2013 PRC Community Health Needs Assessment Report

Hoag Memorial Hospital Presbyterian (HMHP) Service Area

Sponsored by
Hoag Memorial Hospital Presbyterian

Professional Research Consultants, Inc.

Table Of Contents

ACCESS TO HEALTH SERVICES

160

HEALTH EDUCATION & OUTREACH

181

LOCAL RESOURCES

186

INTRODUCTION

Project Overview

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Hoag Memorial Hospital Presbyterian (HMHP). Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.

- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Hoag Memorial Hospital Presbyterian by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through two Key Informant Focus Groups.

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Hoag Memorial Hospital Presbyterian and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "HMHP Service Area" in this report) is defined as each of the 56 residential ZIP Codes comprising the hospital's service area. This community definition, determined based on the ZIP Codes of residence of recent patients of Hoag Memorial Hospital Presbyterian, is illustrated in the following map.
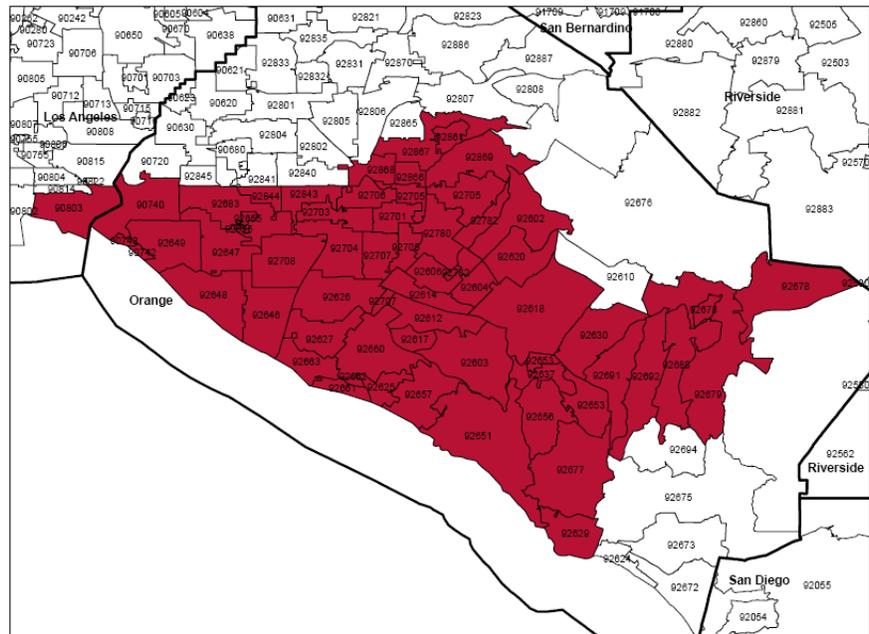
Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 751 individuals age 18 and older in the HMHP Service Area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 751 respondents is ±3.5% at the 95 percent level of confidence.

Expected Error Ranges for a Sample of 751 Respondents at the 95 Percent Level of Confidence
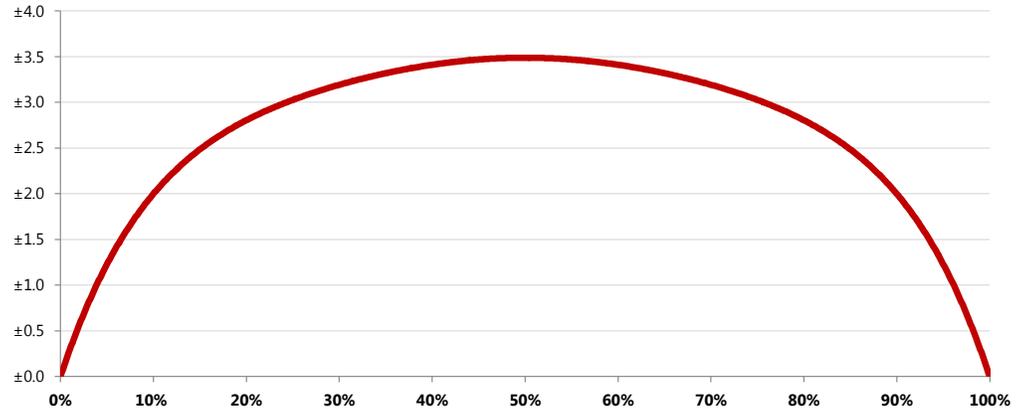
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 751 respondents answered a certain question with a "yes," it can be asserted that between 8.0% and 12.0% (10% ± 2.0%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.5% and 53.5% (50% ± 3.5%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the HMHP Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

Population & Sample Characteristics
(Hoag Memorial Hospital Presbyterian Service Area, 2013)
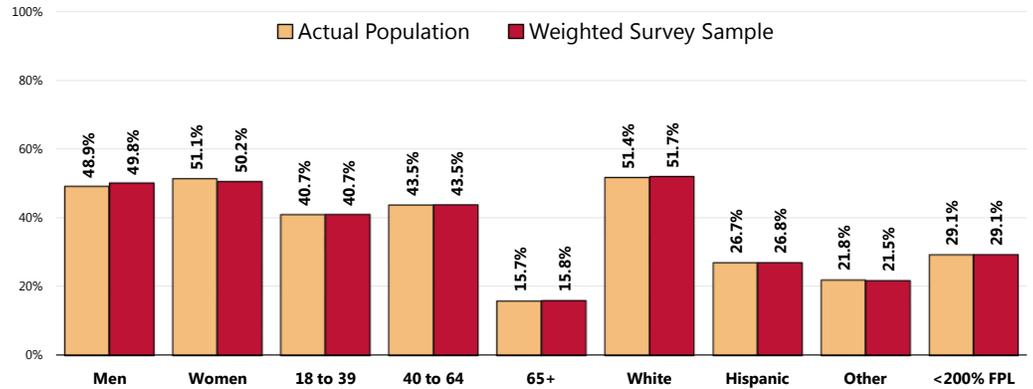
Sources:
● Census 2010, Summary File 3 (SF 3). U.S. Census Bureau.
● 2013 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2013 guidelines place the poverty threshold for a family of four at $23,550 annual household income or lower)*. In sample segmentation: "**very low income**" refers to community members living in a household with defined poverty status; "**low income**" refers to households with incomes just above the poverty level, earning up to twice the poverty threshold; and "**mid/high income**" refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Key Informant Focus Groups

As part of this Community Health Needs Assessment, two focus groups were held on June 13, 2013. Participants included 21 local key informants: physicians, a public health representative, other health professionals, social service providers, business leaders and other community leaders.

Hoag Memorial Hospital Presbyterian recruited the participants for the focus groups. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Final participation included representatives of the organizations outlined in the following tables. Through this process, input was gathered from a representative of public health, as well as several individuals whose organizations work with low-income, minority (including Hispanic, Asian Americans, and undocumented residents), refugees from Africa and the Middle East, and other medically underserved populations (specifically, children and college-age adolescents, elderly, disabled, the uninsured/underinsured, and Medicaid recipients).

Key Informant Focus Group: Health Providers	Populations Served		
Thursday, June 13th, 7:30 to 9:30 AM	Medically Underserved	Low-Income Residents	Minority Populations
Organizations Represented			
Santa Ana College	X	X	X
Hope Clinic - NMUSD	X	X	X
UCI Institute for Memory Impairments and Neurological Disorders			
OCC - Student Health Center	X	X	X
Orange County Health Care Agency	X	X	X
Orange County Department of Education	X	X	X
Share Our Selves Community Health Center	X	X	X
Latino Health Access	X	X	X
Dr. Riba's Health Club, Inc.	X	X	X
UCI Nursing Science			X

Key Informant Focus Group: Social Services & Other Community Leaders	Populations Served		
Thursday, June 13th, Noon to 2:00 PM	Medically Underserved	Low-Income Residents	Minority Populations
Organizations Represented			
City of Irvine			
HURTT Family Health Clinic			
Newport Mesa Unified School District	X	X	X
Human Options	X	X	X
Access California Services	X	X	X
Council on Aging	X	X	X
Community Action Partnership of Orange County			
Orange County Braille Institute	X	X	X
Orange County Human Relations	X	X	X
Newport Beach Police Department			

Audio from the focus groups sessions was recorded, from which verbatim comments in this report are taken. There are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

NOTE: These findings represent qualitative rather than quantitative data. The groups were designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the service area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- California Department of Public Health
- Centers for Disease Control & Prevention
- National Center for Health Statistics
- State of California Department of Justice

- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect county-level data (Orange County).

Benchmark Data

California Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2011 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Summary of Findings

Significant Health Needs of the Community

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	

Access to Health Services	• Lack of Health Insurance Coverage
	  o Insurance Instability
	  o Supplemental Coverage (Seniors)
	• *Access to Healthcare ranked as the #5 top concern among focus group participants; they emphasized:*
	  o Barriers to Accessing Care (Including Language and Transportation)
	  o Uninsured/Under-Insured Population
	  o Low-Income Population

Dementias, Including Alzheimer's Disease	• Alzheimer's Disease Deaths

Educational & Community-Based Programs	• Attendance at Health Promotion Events
	• *Health Education & Prevention ranked as the #4 top concern among focus group participants; they emphasized:*
	  o Preventive Care Programs
	  o Funding

Immunization & Infectious Diseases	• Pneumonia/Influenza Deaths • Pertussis Incidence • Tuberculosis Incidence

Mental Health & Mental Disorders	• *Mental Health ranked as the #1 top concern among focus group participants; they emphasized:*
	  o Limited resources
	  o Stigma
	  o Lack of integration (physical/mental)

Nutrition, Physical Activity & Weight	• Children's Computer Time
	• *Obesity & Nutrition ranked as the #3 top concern among focus group participants; they emphasized:*
	  o Childhood Obesity
	  o Need for Nutrition Education

Substance Abuse	• Cirrhosis/Liver Disease Deaths
	• Adults Seeking Professional Help
	• *Substance Abuse ranked as the #2 top concern among focus group participants; they emphasized:*
	  o Lack of Treatment Centers
	  o Binge Drinking
	  o Prescription Drug Abuse

Tobacco Use	• Smoking Cessation Attempts

After reviewing the Community Health Needs Assessment report, the Community Health Department staff and the Community Benefit Committee members met to evaluate and prioritize the top health needs for the community. Data for the community were examined, and attendees were asked to evaluate each significant health issue (see Areas of Opportunity in the Summary section) along the following criteria:

- **Magnitude** — the number of persons affected, as well as differences from state/national data or Healthy People 2020 objectives
- **Impact/Seriousness** — the degree to which issue affects/exacerbates other health issues, as well as the degree to which it leads to death, disability or loss of quality of life
- **Feasibility** — the ability to reasonably impact the issue, given available resources
- **Consequences of Inaction** — the risk of exacerbating the problem by not addressing at the earliest opportunity

This process yielded the following **priorities** for Hoag Memorial Hospital Presbyterian to address in improving the health of the community:

1. **Access to Care for Vulnerable Populations**

2. **Health Education & Prevention**

3. **Nutrition/Physical Activity/Weight Management**

4. **Health Professional Education Programs**

These priorities, and plans to address these, will be integrated into Hoag Memorial Hospital Presbyterian's Implementation Strategy for the coming years.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Hoag Memorial Hospital Presbyterian Service Area, grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables

■ In the following charts, HMHP Service Area results are shown in the larger, blue column.

■ The columns to the right of the HMHP Service Area column provide comparisons between the service area and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether the HMHP Service Area compares favorably (☀), unfavorably (☁), or comparably (☁) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Access to Health Services	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	**20.5**	☁ 21.5	🌧 14.9	🌧 0.0
% [65+] With Medicare Supplement Insurance	**64.9**		🌧 75.5	
% [Insured] Insurance Covers Prescriptions	**93.8**		☁ 93.9	
% [Insured] Went Without Coverage in Past Year	**7.7**		🌧 4.8	
% Difficulty Accessing Healthcare in Past Year (Composite)	**32.3**		☀ 37.3	
% Cost Prevented Getting Prescription in Past Year	**12.4**		☁ 15.0	
% Cost Prevented Physician Visit in Past Year	**12.6**		☁ 14.0	
% Difficulty Getting Appointment in Past Year	**12.0**		☀ 16.5	
% Difficulty Finding Physician in Past Year	**9.3**		☁ 10.7	
% Transportation Hindered Dr Visit in Past Year	**6.3**		☁ 7.7	
% Skipped Prescription Doses to Save Costs	**8.4**		☀ 14.8	
% Difficulty Getting Child's Healthcare in Past Year	**1.8**		☁ 1.9	
% [Age 18+] Have a Specific Source of Ongoing Care	**75.8**		☁ 76.3	🌧 95.0
% [Age 18-64] Have a Specific Source of Ongoing Care	**73.8**		☁ 75.1	🌧 89.4
% [Age 65+] Have a Specific Source of Ongoing Care	**84.0**		☁ 82.6	🌧 100.0
% Have Had Routine Checkup in Past Year	**67.5**		☁ 67.3	
% Child Has Had Checkup in Past Year	**87.3**		☁ 87.0	

Access To Health Services (continued)	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Two or More ER Visits in Past Year	5.6		☁ 6.5	
% Rate Local Healthcare "Fair/Poor"	11.5		☀ 15.3	
		☀ better	☁ similar	🌧 worse

Arthritis, Osteoporosis & Chronic Back Conditions	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	30.0		☁ 35.4	
% [50+] Osteoporosis	10.3		☁ 11.4	🌧 5.3
% Sciatica/Chronic Back Pain	16.8		☀ 21.5	
		☀ better	☁ similar	🌧 worse

Cancer	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	149.0	☀ 158.2	☀ 174.2	☀ 160.6
Lung Cancer (Age-Adjusted Death Rate)	35.1	☀ 37.6	☀ 50.5	☀ 45.5
Prostate Cancer (Age-Adjusted Death Rate)	20.8	☀ 22.0	☀ 22.3	☁ 21.2
Female Breast Cancer (Age-Adjusted Death Rate)	21.3	☁ 21.6	☁ 22.3	☁ 20.6
Colorectal Cancer (Age-Adjusted Death Rate)	13.1	☀ 14.7	☀ 16.1	☀ 14.5
% Skin Cancer	7.2	☁ 5.8	☁ 8.1	
% Cancer (Other Than Skin)	5.6	☁ 5.8	☁ 5.5	

Cancer (continued)

Cancer (continued)	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% [Men 50+] Prostate Exam in Past 2 Years	76.5		☁ similar 70.5	
% [Women 50-74] Mammogram in Past 2 Years	76.7	☁ similar 81.4	☁ similar 79.9	☁ similar 81.1
% [Women 21-65] Pap Smear in Past 3 Years	83.4	☁ similar 80.8	☁ similar 84.7	🌧 worse 93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	71.1	☀ better 61.5	☁ similar 72.0	
% [Age 50+] Blood Stool Test in Past 2 Years	35.1	☀ better 27.0	☀ better 28.3	
% [Age 50-75] Colorectal Cancer Screening	72.8			☁ similar 70.5

	☀ better	☁ similar	🌧 worse

Chronic Kidney Disease

Chronic Kidney Disease	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Kidney Disease (Age-Adjusted Death Rate)	8.7	☁ similar 8.6	☀ better 15.2	

	☀ better	☁ similar	🌧 worse

Diabetes

Diabetes	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Diabetes Mellitus (Age-Adjusted Death Rate)	14.4	☀ better 20.3	☀ better 21.3	☀ better 19.6
% Diabetes/High Blood Sugar	8.9	☁ similar 8.9	☁ similar 10.1	

	☀ better	☁ similar	🌧 worse

Dementias, Including Alzheimer's Disease	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Alzheimer's Disease (Age-Adjusted Death Rate)	32.1	🌧 29.2	🌧 25.0	
% Member of Family Has Alzheimer's Disease/Dementia	23.6			
		☀ better	☁ similar	🌧 worse

Educational & Community-Based Programs	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Attended Health Event in Past Year	16.5		🌧 22.2	
		☀ better	☁ similar	🌧 worse

Family Planning	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Births to Teenagers	6.7	☀ 9.0	☀ 9.9	
		☀ better	☁ similar	🌧 worse

General Health Status	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% "Fair/Poor" Physical Health	16.9	☁ 18.7	☁ 16.8	
% Activity Limitations	16.2	☀ 21.3	☁ 17.0	
% 3+ Days When Poor Health Restricted Activities	9.8			
		☀ better	☁ similar	🌧 worse

18

Hearing & Other Sensory or Communication Disorders	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Deafness/Trouble Hearing	8.3		☁ 9.6	
		☀ better	☁ similar	🌧 worse

Heart Disease & Stroke	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	153.5	☀ 168.2	☀ 184.6	☁ 152.7
Stroke (Age-Adjusted Death Rate)	37.7	☁ 39.2	☀ 40.2	🌧 33.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	4.6		☁ 6.1	
% Blood Pressure Checked in Past 2 Years	94.2		☁ 94.7	☁ 94.9
% Told Have High Blood Pressure (Ever)	30.6	☁ 27.8	☁ 34.3	🌧 26.9
% [HBP] Taking Action to Control High Blood Pressure	96.7		☀ 89.1	
% Cholesterol Checked in Past 5 Years	93.7	☀ 75.5	☀ 90.7	☀ 82.1
% Told Have High Cholesterol (Ever)	30.8	☀ 36.0	☁ 31.4	🌧 13.5
% [HBC] Taking Action to Control High Blood Cholesterol	92.4		☁ 89.1	
% 1+ Cardiovascular Risk Factor	75.9		☀ 86.3	
		☀ better	☁ similar	🌧 worse

Immunization & Infectious Diseases

Immunization & Infectious Diseases	HMHP Service Area	vs. CA	vs. US	vs. HP2020
Pertussis per 100,000	8.1	🌧 (worse) 5.8	🌧 (worse) 4.5	
% [Age 65+] Flu Shot in Past Year	74.9	☀ (better) 57.2	☁ (similar) 71.6	🌧 (worse) 90.0
% [High-Risk 18-64] Flu Shot in Past Year	49.6		☁ (similar) 52.5	🌧 (worse) 90.0
% [Age 65+] Pneumonia Vaccine Ever	76.3	☀ (better) 68.1	☁ (similar) 68.1	🌧 (worse) 90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever	36.4		☁ (similar) 32.0	🌧 (worse) 60.0
Tuberculosis Incidence per 100,000	6.8	🌧 (worse) 6.4	🌧 (worse) 3.6	🌧 (worse) 1.0

Legend: ☀ = better, ☁ = similar, 🌧 = worse

Injury & Violence Prevention

Injury & Violence Prevention	HMHP Service Area	vs. CA	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	23.3	☀ (better) 28.9	☀ (better) 38.2	☀ (better) 36.0
Motor Vehicle Crashes (Age-Adjusted Death Rate)	5.6	☀ (better) 8.8	☀ (better) 11.9	☀ (better) 12.4
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	92.8		☁ (similar) 91.6	
% Child [Age 5-17] "Always" Wears Bicycle Helmet	59.3		☀ (better) 35.3	
Firearm-Related Deaths (Age-Adjusted Death Rate)	4.7	☀ (better) 8.1	☀ (better) 10.2	☀ (better) 9.2
% Firearm in Home	17.2		☀ (better) 37.9	
% [Homes With Children] Firearm in Home	15.0		☀ (better) 34.4	
Homicide (Age-Adjusted Death Rate)	2.4	☀ (better) 5.6	☀ (better) 5.6	☀ (better) 5.5
Violent Crime per 100,000	229.6	☀ (better) 441.2	☀ (better) 407.3	

Injury & Violence Prevention (continued)

Injury & Violence Prevention (continued)	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Victim of Violent Crime in Past 5 Years	2.3		☁ 1.6	
% "Fair/Poor" Neighborhood Safety & Security	9.6			
Domestic Violence Offenses per 100,000	353.6	☀ 439.4		
% Ever Threatened With Violence by Intimate Partner	8.6		☀ 11.7	
% Victim of Domestic Violence (Ever)	9.5		☀ 13.5	
		☀ better	☁ similar	🌧 worse

Maternal, Infant & Child Health

Maternal, Infant & Child Health	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Late or No Prenatal Care	1.9	☀ 3.2		
% of Low Birthweight Births	6.5	☁ 6.8	☀ 8.2	☀ 7.8
Infant Death Rate	4.5	☀ 5.1	☀ 6.5	☀ 6.0
		☀ better	☁ similar	🌧 worse

Mental Health & Mental Disorders

Mental Health & Mental Disorders	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	13.2		☁ 11.7	
% Major Depression	7.9		☀ 11.7	
% Symptoms of Chronic Depression (2+ Years)	27.1		☁ 26.5	

Mental Health & Mental Disorders (continued)

Mental Health & Mental Disorders (continued)	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Suicide (Age-Adjusted Death Rate)	9.1	☀️ better 10.3	☀️ better 11.8	☀️ better 10.2
% [Those With Major Depression] Seeking Help	81.3		☁️ similar 82.0	☁️ similar 75.1
% Typical Day Is "Extremely/Very" Stressful	10.7		☁️ similar 11.5	
% "Dissatisfied/Very Dissatisfied" With Life	4.8			
% Do Not Get Adequate Social/Emotional Support	7.8			
% 3+ Days of Poor Mental Health/Past Month	15.9			
% Child [Age 5-17] Takes Prescription for ADD/ADHD	2.4		☀️ better 6.5	

	☀️	☁️	🌧️
	better	similar	worse

Nutrition & Weight Status

Nutrition & Weight Status	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	50.1		☁️ similar 48.8	
% Consumed 3+ Fast Food Meals in the Past Week	20.7			
% Consumed >7 Servings of Junk Food in the Past Week	10.0			
% Drink 7+ Servings of Soda per Week	10.5			
% Medical Advice on Nutrition in Past Year	38.8		☁️ similar 41.9	
% Healthy Weight (BMI 18.5-24.9)	45.7		☀️ better 31.7	☀️ better 33.9
% Overweight	51.9	☀️ better 60.2	☀️ better 66.9	

Nutrition & Weight Status (continued)

Nutrition & Weight Status (continued)	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Obese	18.7	☀ better 23.8	☀ better 28.5	☀ better 30.6
% Medical Advice on Weight in Past Year	23.8		☁ similar 25.7	
% [Overweights] Counseled About Weight in Past Year	32.5		☁ similar 30.9	
% [Obese Adults] Counseled About Weight in Past Year	51.3		☁ similar 47.4	☀ better 31.8
% [Overweights] Trying to Lose Weight Both Diet/Exercise	47.3		☀ better 38.6	
% Children [Age 5-17] Overweight	16.6		☀ better 30.7	
% Children [Age 5-17] Obese	7.8		☀ better 18.9	☀ better 14.6
		☀ better	☁ similar	🌧 worse

Oral Health

Oral Health	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	73.3	☀ better 69.6	☀ better 66.9	☀ better 49.0
% Child [Age 2-17] Dental Visit in Past Year	85.4		☁ similar 79.2	☀ better 49.0
% Have Dental Insurance	63.2		☁ similar 60.8	
		☀ better	☁ similar	🌧 worse

Physical Activity

Physical Activity	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% [Employed] Job Entails Mostly Sitting/Standing	67.1		☁ similar 63.2	
% No Leisure-Time Physical Activity	19.0	☁ similar 19.1	☀ better 28.7	☀ better 32.6
% Meeting Physical Activity Guidelines	51.3		☀ better 42.7	

Physical Activity (continued)

Physical Activity (continued)	HMHP Service Area	vs. CA	vs. US	vs. HP2020
		HMHP Service Area vs. Benchmarks		
% Moderate Physical Activity	29.9		☀️ 23.9	
% Vigorous Physical Activity	36.5		☁️ 34.8	
% [Adults] 3+ Hours per Day of Total Screen Time	65.2			
% Medical Advice on Physical Activity in Past Year	49.5		☁️ 47.8	
% Child [Age 5-17] Watches TV 3+ Hours per Day	20.3		☁️ 19.7	
% Child [Age 5-17] Uses Computer 3+ Hours per Day	19.2		🌧️ 9.9	
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time	49.8		☁️ 43.4	
		☀️ better	☁️ similar	🌧️ worse

Respiratory Diseases

Respiratory Diseases	HMHP Service Area	vs. CA	vs. US	vs. HP2020
		HMHP Service Area vs. Benchmarks		
CLRD (Age-Adjusted Death Rate)	32.9	☀️ 38.1	☀️ 43.2	
Pneumonia/Influenza (Age-Adjusted Death Rate)	18.5	☁️ 17.9	🌧️ 16.4	
% Nasal/Hay Fever Allergies	17.6		☀️ 27.3	
% Chronic Lung Disease	5.6		☀️ 8.4	
% [Adult] Currently Has Asthma	5.3	☀️ 8.4	☁️ 7.5	
% [Child 0-17] Currently Has Asthma	6.7		☁️ 6.8	
		☀️ better	☁️ similar	🌧️ worse

Sexually Transmitted Diseases

Sexually Transmitted Diseases	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000	31.5	☀️ better 69.9	☀️ better 101.0	
Primary & Secondary Syphilis Incidence per 100,000	2.6	☀️ better 5.8	☀️ better 4.5	
Chlamydia Incidence per 100,000	266.9	☀️ better 417.5	☀️ better 429.6	
Hepatitis B Incidence per 100,000	0.3	☀️ better 0.4	☀️ better 1.2	
		☀️ better	⛅ similar	🌧 worse

Substance Abuse

Substance Abuse	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	9.7	☀️ better 11.3	🌧 worse 9.2	🌧 worse 8.2
% Current Drinker	55.7	⛅ similar 57.1	⛅ similar 58.8	
% Chronic Drinker (Average 2+ Drinks/Day)	3.7	☀️ better 6.2	⛅ similar 5.6	
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	13.6	☀️ better 18.6	⛅ similar 16.7	☀️ better 24.3
% Drinking & Driving in Past Month	3.3		⛅ similar 3.5	
% Driving Drunk or Riding with Drunk Driver	5.9		⛅ similar 5.5	
Drug-Induced Deaths (Age-Adjusted Death Rate)	10.7	⛅ similar 11.2	☀️ better 12.7	☀️ better 11.3
% Medicine is Kept in a Locked, Secure Place	20.7			
% Illicit Drug Use in Past Month	2.8		⛅ similar 1.7	☀️ better 7.1
% Ever Sought Help for Alcohol or Drug Problem	2.1		🌧 worse 3.9	
		☀️ better	⛅ similar	🌧 worse

Tobacco Use	HMHP Service Area	HMHP Service Area vs. Benchmarks		
		vs. CA	vs. US	vs. HP2020
% Current Smoker	8.7	☀️ 13.6	☀️ 16.6	☀️ 12.0
% Someone Smokes at Home	7.9		☀️ 13.6	
% [Non-Smokers] Someone Smokes in the Home	4.2		☁️ 5.7	
% [Household With Children] Someone Smokes in the Home	7.7		☁️ 12.1	
% [Smokers] Received Advice to Quit Smoking	61.6		☁️ 63.7	
% [Smokers] Have Quit Smoking 1+ Days in Past Year	21.9		🌧️ 56.2	🌧️ 80.0
% Smoke Cigars	5.1		☁️ 4.2	🌧️ 0.2
% Use Smokeless Tobacco	2.1		☁️ 2.8	🌧️ 0.3
		☀️ better	☁️ similar	🌧️ worse
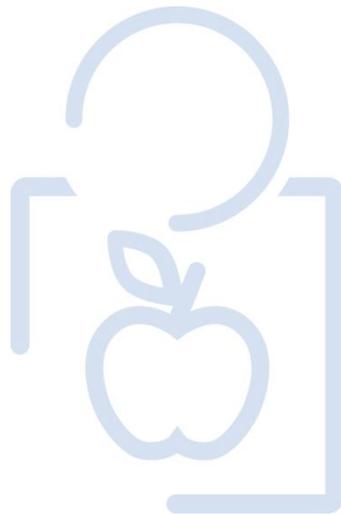
GENERAL HEALTH STATUS

Overall Health Status

Self-Reported Health Status

A total of 54.4% of HMHP Service Area adults rate their overall health as "excellent" or "very good."

- Another 28.7% gave "good" ratings of their overall health.
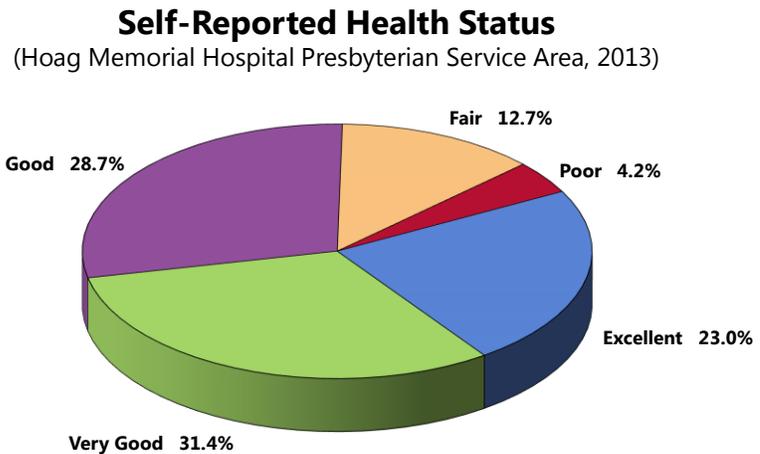
Self-Reported Health Status
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Fair 12.7%
Poor 4.2%
Good 28.7%
Excellent 23.0%
Very Good 31.4%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.

However, 16.9% of HMHP Service Area adults believe that their overall health is "fair" or "poor."

- Comparable to statewide findings.
- Nearly identical to the national prevalence.

Experience "Fair" or "Poor" Overall Health

	HMHP Service Area	California	United States
	16.9%	18.7%	16.8%
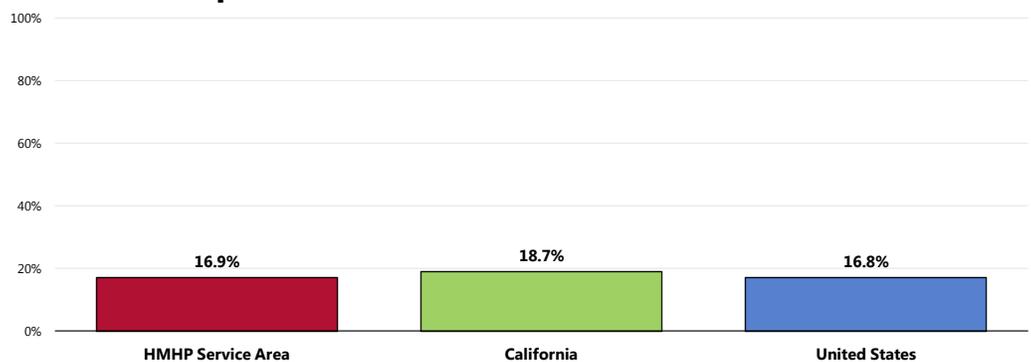
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Adults <u>more</u> likely to report experiencing "fair" or "poor" overall health include:

- Residents living at lower incomes (note the negative correlation with age).
- Hispanics.

Experience "Fair" or "Poor" Overall Health
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
16.0%	17.9%	16.0%	17.2%	17.3%	29.2%	23.3%	12.0%	13.6%	27.6%	11.4%	16.9%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

■ Experience difficulties or delays in getting the health care they need.

■ Not have had an annual dental visit.

■ Not have had a mammogram in past 2 years.

■ Not have had a Pap test within the past 3 years.

■ Not engage in fitness activities.

■ Use tobacco.

■ Be overweight or obese.

■ Have high blood pressure.

■ Experience symptoms of psychological distress.

■ Receive less social-emotional support.

■ Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

■ **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.

■ **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.

■ **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.
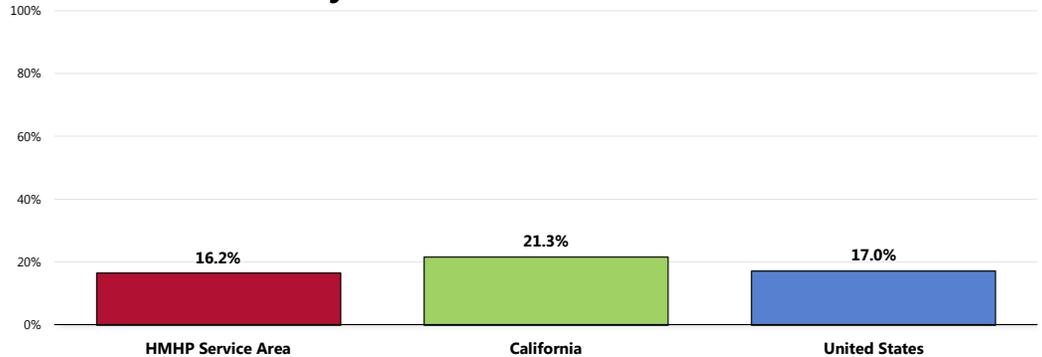
– Healthy People 2020 (www.healthypeople.gov)

A total of 16.2% of HMHP Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- More favorable than the prevalence statewide.

- Similar to the national prevalence.

Limited in Activities in Some Way
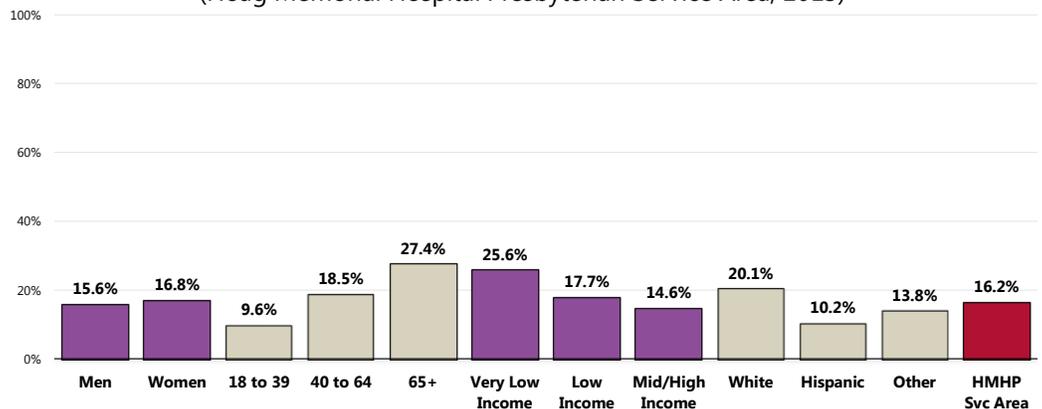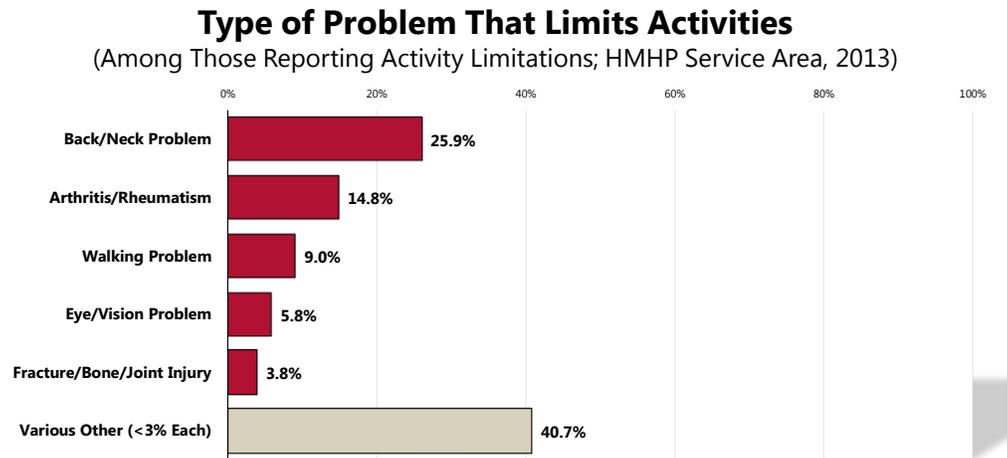## Due to a Physical, Mental or Emotional Problem

HMHP Service Area	California	United States
16.2%	21.3%	17.0%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

In looking at responses by key demographic characteristics, note the following:

- Adults age 40 and older are much more often limited in activities (note the positive correlation with age).

- Note also the negative correlation between income and reports of activity limitations.

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
15.6%	16.8%	9.6%	18.5%	27.4%	25.6%	17.7%	14.6%	20.1%	10.2%	13.8%	16.2%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]
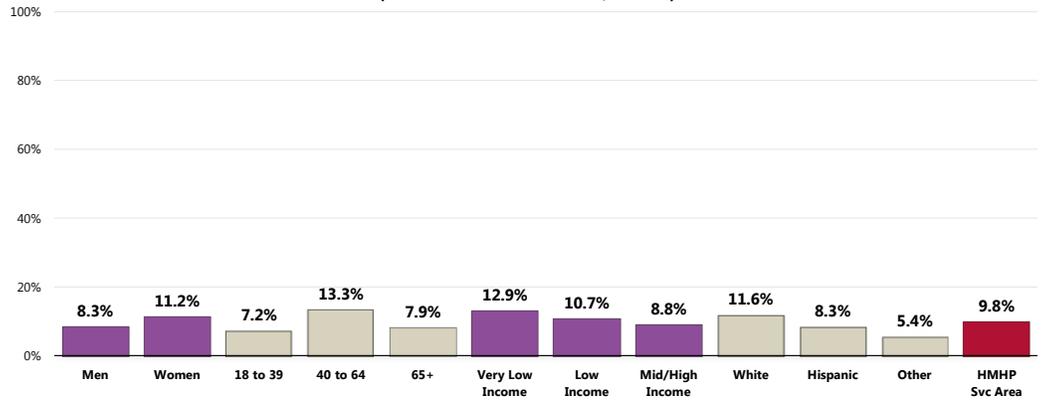Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among persons reporting activity limitations, these are most often attributed to musculoskeletal issues, such as back/neck problems, arthritis/rheumatism, difficulty walking, or fractures or bone/joint injuries.

Eye and vision problems were also noted with some frequency, as shown.

Type of Problem That Limits Activities
(Among Those Reporting Activity Limitations; HMHP Service Area, 2013)

Category	Percentage
Back/Neck Problem	25.9%
Arthritis/Rheumatism	14.8%
Walking Problem	9.0%
Eye/Vision Problem	5.8%
Fracture/Bone/Joint Injury	3.8%
Various Other (<3% Each)	40.7%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: • Asked of those respondents reporting activity limitations.

Days of Poor Physical/Mental Health

The vast majority (86.7%) of survey respondents reports no days in the past month on which their physical or mental health restricted their usual activities.

- On the other hand, 9.8% report 3 or more days of restricted activities in the past month.

Days On Which Poor Physical or Mental Health Restricted Usual Activities in the Past Month
(HMHP Service Area, 2013)
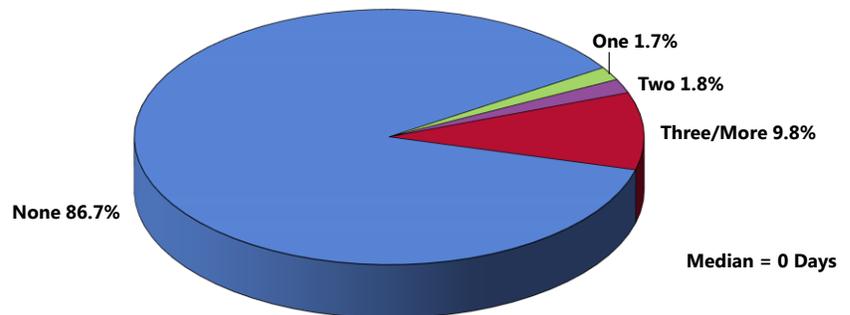
One 1.7%
Two 1.8%
Three/More 9.8%
None 86.7%
Median = 0 Days

Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
Notes: • Asked of all respondents.

Adults age 40 to 64 are more likely to report that poor physical or mental health restricted their activities for 3 or more days in the past month.

Poor Physical/Mental Health
Restricted Activities for 3+ Days in the Past Month
(HMHP Service Area, 2013)

Category	Value
Men	8.3%
Women	11.2%
18 to 39	7.2%
40 to 64	13.3%
65+	7.9%
Very Low Income	12.9%
Low Income	10.7%
Mid/High Income	8.8%
White	11.6%
Hispanic	8.3%
Other	5.4%
HMHP Svc Area	9.8%

Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders.

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the national Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The understanding of how the brain functions under normal conditions and in response to stressors, combined with knowledge of how the brain develops over time, has been essential to that progress. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.

- The greatest opportunity for prevention is among young people.

- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.

- The incidence of depression among pregnant women and adolescents can be reduced.

- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.

- There are potential indicated preventive interventions for schizophrenia.

- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.

- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.

- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting.

- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.

- Implementation is complex, and it is important that interventions be relevant to the target audiences.

In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

– Healthy People 2020 (www.healthypeople.gov)

Mental Health Status

Self-Reported Mental Health Status
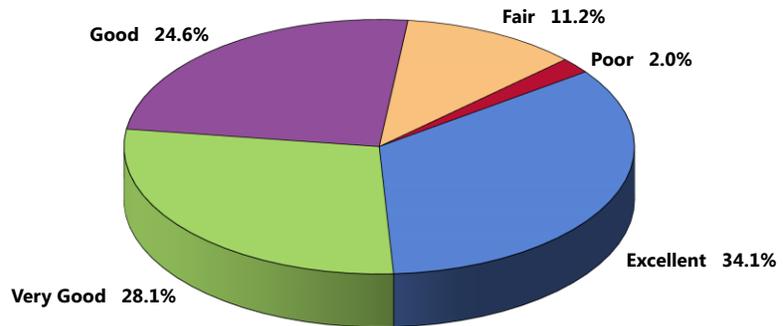
A total of 62.2% of HMHP Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 24.6% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status
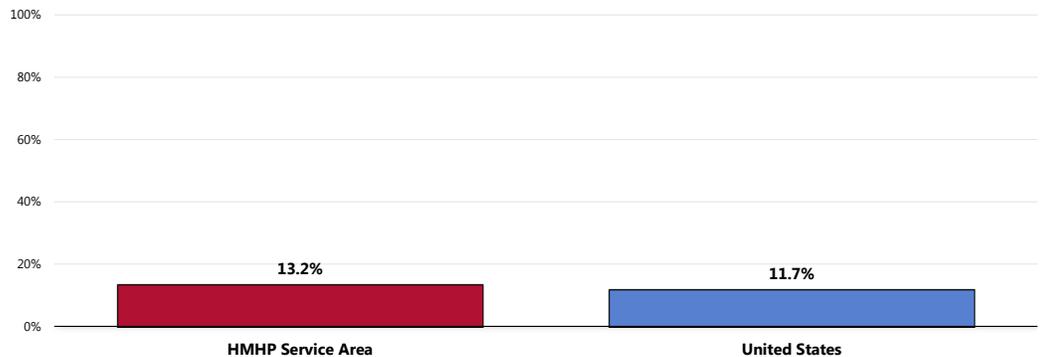(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Good 24.6%
Fair 11.2%
Poor 2.0%
Excellent 34.1%
Very Good 28.1%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]
Notes: ● Asked of all respondents.

A total of 13.2% of HMHP Service Area adults, however, believe that their overall mental health is "fair" or "poor."

- Similar to the "fair/poor" response reported nationally.

Experience "Fair" or "Poor" Mental Health

13.2% HMHP Service Area
11.7% United States

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

- Note the <u>negative</u> correlation between poor mental health and age.

- Note also the negative correlation with income, as shown.

Experience "Fair" or "Poor" Mental Health
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

	Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
%	12.5%	14.0%	15.4%	13.3%	6.3%	21.8%	16.4%	9.9%	10.9%	17.7%	12.7%	13.2%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Days of Poor Mental Health

In the past month, 67.0% of survey respondents did not experience any days of poor mental health.

- In contrast, 18.1% of HMHP Service Area residents experienced <u>3 or more days</u> of poor mental health in the past month.

Days of Poor Mental Health in the Past Month
(HMHP Service Area, 2013)
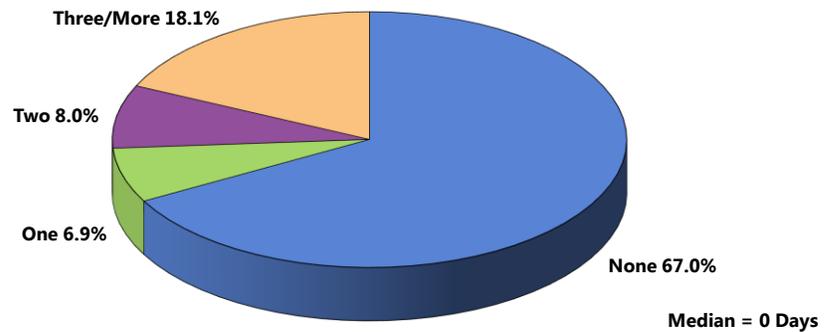
Three/More 18.1%
Two 8.0%
One 6.9%
None 67.0%

Median = 0 Days

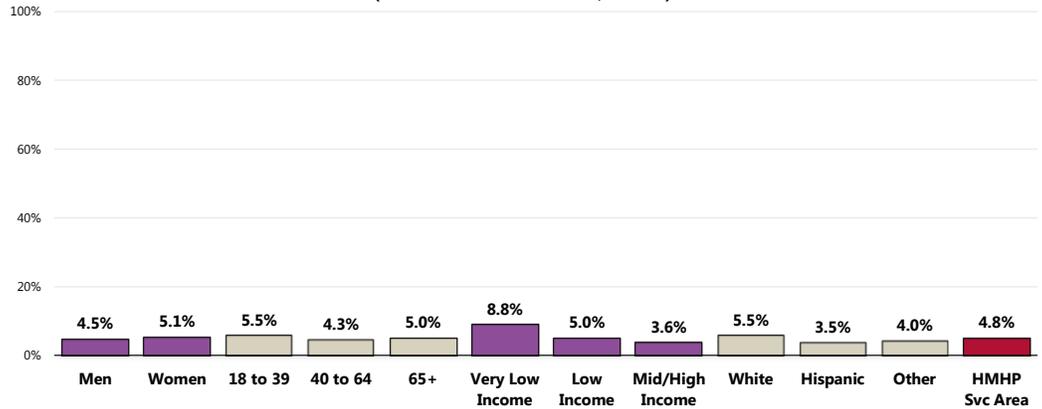Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]
Notes: ● Asked of all respondents.

👪 Adults under 65 are more likely to report experiencing 3+ days of poor mental health in the past month.

Experienced 3+ Days of Poor Mental Health in the Past Month
(HMHP Service Area, 2013)

Category	Percentage
Men	15.6%
Women	16.2%
18 to 39	17.4%
40 to 64	16.6%
65+	9.8%
Very Low Income	18.1%
Low Income	14.5%
Mid/High Income	17.4%
White	18.5%
Hispanic	11.5%
Other	13.3%
HMHP Svc Area	15.9%

Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Satisfaction With Life

The initial inquiry of the PRC Community Health Survey asked respondents the following:

"In general, how satisfied are you with your life?"

In general, survey respondents expressed high levels of satisfaction with their lives: 40.6% of are "very satisfied" with their lives, and another 54.6% of respondents gave "satisfied" indications.

Rating of General Satisfaction With Life
(HMHP Service Area, 2013)
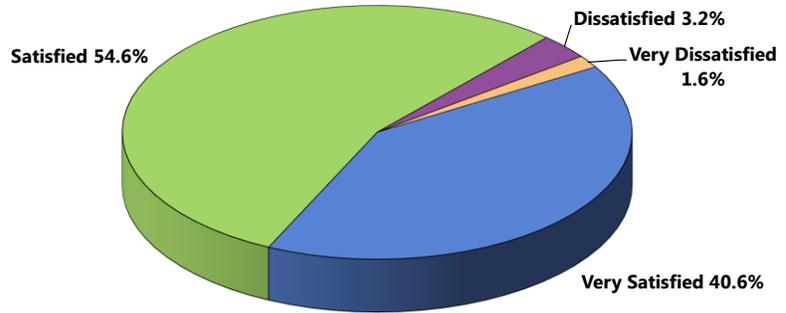
Rating	Percentage
Satisfied	54.6%
Dissatisfied	3.2%
Very Dissatisfied	1.6%
Very Satisfied	40.6%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 4]
Notes: ● Asked of all respondents.

