care behaviors. For instance, participants shared that often they did not disclose their pain or discomfort to a provider because they did not want to inconvenience the provider with such information or cause the provider to get upset with them. Lastly, they shared that members have a pain tolerance and may not disclose these issues to a provider, which may impede the opportunity to diagnose an ailment or illness. Cambodian focus group participants also spoke about the importance of gender concordance with providers when discussing health concerns, a particular example was breast screening by a male provider. The desire for gender concordance between the patient and provider, and modesty were important issues that could pose as barriers to care. Lastly, the Cambodian focus group participants spoke about the importance of cultural awareness and understanding. They shared that understanding cultural health practices and beliefs was important in the patient provider communication, and was even more important than linguistic concordance.

The Cambodian community spoke at length of the lack of access to health care in their language. Many stated they were limited English proficient and their children are not fluent in Khmer, therefore creating a communication barrier. As a result, interpreters are needed, but often facilities do not have Khmer speaking staff or interpreters available. They also shared that while the community has some Cambodian doctors, most do not speak Khmer fluently, adding to the language access problem.

The Cambodian focus group participants spoke in depth about language access and social isolation. They shared that their limited English fluency restricted their ability to interact with and engage with others, including their neighbors and health care providers. This created a dependency on their children to link them to information and services. A conundrum faced by the Cambodian community was the dependency on their children for language access; however, many of their children, whether Cambodian or American born, had limited fluency in Khmer and could not provide adequate interpretation for their parents, especially regarding health issues. The Cambodian focus group participants were dependent on their children to get to and from programs and services. While the Latino focus group participants also expressed transportation as a barrier, they did not allude to the dependency on their children for transportation.

The Cambodian community expressed many concerns about feeling that they were not afforded equitable resources and services in the community. In particular, they shared how they felt that other cities (e.g. Long Beach and Los Angeles) had more Khmer-

language services and programs, and that in Orange County the only services provided in Khmer were by The Cambodian Family. There was also the perception that Khmer-speaking staff was inaccessible and community members would leave without receiving the services they sought. Another issue, specific to the Cambodian community was the intergenerational conflict that arose because of the interdependency of parents and adult children. Older adults are not fluent in English and younger adults lack fluency in Khmer. Khmer adults rely on their young adult children to help transport them to programs and services, and many of them work during traditional work hours and have to take time off (often losing pay) to help their parents.

The Cambodian focus group participants spoke in great length about the importance and need for Khmer speaking doctors, interpreters, and staff. Their community is lacking many resources that are made available to other communities, e.g., the Vietnamese community or Cambodian community in Long Beach. They spoke of advocating for more equitable culturally and linguistically appropriate services for their community and more programs like The Cambodian Family. The Cambodian community provided an in-depth discussion around the importance of culturally and linguistically appropriate health care. In particular, they spoke of the need to have providers who have cultural awareness of traditional health practices and beliefs.

The Cambodian focus group participants also spoke about a need for a community center where programs and services could be offered, and more importantly, community members would have a gathering site where they could socialize. They felt that socialization would contribute to good health, providing social support to many community members. Others also expressed an interest in a community center to serve as a gathering and discussion space to identify issues for advocacy in the community.

Lastly, the Cambodian focus group participants expressed great interest in learning more about resources in the community via ethnic media (e.g. newspaper, radio, or television). They felt that this would have a broader reach and help community members to be aware of available resources.

Where do you go to find information?
Identified sources for the community were:

- Schools
- Internet
- Newspapers and magazines
- 2-1-1

Appendix 2: Healthcare Facilities within Primary Service Area

Name	Address	Description of Services Provided
Hospitals		
St. Joseph Hospital Orange	1100 W Stewart Drive Orange, CA 92868	*Primary and specialty medical care services*
CHOC Children's Hospital	1201 W La Veta Ave, Orange, CA 92868	*Primary and specialty medical care services for children*
UCI Medical Center	101 The City Drive South Orange, CA 92868	*Primary and specialty medical care services*
Western Medical Center	1001 N Tustin Ave Santa Ana, CA 92705	*Primary and specialty medical care services*
Kaiser Permanente Hospital and Clinics	3460 E La Palma Anaheim, CA 92806	*Primary and specialty medical care services*
Community Clinics		
AltaMed Orange Chapman	4010 E Chapman Ave Orange, CA 92869	*Primary medical care services*
Birth Choice Health Center	1215 E Chapman Ave Orange, CA 92866	*Obstetrical services*
CHOC Clinic at Orange	455 S Main St Orange, CA 92868	*Primary medical care services for children*
Healthy Smiles for Kids of OC Smile Clinic at CHOC	355 S Main St Orange, CA 92868	*Dental services for children*
La Amistad	353 S Main St Orange, CA 92868	*Primary medical care services*
Lestonnac Free Clinic	1215 E Chapman Ave #1 Orange, CA 92866	*Primary medical care services*
Planned Parenthood	700 S Tustin Ave Orange, CA 92866	*Reproductive health care*
Puente de la Salud Mobile Clinic	1100 West Stewart Drive Orange, CA 92868 and mobile	*Primary medical care services*
AltaMed	1400 N Main St	*Primary medical care services*

Name	Address	Description of Services Provided
Santa Ana Main	Santa Ana, CA 92701	
AltaMed Santa Ana 17th St	1227 W 17th St Santa Ana, CA 92706	*Primary medical care services*
AltaMed Santa Ana Broadway	1515 S Broadway Santa Ana, CA 92707	*Primary medical care services*
AltaMed Santa Ana Central	1155 W Central Ave Santa Ana, CA 92707	*Primary medical care services*
Birth Choice Health Center	415 N Sycamore St Santa Ana, CA 91701	*Obstetrical services*
CHOC at Boys and Girls Club of Santa Ana	1000 W Highland Santa Ana, CA 92703	*Primary medical care services - pediatric*
Clinica CHOC Para Ninos	406 S Main St Santa Ana, CA 92701	*Primary medical care services for children*
Kaiser Permanente Harbor MacArthur Clinic	3401 S. Harbor St Santa Ana, CA 92704	*Primary and specialty medical care services*
Kaiser Permanente Santa Ana Clinic	1900 E 4th St. Santa Ana, CA 92705	*Primary medical care services*
Orange County Health Care Agency	1725 W 17th Street Santa Ana, CA 92706	*Primary medical and dental care services*
Planned Parenthood	1421 E 17th St Santa Ana, CA 92705	*Reproductive health care*
Serve the People Health Center	1206 East 17th Street Santa Ana, CA 92701	*Primary medical care services*
SOS El Sol Wellness Center	331 W Halesworth Santa Ana, CA 92701	*Primary medical care services for children*
UCI Santa Ana	800 N Main St Santa Ana, CA 92701	*Primary medical care services*
AltaMed Anaheim Lincoln	1814 W Lincoln Ave Anaheim, CA 92801	*Primary medical care and dental services*
AltaMed Anaheim Lincoln	1814 Lincoln Ave Anaheim, CA 92801	*Primary medical care services*
Central City Community Health Center	2237 W Ball Road Anaheim, CA 92804	*Primary medical care services*
Planned Parenthood	303 W Lincoln Ave Anaheim, CA 92804	*Reproductive health care*

