CHC
Community Health Councils, Inc.

South Los Angeles
Health Equity Scorecard

Annie Park, MSW

Nancy Watson, MSW

Lark Galloway-Gilliam, MPA

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Community Health Councils (CHC) is a non-profit, community-based health advocacy, policy and educational organization. Established in 1992, our mission is to improve health and increase access to quality healthcare for uninsured, under-resourced and underserved populations.

Coalition for Health & Justice (CHJ), founded in 2004 to address the growing healthcare crisis in South Los Angeles, is a coalition of diverse leadership throughout South Los Angeles working to ensure access to quality healthcare for underserved residents of South Los Angeles.

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EXECUTIVE SUMMARY

The area known as South Los Angeles has become an icon for the plight and struggle of the inner city. Home to more than one million people, South Los Angeles encapsulates the health consequences resulting from the disturbing inequality in the distribution of power, income, goods, and services in Los Angeles County. Options and opportunities for healthy choices are constrained by fewer and often inferior basic healthcare and physical resources. From hospitals, clinics, and preventive care services to healthy foods, places to be physically active, safe housing, and adequate schools, South LA residents are forced to live and raise their families with less. The social and economic impact is a population with the highest overall rates of disease and premature deaths in the county from such preventable conditions as coronary heart disease, homicide, diabetes, lung cancer, and motor vehicle crashes. **More than any other region of the county, South LA is disproportionately disadvantaged and harmed by inequities in the healthcare and physical resource environments.**

To assess the extent to which these inequities determine and shape the health of the South LA community, Community Health Councils collaborated with the Coalition for Health and Justice in a year-long study examining the healthcare and physical environment resources in the area. What emerges is a *Health Equity Scorecard* of the health status of South LA that takes into account the multiple public and private policies that ultimately influence the health of area residents through investments—or their lack—in the economic, education, housing, and healthcare systems that serve the community. The *Scorecard* also identifies incremental steps by which South LA can be helped to achieve health equity.

THE STUDY

The study examined 50 socioeconomic and environmental factors that influence health behaviors and outcomes. Scores were calculated for the 100-square-mile area of South LA, and for comparison, the area of West LA, where there are more favorable health outcomes. Both areas were evaluated against our baseline: the whole of Los Angeles County. The resources were grouped into broad categories of capacity and access (see Chart), then each category was scored in comparison to the county as a whole.

THE FINDINGS

The following chart summarizes the status of South LA and West LA for each broad category of healthcare or physical environment resources relative to the county as a whole. Thus, for the overall healthcare environment, South LA has 43 percent fewer resources than LA County, and West LA has 72 percent more resources than LA County, for a total disparity of 115 percentage points between the two communities. Similarly, South LA also has 43 percent fewer physical environment resources than LA County, while West LA has 42 percent more resources of this type than LA County, for an overall disparity of 85 percentage points between the two communities.

Disparities in Healthcare and Physical Environment Resources:

South LA and West LA Compared to LA County

CATEGORY	SOUTH LA	WEST LA	DISPARITY (Percentage points)
Healthcare Environment Resources	**-43%**	+72%	115
Healthcare Facilities	**-28%**	59%	87
Healthcare Workforce	**-76%**	182%	258
Healthcare Financing	**-65%**	22%	87
Healthcare Coverage	**-30%**	38%	68
Primary & Preventive Care Access	**-34%**	27%	61
Primary & Preventive Care Utilization	**-24%**	103%	127
Physical Environment Resources	**-43%**	+42%	85
Nutrition	**-106%**	101%	207
Physical Activity Options	**-55%**	24%	79
Public Safety	**-17%**	7%	24
Housing	**-40%**	16%	56
Schools	**-43%**	63%	106
Air & Land	**5%**	39%	34

Disparities for specific groupings of resources are, in some instances, even greater. For example, the difference in the number of healthcare workers between South LA and West LA is 258 percentage points (due in large part to the closing of multiple facilities in South LA since 2000). The difference in the availability of healthy food options is 207 percentage points. In short, the study shows unequivocally that South LA does not share equally in the overall regional resources.

Several other healthcare and physical environment indicators reveal chasms between conditions in South LA and West LA:

- LA County overall has 57 pediatricians for every 100,000 children. In South LA, there are approximately 11 pediatricians for every 100,000 children, compared to 193 pediatricians for every 100,000 children in West LA.
- In LA County overall, 22 percent of adults between the ages of 18 and 64 are uninsured. In South LA, 30 percent of adults are uninsured, compared to 12 percent in West LA.
- Uninsured women in South LA are less likely to receive preventive screening services. Only 34 mammograms per 1,000 uninsured women occurred through the South LA Public Private Partner (PPP) clinics, compared to 169 mammogram screenings per 1,000 uninsured women through West LA PPP clinics and 41 mammograms per 1,000 uninsured women at PPP clinics throughout LA County.
- South LA has 8.5 liquor stores per square mile compared to 1.97 stores in West LA.
- South LA has 0.10 large-scale supermarkets per square mile, while West LA has 0.14 per square mile.

- In South LA, 37 percent of households are overcrowded compared to fewer than 8 percent of households in West LA.
- In South LA, 64 percent of schools are classified as insufficiently staffed, resourced, and without a clean, safe, and functional learning environment according to Williams settlement standards. Only 8 percent of West LA schools did not meet these standards.

CONCLUSIONS

The data in and of themselves do not add up to a groundbreaking discovery: It has long been clear that residents in the poorer part of the county have worse health than those in the wealthier sections. However, the findings of this study point to the interrelationship among many factors that contribute to health, high among them the depressed socioeconomic status of residents of South LA. Similar to health outcomes, the challenges and disparities in the socioeconomic conditions found in South LA are not simply a result of individual behavior but rather an outgrowth of racial segregation and public and private policies and systems that concentrate poverty.

To bring health equity to all residents of Los Angeles County will take coordinated leadership and a comprehensive agenda for policy change that reinvests economic, political and social capital in underserved communities to achieve parity. Such an agenda can go a long way toward reversing the intentional or unintentional absence of positive public, economic, and institutional policies that isolate whole segments of the population from access and opportunity.

The compilation of data presented in the *Health Equity Scorecard* is the first to link a comprehensive overview of the community's health with immediate policy opportunities to eliminate inequities in the resource environment and ultimately banish health disparities. What emerges from the *Scorecard* findings is the degree to which disparities exist. These findings provide a framework from which to galvanize support across public and private sectors in Los Angeles County for policy change and community reinvestment for health equity.

Inequality in the health of South LA is a "condition" that goes beyond the limits of any single city and necessitates collaboration and cooperation at every level of government and across jurisdictions. The *Scorecard* is designed to help break through artificial policy silos and the political gridlock that has prevented the revitalization of South LA.

ACTION STEPS

Achieving health equity in both physical and healthcare resources will take coordinated leadership and a comprehensive agenda for policy change. These efforts must extend beyond the walls of City Hall and include the active participation of community, business and faith-based leadership. Every step will require coordinated efforts across multiple stakeholders.

A joint power agreement is needed between county and city elected officials and their respective agencies that outlines a comprehensive plan to address the economic, social and political hurdles contributing to poor health and identifies benchmarks and performance standards for public accountability.

A number of coalitions and organizations are already hard at work addressing these indicators. The *Scorecard* is intended to guide the agenda for South LA through the following key recommendations, presented here with agencies accountable for their implementation:

HEALTHCARE ENVIRONMENT RESOURCES

ACTION NEEDED	ACCOUNTABLE AGENCIES
1. Reopen LA County Martin Luther King Jr. Medical Center and reestablish the facility as a teaching hospital along with the restoration of county outpatient services levels.	• Governor Arnold Schwarzenegger • California Department of Health Care Services • California State Legislature • Centers for Medicare and Medicaid Services • Los Angeles County Board of Supervisors • Los Angeles County Chief Executive Officer • Los Angeles County Department of Health Services
2. Preserve the level of funding previously allocated for MLK Medical Center for South LA healthcare providers through the extension of SB 474 South LA Preservation fund.	• California State Legislature • Los Angeles Congressional Delegation • Los Angeles County Board of Supervisors
3. Increase primary and urgent care services in the South LA community clinic network through equitable Public Private Partnership funding from the county and an infusion of capital funding.	• Los Angeles County Board of Supervisors • Los Angeles County Chief Executive Officer • Los Angeles County Department of Health Services • Los Angeles Unified School District
4. Streamline enrollment systems and financial eligibility categories to reduce enrollment barriers for public programs.	• California Department of Health Services/MRMIB • Los Angeles County Department of Health Services
5. Strengthen systems for prevention, treatment, and management of chronic disease through higher provider reimbursement for delivery of continuous, coordinated quality disease management care.	• Los Angeles Congressional Delegation • California State Legislature • California Department of Health Services/ Public Health • Los Angeles County Board of Supervisors • LA County Public Health/Health Services

PHYSICAL ENVIRONMENT RESOURCES

ACTION NEEDED	ACCOUNTABLE AGENCIES
1. Incorporate health into local government planning including the general plan, redevelopment, and transportation planning.	• City and county planning agencies • Los Angeles Metropolitan Transportation Authority
2. Provide block grants, targeted tax credits, redevelopment funding, and other financing vehicles to business owners to transform liquor and convenience stores and develop new retail supermarkets tied to healthy food products.	• Los Angeles City Council and other city councils (Compton, Inglewood, Hawthorne, etc.) • Community Development Departments
3. In the next three years, reduce the number of schools deemed as having substandard facilities by 33 percent through staff training and targeted policy changes.	• Los Angeles Unified School District and other City School Districts • Los Angeles County Office of Education
4. Establish a citywide plan for the equitable geographic distribution of affordable housing through mixed-use neighborhoods particularly when rebuilding public housing.	• LA Housing Authority • LA Building/Safety • CRA • City Councils • Planning Departments
5. Enhance the role and authority of local health departments to regulate and enforce the quality and condition of food in local markets.	• Los Angeles County Board of Supervisors • Los Angeles County Department of Public Health

INTRODUCTION

South Los Angeles is a series of contiguous communities with a shared history and the highest morbidity and mortality rates in Los Angeles County. Community Health Councils in collaboration with the Coalition for Health and Justice examined the intersection between the health of the community and the distribution, capacity and quality of basic resources in Los Angeles County. The result is the *South Los Angeles Health Equity Scorecard*. The *Scorecard* uses the "Multi-Determinants of Health" model and goes beyond the articulation of the "healthcare crisis" and traditional categorical boundaries of public health to study the health status of the community in the context of the built environment and social and economic policies. A recent report by the World Health Organization *Commission on the Social Determinants of Health* concluded that inequities in health are caused by the unequal distribution of power, income, goods, and services. The *Scorecard* tests this conclusion by compiling data from a wide range of sectors and resources to (1) assess to what extent inequities exist in the resource environment and (2) determine to what degree they mirror disparities in health. The *Scorecard* shifts the focus and analysis from individual behavior to the larger socio-economic and political responsibilities we share as a society. Each section concludes with a summary of the incremental steps that can be taken towards a more comprehensive solution.