Adults <u>more</u> likely to report low levels of satisfaction ("dissatisfied" or "very dissatisfied" responses) include:

- Residents living at lower incomes (note the negative correlation with income).

- Other differences within demographic groups, as illustrated in the following chart, are <u>not</u> statistically significant.

"Dissatisfied/Very Dissatisfied" With Life
(HMHP Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
4.5%	5.1%	5.5%	4.3%	5.0%	8.8%	5.0%	3.6%	5.5%	3.5%	4.0%	4.8%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 4]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Depression

Major Depression

A total of 7.9% of HMHP Service Area adults have been diagnosed with major depression by a physician.

- Lower than the national finding.

Have Been Diagnosed With Major Depression

HMHP Service Area	United States
7.9%	11.7%
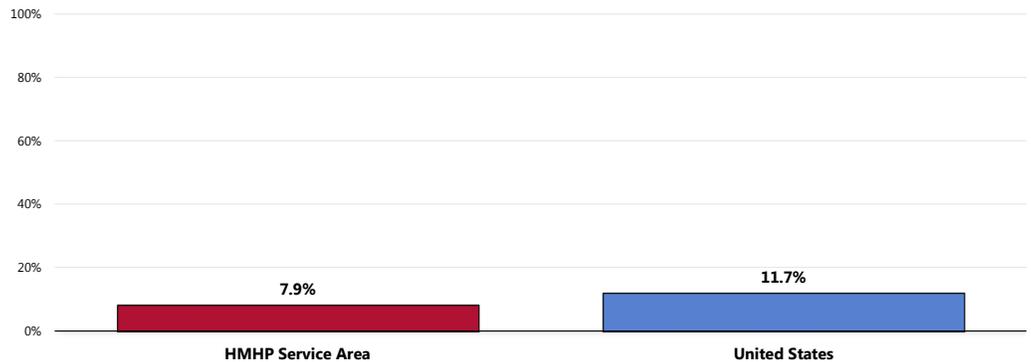
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 31]
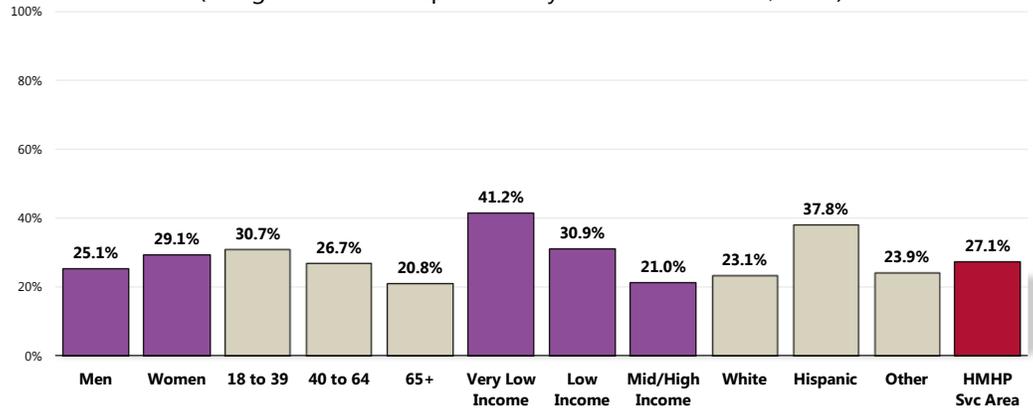- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

👪 The prevalence of major depression is notably higher among community members living at very low incomes.

Have Been Diagnosed With Major Depression
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

|											
Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
6.6%	9.2%	6.0%	10.4%	7.3%	14.6%	3.8%	6.3%	8.9%	7.1%	7.2%	7.9%
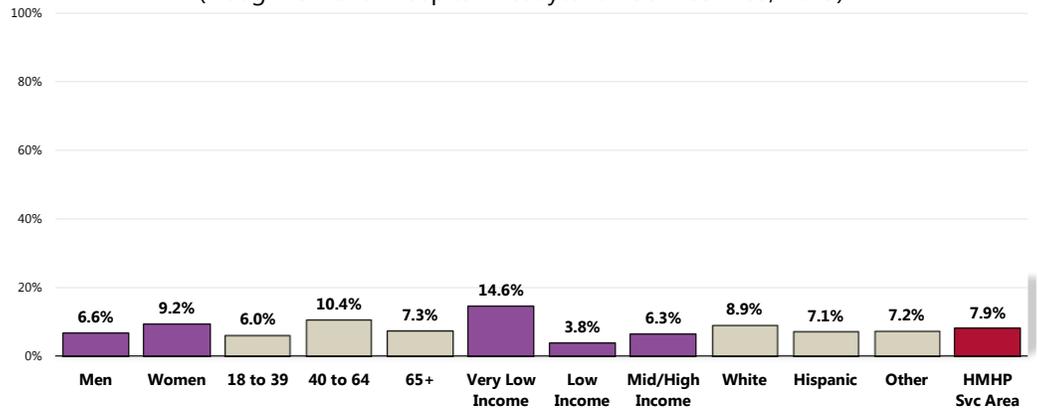
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 31]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Symptoms of Chronic Depression

A total of 27.1% of HMHP Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (chronic depression).

● Similar to the national prevalence.

Have Experienced Symptoms of Chronic Depression
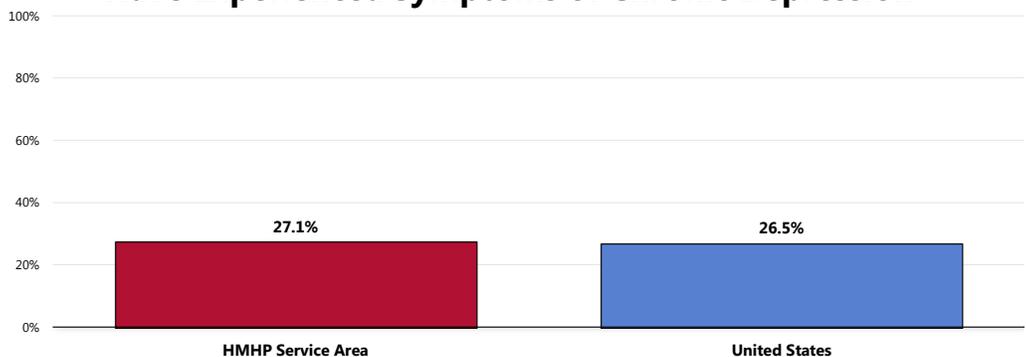
HMHP Service Area	United States
27.1%	26.5%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Note that the prevalence of chronic depression is notably higher among:

- 👪 Young adults (note the negative correlation with age).
- 👪 Adults with lower incomes (note the negative correlation with income).
- 👪 Hispanic adults.

Have Experienced Symptoms of Chronic Depression
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Category	Value
Men	25.1%
Women	29.1%
18 to 39	30.7%
40 to 64	26.7%
65+	20.8%
Very Low Income	41.2%
Low Income	30.9%
Mid/High Income	21.0%
White	23.1%
Hispanic	37.8%
Other	23.9%
HMHP Svc Area	27.1%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

More than one-half of HMHP Service Area adults consider their typical day to be "not very stressful" (27.9%) or "not at all stressful" (10.7%).

- Another 50.6% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Moderately Stressful 50.6%
Not Very Stressful 27.9%
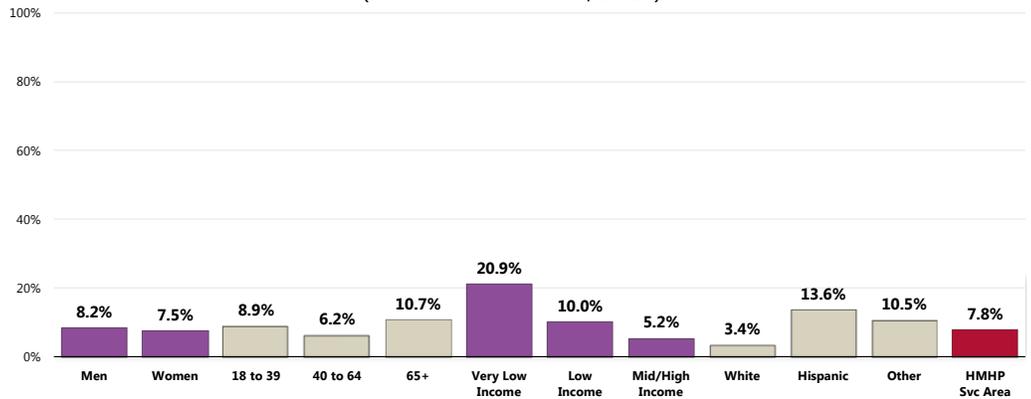Not At All Stressful 10.7%
Extremely Stressful 2.0%
Very Stressful 8.7%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
Notes: • Asked of all respondents.

In contrast, 10.7% of HMHP Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Comparable to national findings.

Perceive Most Days As "Extremely" or "Very" Stressful
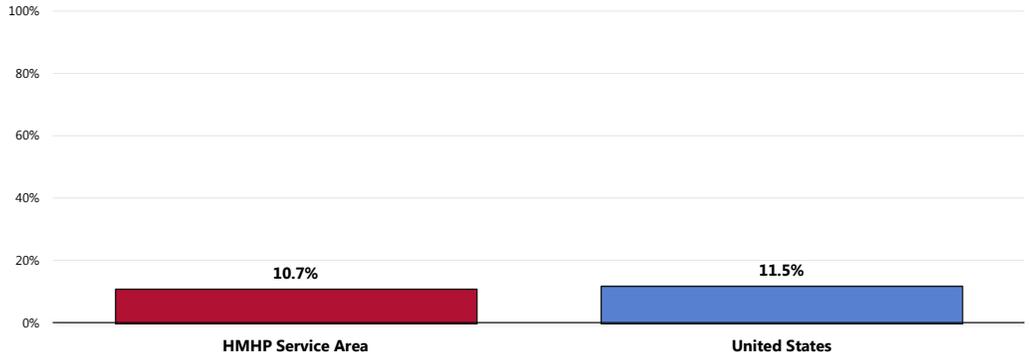
HMHP Service Area	10.7%
United States	11.5%

- Note that high stress levels are more prevalent among adults under 65 and Whites.

Perceive Most Days as "Extremely" or "Very" Stressful
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
10.4%	11.1%	12.1%	12.2%	3.5%	8.7%	11.1%	11.6%	15.6%	6.0%	5.2%	10.7%

A total of 76.4% of survey respondents report "always" or "usually" receiving the social and emotional support that they need.

- Another 15.8% "sometimes" get the support they need.

Frequency of Social and Emotional Support
(HMHP Service Area, 2013)
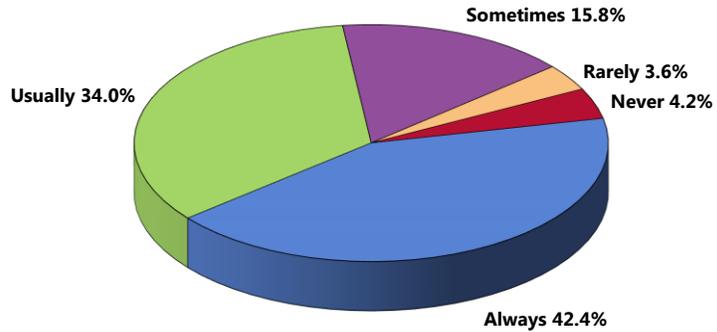
Sometimes 15.8%
Rarely 3.6%
Never 4.2%
Usually 34.0%
Always 42.4%

Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc.   [Item 113]
Notes: ● Asked of all respondents.

- Note the <u>negative</u> correlation between lack of support and income.

- Non-White adults are <u>much more likely</u> to report a lack of social or emotional support.

Do Not "Always/Usually" Get Social and Emotional Support
(HMHP Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
8.2%	7.5%	8.9%	6.2%	10.7%	20.9%	10.0%	5.2%	3.4%	13.6%	10.5%	7.8%

Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc.   [Item 113]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
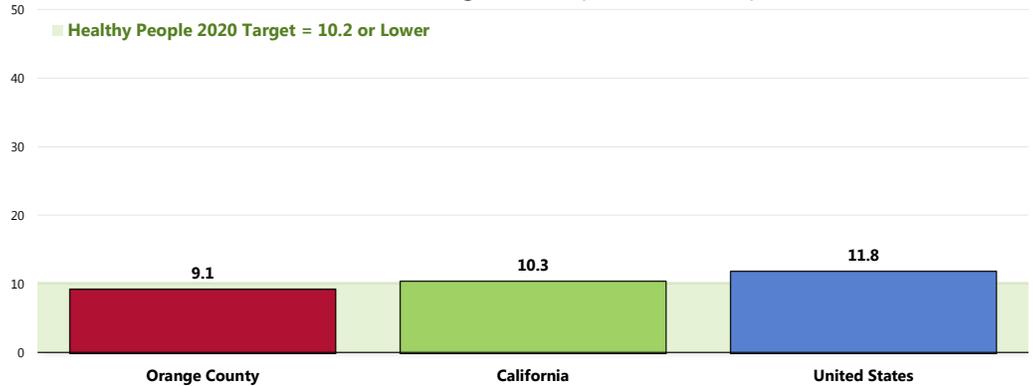
Suicide

Between 2008 and 2010, there was an annual average age-adjusted suicide rate of 9.1 deaths per 100,000 population in Orange County.

- Lower than the statewide rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target of 10.2 or lower.

Suicide: Age-Adjusted Mortality
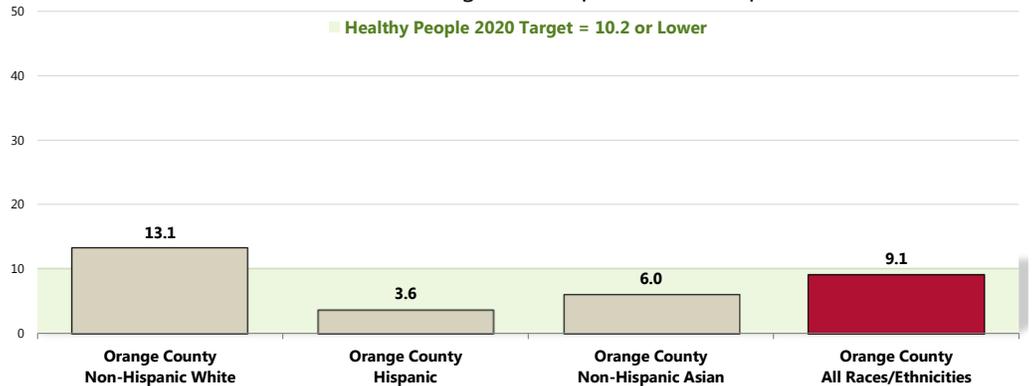### (2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower

Orange County	California	United States
9.1	10.3	11.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

👪 The suicide rate in Orange County is dramatically higher among Non-Hispanic Whites than among Hispanics and Non-Hispanic Asians.

Suicide: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
13.1	3.6	6.0	9.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Mental Health Treatment

Among adults with diagnosed depression, 81.3% acknowledge that they have sought professional help for a mental or emotional problem.

- Similar to national findings.

- Similar to the Healthy People 2020 target of 75.1% or higher.

Have Sought Professional Help for a Mental or Emotional Problem
(Among Those With Major Depression)

	HMHP Service Area	United States
Healthy People 2020 Target = 75.1% or Higher	81.3%	82.0%
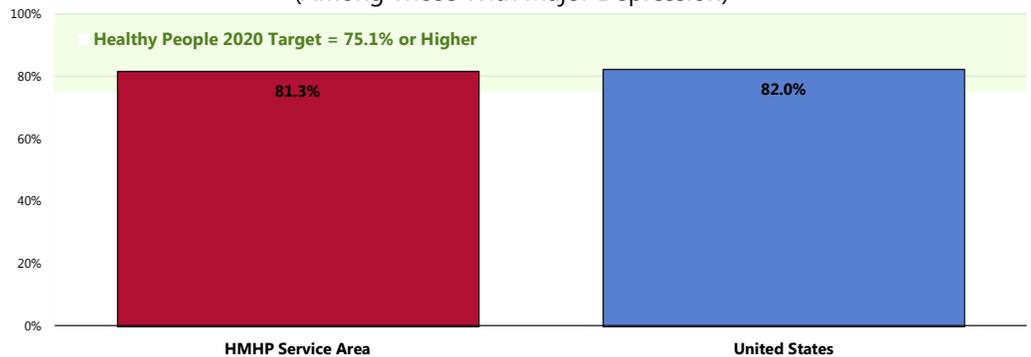
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-9.2]

Notes:
- Asked of those respondents with major depression diagnosed by a physician.

Needed Services in the Past Year

According to survey data, a total of 9.9% of HMHP Service Area adults have needed some type of mental health services in the past year.

- Of these residents, 11.7% could not get the services that they needed.

Needed Mental Health Services in the Past Year
(HMHP Service Area, 2013)
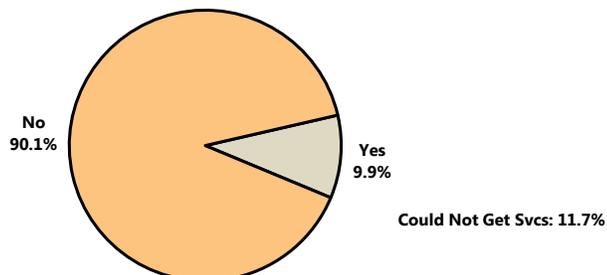
No 90.1%
Yes 9.9%
Could Not Get Svcs: 11.7%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 118-119]

Notes:
- Asked of all respondents.

Children & ADD/ADHD

Among HMHP Service Area adults with children age 5 to 17, 2.4% report that their child takes medication for ADD/ADHD.

- Lower than the national prevalence.

- Much higher in boys than in girls (4.1% vs. 0.4%, respectively); not shown.

Child Takes Medication for ADD/ADHD
(Among Parents of Children 5-17)

Yes 2.4%

No 97.6%

HMHP Service Area

Yes 6.5%

No 93.5%

United States
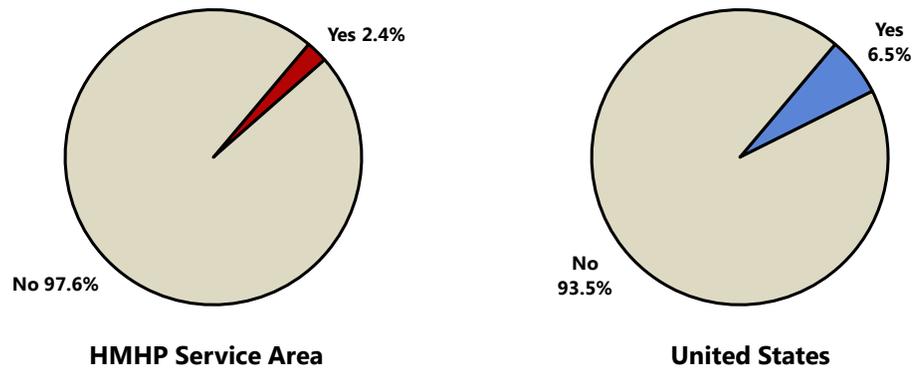
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
          • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children age 5 to 17.

Related Focus Group Findings: Mental Health

Focus group participants spent time discussing mental health in the community. The main issues include:

- Limited number of behavioral health providers and services

- Stigma

- Lack of integration of physical and mental health

During the focus groups, issues surrounding mental illness and mental healthcare services arose several times. Focus group members discussed at length the **limited number of behavioral health providers and services** available in the community for the underinsured and uninsured. Facilities also struggle to hire psychiatrists and psychologists. A respondent explains the issue:

> *"Mental health is probably the most challenging access point of care in Orange County. I have nurse practitioners, PA's trying to manage a high level of psychiatric disorder that they've not been trained in and are putting themselves at risk, so to get the ability to hire someone like a psychiatrist or even a nurse practitioner trained in that field is extremely challenging." — Healthcare Provider*

Due to the inadequate number of psychiatrists and other mental health facilities, family practice physicians must provide treatment for anyone with a behavioral health concern. In addition, schools struggle with students who have mental health issues because there are limited places to treat young people exhibiting mental illness:

"We work with our school district that has a family resource center; but recently the laws around mental health changed which affected federal funding. The federal government is pushing mental health into the school districts without providing any subsidy. We have one of the only family resource centers left, and it's heavily subsidized by the city. When it comes to our lower-income and our immigrant populations, there is a lack of mental health services. We utilize HOPE all the time but otherwise there are very limited resources." — Community Leader

Participants also mentioned that in some populations a **stigma** is still associated with mental health, which deters these individuals from seeking services:

"The stigma associated with mental health is not so much from the provider end, but from the grassroots community especially with the underserved or underrepresented communities, the types of cultural beliefs about mental health issues provide a barrier to access mental health services." — Healthcare Provider

The lack of **integration between physical health and mental health** providers was also discussed in both focus groups:

"There needs to be an understanding that treatment is all encompassing, especially for many of us who deal with high risk families. The mental health component is a big part of why they are not able to navigate the healthcare system and receive the treatment they need for their physical and mental health. I do think that there should be a better merge of medical and mental health services." — Healthcare Provider
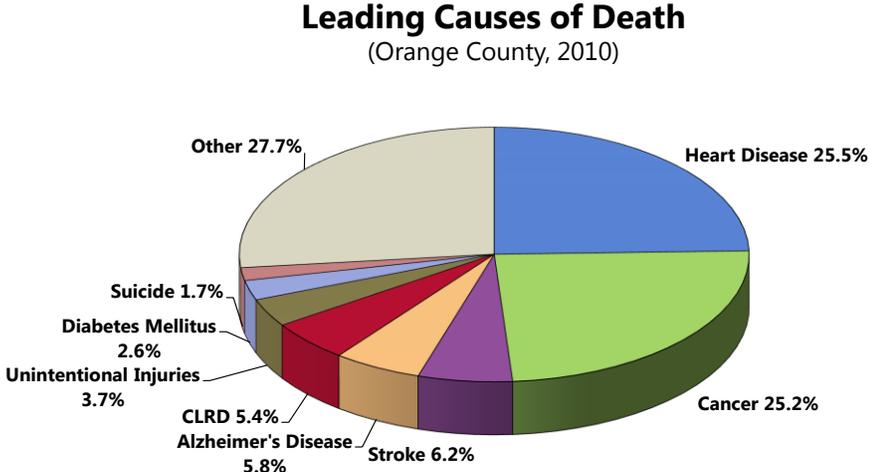
DEATH, DISEASE & CHRONIC CONDITIONS
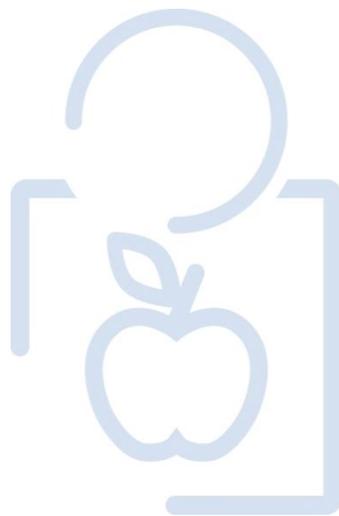
Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for over one-half of all 2010 deaths in Orange County.

Leading Causes of Death
(Orange County, 2010)

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, California and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines 2008-2010 annual average age-adjusted death rates per 100,000 population for selected causes of death in Orange County.

Age-adjusted mortality rates in Orange County are worse than national rates for pneumonia/influenza, Alzheimer's disease, and cirrhosis/liver disease.

Of the causes outlined in the following chart for which Healthy People 2020 objectives have been established, Orange County rates fail to satisfy the related goals for stroke and cirrhosis/liver disease.

Age-Adjusted Death Rates for Selected Causes
(2008-2010 Deaths per 100,000)

	Orange County	California	US	HP2020
Diseases of the Heart	153.5	168.2	184.6	152.7*
Malignant Neoplasms (Cancers)	149.0	158.2	174.2	160.6
Cerebrovascular Disease (Stroke)	37.7	39.2	40.2	33.8
Chronic Lower Respiratory Disease (CLRD)	32.9	38.1	43.2	n/a
Alzheimer's Disease	32.1	29.2	25.0	n/a
Unintentional Injuries	23.3	28.9	38.2	36
Pneumonia/Influenza	18.5	17.9	16.4	n/a
Diabetes Mellitus	14.4	20.3	21.3	19.6*
Drug-Induced	10.7	11.2	12.7	11.3
Cirrhosis/Liver Disease	9.7	11.3	9.2	8.2
Intentional Self-Harm (Suicide)	9.1	10.3	11.8	10.2
Kidney Diseases	8.7	8.6	15.2	n/a
Motor Vehicle Deaths	5.6	8.8	11.9	12.4
Firearm-Related	4.7	8.1	10.2	9.2
Homicide/Legal Intervention	2.4	5.6	5.6	5.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.
Note: • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
• *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
• Local, state and national data are simple three-year averages.

Cardiovascular Disease

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.
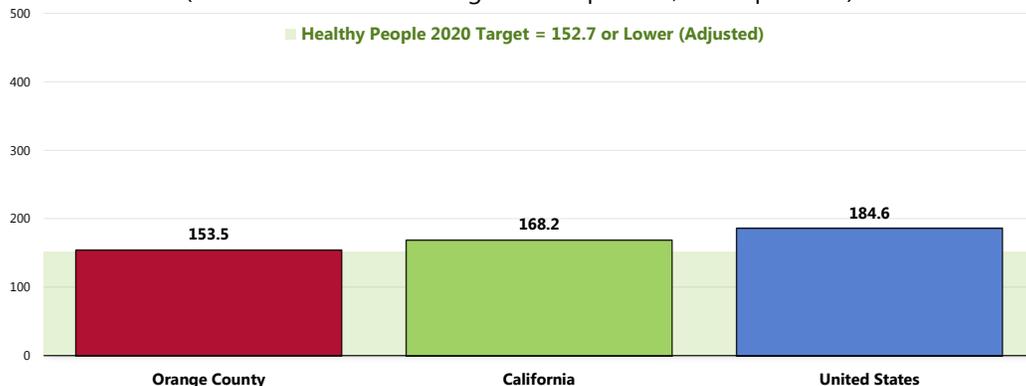
Between 2008 and 2010 there was an annual average age-adjusted heart disease mortality rate of 153.5 deaths per 100,000 population in Orange County.

- Lower than the statewide rate.
- Lower than the national rate.
- Similar to the Healthy People 2020 target (as adjusted to account for all diseases of the heart).

Heart Disease: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 152.7 or Lower (Adjusted)

	Orange County	California	United States
Value	153.5	168.2	184.6

Sources:
• CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
• Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

By race, the heart disease mortality rate is higher among Whites when compared with Hispanics and Asians in Orange County.

Heart Disease: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 152.7 or Lower (Adjusted)

	Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
Value	168.4	127.0	103.5	153.5

Sources:
• CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
• Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Between 2008 and 2010, there was an annual average age-adjusted stroke mortality rate of 37.7 deaths per 100,000 population in Orange County.

- Similar to the California rate.
- More favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 33.8 or lower.

Stroke: Age-Adjusted Mortality
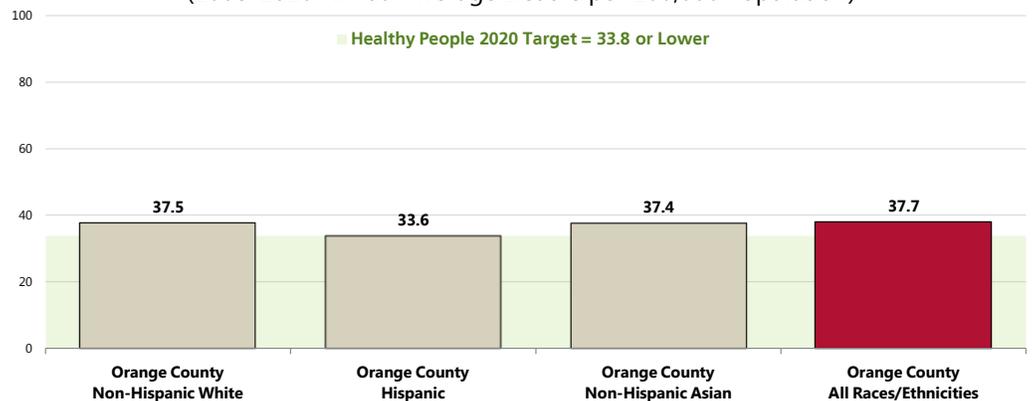(2008-2010 Annual Average Deaths per 100,000 Population)
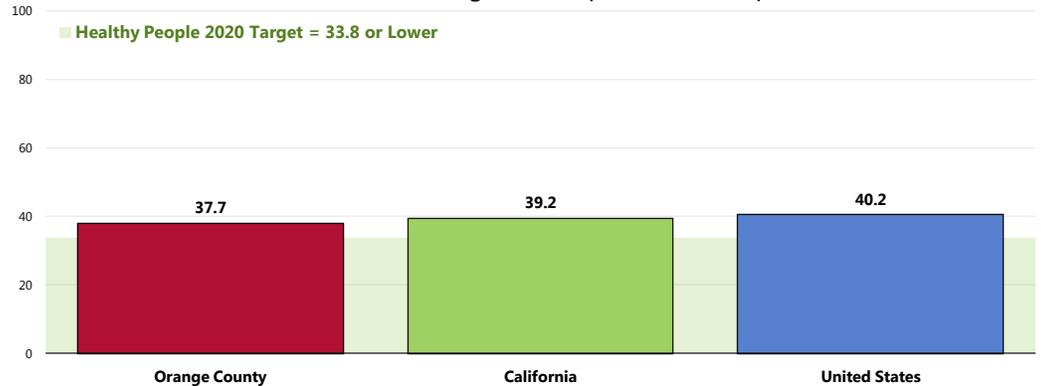
Healthy People 2020 Target = 33.8 or Lower

Orange County	California	United States
37.7	39.2	40.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

- Stroke mortality is higher among Whites and Asians when compared with Hispanics in Orange County.

Stroke: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 33.8 or Lower

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
37.5	33.6	37.4	37.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 4.6% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

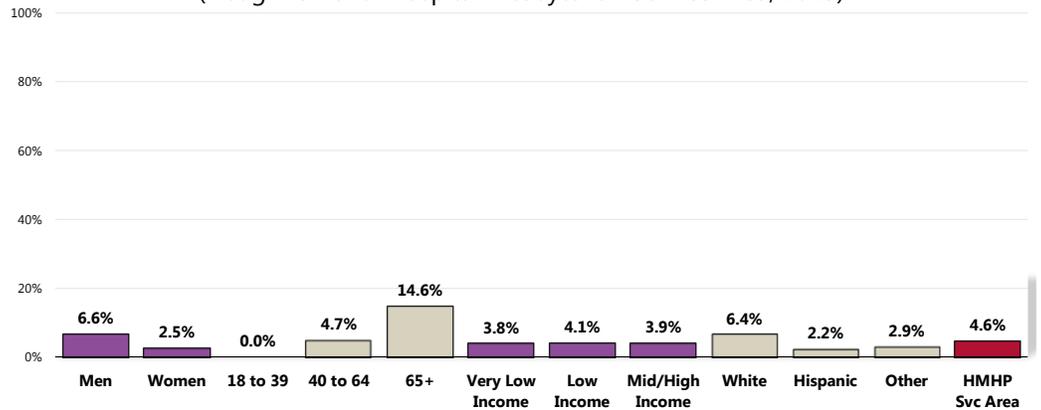- Similar to the national prevalence.

Prevalence of Heart Disease

	HMHP Service Area	United States
	4.6%	6.1%
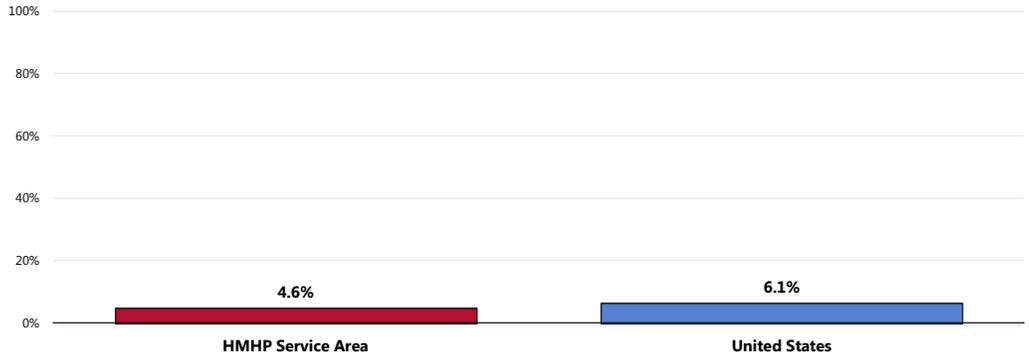
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
          ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Adults more likely to have been diagnosed with chronic heart disease include:

- Men.

- Adults age 40 and older, and especially seniors (age 65+).

Prevalence of Heart Disease
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
6.6%	2.5%	0.0%	4.7%	14.6%	3.8%	4.1%	3.9%	6.4%	2.2%	2.9%	4.6%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
Notes: ● Asked of all respondents.
          ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
          ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Cardiovascular Risk Factors

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

  – Healthy People 2020 (www.healthypeople.gov)

Hypertension (High Blood Pressure)

High Blood Pressure Testing

A total of 94.2% of HMHP Service Area adults have had their blood pressure tested within the past two years.

- Similar to national findings.
- Similar to the Healthy People 2020 target (94.9% or higher).

Have Had Blood Pressure Checked in the Past Two Years

Healthy People 2020 Target = 94.9% or Higher

	HMHP Service Area	United States
	94.2%	94.7%
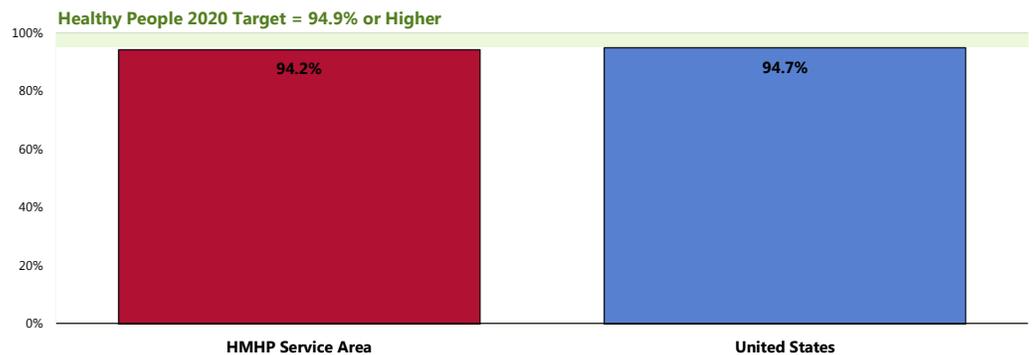
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
          • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
          • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]
Notes: • Asked of all respondents.

Prevalence of Hypertension

A total of 30.6% of adults have been told at some point that their blood pressure was high.

- Comparable to the California prevalence.
- Comparable to the national prevalence.
- Fails to satisfy the Healthy People 2020 target (26.9% or lower).
- Among hypertensive adults, 61.0% have been diagnosed with high blood pressure more than once.

Prevalence of High Blood Pressure
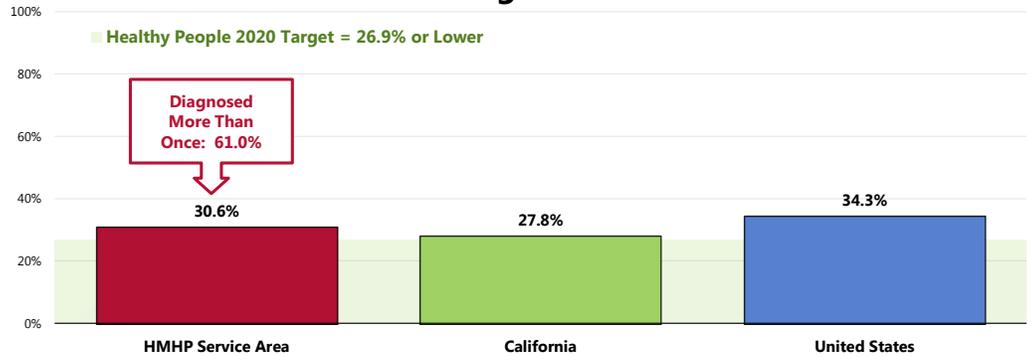
Healthy People 2020 Target = 26.9% or Lower

Diagnosed More Than Once: 61.0%

	HMHP Service Area	California	United States
	30.6%	27.8%	34.3%

Hypertension diagnoses are higher among:

   ᴴᵗᴴ   Men.

   ᴴᵗᴴ   Seniors (note the strong correlation with age).

   ᴴᵗᴴ   Adults living on higher incomes.

   ᴴᵗᴴ   White residents.

Prevalence of High Blood Pressure
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Healthy People 2020 Target = 26.9% or Lower

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
35.6%	25.5%	15.8%	30.7%	67.5%	21.0%	33.0%	29.4%	36.2%	24.2%	24.1%	30.6%

Respondents reporting high blood pressure were further asked:

"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"

Among respondents who have been told that their blood pressure was high, 96.7% report that they are currently taking actions to control their condition.

- Higher than the national findings.

Taking Action to Control Hypertension
(Among Adults With High Blood Pressure)
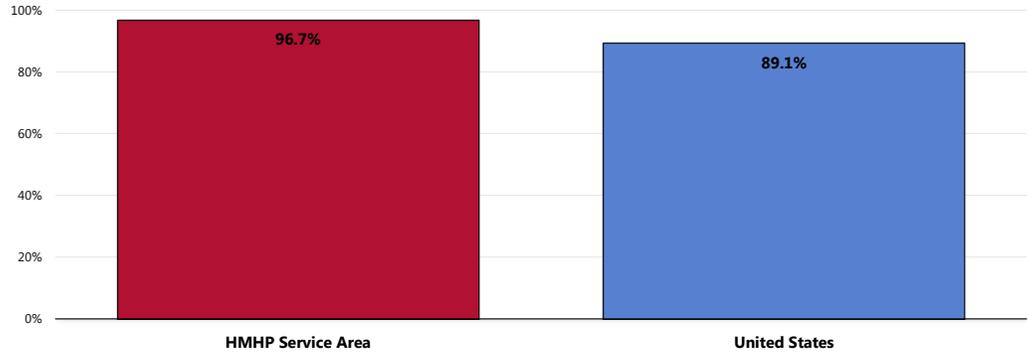
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents who have been diagnosed with high blood pressure.
● In this case, the term "action" refers to medication, change in diet, and/or exercise.

High Blood Cholesterol

Blood Cholesterol Testing

A total of 93.7% of HMHP Service Area adults have had their blood cholesterol checked within the past five years.

- More favorable than California findings.

- More favorable than the national findings.

- Satisfies the Healthy People 2020 target (82.1% or higher).

Have Had Blood
Cholesterol Levels Checked in the Past Five Years
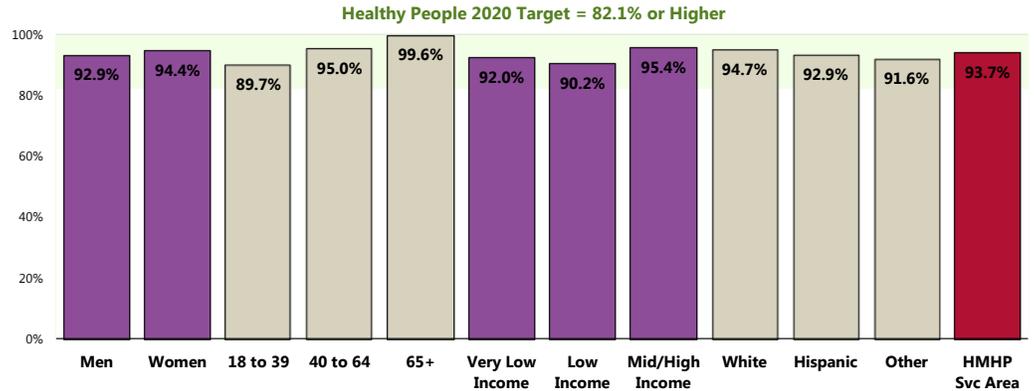
Healthy People 2020 Target = 82.1% or Higher
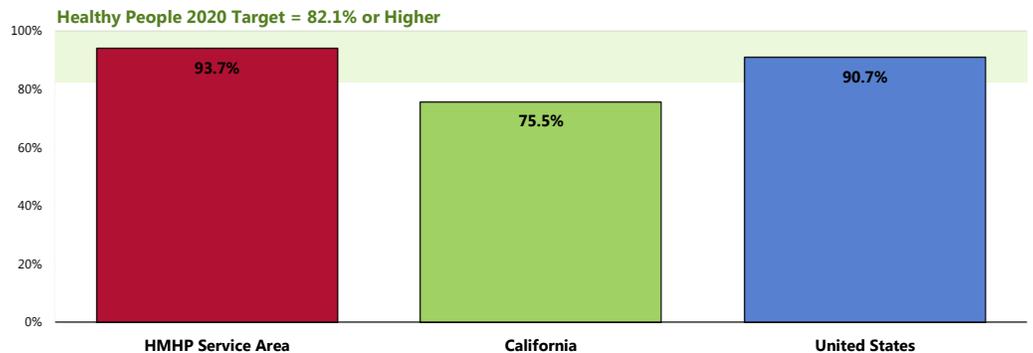
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
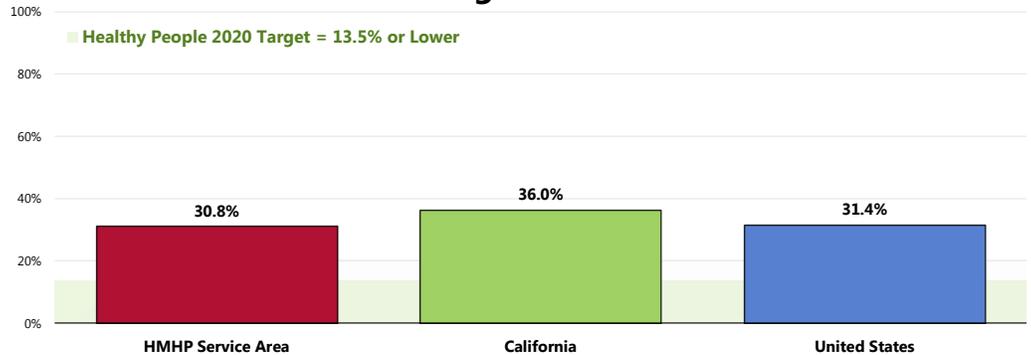● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]
Notes: ● Asked of all respondents.

Adults under age 40 report <u>lower</u> screening levels (note the correlation with age).

Have Had Blood
Cholesterol Levels Checked in the Past Five Years
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Healthy People 2020 Target = 82.1% or Higher

Category	Value
Men	92.9%
Women	94.4%
18 to 39	89.7%
40 to 64	95.0%
65+	99.6%
Very Low Income	92.0%
Low Income	90.2%
Mid/High Income	95.4%
White	94.7%
Hispanic	92.9%
Other	91.6%
HMHP Svc Area	93.7%

Sources:
● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]
Notes:
● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Self-Reported High Blood Cholesterol

A total of 30.8% of adults have been told by a health professional that their cholesterol level was high.

- More favorable than the California findings.

- Similar to the national prevalence.

- More than twice the Healthy People 2020 target (13.5% or lower).
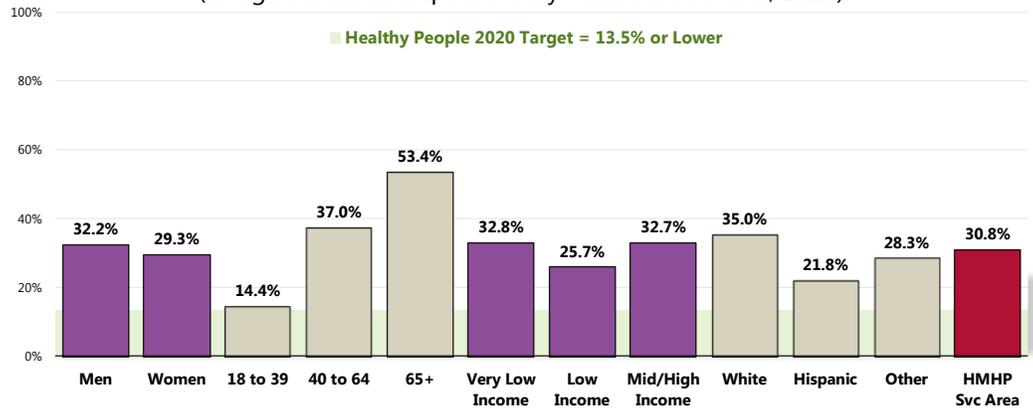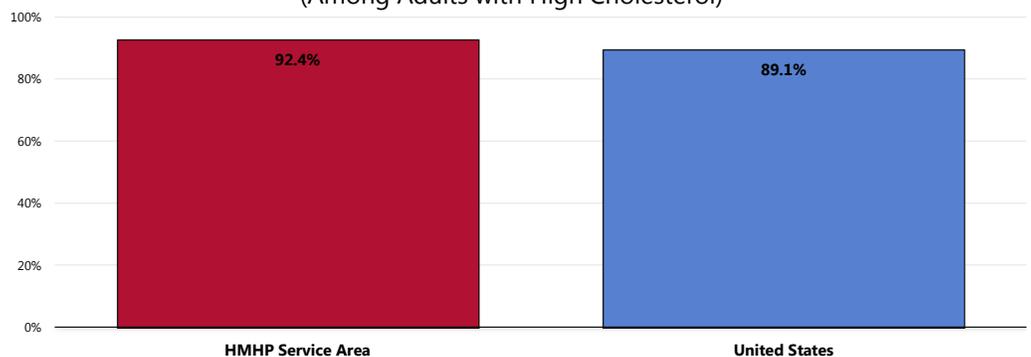
Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower

HMHP Service Area	California	United States
30.8%	36.0%	31.4%

Sources:
● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]
Notes:
● Asked of all respondents.
● *The California data reflects those adults who have been tested for high cholesterol <u>and</u> who have been diagnosed with it.

Note that 10.7% of HMHP Service Area adults report not having high blood cholesterol, but: 1) have never had their blood cholesterol levels tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

👫 Note the positive correlation between age and high blood cholesterol.

Prevalence of High Blood Cholesterol
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Healthy People 2020 Target = 13.5% or Lower

	Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
	32.2%	29.3%	14.4%	37.0%	53.4%	32.8%	25.7%	32.7%	35.0%	21.8%	28.3%	30.8%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

High Cholesterol Management

Among adults who have been told that their blood cholesterol was high, 92.4% report that they are currently taking actions to control their cholesterol levels.

● Comparable to that found nationwide.

Respondents reporting high cholesterol were further asked:

"Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"

Taking Action to Control High Blood Cholesterol Levels
(Among Adults with High Cholesterol)

HMHP Service Area	United States
92.4%	89.1%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 51]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents who have been diagnosed with high blood cholesterol levels.
• In this case, the term "action" refers to medication, change in diet, and/or exercise.

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

    – National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

    – National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Total Cardiovascular Risk

A total of 75.9% of HMHP Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Notably lower than national findings.