Name	Address	Description of Services Provided
UCI Family Health Center – Anaheim	300 W Carl Karcher Way Anaheim, CA 92801	*Primary medical care services*
AltaMed Garden Grove Harbor	12751 Harbor Blvd Garden Grove, CA 92840	*Primary medical care services*
Central City Community Health Center	12511 Brookhurst St Garden Grove, CA 92840	*Primary medical care services*
CHOC Clinic Garden Grove	10602 Chapman Ave Garden Grove, CA 92840	*Primary medical care services for children*
Healthy Smiles for Kids Mobile Van	10602 Chapman Ave Garden Grove, CA 92840	*Primary medical and dental care services*
Nhan Hoa Health Clinic	7761 Garden Grove Blvd Garden Grove, CA 92841	*Primary medical care services*
VNCOC Asian Health Center	9862 Chapman Ave Garden Grove, CA 92841	*Primary medical care services*
Planned Parenthood	14372 Beach Blvd Westminster, CA 92683	*Reproductive health care*
UCI Westminster	15355 Brookhurst St Westminster, CA 92683	*Primary medical care services*
Hurtt Family Health Center at OC Rescue Mission	One Hope Drive Tustin, CA 92782	*Primary medical care services*
Lestonnac Free Clinic – Tustin	14642 Newport Ave Tustin, CA 92780	*Primary medical care services*

Appendix 3: Ministry Community Benefit Committee Roster

Name	Title	Affiliation or Organization
Sr. Nadine McGuinness, Chairperson	Member, Board of Directors	St. Joseph Hospital
Iosefa Alofaituli	Executive Director	Oak View Renewal Partnership
Liz Bear	CEO	Healthy Smiles of Orange County
Michael Cater	Physician	Pediatrics & Adult Medicine, Inc.
Monique Daviss	Executive Director	El Sol Science and Arts Academy
Ron DiLuigi	VP, Advocacy & Government Affairs	St. Joseph Health
Sr. Martha Ann Fitzpatrick	VP, Advocacy	Mission Hospital
Mary Anne Foo	Executive Director	Orange County Asian & Pacific Islander Community Alliance, Inc.
Rosemary Liegler		Community Member
Steve Moreau	President & CEO	St. Joseph Hospital
Pamela Pimental	CEO	MOMS Orange County
Frank Quevedo	Member, Board of Directors	St. Joseph Hospital
Sr. Christine Ray	Member, Board of Directors	St. Joseph Hospital
Ruth Seigle	Chair of the SJO Foundation Care for the Poor Committee	Community Member

Appendix 4: PRC CHNA Data

Summary of Community Health Survey

In 2012, Professional Research Consultants, Inc. conducted a telephone survey of 1,250 residents of the St. Joseph Hospital Community Benefit Service Area. The survey instrument was based largely on the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, as well as various other public health surveys and customized questions addressing gaps in indicator data relative to national health promotion and disease prevention objectives targeted by Healthy People 2020. The responses were weighted to match the demographic characteristics of the population and thereby improve the representativeness of the results.

In this summary of the results, the tables with arrows compare SJH Community Benefit Service Area Health Indictors with local, state, and national indicators. The Healthy People 2020 Targets, 10-year objectives for health promotion and disease prevention, were included if they were available. The results from 2012 are compared to results of a similar survey conducted in 2007, however, it should be noted that the survey respondents were different in each year, which could contribute to differences despite the weighting to match demographic characteristics. Trends are indicated by a red or green directional arrow to indicate whether the change from 2007 to 2012 was in the desired direction. The GREEN ↑ means the change was in the right direction; the RED ↓ indicates that it was in the wrong direction; and the BLUE - means there was no 2007 data available for a comparison. Using the same labeling for Healthy People 2020, the GREEN ↑ indicates better than the 2020 target; the RED ↓ indicates worse than the 2020 target. NA signifies there is no Healthy People 2010 target. In each table, the areas showing improvement are presented first, followed by the areas that worsened.

Following each trend table, is a table that highlights findings of interest for specific population subgroups. For example, in the first set of tables, we see that the prevalence of asthma in children declined, which is good; we also learn that the prevalence of asthma in older children is lower than that for younger children.

The epidemiological terms in the summaries describe disease occurrence. A prevalence rate refers to the total number of cases of disease that exist in the population, either during a period of time or at a specific point in time. Proportion is used as descriptive measure. It is the fraction of a population that has a specific characteristic of interest.

Health Concern Prevalence rate unless specified	**SJH 2007**	**SJH 2012**	**Trend**	**So Cal 2012**	**CA 2012**	**USA 2012**	**Healthy People 2020 Target**
Asthma in Children	12.7	9.9	↑	10.8	14.2	11.8	NA
Cancer (excluding skin cancer)	4.26	4.1	↑	4.5	NA	5.5	NA
Skin Cancer	5.2	4.9	↑	6.0	NA	8.1	NA
Diabetes Management Classes (proportion of adults)	57.2	52.9	↑	54.8	NA	56.8	62.0 ↑
Depressed and Sought Help (proportion of adults)	42.5	70.5	↑	76.7	NA	82.0	NA
High Cholesterol	31.9	26.8	↑	28.6	36.5	37.4	13.5↓
Cardiovascular Risk Factors (proportion of adults)	81.8	76.6	↑	77.8	NA	86.3	NA
Fair or Poor Self-Rated Health (proportion of adults)	21.4	18.4	↑	17.9	18.1	17.0	NA
Asthma in Adults	3.9	5.7	↓	6.4	7.7	8.8	NA
Diabetes	7.2	12.3	↓	12.0	8.6	8.7	NA
Chronic Heart Disease	3.7	4.9	↓	5.0	NA	6.1	NA

Health Concern Prevalence rate unless specified	SJH 2007	SJH 2012	Trend	So Cal 2012	CA 2012	USA 2012	Healthy People 2020 Target
Stroke	1.5	2.0	↓	2.1	2.3	2.6	NA
Hypertension	25.5	27.0	↓	28.1	25.7	28.7	26.9↓
Major Depression	6.8	7.0	↓	8.0	NA	11.7	NA
Fair or Poor Mental Health (proportion of adults)	10.9	11.8	↓	12.1	NA	11.7	NA
Arthritis	27.9	28.1	↓	28.2	NA	35.4	NA
Osteoporosis (proportion of adults)	8.1	10.1	↓	11.0	NA	11.4	5.3↓
Activity Limitation (proportion of adults)	13.8	18.1	↓	19.8	18.1	20.9	NA
Prediabetes	NA	7.4	-	8.3	NA	85.0	NA

Health Concern Prevalence or Proportion Rates	Findings
Prevalence of Asthma In Children	Children, ages 13-17, have a lower rate than children, ages 5-12, 11.8% and 13.0% respectively.

Health Concern Prevalence or Proportion Rates	Findings
Prevalence of Cancer	Adults, ages 65+ have higher rate (14.0%) than adults, ages 40-64 (4.3%). College or more educated adults had a higher rate (5.6%) than adults with high school or more education (3.6%).
Prevalence of Skin Cancer	Adults over age 65 have twice the rate of skin cancer than younger adults, ages 40-64, 14.6% and 7.0% respectively. College or more educated adults have a higher rate than adults with high school or more education, 6.5% and 4.9% respectively.
Proportion of Adults with Diabetes Who Have Attended Self-Management Courses	Adults, ages 40-64, have a higher proportion than adults, ages 65+, 59.0% and 47.0% respectively. College or more educated adults have a higher proportion than adults with high school or more education, 68.6% and 52.5% respectively.
Proportion of Adults with Depression who have sought help	Adults, ages 18-39 have a higher proportion (85.8%) than adults, ages 40-64 (66.8%).
Cholesterol	The prevalence of high cholesterol is higher among adults 65+ (48.57%) than adults ages 40-64 (39.8%). Caucasians have a higher rate than Hispanics, 38.0% and 24.8% respectively. Adults at the 100% to 200% poverty level have a lower rate (21.3%) than adults below the poverty level and over 200% poverty level, 30.9% and 29.8% respectively.

