



2023 Community Health Needs Assessment



SFCCHC

SAN FERNANDO COMMUNITY
HEALTH CENTER

2023 Community Health Needs Assessment

Conducted on behalf of

San Fernando Community Health Center

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1 INTRODUCTION

Our History

San Fernando Community Health Center (SFCHC) is a state-of-the-art, Federally Qualified Health Center (FQHC) located in the northwestern region of Los Angeles (LA) County. SFCHC began in 1923 as the San Fernando Valley's first hospital, San Fernando Community Hospital, later doing business as (dba) Mission Community Hospital (MCH). MCH provided high-quality affordable healthcare to the surrounding community with an emphasis on serving the most vulnerable. In 2013, MCH was purchased by a for-profit firm. Prior to the sale of the hospital, the hospital Board supported the construction of a new comprehensive primary care facility. This new health center is now operated by the nonprofit entity that formerly operated the hospital and its governance is completely independent from the for-profit hospital. The non-profit, San Fernando Community Hospital, now uses the dba San Fernando Community Health Center. SFCHC received its FQHC designation in August 2015.

As a FQHC, SFCHC is required to report data on patient demographics, services provided, clinical indicators, utilization rates, costs, and revenues. The FQHC designation allows SFCHC to provide quality care at an affordable price to everyone in the San Fernando Valley community. As a HRSA Health Center Quality Leader, SFCHC was among the top 30% of all HRSA-supported health centers in the nation that achieved the best overall clinical outcomes, demonstrating high-quality across clinical operations. As the medical home to over 6,000 patients annually, SFCHC strives to provide their patients with comprehensive and compassionate care.



Our Services

As a contributor to the safety net in LA County, SFCHC operates two service delivery sites, which in total provide culturally and linguistically appropriate high-quality and accessible preventive, primary, and specialized healthcare targeting the low-income, homeless and underserved communities. Services include medical, dental, mental health, enabling and health education services, with well-child checkups; well-woman exams; physical exams; management and treatment of diabetes and other chronic illnesses; medication management; low-cost referrals for specialized needs; preventive, restorative, and emergency dentistry; individual and family counseling; and patient education classes. SFCHC's Teaching Kitchen, which is used to provide instruction in nutrition and diabetes management, stands out as a unique service that other FQHCs do not offer. In CY 2022, SFCHC served 8003 unduplicated patients with 50,909 visits across service lines.

SFCHC's main site at 732 Mott Street Suite 100-110, San Fernando, CA 91340 is housed in the same historical location that was the site of the first hospital. This clinic space encompasses 17,115 square feet and includes primary medical, dental, behavioral health, and enabling and health education services. The health center's satellite site at 11134 Sepulveda Boulevard Mission Hills, CA 91346, within the Harbor Cares Recuperative Center, is 1,502 square feet and provides medical, case management and preventive dental services with referrals provided to the main site per patients' needs. SFCHC is a patient-centered medical home – a model of primary care that combines teamwork and information technology to improve care, improve patients' experience of care, and reduce costs. Medical homes foster ongoing partnerships between patients and their personal clinicians, instead of approaching care as the sum of episodic office visits. Each patient's care is overseen by clinician-led care teams that coordinate treatment across the health care system. Research shows that medical homes can lead to higher quality and lower costs and can improve patient and provider reported experiences of care.

Governance

SFCHC's governing Board of Directors (Board) consists of local leaders, advocates and patients who live and work in the community. These dedicated individuals approve all major organizational decisions and have fiduciary, quality assurance, and policy-making responsibilities. The Board maintains a clear line of authority to SFCHC's Chief Executive Officer and the management team. Current Board members are:

- Martin Adams, Chair
- Aaron Morris, Vice Chair
- Louise Oliver, Secretary
- Cesar De La Cruz, Treasurer
- Maritza Artan, Member
- Annette Besnilian, Member
- Joni Novosel, Member
- Patricia Ochoa, Member
- Dianne Philibosian, Member
- Precious Querubin, Member
- Arlene Rodriguez, Member



2 CHNA FRAMEWORK

As the healthcare system continues to evolve and community health needs shift, it is important for SFCHC to conduct a formal Community Health Needs Assessment (CHNA) to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations. This assessment helps us consider solutions to fulfill unmet needs while continuing to strengthen local resources. It will guide our grant development priorities and inform our 2023-2026 strategic plan.

Another important factor in establishing the CHNA framework is compliance with the Health Center Program under Section 330(k)(2) and Section 330(k)(3)(J) of the Public Health Services (PHS) Act. Under this program, SFCHC must define the boundaries of the area it serves (“service area”) based on where existing patient populations reside. SFCHC is also required to complete a needs assessment of its service area and patient population for the purposes of informing and improving the delivery of health center services.

Section 3 of this report introduces the population living in SFCHC’s service area and those factors associated with access to care and health care utilization (for example, occupation, income level, education, transportation, etc.). These factors, known as Social Determinants of Health (SDOH), are the conditions in which people are born, live, learn, work, play and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.¹ These circumstances are mostly determined by a distribution of money, power, and resources. Many of these circumstances aren’t fair, and the unjust differences in the social determinants of health lead to poorer

¹ <https://www.cdc.gov/socialdeterminants/index.htm>

health outcomes such as obesity, heart disease, diabetes and cancer. Finally, Section 4 highlights the most significant health needs within SFCHC's service based on quantitative, secondary data as well as community input. Narrowing health disparities and addressing health needs is key to improving the health of SFCHC's target population and reducing unnecessary health care costs. SFCHC acknowledges that, on its own, it cannot reduce longstanding disparities in health, but it is committed to work with partners in housing, social services, and others to help.

The overall goals of SFCHC's 2023 CHNA are the following:

1. Engage public health and community stakeholders including low-income, minority, and other underserved populations;
2. Understand the health behaviors, risk factors and social determinants that impact health;
3. Assess and understand the community's health issues and needs; and
4. Use CHNA findings to inform SFCHC's 2023-2026 strategic plan.





3 OUR COMMUNITY

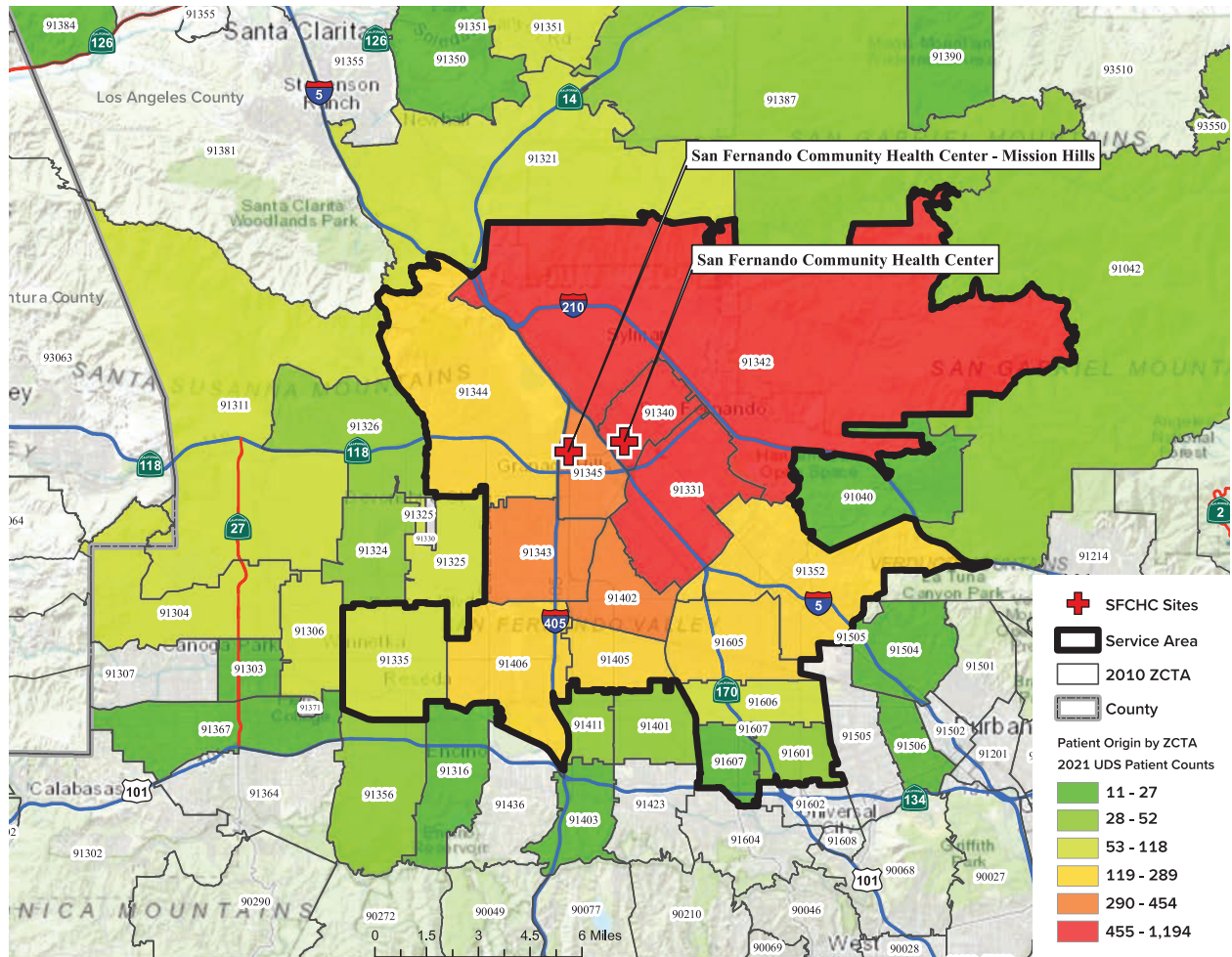
Service Area

LA County is one of the smallest counties in California. It covers approximately 4,058 square miles, which is only 2.6% of the state's land area. However, its 10 million residents represent one quarter of California's total population, making it the most populous county in the nation. SFCHC conducted a patient origin study by reviewing data on where its 2022 patient population resides, as documented by the zip codes in the health center's electronic health record system. The zip codes shown in Figure 1 below represent 85% of SFCHC patients seen in 2022 and define SFCHC's service area.