Present One or More Cardiovascular Risks or Behaviors

	HMHP Service Area	United States
	75.9%	86.3%
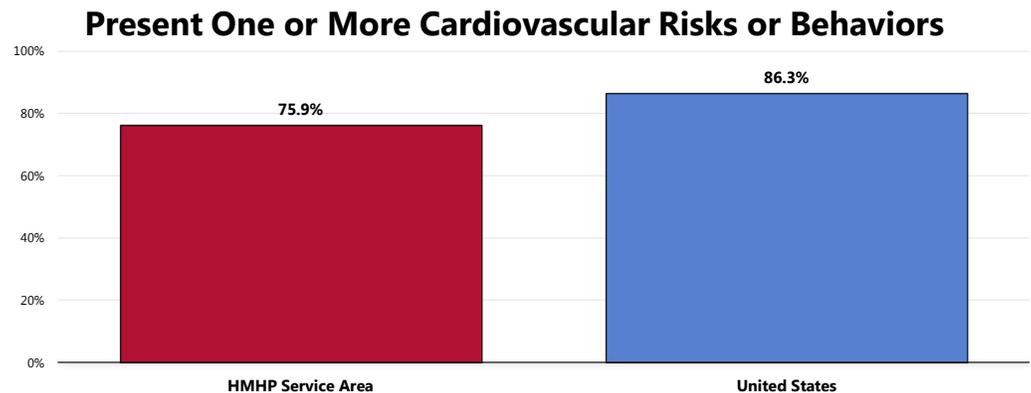
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
         • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
         • Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
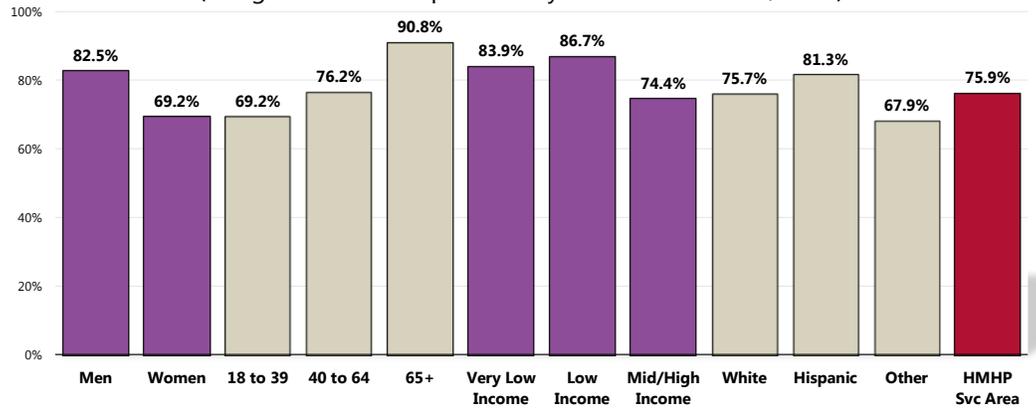
Adults more likely to exhibit cardiovascular risk factors include:

- 👫 Men.

- 👫 Seniors.

- 👫 Adults living in the lower income categories.

- 👫 Hispanic adults.

Present One or More Cardiovascular Risks or Behaviors
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Category	Percent
Men	82.5%
Women	69.2%
18 to 39	69.2%
40 to 64	76.2%
65+	90.8%
Very Low Income	83.9%
Low Income	86.7%
Mid/High Income	74.4%
White	75.7%
Hispanic	81.3%
Other	67.9%
HMHP Svc Area	75.9%

Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:
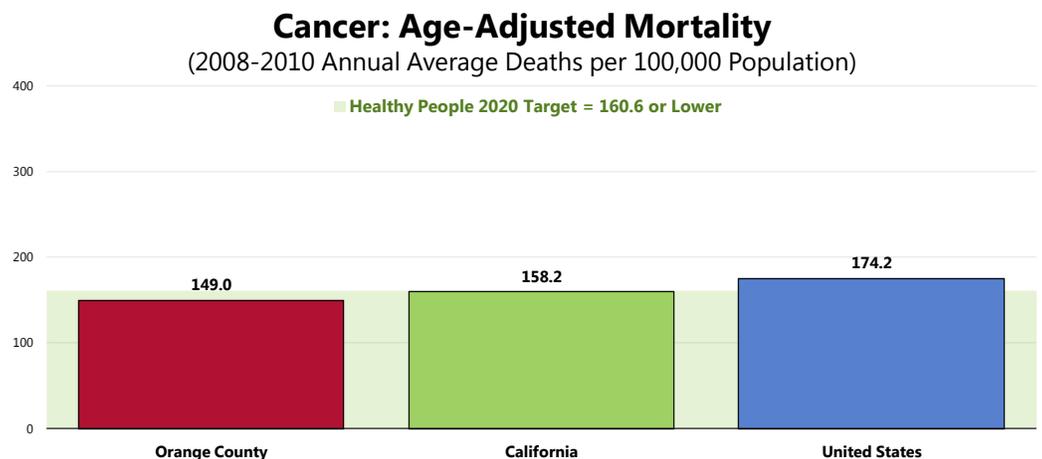
- Breast cancer (using mammography)

- Cervical cancer (using Pap tests)

- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

 – Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2008 and 2010, there was an annual average age-adjusted cancer mortality rate of 149.0 deaths per 100,000 population in Orange County.

- More favorable than the statewide rate.

- More favorable than the national rate.

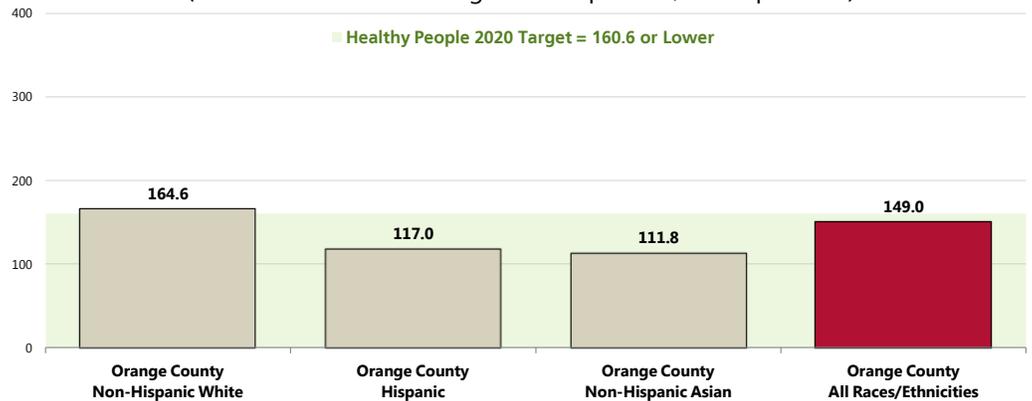- Satisfies the Healthy People 2020 target of 160.6 or lower.

Cancer: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 160.6 or Lower

	Orange County	California	United States
	149.0	158.2	174.2

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.

The cancer mortality rate is notably higher among Whites than among Hispanics and Asians in Orange County.

Cancer: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 160.6 or Lower

	Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
Rate	164.6	117.0	111.8	149.0

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
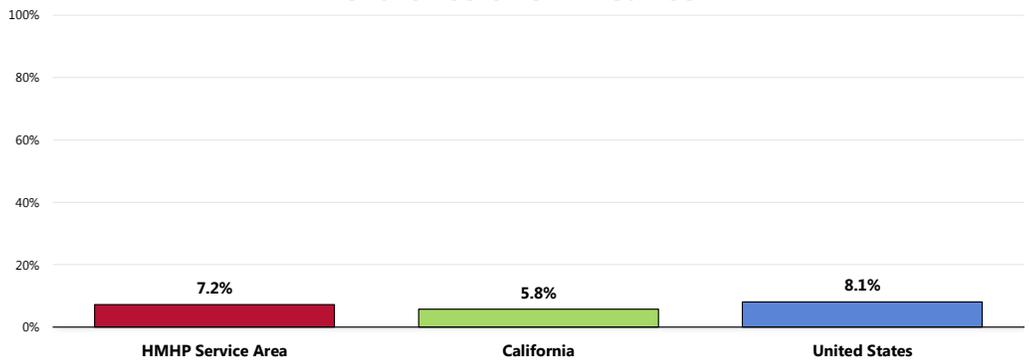● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in Orange County.

Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both genders).

As can be seen in the following chart (referencing 2008-2010 annual average age-adjusted death rates):

- The Orange County **lung cancer** death rate is <u>lower than</u> both the state and national rates.

- The county's **prostate cancer** death rate is <u>lower</u> than both the state and national rates.

- The Orange County **female breast cancer** death rate is comparable to both the California and US rates.

- The **colorectal cancer** death rate is <u>lower</u> than both the state and national rates.

Note that the Orange County lung and colorectal cancer rates satisfy the related Healthy People 2020 targets (the prostate and female breast cancer rates are similar to their respective goals).

Age-Adjusted Cancer Death Rates by Site
(2008-2010 Annual Average Deaths per 100,000 Population)

	Orange County	California	US	HP2020
Lung Cancer	35.1	37.6	50.5	45.5
Prostate Cancer	20.8	22.0	22.3	21.2
Female Breast Cancer	21.3	21.6	22.3	20.6
Colorectal Cancer	13.1	14.7	16.1	14.5

Prevalence of Cancer

Skin Cancer

A total of 7.2% of surveyed HMHP Service Area adults report having been diagnosed with skin cancer.

- Statistically similar to the state prevalence.
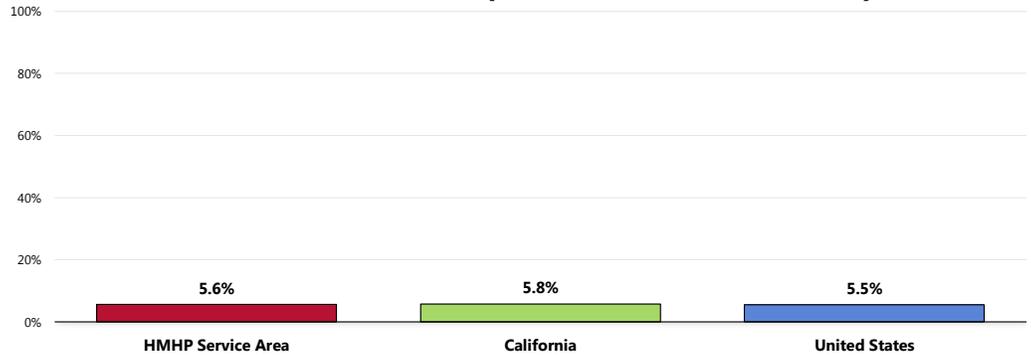- Similar to the national average.

Prevalence of Skin Cancer

Other Cancer

A total of 5.6% of respondents have been diagnosed with some type of (non-skin) cancer.

- Similar to the California prevalence.
- Similar to the US prevalence.

Prevalence of Cancer (Other Than Skin Cancer)

	HMHP Service Area	California	United States
	5.6%	5.8%	5.5%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 28]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.

- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to four cancer sites: prostate cancer (prostate-specific antigen testing and digital rectal examination); female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Prostate Cancer Screenings

The US Preventive Services Task Force (USPSTF) concludes that the current evidence is <u>insufficient</u> to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years.

Rationale: Prostate cancer is the most common nonskin cancer and the second-leading cause of cancer death in men in the United States. The USPSTF found convincing evidence that prostate-specific antigen (PSA) screening can detect some cases of prostate cancer.

In men younger than age 75 years, the USPSTF found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes compared with treatment after clinical detection.

The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate-to-substantial harms, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime.

There is also adequate evidence that the screening process produces at least small harms, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results.

The USPSTF recommends against screening for prostate cancer in men age 75 years or older.

Rationale: In men age 75 years or older, the USPSTF found adequate evidence that the incremental benefits of treatment for prostate cancer detected by screening are small to none.

Given the uncertainties and controversy surrounding prostate cancer screening in men younger than age 75 years, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment. Men should be informed of the gaps in the evidence and should be assisted in considering their personal preferences before deciding whether to be tested.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

PSA Testing and/or Digital Rectal Examination

Among men age 50 and older, just over three-fourths (76.5%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

- Statistically similar to national findings.

Note: Due to recent (2008) changes in clinical recommendations against routine PSA testing, it is anticipated that testing levels will begin to decline.

Have Had a Prostate Screening in the Past Two Years
(Among Men 50+)

HMHP Service Area	United States
76.5%	70.5%
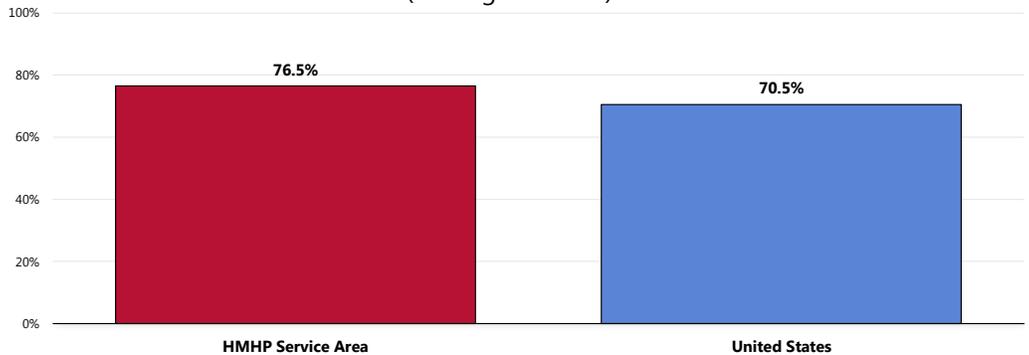
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all male respondents 50 and older.

Female Breast Cancer Screening

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

–   US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Mammography

Among women age 50-74, 76.7% had a mammogram within the past two years.

- Similar to statewide findings (which represent all women 50+).
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- Among women 40+, 71.3% had a mammogram in the past two years.

Have Had a Mammogram in the Past Two Years
(Among Women 50-74)

Healthy People 2020 Target = 81.1% or Higher

HMHP Service Area	California *	United States
76.7%	81.4%	79.9%

Women 40+ = 71.3%
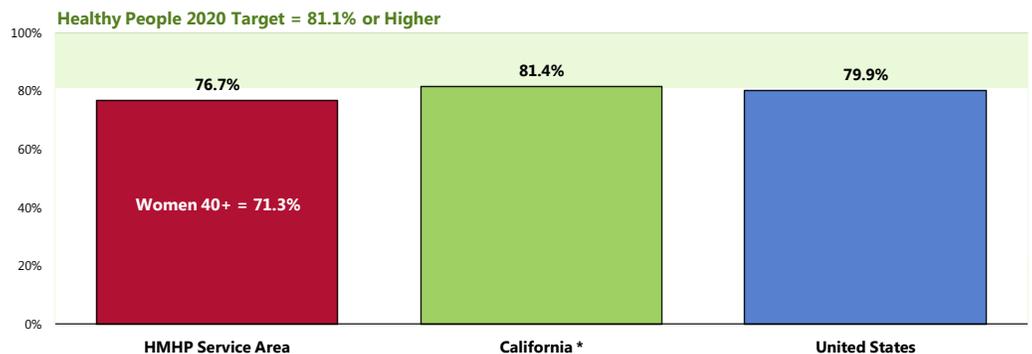
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 152-153]
        ● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
        ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
        ● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]
Notes: ● Reflects female respondents 50 to 74.
        ● *Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).

Cervical Cancer Screenings

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Pap Smear Testing

Among women age 21 to 65, 83.4% had a Pap smear within the past three years.

- Comparable to California findings (which represents all women 18+).
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).

Have Had a Pap Smear in the Past Three Years
(Among Women 21-65)

Healthy People 2020 Target = 93.0% or Higher

HMHP Service Area	California*	United States
83.4%	80.8%	84.7%
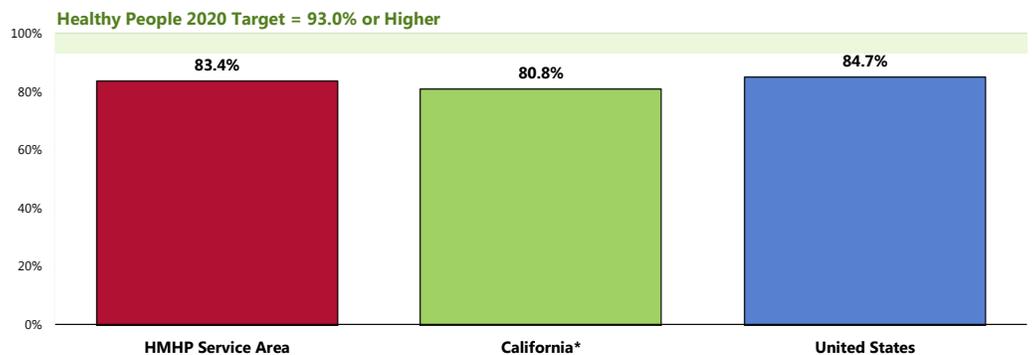
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes:
- Reflects female respondents age 21-65.
- *Note that the California percentage represents all women 18 and older.

Colorectal Cancer Screenings

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screening

Among adults age 50-75, 72.8% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/ colonoscopy [lower endoscopy] within the past 10 years).
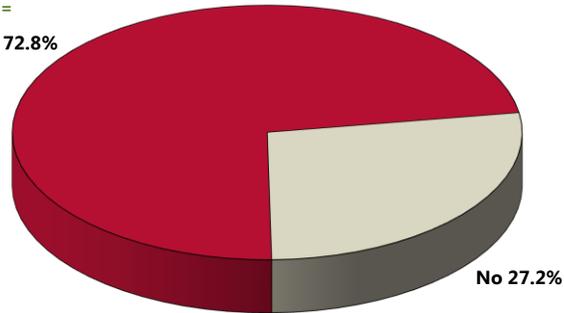
- Comparable to the Healthy People 2020 target (70.5% or higher).

Have Had a Colorectal Cancer Screening
(Among Hoag Memorial Hospital Presbyterian Service Area Adults 50-75, 2011)

Healthy People 2020 Target = 70.5% or Higher

Yes 72.8%

No 27.2%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
          • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]
Notes: • Asked of all respondents age 50 through 75.
        • In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.
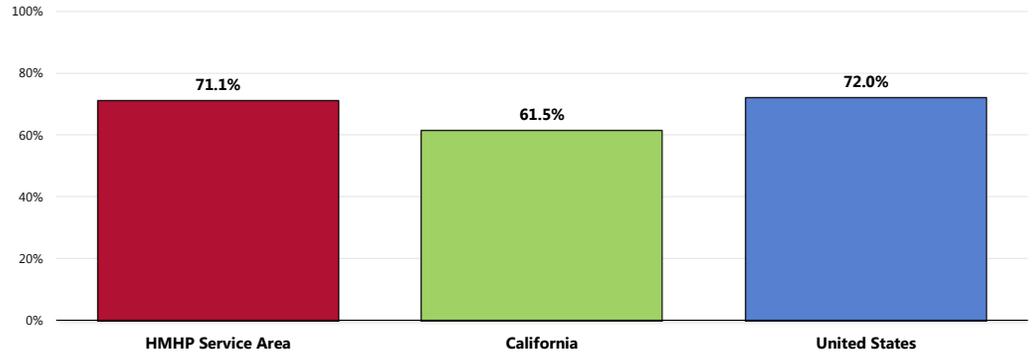
Lower Endoscopy

Among adults age 50 and older, 71.1% have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.

- More favorable than California findings.
- Comparable to national findings.

Have Ever Had a Lower Endoscopy Exam
(Among Adults 50+)

Category	Percentage
HMHP Service Area	71.1%
California	61.5%
United States	72.0%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents 50+.
- Lower endoscopy includes either sigmoidoscopy or colonoscopy.

Blood Stool Testing

Among adults age 50 and older, 35.1% have had a blood stool test (aka "fecal occult blood test") within the past two years.

- Higher than California findings.
- Higher than national findings.

Have Had a Blood Stool Test in the Past Two Years
(Among Adults 50+)

Category	Percentage
HMHP Service Area	35.1%
California	27.0%
United States	28.3%
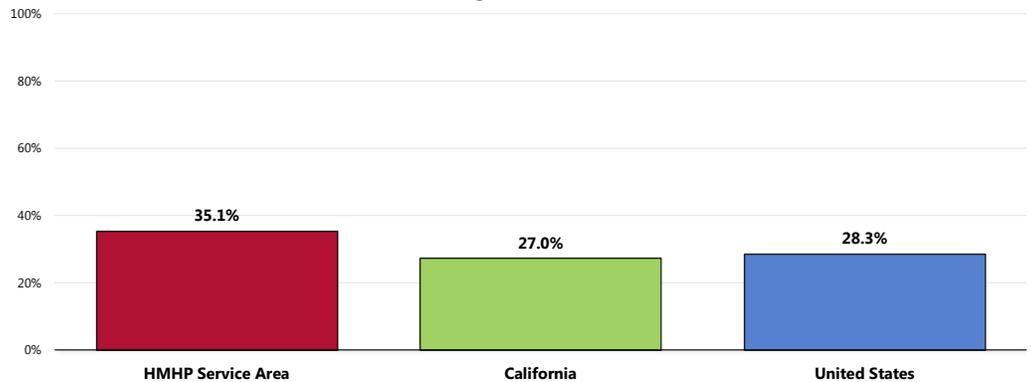
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents 50+.

Respiratory Disease

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

Several additional respiratory conditions and respiratory hazards, including infectious agents and occupational and environmental exposures, are covered in other areas of Healthy People 2020. Examples include tuberculosis, lung cancer, acquired immunodeficiency syndrome (AIDS), pneumonia, occupational lung disease, and smoking. Sleep Health is now a separate topic area of Healthy People 2020.

Currently in the United States, more than 23 million people have asthma. Approximately 13.6 million adults have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

– Healthy People 2020 (www.healthypeople.gov)

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2008 and 2010, there was an annual average age-adjusted CLRD mortality rate of 32.9 deaths per 100,000 population in Orange County.

- Lower than found statewide.
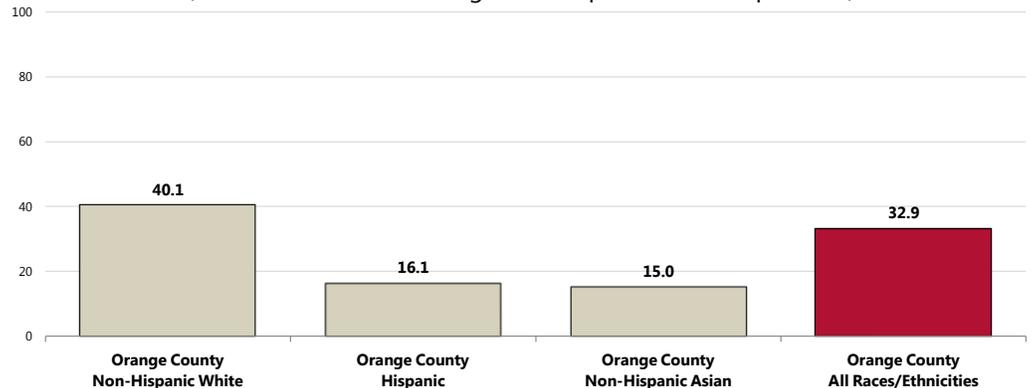- Lower than the national rate.

CLRD: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)
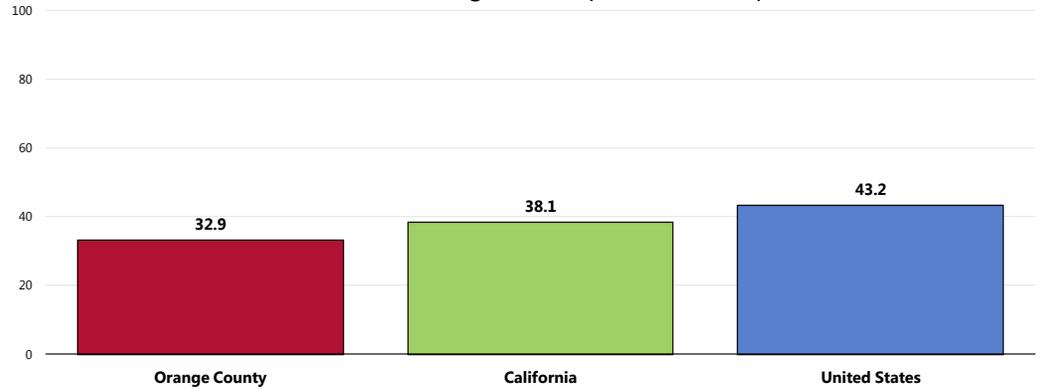
Orange County	California	United States
32.9	38.1	43.2

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.
● CLRD is chronic lower respiratory disease.

CLRD mortality is notably higher among Orange County Whites than among Hispanics and Asians.

CLRD: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
40.1	16.1	15.0	32.9

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.
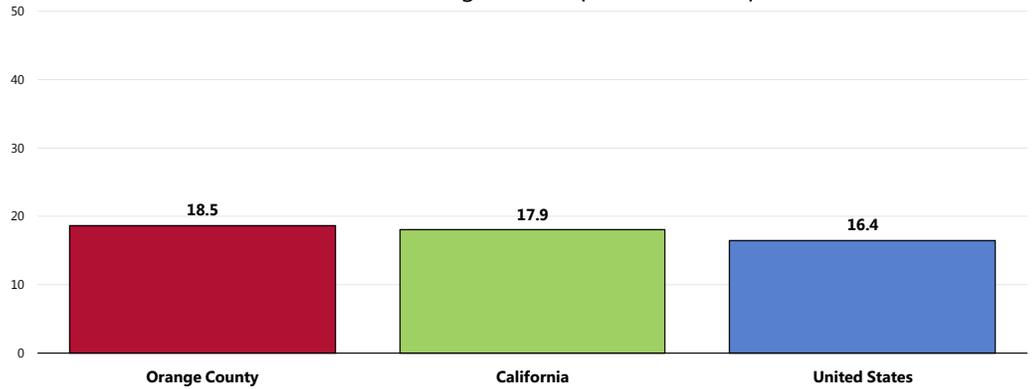● CLRD is chronic lower respiratory disease.

For prevalence of vaccinations for pneumonia and influenza, see also "Immunization & Infectious Disease."

Between 2008 and 2010, there was an annual average age-adjusted pneumonia/ influenza mortality rate of 18.5 deaths per 100,000 population in Orange County.

● Comparable to the state rate.
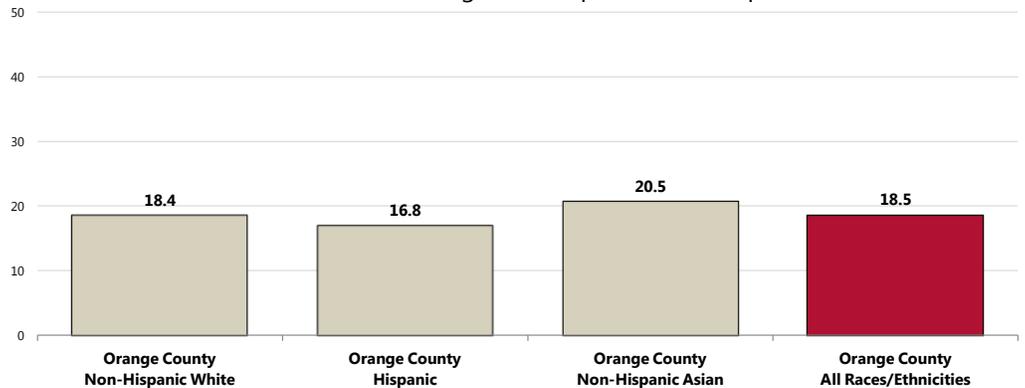
● Higher than the national rate.

Pneumonia/Influenza: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Orange County	California	United States
18.5	17.9	16.4

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

👪 The pneumonia/influenza mortality rate in Orange County is higher among Asians.

Pneumonia/Influenza: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
18.4	16.8	20.5	18.5

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

Prevalence of Respiratory Conditions

Nasal/Hay Fever Allergies

A total of 17.6% of HMHP Service Area adults currently suffer from or have been diagnosed with nasal/hay fever allergies.

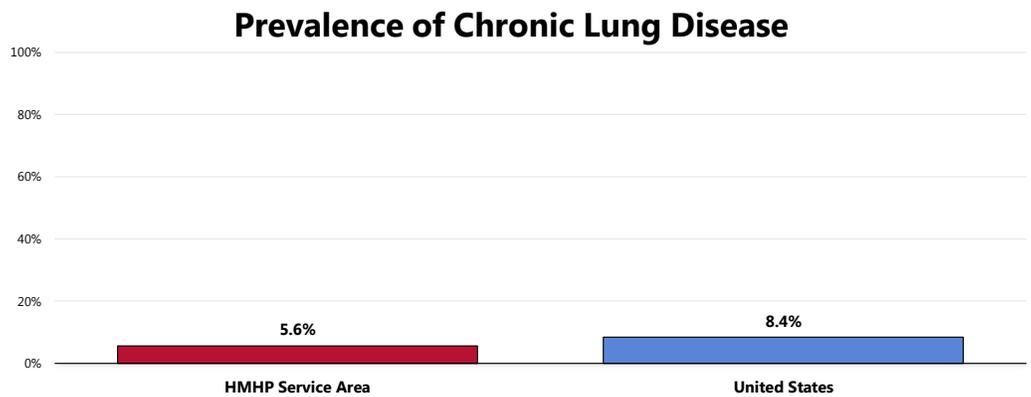● Well below the national prevalence.

Prevalence of Nasal/Hay Fever Allergies

	HMHP Service Area	United States
	17.6%	27.3%
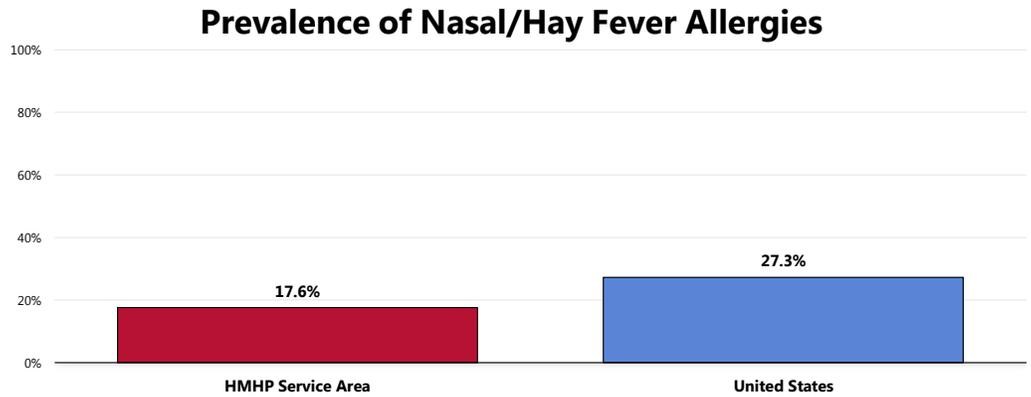
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Chronic Lung Disease

A total of 5.6% of HMHP Service Area adults suffer from chronic lung disease.

● Lower than the national prevalence.

Prevalence of Chronic Lung Disease

	HMHP Service Area	United States
	5.6%	8.4%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
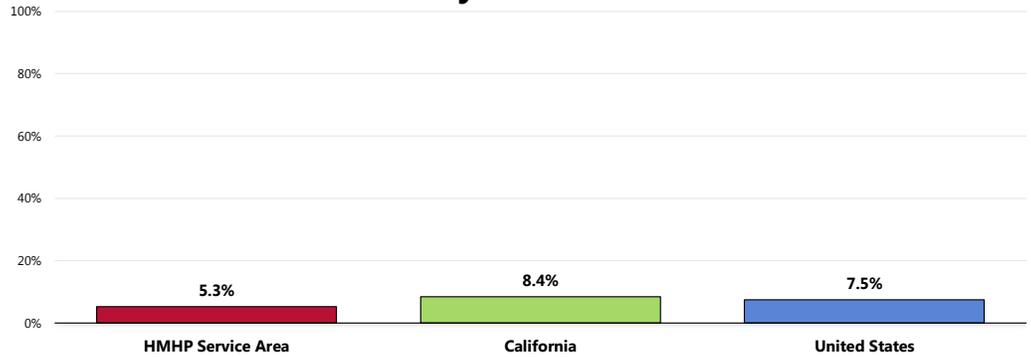Notes: ● Asked of all respondents.

Adults

A total of 5.3% of HMHP Service Area adults currently suffer from asthma.

● Better than the statewide prevalence.

● Similar to the national prevalence.

Currently Have Asthma

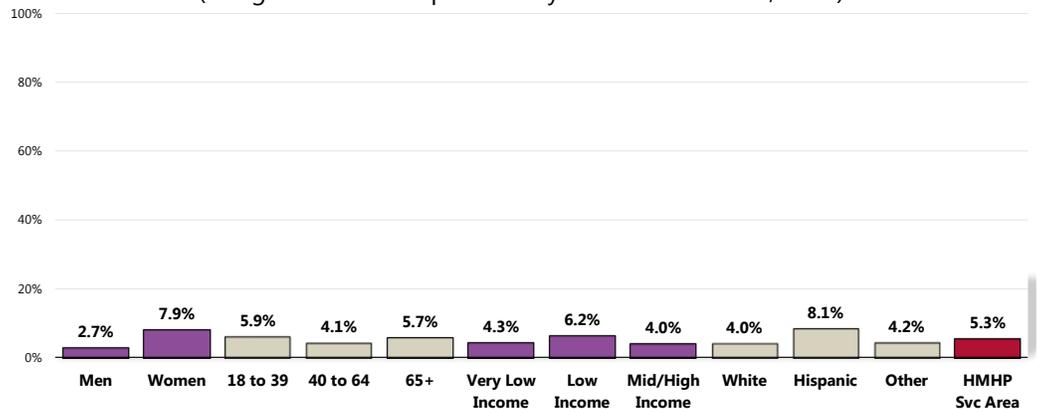|	HMHP Service Area	California	United States
	5.3%	8.4%	7.5%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 159]
　　　　● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
　　　　● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
Notes: ● Asked of all respondents.

👫 Women in the service area are statistically more likely to suffer from asthma.

Currently Have Asthma
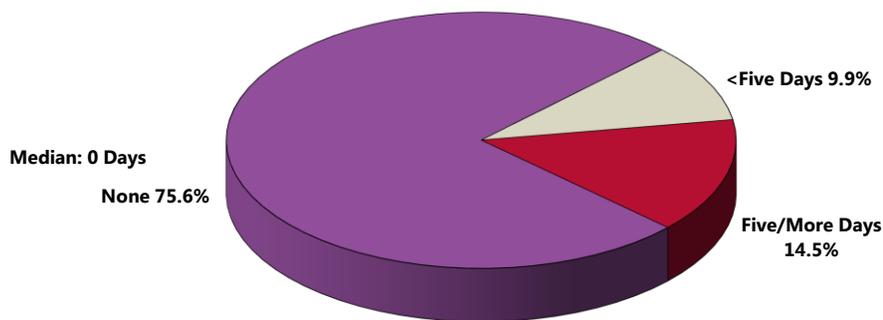(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
2.7%	7.9%	5.9%	4.1%	5.7%	4.3%	6.2%	4.0%	4.0%	8.1%	4.2%	5.3%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 159]
Notes: ● Asked of all respondents.
　　　　● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
　　　　● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

A total of 14.5% of respondents with asthma report <u>5 or more days</u> in the past year on which they were unable to work or carry out their usual activities because of their asthma.

Number of Days in Past Year
on Which Asthma Interfered With Work or Usual Activities
(Among HMHP Service Area Adults w/Asthma, 2013)

<Five Days 9.9%

Median: 0 Days

None 75.6%

Five/More Days
14.5%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]
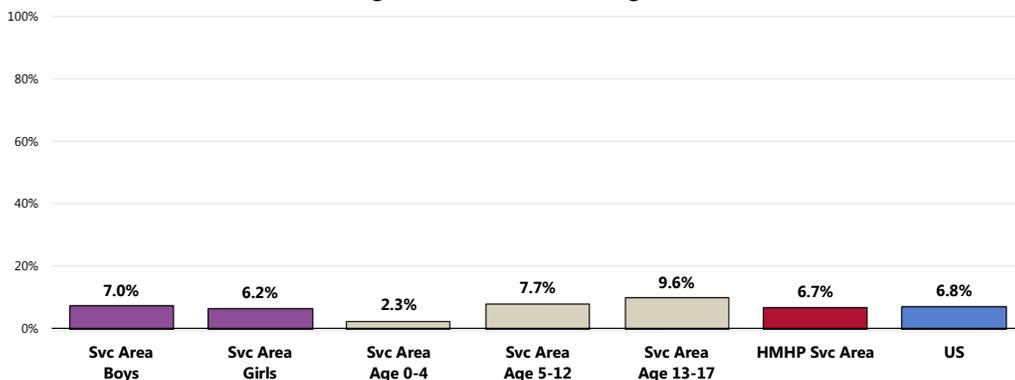Notes: • Asked of all respondents with asthma.

Children

Among HMHP Service Area children under age 18, 6.7% currently have asthma.

- Nearly identical to the national figure.

- Similar by gender, higher among children age 5 and up.

Child Currently Has Asthma
(Among Parents of Children Age 0-17)

	Svc Area Boys	Svc Area Girls	Svc Area Age 0-4	Svc Area Age 5-12	Svc Area Age 13-17	HMHP Svc Area	US
	7.0%	6.2%	2.3%	7.7%	9.6%	6.7%	6.8%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 160]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

A total of 14.5% of respondents with asthma report <u>5 or more days</u> in the past year on which they were unable to work or carry out their usual activities because of their asthma.

Number of Days in Past Year
on Which Asthma Interfered With Work or Usual Activities
(Among HMHP Service Area Adults w/Asthma, 2013)

<Five Days 9.9%

Median: 0 Days

None 75.6%

Five/More Days
14.5%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]
Notes: • Asked of all respondents with asthma.

Children

Among HMHP Service Area children under age 18, 6.7% currently have asthma.

- Nearly identical to the national figure.

- Similar by gender, higher among children age 5 and up.

Child Currently Has Asthma
(Among Parents of Children Age 0-17)

	Svc Area Boys	Svc Area Girls	Svc Area Age 0-4	Svc Area Age 5-12	Svc Area Age 13-17	HMHP Svc Area	US
	7.0%	6.2%	2.3%	7.7%	9.6%	6.7%	6.8%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 160]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Professional Research Consultants, Inc.

74

Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death

- Disability

- Poor mental health

- High medical costs

- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment

- Improvements in product safety

- Legislation and enforcement

- Education and behavior change

- Technology and engineering

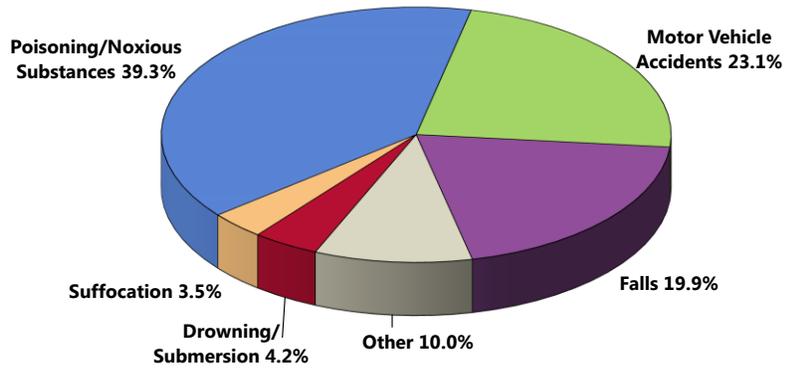Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence

- Improving problem-solving skills (for example, parenting, conflict resolution, coping)

- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Poisoning/noxious substances (including the ingestion of toxins, as well as unintentional drug overdoses) **was the leading cause of accidental death in Orange County during 2008-2010. Motor vehicle accidents and falls also accounted for a significant share of accidental deaths.**

Leading Causes of Accidental Death
(Orange County, 2008-2010)

Poisoning/Noxious Substances 39.3%

Motor Vehicle Accidents 23.1%

Suffocation 3.5%

Drowning/ Submersion 4.2%

Other 10.0%

Falls 19.9%

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2008 and 2010, there was an annual average age-adjusted unintentional injury mortality rate of 23.3 deaths per 100,000 population in Orange County.

- More favorable than the California rate.

- More favorable than the national rate.

- Satisfies the Healthy People 2020 target (36.0 or lower).

Unintentional Injuries: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.0 or Lower

	Orange County	California	United States
	23.3	28.9	38.2

The mortality rate is notably higher among Whites when compared with Hispanics and Asians in Orange County.

Unintentional Injuries: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.0 or Lower

	30.5	19.3	13.1	23.3
	Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
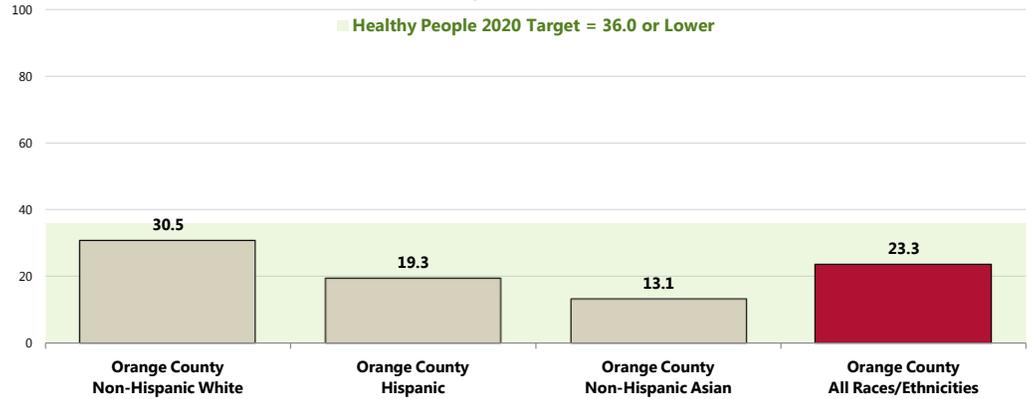
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
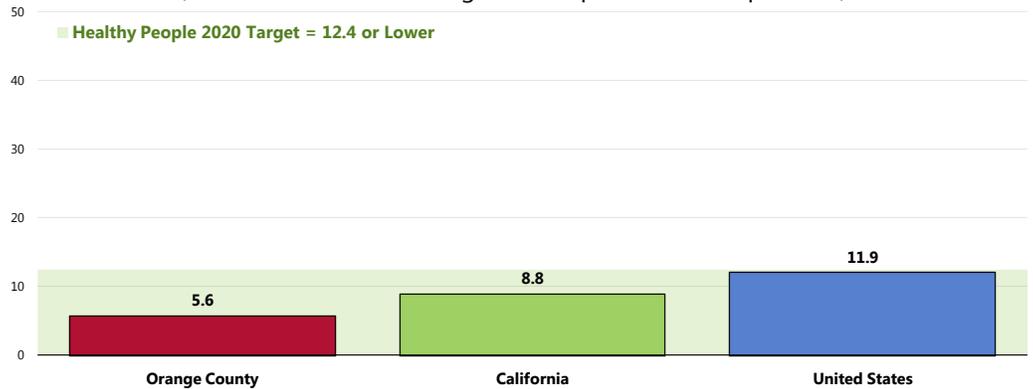• Local, state and national data are simple three-year averages.

Motor Vehicle Safety

Age-Adjusted Motor-Vehicle Related Deaths

Between 2008 and 2010, there was an annual average age-adjusted motor vehicle crash mortality rate of 5.6 deaths per 100,000 population in Orange County.

- Lower than found statewide.
- Much lower than found nationally.
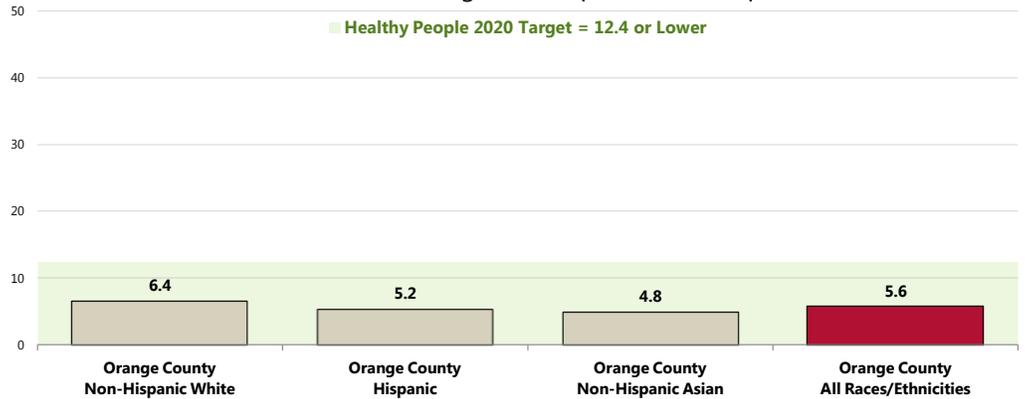- Satisfies the Healthy People 2020 target (12.4 or lower).

Motor Vehicle Crashes: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 12.4 or Lower

5.6	8.8	11.9
Orange County	California	United States

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

The Orange County motor vehicle crash mortality rate is higher among Whites than among Hispanics and Asians.

Motor Vehicle Crashes: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 12.4 or Lower

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
6.4	5.2	4.8	5.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

Children's Seat Belt Usage

A full 92.8% of HMHP Service Area parents report that their child (age 0 to 17) "always" wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

● Statistically similar to what is found nationally.

Child "Always" Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle
(Among Parents of Children Age 0-17)

HMHP Service Area	United States
92.8%	91.6%
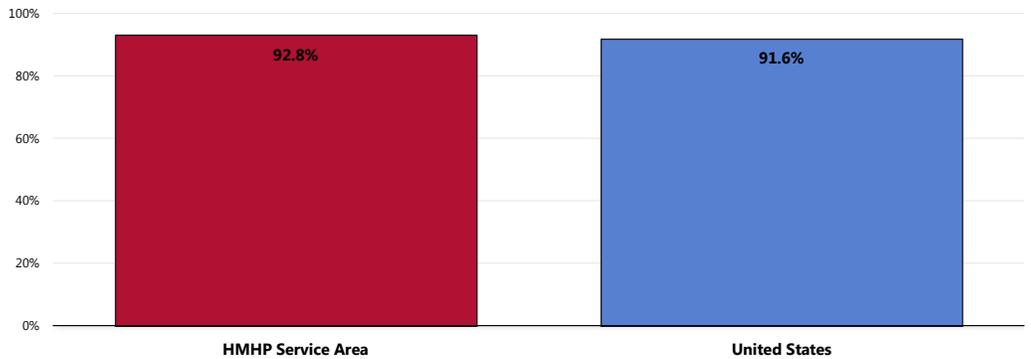
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 139]
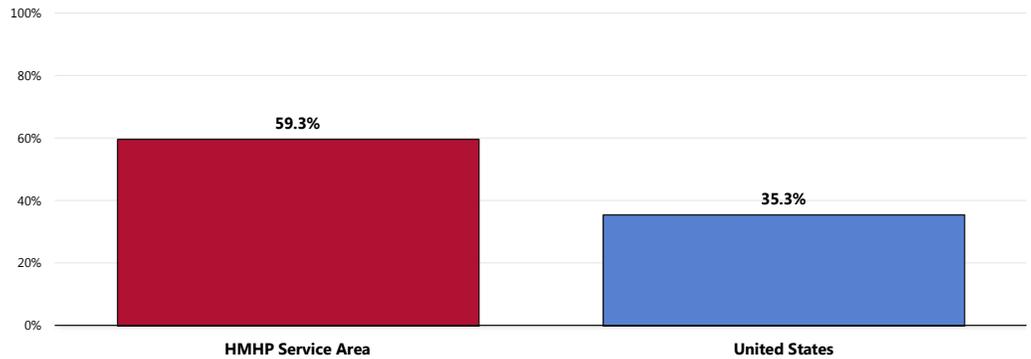● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
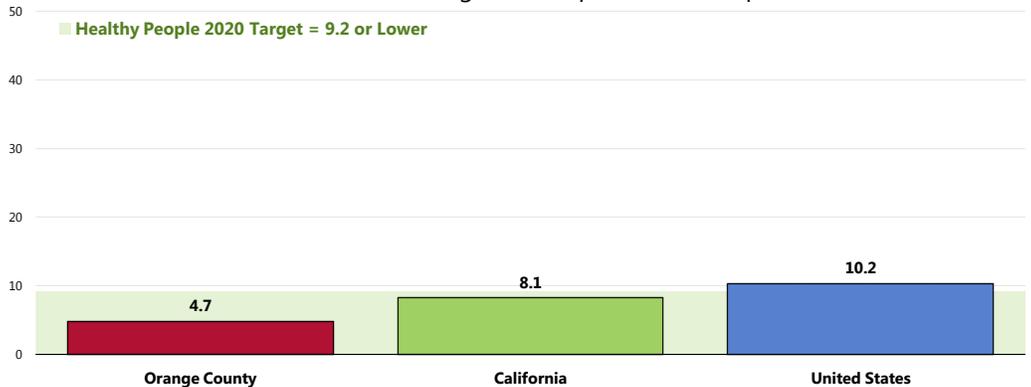Notes: ● Asked of all respondents with children 0 to 17 in the household.

Nearly 6 in 10 HMHP Service Area children age 5 to 17 (59.3%) are reported to "always" wear a helmet when riding a bicycle.

- Much higher than the national prevalence.