Health Concern Prevalence or Proportion Rates	Findings
	High school or more educated adults have a lower rate (24.5%) than adults with less than a high school diploma and college and more educated adults, 30.8% and 28.6% respectively.
Cardiovascular Risk Factors (proportion of adults)	Adults, ages 65+ (89.2%) have a higher proportion than adults, ages 18-39, and ages 40-64, 64.8%, 87.3% respectively. Caucasians have a higher proportion than Hispanics, 83.3% and 79.1% respectively. College or more educated adults have a lower proportion (72.4%) than adults with high school or more education and adults with less than a high school diploma, 79.1% and 79.0% respectively. Adults below the poverty level have a higher proportion (81%) than adults at 100% to 200% poverty level and over 200% poverty level, 76.1% and 76.8% respectively.
Proportion of Adults who report (Self-Rated) Fair or Poor Health	Adults, ages 65+ have a higher rate (31.6%) than adults ages 18-39 and adults, ages 40-64, 12.7% and20.6% respectively. Hispanics have a higher rate than Caucasians, 27.5% and 12.2% respectively. Adults with less than a high school diploma had a higher rate (43.4%) than adults with a high school or more education and college or more educated adults, 18.0% and 8.2% respectively. Adults below the poverty level had a higher rate (35.7%) than at the 100% to 200% poverty level and adults over 200% poverty level, 21.4% and 12.4%

Health Concern Prevalence or Proportion Rates	Findings
	respectively.
Prediabetes	Adults, ages 65+ than adults, have a higher rate than adults, ages 40-64, 14.5% and 11.0% respectively. Caucasians have a higher rate than Hispanics, 11.1% and 7.1% respectively.
Prevalence of Asthma in Adults	Adults, ages 40-64, have a higher rate (5.6%) than adults, ages 18-39 (4.8%). Caucasians have twice the asthma rate as Hispanics, 8.4% and 4.1% respectively. College or more educated adults have a higher rate than adults with high school or more education, 7.0% and 5.6% respectively.
Diabetes	Younger adults, ages 40-64, have a lower rate than older adults, ages 65+, 18.2% and 28.7% respectively. Individuals with less than a high school diploma have a higher rate(21.0%) than adults with high school or more education and adults with college education or more, 10.6% and 11.4% respectively.
Heart Disease (Heart Attack, Angina, Coronary Disease) Prevalence	Adults, ages 40-64 have a lower rate of heart disease than older adults, ages 65+, 5.9% and 15.0% respectively. Caucasians have a higher rate than Hispanics, 6.5%, and 3.9% respectively.
Stroke Prevalence	Statistically unreliable sample sizes.

Health Concern Prevalence or Proportion Rates	Findings
Hypertension	Adults, ages 65+ have a higher rate (52.7%) than adults ages 18-39 and adults, ages 40-64, 10.8% and 37.8% respectively. Caucasians have a higher rate than Hispanics, 38.6% and 21.9% respectively. High school or more educated adults have a lower rate (25.7%) than adults with less than a high school diploma and college or more educated adults, 27.4% and 28.5% respectively. Adults at the 100% to 200% poverty level have a lower rate (16.6%) than adults below poverty level and adults over 200% poverty level, 24.6% NS 29.4% respectively.
Major Depression	Adults, ages, 40-64 have a higher rate (9.0%) than adults, ages 18-39, (5..0%). Caucasians have a higher rate than Hispanics, 8.9% and 6.7% respectively. College or more educated adults have a lower rate (4.6%) than adults with high school or more education and adults with less than a high school diploma, 7.4% and 10.0% respectively
Proportion of Adults with Fair/Poor Mental Health	Adults, ages 65+ have a higher proportion (13.22%) than adults ages 18-39 and ages 40-64, 11.7% and 11.5% respectively. Caucasians have a lower proportion than Hispanics, 8.1% and 18.9% respectively.

Health Concern Prevalence or Proportion Rates	Findings
	Adults below the poverty level have a higher proportion (25.5%) than adults at 100% to 200% poverty level and over 200% poverty level, 19.5%, and 6.9% respectively. College or more educated adults have a lower proportion (5.9%) than adults with high school or more education and adults with less than a high school diploma, 11.5% and 26.4% respectively.
Arthritis/Rheumatism Prevalence Among Adults Aged 50+	Adults, ages 65+, have a higher rate (43.7%) than adults, ages 50-64 (20.3%). Other category has a higher rate (37.1%) than Caucasians and Hispanics, 26.7%, and24.9% respectively. Adults below the poverty level have a higher rate (45.0%) than adults at 100% to 200% poverty level and over 200% poverty level, 33.5%, 26.5% respectively. College or more educated adults have a lower rate (21.6%) than adults with high school or more education and adults with less than a high school diploma, 31.2% and 35.7% respectively.
Proportion of Adults 50+ with Osteoporosis	Adults, ages 65+, have a higher proportion (20.1%) than adults, ages, 50-64(6.2%) Other category has a higher proportion (12.1%) than Caucasians and Hispanics, 10.9% and 10.3% respectively. Adults below the poverty level have a higher proportion (23.4%) than adults at 100% to 200% poverty level and over the 200% poverty level, 10.4%

Health Concern Prevalence or Proportion Rates	Findings
	and 8.3% respectively. High school and more educated adults have a lower proportion (9.4%) than college or more educated adults and adults with less than a high school diploma, 9.9% and 16.7% respectively.
Proportion of Adults with Activity Limitations Due to Physical/Mental Problems	Adults, ages, 65+, have a higher proportion (34.4%) than adults, ages 18-39, and ages 40-64, 9.6% and 22.5% respectively. Caucasians have higher proportion (27.4%) than Hispanics (12.2%). Adults over the 200% poverty level have a higher proportion (19.5%) than adults at the 100% to 200% poverty level (13.0%). Adults with less than a high school diploma have a lower proportion (15.9%) than college or more educated adults and adults with high school or more education, 18.7% and 18.4% respectively.