SFCHC's service area is located in the San Fernando Valley, a region of LA County nestled to the northwest of the Los Angeles basin. The San Fernando Valley is bounded by the San Gabriel (north and northeast), Santa Susana (north), and Santa Monica (south) mountains and the Simi Hills (west). Originally an agricultural area, the San Fernando Valley occupies 260 square miles and is where the Golden State Freeway (I-5) and the San Diego Freeway (I-405) connect. The Ronald Reagan Freeway (CA-118) bisects the community.

FIGURE 1: SFCHC Patient origin and service area map



SFCHC's service area consists of 15 zip codes (see Table 1). The top three zip codes making up where 45% of SFCHC patients reside are 91340, 91331, and 91342. These three zip codes represent 28% of the total population of SFCHC service area.

TABLE 1: SFCHC service area zip codes based on patient origin study

ZIP CODE	POST OFFICE NAME	TOTAL POPULATION	% SFCHC PATIENTS
91342	Sylmar	94,432	16.7%
91331	Pacoima	103,683	15.4%
91340	San Fernando	37,221	13.0%
91343	North Hills	65,344	6.3%
91345	Mission Hills	18,825	5.9%
91402	Panorama City	70,702	5.8%
91352	Sun Valley	46,027	4.0%
91344	Granada Hills	55,694	3.0%
91605	North Hollywood	52,345	2.3%
91406	Van Nuys	54,309	2.1%
91405	Van Nuys	56,821	2.0%
91335	Reseda	80,937	1.6%
91606	North Hollywood	45,003	0.9%
91601	North Hollywood	35,312	0.6%
91607	Valley Village	31,039	0.4%
		847,694	85.0%

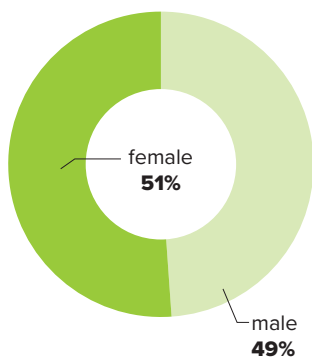
Demographics

Per the U.S. Census Bureau's 2020 American Community Survey (ACS) 5-year estimate, there are 847,694 people living in SFCHC's service area. This population increased by 3.2% between 2010 and 2020, more than LA County's overall increase of 2.3%. Of the 847,694 residents of SFCHC's service area, 51% were females (429,764) and 49% were males (417,930). About 23% of the population were children 17 years of age or younger, 65% were adults between 18 and 64 years, and 12% were 65 years of age and older. Almost two-thirds (63%) were Hispanic or Latino (any race), 23% White, 9% Asian, 4% Black, and 2% identified as other or multiple races.

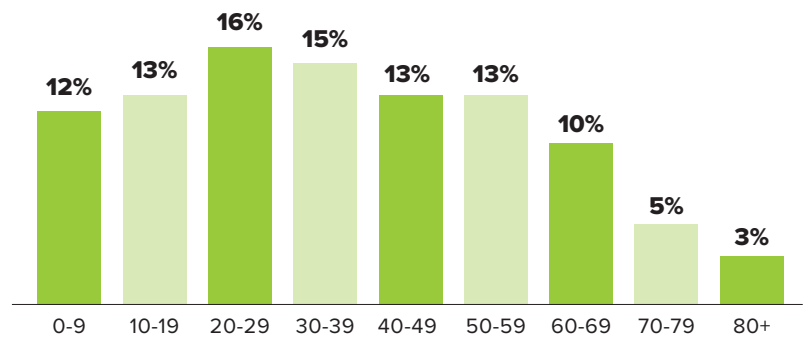
FIGURE 2: Service area demographics

Source: American Community Survey 2020, 5-year estimates

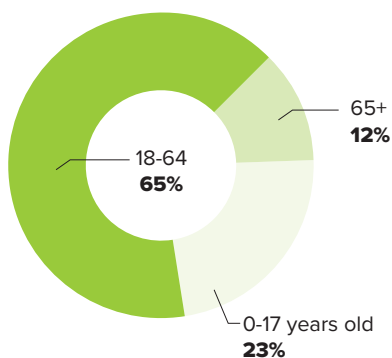
population by age category



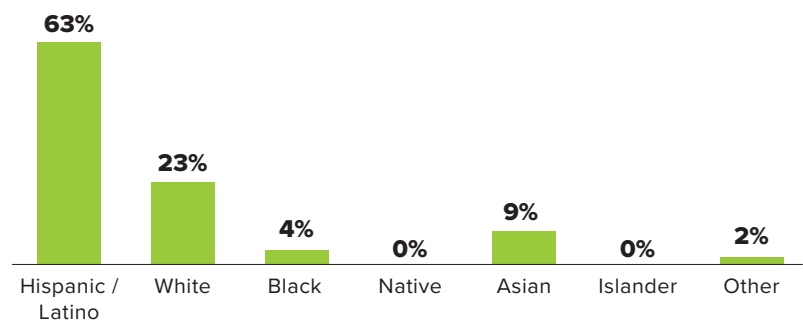
population by age range



population by sex



population by race & ethnicity



Economic Stability

INCOME

Income is one of the strongest predictors of health outcomes worldwide. People living in poverty are at increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy.² Programs and policies that make food, housing, health care, and education more affordable can help reduce poverty.^{3, 4}

As shown in Figure 3, SFCHC's service area has a higher rate of poverty than LA County overall. More than 125,000 residents of SFCHC's service area (15%) live below the federal poverty level (FPL) and another 188,200 (22%) live between 100 and 199% FPL. In total, 37% of SFCHC's service area (311,481 residents) live below 200% FPL and are considered "low-income." In 2023, 200% FPL corresponds to an annual income of \$29,160 for one person and \$60,000 for a family of 4.⁵ The median household income for SFCHC's service area (\$65,351) is 8% lower than LA County (\$71,358) and 17% lower than California (\$78,672) despite the high cost of living of Southern California. Racial and ethnic minorities are more likely than non-minority groups to experience poverty at some point in their lives.⁶ Indeed, White, non-Hispanic/Latino residents of SFCHC's service area make significantly more money than any other race/ethnic group. Among non-White residents, Hispanic/ Latinos make the least. See Figure 4.

FIGURE 3: Poverty and income in SFCHC's service area

Source: U.S. Census Bureau, 2020 ACS 5-year estimates

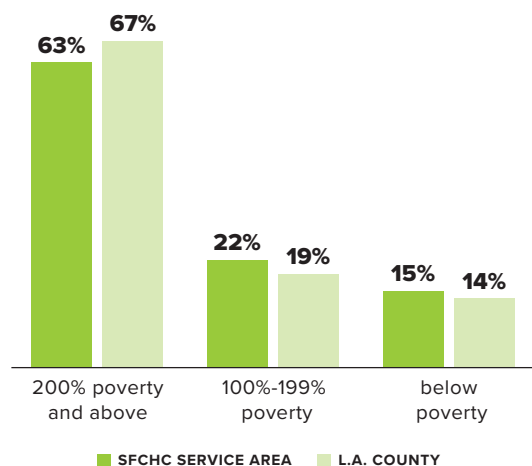
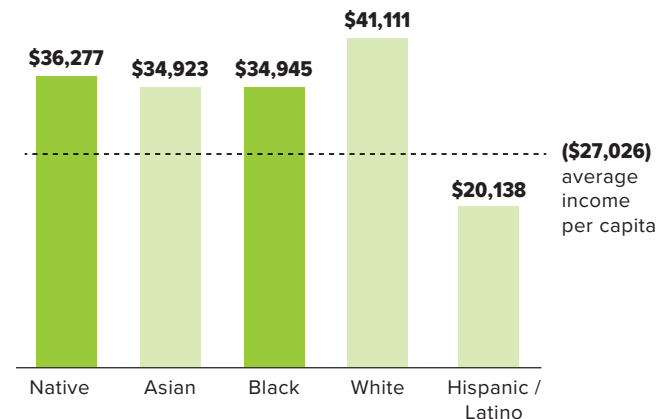


FIGURE 4: Per capita income by race/ethnicity – SFCHC service area

Source: U.S. Census Bureau, 2020 ACS 5-year estimates



² Mode NA, Evans MK, Zonderman AB (2016) Race, Neighborhood Economic Status, Income Inequality and Mortality. PLoS ONE 11(5): e0154535. <https://doi.org/10.1371/journal.pone.0154535>

³ Woolf, S.H., et. al (2015). How are Income and Wealth Linked to Health and Longevity?

⁴ "Health, Income, & Poverty: Where We Are & What Could Help," Health Affairs Health Policy Brief, October 4, 2018. <https://doi.org/10.1377/hpb20180817.901935>

⁵ <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

⁶ Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: What the patterns tell us. Am J Public Health. 2010;100(S1):S188-S196.



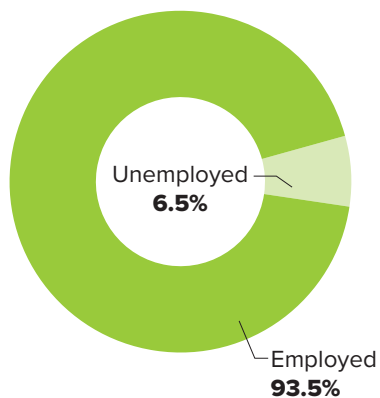
EMPLOYMENT

Many low-income households have low-paying jobs or struggle with unemployment. This also holds true in SFCHC's service area where residents living below poverty are more likely to be unemployed or not participate in the labor force, compared to the service area overall. While the average unemployment rate for SFCHC's service area was 6.5% based on the most recent 2020 American Community Survey 5-year estimates, for those living below poverty, the unemployment rate was triple that at 19.8%. See Figure 5 below.