The *Scorecard* synthesizes 50 socioeconomic and environmental factors that influence health behaviors and outcomes and underlie the most disparate health outcomes in South LA. Comparisons and contrasts are made between the levels of access, capacity and quality of community, health, and economic resources in South Los Angeles and the overall resource environments of LA County and West Los Angeles, where we find more favorable health outcomes. The *Scorecard* is designed to help break through artificial policy silos and the intellectual, ethical, and political gridlock that has prevented the revitalization of South LA, even following the 1992 civil unrest. Through the *Scorecard,* we seek to galvanize both public and private resources to drive community reinvestment. The *Scorecard* identifies many immediate policy opportunities and tools that can be used to eliminate inequities in the resource environment and ultimately disparities in health.

We begin by providing a profile of the community using demographics and socioeconomic indicators and follow this with an overview of the health outcomes in South LA. The *Scorecard* itself is divided into two domains: Healthcare Environment Resources and the Physical Environment Resources. Each domain is scored according to six sub-areas of study. The Healthcare Environment Resources domain examines the following indicators:

- *Healthcare Facilities* – healthcare facilities including hospital and ER beds, community clinics, HIV/mental health providers, and pharmacies
- *Healthcare Workforce* – doctors, specialists, dentists
- *Healthcare Financing* – public funding and costs of care
- *Healthcare Coverage* – the uninsured population
- *Primary & Preventive Care Access* – regular source of care, difficulties in accessing care
- *Primary & Preventive Care Utilization* – utilization of recommended services, such as cancer screenings, regular doctor and dentist visits.

The Physical Environment Resources domain examines:

- *Nutrition* – grocery stores, farmers' markets
- *Physical Activity* – parks and green space, bicycle lanes
- *Public Safety* – crime rates and traffic accidents
- *Housing* – age and structural safety of housing units
- *Schools* – proximity to freeways and structural safety
- *Air & Land Quality* – toxic waste sites.

As this is the first attempt at a community *Scorecard* of this size and scale, many indicators were left out due to constraints of time, resources, and data. We take these not as faults, but as lessons learned and opportunities to improve the next report. Each of the scored domain sub-sections concludes with policy recommendations and action steps to pursue until the next publication of the *Scorecard*. It is our hope that the *Scorecard* will be used as a tool and catalyst for education and organizing within the community and across interest areas.

BACKGROUND

Faced with the downward spiral and impending closure of services at Los Angeles County Martin Luther King-Charles Drew Medical Center, a broad cross section of stakeholders in South Los Angeles formed the Coalition of Health and Justice (CHJ). The *South Los Angeles Health Equity Scorecard* grew out of the partnership between Community Health Councils and CHJ to improve the overall public health of South LA by strengthening public policy, accountability, community participation and partnerships with government and the private sector. Modeled after the idea of using community-based participatory research as a strong and effective tool for improving population health, the project relied heavily on an Advisory Committee of advocates, researchers, public health workers, and healthcare experts to guide its efforts. Formed in February 2007, the Advisory Committee prioritized and selected indicators, recommended data sources, advised on community needs not identified through traditional means, provided input and reviewed content.

Community Health Councils led the research effort through the collection and analysis of data and the preparation of this report. After the work of the Advisory Committee, the data collected, the domain scores, and the accompanying research were presented to a broader community of health advocates, experts, researchers, policymakers, and public health officials at the *Scorecard Policy Summit* held in June 2008. Over 100 attendees at the *Summit* were divided into workgroups and asked to provide policy recommendations around the data and indicators most relevant to their knowledge and respective organizations' missions. The policy recommendations included in the *Scorecard* reflect the contributions of the *Summit* participants, the CHJ, and other experts for an advocacy agenda for policymakers and community advocates to improve the health of South Los Angeles.

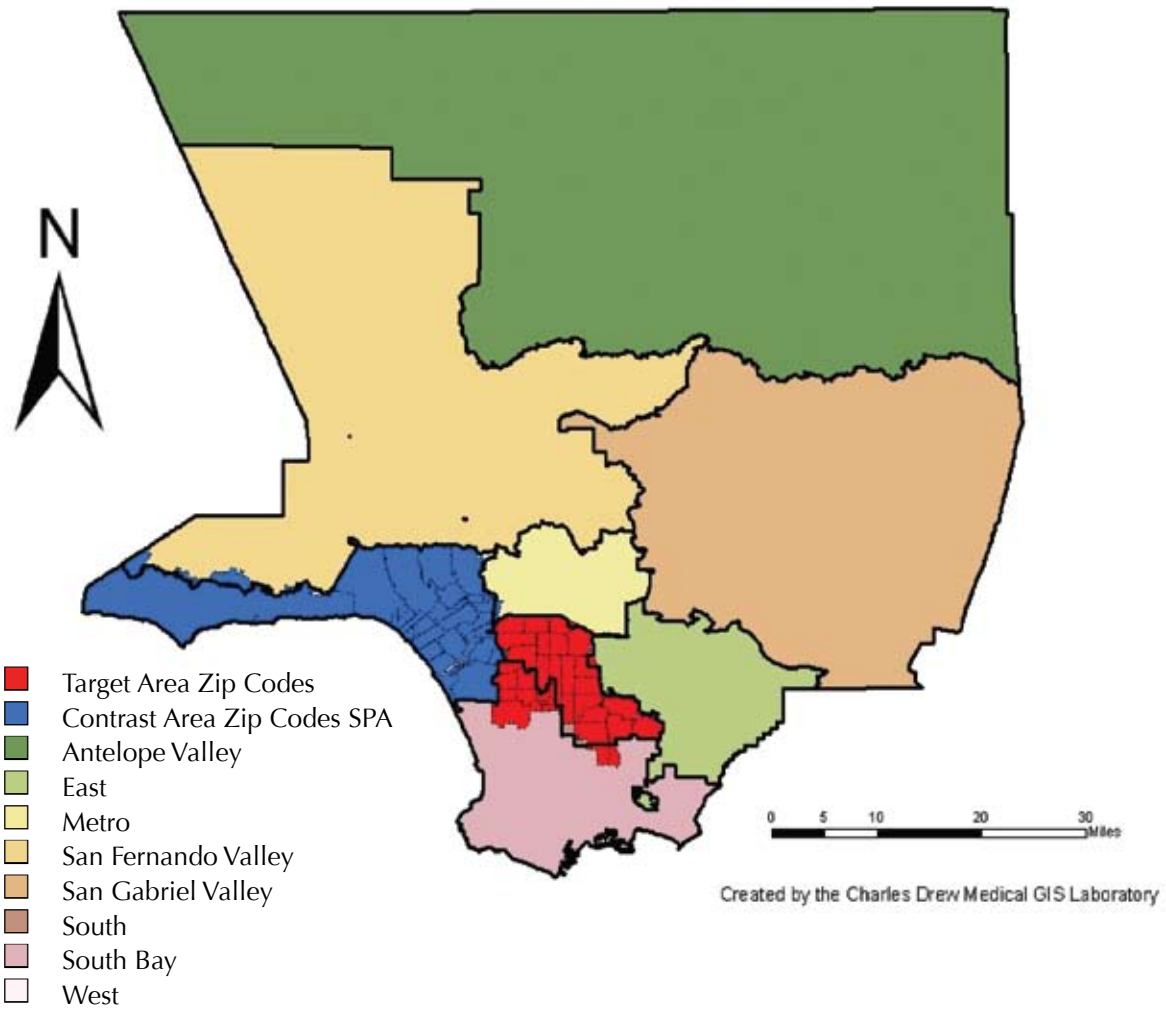
South Los Angeles is a series of contiguous communities with a shared history and the highest morbidity and mortality rates in Los Angeles County ...The Scorecard shifts the focus and analysis from individual behavior to the larger socio-economic and political responsibilities we share as a society.

STUDY DESIGN

DEFINITION OF STUDY AREAS

As a first step, the Advisory Committee selected a geographic definition of "South Los Angeles." The target area of South Los Angeles is defined by a series of zip codes that closely align with the boundaries of Service Planning Area (SPA) 6 and the cities of Hawthorne, Inglewood and unincorporated Lennox.[i] Hawthorne, Inglewood and Lennox—though incorporated in SPA 8 under the county service planning area designations—were designated as part of South LA for several reasons, including the common public perception that these areas are part of "South Los Angeles" and the fact that the health outcomes for these communities tend to be consistent with those seen in SPA 6. West LA is defined by a series of zip codes aligned with the SPA 5 borders. The list of zip codes and cities/communities included in the *Scorecard* target and contrast areas, along with a map of the zip code clusters and their locations within Los Angeles County, is available in Appendix 3.

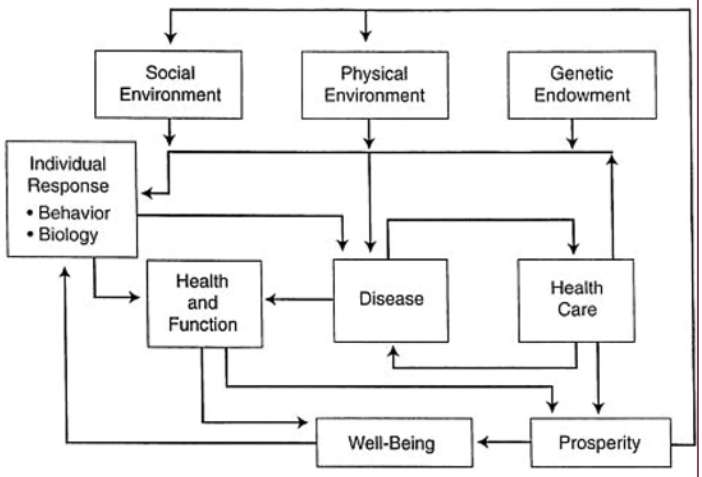
Figure 1. Los Angeles County SPA Boundaries and Scorecard Target and Contrast Areas



[i] Los Angeles County is divided into eight Service Planning Areas (SPA). Each SPA is responsible for planning public health and clinical services according to the needs of the communities within that area. For the purposes of this report, South LA is used to distinguish the Scorecard target area. South LA – SPA 6 distinguishes data only for this SPA. Because the contrast area, West LA, aligns with SPA 5, West LA and SPA 5 are used interchangeably.

SELECTION OF DATA INDICATORS

Figure 2. Multiple Determinants of Health



Source: Reprinted from R.G. Evans and G.L. Stoddart, 1990, Producing Health, Consuming Health Care, *Social Science and* Medicine 31:1347–1363, with permission from Elsevier Science Ltd, Kidlington, UK.

After defining the geographic boundaries of the project study areas, the Advisory Committee selected a list of health outcomes regularly ranked as poor or poorest among South LA residents against which the health indicators were selected. Focusing on the social and physical environments in the multiple-determinants of health model, the Advisory Committee developed an initial list of health indicators, with each indicator seen as directly contributing to one or more of the worse or deteriorating health outcomes. The indicators were then evaluated against a set of pre-defined criteria developed by the Advisory Committee, such as the ready availability of the data, the suitability of the data given the target and contrast area boundaries, a link to one or more health statuses, cost effectiveness, and more. Indicators that were agreed to be relatively unassailable to outside influence, such as genetic response and to some degree individual response, were omitted in order to focus on actionable policy issues that could be influenced by community advocacy. The indicators included in the *Scorecard* only provide a partial picture of the lack of resources, both physical and socio-economic, in South Los Angeles, and are by no means a totality of the area's barriers to good health.