Health Behaviors Prevalence rate unless specified	**SJH 2007**	**SJH 2012**	**Trend**	**So Cal 2012**	**CA 2012**	**USA 2012**	**Healthy People 2020 Target**
Adults Eating 5+ Servings of Fruits and Vegetables per Day	45.8	47.1	↑	47.8	27.7	48.8	N/A
Proportion of Adults Meeting Physical Activity Guidelines	44.4	48.5	↑	48.9	51.3	42.7	N/A
Chronic Drinking	4.2	2.9	↑	3.9	5.7	4.9	N/A
Adult Current Smokers	11.9	9.9	↑	11.1	12.1	17.3	N/A
Proportion of Homes in which Children are Exposed to Smoking	10.2	9.9	↑	9.9	9.6	N/A	N/A
Proportion of At Risk Adults Aged 18-64 who Have Received a Flu Shot	33.4	49.2	↑	46.9	N/A	52.5	N/A
Proportion of Adults Aged 65+ who Have Received a Pneumonia Shot	65.3	69.5	↑	70.4	62.6	68.6	90%↓
Proportion of At Risk Adults Aged 18-64 who Have Received a Pneumonia Shot	14.5	41.7	↑	38.4	N/A	32.0	60%↓

Health Behaviors Prevalence rate unless specified	**SJH 2007**	**SJH 2012**	**Trend**	**So Cal 2012**	**CA 2012**	**USA 2012**	**Healthy People 2020 Target**
Proportion of Women Aged 18+ Who Had a Pap Test in the Past 3 Years	85.1	86.5	↑	86.0	80.8	81.0	93%↓
Proportion of Adults Aged 50+ Who Had a Colorectal Cancer Screening	62.9	73.2	↑	73.5	61.5	72.0	70.5%↑
Proportion of Children Who Have Had a Dental Visit in the Past Year	79.3	85.4	↑	85.3	N/A	79.2	N/A
Adult Obesity	20.4	25.5	↓	25.5	24.7	27.6	22.9 ↓
Adult Overweight and Obesity	53.3	59.7	↓	60.4	61.6	63.8	N/A
Weight Loss Attempt	49.4	42.4	↓	42.9	N/A	38.6	14.6 ↑
Childhood Obesity (Aged 5-17)	13.9	20.0	↓	18.5	N/A	18.9	N/A
Childhood Overweight and Obesity	21.1	34.4	↓	31.4	N/A	49.6	N/A
Very/Somewhat Difficult Obtaining Fresh, Affordable Produce	8.7	17.9	↓	14.4	N/A	N/A	N/A
Binge Drinking	15.2	16.7	↓	17.2	15.8	15.1	N/A
Proportion of Adults Aged 65+ Who Have Received a Flu	73.7	64.6	↓	70.6	63.0	67.4	90%↓

Health Behaviors Prevalence rate unless specified	**SJH 2007**	**SJH 2012**	**Trend**	**So Cal 2012**	**CA 2012**	**USA 2012**	**Healthy People 2020 Target**
Shot							
Proportion of Women Aged 50+ Who Had a Mammogram in the Past Two Years	85.4	84.6	↓	84.0	81.4	77.8	81%↑
Proportion of Men 50+ Who Had a PSA Test in the Past 2 Years	N/A	76.4	-	78.2	N/A	70.5	N/A
Proportion of People without Dental Coverage	N/A	39.0	-	38.6	N/A	N/A	N/A
Proportion of Adults Who Visited a Dentist in the Past Year	N/A	66.8	-	67.3	69.6	69.6	N/A
Proportion of Adults Who Had their Teeth Cleaned in the Past Year	N/A	63.9	-	64.3	N/A	N/A	N/A

Health Concern Prevalence or Proportion Rates	**Findings**
Proportion of Adults Eating 5+ Servings of Fruits and Vegetables per Day	Adults, 18-39, have a higher proportion (51.2%) than adults, ages 40-64, and adults, ages 65+, 42.8% and 44.7% respectively. Caucasians have a lower proportion (45.6%) than Hispanics and Other, 49.3% and 46.5% respectively.

Health Concern Prevalence or Proportion Rates	Findings
	Adults below poverty level have a higher proportion (49.2%) than adults at the 100% to 200% poverty level and adults over 200% poverty level, 48.9% and 46.5% respectively. Adults with college or more education have a higher proportion (52.3%) than adults with less than a high school diploma and adults with high school or more education, 49.5% and 42.9% respectively.
Proportion of Adults Meeting Physical Activity Guidelines	Adults, ages 18-39, have a higher proportion (51.7%) than adults, ages 40-64 and adults, 65+, 47.9% and 38.3% respectively. Other category has a higher proportion (50.6%) than Caucasians and Hispanics, 48.8% and 47.6% respectively. Adults over 200% poverty level have a higher proportion (50.8%) than adults at the 100% to 200% poverty level and adults below the poverty level, 41.8% and 47.5% respectively. Adults with college or more education have a higher proportion (50.8%) than adults with less than a high school diploma and adults with high school or more education, 40.5% and 49.3% respectively.
Demographic Summary Prevalence of Chronic Drinking (Average of 2+ Drinks/Day)	Statistically unreliable data.

Health Concern Prevalence or Proportion Rates	Findings
Prevalence of Adult Current Smokers	Adults, ages 40-64, have a higher rate (11.6%) than adults, ages 18-39 (9.4%). Caucasians have a higher rate (12.6%) than Hispanics and Other, 7.1% and 10.5 respectively. Adults at the 100% to 200% poverty level have a lower rate than adults over 200% poverty level, 15.2% and 17.9% respectively. Adults with college or more education have a lower rate (5.6%) than adults with high school or more education (12.80%).
Proportion of Homes in which Children are Exposed to Smoking	Statistically unreliable data.
Proportion of At Risk Adults Aged 18-64 who Have Received a Flu Shot	Adults, ages 40-64, have a higher proportion (55.6%) than adults, ages 18-39 (40.5%). Caucasians have a lower proportion (47.4%) than Hispanics and Other, 50.9% and 50.2% respectively. Adults with less than a high school diploma have a higher proportion (57.5%) than adults with high school or more education and adults with college or more education, 44.6% and 54.2% respectively.
Proportion of Adults Aged 65+ who Have Received a Pneumonia Shot	Caucasians have a higher proportion (75.3%) than Hispanics and Other, 69.3% and 51.4% respectively. Adults with high school or more education have a higher proportion (73.2%) than adults with college or more education (67.9%).

Health Concern Prevalence or Proportion Rates	Findings
Proportion of At Risk Adults Aged 18-64 who Have Received a Pneumonia Shot	Adults, ages 40-64, have a higher proportion (45.7%) than adults, ages, and 18-39 (37.5%). Hispanics have a higher proportion (48.9%) than Caucasians and Other, 38.0% and 36.0% respectively. Adults with high school or more education have a higher proportion (43.2%) than adults with less than a high school diploma and adults with college or more education, 42.7% and 38.9% respectively.
Proportion of Women Aged 18+ Who have Received a Pap Test in the Past 3 Years	Women, ages, 40-64 have a higher proportion (88.8%) than women, ages 18-39 (84.6%). Hispanics have a higher proportion (89.2%) than Caucasians and Other, 87.8% and 79.0% respectively. Women below the poverty level have a higher proportion (90.9%) than women at the 100% to 200% poverty level and women over 200% poverty level, 74.9% and 89.4% respectively. Women with less than a high school diploma have a higher proportion (89.4%) than women with high school or more education and women with college or more education, 84.8% and 87.1% respectively.
Proportion of Adults Aged 50 -75 Who Have Had a Colorectal Cancer Screening	The proportion of adults ages 50-75 that have had a colorectal cancer screening is 73.2%.

Health Concern Prevalence or Proportion Rates	Findings
Proportion of Children Who Have Had a Dental Visit in Past Year	Children, ages 0-4, have a lower proportion (59.2%) than children, ages, 5-12, and children, ages, 13-17, 92.5% and 91.4 respectively. Other category has higher proportion (86.7%) than Caucasians and Hispanics, 83.4% and 85.5% respectively. Children below poverty level have a lower proportion (82.5%) than children at the 100% to 200% poverty level and children over the 200% poverty level, 84.4% and 88.1% respectively. Children in homes with adult education level at less than a high school diploma have lower proportion (77.5%) than children with adult education level at a high school or more education and children with adult level at college or more education , 87.3% and 87.4% respectively.
Prevalence of Obesity Among Adults	Adults ages 40-64 have a higher rate (33.4%) than adults ages 65+ and adults, ages 18-39, 22.8% and 19.6% respectively. Caucasians have a lower rate (25.7%) than Hispanics (31.5%). Adults at the below poverty level had a higher rate (29.4%) than adults at the 100% to 200% poverty level and adults over 200% poverty level, 24.5% and 25.6% respectively. Adults with college or more education have a lower rate (20.7%) than adults with high school or more education and adults with less than a high school diploma, 26.3% and 35.6% respectively.