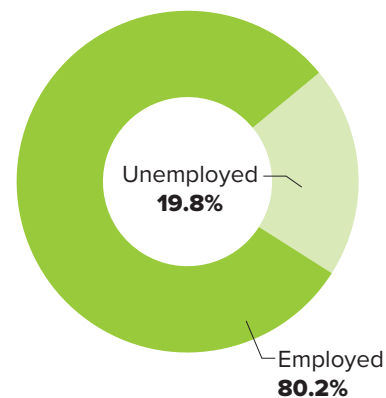
FIGURE 5: Employment in SFCHC service area, civilian population age 16 and over

Source: U.S. Census Bureau, 2020 ACS 5-Year Estimates

unemployment rate, all income levels



unemployment rate, <100% FPL



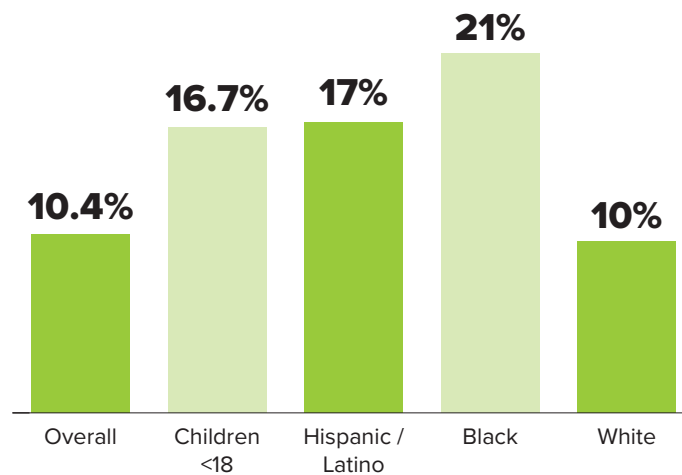
FOOD INSECURITY

Food insecurity is defined as the disruption of food intake or eating patterns because of lack of money and other resources. Food insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. Food insecurity is influenced by a number of factors including income, employment, race/ethnicity, and disability.⁷

In 2020, 10.4% of individuals living in California's 29th Congressional District (where SFCHC service area is located), were food insecure and 93% of them were eligible for the Federal Supplemental Nutrition Assistance Program (SNAP) – known as CalFresh in California—or other nutrition programs based on their income.⁸ As shown in Figure 6 below, there are stark disparities in food insecurity by race and ethnicity.

FIGURE 6: Food insecurity by race/ethnicity and age group in CA 29th Congressional District, 2020

Source: Map the Meal Gap, 2020



Being food insecure is a risk factor for poor diabetes control. Low-income diabetics are at elevated risks for hypoglycemia, if they are food insecure; as they reduce their food intake, but maintain their medication compliance, they are more likely to experience hypoglycemia that can lead to hospitalization and further poor health outcomes related to their diabetes.⁹

⁷ Coleman-Jensen A, Rabbitt MP, Gregory CA, Singh A. Household food insecurity in the United States in 2016. USDA-ERS Economic Research Report No. (ERR-237). 2017.

⁸ Gundersen, C., Strayer, M., Dewey, A., Hake, M., & Engelhard, E. (2022). Map the Meal Gap 2022: An Analysis of County and Congressional District Food Insecurity and County Food Cost in the US in 2020. Feeding America.

⁹ Seligman HK, Lyles, C, et al. A Pilot Food Bank Intervention Featuring Diabetes-Appropriate Food Improved Glycemic Control Among Clients in Three States. Health Affairs. 2015;34(11):1956-63. Available from: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0641>

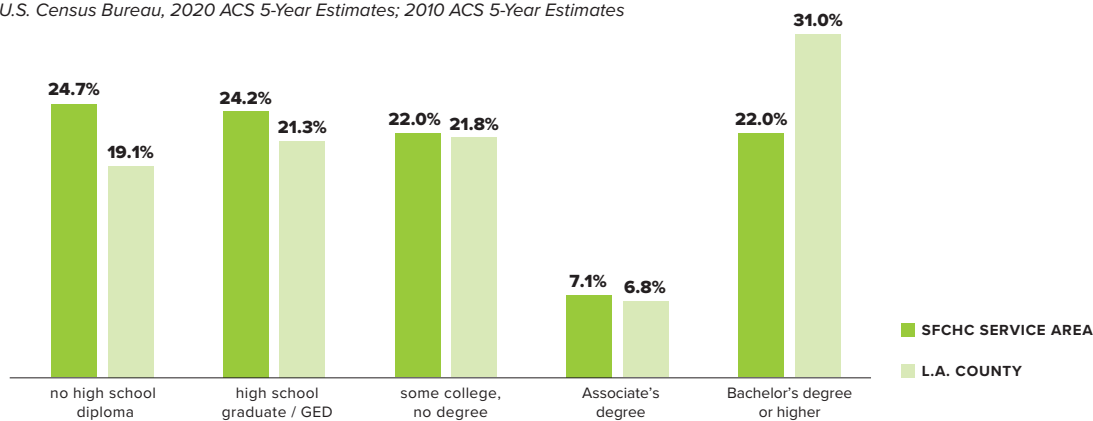
Education

The socioeconomic status of young children's families and communities significantly affects their educational outcomes. Specifically, poverty has been shown to negatively influence the academic achievement of young children.¹⁰ Students from low-income families often have less access to resources and they tend to live in communities with underperforming schools. Research shows that, in their later years, these children from disadvantaged backgrounds are more likely to need special education, repeat grades, and drop out of high school.¹¹ Children from communities with higher socioeconomic status and more resources experience safer and more supportive environments and better early education programs.

A high school diploma is a standard requirement for most jobs – and for higher education opportunities. Research consistently shows that employment prospects and lifelong earning potential are better for high school graduates.¹² Dropping out of high school is linked to limited employment prospects, low wages, and poverty.^{13, 14} As shown in Figure 7, a greater percentage of residents 18 years or older from SFCHC's service area do not have a high school diploma (24.7%), compared to LA County (19.1%). Lack of education is a major impediment to wage growth among SFCHC service area workers.

FIGURE 7: Educational attainment for population 18 years or older

Source: U.S. Census Bureau, 2020 ACS 5-Year Estimates; 2010 ACS 5-Year Estimates



Individuals who do not graduate high school are more likely to self-report overall poor health. They also more frequently report suffering from at least one chronic health condition than graduates.¹⁵ Ultimately, finishing more years of high school, and especially earning a high school diploma, provides individuals with the opportunity to earn a higher income and gain access to better living conditions, healthier foods, and health care services. Overall, high school graduation has the potential to improve population health.¹⁶

¹⁰ Campbell F, Conti G, Heckman JJ, Moon SH, Pinto R, Pungello E, et al. Early childhood investments substantially boost adult health. *Science*. 2014;343(6178):1478–85.

¹¹ Karoly LA, Kilburn MR, Cannon JS. Early childhood interventions: proven results, future promise. Santa Monica (CA); Rand Corporation; 2005

¹² Day JC, Newburger EC. The big payoff: educational attainment and synthetic estimates of work-life earnings. Special Studies. Current Population Reports. U.S. Census Bureau; 2002. Report No.: P23-210.

¹³ Freudenberg N, Ruglis J. Reframing school dropout as a public health issue. *Prev Chronic Dis*. 2007;4(4):A107

¹⁴ Hahn RA, Knopf JA, Wilson SJ, Truman BI, Milstein B, Johnson RL, et al. Programs to increase high school completion: a community guide systematic health equity review. *American Journal of Preventive Medicine*. 2015;48(5):599–608. doi: 10.1016/j.amepre.2014.12.005.

¹⁵ Vaughn MG, Salas-Wright CP, Maynard BR. Dropping out of school and chronic disease in the United States. *J Public Health*. 2014;22(3):265–70.

¹⁶ Krueger PM, Tran MK, Hummer RA, Chang VW. Mortality attributable to low levels of education in the United States. *PLoS One*. 2015;10(7): e0131809.

Healthcare Access

Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities. Some of these obstacles include lack of health insurance, poor access to transportation, language barriers, and a shortage of primary care providers.¹⁷

Vulnerable populations are particularly at risk for insufficient health insurance coverage: people with lower incomes are often uninsured, and minorities account for over half of the uninsured population.¹⁸ According to the U.S. Census Bureau, 29% of SFCHC service area residents have Medi-Cal (California's Medicaid program) and 11.4% are uninsured. These percentages are higher than LA County, where 23% have Medi-Cal and only 9% are uninsured. The service area's private insurance rate of 48.5% is much lower than LA County (55.3%). See Figure 8.

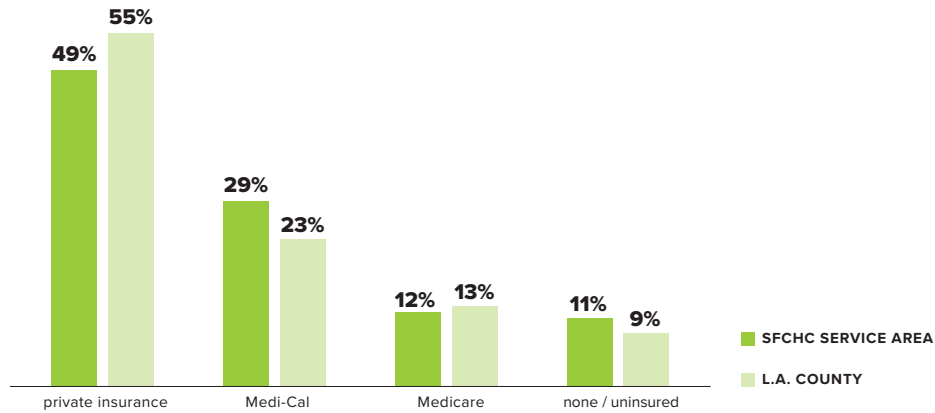
¹⁷ Call K, McAlpine D, Garcia C, Shippee N, Beeba T, Adeniyi T, et al. Barriers to care in an ethnically diverse publicly insured population: is health care reform enough? *Med Care*. 2014;52:720–27.

¹⁸ Majerol M, Newkirk V, Garfield R. The uninsured: a primer: key facts about health insurance and the uninsured in America. Menlo Park, CA: Kaiser Family Foundation; 2015.



FIGURE 8: Health insurance status of SFCHC service area and LA County

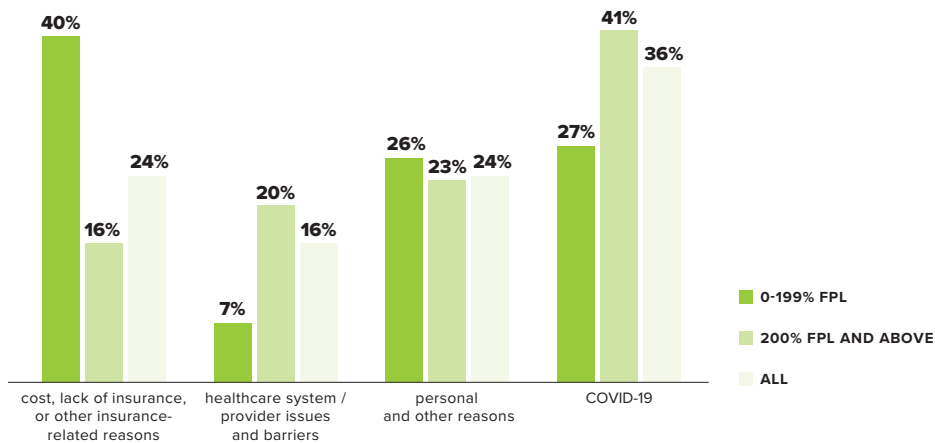
Source: U.S. Census Bureau, 2020 ACS 5-Year Estimates



Low-income individuals experience several challenges with accessing any type of health care and are therefore more likely to delay or forget their care. Within SFCHC's service area, 20% of low-income individuals delayed or didn't get medical care in the past year compared to 13% of residents at or above 200% FPL. Of those that delayed or didn't get care, the main reasons were different based on income level. While 40% of low-income individuals delayed care due to cost, lack of insurance, or other insurance-related reasons, only 16% of those above 200% FPL delayed care for the same reason. See Figure 9.