Child "Always" Wears a Helmet When Riding a Bicycle
(Among Parents of Children Age 5-17)

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children age 5 to 17 at home.

Firearm Safety

Age-Adjusted Firearm-Related Deaths

Between 2008 and 2010, there was an annual average age-adjusted rate of 4.7 deaths per 100,000 population due to firearms in Orange County.

- Lower than found statewide.

- Lower than found nationally.

- Satisfies the Healthy People 2020 objective (9.2 or lower).

Firearms-Related Deaths: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)
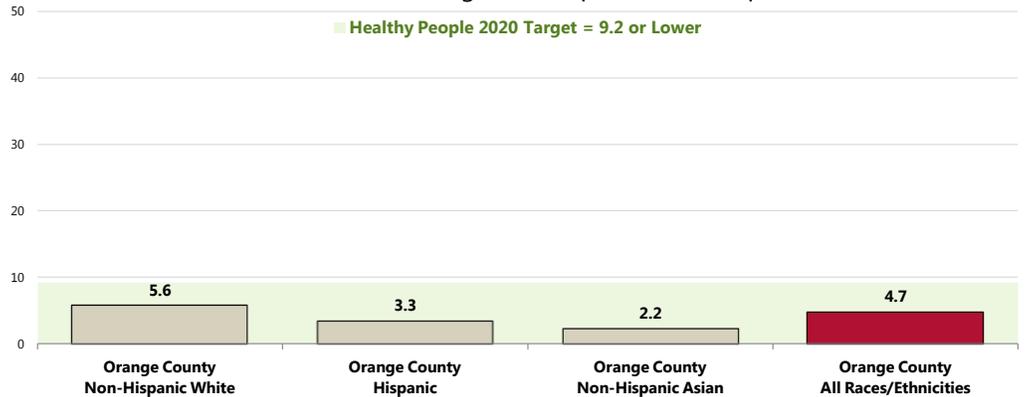
Healthy People 2020 Target = 9.2 or Lower

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● Local, state and national data are simple three-year averages.

👪 The county's firearm-related mortality rate is higher among Whites than among Hispanics and Asians.

Firearms-Related Deaths: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.2 or Lower

5.6	3.3	2.2	4.7
Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

Presence of Firearms in Homes

Overall, 17.2% of HMHP Service Area adults have a firearm kept in or around their home.

- Much lower than the national prevalence.

👪 Among HMHP Service Area households with children, 15.0% have a firearm kept in or around the house (more favorable than reported nationally).

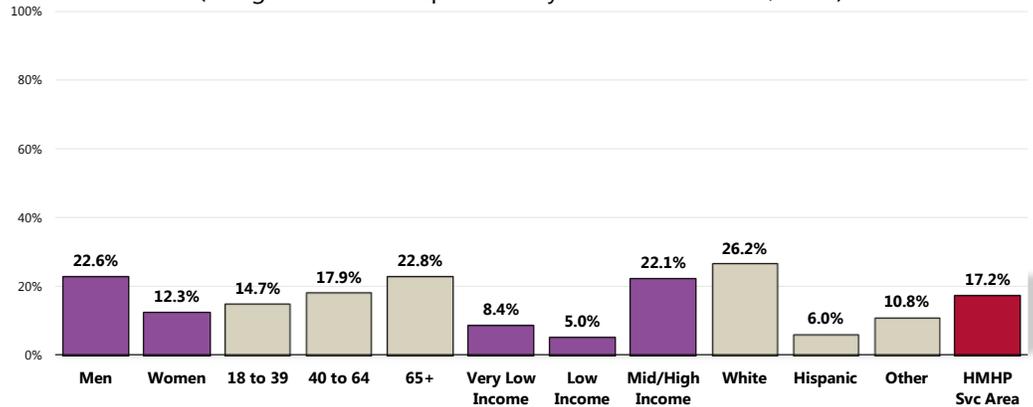Survey respondents were further asked about the presence of weapons in the home:

"Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, 'firearms' include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire."

Have a Firearm Kept in or Around the Home

Households With Children: 15.0% (vs. 34.4% nationwide)

HMHP Service Area	United States
17.2%	37.9%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 57, 161]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

Reports of firearms in or around the home are <u>more</u> prevalent among the following respondent groups:

👪 Men.

👪 Higher-income households.

👪 White respondents.

Have a Firearm Kept in or Around the House
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	22.6%	
Women	12.3%	
18 to 39	14.7%	
40 to 64	17.9%	
65+	22.8%	
Very Low Income	8.4%	
Low Income	5.0%	
Mid/High Income	22.1%	
White	26.2%	
Hispanic	6.0%	
Other	10.8%	
HMHP Svc Area	17.2%	

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 57]
Notes: ● Asked of all respondents.
● In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Between 2008 and 2010, there was an annual average age-adjusted homicide rate of 2.4 deaths per 100,000 population in Orange County.

● More favorable than the rate found statewide.

● More favorable than the national rate.

● Satisfies the Healthy People 2020 target of 5.5 or lower.

RELATED ISSUE:
See also *Suicide* in the **Mental Health & Mental Disorders** section of this report.
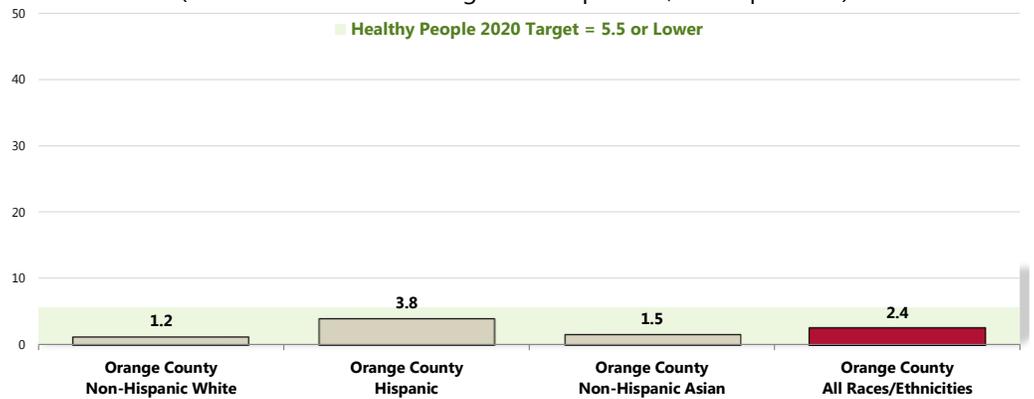
Homicide: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)
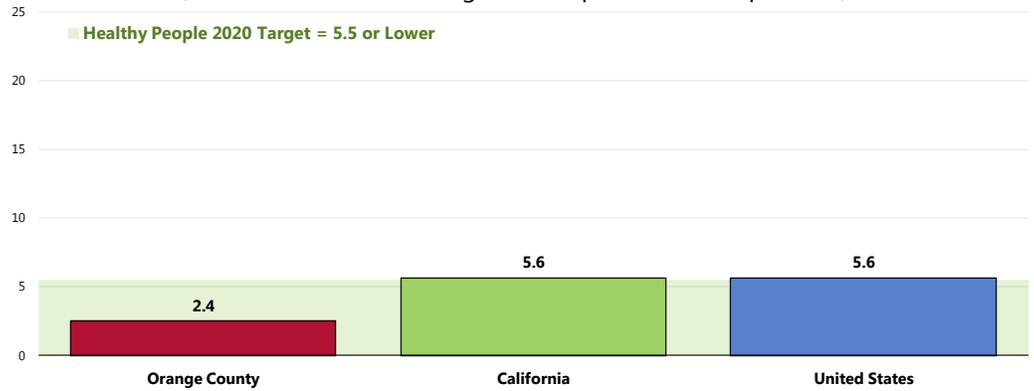
Healthy People 2020 Target = 5.5 or Lower

Orange County	California	United States
2.4	5.6	5.6

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

The homicide rate is higher among Hispanics in Orange County.

Homicide: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 5.5 or Lower

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
1.2	3.8	1.5	2.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.

Violent Crime Rates

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Between 2009 and 2011, there was an annual average violent crime rate of 229.6 offenses per 100,000 population in Orange County.

- Well below the California rate for the same period.
- Well below the national rate.

Violent Crime Rates
(2009-2011 Annual Average Offenses per 100,000 Population)

Orange County: 229.6
California: 441.2
United States: 407.3
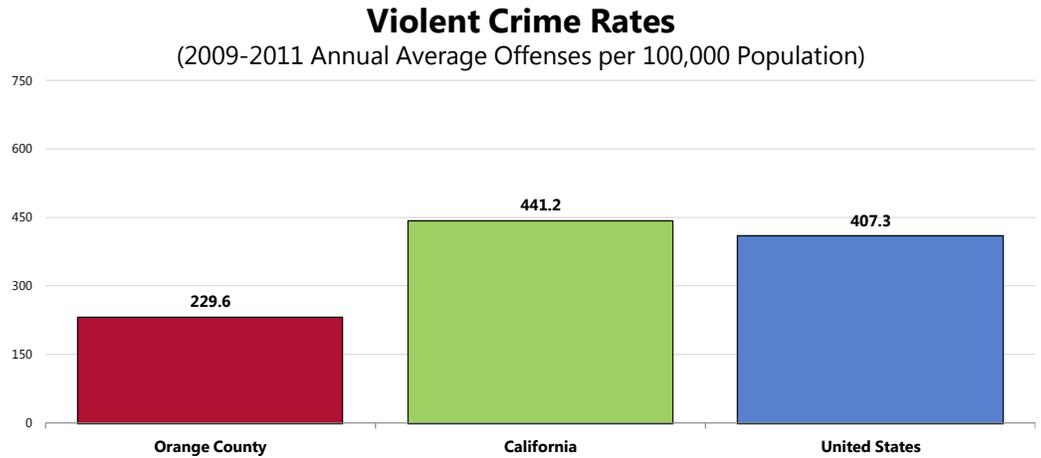
Sources: • State of California Department of Justice, Criminal Justice Statistics Center
• US Department of Justice, Federal Bureau of Investigation
Notes: • Rates are offenses per 100,000 population among agencies reporting.

Experience With Violent Crime

According to survey data, 2.3% of HMHP Service Area adults acknowledge being the victim of a violent crime in the past five years.

- Statistically similar to national findings.

Victim of a Violent Crime in the Past Five Years

HMHP Service Area: 2.3%
United States: 1.6%
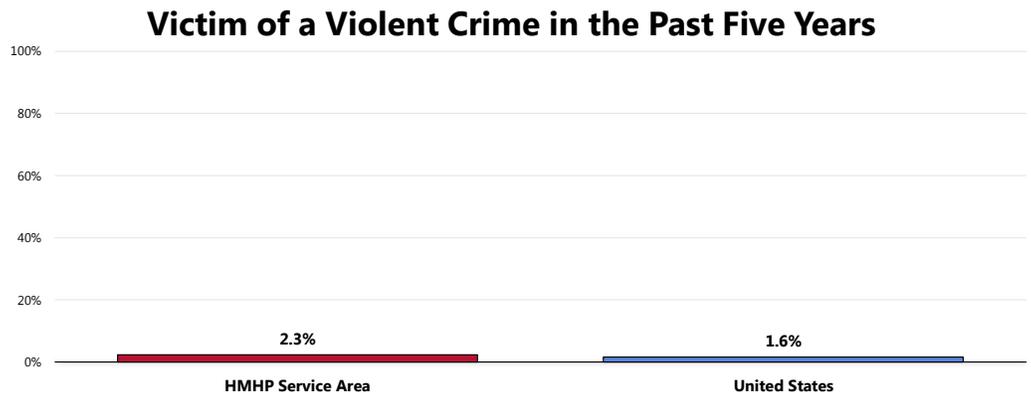
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

👪 Reports of violence are notably higher among residents living in the lower income categories.

Victim of a Violent Crime in the Past Five Years
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
1.7%	2.9%	3.7%	2.0%	0.0%	4.7%	4.7%	1.2%	1.1%	5.3%	1.8%	2.3%
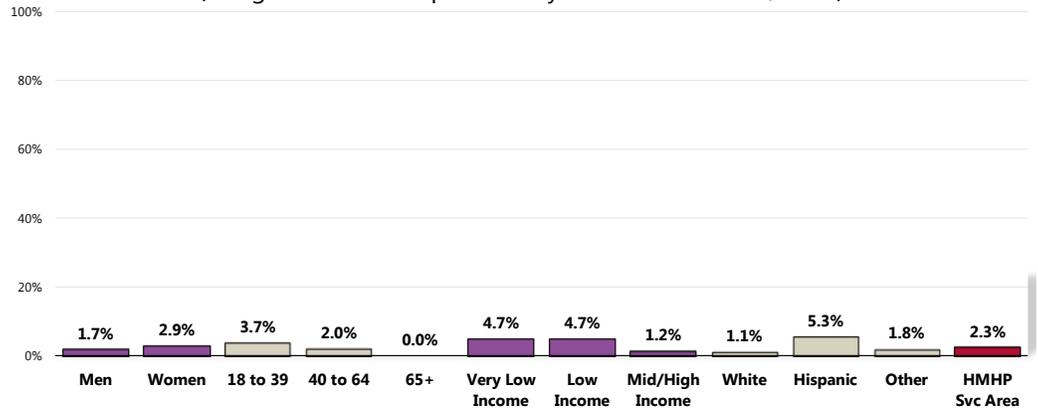
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Rating of Neighborhood Safety

When asked to rate their feelings of safety when walking in their neighborhood, 73.5% of survey respondents gave "excellent" or "very good" ratings.

● Another 16.8% of adults gave "good" ratings to their neighborhood safety.

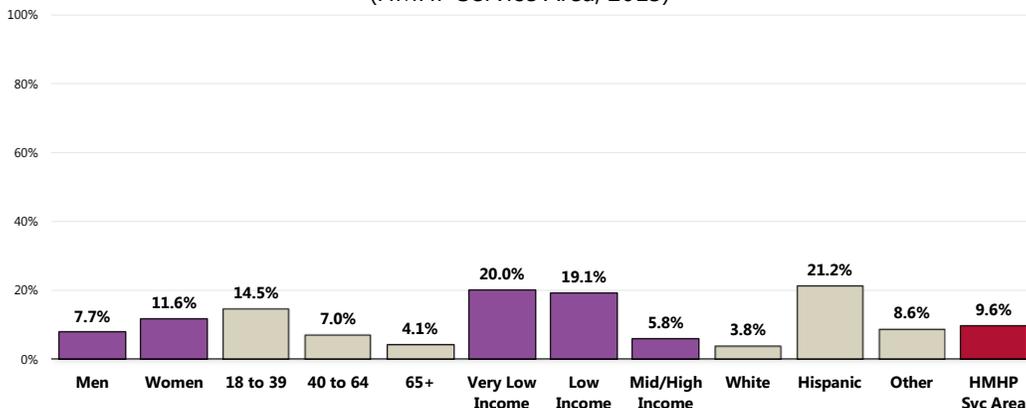## Rating of Neighborhood's Safety and Security
(HMHP Service Area, 2013)
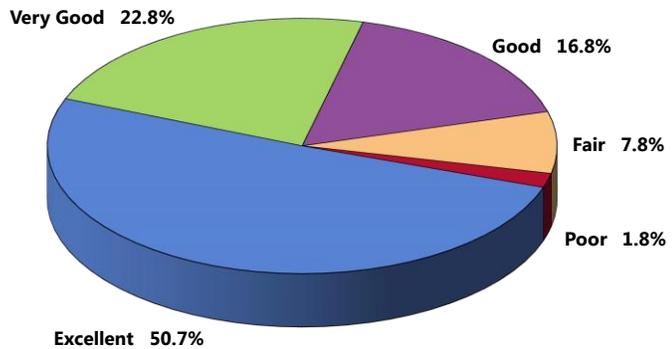
Very Good 22.8%
Good 16.8%
Fair 7.8%
Poor 1.8%
Excellent 50.7%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]
Notes: • Asked of all respondents.

However, 9.6% rate the safety and security of their neighborhood as only "fair" or "poor."

👥 Young adults, those in lower income categories, and Hispanics are much more likely to consider their neighborhood's safety to be "fair" or "poor."

Consider Neighborhood Safety and Security to be "Fair/Poor"
(HMHP Service Area, 2013)

Category	Value
Men	7.7%
Women	11.6%
18 to 39	14.5%
40 to 64	7.0%
65+	4.1%
Very Low Income	20.0%
Low Income	19.1%
Mid/High Income	5.8%
White	3.8%
Hispanic	21.2%
Other	8.6%
HMHP Svc Area	9.6%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Family Violence

Domestic Violence Rates

Between 2009 and 2011, there was an annual average domestic violence rate of 353.6 offenses per 100,000 population in Orange County.

● Well below the California rate for the same period.

Keep in mind that these data only reflect those incidents reported to law enforcement (offenses).

Domestic Violence Rates
(2009-2011 Annual Average Offenses per 100,000 Population)

Region	Rate
Orange County	353.6
California	439.4
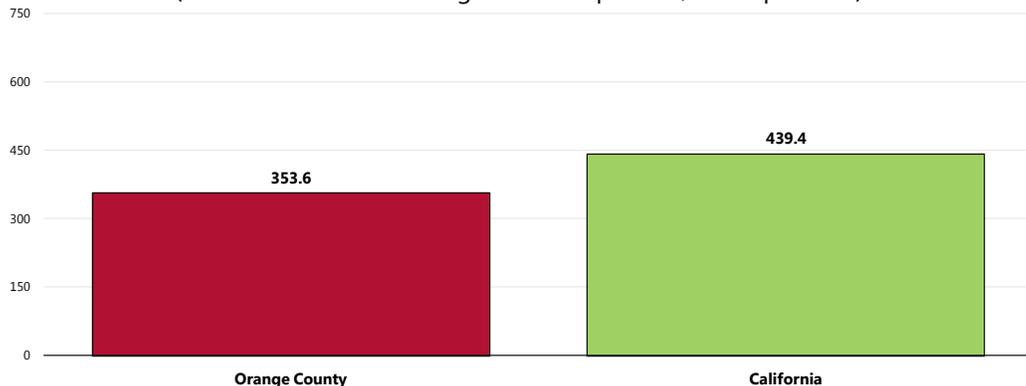
Sources: • State of California Department of Justice, Criminal Justice Statistics Center
Notes: • Rates are domestic calls for assistance per 100,000 population.

A total of 8.6% of HMHP Service Area adults report that they have ever been threatened with physical violence by an intimate partner.

- More favorable than that reported nationally.

A total of 9.5% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- More favorable than national findings.

Respondents were told:

"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

8.6% of adults have been *threatened* with violence by an intimate partner. (US=11.7%)

- HMHP Service Area: 9.5%
- United States: 13.5%
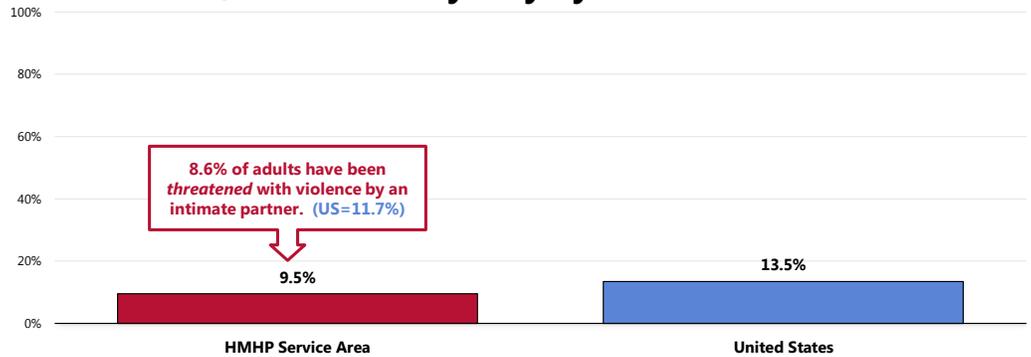
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 55-56]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

No statistical difference by key demographic characteristics.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
9.9%	9.1%	11.2%	9.8%	5.9%	9.2%	6.5%	10.5%	9.3%	11.8%	7.1%	9.5%
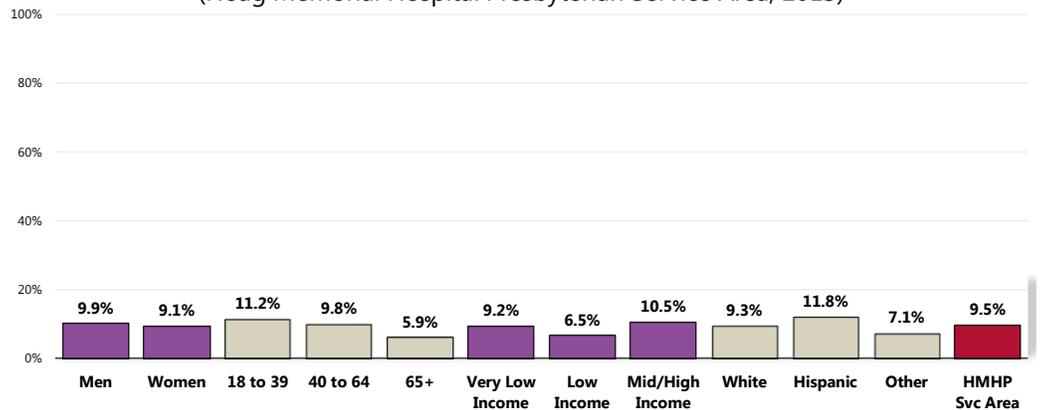
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Participants agree that **domestic violence** places stress in the mental health system. The perception is that domestic violence is the gateway to long-term problems in both physical and mental health:

> *"A client, whether a child or adult, who has been a victim of domestic violence is experiencing post-traumatic stress at that moment and we are met with barriers for them to access care. When I call Orange County Mental Health there is at least a month wait for an appointment and this client needs to be seen ASAP." — Community Leader*

> *"A lot of studies found that most of the adults in the mental health system had experienced in their childhood some type of intimate partner or domestic violence. This exposure, later on, led to smoking, drug use, intimate partner violence, heart disease, alcoholism and suicide. This study really showed the impact of what domestic violence does to a child and then to an adult and how these types of events will continue to perpetuate the violence cycle and the physical and mental health conditions associated with it." — Community Leader*

Participants worry about the increase in **fraud and physical abuse of the elderly** and how these types of crimes go unreported to authorities:

> *"Financial elderly abuse is one of the fastest growing crimes in America today, and it's one of the programs that we are actively involved with promoting information about. As people age they become very vulnerable to this type of abuse. A family member, a stranger or a caregiver can be taking advantage of them without anyone reporting this type of crime." — Community Leader*

Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes.

Effective therapy can prevent or delay diabetic complications. However, almost 25% of Americans with diabetes mellitus are undiagnosed, and another 57 million Americans have blood glucose levels that greatly increase their risk of developing diabetes mellitus in the next several years. Few people receive effective preventive care, which makes diabetes mellitus an immense and complex public health challenge.

Diabetes mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. Diabetes mellitus:

- Lowers life expectancy by up to 15 years.

- Increases the risk of heart disease by 2 to 4 times.

- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

In addition to these human costs, the estimated total financial cost of diabetes mellitus in the US in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.
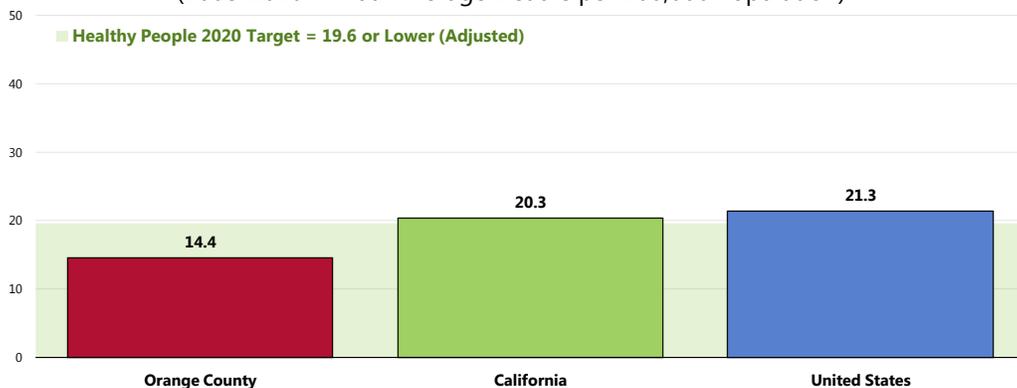
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Between 2008 and 2010, there was an annual average age-adjusted diabetes mortality rate of 14.4 deaths per 100,000 population in Orange County.

- More favorable than that found statewide.

- More favorable than the national rate.

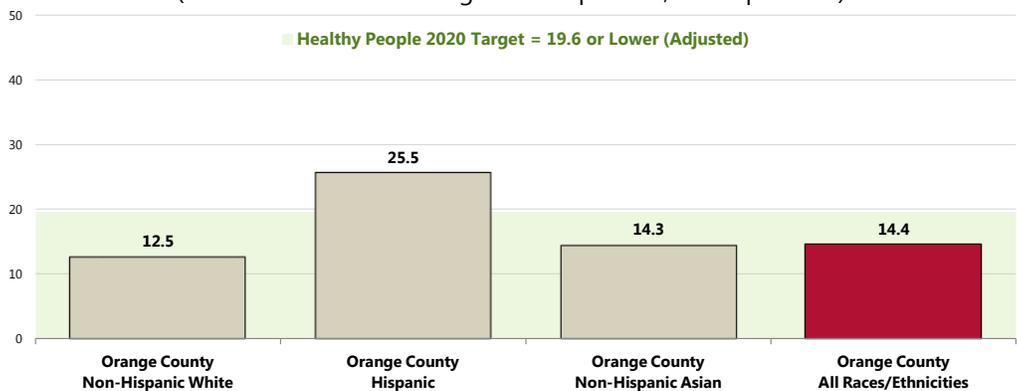- Satisfies the Healthy People 2020 target (19.6 or lower).

Diabetes: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 19.6 or Lower (Adjusted)

| Orange County	California	United States
14.4	20.3	21.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

The diabetes mortality rate in Orange County is notably higher among Hispanics than among Whites and Asians.

Diabetes: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 19.6 or Lower (Adjusted)

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
12.5	25.5	14.3	14.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
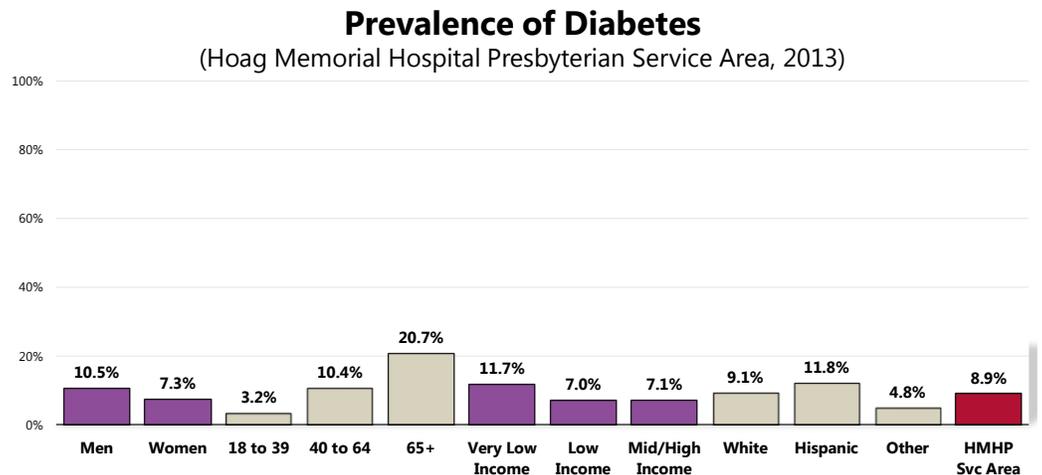
Prevalence of Diabetes

A total of 8.9% of HMHP Service Area adults report having been diagnosed with diabetes.

- Identical to the proportion statewide.
- Similar to the national proportion.

Prevalence of Diabetes

HMHP Service Area	California	United States
8.9%	8.9%	10.1%
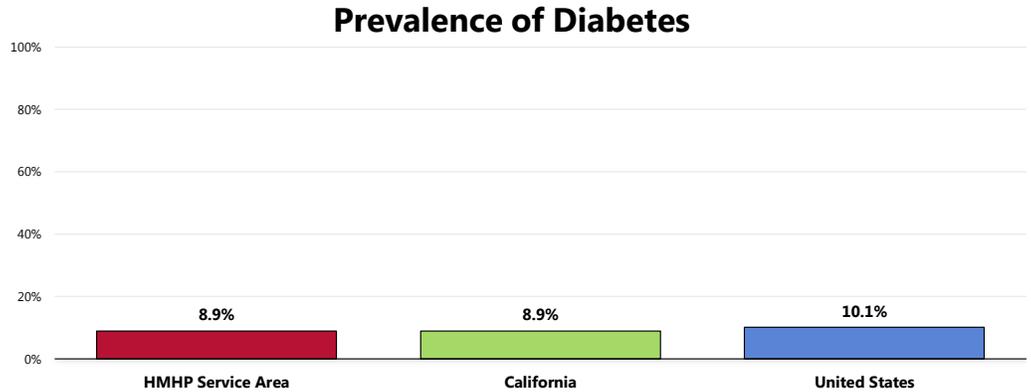
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 37]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.

Notes:
- Asked of all respondents.
- Local and national data exclude gestation diabetes (occurring only during pregnancy).

- A higher prevalence of diabetes is reported among Hispanics and adults living in poverty in the HMHP Service Area.
- Note also the strong positive correlation between diabetes and age (with 20.7% of seniors with diabetes).

Prevalence of Diabetes
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
10.5%	7.3%	3.2%	10.4%	20.7%	11.7%	7.0%	7.1%	9.1%	11.8%	4.8%	8.9%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 37]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestation diabetes (occurring only during pregnancy).

While 8.9% of service area adults are diabetic (as noted previously)**, another 9.5% have been told by a doctor or other health professional that they have "pre-diabetes" or "borderline diabetes."**

Have Been Diagnosed With Diabetes or Pre-Diabetes/Borderline Diabetes
### (Hoag Memorial Hospital Presbyterian Service Area, 2013)

Not Diabetic or
Borderline* 81.7%

Diabetes 8.9%

Borderline/
Pre-Diabetes 9.5%
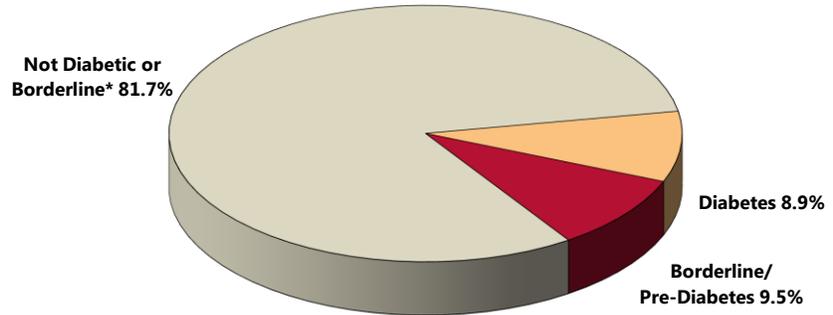
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
Notes: ● Asked of all respondents.
● * "Not Diabetic or Borderline" includes 0.3% of respondents who are women diagnosed with diabetes only while pregnant (gestational diabetes).

Family History

Note also that 31.3% of all survey respondents indicate that a member or members of their immediate families have had diabetes.

Any Members of Immediate Family Have Had Diabetes
(HMHP Service Area, 2013)

Yes 31.3%

No 68.7%
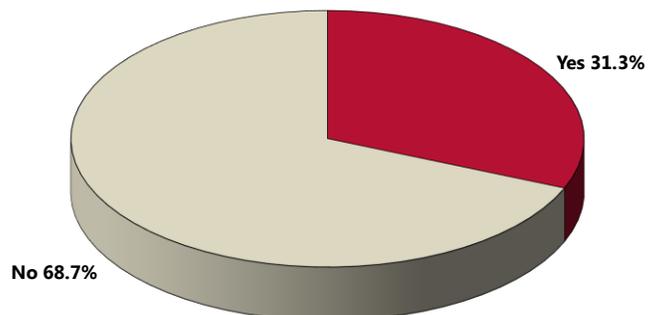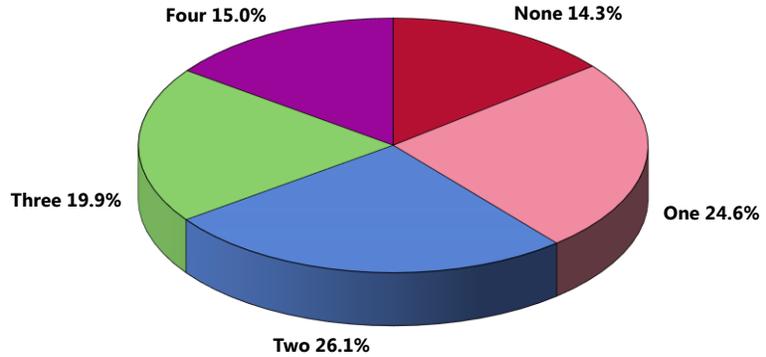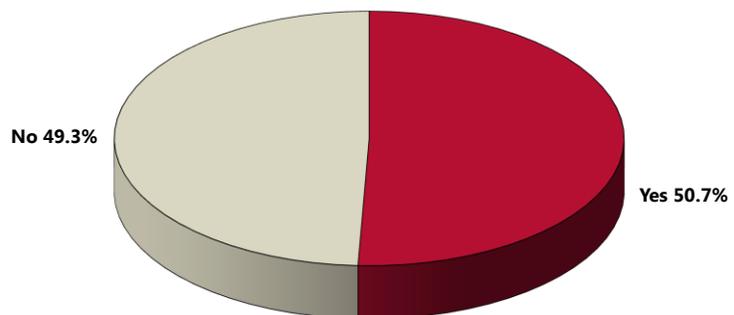
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 45]
Notes: ● Asked of all respondents.
● Excludes diabetes occurring only during pregnancy (gestational diabetes).

Diabetes Treatment

Insulin

Among adults with diabetes, most (77.5%) are currently taking insulin or some type of medication to manage their condition.

Taking Insulin or Other Medication for Diabetes
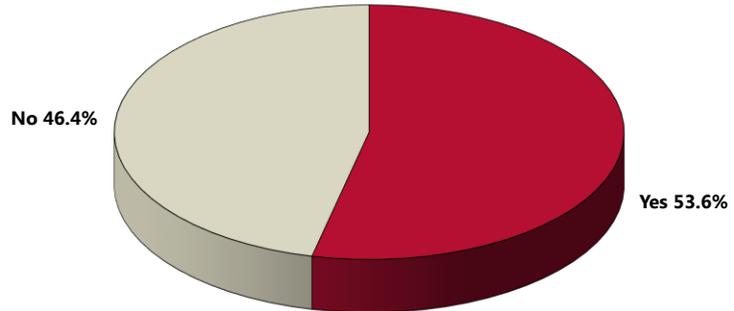(Among HMHP Service Area Diabetics)

No 22.5%

Yes 77.5%
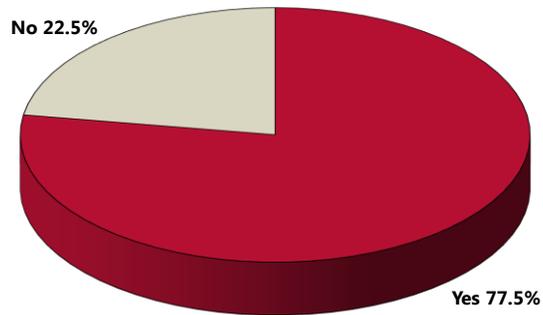
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
Notes: ● Asked of all diabetic respondents.

Medical Visits

In the past year, 14.5% of service area diabetics did not have any diabetes-related medical visits, while 6.5% report 5 or more of these visits in the past year.

Number of Diabetes-Related Visits
to a Medical Professional in the Past Year
(Among HMHP Service Area Diabetics)

Five/More 6.5%

Four 15.2%

None 14.5%

One 15.9%

Three 25.0%

Two 22.9%
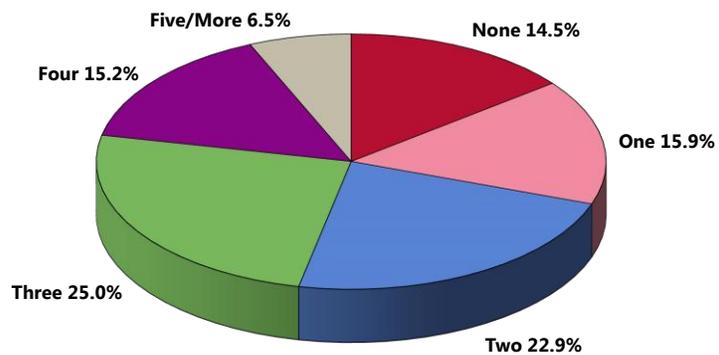
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 41]
Notes: ● Asked of all diabetic respondents.

Among diabetic survey respondents, 14.3% did not have <u>any</u> A1C checks in the past year; in contrast, 15.0% of diabetics had four A1C checks.

Frequency of A1C Checks in the Past Year
(Among HMHP Service Area Diabetics)

Four 15.0%
None 14.3%
Three 19.9%
One 24.6%
Two 26.1%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 42]
Notes: ● Asked of all diabetic respondents.

Diabetes Education

One-half (50.7%) of surveyed diabetics have taken a course on managing their diabetes.

Have Taken a Course On Diabetes Management
(Among HMHP Service Area Diabetics)

No 49.3%
Yes 50.7%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 43]
Notes: ● Asked of all diabetic respondents.

Diabetes Screening

Of service area adults who have <u>not</u> been diagnosed with diabetes (and including those who may be pre-diabetic or borderline diabetic)**, 53.6% have had a test for diabetes or high blood sugar in the past three years.**

Tested for Diabetes or High Blood Sugar in the Past 3 Years
(Among HMHP Service Area Non-Diabetics)

No 46.4%

Yes 53.6%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]
Notes: • Asked of all non-diabetic respondents.

Alzheimer's Disease

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2008 and 2010, there was an annual average age-adjusted Alzheimer's disease mortality rate of 32.1 deaths per 100,000 population in Orange County.

- Less favorable than the statewide rate.
- Less favorable than the national rate.

Alzheimer's Disease: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Orange County	California	United States
32.1	29.2	25.0

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

The Alzheimer's disease mortality rate is higher among Whites in Orange County.

Alzheimer's Disease: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
36.0	23.8	16.2	32.1

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

Family Member With Alzheimer's Disease

In the service area, 23.6% of residents have family members who have been diagnosed with Alzheimer's disease or dementia.

Member of Family Has Been
Diagnosed With Alzheimer's Disease or Dementia
(HMHP Service Area, 2013)

Yes 23.6%

No 76.4%
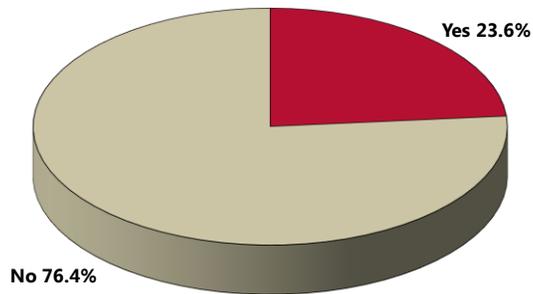
Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
Notes: ● Asked of all respondents.

Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

‒ Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2008 and 2010 there was an annual average age-adjusted kidney disease mortality rate of 8.7 deaths per 100,000 population in Orange County.

- Comparable to the rate found statewide.
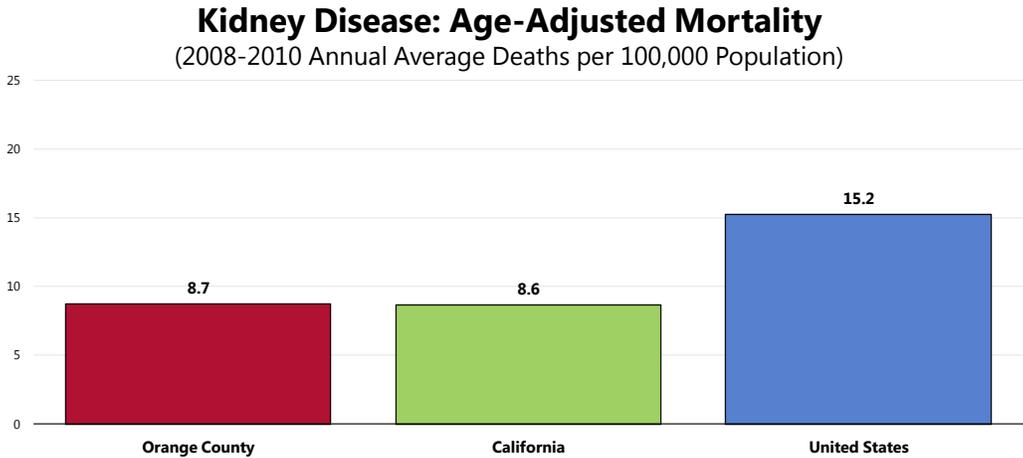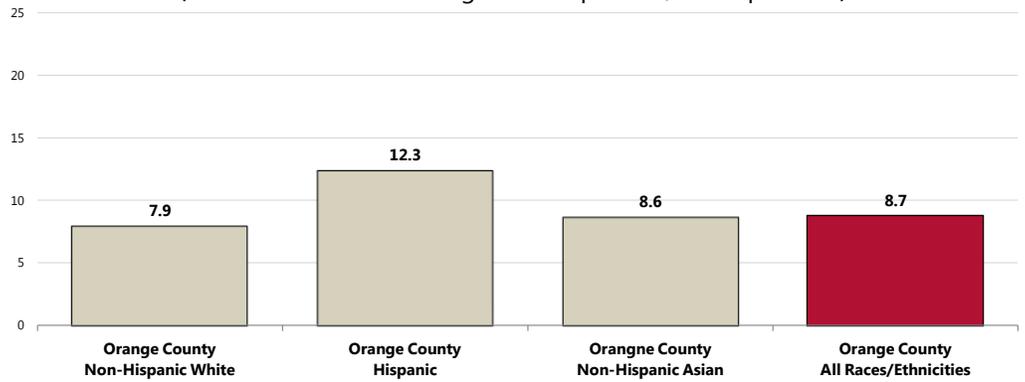
- More favorable than the national rate.

Kidney Disease: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

	Orange County	California	United States
	8.7	8.6	15.2

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
Data extracted June 2013.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

The kidney disease mortality rate in Orange County is much higher in the Hispanic population.

Kidney Disease: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

	Orange County Non-Hispanic White	Orange County Hispanic	Orangne County Non-Hispanic Asian	Orange County All Races/Ethnicities
Rate	7.9	12.3	8.6	8.7

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

Potentially Disabling Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.

- 2-8% have chronic back pain (pain that lasts more than 3 months).

- 3-4% of the population is temporarily disabled due to back pain.

- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).

- 3rd most common reason to undergo a surgical procedure.

- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Pain

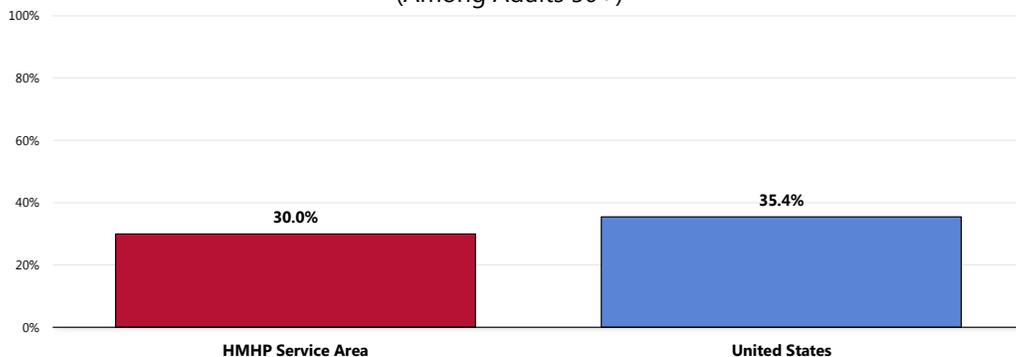### Prevalence of Arthritis/Rheumatism

A total of 30.0% of HMHP Service Area adults age 50 and older report suffering from arthritis or rheumatism.

- Statistically comparable to that found nationwide.

Prevalence of Arthritis/Rheumatism
(Among Adults 50+)

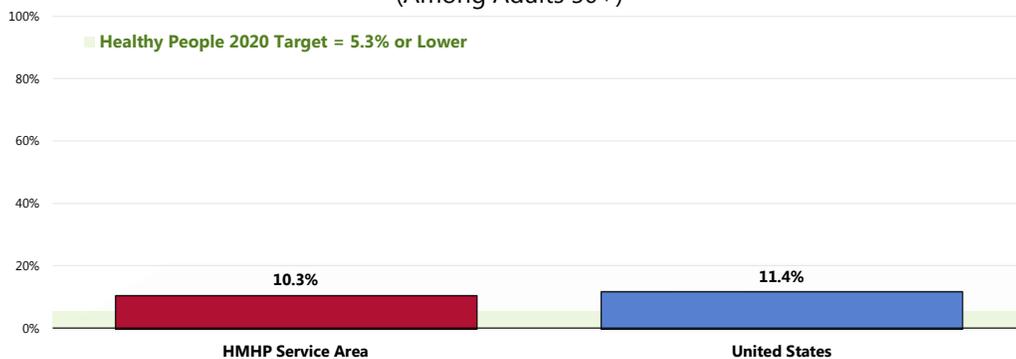|	
HMHP Service Area 30.0%	**United States** 35.4%

Prevalence of Osteoporosis

A total of 10.3% of survey respondents age 50 and older have osteoporosis.

- Similar to that found nationwide.

- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.

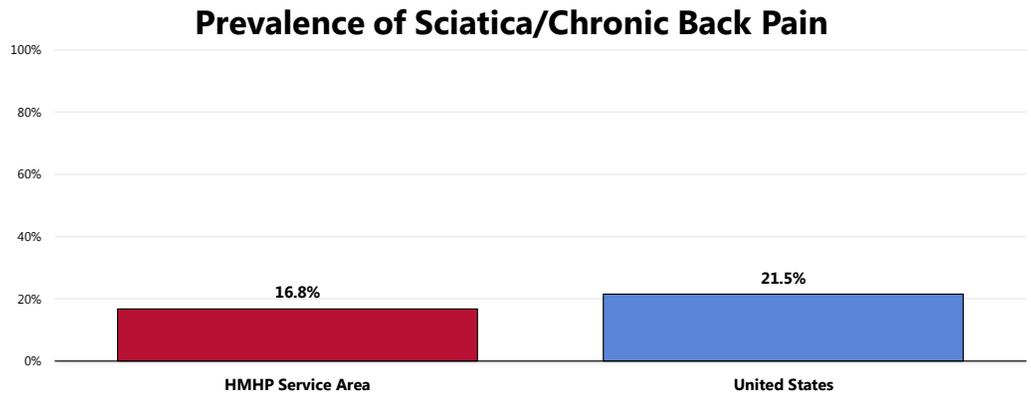## Prevalence of Osteoporosis
(Among Adults 50+)

Healthy People 2020 Target = 5.3% or Lower

HMHP Service Area 10.3%	**United States** 11.4%

A total of 16.8% of survey respondents suffer from chronic back pain or sciatica.

- More favorable than that found nationwide.

Prevalence of Sciatica/Chronic Back Pain

```
100%

 80%

 60%

 40%

 20%          16.8%                           21.5%

  0%
         HMHP Service Area              United States
```

Hearing Trouble

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.
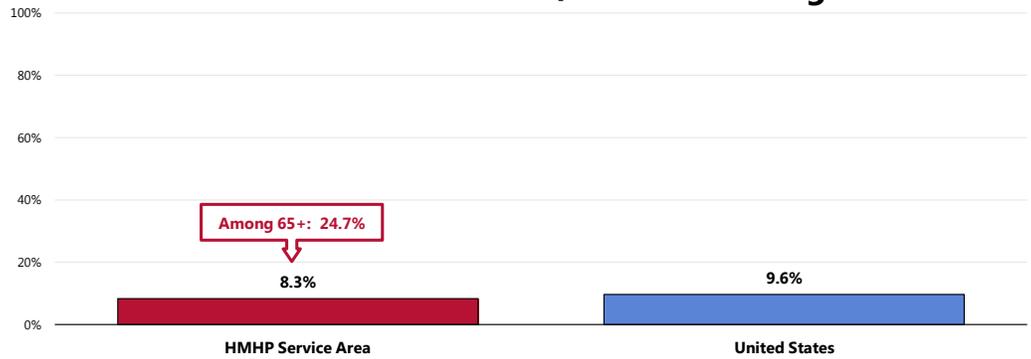
– Healthy People 2020 (www.healthypeople.gov)

In all, 8.3% of HMHP Service Area adults report being deaf or having difficulty hearing.