Health Concern Prevalence or Proportion Rates	Findings
Prevalence of Overweight and Obesity Among Adults	Adults ages 40-64 have a higher rate (70.6%) than adults ages 65+ and adults, ages 18-39, 63.7% and 49.7% respectively. Caucasians have a slightly lower rate (63.7%) than Hispanics (65.4%). Adults at the below poverty level had a higher rate (61.3%) than adults at the 100% to 200% poverty level and adults over 200% poverty level, 57.9% and 60.9% respectively. Adults with college or more education have a lower rate (55.6%) than adults with high school or more education and adults with less than a high school diploma, 60.7% and 66.7% respectively.
Proportion of Overweight or Obese Adults Trying to Lose Weight with Diet/Exercise	Adults, ages 65+, have a lower proportion (27.4%) than adults, ages 18-39, and adults, ages 40-64, 45.37% and 44.8% respectively. Adults in the Other category have a lower proportion (31.7%) than Caucasians and Hispanics, 44.9% and 44.8% respectively. Adults below poverty level have a higher proportion (47.0%) than adults at the 100% to 200% poverty level and at the over 200% poverty level, 30.8% and 45.0% respectively. Adults with less than a high school diploma have a lower proportion (33.0%) than college or more educated adults and adults with high school or more education, 42.6% and 44.6% respectively.
Prevalence of Obesity (BMI ≥ 95th Percentile) Among Children Aged 5-	Children ages, 5-12, have a higher rate (31.7%) than children, ages, 13-17 (7.5%).

Health Concern Prevalence or Proportion Rates	Findings
17	
Prevalence of Overweight and Obesity (BMI ≥ 85th Percentile) Among Children Aged 5-17	Children ages, 5-12. have a higher rate (43.3%) than children ages, 13-17 (25.0%). Children at the 100% to 200% poverty level have a higher rate (42.7%) than children over the 200% poverty level (29.0%).
Proportion of "Very/Somewhat" Difficult Obtaining Affordable, Fresh Produce	Adults, ages 65+ have a lower proportion (10.6%) than adults, ages, 18-39 and adults, ages 40-64, 15.7% and 15.6% respectively. Caucasians have a lower proportion (8.0%) than Hispanics (24.1%). Adults below the poverty level have a higher proportion (31.7%) than adults at the 100% to 200% poverty level and adults over 200% poverty level, 24.8% and 8.6% respectively. Adults with college or more education have a lower proportion (7.7%) than adults with less than a high school diploma and adults with high school or more education, 36.6% and 13.7% respectively.
Prevalence of Binge Drinking (Single Occasion-5+ Drinks for Men, 4+ for Women)	Adults, ages 40-64, have a lower rate (16.1%) than adults, ages 18-39 (20.5%). Caucasians have a lower rate (16.3%) than Hispanics (20.6%). Adults at the 100% to 200% poverty level have a lower rate than adults over 200% poverty level, 15.2% and 17.9% respectively.

Health Concern Prevalence or Proportion Rates	Findings
	Adults with college or more education have a lower rate (13.3%) than adults with high school or more education and adults with less than a high school diploma, 19.1% and 16.2% respectively.
Proportion of Adults Aged 65+ who Have Received a Flu Shot	Caucasians have a higher proportion (68.4%) than Hispanics and Other, 53.6% and 64.2% respectively. Adults with high school or more education have a higher proportion (72.5%) than adults with college or more education (60.0%).
Proportion of Women Aged 50+ Who Had a Mammogram in the Past Two Years	Women, ages 65+ have a higher proportion rate (86.4%) than women, ages 50-64 (84.1%). Caucasians have a higher proportion (85.6%) than Hispanics and Other, 82.4% and 84.6% respectively. Women with less than a high school diploma have a higher proportion (89.1%) than adults with high school or more education and adults with college or more education, 87.6% and 79.7% respectively.
Proportion of Men Aged 50+ Who have Received the PSA Test in the Past 2 Years	Men ages 65+ have a higher proportion (86.4%) than men, ages 50-64 (84.1%). Caucasians have a higher proportion (85.6%) than Hispanics and Other, 82.4% and 84.6% respectively. Men with high school or more education have a higher proportion (87.6%) than men with college or more education (79.7%).

Health Concern Prevalence or Proportion Rates	Findings
Proportion of People without Dental Coverage	Adults, ages 65+ have a higher proportion (51.2%) than adults ages 18-39 and adults, ages 40-64, 40.3% and 34.93% respectively. Caucasians have a lower proportion (31.76%) than Hispanics and Other, 48.5% and 32.5% respectively. Adults below the poverty level have a higher proportion (73.1%) than adults at the 100% to 200% poverty level and adults over 200% poverty level, 35.0% and 25.7% respectively. Adults with college or more education have a lower proportion (25.3%) than adults with less than a high school diploma and adults with high school or more education, 68.3% and 40.1% respectively.
Proportion of Adults Who Visited a Dentist in the Past Year	Adults, ages 40-64, have a higher proportion (68.5%) than adults, ages 18-39 and adults, ages 65+, 64.8% and 68.0% respectively. Caucasians have a higher proportion (71.3%) than Hispanics and other 60.8% and 70.8% respectively. Adults below poverty level have a lower proportion (46.4%) than adults at the 100% to 200% poverty level and adults over 200% poverty level, 56.0% and 75.3% respectively. Adults with less than a high school diploma have lower proportion (45.5%) than adults with a high school or more education and adults with college or more education, 65.7% and 77.5% respectively.

Health Concern Prevalence or Proportion Rates	Findings
Proportion of Adults Who Had their Teeth Cleaned in the Past Year	Adults ages 65+ have lower proportion (61.7%) than adults, ages 18-39 and adults, ages 40-64, 62.8% and 65.3% respectively. Caucasians have a higher proportion (68.4%) than Hispanics and Other 58.1% and 67.3% respectively. Adults below the poverty level have a lower proportion (44.0%) than adults at the 100% to 200% poverty level and adults over 200% poverty level, 52.4% and 75.3% respectively. Adults with less than a high school diploma have lower proportion (42.3%) than adults with a high school or more education and adults with college or more education, 63.0% and 74.0% respectively.

Health Access Prevalence rate unless specified	**SJH 2007**	**SJH 2012**	**Trend**	**So Cal 2012**	**CA 2012**	**USA 2012**	**Healthy People 2020 Target**
Proportion of Adults Who Have Not Had a Routine Checkup in Past Year	35.9	32.4	↑	32.6	N/A	32.7	N/A
Proportion of Children Who Have Had a Routine Checkup in the Past Year	85.6	85.9	↑	86.4	N/A	87.0	N/A
Proportion of Adults who Visited the ED2+ Times in the Past Year	4.6	3.9	↑	4.9	N/A	6.5	N/A
Proportion of Uninsured Adults Ages 18-64	14.5	24.5	↓	22.3	20.9	17.9	0%
Prevalence of Access Difficulties	28.9	31.3	↓	32.2	N/A	37.3	9.0%↓
Proportion of People with an Ongoing Source of Care	82.3	66.4	↓	67.0	83.5	76.3	95%↓

Health Concern Prevalence or Proportion Rates	**Findings**
Proportion of Adults Who Have Not Had a Routine Checkup in Past Year	Adults, ages 18-39, have a higher proportion (34.5%) than adults, ages 40-64, and adults, ages 65+, 30.7% and 21.7% respectively.