FIGURE 9: Main reason for delaying or forgoing needed medical care in the past year

Source: 2021 California Health Interview Survey (CHIS)



Health insurance alone cannot remove every barrier to care. Inconvenient or unreliable transportation can interfere with consistent access to health care, potentially contributing to negative health outcomes. Studies have shown that lack of transportation can lead to patients, especially those from vulnerable populations, delaying or skipping medication, rescheduling or missing appointments, and postponing care.¹⁹ Within SFCHC's service area 16% of all households have a vehicle shortage, defined as having fewer vehicles than workers in the household, or no vehicles at all, representing more than 41,000 households.

¹⁹ Syed ST, Gerber BS, Sharp LK. Traveling towards disease: transportation barriers to health care access. J Community Health. 2013 Oct;38(5):976-93.

FIGURE 10: Vehicle shortage in SFCHC service area households

Source: U.S. Census Bureau, 2020 ACS 5-Year Estimates

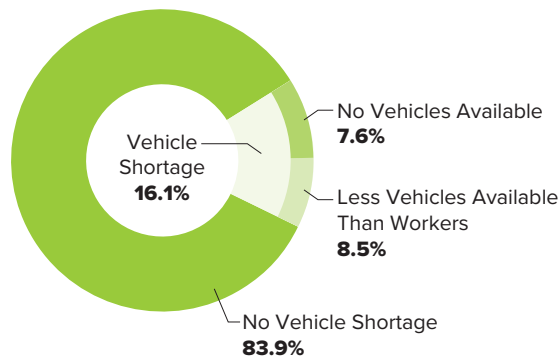
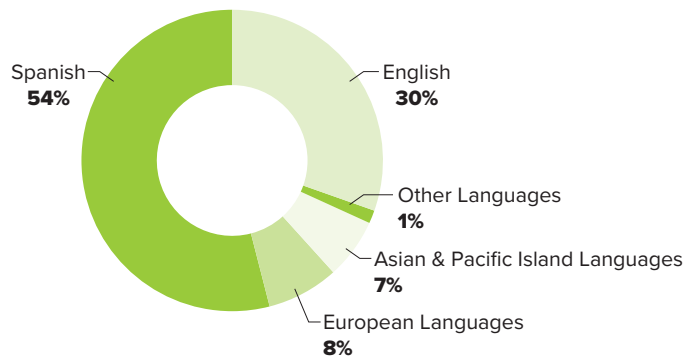


FIGURE 11: Major languages spoken at home, population 25 years and older

Source: U.S. Census Bureau, 2020 ACS 5-Year Estimates



Individuals who do not speak English at home, immigrants, and those with lower levels of education are at higher risk for having limited English language skills and low literacy, creating a barrier to accessing health care services, communicating with health care providers, and following medication instructions—all of which may adversely affect their health. Indeed, research has shown a positive correlation between limited literacy skills and chronic conditions, including diabetes and cancer.^{20, 21} As shown in Figure 11, more than half of all households in SFCHC’s service area (54%) speak Spanish at home and only 30% speak English. The rest speak a mix of European, Asian and Pacific Island languages. Among the non-English population 25 years of age and older living in SFCHC’s service area, 55.3% believe they speak English “very well” and 44.7% say they speak English less than “very well” – this represents 248,366 adults who may experience language barriers when accessing healthcare services. The need for well-trained interpreters and bilingual health care providers is critical, as these have shown to improve patient satisfaction, quality of care, and health outcomes for individuals with limited English proficiency.²²

Limited availability of health care resources is another barrier that may reduce access to health services and increase the risk of poor health outcomes.²³ Provider shortages may mean that patients experience longer wait times and delayed care. Not only are health care resources more prevalent in communities where more residents are insured, but the type of insurance individuals have matter as well. People with Medi-Cal or who are uninsured are significantly more likely to report having difficulty finding a provider.²⁴ Without a regular source of care, these individuals are also less likely to receive preventive services for chronic conditions such as asthma, diabetes, or heart disease, making them more likely to develop severe yet preventable health conditions and to be diagnosed at more advanced disease stages.²⁵

²⁰DuBard CA, Gizlice Z. Language spoken and differences in health status, access to care, and receipt of preventive services among US Hispanics. *Am J Public Health*. 2008;98(11): 2021–2028. doi:10.2105/ajph.2007.119008

²¹DeWalt DA, Berkman ND, et al. Literacy and health outcomes. *J Gen Intern Med*. 2004;19(12):1228–39.

²²Neuhauser L, Kreps GL. Online cancer communication: meeting the literacy, cultural and linguistic needs of diverse audiences. *Patient Educ Couns*. 2008;71(3): 365–77

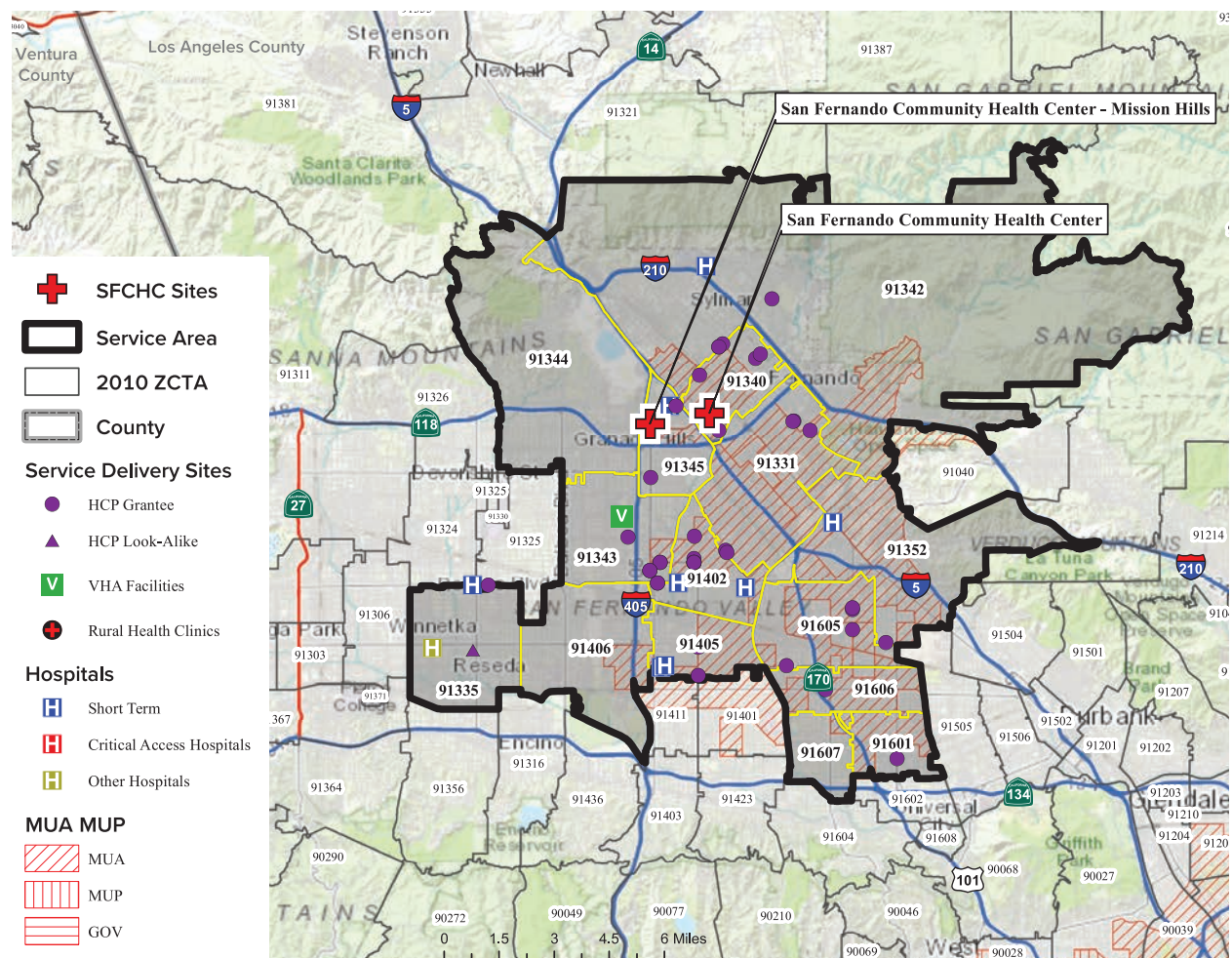
²³Call K, McAlpine D, Garcia C, Shippee N, Beeba T, Adeniyi T, et al. Barriers to care in an ethnically diverse publicly insured population: is health care reform enough? *Med Care*. 2014;52:720–27.

²⁴You’ve Got Medicaid – Why Can’t You See the Doctor? Elizabeth Renter. <http://health.usnews.com/health-news/health-insurance/articles/2015/05/26/youve-got-medicaid-why-cant-you-see-the-doctor>

²⁵Medicaid Provides Poor Quality Care: What the Research Shows. Brian Blase. <http://www.heritage.org/research/reports/2011/05/medicaid-provides-poor-quality-care-what-the-research-shows>

Almost one quarter (22.5%) of SFCHC's service area belongs to a Medically Underserved Area (MUA), which is an area designated by HRSA as having too few primary care providers and high poverty. SFCHC's service area is part of the following four MUAs: Panorama City (ID 07431), Van Nuys Central (ID 07426), Pacoima East/Sun Valley (ID 07366), and North Hollywood (ID 07330). In addition, 22.3% of the service area is designated as a Health Professional Shortage Area (HPSA). These are low-income areas designated by HRSA as having shortage of primary care, dental and/or mental health providers. SFCHC's service area is part of the following three HPSAs: North Hollywood Central (ID 1064753503), San Fernando West (ID 1069894178), and Pacoima East/Sun Valley (ID 1065355600). See Figure 12 below.