DATA COLLECTION

The data in this report come from a variety of sources: public departments, non-profit research organizations, academic institutions, and private enterprises. Data were collected by the different boundaries and in some cases were aggregated based on the target and contrast area zip codes. Every effort was made to keep target and contrast areas as uniform as possible, though there are several indicators where we were forced to slightly adjust the boundaries based upon how the data were collected. Every effort was made to use a consistent time period of review across indicators, particularly within the categories; however, this was not always possible. Despite this limitation, the data provide a reasonable representation of the access, utilization and capacity of critical health resources in LA County. A list of data sources, notes and limitations is contained in Appendix 1.

SCORING METHODOLOGY

Each indicator is scored based on the percent difference between the target (South LA) and contrast (West LA) areas to LA County; these scores are then weighted and averaged to compute an "equity score," first for the domain sub-sections of data and then the larger domain. This method has the advantage of normalizing the data by using LA County resources as a baseline. Not only does this method show which area is performing better, but also how each area is doing in relation to the baseline.

The indicators, while scored, were not computed for statistical significance, and should not be used or described as such. Table 1 provides a complete list of indicators by category within each domain. A more in depth discussion of the scoring formula and methodology is provided in Appendix 2.

Table 1. Scorecard Data Indicators

HEALTHCARE ENVIRONMENT RESOURCES
Healthcare Facilities
General acute care hospitals per 100,000 population
Emergency treatment stations per 100,000 population
Bed supply per 1,000 population
Community clinic supply (public and public-private partnership) per 1,000 uninsured population
School-based health centers per 1,000 uninsured child population
Mental health agencies (public and publicly-contracted) per 100,000 population
Pharmacies per 100,000 population
Agencies that offer HIV/STD screenings per 100,000 population
Healthcare Workforce
General practice physicians (Family medicine, general practice, general preventive and internal medicine) per 1,000 population
Key specialty physicians (Oncologists, cardiologists, ob/gyn) per 100,000 population
Pediatricians per 100,000 child population
General practice dentists per 1,000 population
Healthcare Financing
County funding for Public-Private Partnership clinics per uninsured person
Hospitals' uncompensated care costs per adjusted patient day
Hospitals' net revenue per adjusted patient day
Hospitals' operating expense per adjusted patient day
Healthcare Coverage
Percent of adults (18-64 years) who reported having no insurance
Percent of children (0-17 years) who reported having no insurance
Percent of adults (18-64 years) who do not have dental insurance
Primary and Preventive Care Access
Percent of adults who reported having a regular source of care
Percent of adults who reported easily obtaining medical care
Percent of adults who could not afford dental care at least once in the past 12 months
Percent of households with no vehicle
Percent of total ER operating hours spent in diversion a year
ER visits that leave without being seen per 1,000 population

Table 1. (Continued)

Primary and Preventive Care Utilization
Percent of adults who reported ER use in the past 12 months
Number of pap smears by PPP clinics per 1,000 uninsured women
Number of mammograms by PPP clinics per 1,000 uninsured women
Percent of men age 40 and over who have never had a PSA test
Percent of population age 2 and over who have never been to a dentist
Percent of population that saw a doctor at least once within the past year
PHYSICAL ENVIRONMENT RESOURCES
Nutrition
Liquor retail licenses per square mile
Large-scale supermarkets (44,000+ square feet) per square mile
Percent of restaurants that are limited service
Food facilities rated "C" or below per square mile
Farmers' markets per square mile
Physical Activity
Percent of children (1-17 years) whose parents reported they could easily get to a park, playground or other safe place to play
Acres of green space/recreation areas per 1,000 population
Miles of county-maintained bicycle lanes per 100,000 population
Public Safety
Percent of adults who believe their neighborhood is safe
Traffic accidents per 1,000 population
Crimes per 1,000 population
Housing
Percent of housing structures built before 1939
Percent of occupied housing units with 1.0 occupants or more per room
Percent of owner-occupied housing units
Schools
Schools with substandard facilities per total schools in the area
LAUSD schools within 500 feet of a freeway per total schools in the area
Air & Land Quality
Percent of industrial/manufacturing zoned land by LA City region
Number of toxic waste sites per 100,000 population
Number of EPA-regulated facilities per 100,000 population

COMMUNITY PROFILE

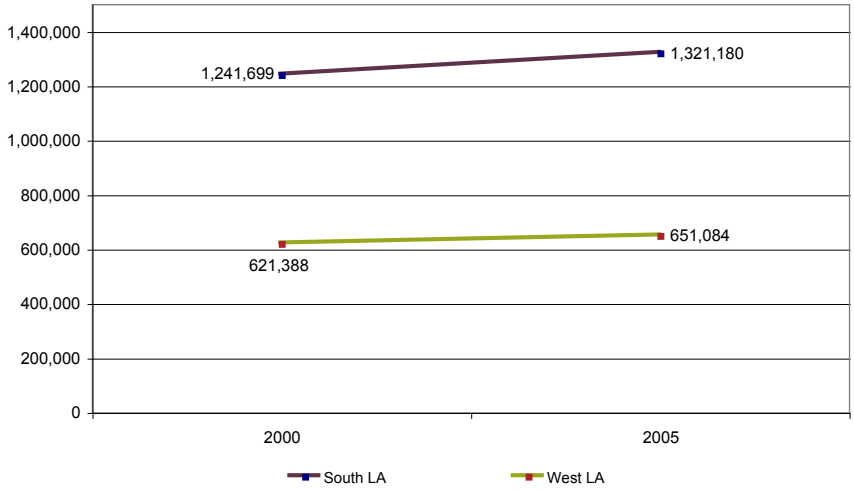
The South Los Angeles community represents some of the greatest assets and yet the most daunting health and socio-economic challenges in Los Angeles and California. To describe the population and area in the aggregate is a disservice to a community that plays a significant cultural and socio-economic role in the larger region, and should not be taken as a complete representation of this unique community. Conventional data and analyses do not allow for an accurate portrayal of the rich contributions, assets, differences and contradictions in South LA's complex history and experience. For area residents, South Los Angeles is a series of discrete neighborhoods: Leimert Park, the Crenshaw District, Morningside Park, West Adams, Hyde Park, View Park, Watts, Compton, Willowbrook, and Baldwin Hills. Its previous designation, South Central Los Angeles was once described as more a condition than a place. Perhaps this is the more accurate understanding of all that is "*South LA.*"

Similar to health outcomes, the challenges and disparities in the socio-economic conditions described below are not simply a result of individual behavior but rather an outgrowth of racial segregation and public and private policies and systems that concentrate poverty. While the population demographics continue to evolve, the geographic area that is now South Los Angeles is in large part a reflection of the historical patterns of desegregation and migration of LA County's African American population against a backdrop of the urban decline in a changing global economy. The eastern portion represents the gateway and point of entry for those who migrated to the west in the hope of new opportunities. The western edge bookmarks the shift from desegregation and the dismantling of housing covenants to racial segregation reframed through economic policy.

POPULATION PROFILE

Despite its smaller geographic size, South LA has more than double the number of residents of West LA (1.32 million vs 651,000). Consequently, population density is more than four times higher. The growth rate for population density from 2000 to 2005 has been 50% higher than for West LA and triple that of Los Angeles County as a whole.

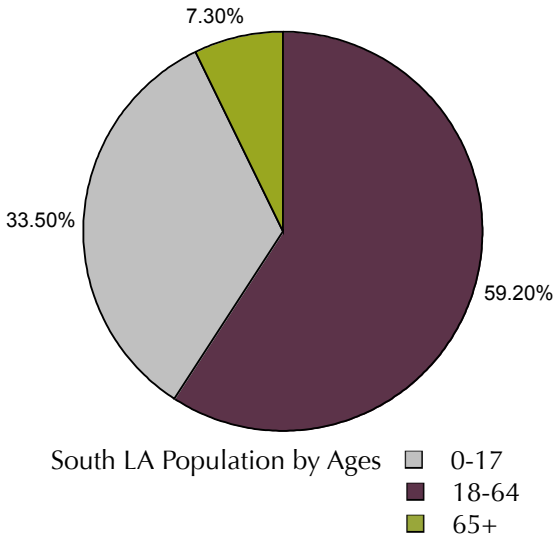
Figure 3. Population Growth in South and West LA



Source: United Way Zip Code Data Book, 2003 and 2007

The age distribution in South LA also carries significant implications for this study: 33.5% of the population is 18 years of age or under. In West LA, the youth population stands at 16.8% and in LA County overall at 27%. On the other end of the spectrum, 7.3% of the population in South LA is 65 and older versus 13.4% in West LA and 10% in LA County.

Figure 4. South LA Population by Age

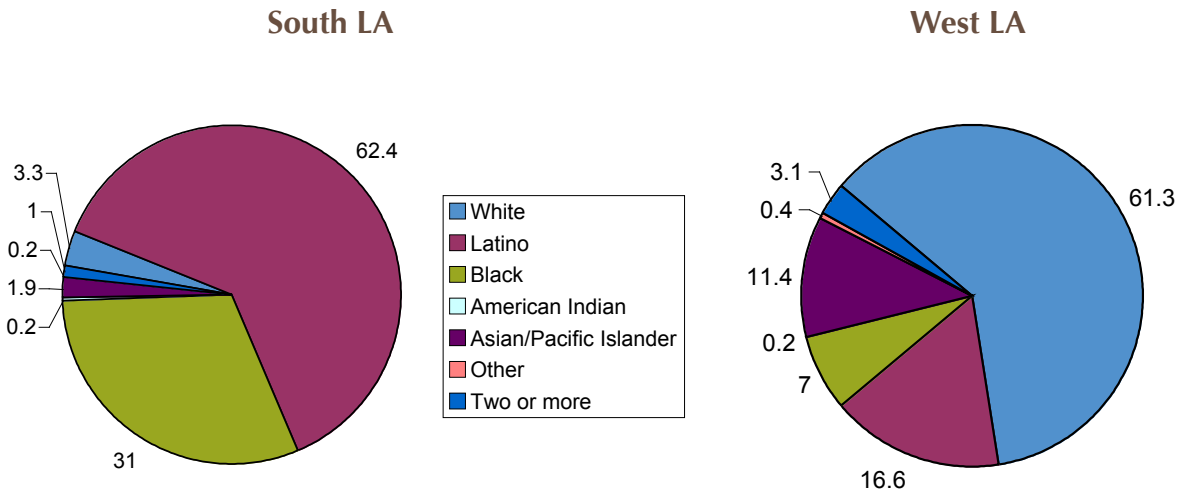


Source: United Way Zip Code Data Book, 2007

South LA provides a unique intersection of race, ethnicity and culture. It is one of the oldest and most well-established communities in the area, reflecting an important segment of the history and population migration patterns of the region. What were once largely white and middle-class communities in many areas of South LA are now home to a diverse blend of racial and ethnic backgrounds. South LA is home to particularly large percentages of Black (31%) and Latino (62%) residents (Figure 5). In contrast, people living in West LA are primarily White (61%) with only 7% Black and 17% Latino residents. South LA has the largest percentage of Black and Latino residents of any Service Planning Area within LA County. 45% of the African American population of Los Angeles County resides in this area; 17% of the Latino population.[ii] While comparable to LA County as a whole, considerably more people living in South LA speak a language other than English at home when compared with West Los Angeles.

[ii] United Way of Greater Los Angeles, Zip Code Data Book Service Planning Area 5, 6 and 8. May 2007. Data aggregated by South and West LA area zip codes.