- Similar to that found nationwide.

- Among HMHP Service Area adults age 65 and older, 24.7% have partial or complete hearing loss.

Prevalence of Deafness/Trouble Hearing

Among 65+: 24.7%

HMHP Service Area: 8.3%

United States: 9.6%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 25]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Related Focus Group Findings: Seniors

According to focus group participants, the **number of seniors in the community will continue to increase in the coming years,** and the county needs to be ready to handle the increase of services for this population.

"In this county there is what we call the tsunami: 835,000 baby boomers who are going to turn 65 in the next 20 years. So imagine 835,000 people on the freeway, seniors on the freeway. It would be nice if we start to address this problem from healthcare services to transportation, since it is a huge problem facing us, and I do not think as a county we have a clear understanding of what we are going to do or how significant this change is going to be." — Community Leader

"We have 2,000 residents on our waiting list for our senior food voucher program, and I want to mention that as life expectancy is extended because of the quality of the healthcare that we do have, people are outliving their savings. This is putting a financial strain on families where children now have to take care of their parents." — Community Leader

"One of the problems we have in Orange County is that at the county level, services are child- and family-focused, and as important as that is, there needs to be recognition to the growing number of older adults moving to or living in our county, which is expected to double by 2030. I think one model of centralized services is for the county to provide an adult day healthcare center where older adults can come and meet with a whole team of professionals who can address their complex and multiple conditions and then coordinate services." — Healthcare Provider

One participant describes some of the senior services initiatives currently in place:

The Orange County Aging Services Collaborative, which has about 25 member organizations, is now involved in senior issues and is collaborating to become the voice for the elderly. The Orange County Healthcare Agency is also involved in looking at elderly issues and bringing more attention to this emerging problem which has been ignored in the past." — Healthcare Provider

INFECTIOUS DISEASE
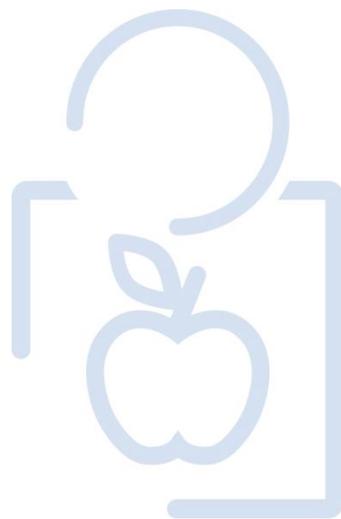
Vaccine-Preventable Conditions

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by $9.9 billion.
- Saves $33.4 billion in indirect costs.

  – Healthy People 2020 (www.healthypeople.gov)

Measles, Mumps, Rubella

There were 3 cases of measles and 6 cases of mumps (no rubella) in Orange County in recent years (2010-2012).
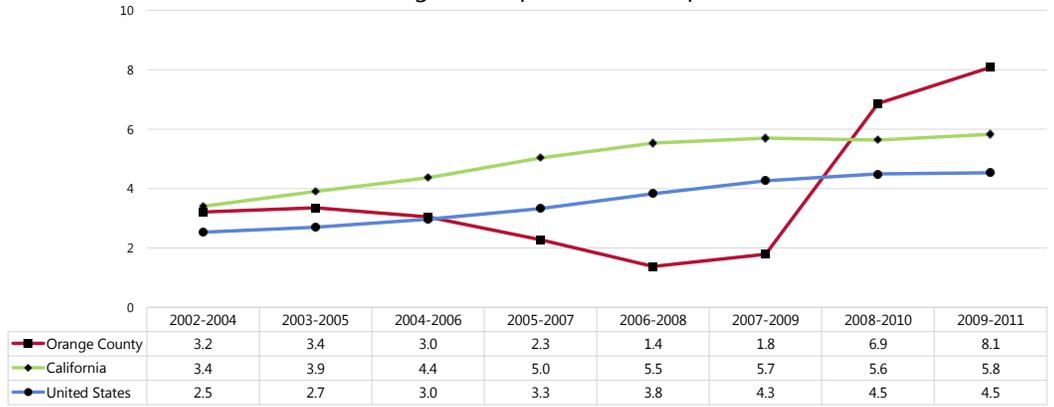
Pertussis

Between 2009 and 2011, the annual average pertussis incidence rate (new cases per year) was 8.1 cases per 100,000 population in Orange County.

- Above the California incidence rate.
- Above the national incidence rate.

"Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

It is usually expressed as cases per 100,000 population per year.

Pertussis Incidence
(Annual Average Cases per 100,000 Population)

	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
Orange County	3.2	3.4	3.0	2.3	1.4	1.8	6.9	8.1
California	3.4	3.9	4.4	5.0	5.5	5.7	5.6	5.8
United States	2.5	2.7	3.0	3.3	3.8	4.3	4.5	4.5

Sources: • California Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Influenza & Pneumonia Vaccination

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

– Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

FluMist® is a vaccine that is sprayed into the nose to help protect against influenza; it is an alternative to traditional flu shots.

Among HMHP Service Area seniors, 74.9% received a flu shot (or FluMist®) within the past year.

- Higher than the California finding.

- Similar to the national finding.

- Fails to satisfy the Healthy People 2020 target (90% or higher).

Have Had a Flu Vaccination in the Past Year
(Among Adults 65+)

	HMHP Service Area	California	United States
Healthy People 2020 Target = 90% or Higher	74.9%	57.2%	71.6%
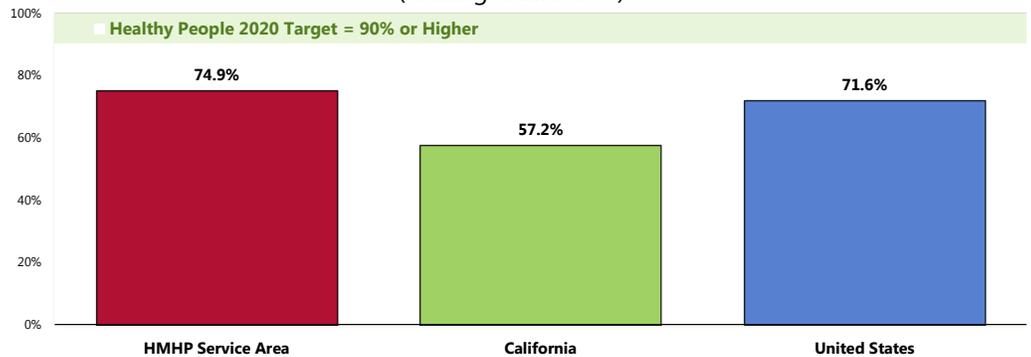
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.7]

Notes:
- Reflects respondents 65 and older.
- Includes FluMist as a form of vaccination.

High-Risk Adults

"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 49.6% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

- Similar to national findings.

- Fails to satisfy the Healthy People 2020 target (90% or higher).

Have Had a Flu Vaccination in the Past Year
(Among High-Risk Adults 18-64)

Healthy People 2020 Target = 90% or Higher

HMHP Service Area	United States
49.6%	52.5%
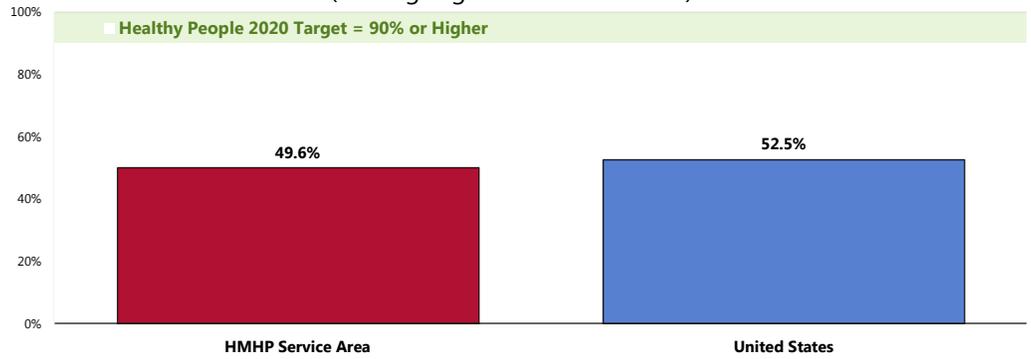
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
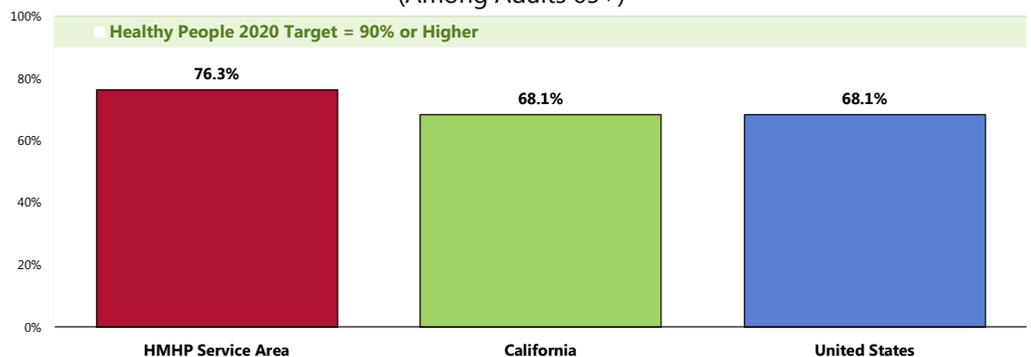- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.6]

Notes:
- Reflects high-risk respondents age 18-64.
- Includes FluMist as a form of vaccination.

Pneumonia Vaccination

Among adults age 65 and older, 76.3% have received a pneumonia vaccination at some point in their lives.

- Statistically higher than the California finding.

- Statistically comparable to the national finding.

   - *Note: Because the national sample in this case is smaller than the statewide sample, the national comparison is statistically similar, whereas the state comparison is statistically significant.*

- Fails to satisfy the Healthy People 2020 target of 90% or higher.

Have Ever Had a Pneumonia Vaccine
(Among Adults 65+)

Healthy People 2020 Target = 90% or Higher

HMHP Service Area	California	United States
76.3%	68.1%	68.1%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
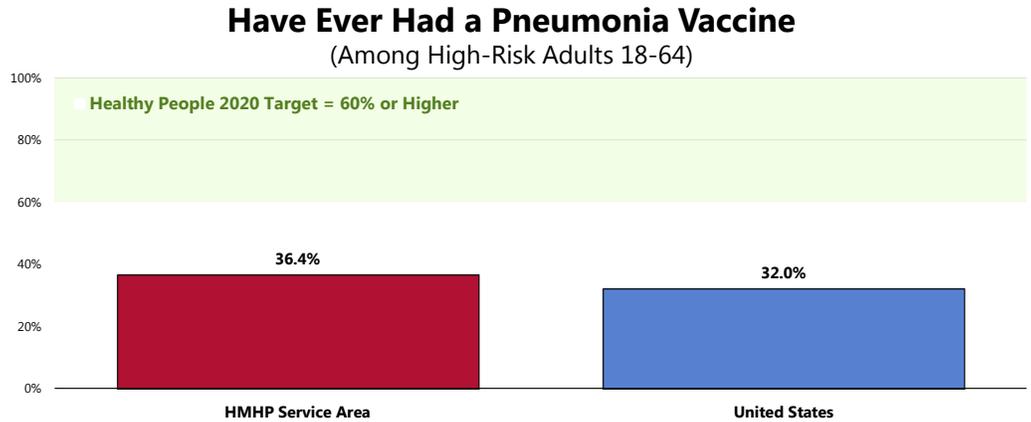- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-13.1]

Notes:
- Reflects respondents 65 and older.

Tuberculosis

Viral hepatitis and tuberculosis (TB) can be prevented, yet healthcare systems often do not make the best use of their available resources to support prevention efforts. Because the US healthcare system focuses on treatment of illnesses, rather than health promotion, patients do not always receive information about prevention and healthy lifestyles. This includes advancing effective and evidence-based viral hepatitis and TB prevention priorities and interventions.

– Healthy People 2020 (www.healthypeople.gov)

Between 2009 and 2011, the annual average tuberculosis incidence rate (new cases per year) was 6.8 cases per 100,000 population in Orange County.

- Above the California incidence rate.

- Well above the national incidence rate.

- Fails to satisfy the Healthy People 2020 target (1.0 or lower).

Tuberculosis Incidence
(2009-2011 Annual Average Cases per 100,000 Population)

Healthy People 2020 Target = 1.0 or Lower

Orange County	California	United States
6.8	6.4	3.6
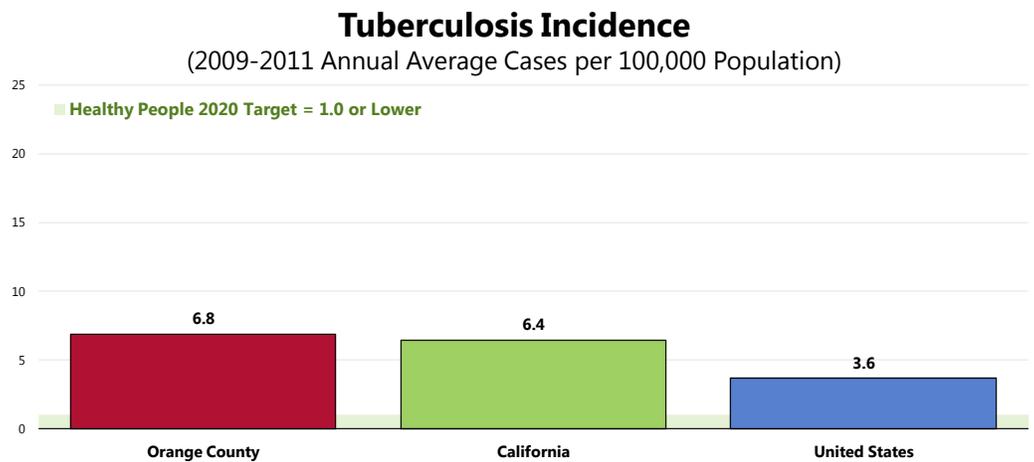
Sources:
- California Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-29]
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

Notes:
- Rates are annual average new cases per 100,000 population.

Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs**. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.

- **Gender disparities**. Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.

- **Age disparities**. Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.

- **Lag time between infection and complications**. Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include:

- **Racial and ethnic disparities**. Certain racial and ethnic groups (mainly African American, Hispanic, and American Indian/Alaska Native populations) have high rates of STDs, compared with rates for whites.

- **Poverty and marginalization**. STDs disproportionately affect disenfranchised people and people in social networks where high-risk sexual behavior is common, and access to care or health-seeking behavior is compromised.

- **Access to health care**. Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for whom access to or use of health services is most limited.

- **Substance abuse**. Many studies document the association of substance abuse with STDs. The introduction of new illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the epidemic spread of STDs.

- **Sexuality and secrecy**. Perhaps the most important social factors contributing to the spread of STDs in the United States are the stigma associated with STDs and the general discomfort of discussing intimate aspects of life, especially those related to sex. These social factors separate the United States from industrialized countries with low rates of STDs.

- **Sexual networks**. Sexual networks refer to groups of people who can be considered "linked" by sequential or concurrent sexual partners. A person may have only 1 sex partner, but if that partner is a member of a risky sexual network, that person is at higher risk for STDs than an individual from a nonrisky network.

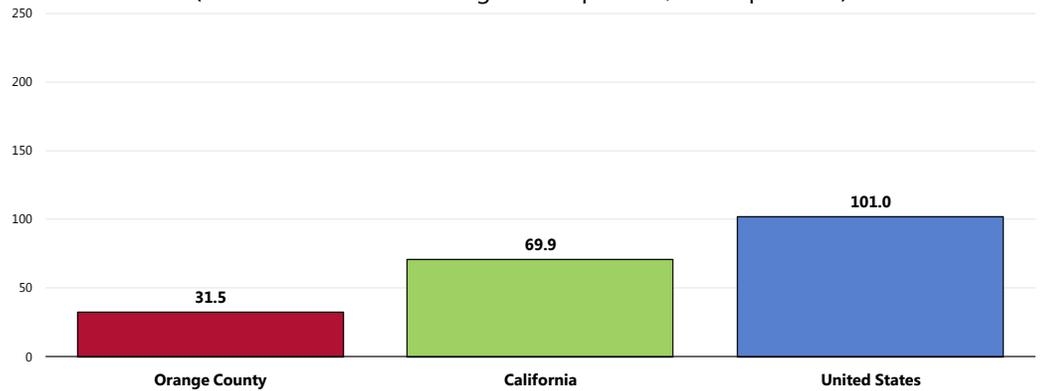– Healthy People 2020 (www.healthypeople.gov)

Gonorrhea

Between 2009 and 2011, the annual average gonorrhea incidence rate was 31.5 cases per 100,000 population in Orange County.

- Notably lower than the California incidence rate.
- Notably lower than the national incidence rate.

Gonorrhea Incidence
(2009-2011 Annual Average Cases per 100,000 Population)

Orange County	California	United States
31.5	69.9	101.0

Sources:
- California Department of Public Health.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
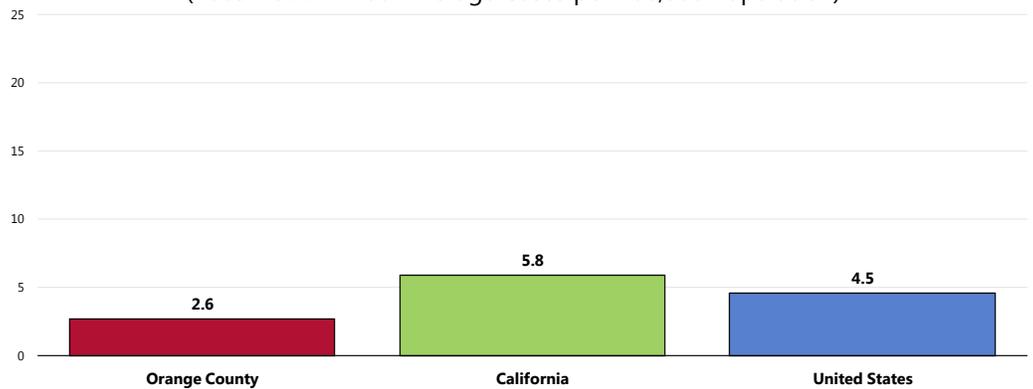- Rates are annual average new cases per 100,000 population.

Syphilis

Between 2009 and 2011, the annual average primary/secondary syphilis incidence rate was 2.6 cases per 100,000 population in Orange County.

- Lower than the California incidence rate.
- Lower than the national incidence rate.

Primary/Secondary Syphilis Incidence
(2009-2011 Annual Average Cases per 100,000 Population)

Orange County	California	United States
2.6	5.8	4.5

Sources:
- California Department of Public Health.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
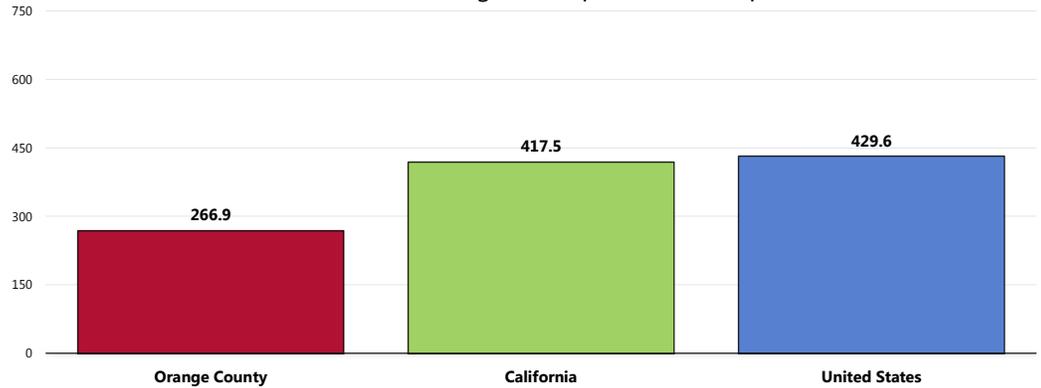- Rates are annual average new cases per 100,000 population.

Chlamydia

Between 2009 and 2011, the annual average chlamydia incidence rate was 266.9 cases per 100,000 population in Orange County.

- More favorable than the California incidence rate.
- More favorable than the national incidence rate.

Chlamydia Incidence
(2009-2011 Annual Average Cases per 100,000 Population)

Orange County	California	United States
266.9	417.5	429.6

Sources: • California Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
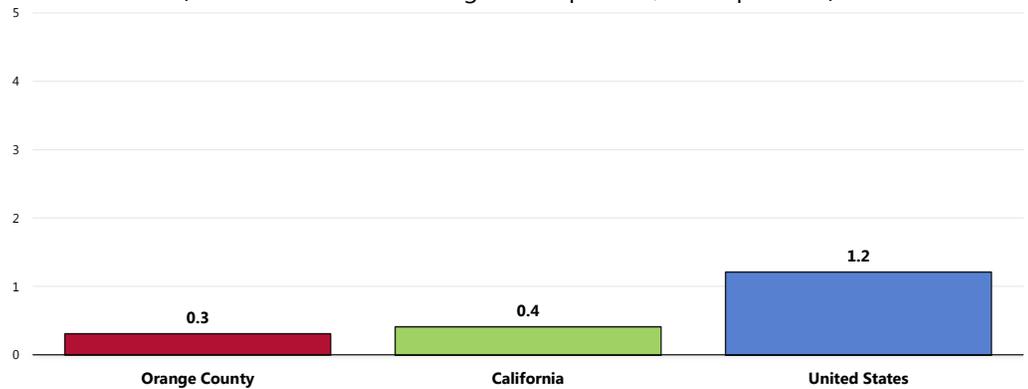Notes: • Rates are annual average new cases per 100,000 population.

Acute Hepatitis B

Hepatitis B Incidence

Between 2010 and 2012, Orange County reported a hepatitis B incidence rate of 0.3 per 100,000 population.

- More favorable than the statewide rate.
- Well below the national rate.

Hepatitis B (Acute) Incidence
(2010-2012 Annual Average Cases per 100,000 Population)

| Orange County	California	United States
0.3	0.4	1.2

Sources: • California Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.
• US rate represents 2008-2010 data.

Focus group participants agree that the **elderly population** has seen a rising incidence of sexually transmitted infections, as one participant explains:

> *"There is an increase in STDs among people who are living in residential care facilities. This is happening because many of them are now single; they lost a spouse; and there isn't a threat of a pregnancy so it is okay to engage in risky sexual behavior. We actually have to lock our doors at our senior centers the nights of our dances because we have residents engaging in sexual activities in the parking lot." — Community Leader*

BIRTHS
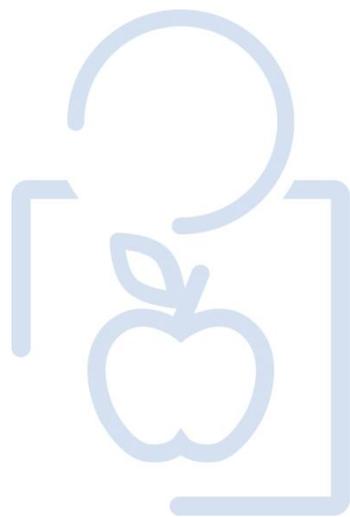
Prenatal Care

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

– Healthy People 2020 (www.healthypeople.gov)

Early and continuous prenatal care is the best assurance of infant health.

Here, "late or no prenatal care" reflects the percentage of live births that received prenatal care beginning in the third trimester or not at all.
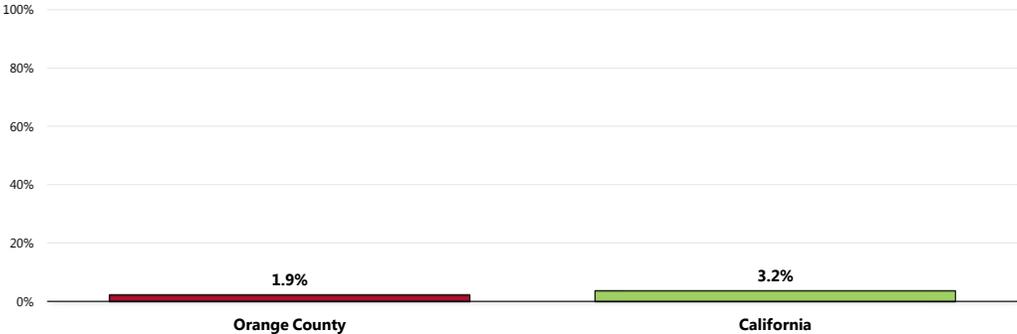
Between 2008 and 2010, 1.9% of all Orange County live births received <u>late or no prenatal care.</u>

- More favorable than the California proportion.

Late or No Prenatal Care
(Percentage of Live Births, 2008-2010)

	Orange County	California
	1.9%	3.2%

Sources:
- California Department of Public Health.

Note:
- Numbers are a percentage of all live births within each population.
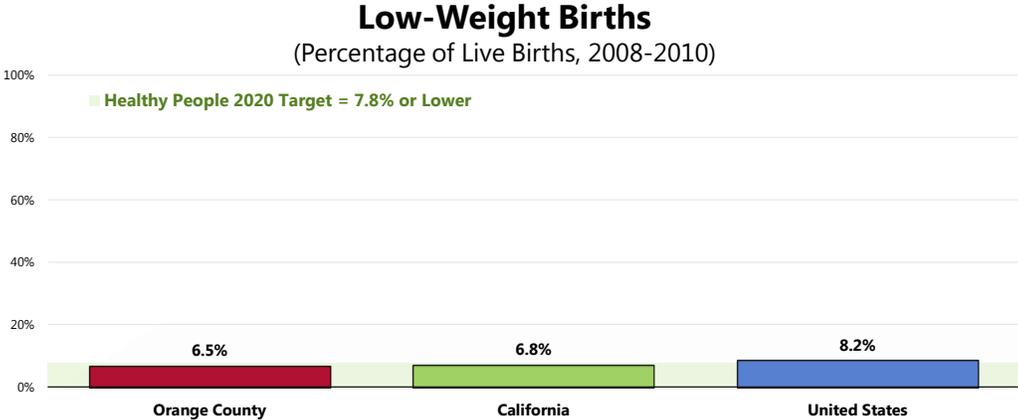- Prenatal care in the third trimester or no prenatal care.

Birth Outcomes & Risks

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births

A total of 6.5% of 2008-2010 Orange County births were low weight.

- Similar to the California proportion.
- Better than the national proportion.
- Satisfies the Healthy People 2020 target (7.8% or lower).

Low-Weight Births
(Percentage of Live Births, 2008-2010)

Healthy People 2020 Target = 7.8% or Lower

Orange County	California	United States
6.5%	6.8%	8.2%

Sources:
- California Department of Public Health.
- Centers for Disease Control and Prevention, National Vital Statistics System.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.
- Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

Infant Mortality

Between 2008 and 2010, there was an annual average of 4.5 infant deaths per 1,000 live births in Orange County.

- More favorable than the California rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.

Infant Mortality Rate
(2008-2010 Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2020 Target = 6.0 or Lower

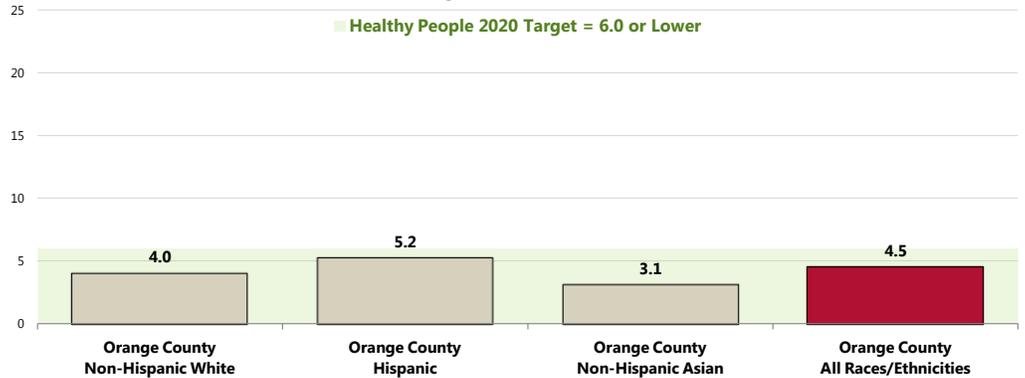| Orange County	California	United States
4.5	5.1	6.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

The infant mortality rate is lower in the county's Asian population.

Infant Mortality Rate by Race
(2008-2010 Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2020 Target = 6.0 or Lower

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
4.0	5.2	3.1	4.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

Family planning is one of the 10 great public health achievements of the 20th century. The availability of family planning services allows individuals to achieve desired birth spacing and family size and contributes to improved health outcomes for infants, children, and women. Family planning services include contraceptive and broader reproductive health services (patient education and counseling), breast and pelvic examinations, breast and cervical cancer screening, sexually transmitted infection (STI) and HIV prevention education/counseling/testing/referral, and pregnancy diagnosis and counseling. For many women, a family planning clinic is their entry point into the healthcare system and is considered to be their usual source of care. This is especially true for women with incomes below the poverty level, women who are uninsured, Hispanic women, and Black women.

Unintended pregnancies (those reported by women as being mistimed or unwanted) are associated with many negative health and economic outcomes. In 2001, almost one-half of all pregnancies in the US were unintended. For women, negative outcomes associated with unintended pregnancy include:

- Delays in initiating prenatal care
- Reduced likelihood of breastfeeding
- Poor maternal mental health
- Lower mother-child relationship quality
- Increased risk of physical violence during pregnancy

Children born as a result of an unintended pregnancy are more likely to experience poor mental and physical health during childhood and poor educational and behavioral outcomes.

- Healthy People 2020 (www.healthypeople.gov)

Births to Teen Mothers

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

A total of 6.7% of 2008-2010 Orange County births were to teenage mothers.

- Lower than the California proportion.
- Lower than the national proportion.

Births to Teen Mothers
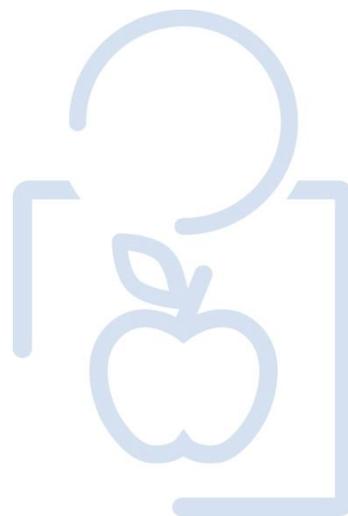(Percentage of Live Births, 2008-2010)
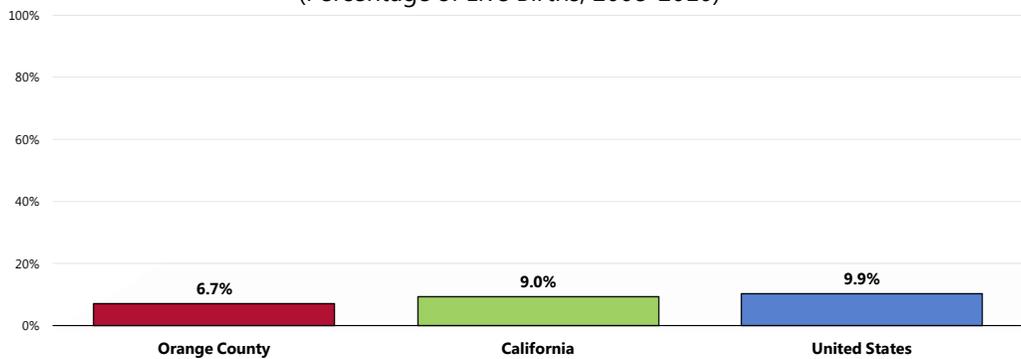
	Orange County	California	United States
	6.7%	9.0%	9.9%

MODIFIABLE HEALTH RISKS

Actual Causes Of Death

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were tobacco (an estimated 435,000 deaths), diet and activity patterns (400,000), alcohol (85,000), microbial agents (75,000), toxic agents (55,000), motor vehicles (43,000), firearms (29,000), sexual behavior (20,000), and illicit use of drugs (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.
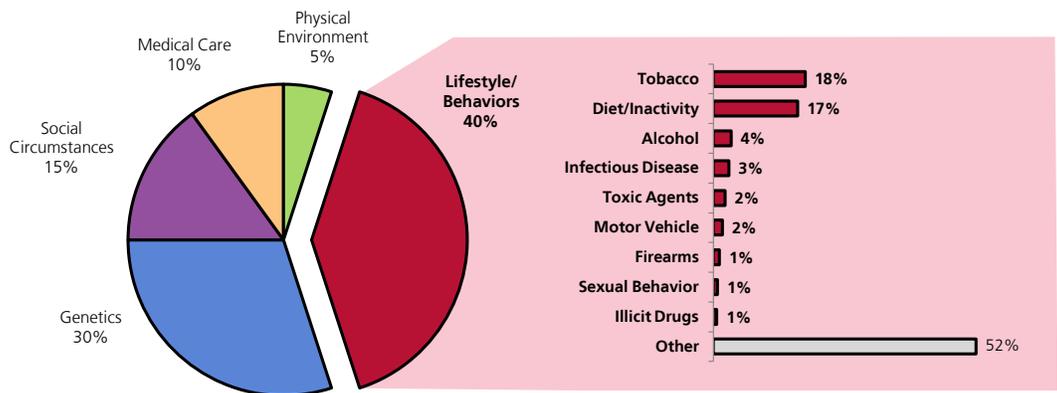
These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

– Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic lung disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88–1232.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States

Physical Environment 5%

Medical Care 10%

Social Circumstances 15%

Genetics 30%

Lifestyle/ Behaviors 40%

Tobacco	18%
Diet/Inactivity	17%
Alcohol	4%
Infectious Disease	3%
Toxic Agents	2%
Motor Vehicle	2%
Firearms	1%
Sexual Behavior	1%
Illicit Drugs	1%
Other	52%

Sources: "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs, Vol. 21, No. 2, March/April 2002.
"Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH) JAMA, 291(2000):1238-1245.

Nutrition

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

– Healthy People 2020 (www.healthypeople.gov)

Fruit & Vegetable Consumption

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 50.1% of HMHP Service Area adults report eating five or more servings of fruits and/or vegetables per day.

● Comparable to national findings.

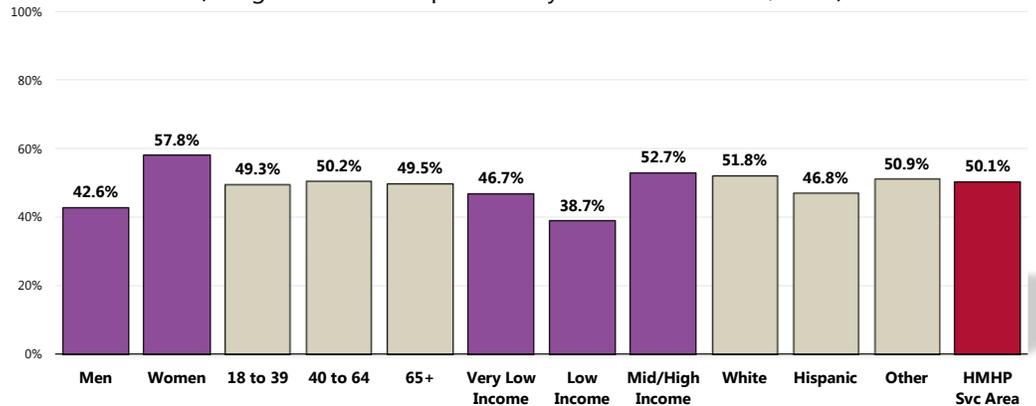### Consume Five or More Servings of Fruits/Vegetables Per Day
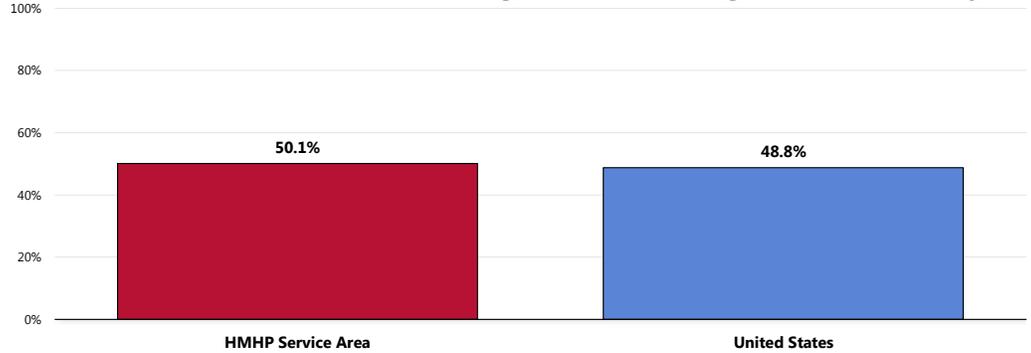
	HMHP Service Area	United States
	50.1%	48.8%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 175]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● For this issue, respondents were asked to recall their food intake on the previous day.

👥 Area men are <u>less</u> likely to get the recommended servings of daily fruits/ vegetables, as are residents living just above the federal poverty level.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
42.6%	57.8%	49.3%	50.2%	49.5%	46.7%	38.7%	52.7%	51.8%	46.8%	50.9%	50.1%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 175]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
● For this issue, respondents were asked to recall their food intake on the previous day.
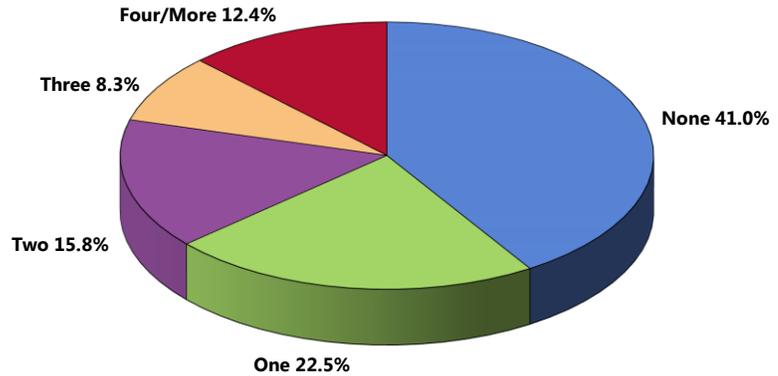
Fast Food Consumption

When asked, the largest share of respondents (41.0%) reported eating <u>no</u> fast food meals in the past week; another 22.5% of respondents had <u>one</u> fast food meal.

- On the other hand, 20.7% had <u>3+ fast food meals</u> in the past week (including breakfasts, lunches, and dinners).

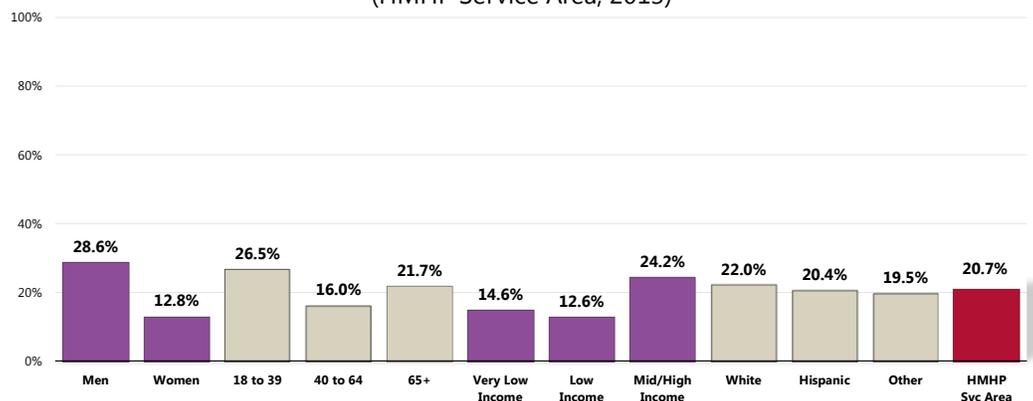### Number of Fast Food Meals Consumed in the Past Week
(HMHP Service Area, 2013)

Pie chart labels: Four/More 12.4%; Three 8.3%; Two 15.8%; One 22.5%; None 41.0%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
Notes: ● Asked of all respondents.
● In this case, respondents were asked to include fast food meals for breakfast, lunch and dinner.

Population segments more likely to have had 3+ fast food meals in the past week include:

- Men.
- Young adults.
- Upper-income residents.

Consumed 3+ Fast Food Meals in the Past Week
(HMHP Service Area, 2013)

Bar chart values: Men 28.6%; Women 12.8%; 18 to 39 26.5%; 40 to 64 16.0%; 65+ 21.7%; Very Low Income 14.6%; Low Income 12.6%; Mid/High Income 24.2%; White 22.0%; Hispanic 20.4%; Other 19.5%; HMHP Svc Area 20.7%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
Notes: ● Asked of all respondents.
● In this case, respondents were asked to include fast food meals for breakfast, lunch and dinner.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Junk Food Consumption

"On average, how many times per day or per week would you say you eat "junk food" such as candy or chips?"
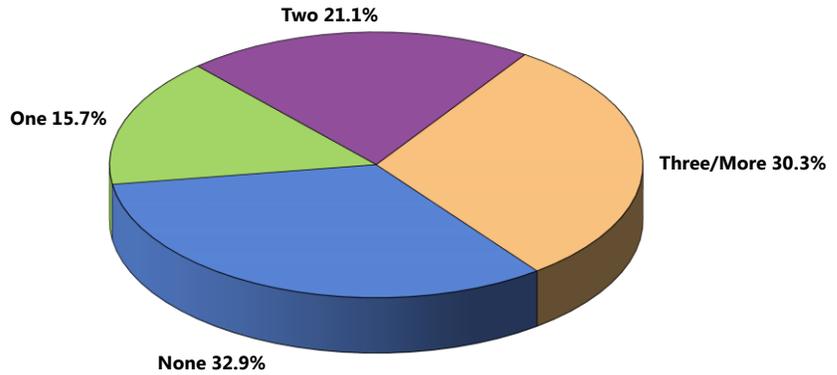
A total of 32.9% of HMHP Service Area adults report eating no servings of junk food in the past week, and 15.7% had just one serving.

- In contrast, 30.3% of survey respondents had <u>3+ servings</u> of junk food (things like candy and chips) in the past week.

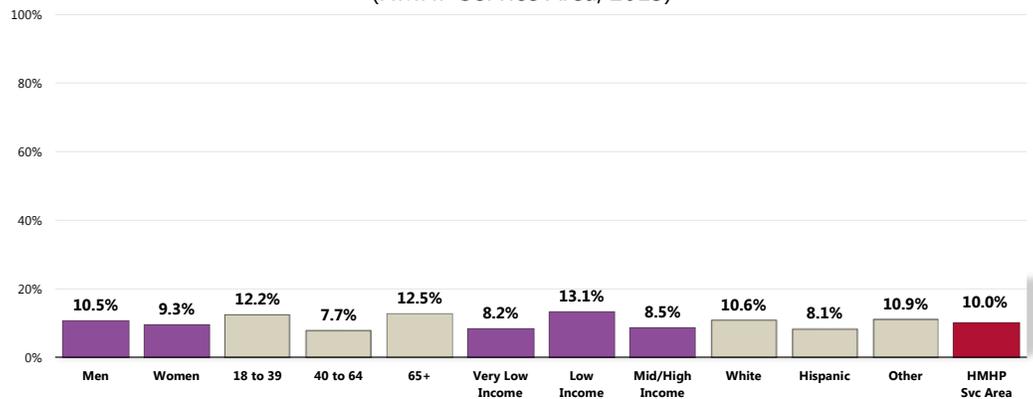## Servings of "Junk Food" in the Past Week
(HMHP Service Area, 2013)

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
Notes: • Asked of all respondents.
• In this case the term "junk food" includes items such as chips, candy, etc.

👪 No significant difference by key demographic characteristics.

Consumed >7 Servings of Junk Food in the Past Week
(HMHP Service Area, 2013)

|										
Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
10.5%	9.3%	12.2%	7.7%	12.5%	8.2%	13.1%	8.5%	10.6%	8.1%	10.9%	10.0%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
• In this case the term "junk food" includes items such as chips, candy, etc.

Soda Consumption

Over one-half (52.3%) of survey respondents had no servings of soda in the past week.

- On the other hand, 10.5% of respondents report having soda 7 or more times in the past week (an average of one or more per day).
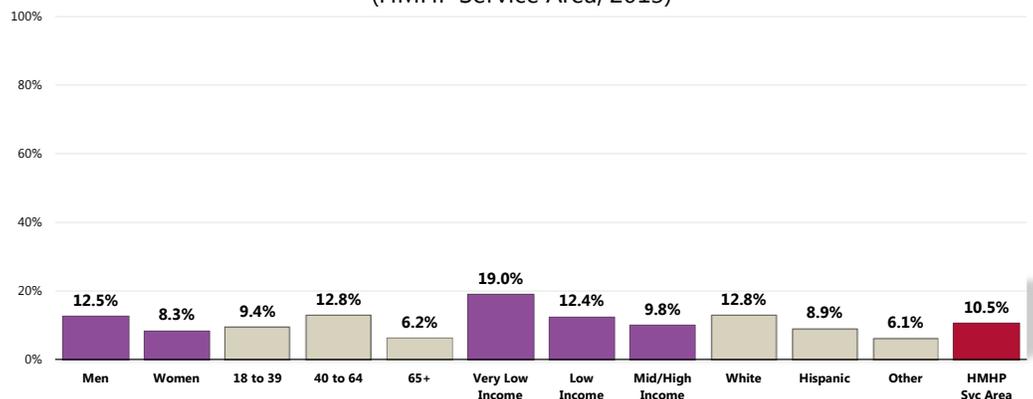
Servings of Soda in the Past Week
(HMHP Service Area, 2013)
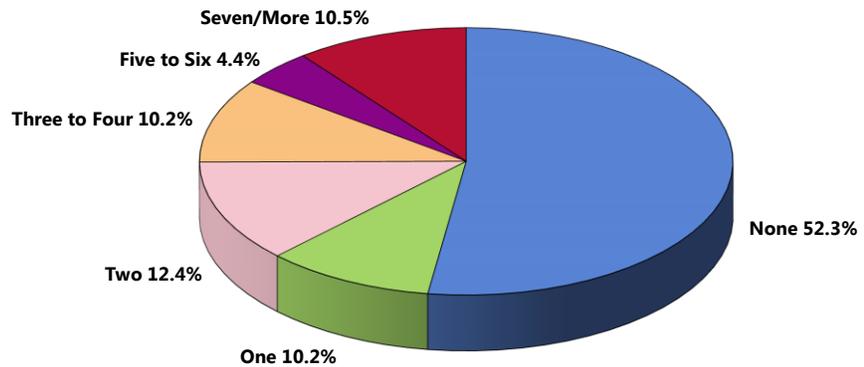
Seven/More 10.5%
Five to Six 4.4%
Three to Four 10.2%
Two 12.4%
One 10.2%
None 52.3%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
Notes: ● Asked of all respondents.
● In this case, a serving represents a 12oz drink of soda or pop.

- Residents more likely to have had 7+ servings of soda in the past week include adults age 40 to 64 and those living on lower incomes (negative correlation with income).