FIGURE 12: MUA/P and HPSA designations for SFCHC service area



Source: UDS Mapper

Neighborhood and Built Environment

HOUSING

Housing instability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, or staying with relatives. These experiences may negatively affect physical health and make it harder to access health care. The Department of Housing and Urban Development (HUD) tracks four housing problems: overcrowding (more than 1 person per room), cost-burden (household spending more than 30% of their income on housing), incomplete kitchen facilities, and incomplete plumbing facilities.

As shown in Figures 13 and 14 below, low-income households in SFCHC's service area are more likely to rent rather than own. In turn, renter-occupied households are more likely to be cost-burdened and have at least one of the four housing problems mentioned above than owner-occupied households. These households are also more likely to be Black or Hispanic/ Latino.²⁶ Almost two-thirds (63.2%) of renter-occupied housing units in SFCHC's service area spend more than 30% of their income on rent, and almost three-fourths (71%) have at least one housing problem.

FIGURE 13: Housing status by household income in SFCHC's service area

Source: Comprehensive Housing Affordability Survey (CHAS) based on 2015-2019 ACS 5-year estimates

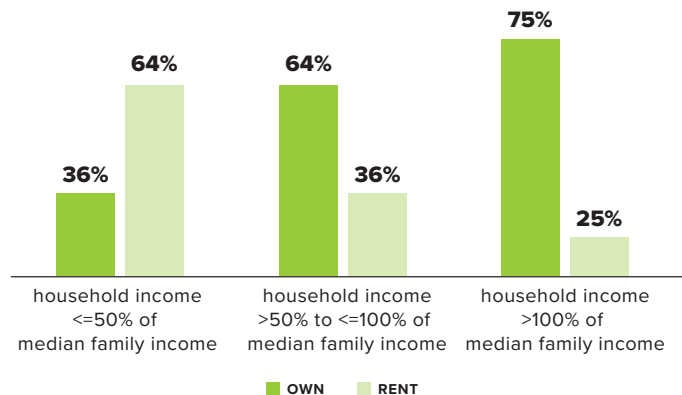
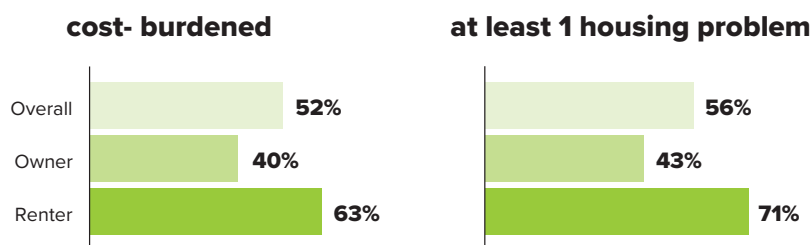


Figure 14: Housing Affordability by housing status in SFCHC's service area

Source: U.S. Census Bureau, 2020 ACS 5-Year Estimates



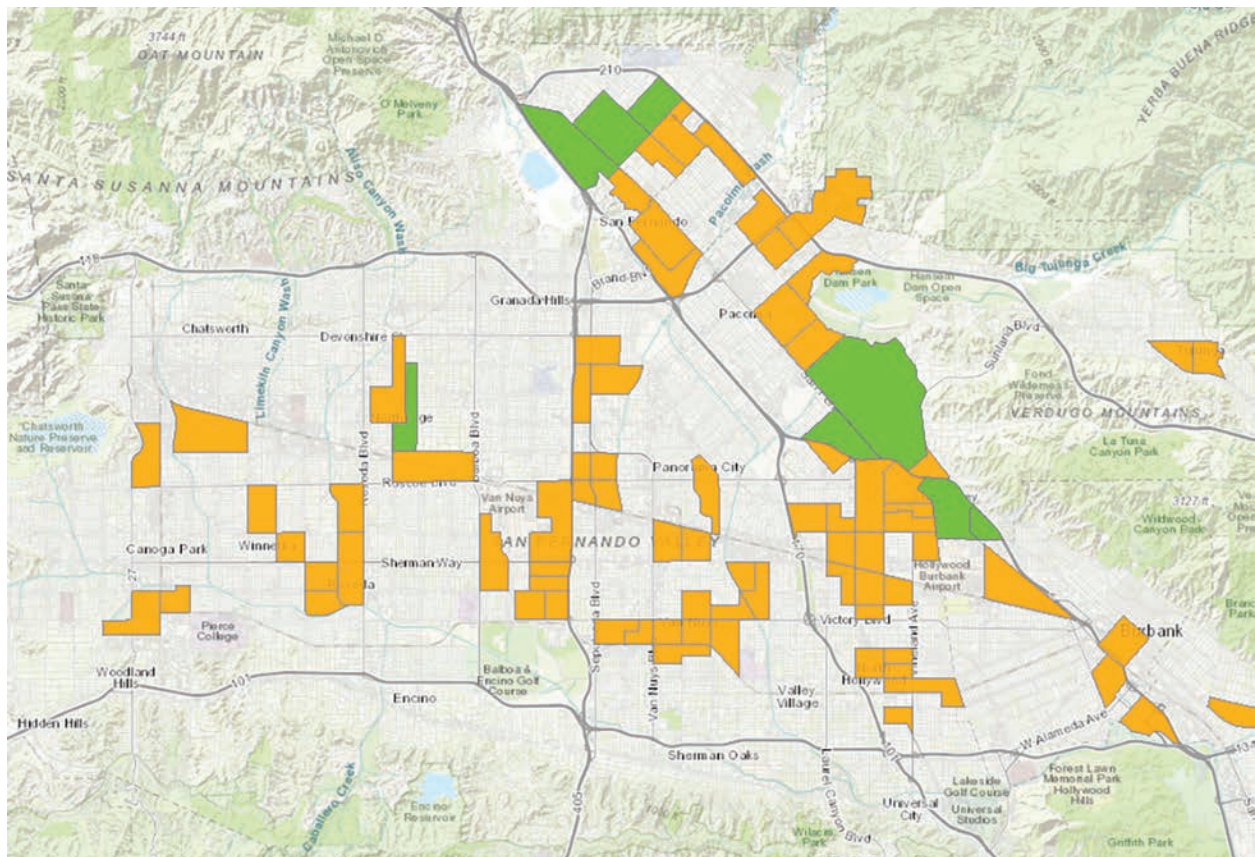
²⁶Hernandez D. Affording housing at the expense of health: Exploring the housing and neighborhood strategies of poor families. J Fam Hist. 2016;37(7):921-46.

ACCESS TO FOOD

Neighborhood conditions affect physical access to food. For example, people living in some low-income neighborhoods may have limited access to full-service supermarkets or grocery stores. Predominantly black and Hispanic neighborhoods have fewer full-service supermarkets than predominantly white and non-Hispanic neighborhoods. Communities that lack affordable and nutritious food are commonly known as “food deserts.” Convenience stores and small independent stores are more common in food deserts than full-service supermarkets or grocery stores. These stores may have higher food prices, lower quality foods, and less variety of foods than supermarkets or grocery stores. Access to healthy foods is also affected by lack of transportation and long distances between residences and supermarkets or grocery stores.²⁷

As shown in Figure 15, several SFCHC service area census tracts are considered both “low income” (poverty rate >20% or median income <80% of median family income for metro area) and “low access” meaning that a significant share of its residents is more than ½ mile (orange) or 1 mile (green) from the nearest supermarket.

FIGURE 15: Low income and low access census tracts, 2019



Source: <https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/>

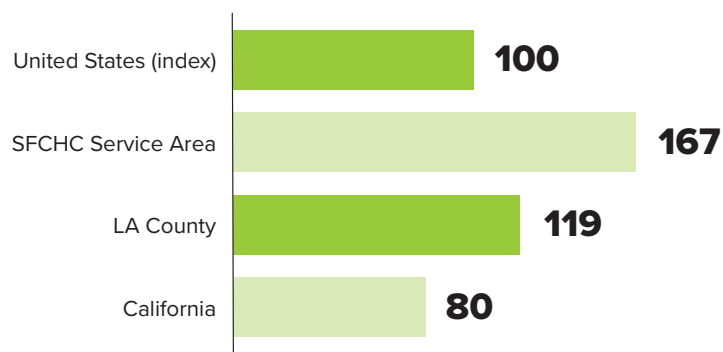
²⁷USDA Economic Research Service. Access to affordable and nutritious food: Measuring and understanding food deserts and their consequences. Available from: https://www.ers.usda.gov/webdocs/publications/42711/12698_ap036fm_1_.pdf?v=41055

CRIME AND VIOLENCE

While crime and violence can affect anyone, certain groups of people are more likely to be exposed. For example, the national homicide rate is consistently higher for Black adolescents and young adults than their White counterparts. The reasons for these disparities are well understood: minority populations are disproportionately exposed to conditions such as concentrated poverty, racism, limited educational and occupational opportunities, and other aspects of social and economic disadvantage contributing to violence.²⁸ It is therefore no surprise that SFCHC's service area crime rate is 67% greater than the national average (crime index: 100=national average).²⁹ See Figure 16.

FIGURE 16: Crime rate for SFCHC's service area compared to LA County, California, and US (2019)

Source: U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division, table 5 (2019)



In addition to the potential for death, disability, and other injuries, people who survive violent crime endure physical pain and suffering and may also experience mental distress and reduced quality of life.³⁰ In particular, children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes, such as depression, anxiety, and post-traumatic stress disorder, regardless of whether they are victims, direct witnesses, or hear about the crime.³¹

²⁸Sheats, K. J., Irving, S. M., Mercy, J. A., Simon, T. R., Crosby, A. E., Ford, D. C., Merrick, M. T., Annor, F. B., & Morgan, R. E. (2018). Violence-related disparities experienced by black youth and young adults: Opportunities for prevention. *American Journal of Preventive Medicine*, 55(4), 462–469. doi: 10.1016/j.amepre.2018.05.017

²⁹Crime rate = total number of arrests in a year divided by the population compared to the national rate, which is indexed to 100 with geographical measures referenced from the national rate. For example, if the crime rate is 130 for a service area, crime in the service area is 30% greater than the national average.