Figure 5. Population by Race for South and West LA



Source: United Way Zip Code Data Book, 2007

ECONOMIC PROFILE

According to the United Way Zip Code Data Book, the median income for South LA/SPA 6 residents ($27,303) in 2000 was less than half that of people living in West LA/SPA 5 ($60,464).[ii] Yet for many, these figures do not provide an accurate analysis of the "buying power" in South LA. Given the population density of the area, an analysis of the annual income earned per acre revealed the "income density" is four times higher in some areas of South LA than the city of LA as a whole: $350,000 a year per acre on average compared with $91,000 per acre citywide.[iii] Despite this deeper analysis of income levels, South LA residents are twice as likely to be unemployed as those people living in West LA (14.1% South LA/SPA 6 vs. 8.2% LA County vs. 6.1% West LA).[ii] Given the disparity in unemployment figures across regions, it is perhaps not surprising that a much higher percentage of families living in South LA have incomes below 200% of the Federal Poverty Level than those living in West LA (26.5%) or LA County (37.7%).[iv] Economically, the South LA region undergoes a high amount of "churn" with new businesses replacing those that close down. Another factor that highlights socioeconomic differences between South LA and West LA is the disparity in education levels. The proportion of people living in South LA with a college degree is less than one fifth that of West LA residents. Again, this may be an oversimplification of a complex community laced with a wide range of socio-economic sub-populations that must be fully understood and appreciated in any effort to address the inequities and disparities facing this community.

A comprehensive listing of these and other relevant data is contained in Appendix 4.

[iii] Los Angeles Neighborhood Market Drill Down: Catalyzing Business Investment in Inner-City Neighborhoods, July 2008, Social Compact, Inc.

[iv] Los Angeles County Department of Public Health. Extracted from July 1, 2005 Population Estimates, prepared by Walter R. McDonald & Associates, Inc. (WRMA) for Urban Research, LA County CEO, released 5/18/2007.

HEALTH STATUS

According to the LA County Department of Public Health's report, *Mortality in Los Angeles County 2005: Leading Causes of Death and Premature Death*, the five leading causes of death in South LA/SPA 6 are coronary heart disease, stroke, homicide, diabetes and lung cancer. When we examine the leading causes of *premature* death, the ranking and causes of death change to include homicide and motor vehicle accidents.[v]

Table 2. South LA/SPA 6 Leading and Premature Causes of Death

RANK	LEADING CAUSE OF DEATH	PREMATURE CAUSE OF DEATH
1	Coronary Heart Disease	Homicide
2	Stroke	Coronary Heart Disease
3	Homicide	Motor Vehicle Crash
4	Diabetes	Diabetes
5	Lung Cancer	Stroke

Source: Mortality in Los Angeles County 2005: Leading Causes of Death and Premature Death, Los Angeles County Department of Public Health

These health outcomes form the foundation of our study. The rates of illness and death are lower in West LA and LA County, and the depth of disparity among the three areas is noteworthy. We provide a brief analysis of the combined leading and premature causes of death. As startling as the disparities may be, it is the underlining social determinants of health that are the subject of this study and not solely individual behavior or the health outcomes themselves. These are highlighted to illustrate the associated risk factors within the community to fuel the health crisis in South LA.

CORONARY HEART DISEASE

Coronary heart disease (CHD) death rates have been decreasing throughout the county since 1999. Nonetheless, the death rate due to CHD in South LA is consistently higher than the county level and sub-county regions, with South LA's CHD death rate 68% higher than West LA's and 23% higher than the county overall.[vi] While we find variances within South LA based on geographic sub-areas, the disparities between even the healthier of the sub-regions of South LA exceed those of the overall county.

Table 3. Death Rate Due to CHD by South LA Health District vs. LA County

	SOUTH	SOUTHWEST	COMPTON	INGLEWOOD	LA COUNTY
Age-adjusted Death Rate per 100,000	226	220	223	199	174

Source: Mortality in Los Angeles County 2005: Leading Causes of Death and Premature Death, Los Angeles County Department of Public Health

[v] Premature death is defined as death before the age of 75.

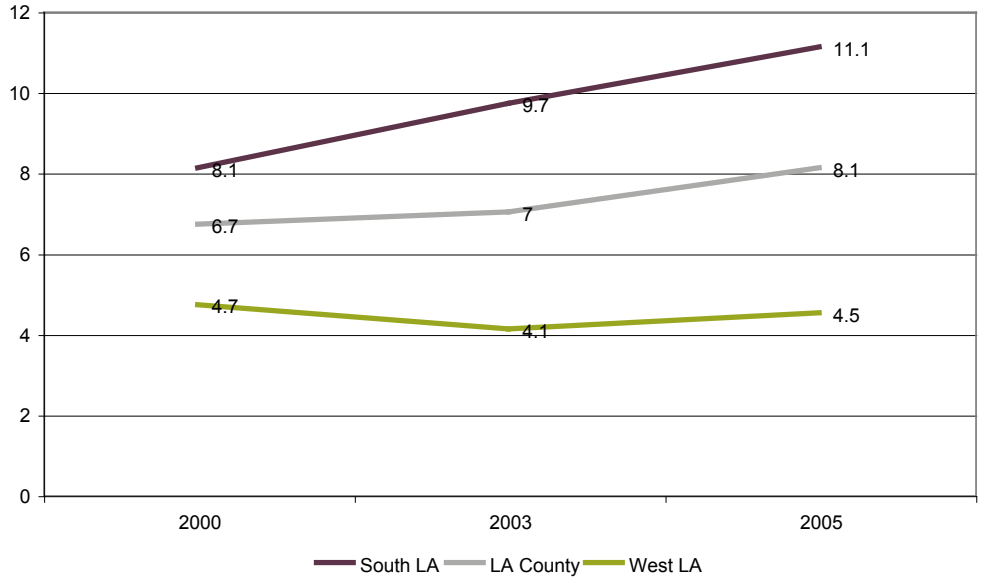
[vi] 1999-2005 Linked Mortality Files for Los Angeles County from the California Death Statistical Master Files, compiled by Data Collection and Analysis Unit, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

Risk factors for CHD include smoking, high blood cholesterol and blood pressure, physical inactivity, obesity and overweight, and diabetes. Predictably, many of the contributing factors to CHD are also included in this Health Status profile, as their rates of morbidity and mortality are notably higher in South Los Angeles.

DIABETES

In the last 15 years, the prevalence of diabetes in the United States has doubled, with 14.6 million American diagnosed in 2005.[1] In California, the age-adjusted percent of adults with diagnosed diabetes rose from 5.3% in 1995 to 7.4% in 2005.[vii] Similarly, the percentage of adults diagnosed with diabetes rose in South LA and LA County between 2000 and 2005. West LA, with a marked decrease between 2000 and 2003, also has increased levels, although they are lower than in 2000.

Figure 6. Percent of Adults Diagnosed with Diabetes



Source: LA County Department of Public Health, Office of Health Assessment and Epidemiology

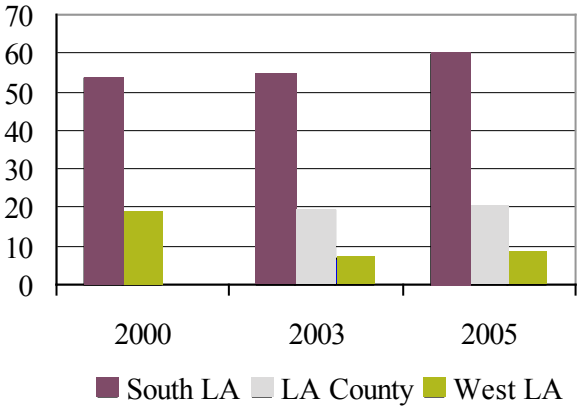
Because diabetes is a risk factor for other chronic illnesses, 58% of adults in LA County with diabetes were also diagnosed with hypertension, 56% were diagnosed with high cholesterol, and 41% suffered from obesity.[2]

[vii] Behavioral Risk Factor Surveillance System. Atlanta, GA: National Center for Chronic Disease Prevention and Health Promotion; 2007. http://www.cdc.gov/brfss/ accessed September 2008.

HOMICIDE

The crude mortality rate due to homicide in people ages 15 to 44 has been increasing throughout the county for the past five years.[viii] In 2004, of the 883 deaths due to homicide in LA County, 40% (353 total deaths) were South LA residents. West LA, however, has had fewer than 30 homicides per year since 1999. The 2005 homicide rate in South LA is 6 times as high as West LA and twice as high as LA County overall.[vi]

Figure 7. Crude Mortality Rate from Homicide in 15-44 Year Olds per 100,000 Persons



Source: LA County Department of Public Health, Office of Health Assessment and Epidemiology

However, these statistics do not tell the whole story. They are perhaps the best illustrations of the importance of examining the data in the context of the larger environment (educational and employment opportunities, children in foster care, etc) to fully appreciate the significance of the underlying social determinants.

LUNG CANCER

Lung cancer is the fifth leading cause of death in South LA/SPA 6 and the third leading cause of death in West LA and LA County overall. Even though lung cancer mortality is ranked higher in West LA and LA County, the actual mortality rate in South LA (43.7) is much higher than for West LA (31) or LA County (35.5).[vi] This is also true for all-cancer mortality and other types of cancer.

Table 4. Age-adjusted Mortality Rates by Cancer Types

	SOUTH LA	LA COUNTY	WEST LA
Lung Cancer	**43.7**	35.5	31.0
Breast Cancer	**27.8**	23.3	25.1
Prostate Cancer	**40.2**	23.4	22.2
All Cancer	**185.7**	158.2	151.9