Drink 7+ Servings of Soda Per Week
(HMHP Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
12.5%	8.3%	9.4%	12.8%	6.2%	19.0%	12.4%	9.8%	12.8%	8.9%	6.1%	10.5%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
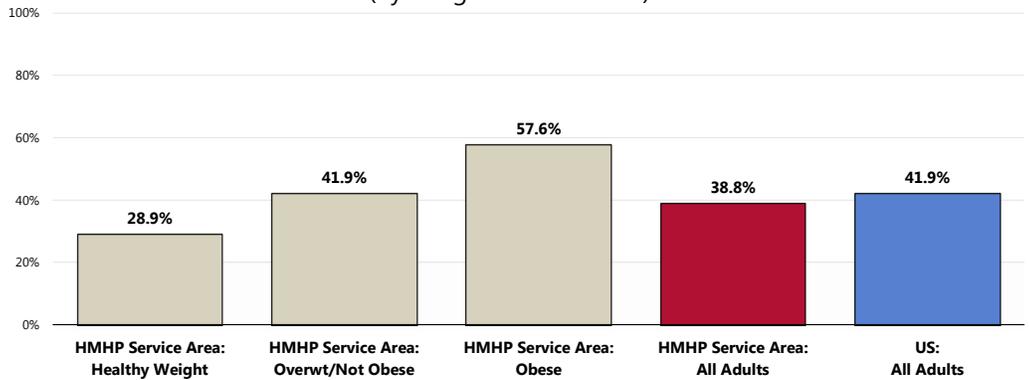
Health Advice About Diet & Nutrition

A total of 38.8% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Comparable to national findings.

- Note: Among obese respondents, 57.6% report receiving diet/nutrition advice (meaning that over 40% did not).

Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional
(By Weight Classification)

Category	Percentage
HMHP Service Area: Healthy Weight	28.9%
HMHP Service Area: Overwt/Not Obese	41.9%
HMHP Service Area: Obese	57.6%
HMHP Service Area: All Adults	38.8%
US: All Adults	41.9%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity:

- Gender (boys)
- Belief in ability to be active (self-efficacy)
- Parental support

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity:

- Parental education
- Gender (boys)
- Personal goals
- Physical education/school sports
- Belief in ability to be active (self-efficacy)
- Support of friends and family

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

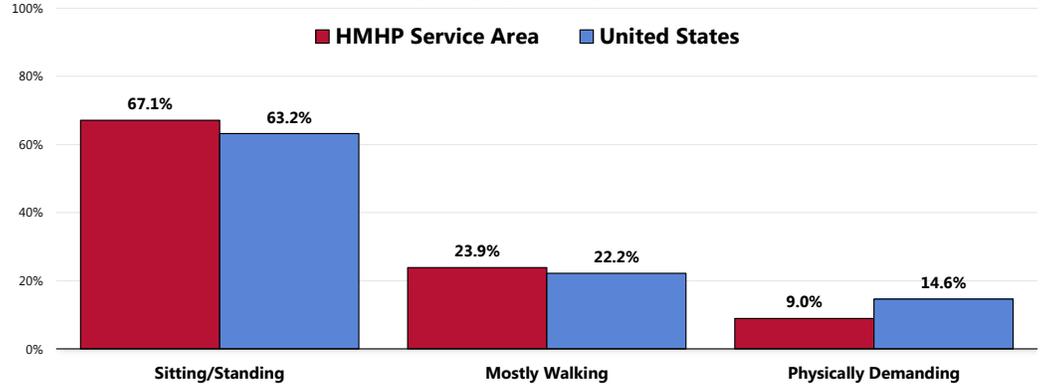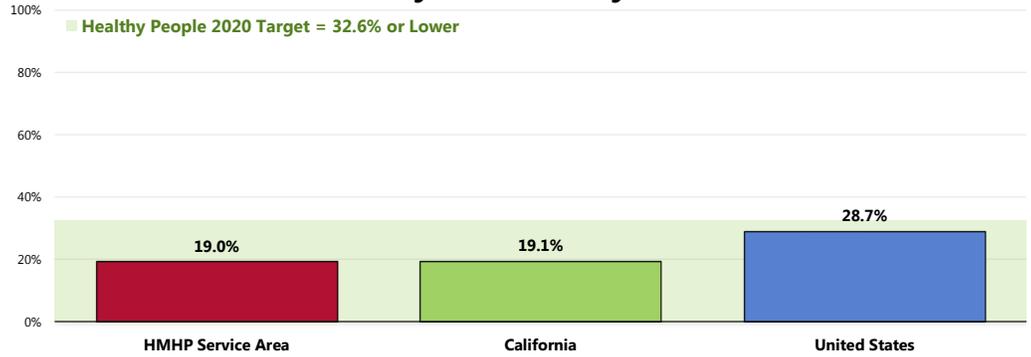- Healthy People 2020 (www.healthypeople.gov)

Level of Activity at Work

A majority of employed respondents reports low levels of physical activity at work.

- Just over 2 in 3 employed respondents (67.1%) report that their job entails mostly sitting or standing, similar to the US figure.

- 23.9% report that their job entails mostly walking (similar to that reported nationally).

- 9.0% report that their work is physically demanding (lower than reported nationally).

Primary Level of Physical Activity At Work
(Among Employed Respondents)

Legend: ■ HMHP Service Area ■ United States

	Sitting/Standing	Mostly Walking	Physically Demanding
HMHP Service Area	67.1%	23.9%	9.0%
United States	63.2%	22.2%	14.6%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of those respondents who are employed for wages.

Leisure-Time Physical Activity

A total of 19.0% of HMHP Service Area adults report no leisure-time physical activity in the past month.

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

- Similar to statewide findings.

- More favorable than national findings.

- Satisfies the Healthy People 2020 target (32.6% or lower).

No Leisure-Time Physical Activity in the Past Month

■ **Healthy People 2020 Target = 32.6% or Lower**

	HMHP Service Area	California	United States
	19.0%	19.1%	28.7%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

👫 Lower-income residents (note the negative correlation with income).

👫 Hispanics.

No Leisure-Time Physical Activity in the Past Month
(Hoag Memorial Hospital Presbyterian Service Area, 2013)
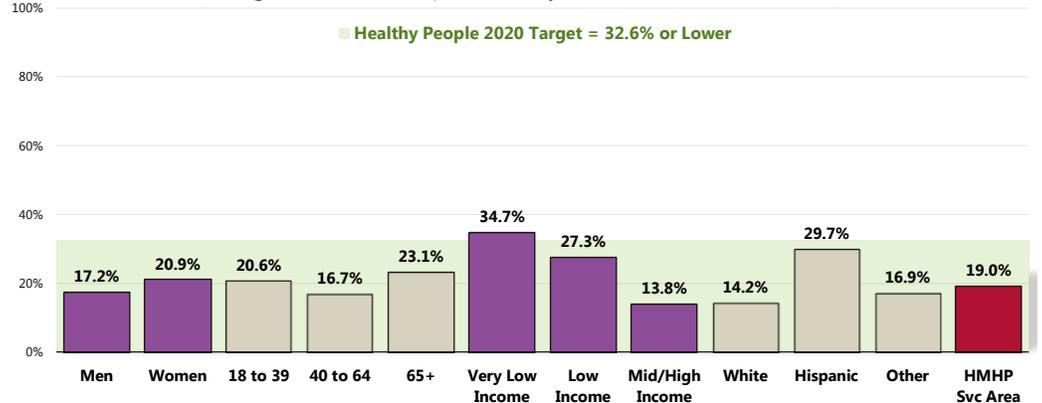
■ **Healthy People 2020 Target = 32.6% or Lower**

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
17.2%	20.9%	20.6%	16.7%	23.1%	34.7%	27.3%	13.8%	14.2%	29.7%	16.9%	19.0%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Levels

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

– 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

Recommended Levels of Physical Activity

A total of 51.3% of HMHP Service Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- More favorable than national findings.

Meets Physical Activity Recommendations

HMHP Service Area	51.3%
United States	42.7%
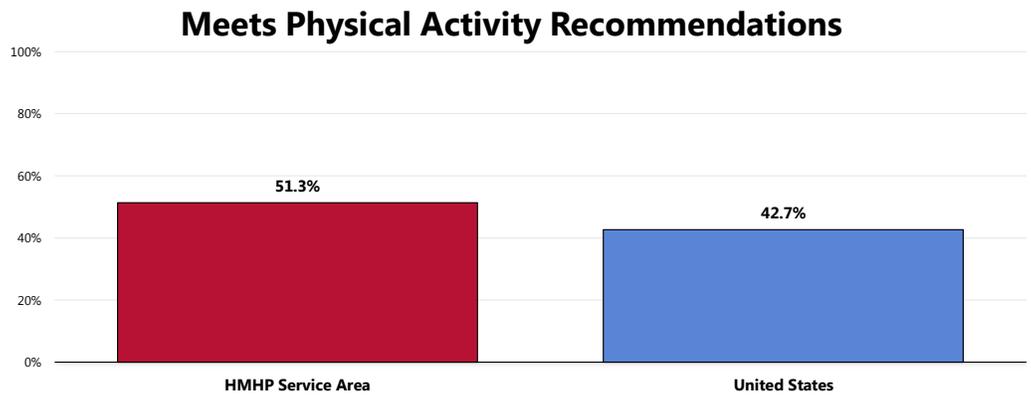
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
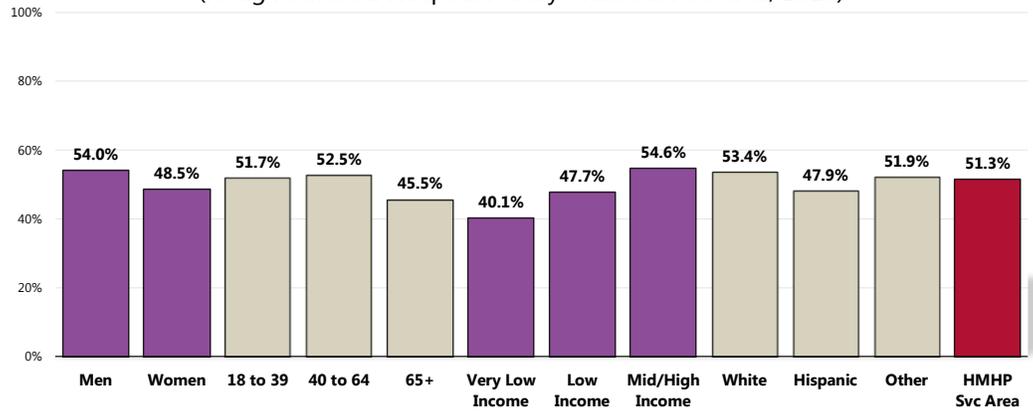
Notes:
- Asked of all respondents.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Residents living in households with lower incomes are less likely to meet physical activity requirements (note the positive correlation with income).

Meets Physical Activity Recommendations
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
54.0%	48.5%	51.7%	52.5%	45.5%	40.1%	47.7%	54.6%	53.4%	47.9%	51.9%	51.3%

Moderate & Vigorous Physical Activity

The individual indicators of moderate and vigorous physical activity are shown here.

In the past month:

A total of 29.9% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).
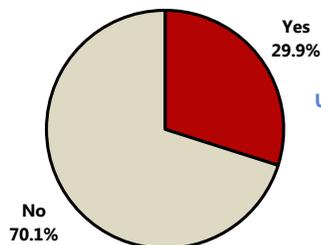
- More favorable than the national level.

A total of 36.5% participated in vigorous physical activity (3 times a week, 20 minutes at a time).
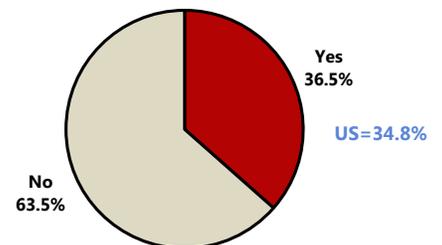
- Comparable to the nationwide figure.

Moderate & Vigorous Physical Activity
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Yes 29.9%
US=23.9%
No 70.1%
Moderate Physical Activity

Yes 36.5%
US=34.8%
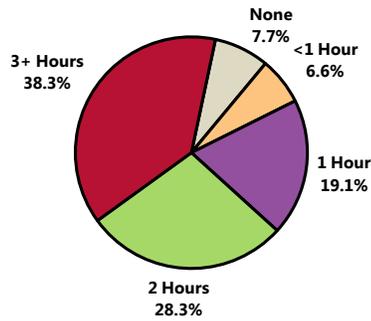No 63.5%
Vigorous Physical Activity
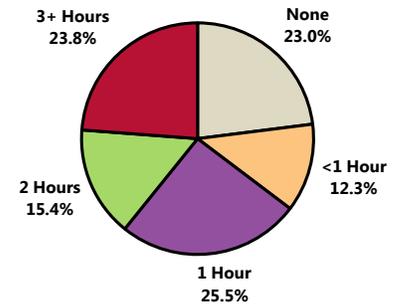
Screen Time

Adults

Among service area adults, 38.3% watch three or more hours of <u>television</u> per day; 23.8% spend three or more hours on <u>other types of screen time</u> for entertainment (video games, Internet, etc.).

Adult's Screen Time
(HMHP Service Area, 2013)

Hours per Day of Television

Hours per Day of Other Screen Time
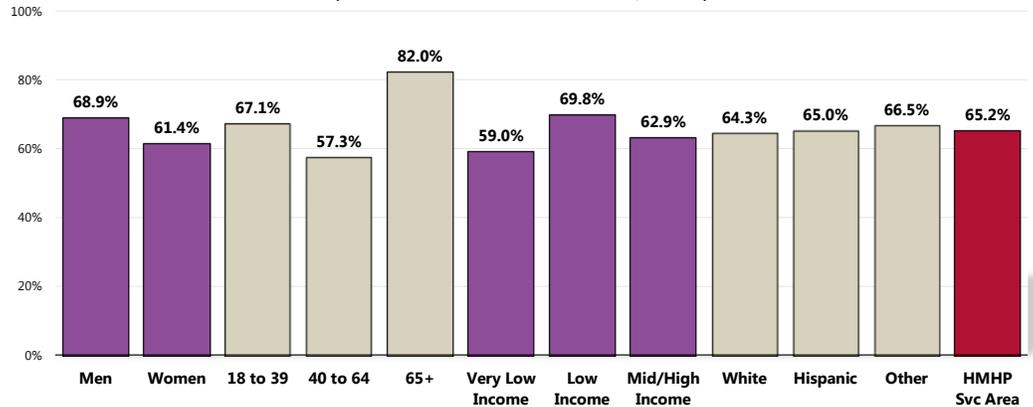(i.e., video games, computer/Internet entertainment)

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 106-107]
Notes: ● Asked of all respondents

When combined, 65.2% of HMHP Service Area adults spend three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

👪 Statistically high among men, young adults, seniors, and residents living just above the federal poverty level.

Combined Screen Time is 3+ Hours Daily
(HMHP Service Area Adults, 2013)

Men	68.9%	
Women	61.4%	
18 to 39	67.1%	
40 to 64	57.3%	
65+	82.0%	
Very Low Income	59.0%	
Low Income	69.8%	
Mid/High Income	62.9%	
White	64.3%	
Hispanic	65.0%	
Other	66.5%	
HMHP Svc Area	65.2%	

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 214]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
● "Three or more hours" includes reported screen time of 180 minutes or more per day.

Among children aged 5 through 17, 20.3% are reported to watch three or more hours of <u>television</u> per day; 19.2% are reported to spend three or more hours on <u>other types of screen time</u> for entertainment (video games, Internet, etc.).
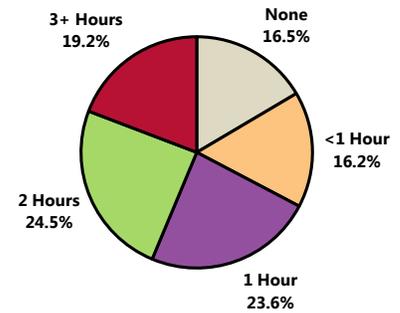
- Time spent on television is comparable to the national figure; computer screen time among service area children is nearly twice the national percentage.

Children's Screen Time
(Among Parents of Children Ages 5-17; HMHP Service Area, 2013)
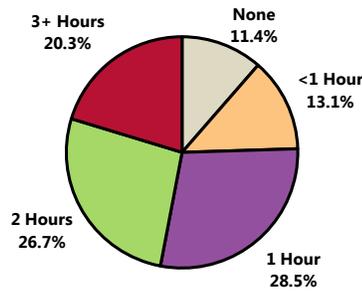
Hours per Day of Television

- 3+ Hours 20.3%
- None 11.4%
- <1 Hour 13.1%
- 1 Hour 28.5%
- 2 Hours 26.7%

Hours per Day of Other Screen Time
(i.e., video games, computer/Internet entertainment)

- 3+ Hours 19.2%
- None 16.5%
- <1 Hour 16.2%
- 1 Hour 23.6%
- 2 Hours 24.5%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 144-145, 182-183]
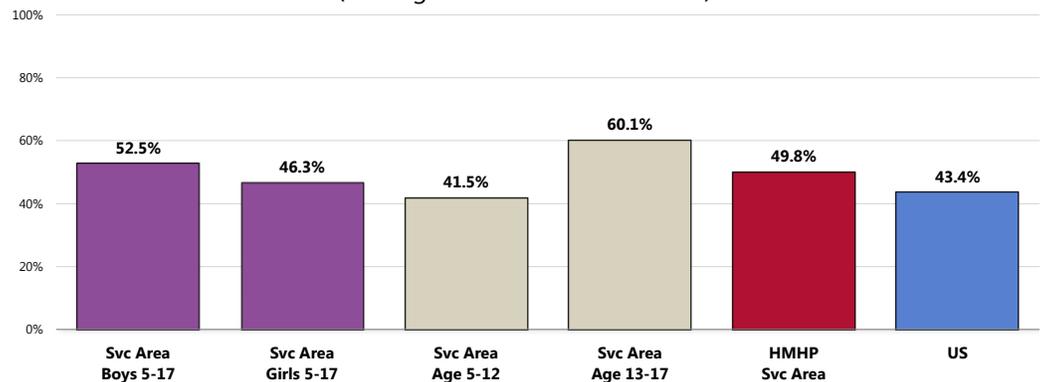Notes: ● Asked of respondents with a child aged 5 to 17 in the household.

When combined, one-half (49.8%) of HMHP Service Area children aged 5 to 17 spends three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

- Similar to the national prevalence.

- Higher in boys (age 5-17) and teens.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]
(Among Parents of Children 5-17)

- Svc Area Boys 5-17: 52.5%
- Svc Area Girls 5-17: 46.3%
- Svc Area Age 5-12: 41.5%
- Svc Area Age 13-17: 60.1%
- HMHP Svc Area: 49.8%
- US: 43.4%

Sources: ● 2013 Professional Research Consultants, Inc. PRC Community Health Survey. [Item 184]
Notes: ● Asked of all respondents with children 5-17 at home.
● For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."
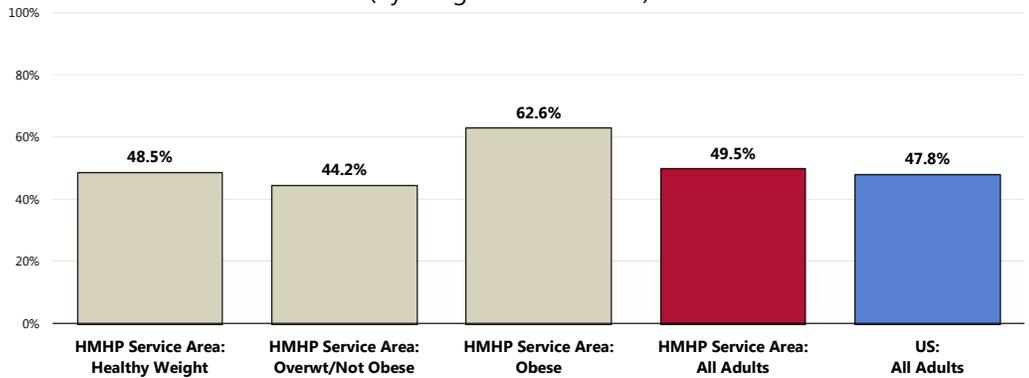● "Three or more hours" includes reported screen time of 180 minutes or more per day.

Health Advice About Physical Activity & Exercise

A total of 49.5% of HMHP Service Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Similar to the national average.

- Note: 62.6% of obese HMHP Service Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

Have Received Advice About Exercise in the
Past Year From a Physician, Nurse, or Other Health Professional
(By Weight Classification)

HMHP Service Area: Healthy Weight	HMHP Service Area: Overwt/Not Obese	HMHP Service Area: Obese	HMHP Service Area: All Adults	US: All Adults
48.5%	44.2%	62.6%	49.5%	47.8%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Weight Status

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

> – Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

> – Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m²)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

Healthy Weight

"Healthy weight "means neither underweight, nor overweight (BMI = 18.5-24.9).

Based on self-reported heights and weights, 45.7% of HMHP Service Area adults are at a healthy weight.

- More favorable than national findings.

- Satisfies the Healthy People 2020 target (33.9% or higher).

Healthy Weight
(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)

Healthy People 2020 Target = 33.9% or Higher

	HMHP Service Area	United States
	45.7%	31.7%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Based on reported heights and weights, asked of all respondents.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-8]
● The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.
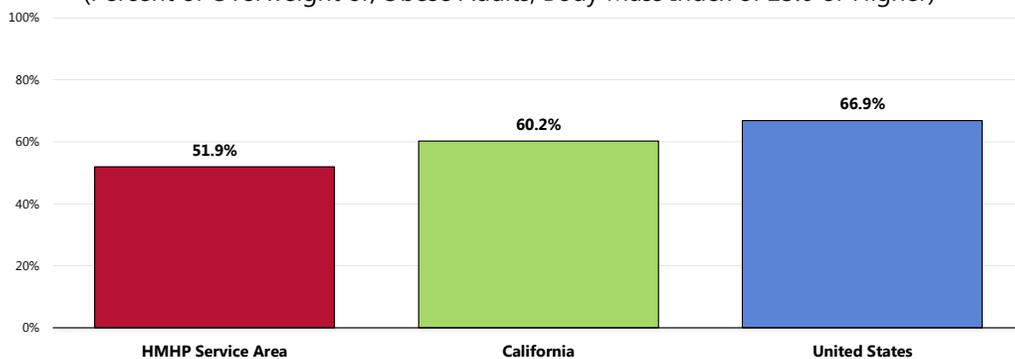
Overweight Status

Here, "overweight" includes those respondents with a BMI value ≥25.

Just over one-half of HMHP Service Area adults (51.9%) are overweight.

● More favorable than the California prevalence.

● More favorable than the US overweight prevalence.

Prevalence of Total Overweight
(Percent of Overweight or/Obese Adults; Body Mass Index of 25.0 or Higher)

	HMHP Service Area	California	United States
	51.9%	60.2%	66.9%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
Notes: ● Based on reported heights and weights, asked of all respondents.
● The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Further, 18.7% of HMHP Service Area adults are obese.

- More favorable than California findings.

- More favorable than US findings.

- Satisfies the Healthy People 2020 target (30.6% or lower).

Prevalence of Obesity
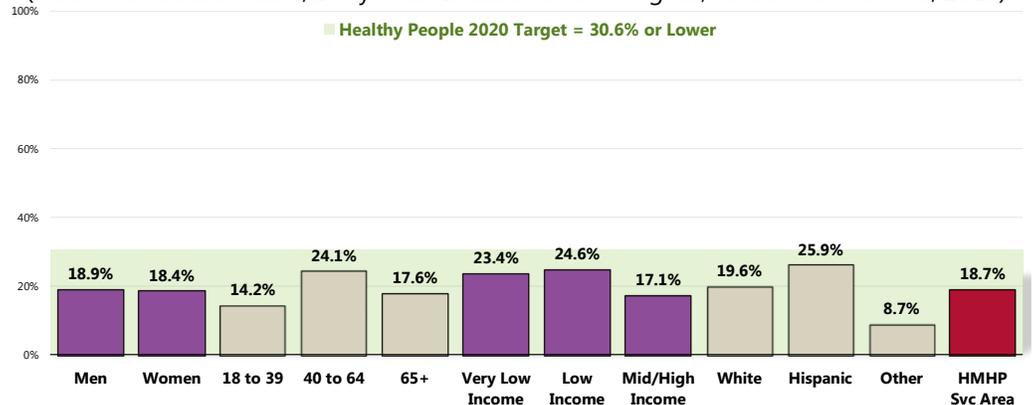(Percent of Obese Adults; Body Mass Index of 30.0 or Higher)

Healthy People 2020 Target = 30.6% or Lower

	HMHP Service Area	California	United States
	18.7%	23.8%	28.5%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Obesity is notably more prevalent among:

- Adults between the ages of 40 and 64.

- Hispanic adults and White adults.

Prevalence of Obesity
(Percent of Obese Adults; Body Mass Index of 30.0 or Higher; HMHP Service Area, 2013)

Healthy People 2020 Target = 30.6% or Lower

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
18.9%	18.4%	14.2%	24.1%	17.6%	23.4%	24.6%	17.1%	19.6%	25.9%	8.7%	18.7%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Overweight and obese adults are more likely to report a number of adverse health conditions.

Among these are:

- Hypertension (high blood pressure).

- High cholesterol.

- "Fair" or "poor" overall health.

- Activity limitations.

- Arthritis/rheumatism.

- Diabetes.

- Major depression.

The correlation between overweight and various health issues cannot be disputed.

Relationship of Overweight With Other Health Issues
(By Weight Classification; Hoag Memorial Hospital Presbyterian Service Area, 2013)
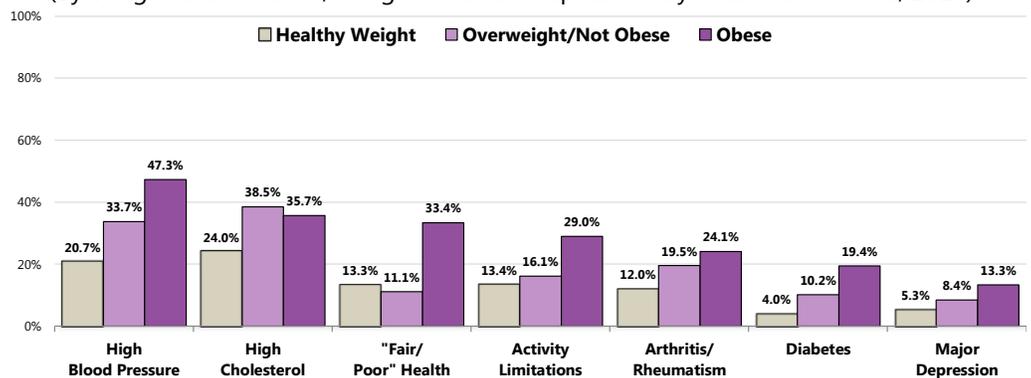
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 26, 31, 37, 121, 148, 149]
Notes: • Based on reported heights and weights, asked of all respondents.

Weight Management

Health Advice

A total of 23.8% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.
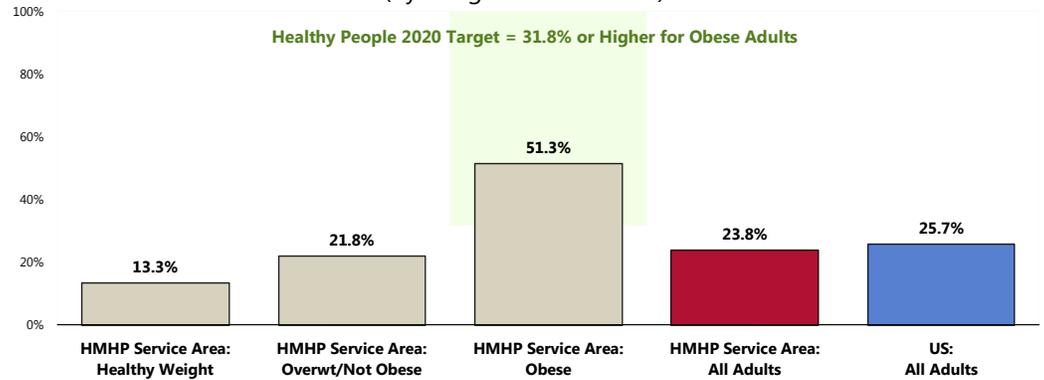
- Statistically similar to the national findings.

- Note that 51.3% of <u>obese</u> adults have been given advice about their weight by a health professional in the past year (while nearly one-half has not).

  – This proportion satisfies the Healthy People 2020 target of 31.8% or higher.

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional
(By Weight Classification)

Healthy People 2020 Target = 31.8% or Higher for Obese Adults

Category	Percentage
HMHP Service Area: Healthy Weight	13.3%
HMHP Service Area: Overwt/Not Obese	21.8%
HMHP Service Area: Obese	51.3%
HMHP Service Area: All Adults	23.8%
US: All Adults	25.7%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 111, 189]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Weight Control

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

– Healthy People 2020 (www.healthypeople.gov)

A total of 47.3% of HMHP Service Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

- More favorable than national findings.

- Note: 52.8% of <u>obese</u> area adults report that they are trying to lose weight through a combination of diet and exercise, more favorable than the US figure.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity
(By Weight Classification)

■ HMHP Svc Area ■ US

Category	HMHP Svc Area	US
Overweight/Obese	47.3%	38.6%
Obese	52.8%	41.1%
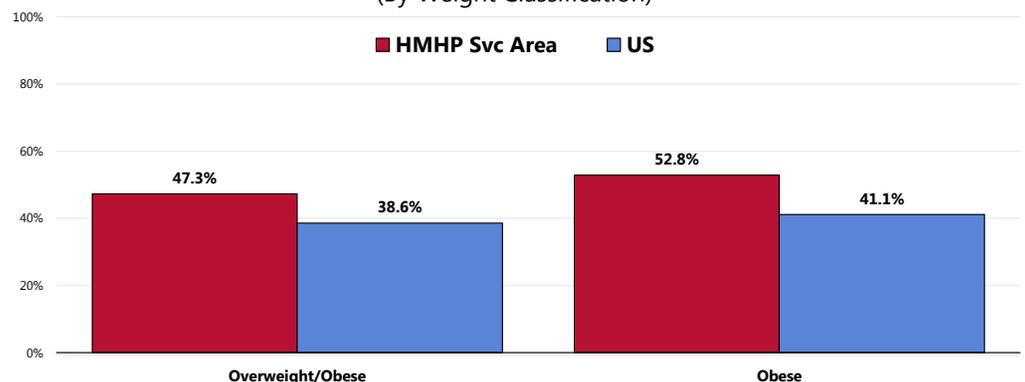
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 187]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Based on reported heights and weights, asked of all respondents.

Childhood Overweight & Obesity

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight   <5th percentile
- Healthy Weight   ≥5th and <85th percentile
- Overweight   ≥85th and <95th percentile
- Obese   ≥95th percentile

– Centers for Disease Control and Prevention.

Based on the heights/weights reported by surveyed parents, 16.6% of HMHP Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Much more favorable than found nationally.

- Statistically high in area boys; similar by age.

Child Total Overweight Prevalence
(Children 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)
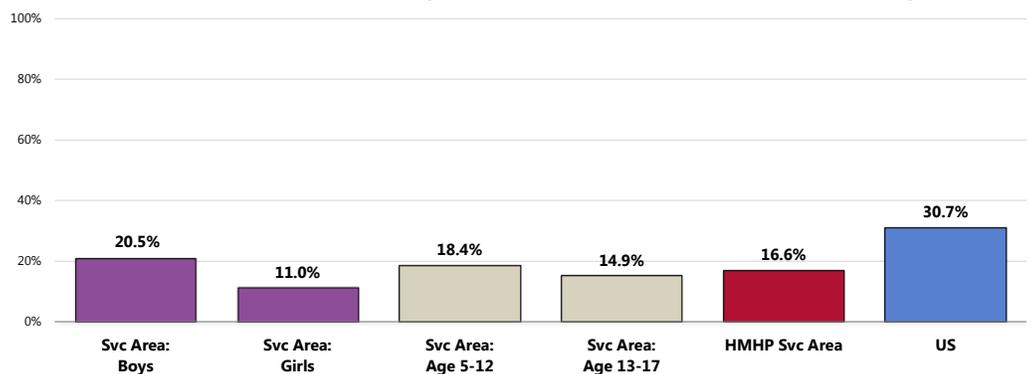
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
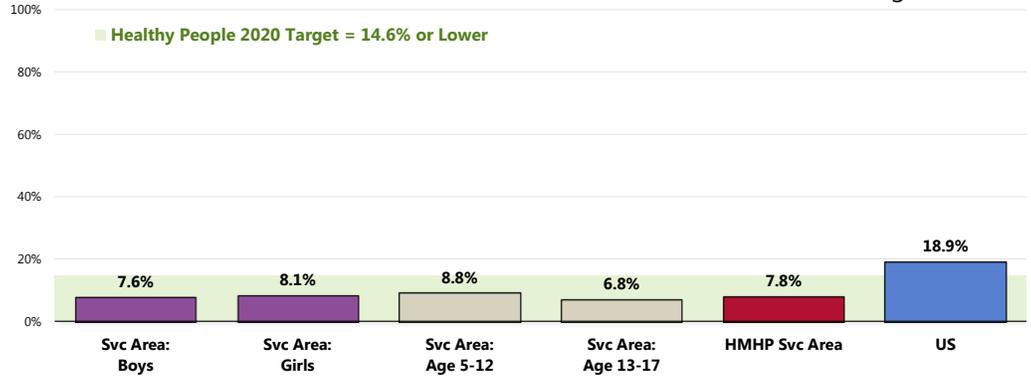● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children age 5-17 at home.
● Overweight among children is estimated based on children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Further, 7.8% of HMHP Service Area children age 5 to 17 are obese (≥95th percentile).

- More favorable than the national percentage.

- Satisfies the Healthy People 2020 target (14.6% or lower for children age 2-19).

- Statistically similar by child's age and gender.

Child Obesity Prevalence

(Percent of Children 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2020 Target = 14.6% or Lower

Svc Area: Boys	Svc Area: Girls	Svc Area: Age 5-12	Svc Area: Age 13-17	HMHP Svc Area	US
7.6%	8.1%	8.8%	6.8%	7.8%	18.9%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-10.4]

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Related Focus Group Findings: Obesity and Nutrition

Many focus group participants discussed nutrition and its relationship to obesity. The main findings include:

- Childhood obesity
- Relationship between nutritious foods and health
- Need for nutrition education

Focus group attendees believe that poor nutrition habits contribute to the high prevalence of **childhood obesity** and other chronic diseases in the community. Participants think that poor nutrition stems from a variety of sources in the community, including socio-economic status:

> *"We talk a lot about nutrition and nutrition education. We think we have been enlightened; yet childhood obesity meets the definition of an epidemic, not just in Orange County but in every state in the nation. So there is a little bit of disconnect between what we think we know about nutrition and people's behavior around food."* — Community Leader

> *"I think obesity leads to a lot of other health issues and the children are the product of their environment if the parent has poor health eating habits, the children are going to have poor eating habits as well. It is not uncommon to find in the homeless shelter that the kids tend to be obese because their parents are obese, and even if there is nutritious food available they still make the wrong food choices."* — Community Leader

Participants agree that residents lack the understanding about the **relationship between nutritious foods and health.** Many residents would benefit from **nutrition education** and providers must not assume everyone knows about the consequences of poor diet. Focus group members had a variety of ideas on how to educate residents on proper nutrition, so that healthy eating becomes a lifelong behavioral change:

"Our clients need to understand the importance of nutrition in the diet and that even though they may be full, it doesn't mean that they are eating properly. I had a child that was three years old, obese and with severe sleep apnea, the mom had a first grade education and was also obese. She did not understand that both of them were starving nutritionally because the only foods at home were tortilla and beans." — Healthcare Provider

"I am excited to say that there are several food pantries in Orange County that stopped giving out just carbohydrates and are now filling the food bags with produce. The problem now is that we hope the client will be able to store it correctly and realizes the importance of incorporating fruits and vegetables in their daily diet." — Healthcare Provider

"We see eating behaviors that are very damaging, but they are connected to other lifestyle choices. We as service providers need to see the connection and develop comprehensive interventions otherwise we end up blaming the clients for not wanting to eat properly. We offer them food and teach them to eat something nutritious and then we get upset when they don't do it and we assume they don't want to eat healthy. We should try to understand the why behind the behavior and offer education on how to make lifestyle changes." — Healthcare Provider

Substance Abuse

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy

- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)

- Other sexually transmitted diseases (STDs)

- Domestic violence

- Child abuse

- Motor vehicle crashes

- Physical fights

- Crime

- Homicide

- Suicide

The field has made progress in addressing substance abuse, particularly among youth. According to data from the national Institute of Drug Abuse (NIDA) Monitoring the Future (MTF) survey, which is an ongoing study of the behaviors and values of America's youth between 2004 and 2009, a drop in drug use (including amphetamines, methamphetamine, cocaine, hallucinogens, and LSD) was reported among students in 8th, 10th, and 12th grades. Note that, despite a decreasing trend in marijuana use which began in the mid-1990s, the trend has stalled in recent years among these youth. Use of alcohol among students in these three grades also decreased during this time.

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.
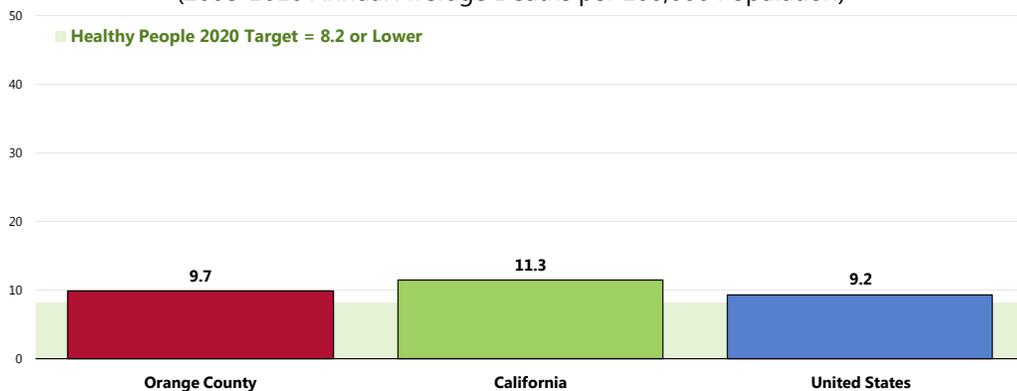
– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2008 and 2010, there was an annual average age-adjusted cirrhosis/liver disease mortality rate of 9.7 deaths per 100,000 population in Orange County.

● Better than the statewide rate.

● Just above the national rate.

● Fails to satisfy the Healthy People 2020 target (8.2 or lower).

Cirrhosis/Liver Disease: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

■ Healthy People 2020 Target = 8.2 or Lower

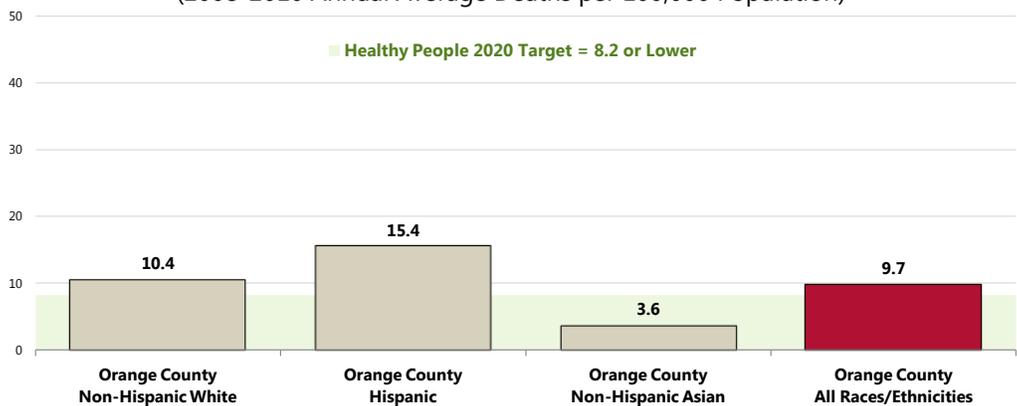|	Orange County	California	United States
Rate	9.7	11.3	9.2

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

👥 The cirrhosis mortality rate is favorably low in the Orange County Asian population.

Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

■ Healthy People 2020 Target = 8.2 or Lower

	Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
Rate	10.4	15.4	3.6	9.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
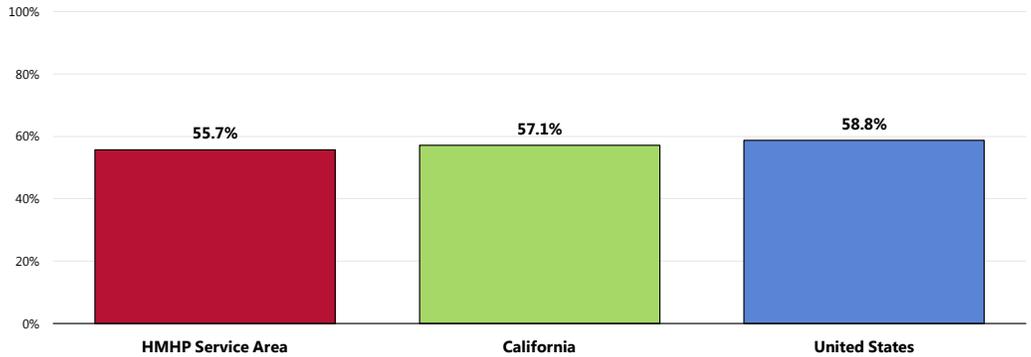● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Current Drinking

A total of 55.7% of area adults had at least one drink of alcohol in the past month (current drinkers).

- Similar to the statewide proportion.

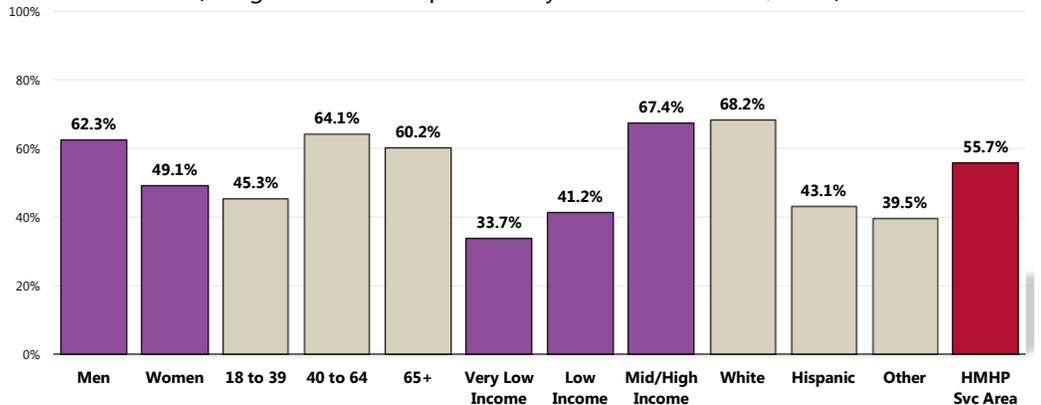- Similar to the national proportion.

Current Drinkers

Bar chart — Current Drinkers:
- HMHP Service Area: 55.7%
- California: 57.1%
- United States: 58.8%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Current drinkers had at least one alcoholic drink in the past month.

Current drinking is more prevalent among:

- Men.

- Adults age 40 and older.

- Upper-income residents.

- Whites.

Current Drinkers
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Bar chart — Current Drinkers:
- Men: 62.3%
- Women: 49.1%
- 18 to 39: 45.3%
- 40 to 64: 64.1%
- 65+: 60.2%
- Very Low Income: 33.7%
- Low Income: 41.2%
- Mid/High Income: 67.4%
- White: 68.2%
- Hispanic: 43.1%
- Other: 39.5%
- HMHP Svc Area: 55.7%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
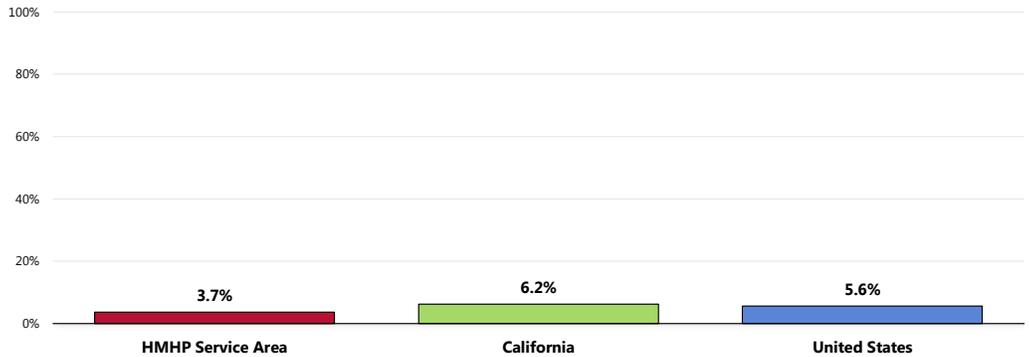● Current drinkers had at least one alcoholic drink in the past month.

A total of 3.7% of area adults averaged two or more drinks of alcohol per day in the past month (chronic drinkers).

- More favorable than the statewide proportion.
- Comparable to the national proportion.

Chronic Drinkers

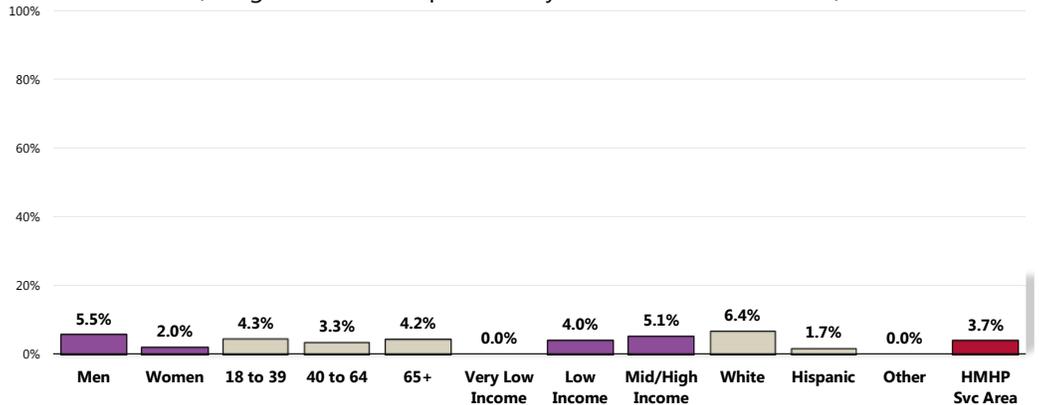|		
HMHP Service Area	California	United States
3.7%	6.2%	5.6%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 196]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Chronic drinkers are defined as having 60+ alcoholic drinks in the past month.
- *The state definition for chronic drinkers is males consuming 2+ drinks per day and females consuming 1+ drink per day.

Chronic drinking is more prevalent among:

- Men.
- Residents living above poverty.
- Whites.

Chronic Drinkers
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
5.5%	2.0%	4.3%	3.3%	4.2%	0.0%	4.0%	5.1%	6.4%	1.7%	0.0%	3.7%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 196]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Chronic drinkers are defined as those having 60+ alcoholic drinks in the past month.

A total of 13.6% of HMHP Service Area adults are binge drinkers.

- Lower than the California figure.

- Statistically similar to national findings.

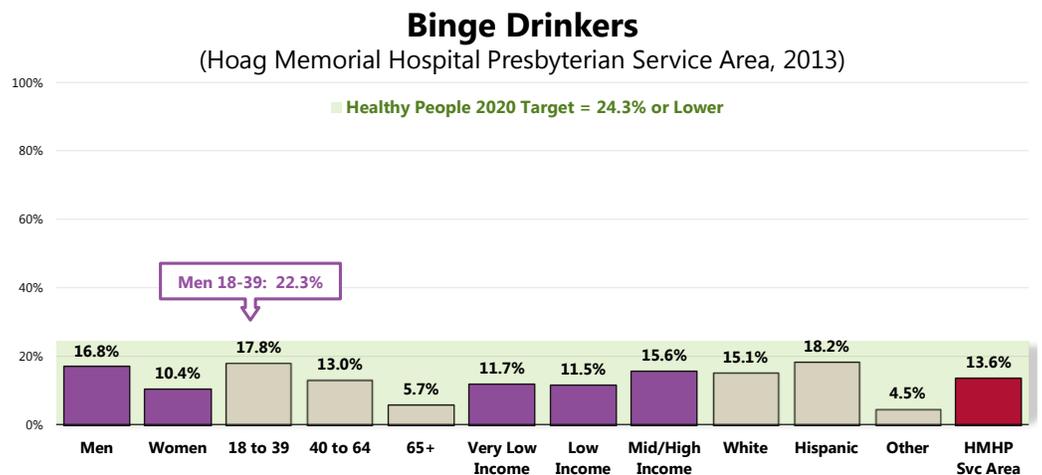- Satisfies the Healthy People 2020 target (24.3% or lower).