³⁰American Public Health Association. (2018, Nov 3). *Violence is a public health issue: Public health is essential to understanding and treating violence in the U.S.* <https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/28/violence-is-a-public-health-issue>

³¹Metzler, M., Merrick, M. T., Klevens, J., Ports, K. A., & Ford, D. C. (2017). Adverse childhood experiences and life opportunities: Shifting the narrative. *Children and Youth Services Review*, 72, 141–149.



4 COMMUNITY HEALTH NEEDS

Quantitative Data

Secondary data on socio-economic indicators, mortality rates, disease prevalence, emergency room usage and hospital admissions were collected and analyzed for SFCHC's service area. The most recently available data, at the time of publication, were pulled from the following sources:

- American Community Survey (U.S. Census Bureau)
- California Health Interview Survey (University of California, Los Angeles)
- Comprehensive Housing Affordability Strategy (U.S. Department of Housing & Urban Development)
- LA County Department of Public Health
- State of California Department of Public Health
- UDS Mapper
- Greater Los Angeles Homeless Count (Los Angeles Homeless Services Authority)
- Centers for Disease Control and Prevention
- Food Access Research Atlas (U.S. Department of Agriculture)

Once the information and data were collected and analyzed, the following 10 health needs or issues were identified, listed here in alphabetical order:

- Asthma/ environmental health issues
- Cancers
- Cardiovascular disease/ stroke
- Homelessness
- Maternal & child health
- Mental health
- Obesity/ diabetes
- Oral health
- Sexually transmitted infections (Hep C, syphilis, HIV)
- Substance use

Community Input

SFCHC recognizes the value of input from community members and local stakeholders during the CHNA process. As the people who live and work in the San Fernando Valley, they have first-hand knowledge of the needs and strengths of their community, and their opinions help to shape our future direction. For primary data, input was collected from 13 residents during two focus groups held at SFCHC in October 2022. The first group was held in Spanish and had eight (8) participants. The second group was in English with five (5) participants. A focus group facilitator explained the purpose of the meeting and introduced the ground rules. All participants signed a consent form to participate in the group and received a \$20 gift card after the meeting. The qualitative data offered through these focus groups provide additional context and depth to the CHNA that may not be fully captured by quantitative data alone.

Finally, input was collected from 18 community leaders via anonymous survey using an online survey tool (*SurveyMonkey*). Leaders were asked to consider the 16 health issues listed above according to four criteria:

- a. Number of people affected** (1=few people affected; 3=most people affected)
- b. Health disparities** (1=all affected equally; 3=strong disparities between groups)
- c. Whether SFCHC has the expertise/resources to address the issue** (1=no, 3=yes)
- d. Community priority** (1= low priority, 3=high priority)

Data Limitations and Information Gaps

Secondary data allows for an examination of the broad health needs within a community. However, data was not always available at the ZIP code level, so LA county, LA city council district, or Service Planning Area (SPA) level data were utilized to estimate service area numbers. In addition, disaggregated data for age, ethnicity, race, and gender are not available for all data indicators, which limited the examination of disparities of health issues within the community. Finally, data is not always collected on an annual basis, meaning that some data points are several years old or are estimates based on multiple years.

The qualitative data gathered from community input also has its limitations. With only 13 focus group participants and 18 community leaders, our sample size was very small and not necessarily representative of the broader population. At times, a stakeholder-identified health issue may not have been reflected by the secondary data indicators or vice-versa.

Identified Health Needs

Analysis of secondary data, input from focus groups, and the stakeholder surveys revealed the following top 5 health needs, in alphabetical order. These significant community health needs will be discussed below:

1

Homelessness

2

Mental Health

3

Obesity / Diabetes

4

Oral Health

5

Substance Abuse

HOMELESSNESS

Homelessness in SFCHC's service area was the top issue raised by focus group participants. It was seen as less of a priority by the key community leaders surveyed. Secondary data from LA County supports the fact that homelessness is a growing problem in this area. Community members shared that having a safe, stable place to live is foundational to a person's physical and mental wellbeing. Therefore, addressing homelessness is an urgent need both for those experiencing homelessness and those living in the community where unhoused individuals set up camp.

The federal government defines homelessness as a condition in which an individual or family lacks a fixed, regular, nighttime residence; resides in a public or private residence that is not designed or intended to be a regular sleeping accommodation for human beings; lives in a supervised shelter designated to provide temporary living arrangements; and/or is at imminent risk of losing their housing and has no subsequent residence identified or resources to obtain other permanent housing.³²

The most recent available data for homelessness in LA County is from the 2022 Greater Los Angeles Homeless Count. This point-in-time count was conducted by the Los Angeles Homeless Services Authority (LAHSA) and hundreds of volunteers across 3 nights in January 2022 and was the first count since the COVID-19 pandemic began. SFCHC service area data was estimated from LA city Council District 7 data, SPA 2 data, and data from the City of San Fernando. *The 2022 Greater Los Angeles Homeless Count estimates a total of 4,289 homeless individuals in SFCHC's service area, a 21% increase from the 2020 homeless count. Of these, 3,154 (73.5%) are unsheltered, living on the street, in tents, or in vehicles. See Table 2 below. Almost half (45%) of homeless individuals in SFCHC's service area are considered chronically homeless, meaning they have been homeless for 12 months or more within the last 3 years. This number has increased by 75% since the 2020 homeless count.*

TABLE 2: Characteristics of homeless population living in SFCHC's service area

	NUMBER OF INDIVIDUALS	PREVALENCE IN HOMELESS POP (%)	% CHANGE FROM 2020
Total homeless population:	4,289	100%	21%
Unsheltered	3,154	73.5%	22%
Sheltered	1,135	26.5%	17%
Among 18+ homeless population:			
Chronically homeless	1,937	45%	75%
Substance use disorder	1,156	27%	42%
Serious mental illness	689	16%	16%

³²42 U.S.C. §11302: General definition of homeless individual.

Available at: <http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section11302&num=0&edition=prelim>

The reasons for homelessness are also complex. High housing costs and a low stock of affordable housing create a precarious situation, especially for lower-income families who face economic insecurity due to a lack of living wage jobs. In general, there is a lack of safety net supports to offset the high cost of living in SFCHC's service area and not enough homelessness services to meet the demand.

The strongest and most consistent risk factors for homelessness are substance use disorders and mental illness, followed by low income and other income-related factors.³³ As shown in Table 1, 27% of homeless individuals in SFCHC's service area have a substance use disorder (SUD) and 16% have a serious mental illness like psychotic disorder or schizophrenia. SUD and mental illness can be both a cause and a result of homelessness.³⁴ Homeless persons addicted to drugs face high barriers to access treatment in the community. Such barriers include long waiting lists for treatment programs that accept Medi-Cal, logistic constraints like the lack of a phone (to call in order to enroll), transportation, lack of documentation, and no help in accessing treatment.³⁵ Similarly, a severe shortage of psychiatric inpatient beds means that emergency room doctors often have little choice but to release mentally ill patients within a few days with nowhere to go. Some patients may be referred to a county or private agency for help. But the time and effort it takes to access those services can be a barrier for many.³⁶

While waiting for permanent housing, it's imperative for homeless people to have a safe place to sleep. The longer people stay unsheltered, the more their mental and physical health deteriorates, making it harder for them to go back to the labor force, find housing, and regain financial stability. Living on the street or in crowded homeless shelters is extremely stressful and made worse by being exposed to communicable disease (e.g. TB, respiratory illnesses, hepatitis, etc.), violence, malnutrition, and harmful weather exposure. Chronic health conditions such as high blood pressure, diabetes, and asthma become worse because there is no safe place to store medications properly. Maintaining a healthy diet is difficult. Behavioral health issues such as depression, alcoholism, or other substance use disorders can develop and/or are made worse in such difficult situations. Minor issues such as cuts or common colds easily develop into larger problems such as infections or pneumonia.

A poll conducted in 2021 found that 94% of LA voters view homelessness as a serious or very serious problem.³⁷ This frustration was felt during the patient focus groups held October 2022. Potential strategies to address homelessness must tackle the affordable housing shortage, the high cost of living, and the lack of economic opportunity and living wage jobs for unskilled workers. Solutions must also involve lowering the barriers for the homeless with a mental illness and/or substance use disorder to seek treatment.

³³Tsai, J., & Rosenheck, R. A. (2015). Risk factors for homelessness among US veterans. *Epidemiologic reviews*, 37, 177–195. <https://doi.org/10.1093/epirev/mxu004>

³⁴Johnson, G., & Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first? *Australian Social Work*, 61(4), 342–356. <https://doi.org/10.1080/03124070802428191>

³⁵Michael D. Brubaker et. al. 2013. Barriers and Supports to Substance Abuse Service Use Among Homeless Adults. *Journal of Addictions & Offender Counseling* 34 (2): 81–98.

³⁶Ryan McBain et. al. Psychiatric & Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County. RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1824-2.html

³⁷<https://www.latimes.com/homeless-housing/story/2021-12-01/la-voters-are-frustrated-impatient-over-persistent-homelessness-crisis>

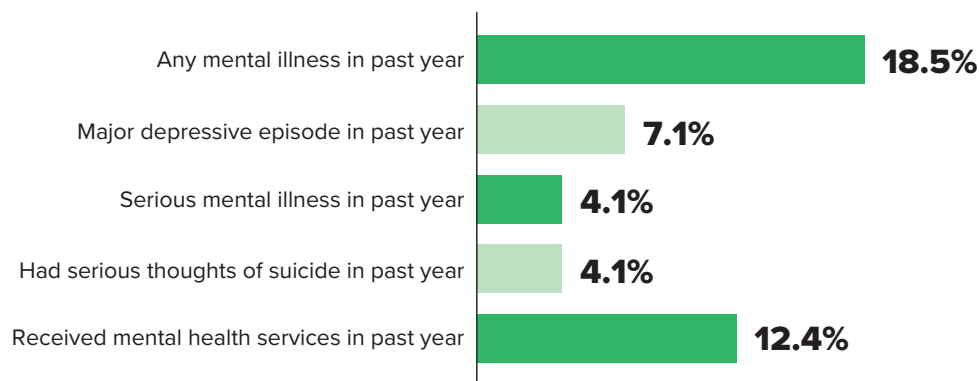
MENTAL HEALTH

Focus group participants shared they are seeing increased incidences of mental health challenges in the community, particularly in the context of the growing number of individuals experiencing homelessness and among young people. Surveyed community stakeholders ranked mental health issues and access to mental health services as one of the top community priorities. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to society. Mental health also plays a major role in people's ability to maintain good physical health. Chronic diseases such as diabetes or cancer can have a profound impact on an individual's mental health; in turn, mental illnesses, such as depression and anxiety, can affect people's ability to participate in treatment and health-promoting behaviors like engaging in adequate physical activity, eating a healthy diet, and not using tobacco products.