Health Concern Prevalence or Proportion Rates	Findings
	Caucasians have a higher proportion (35.4%) than Hispanics and Other, 32.5% and 26.6% respectively. Adults at the 100% to 200% poverty level have a higher proportion (37.1%) than adults below the poverty level and adults over 200% poverty level, 35.8% and 31.0% respectively. Adults with a with high school or more education have a higher proportion (36.6%) than adults with less than a high school diploma and adults with college or more education , 27.4% and 27.5% respectively.
Proportion of Children Who Have Had a Routine Checkup in the Past Year	Children, ages 0-4, have a higher proportion (96.8%) than children, ages, 5-12, and children, ages, 13-17, 80.8% and 83.3% respectively. Other category has higher proportion (87.6%) than Caucasians and Hispanics, 84.3% and 85.7% respectively. Children below the poverty level have a lower proportion (78.7%) than children at the 100% to 200% poverty level and children over 200% poverty level, 89.0% and 87.3 % respectively. Children in homes with adult education level at less than a high school diploma have lower proportion (78.8%) than children with adult education level at high school or more education and children with adult level education at college or more, 87.1% and 88.0% respectively.
Proportion of Adults Who Visited the Emergency Department Two Times or More in the Past Year	Adults ages 65+, have a higher proportion (5.7%) than adults, ages 18-39 and adults, ages 40-64, 3.9% and 3.6% respectively.

Health Concern Prevalence or Proportion Rates	Findings
	Caucasians have a higher proportion (5.8%) than Hispanics (4.0%).
Proportion of Adults Aged 18-64 without Health Insurance	Adults, ages 18-39, have higher proportion (27.9%) than adults, ages 40-64 (18.6%). Hispanics have a higher proportion (35.0%) than Caucasians and Other, 14.2% and 17.5% respectively. Adults at the 100% to 200% poverty level have a higher proportion (44.2%) than adults below the poverty level and adults at the over 200% poverty level, 41.6% and 13.6% respectively. Adults with less than a high school diploma have a higher proportion (51.1%) than adults with a high school or more education and adults with college or more education, 24.6% and 11.8% respectively.
Proportion of Access Difficulties	Adults ages, 18-39 have a higher proportion (34.5%) than adults, ages 40-64 and adults, ages 65+, 30.0% and 21.7% respectively. Hispanics have a higher proportion (35.4%) than Caucasians and Other, 28.5% and 29.1% respectively. Adults below the poverty level have a higher proportion (48.2%) than adults at the 100% to 200% poverty level and adults over the 200% poverty level, 38.2% and 25.9% respectively. Adults less than a high school diploma have a higher proportion (41.8%) than adults with a high school or more education and adults with college or more education , 33.2% and 23.7% respectively.

Health Concern Prevalence or Proportion Rates	Findings
Proportion of People with an Ongoing Source of Care	Adults, ages 18-39, have lower proportion (60.1%) than adults, ages 40-64, and adults ages 65+, 71.3% and 70.7% respectively. Other has a lower proportion (56.6%) than Caucasians and Hispanics, 76.4% and 64.0% respectively. Adults below the poverty level have a lower proportion (58.7%) than adults at the 100% to 200% poverty and adults over the 200% poverty level, 61.3% and 70.9% respectively. Adults with less than a high school diploma have a higher proportion (56.9%) than adults with a high school or more education and adults with college or more education, 65.2% and 72.2% respectively.

Appendix 5: Hospital Total Service Are Indicators

Indicator	Hospital Total Service Area									
	Anaheim	Buena Park	Corona	Costa Mesa	Cypress	Foothill Ranch	Fountain Valley	Orange County	CA	U.S.
Population	351,340	80,670	232,975	110,845	48,688	11,253	55,313	3,054,269	37,707,477	313,129,017
Average HH Size	3.4	3.4	3.3	2.7	3.0	3.0	3.0	3.0	2.9	2.6
Ages %										
0-17	27.5	25.4	30.4	21.6	23.7	30.2	21.1	24.1	24.6	23.5
65+	9.2	10.6	7.3	9.2	13.0	3.5	17.6	12.1	11.9	13.6
Ethnicity										
White Alone	52.3	44.6	56.8	68.7	54.6	67.4	55.9	59.8	56.9	71.9
Black Alone	2.7	3.9	6.3	1.5	3.0	1.7	0.9	1.9	6.1	12.6
Asian Alone	15.1	26.7	12.4	7.8	31.2	21.8	33.7	18.2	13.2	4.9
All Other	29.9	24.8	24.5	22.0	11.2	9.1	9.5	20.2	23.7	10.6
Hispanic Origin [1]	53.0	40.0	42.9	35.7	18.2	13.0	13.5	34.5	38.4	16.9
Foreign born (%)	37.9	33.0	21.4	29.2	21.3	17.5	27.6	29.9	26.2	11.1
Not U.S. Citizen	85,851	15,159	15,872	23,057	4,142	928	5,409	527,307	5,390,989	18,565,263
Spanish-Primary Language Spoken at Home (%)	40.4	26.2	28.7	27.0	8.9	6.8	7.2	26.5	28.2	12.1
25+ with no HS diploma (%)	26.9	19.7	17.6	14.2	8.3	2.8	11.1	17.0	19.5	15.4
% of Housing Units with 7+ People	7.8	5.7	5.8	3.5	2.2	1.1	3.1	5.0	4.0	1.8
% Households Below Poverty	11.9	9.9	6.7	10.2	5.4	3.0	6.4	4.8	6.7	6.6

Indicator	Hospital Total Service Area									
	Fullerton	Garden Grove	Huntington Beach	Irvine	Lake Forest	Midway City	Orange	Orange County	CA	U.S.
Population	135,014	173,701	191,218	215,593	59,271	6,833	141,910	3,054,269	37,707,477	313,129,017
Average HH Size	2.9	3.7	2.5	2.6	2.9	3.3	3.0	3.0	2.9	2.6
Age (%)										
0-17	23.4	25.6	20.6	21.6	23.3	24.7	23.5	24.1	24.6	23.5
65+	11.8	10.9	14.2	8.8	10.7	11.5	10.8	12.1	11.9	13.6
Race/Ethnicity (%)										
White Alone	54.0	39.8	76.6	50.7	69.5	27.6	66.9	59.8	56.9	71.9
Black Alone	2.3	1.3	0.9	1.7	1.7	0.6	1.6	1.9	6.1	12.6
Asian Alone	22.8	36.9	11.1	39.0	12.2	55.6	11.1	18.2	13.2	4.9
All Other	20.9	22.0	11.3	8.6	16.6	16.2	20.4	20.2	23.7	10.6
Hispanic Origin[1]	34.4	37.3	17.0	9.3	28.1	24.6	38.7	34.5	38.4	16.9
Foreign born (%)	28.9	43.1	16.9	32.1	21.1	42.8	25.1	29.9	26.2	11.1
Not U.S. Citizen	22,849	41,442	15,411	23,583	7,051	1,781	20,582	527,307	5,390,989	18,565,263
Spanish-Primary Language Spoken at Home (%)	22.6	29.1	9.6	5.4	18.1	18.2	28.5	26.5	28.2	12.1
25+ with no HS diploma (%)	14.1	28.0	7.2	3.6	9.2	32.0	17.9	17.0	19.5	15.4
% of Housing Units with 7+ People	3.6	9.6	1.4	0.7	3.6	8.9	4.4	5.0	4.0	1.8
% Households Below Poverty	10.3	12.7	6.5	9.7	4.9	14.2	7.9	4.8	6.7	6.6
Female Headed HH with Children <18 (%)	6.7	8.2	5.4	5.1	6.0	8.4	6.8	6.6	8.3	8.5