Binge Drinkers

Healthy People 2020 Target = 24.3% or Lower

HMHP Service Area	California	United States
13.6%	18.6%	16.7%
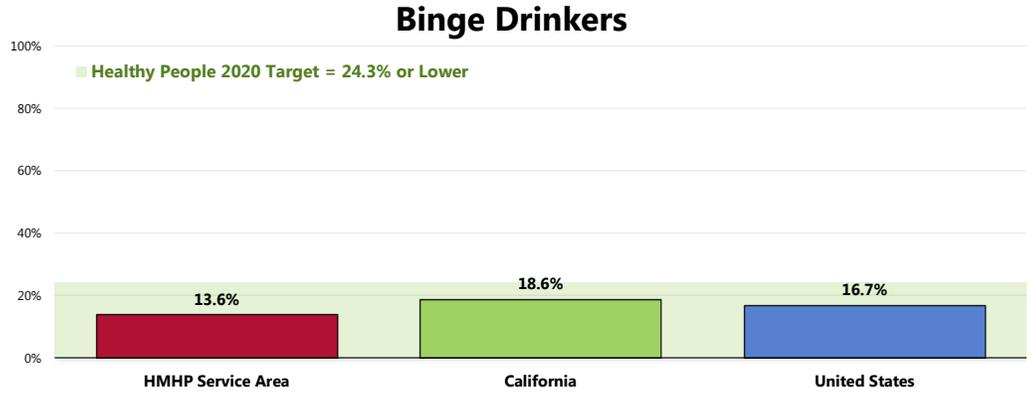
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-14.3]

Notes:
- Asked of all respondents.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.

Binge drinking is more prevalent among:

- Men (especially those under age 40).

- Adults under age 40.

- Whites and Hispanics.

Binge Drinkers
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Healthy People 2020 Target = 24.3% or Lower

Men 18-39: 22.3%

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
16.8%	10.4%	17.8%	13.0%	5.7%	11.7%	11.5%	15.6%	15.1%	18.2%	4.5%	13.6%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-14.3]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion
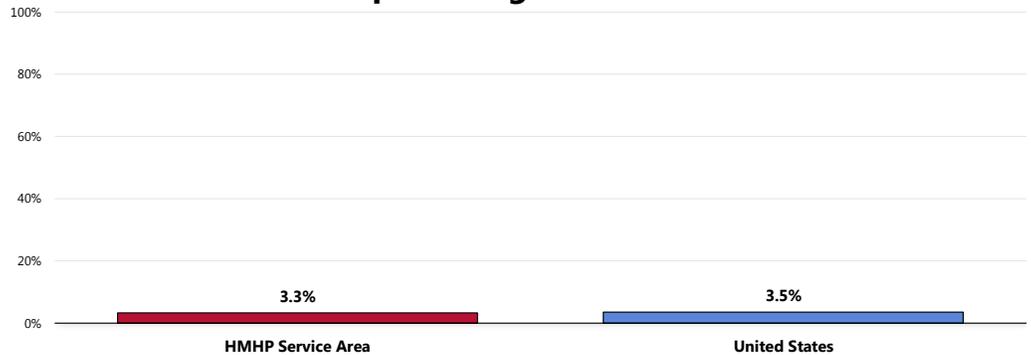
A total of 3.3% of HMHP Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- Similar to the national findings.

Have Driven in the Past Month After Perhaps Having Too Much to Drink

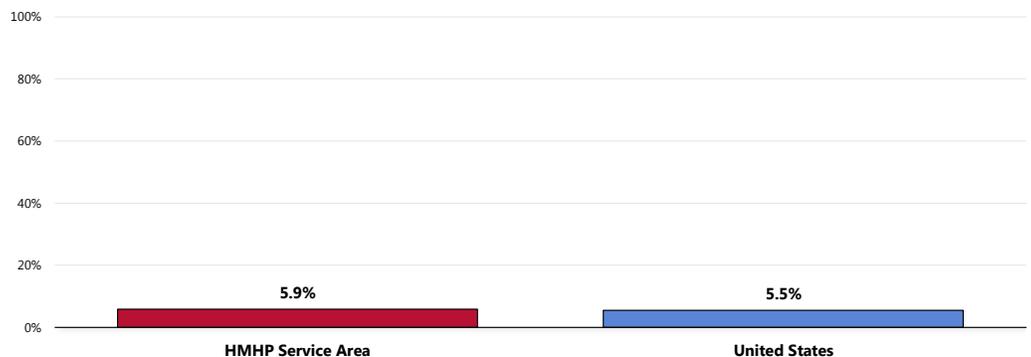HMHP Service Area: 3.3%
United States: 3.5%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

A total of 5.9% of HMHP Service Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- Comparable to the national findings.

Have Driven Drunk OR Ridden With a Driver in the Past Month Who Had Too Much to Drink

HMHP Service Area: 5.9%
United States: 5.5%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 198]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
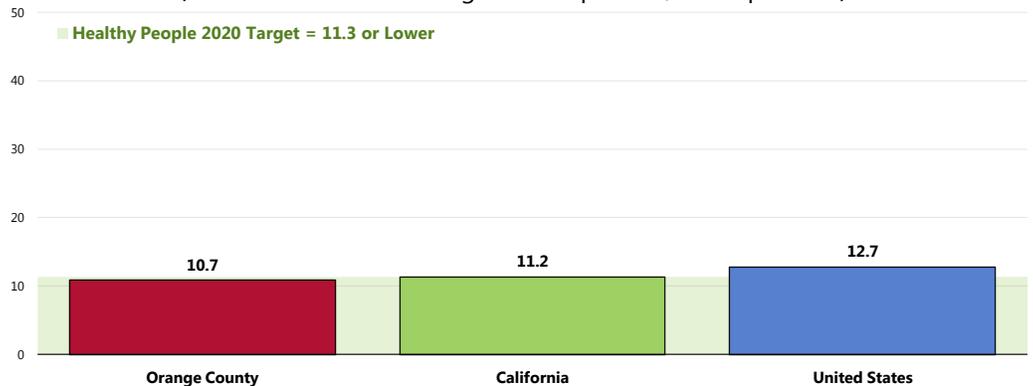Notes: • Asked of all respondents.

Between 2008 and 2010, there was an annual average age-adjusted drug-induced mortality rate of 10.7 deaths per 100,000 population in Orange County.

- Similar to the statewide rate.

- Lower than the national rate.

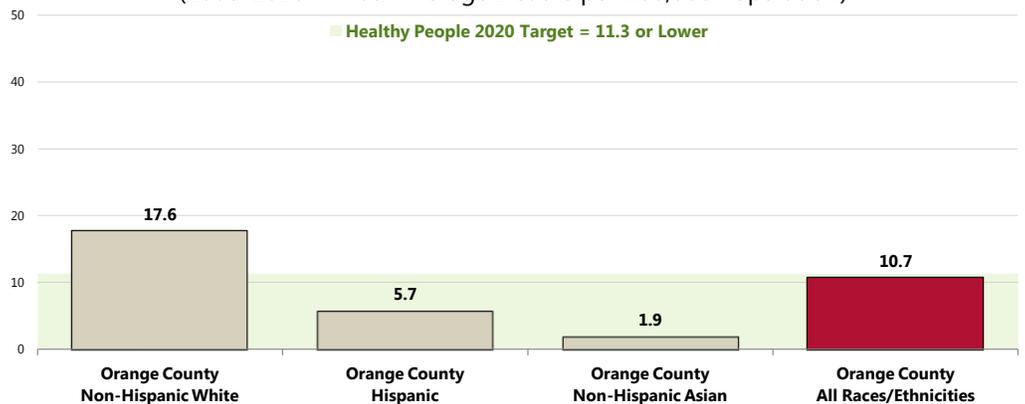- Satisfies the Healthy People 2020 target (11.3 or lower).

Drug-Induced Deaths: Age-Adjusted Mortality
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower

Orange County	California	United States
10.7	11.2	12.7

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.

The drug-induced mortality rate is much higher among Orange County Whites than among Hispanics and Asians.

Drug-Induced Deaths: Age-Adjusted Mortality by Race
(2008-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower

Orange County Non-Hispanic White	Orange County Hispanic	Orange County Non-Hispanic Asian	Orange County All Races/Ethnicities
17.6	5.7	1.9	10.7

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• County, state and national data are simple three-year averages.

Illicit Drug Use

A total of 2.8% of HMHP Service Area adults acknowledge using an illicit drug in the past month.

- Similar to the proportion found nationally.

- Satisfies the Healthy People 2020 target of 7.1% or lower.
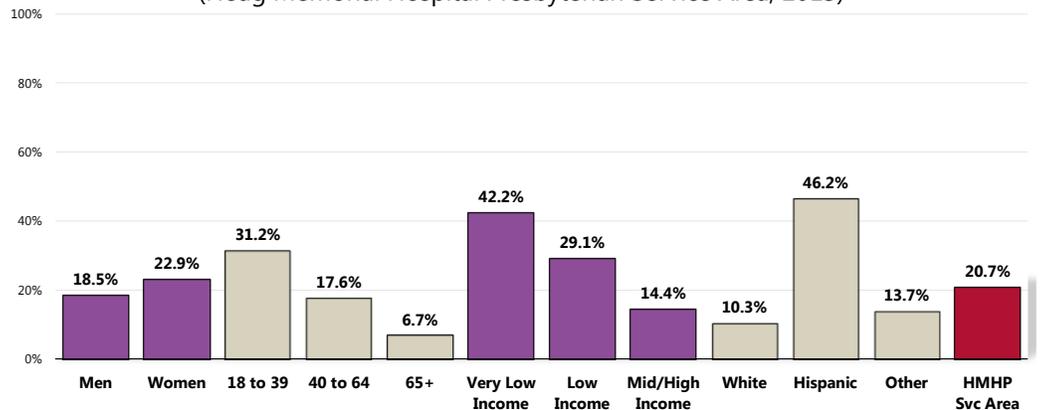
Illicit Drug Use in the Past Month

Healthy People 2020 Target = 7.1% or Lower

HMHP Service Area	United States
2.8%	1.7%

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.
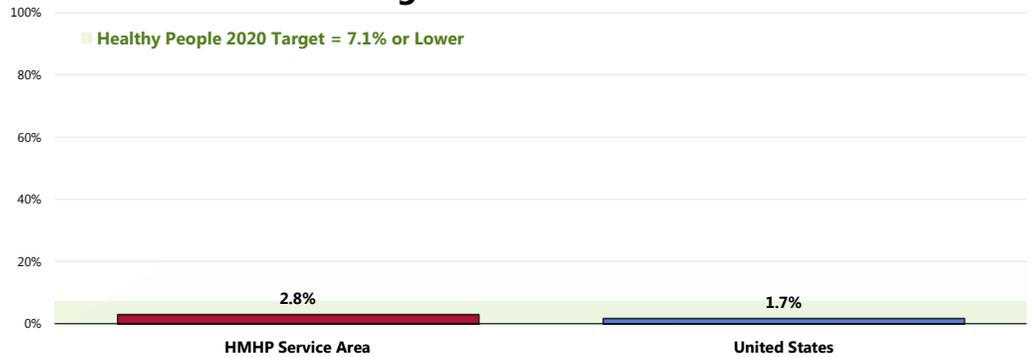
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 72]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.

Medication Safety

When asked, 20.7% of survey respondents indicate that their medicine is kept in a locked, secure place.

- Less likely among residents age 40+ (note the negative correlation with age), upper-income residents (negative correlation), Whites, and "Other" race adults.

Medicine is Kept in a Locked, Secure Place
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

| Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
18.5%	22.9%	31.2%	17.6%	6.7%	42.2%	29.1%	14.4%	10.3%	46.2%	13.7%	20.7%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Alcohol & Drug Treatment

A total of 2.1% of HMHP Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Lower than the national prevalence.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

HMHP Service Area	2.1%
United States	3.9%
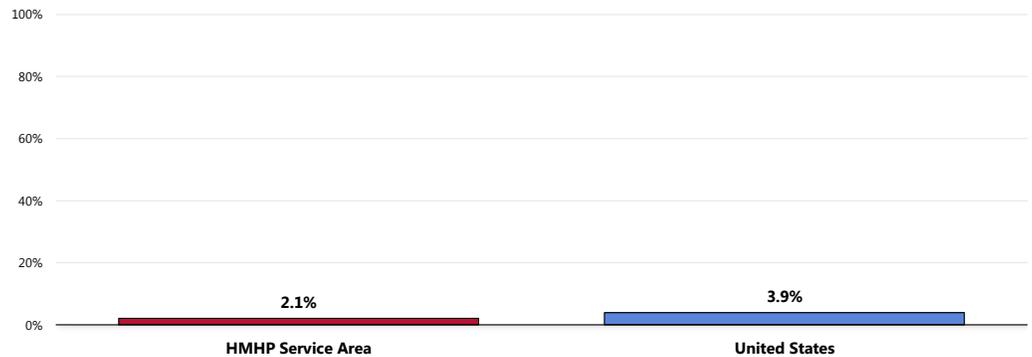
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 73]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Related Focus Group Findings: Substance Abuse

Focus group participants are concerned with substance abuse in the community, discussing the following issues:

- Lack of treatment centers
- Increase in binge drinking
- Prescription drug abuse

A number of focus group participants express concern with the increase of substance use and abuse in the community, especially heroin, alcohol, and prescription drugs. Marijuana use is also very prevalent, but participants did not express concern with its use or abuse in the community. Key informants expressed frustration about the **lack of treatment centers** available once a resident wishes to seek help. Participants also worry about the increase in alcohol consumption and **binge drinking** among adolescents, and the **abuse of prescription drugs** across all age groups.

> *"Heroin is making a huge comeback and this is related to the use of the prescription med Oxycodone, which is the synthetic form of heroin and is very easy to access. It is synthetic heroine. So now kids are finding heroin easier and cheaper. Unfortunately the problem is not only with young people but we also have adults using heroine. Lately we have seen a large number of overdoses related to this heroin use."* — Community Leader

> *"There is an increase in binge drinking with college kids, and they don't perceive it as having a drinking issue because they are only doing it on the weekends or spring break."* — Healthcare Provider

"In Newport Beach we have more alcohol licensed establishments than any city in the county. And we have more people die in automobiles DUI related traffic accidents than any community in the county. We have more people die in DUI crashes than homicides in this city." —Community Leader

Participants also feel that the educational programs that address substance abuse among college students can have an impact. A key informant describes a successful program:

"We did an anti-binge drinking campaign on our campus this last semester initiated by the healthcare agency in collaboration with the University of Alabama. It used social media and humor to make the statement that you cannot keep drinking a secret anymore. We followed the program with a summit on campus and one college student stated that she was that girl laying on the street who somebody posted on Facebook. I think students are realizing if you binge drink people are going to find out." — Healthcare Provider

Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the US $193 billion annually in direct medical expenses and lost productivity.

Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer

- Heart disease

- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)

- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

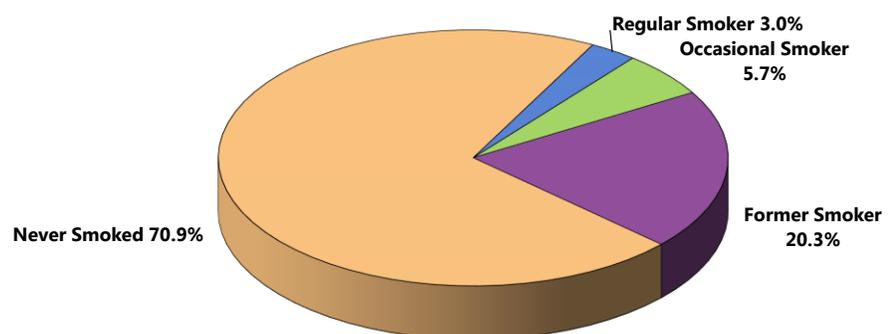– Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 8.7% of HMHP Service Area adults currently smoke cigarettes, either regularly (3.0% every day) or occasionally (5.7% on some days).
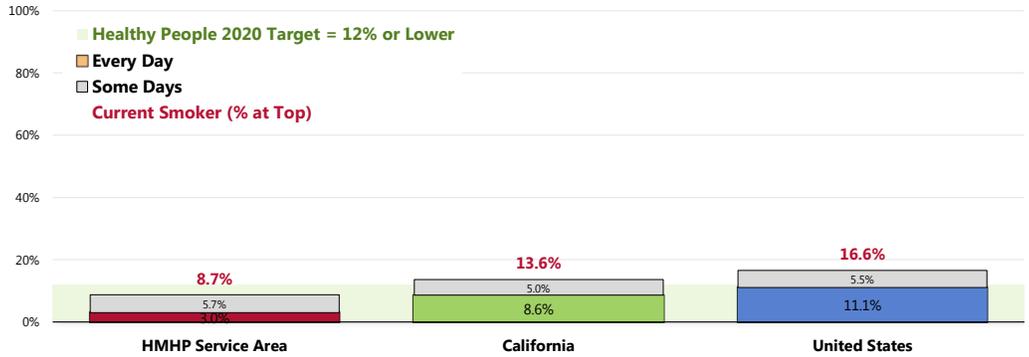
Cigarette Smoking Prevalence
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Regular Smoker 3.0%
Occasional Smoker 5.7%
Former Smoker 20.3%
Never Smoked 70.9%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]
Notes: ● Asked of all respondents.

- Better than statewide findings.

- Better than national findings.

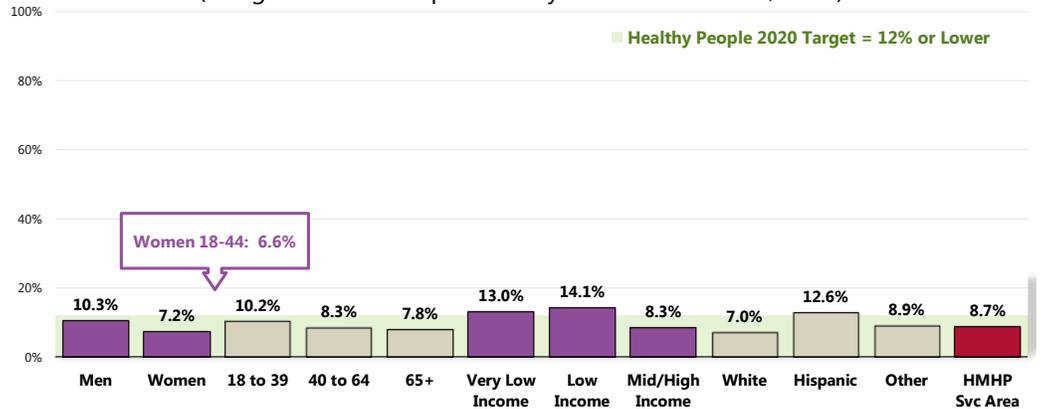- Satisfies the Healthy People 2020 target (12% or lower).

Current Smokers

Healthy People 2020 Target = 12% or Lower
■ Every Day
□ Some Days
Current Smoker (% at Top)

	HMHP Service Area	California	United States
Current Smoker	8.7%	13.6%	16.6%
Some Days	5.7%	5.0%	5.5%
Every Day	3.0%	8.6%	11.1%

👪 No statistical difference by key demographic characteristics.

👪 Note that 6.6% of women of child-bearing age (ages 18 to 44) currently smoke. This is notable given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.

Current Smokers
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Healthy People 2020 Target = 12% or Lower

Women 18-44: 6.6%

| Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
10.3%	7.2%	10.2%	8.3%	7.8%	13.0%	14.1%	8.3%	7.0%	12.6%	8.9%	8.7%

A total of 7.9% of HMHP Service Area adults (including smokers and non-smokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- More favorable than national findings.

- Note that 4.2% of HMHP Service Area non-smokers are exposed to cigarette smoke at home.

Member of Household Smokes at Home

Non-smokers exposed to smoke in the home: 4.2%

HMHP Service Area: 7.9%
United States: 13.6%
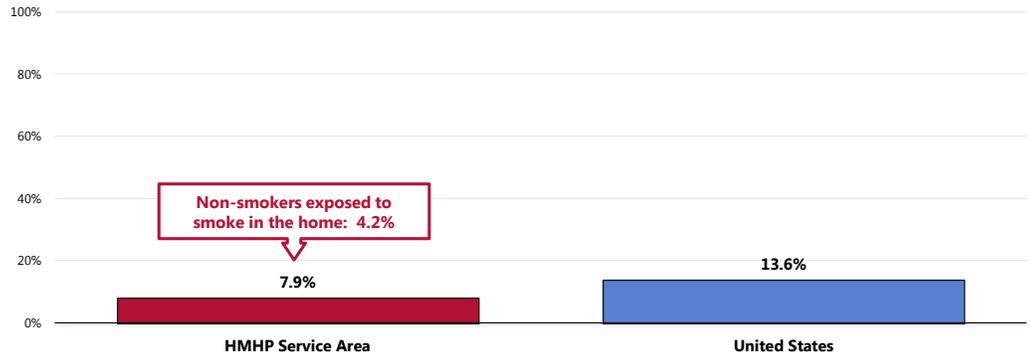
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 63, 193]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
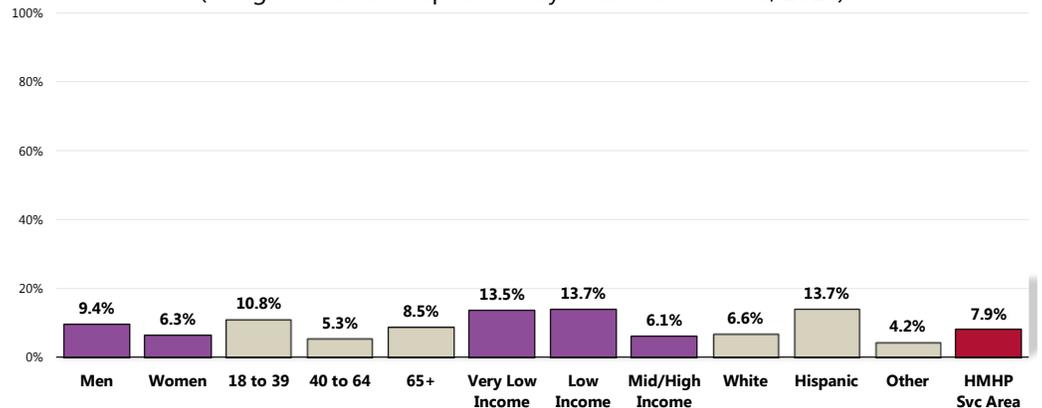Notes: ● Asked of all respondents.
● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Notably higher among:

- Young adults.

- Residents in the lower income categories.

- Hispanics.

Member of Household Smokes At Home
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
9.4%	6.3%	10.8%	5.3%	8.5%	13.5%	13.7%	6.1%	6.6%	13.7%	4.2%	7.9%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 63]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

In households with children, 7.7% have someone who smokes cigarettes in the home.

- Statistically comparable to national findings.

Percentage of Households With Children in Which Someone Smokes in the Home
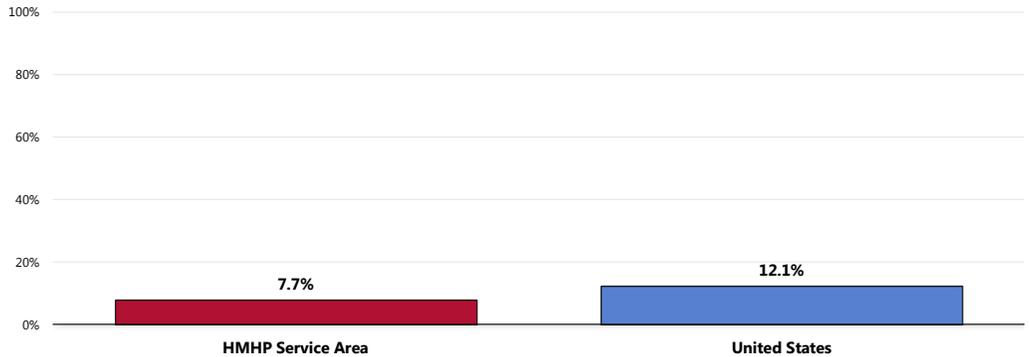
Smoking Cessation

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

  – Healthy People 2020 (www.healthypeople.gov)

Health Advice About Smoking Cessation

A total of 61.6% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Similar to the national percentage.

Advised by a Healthcare Professional in the Past Year to Quit Smoking
(Among Current Smokers)
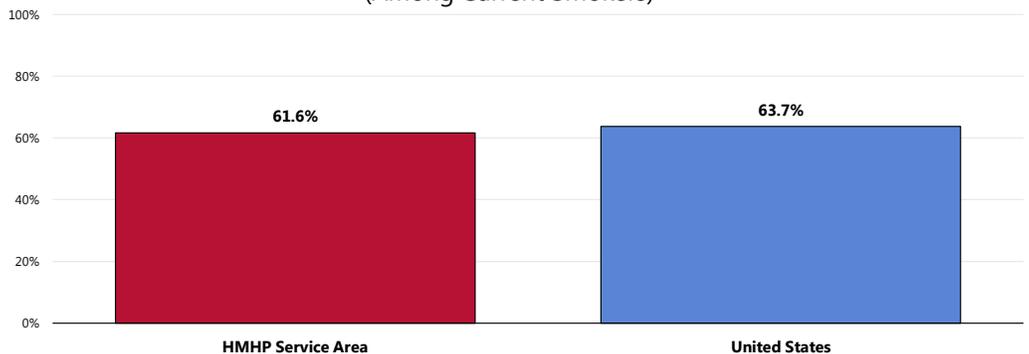
A total of 21.9% of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Well below the national percentage.

- Far from satisfying the Healthy People 2020 target (80% or higher).

Have Stopped Smoking for One Day or Longer In the Past Year in an Attempt to Quit Smoking
(Among Everyday Smokers)

Healthy People 2020 Target = 80% or Higher

HMHP Service Area	United States
21.9%	56.2%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
          • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
          • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-4.1]
Notes: • Asked of respondents who smoke cigarettes every day.

Other Tobacco Use

Cigars

A total of 5.1% of HMHP Service Area adults use cigars every day or on some days.

- Similar to the national percentage.

- Fails to satisfy the Healthy People 2020 target (0.2% or lower).

Use of Cigars

Healthy People 2020 Target = 0.2% or Lower

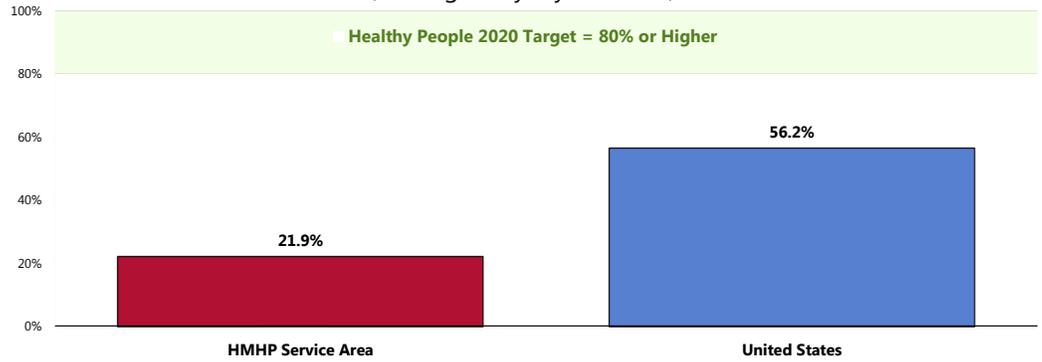| HMHP Service Area	United States
5.1%	4.2%
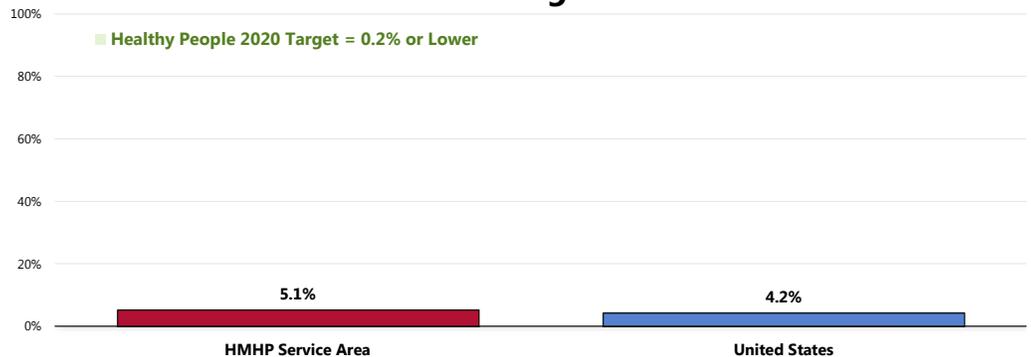
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 65]
          • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
          • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.3]
Notes: • Asked of all respondents.

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 2.1% of HMHP Service Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).

Use of Smokeless Tobacco

■ **Healthy People 2020 Target = 0.3% or Lower**

HMHP Service Area	2.1%
United States	2.8%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 64]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.2]

Notes:
- Asked of all respondents.
- Smokeless tobacco includes chewing tobacco or snuff.

ACCESS TO HEALTH SERVICES

Health Insurance Coverage
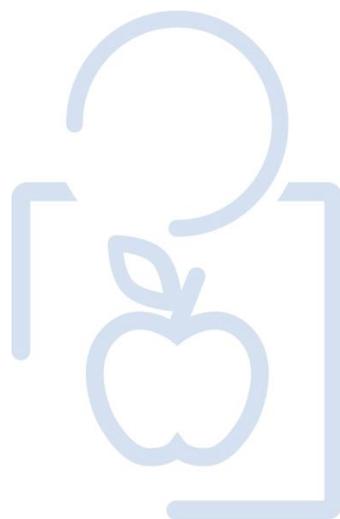
Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 63.3% of HMHP Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 16.2% report coverage through a government-sponsored program (e.g., Medicare, MediCal, military benefits).

Healthcare Insurance Coverage
(Among Adults 18-64; Hoag Memorial Hospital Presbyterian Service Area, 2013)

No Insurance/ Self-Pay 20.5%

Other Gov't Coverage 1.7%

Medicaid & Medicare 1.1%

VA/Military 2.4%

Medicare 3.9%

MediCal 7.1%

Insured, Unknown Type 0.3%

Insured, Self-Purchase 9.2%

Insured, Employer-Based 53.8%
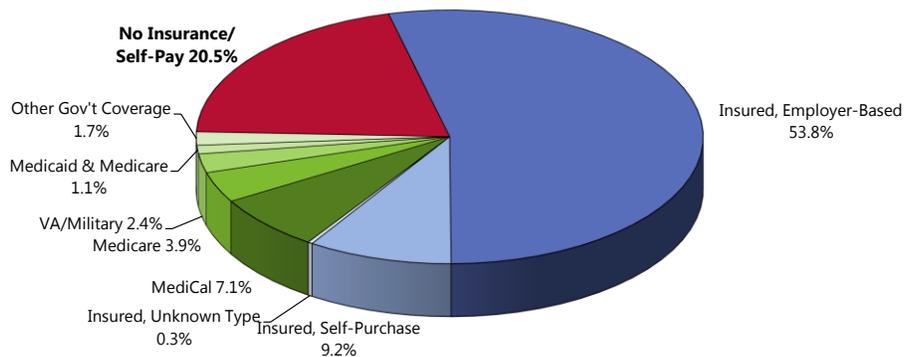
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]
Notes: ● Reflects respondents age 18 to 64.

Prescription Drug Coverage

Among insured adults, 93.8% report having prescription coverage as part of their insurance plan.

- Nearly identical to the national prevalence.

Health Insurance Covers Prescriptions at Least in Part
(Among Insured Respondents)

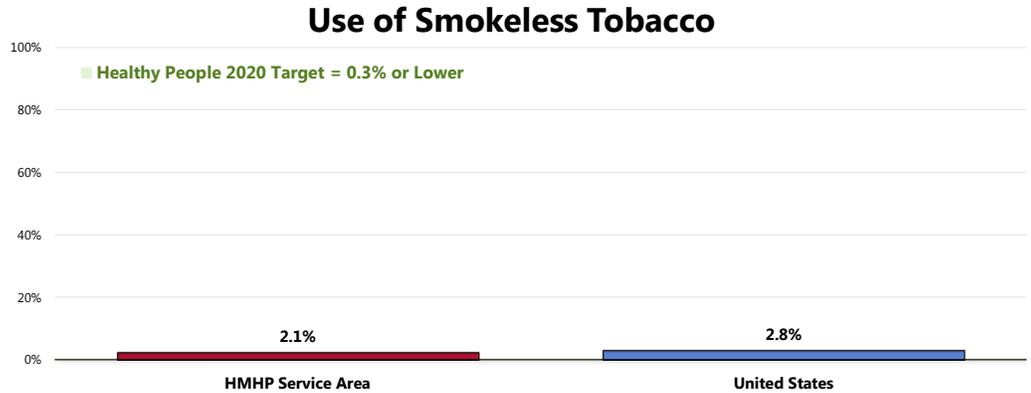|	HMHP Service Area	United States
	93.8%	93.9%
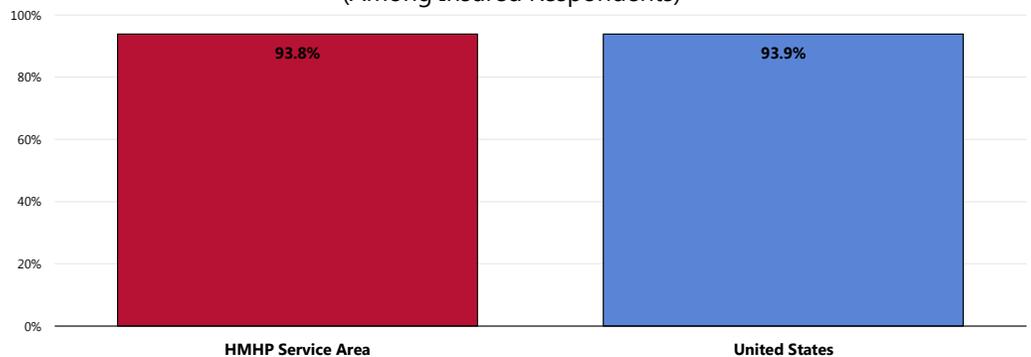
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 85]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with healthcare insurance coverage.

Most insured adults (89.5%) report that their coverage pays for at least some of their mental health services.

Health Insurance Covers At Least Part of Mental Health Services
(Among Insured Respondents)

Yes 89.5%

No 10.5%
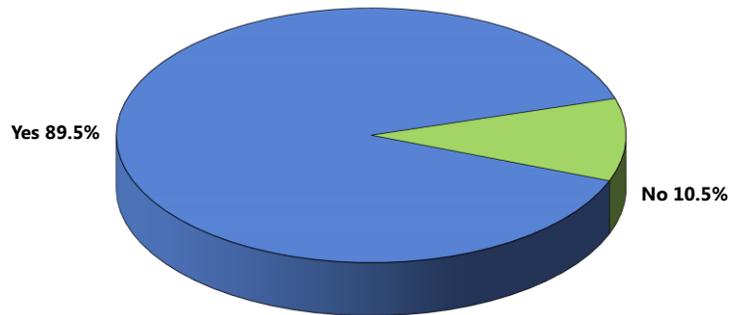
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
Notes: ● Asked of all respondents with healthcare insurance coverage.

Supplemental Coverage

Among Medicare recipients, the majority (64.9%) has additional, supplemental healthcare coverage.

● Lower than that reported among Medicare recipients nationwide.

Have Supplemental Coverage in Addition to Medicare
(Among Adults 65+)

	64.9%	75.5%
	HMHP Service Area	United States
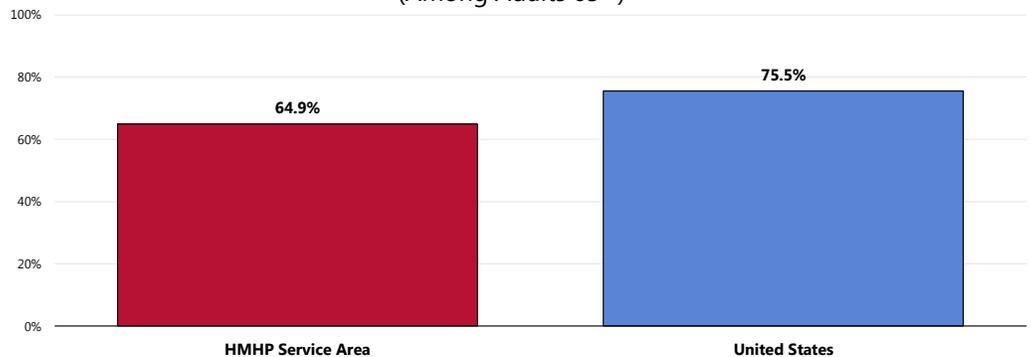
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 84]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of respondents age 65+.

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have <u>no</u> type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 20.5% report having no insurance coverage for healthcare expenses.

- Similar to the state finding.

- Less favorable than the national finding.

- The Healthy People 2020 target is universal coverage (0% uninsured).

Lack of Healthcare Insurance Coverage
(Among Adults 18-64)
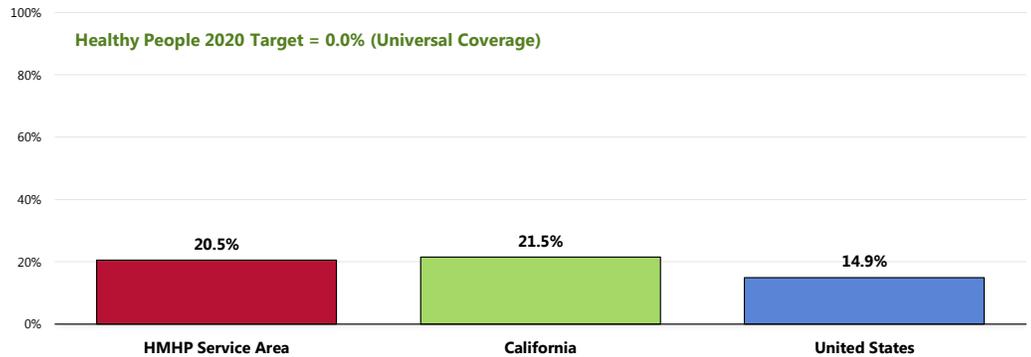
Healthy People 2020 Target = 0.0% (Universal Coverage)

HMHP Service Area	20.5%
California	21.5%
United States	14.9%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

The following adults (age 18-64) are more likely to be without healthcare coverage:

- Young adults.
- Lower-income residents.
- Hispanics.

Lack of Healthcare Insurance Coverage
(Among Adults 18-64; Hoag Memorial Hospital Presbyterian Service Area, 2013)

Healthy People 2020 Target = 0.0% (Universal Coverage)

| Category	Value
Men	22.8%
Women	18.3%
18 to 39	24.4%
40 to 64	17.0%
Very Low Income	45.7%
Low Income	35.3%
Mid/High Income	11.6%
White	12.7%
Hispanic	38.5%
Other	15.3%
HMHP Svc Area	20.5%
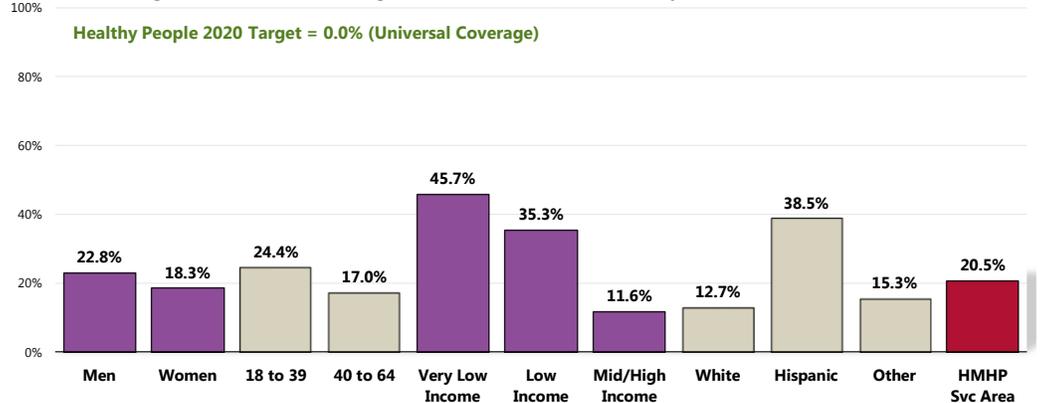
Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

👪 As might be expected, uninsured adults in the HMHP Service Area are less likely to receive routine care and preventive health screenings, and are more likely to have experienced difficulties accessing healthcare.

Preventive Healthcare
(By Insured Status; HMHP Service Area, 2013)

Bar chart with legend: ☐ Uninsured ■ Insured

- Blood Pressure Test in Past 2 Yrs: Uninsured 85.9%, Insured 96.1%
- Cholesterol Test in Past 5 Yrs: Uninsured 86.1%, Insured 94.9%
- Specific Source of Ongoing Care: Uninsured 49.6%, Insured 81.3%
- Checkup in Past Year: Uninsured 48.4%, Insured 71.8%
- Access Difficulties: Uninsured 52.5%, Insured 28.5%
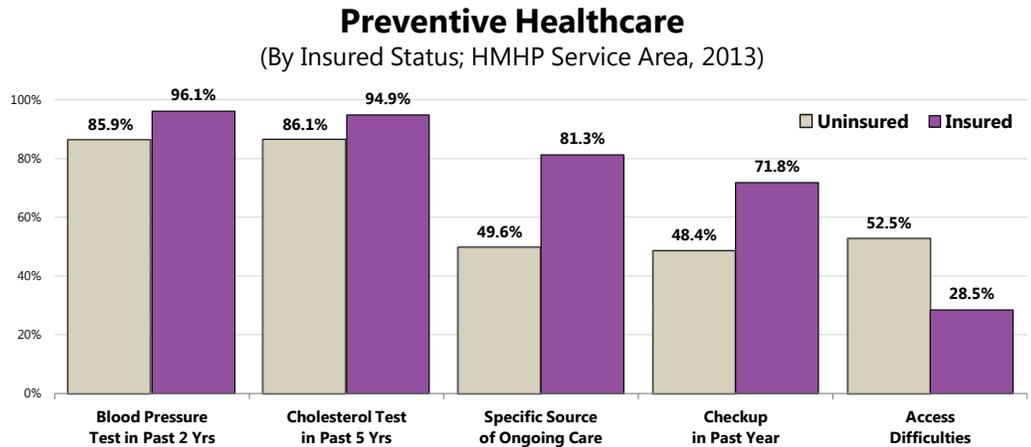
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 16, 49, 52, 200, 203]
Notes: • Asked of all respondents.

Recent Lack of Coverage (Insurance Instability)

Among currently insured adults in the HMHP Service Area, 7.7% report that they were without healthcare coverage at some point in the past year.

● Higher than the US prevalence.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year
(Among Insured Adults)

- HMHP Service Area: 7.7%
- United States: 4.8%
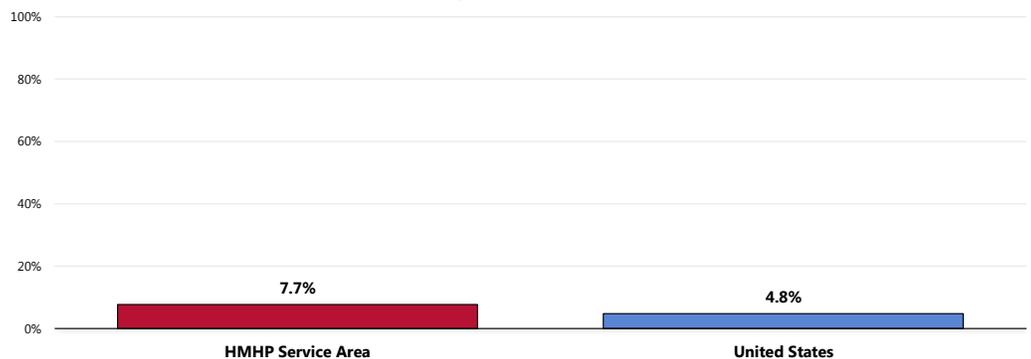
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 87]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all insured respondents.

Among insured adults, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Men.

- Adults under age 40.

- Lower-income residents (note the negative correlation with income).

- Hispanics.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year
(Among Insured Adults; Hoag Memorial Hospital Presbyterian Service Area, 2013)

	Value
Men	10.4%
Women	5.2%
18 to 39	14.4%
40 to 64	5.4%
65+	1.2%
Very Low Income	17.7%
Low Income	11.6%
Mid/High Income	3.3%
White	3.9%
Hispanic	23.1%
Other	3.5%
HMHP Svc Area	7.7%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 87]
Notes: ● Asked of all insured respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

   – Healthy People 2020 (www.healthypeople.gov)

Difficulties Accessing Services

This indicator reflects the percentage of the <u>total</u> population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 32.3% of HMHP Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- ● More favorable than national findings.

**Experienced Difficulties or Delays of Some Kind
in Receiving Needed Healthcare in the Past Year**

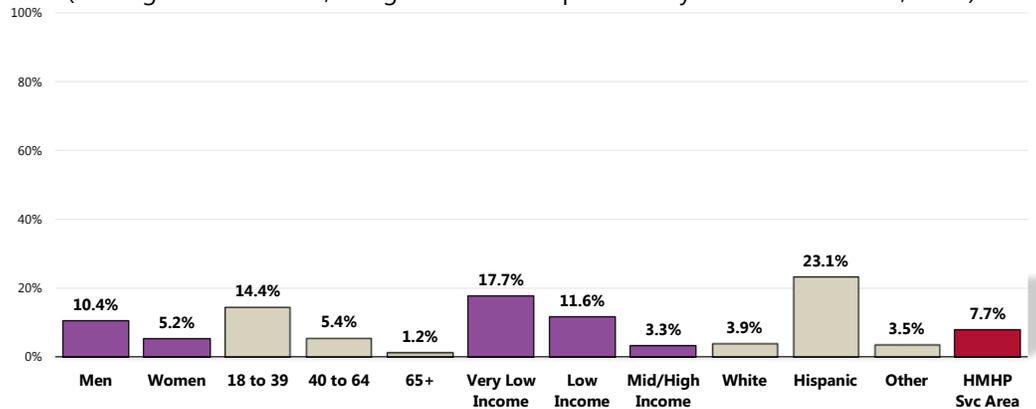|	HMHP Service Area	United States
	32.3%	37.3%
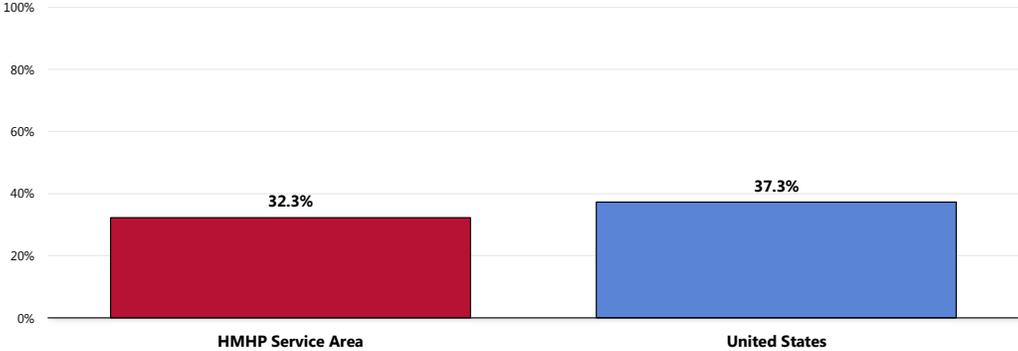
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 203]
       ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
     ● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups <u>more often</u> report difficulties accessing healthcare services:

- ♦ Adults under the age of 65.
- ♦ Lower-income residents.
- ♦ Hispanics.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Category	Percentage
Men	29.1%
Women	35.5%
18 to 39	36.5%
40 to 64	35.1%
65+	14.3%
Very Low Income	45.6%
Low Income	46.2%
Mid/High Income	27.3%
White	30.0%
Hispanic	42.1%
Other	26.9%
HMHP Svc Area	32.3%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 203]

Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
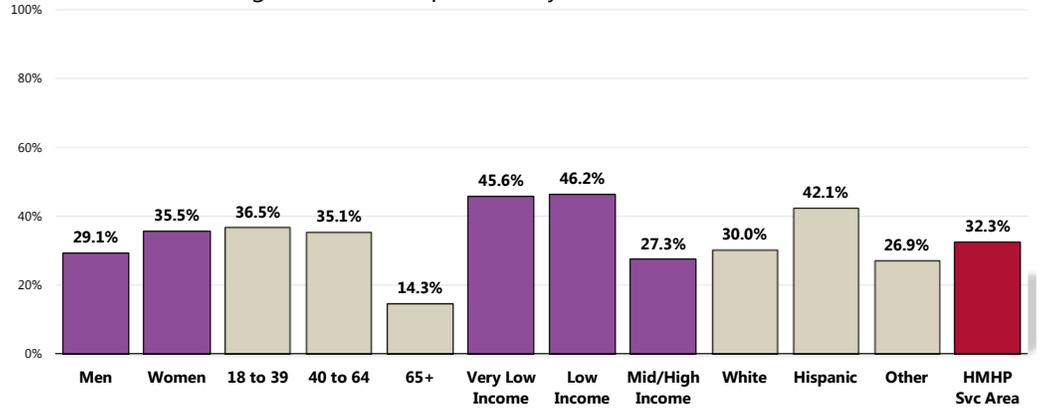- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Barriers to Healthcare Access

To better understand healthcare access barriers, survey participants were asked whether any of five types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, cost of physician visits, cost of prescriptions, and appointment availability impacted the greatest shares of service area adults (each prevented 12%-13% of respondents from receiving needed services).