Rates of mental illness and psychological distress have been on the rise. In LA County, the percentage of adults who reported experiencing serious psychological distress increased by one-third, from 9.8% in 2015 to 13% in 2019.³⁸ Annual averages from 2016-2018 and population estimates show that, within SFCHC's service area, about one in six adults (18.5%) experienced a mental, behavioral, or emotional disorder (any mental illness) over the course of 12 months. However only about two-thirds received mental health services (12.4%). In addition, one in 14 adults experienced a major depressive episode (7.1%); and about one in 26 adults living in SFCHC's service area (4.1%) experienced a serious mental illness (SMI) that resulted in difficulty carrying out major life activities. See Figure 17.

FIGURE 17: National Survey on Drug Use and Health – Adults 18+

Source: SAMHSA, 2016-2018 National Survey on Drug Use and Health. Service Area estimates extrapolated by DataFox from LA County SPA data based on spatial extrapolation of service area to SPA

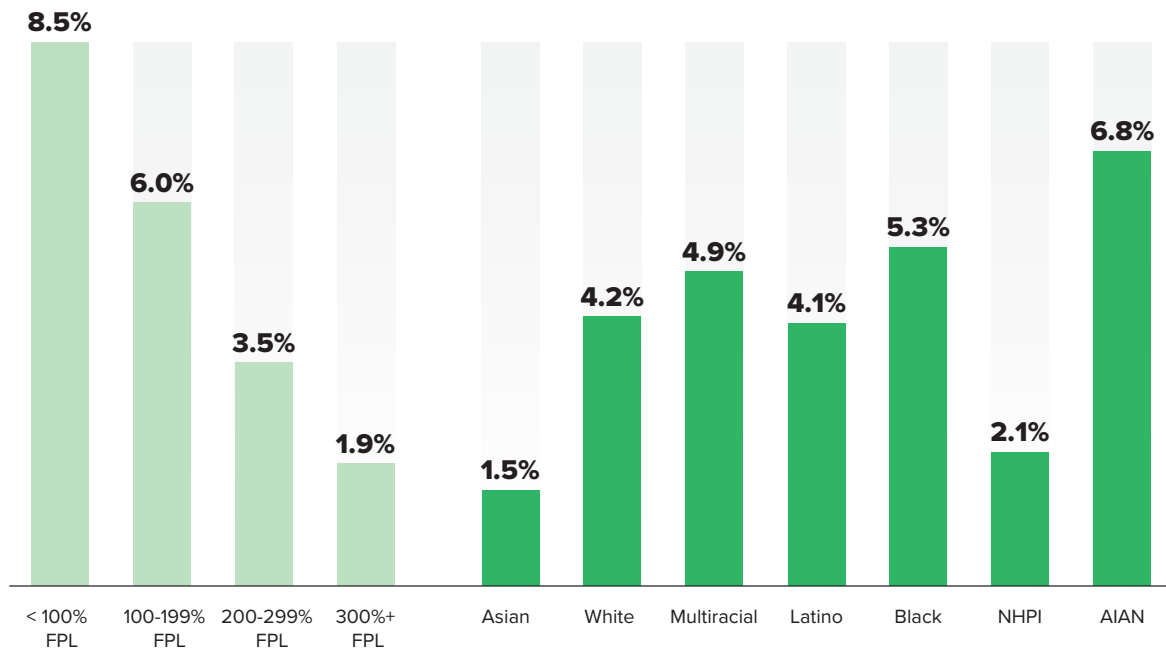


Like other health issues, the prevalence of SMI varies by income, with much higher rates of mental illness for both children and adults in families with incomes below 100% FPL. Rates of SMI also varied among racial and ethnic groups. American Indian and Alaska Native adults experienced the highest rates, followed by Black and multiracial adults. See Figure 18.

³⁸California Health Care Almanac (2022). Mental Health in California: Waiting for Care. California Health Care Foundation. Available at: <https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf>

FIGURE 18: SMI prevalence in adults by income and race/ethnicity, 2019

Source: <https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf>



Unfortunately, across the state, many low-income individuals with mental health concerns do not have access to the treatment they need. Insufficient private insurance coverage for mental health services and insufficient availability of publicly funded treatment services are significant barriers for many and lead to missed opportunities for early problem identification and prevention—resulting in more people experiencing mental health crises. From 2011 to 2020, emergency department discharges to psychiatric care in California increased by more than 50% from 20.4 to 32.2 per 10,000 population.

Common themes for effective strategies to address behavioral health challenges include the following:

- Improve access to counseling and mental health services
- Integrate mental health care and primary care
- Utilize health education classes and workshops
- Provide mentorship to young people
- Increase mental health awareness and reduce stigma

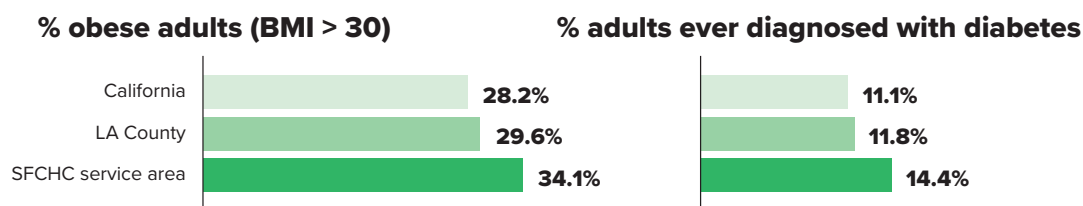
OBESITY / DIABETES

Focus group participants shared their concerns about the high numbers of people in their community with chronic diseases, in particular obesity and diabetes. There was specific discussion around the connection between obesity/ diabetes and the lack of affordable nutritious foods and community spaces to exercise. Surveyed community leaders also ranked obesity and diabetes as a top priority for SFCHC's service area, one that affects racial and ethnic groups differently.

Obesity is a major risk factor heart disease, stroke, type 2 diabetes and certain types of cancer. These are among the leading causes of preventable, premature death. The estimated annual medical cost of obesity in the United States was nearly \$173 billion in 2019 dollars. Medical costs for adults who had obesity were \$1,861 higher than medical costs for people with healthy weight.³⁹ Uncontrolled diabetes can lead to significant disability, including blindness, amputations, and kidney failure. Over 40% of new cases of end-stage renal failure are attributed to diabetes and about 60% of all non-traumatic lower-limb amputations in adults occur in people with diabetes.⁴⁰ In SFCHC's service area, over one third of adults (34.1%) are obese, with a body mass index (BMI) of 30.0 or above. This rate is significantly higher than LA County (29.6%) and California (28.2%). See Figure 19.

FIGURE 19: Obesity rates

Source: California Health Interview Survey: Neighborhood Edition (CHIS NE), 2020. Zip Code Level data



Communities of color and under-resourced communities experience significant disparities in metabolic health, including obesity and type 2 diabetes. These health disparities are related to social and physical determinants of health (higher cost of healthy foods, food deserts, no time or safe location for physical activity) as well as differences in attitudes and cultural norms regarding food and weight. Studies have shown that individuals with greater access to greenspace have lower rates of diabetes, that communities with greater access to supermarkets and limited access to convenience stores have lower levels of obesity, and that adults with diabetes and food insecurity are 40% more likely to have poor glycemic control.⁴¹

As shown in Figure 19, Hispanics/Latinos, Blacks, and low-income populations across LA County have higher obesity rates and diabetes prevalence than other racial and ethnic groups and higher income populations (disaggregated data by race/ethnicity and income was not available at the zip code level). In addition, people

³⁹Zachary Ward et al. (2021) Association of body mass index with health care expenditures in the United States by age and sex. PLOS ONE 16(3):e0247307. <https://doi.org/10.1371/journal.pone.0247307>

⁴⁰CDC. National Diabetes Statistics Report website. <https://www.cdc.gov/diabetes/data/statistics-report/index.html>. Accessed 01/18/2023.

⁴¹Cleveland, J.C., Espinoza, J., Holzhausen, E.A. et al. The impact of social determinants of health on obesity and diabetes disparities among Latino communities in Southern California. *BMC Public Health* 23, 37 (2023). <https://doi.org/10.1186/s12889-022-14868-1>

with diabetes who do not have health insurance have 168% more emergency department visits than people who have insurance.⁴² As shown in Figure 20, annual rates of ER and hospital admissions due to diabetes – a condition that should not require hospitalization with timely and effective outpatient care – are significantly higher within SFCHC’s service area than LA County.