Indicator	Hospital Total Service Area										
	Placentia	Santa Ana	Silverado	Stanton	Tustin	Villa Park	Westminster	Yorba Linda	Orange County	CA	U.S.
Population	51,981	349,534	1,511	32,276	76,239	5,790	91,344	66,485	3,054,269	37,707,477	313,129,017
Average HH Size	3.1	4.4	2.3	3.5	3.0	2.9	3.4	3.0	3.0	2.9	2.6
Age (%)											
0-17	24.4	30.2	15.0	26.7	26.4	20.1	23.4	24.6	24.1	24.6	23.5
65+	12.6	7.6	8.6	10.5	9.1	24.0	14.2	12.0	12.1	11.9	13.6
Race/Ethnicity (%)											
White Alone	62.5	48.4	90.1	45.1	55.1	78.6	36.4	75.3	59.8	56.9	71.9
Black Alone	1.9	1.5	0.3	2.5	2.2	0.8	1.0	1.3	1.9	6.1	12.6
Asian Alone	14.8	10.4	2.8	23.4	18.1	14.3	46.6	15.4	18.2	13.2	4.9
All Other	20.8	39.7	6.8	29.0	24.5	6.3	16.0	8.0	20.2	23.7	10.6
Hispanic Origin [1]	35.6	73.8	7.5	49.5	39.3	10.8	24.0	14.4	34.5	38.4	16.9
Foreign born (%)	24.5	53.3	6.3	41.3	33.3	13.5	42.6	13.9	29.9	26.2	11.1
Not U.S. Citizen	6,955	137,664	80	10,904	14,696	211	18,277	3,042	527,307	5,390,989	18,565,263
Spanish-Primary Language Spoken at Home (%)	20.8	61.5	2.3	38.2	27.8	5.1	16.8	7.5	26.5	28.2	12.1
25+ with no HS diploma (%)	13.7	44.8	3.6	30.9	15.4	4.2	25.5	4.5	17.0	19.5	15.4
% of Housing Units with 7+ People	4.2	15.6	0.7	9.3	3.6	1.3	7.1	1.4	5.0	4.0	1.8
% Households Below Poverty	8.2	14.1	5.0	12.3	8.2	4.7	11.6	2.7	4.8	6.7	6.6
Female Headed HH with Children <18 (%)	6.5	10.0	4.5	9.3	8.2	2.2	7.1	4.5	6.6	8.3	8.5

Indicator	Hospital Total Service Area												
	Anaheim							Buena Park		Corona			
	92801	92802	92804	92805	92806	92807	92808	90620	90621	92879	92880	92881	92882
Population	60,081	42,403	84,817	71,003	36,821	36,131	20,084	45,517	35,153	46,729	58,510	32,683	67,956
Average HH Size	3.5	3.7	3.4	3.9	3.2	2.9	2.8	3.4	3.4	3.4	3.8	3.4	3.5
Age (%)													
0-17	29.2	29.4	26.8	30.6	24.9	22.2	25.2	23.8	27.4	29.3	32.1	30.3	30.4
65+	8.4	8.6	10.2	6.2	9.8	14.1	8.8	12.2	8.5	7.8	5.8	7.8	7.0
Race/Ethnicity (%)													
White Alone	46.7	48.4	46.7	51.2	54.7	70.5	67.8	50.2	37.5	52.6	47.8	66.1	59.2
Black Alone	3.8	2.6	3.3	1.8	2.5	2.1	1.9	3.4	4.5	7.3	8.3	5.9	4.1
Asian Alone	15.8	14.0	21.6	7.3	11.6	15.6	21.5	25.6	28.1	9.6	21.0	10.3	8.8
All Other	33.8	35.0	28.4	39.8	31.2	11.9	8.8	20.8	29.9	30.6	22.8	17.6	28.0
Hispanic Origin[1]	59.5	61.4	46.8	76.2	54.6	21.1	14.4	34.4	47.3	52.9	40.1	31.9	49.2
Spanish-Primary Language Spoken at Home (%)	44.0	47.5	35.8	64.4	40.1	12.1	6.2	21.3	32.1	37.1	28.6	18.3	33.4
25+ with no HS diploma (%)	29.1	33.1	25.8	44.4	25.5	8.1	3.8	16.0	24.5	26.1	14.7	10.1	21.4
% of Housing Units with 7+ People	9.4	10.1	7.9	12.4	6.4	1.8	0.9	5.2	6.3	6.9	7.0	4.2	6.0
% Households Below Poverty	14.1	16.3	14.5	15.3	8.0	3.9	3.6	7.4	12.8	10.4	4.9	2.9	9.0
Female Headed HH with Children <18 (%)	11.0	11.0	10.0	10.3	8.5	5.4	5.3	8.0	10.4	10.5	6.6	6.8	8.8

Indicator	Hospital Total Service Area											
	Corona	Costa Mesa		Cypress	Foothill Ranch	Fountain Valley	Fullerton		Garden Grove			
	92883	92626	92627	90630	92610	92708	92831	92833	92840	92841	92843	92844
Population	27,097	50,562	60,283	48,688	11,253	55,313	34,675	51,948	54,542	32,985	45,537	24,304
Average HH Size	3.2	2.6	2.8	3.0	3.0	2.9	2.6	3.2	3.6	3.6	4.2	3.7
Age (%)												
0-17	29.0	19.3	23.5	23.7	30.2	21.1	19.7	25.9	25.6	24.3	27.8	24.6
65+	9.4	10.5	8.2	13.0	3.5	17.6	9.7	10.5	10.6	11.7	9.2	10.0
Race/Ethnicity (%)												
White Alone	66.1	67.5	69.7	54.6	67.4	55.9	58.3	43.5	42.3	39.9	31.8	24.1
Black Alone	6.5	1.9	1.1	3.0	1.7	0.9	2.9	2.0	1.5	1.5	1.0	1.2
Asian Alone	10.2	12.8	3.7	31.2	21.8	33.7	16.0	34.4	30.5	39.4	40.0	58.3
All Other	17.2	17.8	25.5	11.2	9.1	9.5	22.8	20.1	25.7	19.2	27.2	16.4
***Hispanic Origin*[1]**	28.8	27.0	42.9	18.2	13.0	13.5	33.7	33.3	44.1	32.1	46.9	24.8
Spanish-Primary Language Spoken at Home (%)	15.3	20.4	32.8	8.9	6.8	7.2	20.9	20.9	35.4	26.5	36.4	20.1
25+ with no HS diploma (%)	9.1	11.3	16.8	8.3	2.8	11.1	14.0	13.0	29.8	24.0	37.4	28.8
% of Housing Units with 7+ People	3.1	2.6	4.4	2.2	1.1	3.1	2.5	4.3	9.7	8.8	14.6	8.9
% Families Below Poverty	3.0	9.7	10.7	5.4	3.0	6.4	15.2	8.8	13.0	10.6	16.5	16.2
Female Headed HH with Children <18 (%)	5.1	5.5	6.9	7.4	4.5	5.2	6.1	7.6	8.1	8.1	9.8	8.5