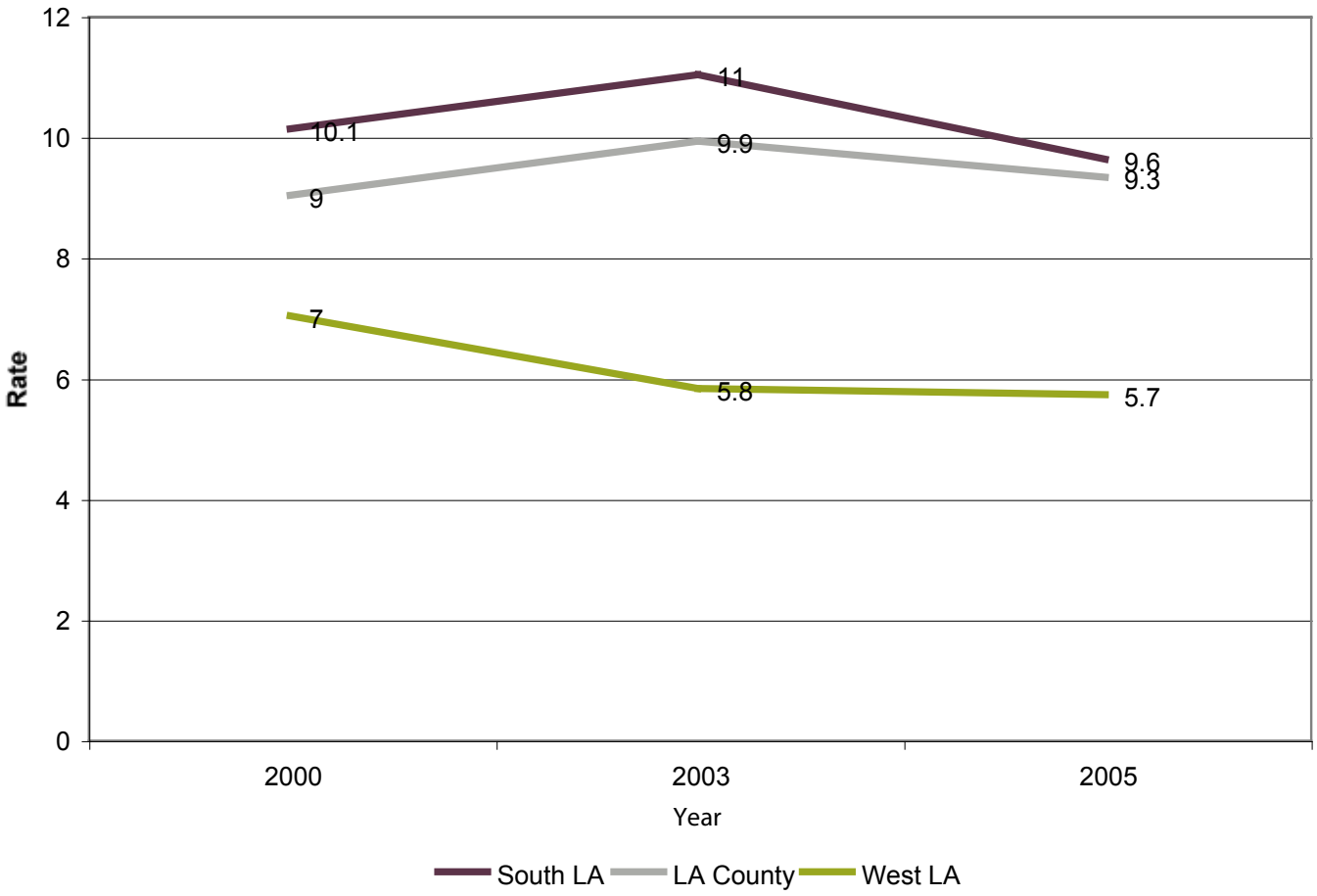
Source: LA County Department of Public Health, Office of Health Assessment and Epidemiology, 2005

[viii] Homicide rates are the crude mortality rate for people between the ages of 15 to 44. Crude mortality is not adjusted for age due to previous population specifications (15-44).

MOTOR VEHICLE CRASH

Motor vehicle crashes are ranked among the top five leading causes of premature death for every SPA. In South LA, the age-adjusted death rate due to car crashes is only 3% higher than the rest of LA County overall, but is 68% higher than West LA.[vi]

Figure 8: Age-adjusted Motor Vehicle Crash Mortality Rate per 100,000 Persons



Source: LA County Department of Public Health, Office of Health Assessment and Epidemiology

STROKE

Stroke is the second or third leading cause of death for all SPAs and the second leading cause of death for LA County overall. Stroke mortality rates in South LA are higher than for any other area of the county except the Antelope Valley. In 2005, the age-adjusted stroke mortality rate in South LA was 32% higher than both West LA and LA County.[vi]

ADDITIONAL HEALTH OUTCOMES

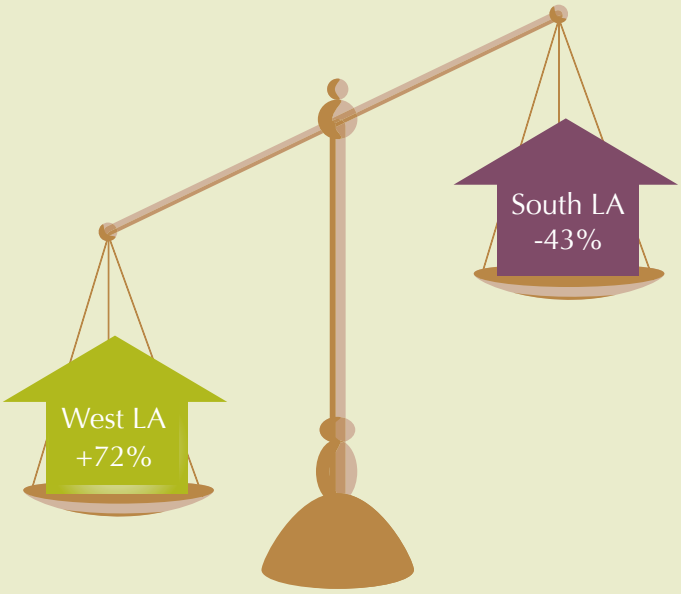
Additional health outcomes in which South LA ranks poorly include prenatal care, low-birth weight babies, and infant mortality affecting mothers and babies; asthma, obesity, lead poisoning affecting children; and liver disease, cancer, mental health, acuity of illness, and behavioral health risk factors. *See Appendix 5 for this data.*

Scorecard Domain 1

Healthcare Environment Resources

HEALTHCARE ENVIRONMENT RESOURCES

Millions of people in the United States have trouble accessing healthcare services. Racial and ethnic consumers tend to receive a lower quality of healthcare, even when they present with the same illnesses, health insurance, and ability to pay for care as the white population.[3] And while the age-adjusted death rate declined by 3.4 percent nationwide between 2003 and 2004, racial and ethnic differences in mortality are stubbornly persistent.[4] The high levels of morbidity and mortality in the population are exacerbated by the growing crisis in the healthcare industry. Escalating cost and disproportionate distribution of resources have compromised the capacity and quality of the healthcare system. In South LA alone:



Healthcare Environment Resources Score

- 30.2% of the non-elderly adult (ages 18-64) population in South LA are uninsured.[ix] The uninsured are 4 times more likely to delay accessing care than those with health coverage, thus increasing the acuity of illness.[5]
- Five emergency rooms and/or hospitals have closed in South LA since 2000, leaving only one full-scale emergency room and trauma center at St. Francis Medical Center in the 94 square-mile geographic area to serve over one million residents.[x]
- South LA hospitals serve increasingly fewer private commercial patients and struggle to provide services to indigent and uninsured populations. In South LA, charity care per adjusted patient day is provided at three times the countywide level.

For South Los Angeles and in many other underserved areas, healthcare coverage is inextricably linked to employment; socio-economic status for the individual; and capacity, access and utilization for healthcare providers. Other than emergency care, federal regulations are increasingly excluding the provision of healthcare services for undocumented immigrants. The 2005 Deficit Reduction Act prohibits undocumented residents from receiving benefits under Medicaid. This impacts the ability of LA County to enroll uninsured adult patients into the local coverage initiative under the state Medicaid waiver. Healthcare financing both in the public and private sectors does not adequately support primary care and often fails to include reimbursement for preventive services and evidenced-based disease management programs. Little if any funding is directed specifically to support the uninsured, placing the burden on the county and local healthcare providers. The financial burden of the uninsured is not equally distributed among the broader healthcare industry in Los Angeles County and elsewhere. When MLK Hospital was shut down by the federal government in 2007, it became the fifteenth general acute-care hospital to close in Los Angeles County since 2000.[6] About half of those hospitals served residents in South Los Angeles. Hospitals across the country are becoming increasingly for-profit and investor owned. With this trend comes an uncertainty and erosion of the traditional healthcare network.

[ix] Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 8,648 Los Angeles County adults representative of the population in Los Angeles County.

[x] On October 1, 2007, Los Angeles Metropolitan Medical Center was licensed to operate an emergency room and opened with four treatment stations. Because of their small size, these stations were not included in the *Scorecard*.

The significance of the dynamic changes occurring within the capacity of the healthcare resource environment goes beyond the direct health needs of a community and has a direct economic impact at the local, state and national levels. In 2006, healthcare consumed approximately 14.4% of the GDP and is expected to rise to 20% by 2016, according to the US Centers for Medicaid and Medicare Services. Healthcare is also the largest industry in the US providing more than 14 million jobs, and it continues to grow. The Department of Labor estimates that healthcare will generate three million new wage and salary jobs between 2006 and 2016, more than any other industry.[7]

In order to assess the healthcare resource environment, we examined six dimensions of capacity and access:

- Healthcare Facilities
- Healthcare Workforce
- Healthcare Financing
- Healthcare Coverage
- Primary & Preventive Care Access
- Primary & Preventive Care Utilization

Previous research shows that there is very little agreement on the optimal level of healthcare capacity needed for a community. Some evidence points to the supply of hospitals, inpatient beds, and specialist physicians as a predictor of utilization but not necessarily improved health outcomes.[8, 9] Others argue for re-organization of service delivery and a more equitable geographic distribution of physicians.[10, 11] Whatever the case may be, local advocates and experts agree that South LA's level of infrastructure and resources remains critically under-staffed and under-funded, causing irreparable harm to residents in need of quality care.

HEALTHCARE FACILITIES

Perhaps the most widely-recognized and frequently-studied aspect of South Los Angeles is its scarcity of medical resources for the population size and health needs of its community. To assess the capacity of existing healthcare environment resources, we examined the number of hospitals, clinics and mental health agencies in proportion to the size of the population. Whether publicly-operated or privately-funded, the existing healthcare infrastructure in South LA that provides critical medical services (hospitals, clinics, physicians, dentists, pharmacies, and more) remains clearly inadequate. In some cases, the resources and services are even diminishing, as evidenced by the August 2007 closure of MLK-Harbor Hospital. Though the numbers in this report are from 2006 and thus some of the indicators include the assets of MLK-Harbor, this snapshot of South LA's loosely-knit healthcare facilities network nonetheless depicts a dire situation. We assessed a number of indicators to measure healthcare facility capacity as seen below.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
General acute care hospitals per 100,000 population[xi]	**0.45**	0.90	1.23
Emergency medical treatment stations per 100,000 population[xii]	**6.66**	14.95	20.43
Bed supply per 1,000 population (averaged)	**0.68**	1.23	1.83
Licensed available bed supply per 1,000 population[xiii]	**1.14**	2.21	3.22
Licensed acute psychiatric bed supply per 1,000 population[xii]	**0.22**	0.24	0.43
Community clinic (DHS & PPP) supply per 1,000 uninsured population[xiv]	**0.09**	0.10	0.12
School-based health centers per 1,000 uninsured children[xv]	**0.11**	0.17	0.50
Mental health agencies per 100,000 population[xvi]	**5.75**	4.26	6.91
Pharmacies per 100,000 population[xvii]	**7.72**	15.14	21.81
Agencies that offer HIV/STD screenings per 100,000 population[xviii]	**1.14**	1.39	1.54

[xi] Office of Statewide Health Planning and Development, Hospital Listings, 2006.

[xii] Office of Statewide Health Planning and Development, Hospital Annual Utilization Profile Report, 2006.

[xiii] Office of Statewide Health Planning and Development, Hospital Annual Financial Profile Report, 2006.

[xiv] Los Angeles County Department of Health Services, Office of Planning and Analysis, 2006.

[xv] California School Health Centers Association, 2007.