- The proportion of HMHP Service Area adults impacted was statistically comparable to or better than that found nationwide for each of the tested barriers.

Barriers to Access Have Prevented Medical Care in the Past Year
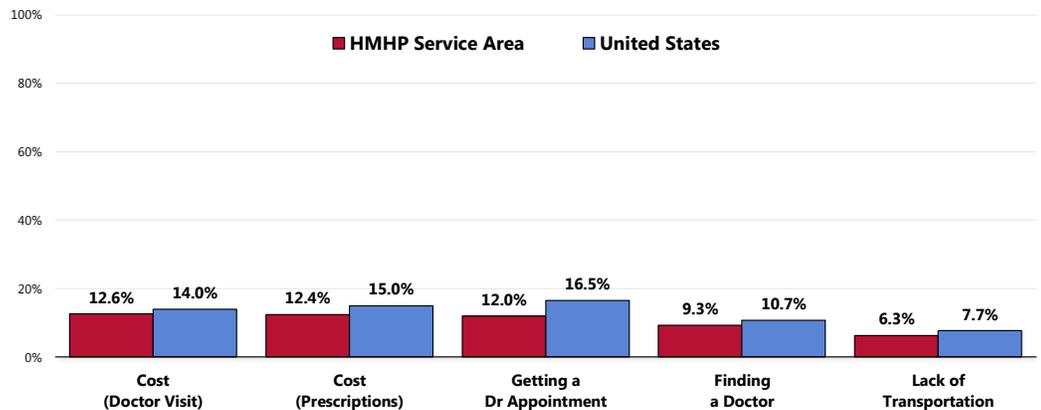
Legend: HMHP Service Area / United States

Barrier	HMHP Service Area	United States
Cost (Doctor Visit)	12.6%	14.0%
Cost (Prescriptions)	12.4%	15.0%
Getting a Dr Appointment	12.0%	16.5%
Finding a Doctor	9.3%	10.7%
Lack of Transportation	6.3%	7.7%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-11]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

👪 As might be expected, HMHP Service Area adults without health insurance are much more likely to report access barriers when compared to the insured population, particularly those related to cost.
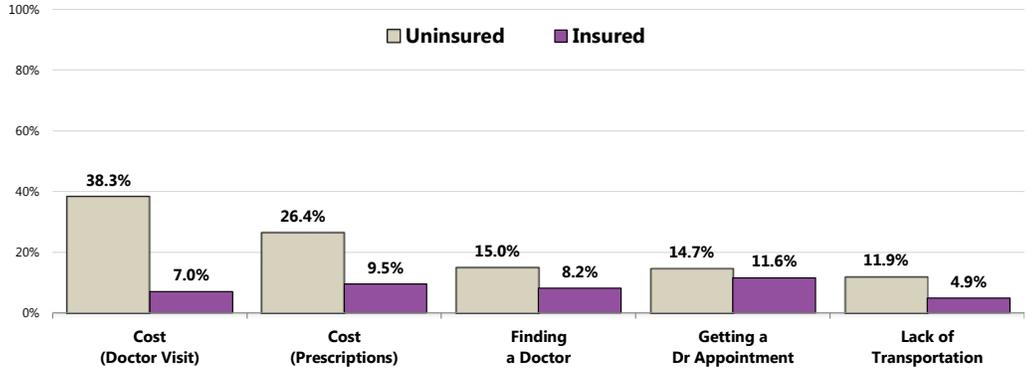
Barriers to Healthcare Access
(By Insured Status, Adults 18+; HMHP Service Area, 2013)

Legend: ☐ Uninsured ■ Insured

Barrier	Uninsured	Insured
Cost (Doctor Visit)	38.3%	7.0%
Cost (Prescriptions)	26.4%	9.5%
Finding a Doctor	15.0%	8.2%
Getting a Dr Appointment	14.7%	11.6%
Lack of Transportation	11.9%	4.9%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-11]
Notes: ● Asked of all respondents.

Prescriptions

Among all HMHP Service Area adults, 8.4% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

● More favorable than national findings.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money
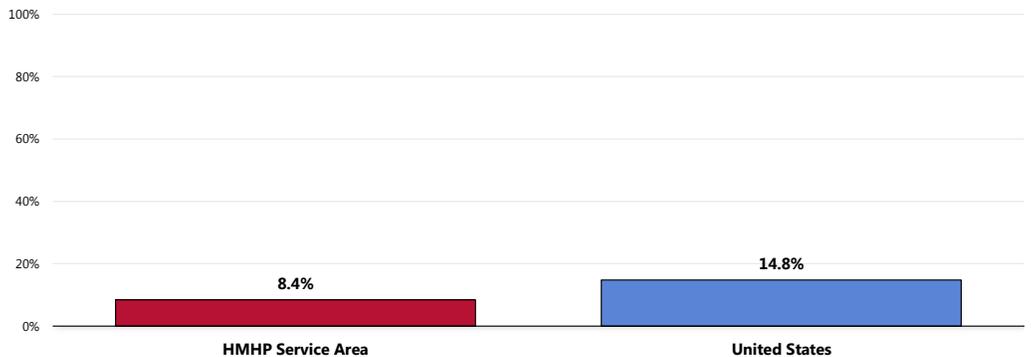
	Percentage
HMHP Service Area	8.4%
United States	14.8%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 12]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- 🏃 Adults age 40 to 64.

- 🏃 Respondents with lower incomes.

- 🏃 Uninsured adults.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

| Category	Value
Men	7.0%
Women	9.9%
18 to 39	5.6%
40 to 64	10.9%
65+	7.7%
Very Low Income	16.0%
Low Income	11.5%
Mid/High Income	6.7%
White	8.4%
Hispanic	10.2%
Other	6.1%
Insured	7.0%
Uninsured	15.5%
HMHP Svc Area	8.4%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 12]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

A total of 1.8% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- ● Similar to what is reported nationwide.

- 🏃 Highest (3.9%) among parents of teens.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Among Parents of Children 0-17)

Parents with trouble obtaining medical care for their child reported barriers due to cost or lack of insurance coverage.

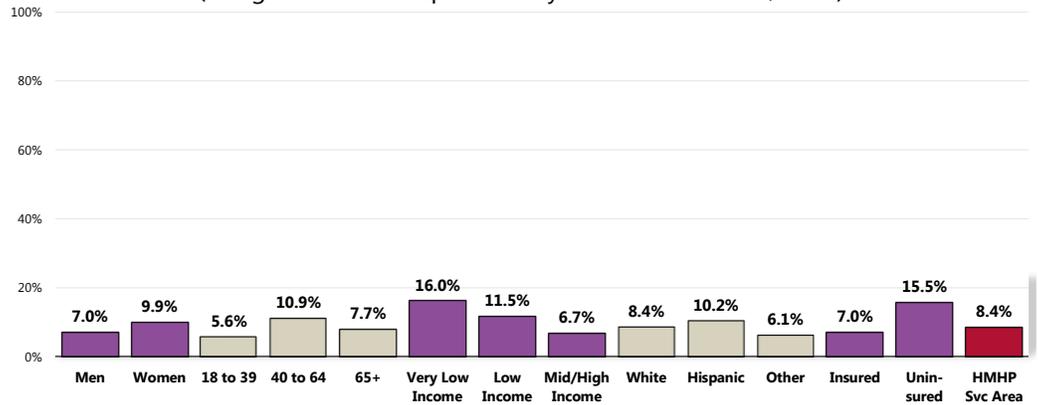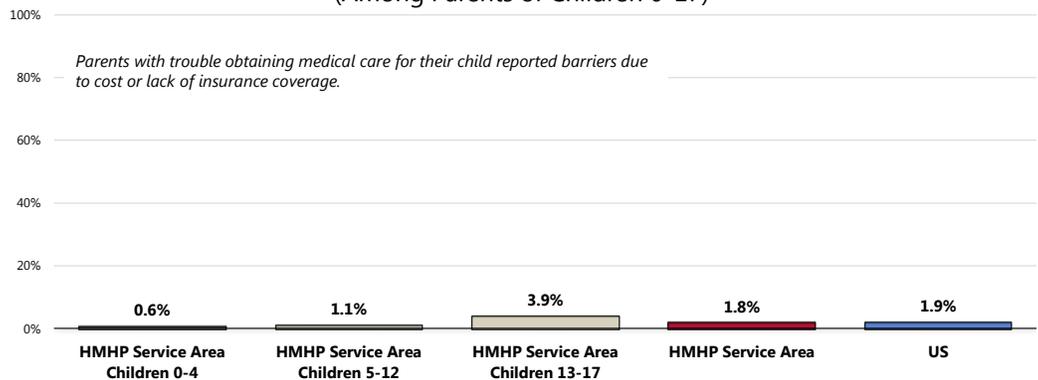| Category	Value
HMHP Service Area Children 0-4	0.6%
HMHP Service Area Children 5-12	1.1%
HMHP Service Area Children 13-17	3.9%
HMHP Service Area	1.8%
US	1.9%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 131-132]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Among the parents experiencing difficulties, **cost or a lack of insurance** were the reasons given.

Many of the key informants participating in the focus groups are concerned with access to healthcare services, discussing such issues as:

- Barriers to access, including language
- Lower-income residents
- Lack of services for the uninsured/underinsured
- Transportation

Focus group participants feel that **residents encounter several barriers when trying to access healthcare services** in the community. Orange County does not have a county hospital. One attendee explains how this negatively impacts the area:

> *"The other very interesting piece about Orange County is the fact that we do not officially have a county hospital system like L.A. This puts a lot of burden and pressure in the local hospitals as well as in the community health centers and all the other physicians and providers of care because we have to take on that extra burden or that extra workload. This affects the overall delivery of care in Orange County." — Healthcare Provider*

There is also the perception that Orange County is an affluent community, but the county does have **residents living at both ends of the socio-economic spectrum**. Some residents reside in higher income communities like Newport Beach, and others live in very low income communities like Costa Mesa. Many of the community members in the low income neighborhoods are immigrants, refugees and non-English speaking people. These residents have limited, fixed, or no income and cannot afford to see a physician, obtain medication, or purchase health insurance, and due to the **language barrier** cannot navigate the system to obtain care:

> *"We have a lot of diversity here in Orange County, and we try really hard to hire the people from the same region or from the same populations so they can understand their culture and their language. Even then our providers may not always speak the language, but culture may be similar. It is a real challenge to try to meet the different languages and cultures." — Community Leader*

> *"When we start looking at the uninsured population culture and language becomes the number one barrier to access care. For example in the uninsured Chinese-American population the starting point is to ask ourselves where are we going to refer these people who are monolingual Chinese older adults. There are probably a handful of providers throughout the county that really could take these types of patients." — Healthcare Provider*

> *"I would agree with the barriers for the undocumented, we have a very difficult time getting them into medical services if it was not for our clinic or the free clinic, or even Share Our Selves (SOS), which has limited their services over the years. We have to wait to receive services or offer to pay for it on our own, and we have a limited budget." — Community Leader*

Key Informants worry about the lack of a coordinated system of care for the **under-insured or uninsured** and share concern that many residents do not know about the resources available:

"We really do not have a coordinated system of care for the uninsured/underinsured population and this limits their access to prevention and overall healthcare. In the future we need to be prepared for the Affordable Care Act implementation, which is going to force coordination of services for outreach and providing access to the limited amount of professional services that will be available to the uninsured population." — Healthcare Provider

Participants express concern regarding the lack of public **transportation** for the community. The bus routes are not an efficient way for residents to get around. Due to the limited transportation options and personal vehicles, getting residents to attend appointments outside of their communities can be a real challenge:

"Trying to get from point A to point B on the buses is not an easy task. The way the system is set up somebody could be on a bus for 90 minutes or 2 hours to get from point A to point B, which is unacceptable for someone who is frail or doesn't understand English. There is not a real direct route to get to any one location. Residents always end up going into the city center and then having to transfer. It is not a real bus friendly community." — Healthcare Provider

Primary Care Services

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider

- Good patient-provider communication

- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

– Healthy People 2020 (www.healthypeople.gov)

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is necessary to establish a "medical home."

A hospital emergency room is <u>not</u> considered a source of ongoing care in this instance.

A total of 75.8% of HMHP Service Area adults were determined to have a specific source of ongoing medical care.

- Similar to national findings.

- Fails to satisfy the Healthy People 2010 objective (95% or higher).

Have a Specific Source of Ongoing Medical Care

[All Ages] Healthy People 2020 Target = 95% or Higher

	HMHP Service Area	United States
	75.8%	76.3%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 200]
         • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
         • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]
Notes: • Asked of all respondents.

When viewed by demographic characteristics, the following population segments are <u>less likely</u> to have a specific source of care:

- Adults under age 40.

- Lower-income adults.

- Hispanics.

- Among adults age 18-64, 73.8% have a specific source for ongoing medical care, similar to national findings.

- Fails to satisfy the Healthy People 2020 target for this age group (89.4% or higher).

👥 Among adults 65+, 84.0% have a specific source for care, comparable to the percentage reported among seniors nationally.

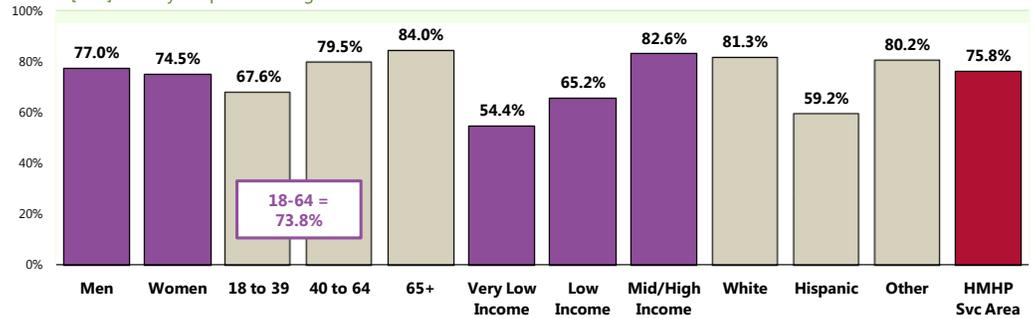- Fails to satisfy the Healthy People 2020 target of 100% for seniors.

Have a Specific Source of Ongoing Medical Care
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

[All Ages] Healthy People 2020 Target = 95.0% or Higher
[18-64] Healthy People 2020 Target = 89.4% or Higher
[65+] Healthy People 2020 Target = 100%

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
77.0%	74.5%	67.6%	79.5%	84.0%	54.4%	65.2%	82.6%	81.3%	59.2%	80.2%	75.8%

18-64 = 73.8%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 200-202]
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives AHS-5.1, 5.3, 5.4]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (46.5%) identified a particular doctor's office.

A total of 27.7% say they usually go to some type of clinic, while 1.5% use a military facility and 1.0% rely on a hospital emergency room.

Particular Place Utilized for Medical Care
(Hoag Memorial Hospital Presbyterian Service Area, 2013)
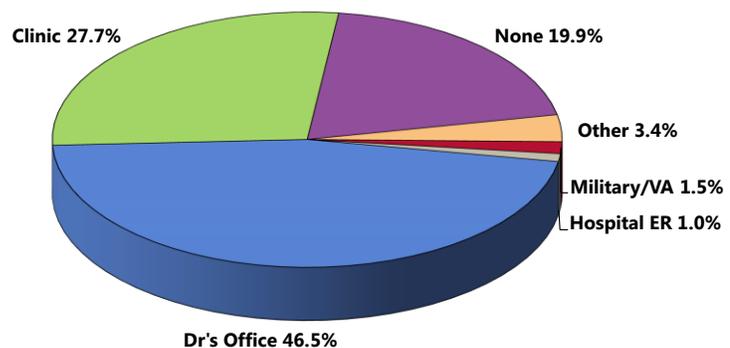
Clinic 27.7%
None 19.9%
Other 3.4%
Military/VA 1.5%
Hospital ER 1.0%
Dr's Office 46.5%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 14-15]
Notes: • Asked of all respondents.

Adults

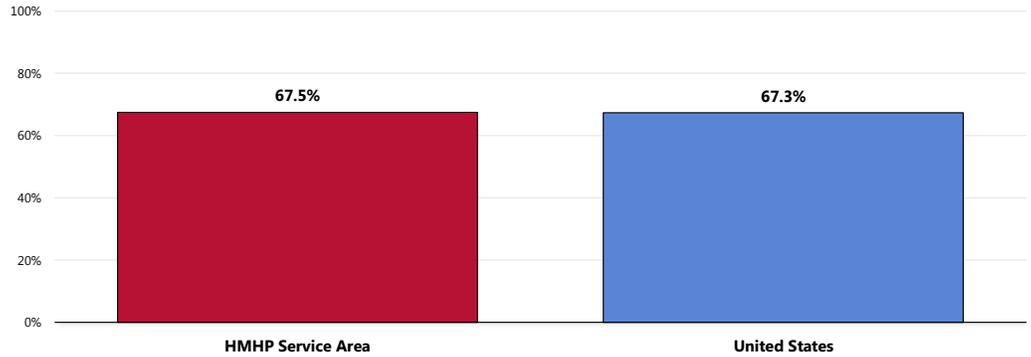**Two-thirds (67.5%) of adults visited a physician for a routine checkup in the past year.**

- Nearly identical to national findings.

Have Visited a Physician for a Checkup in the Past Year

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 16]
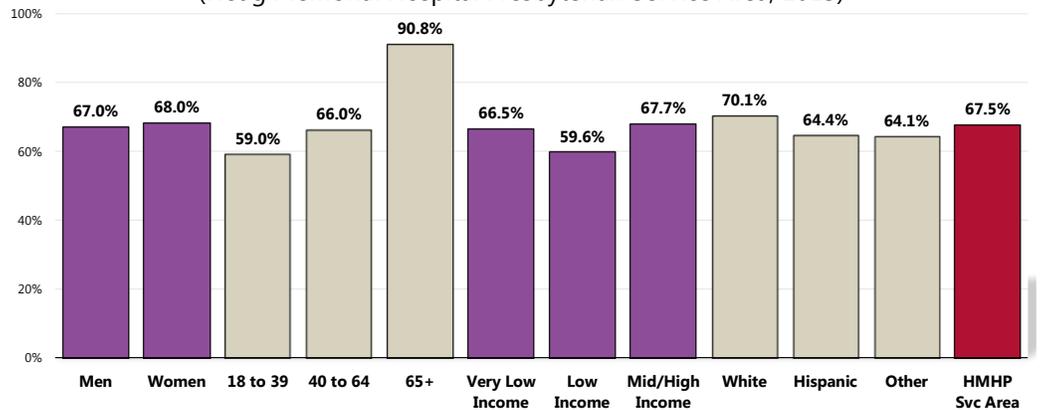• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Adults under age 40 are _less likely_ to have received routine care in the past year (note the positive correlation with age).

Have Visited a Physician for a Checkup in the Past Year
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 16]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
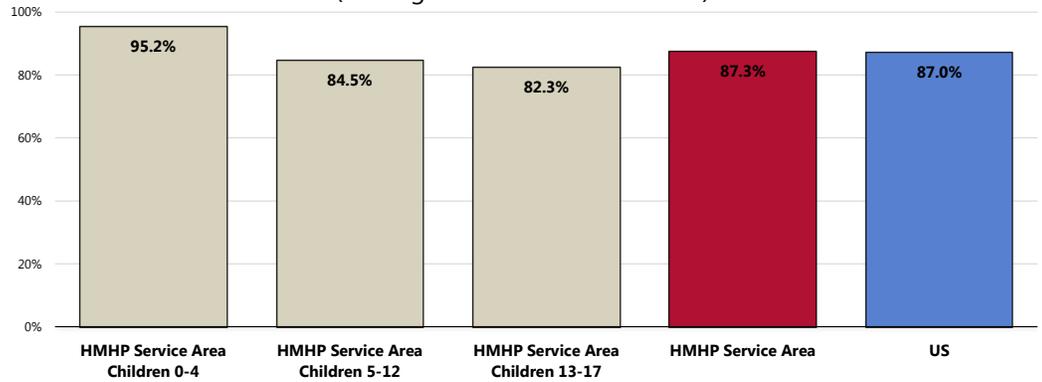
Among surveyed parents, 87.3% report that their child has had a routine checkup in the past year.

- Similar to national findings.

- Note that routine checkups are highest in HMHP Service Area among children under age 5.

Child Has Visited a Physician for a Routine Checkup in the Past Year
(Among Parents of Children 0-17)

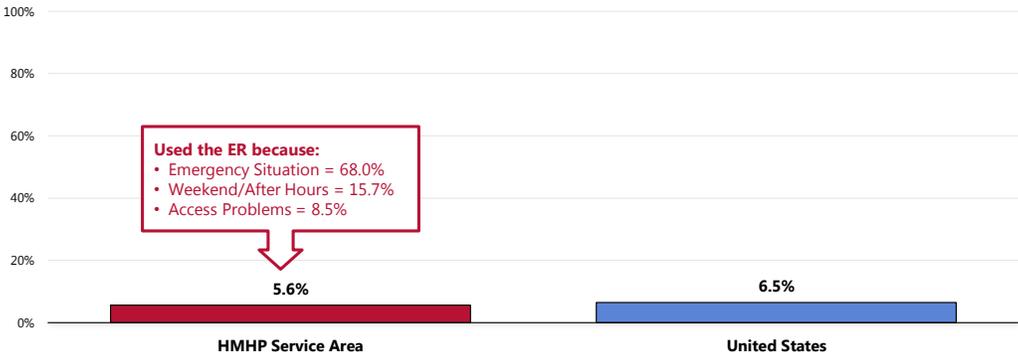| Category	Percent
HMHP Service Area Children 0-4	95.2%
HMHP Service Area Children 5-12	84.5%
HMHP Service Area Children 13-17	82.3%
HMHP Service Area	87.3%
US	87.0%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 133]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 5.6% of HMHP Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Similar to national findings.

Have Used a Hospital Emergency Room More Than Once in the Past Year

Used the ER because:
- Emergency Situation = 68.0%
- Weekend/After Hours = 15.7%
- Access Problems = 8.5%

	HMHP Service Area	United States
	5.6%	6.5%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
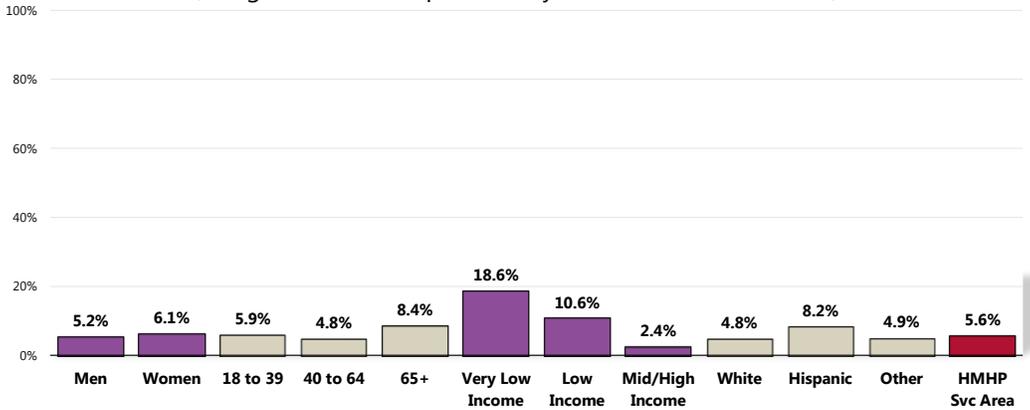● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Of those using a hospital ER, 68.0% say this was due to an **emergency or life-threatening situation**, while 15.7% indicated that the visit was during **after-hours or on the weekend**. A total of 8.5% cited **difficulties accessing primary care** for various reasons.

- Note the negative correlation between ER use and household income level.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
5.2%	6.1%	5.9%	4.8%	8.4%	18.6%	10.6%	2.4%	4.8%	8.2%	4.9%	5.6%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Oral Health

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include:

- Tobacco use
- Excessive alcohol use
- Poor dietary choices

Barriers that can limit a person's use of preventive interventions and treatments include:

- Limited access to and availability of dental services
- Lack of awareness of the need for care
- Cost
- Fear of dental procedures

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Community water fluoridation and school-based dental sealant programs are 2 leading evidence-based interventions to prevent tooth decay.

Major improvements have occurred in the nation's oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent CDC publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased.

Lack of access to dental care for all ages remains a public health challenge. This issue was highlighted in a 2008 Government Accountability Office (GAO) report that described difficulties in accessing dental care for low-income children. In addition, the Institute of Medicine (IOM) has convened an expert panel to evaluate factors that influence access to dental care.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.
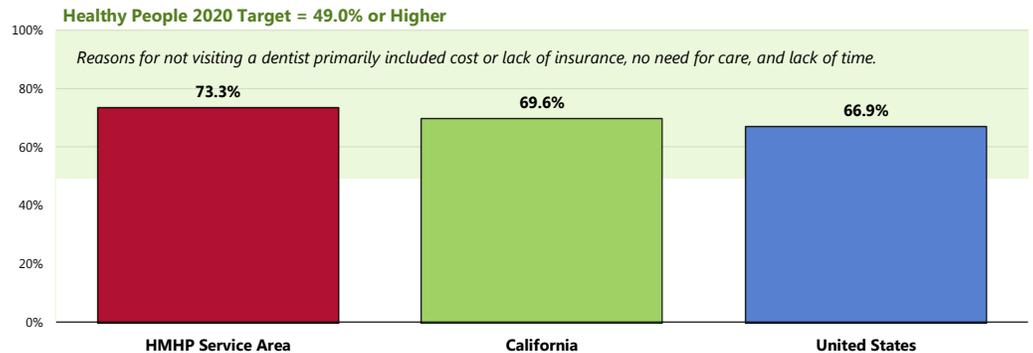
  – Healthy People 2020 (www.healthypeople.gov)

Dental Care

Adults

Nearly three-fourths (73.3%) of service area adults have visited a dentist or dental clinic (for any reason) in the past year.

- More favorable than statewide findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 Target = 49.0% or Higher

Reasons for not visiting a dentist primarily included cost or lack of insurance, no need for care, and lack of time.

HMHP Service Area	California	United States
73.3%	69.6%	66.9%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 19-20]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
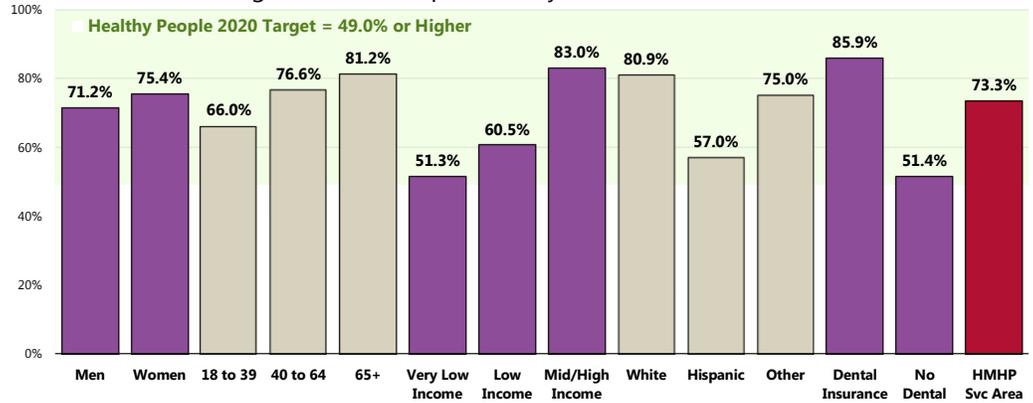
Notes:
- Asked of all respondents.

Among residents without recent dental care, reasons included cost, lack of insurance coverage, no need for care, and lack of time.

Note the following:

- There is a positive correlation between age and recent dental visits.
- Persons living in the higher income categories report much higher utilization of oral health services.
- Whites and "Other" race adults are much more likely than Hispanics to report recent dental care.
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

Have Visited a Dentist or
Dental Clinic Within the Past Year
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Healthy People 2020 Target = 49.0% or Higher

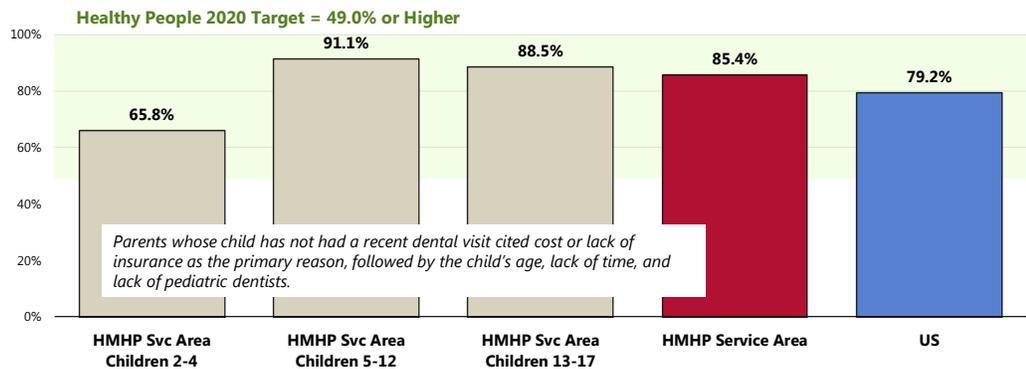| Category	Value
Men	71.2%
Women	75.4%
18 to 39	66.0%
40 to 64	76.6%
65+	81.2%
Very Low Income	51.3%
Low Income	60.5%
Mid/High Income	83.0%
White	80.9%
Hispanic	57.0%
Other	75.0%
Dental Insurance	85.9%
No Dental	51.4%
HMHP Svc Area	73.3%

Children

A total of 85.4% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Comparable to national findings.

- Satisfies the Healthy People 2020 target (49% or higher).

- As might be expected, regular dental care is notably lower among children age 2 to 4.

Child Has Visited a Dentist or
Dental Clinic Within the Past Year
(Among Parents of Children 2-17)

Healthy People 2020 Target = 49.0% or Higher

Category	Value
HMHP Svc Area Children 2-4	65.8%
HMHP Svc Area Children 5-12	91.1%
HMHP Svc Area Children 13-17	88.5%
HMHP Service Area	85.4%
US	79.2%

Parents whose child has not had a recent dental visit cited cost or lack of insurance as the primary reason, followed by the child's age, lack of time, and lack of pediatric dentists.

Parents of children without recent dental care cited cost or lack of insurance as their primary reason, followed by the child's age, lack of time, and lack of pediatric dentists.

Dental Insurance

Over 6 in 10 HMHP Service Area adults (63.2%) have dental insurance that covers all or part of their dental care costs.

- Comparable to the national finding.

Have Insurance Coverage That Pays All or Part of Dental Care Costs
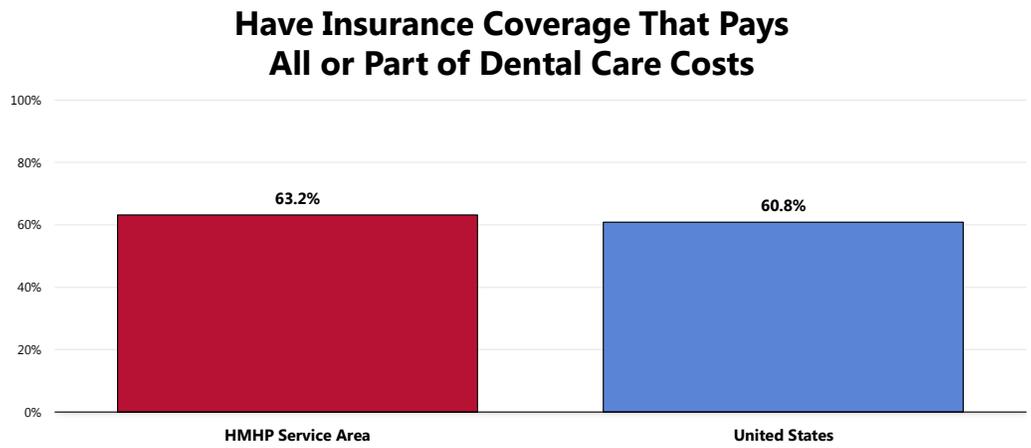

Chart showing: HMHP Service Area 63.2%, United States 60.8%
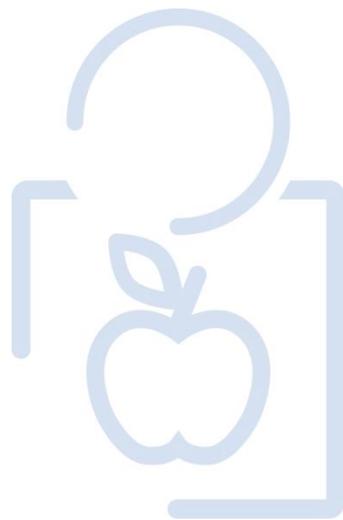
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

HEALTH EDUCATION & OUTREACH

Healthcare Information Sources

Family physicians and the Internet are residents' primary sources of healthcare information.

- 43.1% of HMHP Service Area adults cited their **family physician** as their primary source of healthcare information.

- The **Internet** received the second-highest response, with 27.9%.

  - Other sources mentioned include friends and relatives (7.1%), and work (3.0%).

- Just 2.9% of survey respondents say that they <u>do not receive any</u> healthcare information.

Primary Source of Healthcare Information
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

- Internet 27.9%
- Other 16.0%
- Friends/Relatives 7.1%
- Work 3.0%
- Don't Receive Any 2.9%
- Family Doctor 43.1%
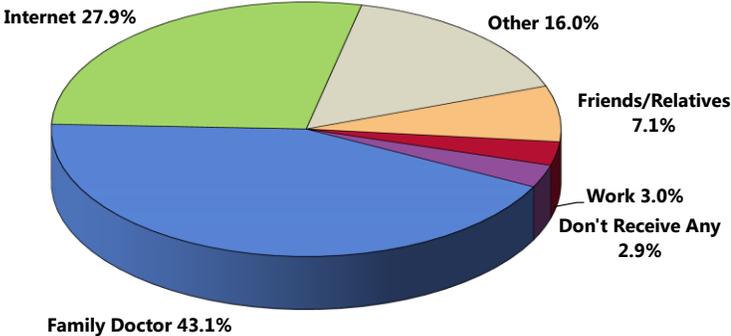
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
Notes: ● Asked of all respondents.

Participation in Health Promotion Events

Educational and community-based programs play a key role in preventing disease and injury, improving health, and enhancing quality of life.

Health status and related-health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Education and community-based programs and strategies are designed to reach people outside of traditional healthcare settings. These settings may include schools, worksites, healthcare facilities, and/or communities.
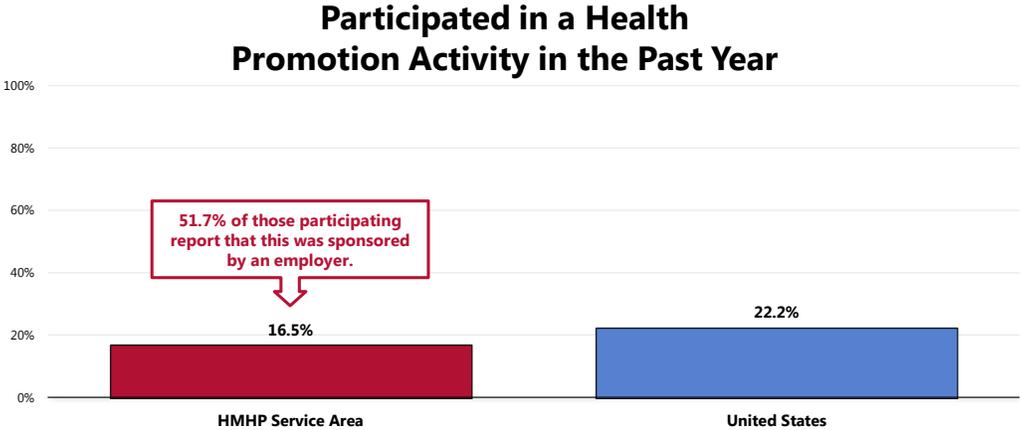
Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

– Healthy People 2020 (www.healthypeople.gov)

A total of 16.5% of HMHP Service Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.

- Lower than the national prevalence.

- Note that 51.7% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer.

Participated in a Health Promotion Activity in the Past Year

51.7% of those participating report that this was sponsored by an employer.

HMHP Service Area	16.5%
United States	22.2%

Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 125-126]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

👪 No difference by key demographic characteristics.

Participated in a Health
Promotion Activity in the Past Year
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

	Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	HMHP Svc Area
%	16.6%	16.4%	15.1%	18.1%	15.5%	15.2%	15.1%	19.0%	17.7%	17.3%	12.8%	16.5%
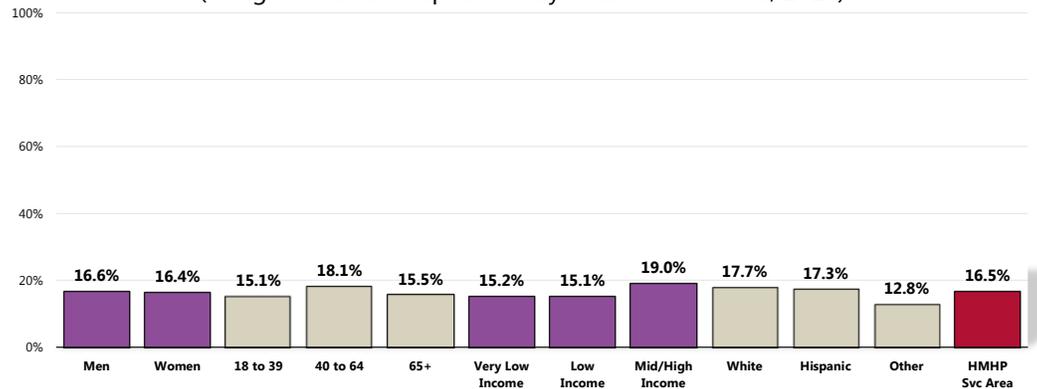
Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Related Focus Group Findings: Health Education and Prevention

Focus group attendees agree that health education and prevention are critical components in creating and maintaining healthy lifestyles. Primary concerns among participants include:

- Importance of preventive healthcare programs
- Funding of prevention programs

Participants believe that health education is an important aspect of prevention and improving the overall health of community members. Several attendees describe the **importance of preventive healthcare programs**:

"We have been doing a lot of education around prevention from the funding that we're getting from Proposition 63. I think this type of education is really benefiting the community that we serve." — Community Leader

"I think also too, as healthcare providers, our emphasis is prevention, but I think that it feels that the community's emphasis is more episodic. Residents will go to see a physician or go to a healthcare center for services only when they are sick. The challenge is to change the mindset." — Healthcare Provider

"It's really important to start off on the right foot and in the right direction. Prevention, in and of itself, will hopefully spill over into the future. It may not affect the first generation or the first child in the family, but maybe the second generation will get the meaning of health prevention. and know the importance of prevention in creating a healthy lifestyle." — Healthcare Provider

Key informants feel that inadequate **funding for prevention programs** exists and note the cessation of previous health education efforts in the schools. Community outreach also suffers now that the school-based programs cease to exist:

> *"We have 28 districts in Orange County, and when we made it through the recession in 2008, the availability of funds was gone. Schools have had to move back from their health partnership and stick to just education. There is not a desire anymore to become a community school offering resources to families right at their doorstep." — Community Leader*
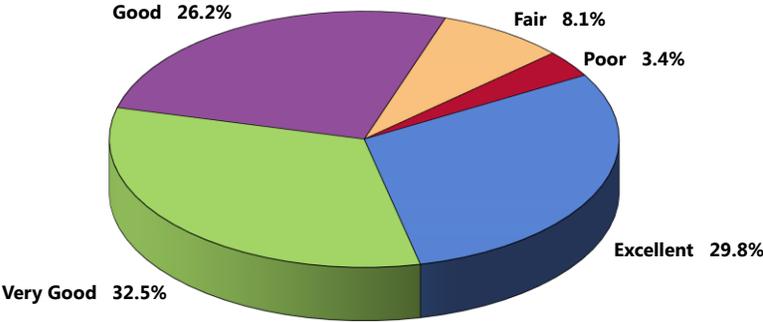
LOCAL RESOURCES
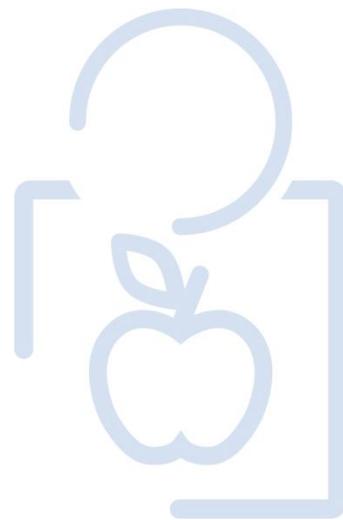
Perceptions of Local Healthcare Services

Just over 6 in 10 HMHP Service Area adults (62.3%) rate the overall healthcare services available in their community as "excellent" or "very good."

- Another 26.2% gave "good" ratings.

Rating of Overall Healthcare
Services Available in the Community
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Good 26.2%

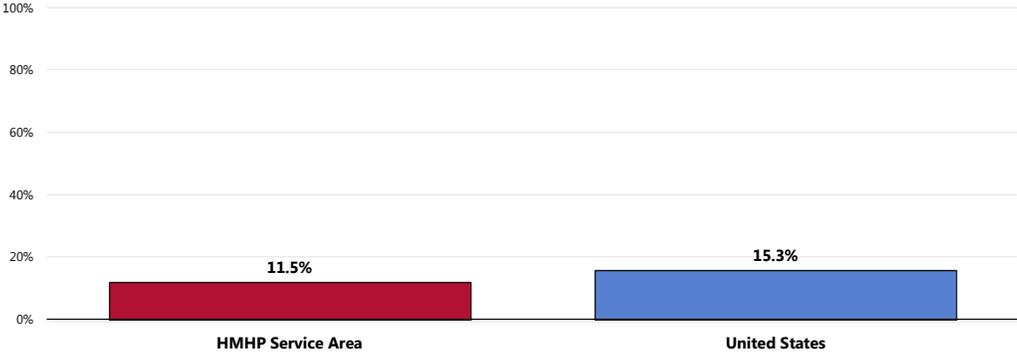Fair 8.1%

Poor 3.4%

Excellent 29.8%

Very Good 32.5%

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: ● Asked of all respondents.

However, 11.5% of residents characterize local healthcare services as "fair" or "poor."

- More favorable than reported nationally.

Perceive Local Healthcare Services as "Fair/Poor"

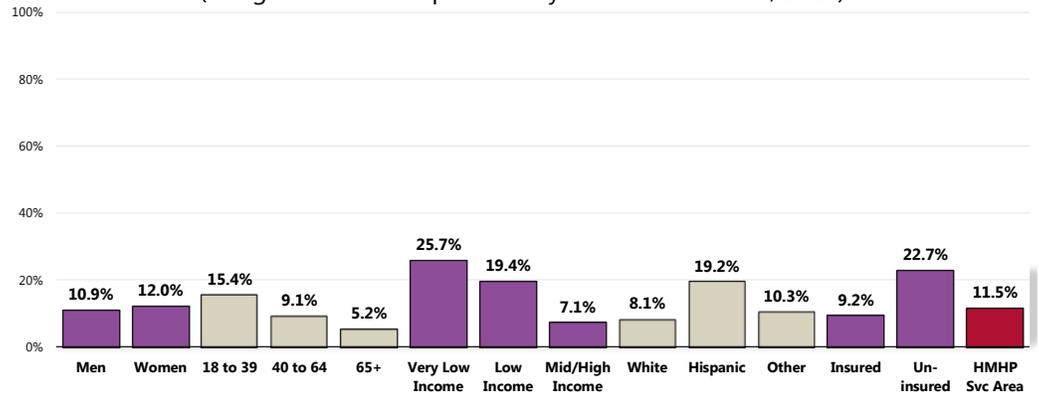|	
11.5%	15.3%
HMHP Service Area	United States

Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

The following residents are more critical of local healthcare services:

- 🧍 Adults under age 40 (note the negative correlation with age).

- 🧍 Residents with lower incomes (negative correlation with income).

- 🧍 Hispanics.

- 🧍 Uninsured adults.

Perceive Local Healthcare Services as "Fair/Poor"
(Hoag Memorial Hospital Presbyterian Service Area, 2013)

Men	Women	18 to 39	40 to 64	65+	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Other	Insured	Un-insured	HMHP Svc Area
10.9%	12.0%	15.4%	9.1%	5.2%	25.7%	19.4%	7.1%	8.1%	19.2%	10.3%	9.2%	22.7%	11.5%

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living below the federal poverty level; "Low Income" includes households living just above poverty, with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified by key informant focus group participants in the course of conducting this Community Health Needs Assessment.

- CalFresh
- CalOptima
- Child Guidance Center
- Children's Hospital of Orange County
- County Food Banks
- Hoag Memorial Hospital Presbyterian
- HOPE
- Jewish Family Services
- MediCal
- Mission Hospital
- Orange County Aging Services Collaborative
- Orange County Community Foundation
- Orange County Healthcare Agency
- Orange County Mental Health Center
- Proposition 63 (Mental Health Services Act)
- Rainbow Directory
- Share Our Selves

Collaboration

All participants agree that there is some collaboration happening in the community between schools, non-profit organizations, government agencies and healthcare facilities. The main ideas surrounding collaboration included:

- Varying opinions on collaboration
- Funding challenges
- Resource directory

Focus group attendees have **varying opinions on the level of collaboration** occurring in the community, and it seems to vary by city:

> *"In our city, I think collaboration is pretty good. Having worked in L.A. city and L.A. County and several large cities throughout Los Angeles County and coming to Orange County in the last seven years, I would say that Irvine has some really good collaboration, excellent collaboration with the school district. I could never get into Long Beach or L.A. County school districts like we do in Irvine." — Community Leader*

> *"There is some resistance in Santa Ana from the school districts to receive outside services. Some of the comments I hear is that the school has their own counselors on a grant and if they refer the students for outside services they might lose the grant so funding becomes the barrier for collaboration." — Community Leader*

Participants agree that the community suffers due to a **lack of funding** for healthcare services in Orange County:

> *"I also think that we are lacking funding and I agree in terms of the county reluctance in bringing money for services. It gets very political sometimes and also it gets very competitive. When it is not public money, it gets competitive because Orange County is perceived as a wealthy county where residents can pay for healthcare services." — Healthcare Provider*

Participants want more transparency about the available services in Orange County. During the focus groups some of the participants did not know of each other's agencies or the services provided by their respective organizations. Key informants believe that a **resource directory** would help eliminate this issue:

> *"I remember the Rainbow Directory was like our Bible and I have not seen one in years and I know we use 2-1-1 for resources, but I don't know what my families are actually finding out there on 2-1-1. I know I refer them to services that I know about, but I don't know if services are centralized in one location." — Healthcare Provider*