Indicator	Hospital Total Service Area											
	Garden Grove	Huntington Beach				Irvine						
	92845	92646	92647	92648	92649	92602	92603	92604	92606	92612	92614	92617
Population	16,333	56,038	56,993	44,458	33,729	22,874	21,598	27,285	24,518	26,082	24,748	14,070
Average HH Size	2.9	2.6	2.9	2.3	2.3	2.7	2.7	2.7	2.8	2.3	2.6	2.5
Age (%)												
0-17	23.0	20.2	24.0	18.4	18.2	28.1	23.1	21.8	25.7	13.5	21.9	7.7
65+	16.2	16.5	11.2	13.3	16.8	5.2	11.7	14.4	6.9	11.8	8.3	1.9
Race/Ethnicity (%)												
White Alone	76.9	81.0	66.7	80.3	81.5	41.7	61.3	59.4	41.7	53.6	53.3	42.5
Black Alone	1.1	0.8	1.4	0.7	0.7	1.9	0.8	1.6	2.1	1.9	1.9	1.8
Asian Alone	12.6	10.7	13.1	10.3	9.5	47.8	31.6	30.9	46.9	35.7	35.5	44.2
All Other	9.4	7.5	18.8	8.7	8.4	8.6	6.2	8.1	9.4	8.8	9.3	11.6
Hispanic Origin[1]	16.2	11.5	27.8	13.6	12.7	9.4	5.5	10.6	10.2	8.5	9.5	12.2
Spanish-Primary Language Spoken at Home (%)	8.5	5.6	17.5	7.1	6.2	4.8	4.0	7.1	4.0	3.9	4.2	9.2
25+ with no HS diploma (%)	7.2	5.1	12.8	5.5	4.3	1.8	2.2	5.8	4.6	3.9	3.5	2.2
% of Housing Units with 7+ People	1.7	0.9	3.3	0.6	0.7	0.9	0.8	1.0	1.0	0.3	0.6	0.1
% Households Below Poverty	4.1	4.9	7.9	8.0	5.3	5.2	6.4	9.1	9.8	17.0	5.3	37.9
Female Headed HH with Children <18 (%)	5.2	4.6	7.6	5.1	4.2	5.9	4.1	5.5	6.1	3.8	6.6	2.0

Indicator	Hospital Total Service Area									
	Irvine		Lake Forest	Midway City	Orange					Placentia
	92618	92620	92630	92655	92865	92866	92867	92868	92869	92870
Population	15,935	38,483	59,271	6,833	19,444	14,951	44,536	25,581	37,398	51,981
Average HH Size	2.2	2.8	2.9	3.7	3.1	2.6	3.2	2.9	3.1	3.1
Age (%)										
0-17	20.5	25.0	23.3	24.7	23.7	22.0	24.9	21.0	23.8	24.4
65+	4.7	8.8	10.7	11.5	11.1	11.0	10.8	8.3	12.5	12.6
Race/Ethnicity (%)										
White Alone	52.1	48.4	69.5	27.6	63.5	70.4	69.9	60.5	68.0	62.5
Black Alone	2.2	1.6	1.7	0.6	1.8	1.5	1.2	3.0	1.1	1.9
Asian Alone	37.1	41.9	12.2	55.6	11.1	5.1	10.6	13.9	12.1	14.8
All Other	8.5	8.1	16.6	16.2	23.6	23.0	18.3	22.6	18.7	20.8
Hispanic Origin[1]	10.9	8.4	28.1	24.6	37.1	40.2	35.9	49.7	34.8	35.6
Spanish-Primary Language Spoken at Home (%)	8.0	4.7	18.1	18.2	23.5	29.9	24.7	37.1	28.8	20.8
25+ with no HS diploma (%)	4.3	2.9	9.2	32.0	15.2	21.2	17.7	21.6	15.7	13.7
% of Housing Units with 7+ People	0.3	1.0	3.6	8.9	4.5	2.3	4.5	3.9	5.6	4.2
% Families Below Poverty	8.2	5.2	4.9	14.2	6.6	11.1	7.8	8.9	6.5	8.2
Female Headed HH with Children <18 (%)	5.0	5.4	6.0	8.4	7.5	6.9	6.3	7.8	6.5	6.5

Indicator	Hospital Total Service Area											
	Santa Ana						Silverado	Stanton	Tustin		Villa Park	Westminster
	92701	92703	92704	92705	92706	92707	92676	90680	92780	92782	92861	92683
Population	52,139	68,926	87,414	45,565	35,216	60,274	1,511	32,276	54,562	21,677	5,790	91,344
Average HH Size	4.3	5.0	4.5	3.1	3.7	4.6	2.3	3.6	3.1	2.6	2.9	3.4
Age (%)												
0-17	34.2	31.3	29.4	26.2	29.8	30.0	15.0	26.7	26.7	25.5	20.1	23.4
65+	5.0	6.5	7.2	14.1	8.8	6.0	8.6	10.5	9.7	7.4	24.0	14.2
Race/Ethnicity (%)												
White Alone	48.8	42.6	41.3	69.4	53.1	46.2	90.1	45.1	54.5	56.6	78.6	36.4
Black Alone	1.5	1.5	1.5	1.4	1.6	1.3	0.3	2.5	2.4	1.8	0.8	1.0
Asian Alone	3.7	13.2	17.3	6.9	8.9	6.6	2.8	23.4	13.0	31.2	14.3	46.6
All Other	46.0	42.7	39.9	22.3	36.5	45.8	6.8	29.0	30.1	10.5	6.3	16.0
Hispanic Origin [1]	88.8	80.4	71.2	41.0	70.2	83.7	7.5	49.5	49.3	14.1	10.8	24.0
Spanish-Primary Language Spoken at Home (%)	76.4	69.9	58.2	29.1	53.7	71.8	2.3	38.2	36.0	6.0	5.1	16.8
25+ with no HS diploma (%)	60.2	55.9	43.2	17.3	36.5	49.4	3.6	30.9	20.6	2.8	4.2	25.5
% of Housing Units with 7+ People	15.7	23.9	18.3	4.0	11.1	19.4	0.7	9.3	5.0	0.7	1.3	7.1
% Households Below Poverty	21.5	17.6	14.2	7.1	13.4	12.0	5.0	12.3	9.7	4.9	4.7	11.6
Female Headed HH with Children <18 (%)	12.9	11.4	9.7	6.8	9.5	10.0	4.5	9.3	9.0	6.6	2.2	7.1

Indicator	Hospital Total Service Area	
	Yorba Linda	
	92886	92887
Population	46,459	20,026
Average HH Size	3.0	3.0
Age (%)		
0-17	24.6	24.6
65+	13.5	8.5
Race/Ethnicity (%)		
White Alone	76.4	72.8
Black Alone	1.3	1.4
Asian Alone	14.2	18.0
All Other	8.1	7.8
Hispanic Origin [1]	15.1	12.8
Spanish-Primary Language Spoken at Home (%)	7.3	8.1
25+ with no HS diploma (%)	5.0	3.4
% of Housing Units with 7+ People	1.5	1.1
% Households Below Poverty	3.2	1.5
Female Headed HH with Children <18 (%)	4.4	4.7