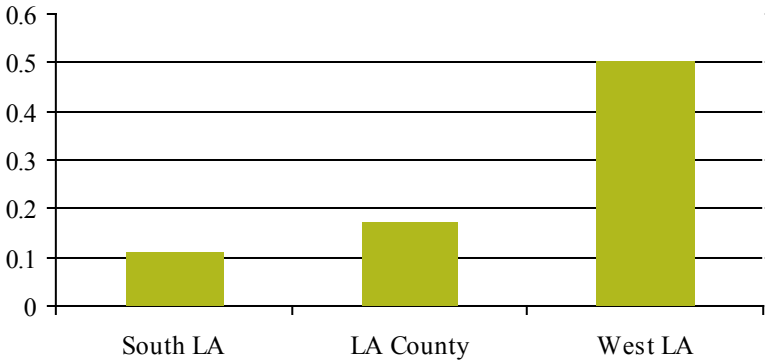
[xvi] Los Angeles County Department of Mental Health, Planning Division. 2007.

[xvii] Personal research of Arleen F. Brown, UCLA Department of Medicine, Division of General Internal Medicine and Health Services Research, 2007.

[xviii] HIV LA Consumer Directory, Office of Aids Program and Policy. < http://www.hivla.org/search.cfm> accessed March 4, 2008.

The largest disparity within health facilities occurs in the supply of school-based health centers. School-based health centers are widely recognized as providing access to a variety of needed services for children and adolescents, including mental health counseling, supervision of children's weight and obesity, and early diagnoses and treatment of asthma, diabetes, and other chronic conditions. South LA has 0.11 school-based health centers (SBHC) per 1,000 uninsured children, or 35% less than the LA County baseline supply of 0.17 per 1,000 uninsured children. West LA, in comparison, has 0.50 SBHC per 1,000 uninsured children or 201% more than the LA County baseline.

Figure 9. School-based Health Clinics per 1,000 Uninsured Children



Source: California School Health Centers Association, 2007

School-based clinics are often the first point of medical contact for some student populations. One study found that the risk of hospitalization decreased 2.4-fold and emergency department visits decreased by 34% for students with asthma who attended schools with SBHC's in Ohio.[12] Similarly, another study conducted in inner-city New York found that students with asthma, in addition to having fewer hospitalizations, also gained three school days from lower absenteeism when treated at an SBHC.[13] Expanding the system of school-based healthcare is particularly crucial in South LA, which has a disproportionate percentage of children who suffer from asthma (8.6%), obesity and overweight (28.8%).

School Health Centers in South LA

Jordan High School Health Center
Foshay Learning Center, CA Medical Center Clinic
Manual Arts High School Health Center
Hyde Park Clinic
Accelerated School – School Based Health Center

The supply of available general acute care beds and licensed acute psychiatric beds per 1,000 population is 0.68 in South LA. By comparison, LA County has 1.23 beds per 1,000 population and West LA has 1.83. Following the closure of both MLK-Harbor and Daniel Freeman Memorial Hospital in December 2007, the inpatient bed capacity in South LA decreased dramatically to 0.43 beds per 1,000 population. Inpatient bed supply demonstrates the second-largest disparity between South and West LA's medical facilities' capacity. The number of EMS treatment stations is another critical area with significantly lower capacity. South LA only has 6.66 EMS stations per 1,000 population, while LA County has 14.95 and West LA has 20.43.

The shortage in Emergency Room capacity can be measured by the 129,069 visits lost following the closures of hospitals (Robert F. Kennedy Memorial, Daniel Freeman Memorial, Orthopedic Hospital, MLK-Harbor Hospital) and emergency rooms (Promise Hospital-Suburban Campus).[xix] Fewer hospital beds and emergency room stations create a downward spiral for insured and uninsured patients. Emergency room wait times increase; ER diversion rates (the hours emergency rooms are closed to ambulance transports due to overcrowding) increase; fewer hospital beds force an exit of physicians and a less competitive environment for insurance companies that cover the insured. The overflow resulting from these regional shortages impacts other neighboring health hospitals and the communities they serve.

Hospitals, DHS and PPP Clinics in South LA

Hospitals

- Centinela Hospital Medical Center
- Los Angeles Metropolitan Medical Center
- St. Francis Medical Center
- Promise Hospital of East Los Angeles – Suburban Campus
- Kedren Community Health Center

DHS Clinics

- Hubert H. Humphrey Comprehensive Health Center
- H. Claude Hudson Comprehensive Health Center
- Martin Luther King, Jr. Multi-service Ambulatory Care Center
- Dollarhide Health Center

PPP Clinics

- Central City Community Health Center
- Northeast Community Clinic
- South Bay Family Healthcare Center
- South Central Family Health Center
- St. John's Well Child and Family Center, Inc.
- T.H.E. Clinic, Inc.
- University Muslim Medical Association, Inc.
- Watts Healthcare Corporation
- BAART Community Healthcare
- Central Neighborhood Medical Group, Inc.
- Compton Central Health Clinic, Inc.
- El Dorado Community Service Center
- Sacred Heart Family Medical Clinics, Inc.

Source: Office of Statewide Health Planning and Development;
Los Angeles County Department of Health Services

[xix] Office of Statewide Health Planning and Development, Hospital Annual Utilization Profile Reports, 2000-2006.

Additional disparities in the supply of health system facilities include:

- **Fewer pharmacies**: South LA has 7.7 pharmacies per 100,000 population, while LA County had 15.1 and West LA has 21.8 pharmacies per 100,000 population. The supplies of pharmacists and pharmacies have come under recent study as possible avenues of chronic disease care and management and improved health outcomes,[14, 15] and others have promoted increased integration and coordination of pharmacies and pharmacists into the safety net.[16]

- **Fewer community clinics and safety-net hospitals**: Community clinics and safety-net hospitals represent a significant portion of the Healthcare Network for the uninsured. In South LA, there are only 0.09 community clinics (DHS-operated and PPP) per 1,000 uninsured population and 0.45 hospitals per 100,000 population. LA County's clinic supply is 0.1 per 1,000 uninsured population and 0.9 hospitals per 100,000 population. Studies have shown that close proximity to safety-net providers increases access to care for the uninsured,[17] which is approximately 30% of the adult and 11% of the child population in South LA.

- **Fewer mental health agencies**: South LA/SPA 6 has 5.8 mental health agency providers per 100,000 population, which is more than the 4.3 available in LA County overall, but less than the 6.9 available in West LA. In 2002, 528 South LA children required out-of-home treatment compared to 109 in West LA.[xx] While fewer adults in South LA report being diagnosed (11.8%) with depression than LA County (12.9%) or West LA (16.6%), US trends also find lower rates among Latino, African American and other racial and ethnic groups, all of whom make up South LA's population. Race and ethnicity, however, determine under-diagnosis of mood disorders and the likelihood that illness will be persistent, more severe or untreated.[18]

- **Fewer resources for HIV/STD screening**: South LA has the highest rates of chlamydia and gonorrhea, and the highest HIV mortality rate in the county, yet there are only 1.1 HIV/STD screening agencies available per 100,000 population. There are 1.4 agencies available countywide and 1.5 available in West LA, per 100,000 populations.

Partial List of Community Agencies Addressing HIV in South LA

- *AIDS Healthcare Foundation:* comprehensive HIV/AIDS medical care
- *Charles R. Drew University of Medicine and Science:* Early Intervention Program offers comprehensive outpatient HIV medical treatment, lab testing and physical exams
- *Hubert Humphrey Comprehensive Health Center:* provides comprehensive medical services including AIDS drug assistance program, case management, prevention health education and support services
- *Minority AIDS Project*: onsite and mobile, standard and rapid HIV testing and counseling
- *Watts Healthcare Corporation Community AIDS Program:* early intervention, comprehensive HIV medical care, dental and vision, OB/GYN urgent care and nutritionist for people with HIV/AIDS
- *The OASIS Clinic offers comprehensive HIV/AIDS medical care, spanning the full spectrum of HIV disease from HIV testing to late-stage AIDS. In addition, the HIV clinic provides primary care to all patients including disease management of hypertension, diabetes, and women's health issues.*

[xx] Department of Mental Health data for services received through DMH in SPA 5 and SPA 6 accessed from http://publichealth.lacounty.gov/childpc/social.htm#mental accessed September 2008.

RECOMMENDATIONS

The lack access and equity in healthcare facilities and thus services in South LA is a complex issue. In the absence of regional planning, the healthcare network has evolved based on market forces that fail to adequately provide for the uninsured and underinsured population. Until recently, there has been little if any coordination and joint planning across hospitals, clinics, their funders or regulators. A comprehensive regional plan for healthcare services is critical to the future of this community.

South Los Angeles Healthcare Leadership Roundtable

The South Los Angeles Healthcare Leadership Roundtable is composed of area healthcare stakeholders: hospital and clinic CEOs, health foundations, research and educational institutions, advocacy organizations and members of the business community. The coalition works in concert with each level of government and the private sector to amend policy and design a system to increase healthcare capacity in South Los Angeles.

Increasing the number of primary care and School-Based Health Clinics is one immediate and relatively cost effective strategy to avert hospitalization and help alleviate the pressure on South LA hospitals. In 2008, Governor Schwarzenegger signed SB 546 authored by Senator Mark Ridley-Thomas to aid the development of new and existing school health centers. Another consideration is the use of urgent care centers strategically placed throughout the area and in proximity to or associated with hospitals to divert inappropriate use of emergency rooms. All of these recommendations require a reinvestment of public and private funding in South LA and planning and coordination not only among the healthcare community, funders and regulators, but also with city planning, transportation and redevelopment to ensure the healthcare capacity of the region.

After the closure of Daniel Freeman Memorial Hospital in 2007, the City of Inglewood adopted a moratorium prohibiting the issuance of building permits, zoning approval, business tax certificates or licenses for non-medical uses in the Residential and Medical Zone. The moratorium was designed to give the city time to assess the impact of the hospital's closure on residents' health and study the feasibility of reestablishing services. California Government Code Section 65858 allows cities or counties to forgo the procedures otherwise required prior to the adoption of a zoning ordinance to protect the public safety, health, and welfare of residents. As an urgency measure, a city or county may adopt an interim ordinance for 2 years prohibiting any uses in conflict with a contemplated general plan, specific plan, or zoning proposal that the legislative body, planning commission or department is studying or intends to study within a reasonable time.

An effort must also be made to retain existing public funding and services historically provided by the county. With the closure of MLK Hospital, county and state officials acted swiftly to retain a portion of the funding for the hospital that would have otherwise been lost because of current hospital financing regulations. SB 474 allowed the county to retain $100 million of the state safety-net care pool under the Medicaid waiver formerly allocated to MLK. The funding was reallocated to impacted hospitals for the increase in uninsured patients and to support primary and urgent care services in the region. This funding is limited to three years and will sunset in August 2010 or, should the hospital reopen before then, be diverted to the reopened facility.

In the absence of a large private sector, the county clinics play an important role in the South LA healthcare network and must be maintained at or above their current service level as a priority during budget shortfalls. The proposed privatization of the county's public healthcare system must be carefully studied and done in consultation with community stakeholders. The closure of MLK created a significant deficit in South LA. Efforts to reopen the facility in the original 18-month timeline have failed. A greater and consistent effort is needed at the state and federal levels to avoid further loss of services in the region.

Funding for mental health services has been a challenge since the closure of state facilities in the mid-1980s. In November 2004, California voters passed Proposition 63, the Mental Health Services Act, which sought to improve mental health service delivery through a comprehensive approach to community-based mental health services. Through MHSA funds, LA County has implemented prevention and early interventions programs, workforce education and training to address cultural competency, facilities and technology improvements, and a community-based system of care service program.