FIGURE 20: Disparities in obesity rate and diabetes prevalence in LA County

Source: California Health Interview Survey (CHIS), 2021

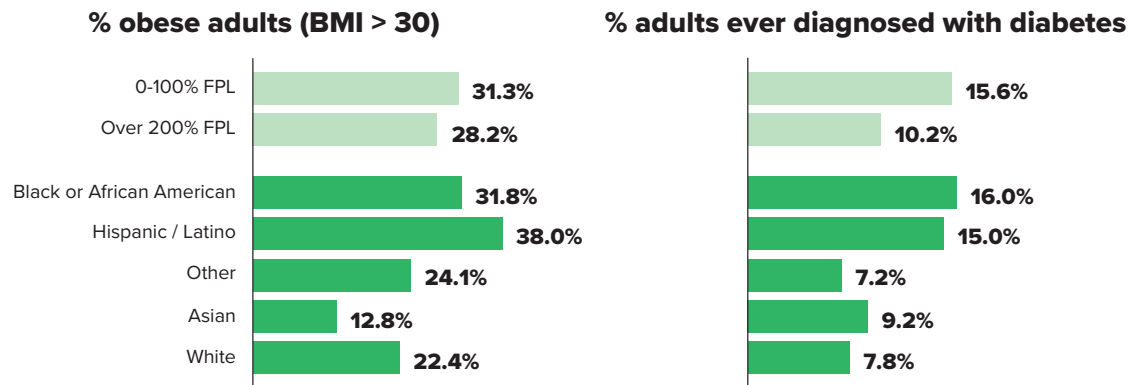
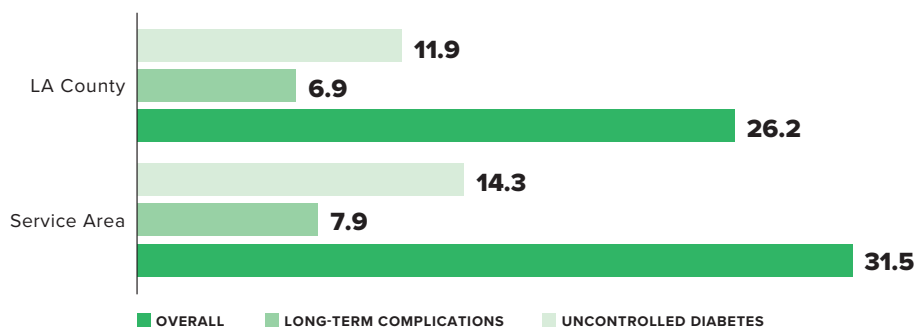


FIGURE 21: Age-adjusted adult ER rate due to diabetes (per 10,000 population)

Source: California Office of Statewide Health Planning and Development, 2015-2017



Focus group participants shared that the following services, programs, and/or resource would be beneficial in improving the health of a community:

- Recreational opportunities such as exercise classes and sports leagues in the park for youth. They expressed that this would not only increase children’s physical activity but keep them “out of trouble.”
- Free or affordable exercise programs like Zumba for adults to keep active.
- Healthy cooking classes to help parents develop skills and learn how to grocery shop and cook on a budget; also for those with diabetes to help manage chronic diseases and adopt healthy habits.
- More markets with healthy food and farmers markets to increase access to organic fruits and vegetables. Also, participants would like to see these healthy food options be more affordable in their local grocery stores.

⁴²American Diabetes Assoc. Economic costs of diabetes in the U.S. in 2017. *Diabetes Care* 2018;41(5):917–928. <https://doi.org/10.2337/dci18-0007>

ORAL HEALTH

Oral health was not mentioned during patient focus groups but was ranked among the top three community health needs by surveyed stakeholders. Secondary data does report that residents of SFCHC's service area fair worse than LA County overall when it comes to oral health and access to dental care. More than one-third (36%) of adults in the service area do not have dental insurance and only 57.8% visited the dentist in the past year. Also, 28% of service area adults have teeth in fair/poor condition compared and one in eight seniors (12%) have lost all their teeth, corresponding to 12,573 adults aged 65 and older. These numbers reflect long-standing racial/ethnic and income disparities in accessing oral health services.⁴³ See below.

FIGURE 22:

Adult oral health in SFCHC service area

Sources:

* CDC, PLACES Project, 2021. <https://www.cdc.gov/places>

^ California Health Interview Survey (CHIS),

Neighborhood Edition, 2020. <https://askchisne.ucla.edu/>

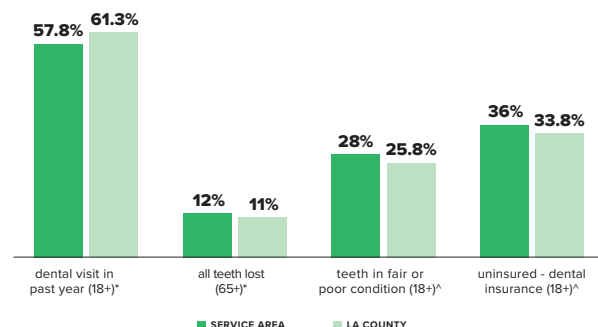
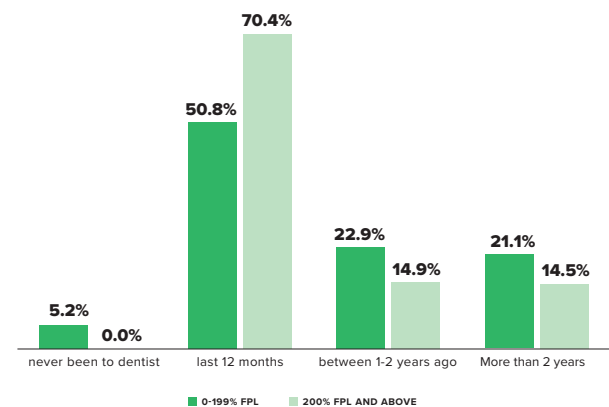


FIGURE 23:

Access to oral health services among adults in SFCHC's service area by poverty level

Source: California Health Interview Survey (CHIS), 2021



Oral health is integral to overall health and access to dental services is essential to promoting and maintaining good oral health. Oral health is related to quality of life and poor oral health can have significant consequences on a person's diet, nutrition, speech, social interaction, self-esteem, mental health, education, and career achievement. Yet, those who need dental care the most are often the least likely to receive it.⁴⁴

There are many barriers impeding access to dental care, both external and internal. External barriers include the prohibitive costs associated with dental care; inability to obtain dental insurance; shortage and maldistribution of dentists; low rate of Medi-Cal provider participation; lack of interdisciplinary collaboration; inadequate dental safety nets, and a complex oral health system that can be difficult to navigate. Internal barriers to oral health care are related to low oral health literacy; fear and anxiety associated with dental care; and perceptions and misconceptions about preventive oral health care. Both the external and internal barriers are further complicated by problems with transportation, childcare, work release, scheduling, and personal mobility.⁴⁵

⁴³Nadereh Pourat and Len Finocchio. Racial and Ethnic Disparities in Dental Care For Publicly Insured Children. Health Affairs, 29, no. 7 (2010): 1356-1363.

⁴⁴https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm

⁴⁵Catherine H. Bersell. Access to Oral Health Care: A National Crisis and Call for Reform. The Journal of Dental Hygiene. February 2017: 91(1): 6-14. <https://jdh.adha.org/content/jdentyhy/91/1/6.full.pdf>

SUBSTANCE USE

Community members were concerned about the increase of substance use, particularly among young people and people experiencing homelessness. They identified opioids and marijuana as the two substances they are most concerned about but also identified fentanyl and alcohol as issues. Community leaders who were surveyed placed substance use as a medium priority and health issue for SFCHC's service area.

Factors that contribute to substance use include:

- Poverty and a lack of opportunities
- Lack of education about risks of substance use
- Increased accessibility of marijuana
- Mental health challenges and use of alcohol and/or drugs as a coping mechanism
- Lack of access to substance use treatment

Substance use among adolescents can lead to increased risk of contracting infections like HIV and hepatitis C, vehicular fatalities, juvenile delinquency, and other problems associated with physical and mental health. As mentioned previously, substance use disorders (SUDs) are strongly associated with homelessness. Indeed, the leading cause of death among people experiencing homelessness in LA County is drug overdoses. In 2021, 36% of homeless deaths were from drug overdoses, mostly from methamphetamines. However homeless advocates are seeing an alarming increase in the percentage of overdose deaths involving fentanyl, a powerful synthetic opioid.⁴⁶

Data on SUD at the zip code level is not available therefore SFCHC service area estimates will be extrapolated from SPA and LA County data based on the most recent 2016-2018 National Survey on Drug Use and Health. As shown in Table 3, individuals aged 12 years and older living in SFCHC's service area use illicit drugs, marijuana, and alcohol at higher rates than LA County overall. However, they use tobacco products, including cigarettes, less often.

TABLE 3: 2016-2018 National Survey on Drug Use and Health, select measures, ages 12+

	SFCHC SERVICE AREA	LA COUNTY
Illicit drug use in past month	14.0%	13.3%
Marijuana use in past month	12.2%	11.6%
Alcohol use in past month	56.2%	50.7%
Binge alcohol use in past month	24.4%	23.8%
Tobacco product use in past month	14.2%	15.3%
Cigarette use in past month	11.7%	12.5%

Source: SAMHSA, 2016-2018 National Survey on Drug Use and Health. Service Area estimates extrapolated by DataFox from LA County SPA data based on spatial extrapolation of service area to SPA

⁴⁶LA County Dept of Public Health, Recent Trends In Mortality Rates and Causes of Death Among People Experiencing Homelessness in LA County, January 2021. Available at: http://www.publichealth.lacounty.gov/chie/reports/HomelessMortality2020_CHIEBrief_Final.pdf

Analysis of national level data on substance use show that past-month and daily alcohol use has been decreasing over the past 20 years. However, binge drinking (five or more drinks in a row in the past two weeks) and high-intensity drinking (10 or more drinks in a row in the past two weeks) have been steadily increasing over the past decade. In addition, marijuana and hallucinogen use in the past year by young adults 19 to 30 years old increased significantly in 2021 compared to five and 10 years ago, reaching historic highs in this age group since 1988.⁴⁷ In the US in 2020, 9.3 million (3.3%) individuals aged 12 or older misused/abused prescription pain relievers in the past year, making it the second most abused illicit drug after marijuana. Over the past decade, there have been steep increases in the number of prescription medication overdose related emergency department (ED) visits, hospitalizations, and deaths. Even though effective treatments exist, only about one in eight adults (12.2%) who need treatment for a substance use disorder receive any type of specialty treatment.⁴⁸

Effective strategies to address substance use include:

- Provide health education in local organizations and schools related to substance use risks
- Hub and spoke model of Medication-Assisted Treatment
- Evidence-based practices adapted to the cultural, social, gender, and demographic contexts of the people served to yield positive outcomes.

⁴⁷ Megan E. Patrick et al. (2022). Monitoring the Future Panel Study annual report: National data on substance use among adults ages 19 to 60, 1976-2021. University of Michigan Institute for Social Research: Ann Arbor, MI. doi:10.7826/ISRUM.06.585140.002.07.0001.2022

⁴⁸ Center for Behavioral Health Statistics and Quality. 2017 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2018





5 CONCLUSION

This 2023 community needs assessment was compiled for SFCHC as an informational resource to guide strategic planning activities, fund development, and program development. The data collected identify common needs, issues, and priorities across various segments of the service area population, as well as those unique to age, race/ethnic, and socio-economic groups within the community.

The data presented here confirm the significant need for high quality, culturally and linguistically competent, coordinated, and comprehensive primary medical, behavioral health, and dental care in the community.

SFCHC is in a unique position to meet the needs of the target population given its current and future resources and its history of successfully serving community populations that are the most vulnerable. With the support of its partners on the federal, state and community levels, SFCHC will continue to adjust and expand its service offerings to close the gap on health disparities in the service area.



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