The following recommendations are offered to begin the process of rebuilding the healthcare network in South Los Angeles.

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Reopen MLK Medical Center and gradually build into a full-scale teaching hospital.	▪ Los Angeles County Board of Supervisors ▪ Los Angeles County Chief Executive Officer ▪ Los Angeles County Department of Health Services ▪ Governor Arnold Schwarzenegger ▪ California Department of Health Care Services ▪ California State Legislature ▪ Centers for Medicare and Medicaid Services
Increase primary care services to low-income and uninsured populations by: ▪ Allocating additional PPP funding for SPA 6 clinics from $4.2 million (FY 2006-07) to at least $10 million with annual adjustments for inflation ▪ Providing capital funding for expansion of primary and urgent care facilities in South LA ▪ Increasing the number of and funding for school-based clinics.	▪ Los Angeles County Board of Supervisors ▪ Los Angeles County Chief Executive Officer ▪ Los Angeles County Department of Health Services ▪ LAUSD
Leverage existing healthcare resources to expand services in South LA by: ▪ Formalizing referral and other relationships to provide care among providers ▪ Creating financial incentives under public funding streams to encourage service integration and partnership ▪ Developing a formalized structure to govern or lead an integrated system of care between hospitals and primary and urgent care clinics.	▪ California State Legislature ▪ LA County Board of Supervisors ▪ California Department of Health Care Services ▪ Los Angeles County Department of Health Services
Ensure access to healthcare services by: ▪ Preserving any current property zoned for medical use ▪ Prohibiting the issuance of building permits, zoning approvals, business tax certificates or licenses for non-medical uses ▪ Working with healthcare providers interested in developing health services on current or new sites.	▪ City Councils ▪ Los Angeles County Board of Supervisors ▪ City and county planning agencies

HEALTHCARE WORKFORCE

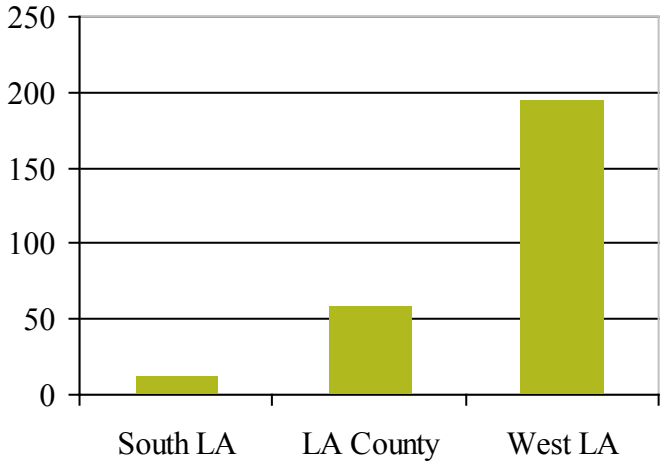
In 1998, the Council on Graduate Medical Education described the problems and challenges of having an inequitable distribution of physicians across different communities. Their report noted that "access to healthcare in the United States is affected by where physicians locate. The tendency for physicians to practice in affluent urban and suburban areas—a phenomenon known as geographic maldistribution of physicians—creates barriers to care for people living in rural and inner-city areas."[19] A decade later, this description continues to be starkly depicted in Los Angeles, where the supply of medical professionals—general practitioners, specialists, pediatricians, and dentists—remains at vastly disparate levels between South LA and its neighboring community of West LA. To assess the capacity of the healthcare workforce, we examined the number of physicians and key specialty areas relative to the health needs of the community.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Physician supply per 1,000 population[xxi]	**0.12**	0.54	1.27
Key specialists supply per 100,000 population (averaged)[xxi]	**1.61**	6.26	19.46
Oncologists per 100,000 population	**0.08**	1.37	4.92
Cardiologists per 100,000 population	**1.59**	5.64	19.97
Obstetricians/gynecologists per 100,000 population	**3.18**	11.79	33.49
Pediatricians per 100,000 children[xxi]	**11.06**	57.24	193.05
General practice dentists per 100,000 population[xxi]	**16.20**	59.79	147.15

The largest disparity is seen in the supply of pediatricians per child populations. While there is no consensus as to the ideal number of pediatricians needed, a number of professional associations have recommended standards. The Graduate Medical Education National Advisory Committee recommends one pediatrician for every 2,000 children, while the Future of Pediatric Education II Report states that one pediatrician is needed for every 1,200-1,400 children.[20] In South LA, there are approximately 0.11 pediatricians per 1,000 child population, or 11 pediatricians for every 100,000 children. LA County fares slightly better with 0.57 pediatricians per 1,000 children, while West LA surpasses the recommended goals with 1.9 pediatricians per 1,000 children.

[xxi] Medical Marketing Services, Inc., 2007.

Figure 10. Pediatricians per 100,000 Children



Source: Medical Marketing Services, Inc., 2007

The "supply" does not meet the "demand" in South LA when demand is defined by healthcare needs. South LA has fewer cardiologists per population than Los Angeles County or the nation, yet the largest percentage of adults in the county diagnosed with hypertension and the highest age-adjusted death rates due to coronary heart disease and stroke. Additional disparities in the supply of the healthcare workforce include:

- South LA residents suffer from high rates of cancer, cardiovascular disease, and adverse birth outcomes. Yet the supply of key specialty physicians (oncologists, cardiologists, obstetricians/gynecologists) is an average of 1.6 specialists per 100,000 population—a far cry from the 6.3 specialists per 100,000 population available countywide and the 19.5 available in West LA.

- Having a larger supply of primary care physicians is associated with lower mortality, longer life expectancy, and better birth outcomes.[21] Yet in South LA, there remain only 0.12 primary care physicians per 1,000 population; LA County and West LA have 0.54 and 1.27 primary care physicians, respectively.

- Oral health is strongly linked to systemic conditions and physical health including cardiovascular disease, diabetes mellitus, osteoporosis, and adverse pregnancy outcomes such as pre-term delivery and low-birthweight infants.[22] South LA, unfortunately, has only 16.2 general practice dentists per 100,000 populations. In addition, roughly 50% of children in South LA rely on Medi-Cal for their dental benefits (known as Denti-Cal), which has been linked to fewer dental visits and a higher probability of never having seen a dentist than children who are privately insured.[23]

Between 2002 and 2007, Strategic Concepts in Policy Education and Organizing (SCOPE) successfully served more than 900 individuals through its Health Care Career Ladder Training Program. Funding was provided by the City of Los Angeles and the Workforce Investment Board. 80% of SCOPE's graduates were placed in healthcare jobs at an average wage of nearly $15. The program not only moved low-wage workers into higher paying healthcare positions, but also helped existing healthcare employees advance into higher-skilled positions.

RECOMMENDATIONS

Since 1981, the UCLA/Drew Medical Education Program has trained physicians with the mission of providing quality care to underserved populations. A recent study found that over 50% of program graduates currently practicing in California are located in medically disadvantaged areas, while only 26% of graduates from the UCLA School of Medicine are practicing in disadvantaged areas.[24] Programs such as these, which provide targeted education and training for future practice in disadvantaged areas, are an integral part of solving the problem of health disparities. The current—and possibly permanent—loss of the 250 residency training slots at MLK Hospital was another serious blow to efforts to improve community health. California currently ranks last in total Medicaid-per-enrollee expenditures, a fact that contributes to low physician participation in the program.

The workforce shortage goes beyond physicians and includes other professions such as nursing. The shortage in nursing personnel is compounded by legislation passed in California that sets nursing staff ratios in an effort to improve the quality of patient care. For regions like South Los Angeles, the challenge can be greater. One of the precipitating factors in the closure of Martin Luther King Hospital was the extraordinary shortage in permanent nursing personnel and the high percentage of traveling or nurse registry personnel.

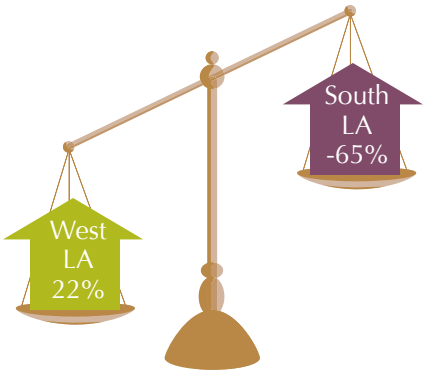
Of the multiple barriers, the major challenge faced is the lack of educational capacity, with nearly half of nursing applicants in LA turned away due to lack of space in 2005.[25] Strategies from recruitment and mentoring to increasing funding for programs are being explored through the LA Health Collaborative, a partnership of nearly 70 private and public organizations dedicated to preserving and improving Los Angeles County's healthcare safety net. The situation is not entirely bleak—new funding for UCLA Bachelors of Nursing program as well as the Governor's initiative and Song Brown provide an opportunity to increase nursing capacity.

> Charles Drew University of Medicine & Science is constructing the first comprehensive nursing school to be built in California in decades and the first ever in South LA. The nursing school's Masters program will open by accepting 40 individuals in Fall 2008.

If health inequities are to be eliminated, more has to be done to provide support for the existing health-care workforce to attract and retain future professionals. The following recommendations are offered as critical next steps:

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Increase Medi-Cal reimbursement rates and provide a differential to create an incentive to retain existing providers to serve South Los Angeles and other underserved communities.	▪ Centers for Medicare and Medicaid Services ▪ California Department of Health Care Services ▪ Los Angeles Congressional Delegation
Create incentives to attract new providers to serve South Los Angeles by: ▪ Developing mentorship and training programs, retaining the 250 training slots under Medicare for MLK hospital and possibly by using funding criteria such as the Song-Brown Family Physician and PA/NP Training Act that favors programs that train physicians and health professionals for practice in medically-underserved communities in California ▪ Increasing funding for loan forgiveness programs on the state (Steve Thompson Memorial Fund) and federal (Private Practice Program Option) levels.	▪ California Medical Assistance Commission (CMAC) ▪ OSHPD California Healthcare Workforce Policy Commission (CHWPC) ▪ Centers for Medicaid and Medicare Services ▪ Los Angeles Congressional Delegation ▪ California State Legislature
Provide financial incentives for specialists and dentists through loan forgiveness or reimbursement rates.	▪ Los Angeles Congressional Delegation ▪ US Department of Health Services, Bureau of Primary Healthcare ▪ California State Legislature
Increase college education of nurses in LA County by: ▪ Supporting the introduction of CINHC to LAC to coordinate resources ▪ Providing scholarships for graduate-level training in return for a teaching commitment ▪ Organizing countywide training for masters-level nurses to teach.	▪ University of California ▪ California State Legislature ▪ Local community colleges and other universities

HEALTHCARE FINANCING



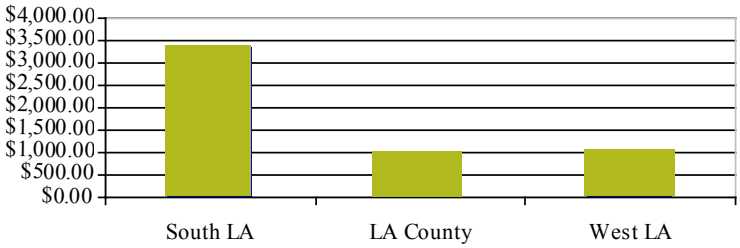
Safety-net hospitals are under continuous pressure to provide and expand services amid requirements raising costs, reductions in public funding, consolidations, increased privatization, diminishing revenue from commercial insurers and policy challenges such as seismic retrofitting and staffing. A recent assessment of California hospitals' financial health revealed that the median operating margin was 1.3% in 2005, with 38.5% of hospitals reporting a negative operating margin.[26] For hospitals in South LA, financial stability is rarely seen given the expanding number of uninsured and indigent patients, the low reimbursement rates for public insurance, inadequate payor mix (Medi-Cal, Medicare and commercial insurance), and the escalating costs of providing healthcare to a population that suffers from acute chronic illnesses. Financial problems account for a majority of the hospitals in Los Angeles County that downsize, close, convert, or are sold.

To assess healthcare financing and the sustainability of the healthcare network, we examined several indicators for both hospitals and community clinics.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
County funding for PPP clinics per uninsured person[xiv]	**$27.12**	$34.05	$65.36
Hospitals' uncompensated care costs per adjusted patient day[xiii]	**$3,338.94**	$1,008.66	$1,024.87
Hospitals' net revenue per adjusted patient day[xiii]	**$1,970.19**	$1,914.01	$2,592.16
Hospitals' operating expenses per adjusted patient day[xiii]	**$2,350.91**	$2,082.26	$2,903.84

South LA hospitals provide three times as much uncompensated care per adjusted patient day as West LA and LA County hospitals. In 2006, providing care to the indigent and uninsured cost South LA hospitals $3,338.94 per adjusted patient day. By comparison, West LA hospitals provided $1,024.87 of uncompensated care; countywide the cost was $1,008.66.

Figure 11. Hospitals' Uncompensated Care Costs per Adjusted Patient Days



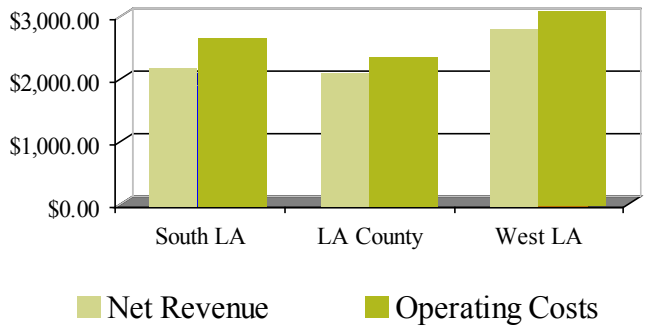
Source: Office of Statewide Health Planning and Development, Hospital Annual Financial Profile Report, 2006

With the closures of Daniel Freeman Memorial and MLK-Harbor, South LA lost an estimated $2,089.93 in uncompensated care costs per adjusted patient day. This arguably translates into a reduction in services to the indigent, an increased burden on the remaining hospitals, and further destabilization of the safety net. Though county government implemented its Impacted Hospitals Program[xxii] to offset the costs to neighboring hospitals of displaced indigent patients, an analysis conducted by the Hospital Association of Southern California found that inpatient utilization trends had shifted throughout the year prior to the closure of MLK-Harbor Hospital. In fact, patient utilization levels at Harbor-UCLA, LAC+USC, and MLK-Harbor had all decreased and were matched by a similar level of increase in utilization at surrounding private hospitals. The private hospitals had been absorbing indigent patients prior to the Impacted Hospitals Program as a result of earlier service reductions and other county policies limiting patient transfers from private hospitals to the county.[27]

Additional disparities in the financial health of hospitals and clinics include:

- **Less county funding for Public-Private Partnership clinics in South LA:** West LA PPP clinics receive an average of $65.36 per uninsured person. South LA clinics receive only a third of this amount, or $27.12 per uninsured person. The overall LA County average for all clinics combined is $34.05 per uninsured person.
- **South LA hospitals have greater budget deficits**: The "profitability" of a hospital is reflected in part by net revenue vs. operating expense per adjusted patient day. As seen in Figure 15, LA County overall has less of a difference between revenues and expenses than South and West LA hospitals, most likely due to the larger sample size. However, the following graph demonstrates that all hospitals, including those in more affluent areas, are struggling with profitability.

Figure 12. Hospitals' Net Revenue and Operating Expenses per Adjusted Patient Days



Source: Office of Statewide Health Planning and Development, Hospital Annual Financial Profile Report, 2006

[xxii] When MLK-Harbor Hospital was closed in August 2007, LA County implemented a closure plan that redirected patient flow to nine private hospitals in proximity to MLK-Harbor, and thus identified as "impacted" by its closure. If patients were "county responsible" and met the criteria of being the county's responsibility, the private hospitals would be reimbursed for the costs of their care. Memorandum to the Board of Supervisors, "Martin-Luther King, Jr. – Harbor Hospital Closure Implementation Plan," August 13, 2007.

RECOMMENDATIONS

Clearly the most significant contributor to South Los Angeles providers' uncompensated care is the inadequate public funding of the safety net to meet the needs of a patient population that is more than half uninsured or enrolled in Medi-Cal. California ranks last in Medi-Cal payments per enrollee in the US[28] and the state's own Medi-Cal payment structure set by the California Medical Assistance Commission reimburses Southern California hospitals at a lower rate overall than Northern California.[29] At the local level, the county's PPP program funding continues to be allocated by an outdated formula[30] that results in South LA receiving only about $4.2 million of the more than $50 million annual budget. A disparity also exists in the reimbursement practices by private insurers. In 2006, Centinela Hospital battled with Blue Cross to increase its insurance contract reimbursement rates, claiming the hospital did not receive equitable reimbursement compared to other hospitals outside the region. The new owner since 2008, Prime Healthcare, has aggressively cancelled and renegotiated all of its insurance contracts; however, at least one major HMO plan walked away from the table.

Many areas of South LA qualify as medically underserved or health professional shortage areas. With these designations, providers receive financial incentives to attract physicians and other health professionals as well as higher reimbursement rates. However, the relatively large number of physician practices to be surveyed in an urban area makes the required FTE survey prohibitive in many cases. The costs of the survey in manpower and consulting costs are quite high and in California, the applicable state agency only provides technical assistance.

The following incremental steps are designed to strengthen the financial viability of and move the South LA healthcare network and safety net towards equity.

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Assess fee for hospitals, health plans and providers who do not serve at least 10% Medi-Cal and provide 5% charity care annually as measured by cost and determined through a cost-to-charge ratio: (*Charity Care*) (*Total Operating Expenses / Gross Patient Revenue*).	▪ California State Legislature ▪ Governor Schwarzenegger ▪ Los Angeles Congressional Delegation
Expand state's authority to assess financial solvency of critical safety-net healthcare facilities and provide financial help using fees pooled from providers not meeting minimum Medi-Cal/uninsured care and up to placing hospital in receivership.	▪ California State Legislature ▪ Governor Schwarzenegger
Establish a Maintenance of Effort requirement tied to licensing for continued operation of safety-net hospitals critical to communities as measured by the number of beds in use per 100,000 population.	▪ California State Legislature ▪ Governor Schwarzenegger
Increase the current reimbursement differential from 10 to 20% for Medicare for providers in MUAs/HPSAs that is tied to quality performance.	▪ Los Angeles Congressional Delegation ▪ Centers for Medicaid and Medicare Services
Provide grants to providers in areas already designated MUAs/HPSAs to reapply to maintain their status or reduce application requirements for redesignations.	▪ Bureau of Primary Health Care ▪ Los Angeles Congressional Delegation

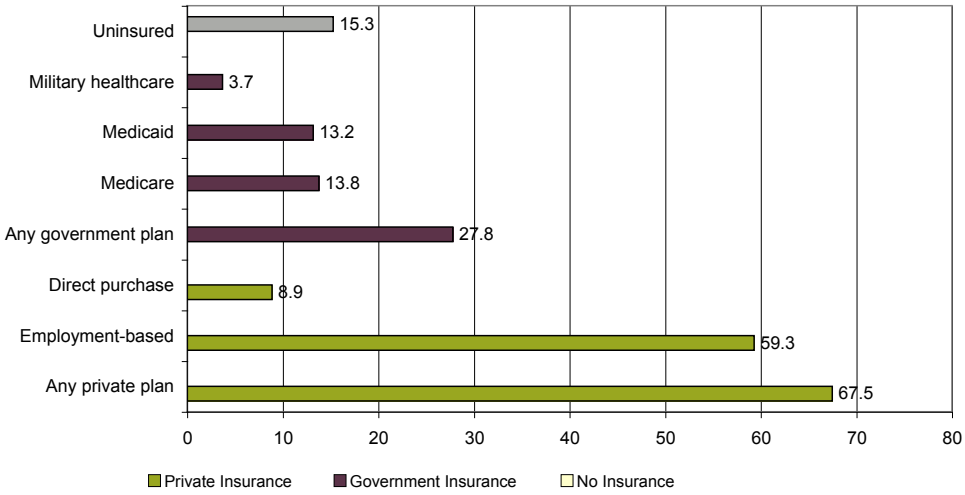
HEALTHCARE COVERAGE

An estimated 45.7 million people, or 15.3% of the population, live without health insurance in the United States; 8.1 million are children under 18 or 11.0% of the total children's population. For the first time in eight years, the number of uninsured in the United States dropped in 2007, largely due to an increase in people covered by publicly-sponsored health programs.[31] Statewide, 18.2% of Californians lacked healthcare coverage in 2007, down from 18.8% the previous year.[32] Despite the small increase in the insured, recent efforts to expand coverage met with resistance and stalled. State and federal budget deficits and immigration policy changes have resulted in reductions in program benefits, the number of persons eligible for programs, and reimbursement for care. Such trends are alarming, particularly given the link between uninsured persons and adverse health outcomes, delay of care, increased use of the emergency room, and premature death.[33] A recent Families USA report estimated that "more than eight working-age Californians or approximately 3,100 people in 2006 die each day due to lack of healthcare coverage."[34]

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Percent of uninsured non-elderly adults (18-64 years old) [xxiii]	**30.4**	21.8	11.8
Percent of uninsured children (0-17 years old)[xxiv]	**10.7**	8.3	4.0
Percent of non-elderly adults without dental insurance [xxv]	**42.6**	37.3	40.0

Healthcare coverage in the US represents a patchwork of payors.

Figure 13. Coverage by Type of Insurance: 2007 (%)



Source: US Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplements. The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

[xxiii] Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 8,648 Los Angeles County adults representative of the population in Los Angeles County. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305).

[xxiv] Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 6,032 parents/guardians of children 0-17 years representative of the population in Los Angeles County. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305).

[xxv] California Health Interview Survey. Los Angeles, CA: UCLA Center for Health Policy Research, 2005. http://www.chis.ucla.edu/ accessed March 5, 2008.

In 2007, 59.3% of working Americans were insured through their employer, while another 27.8% were covered through public insurance.[31] Healthcare coverage is largely a function of income and age. Many are afforded coverage through government-sponsored programs such as Medicare for seniors and Medicaid or SCHIP for children and families. While employer-based coverage is the single largest source of healthcare coverage, 18.8% of employed persons were uninsured in 2006. One third of uninsured workers are in families that earn less than $20,000 per year.[35] This becomes relevant when we examine the rate of coverage in South LA compared to other regions of the county.

The lack of coverage for children and non-elderly adults plays a significant role in the capacity of the regional healthcare network. The percentage of uncompensated care will vary by community and is in large part a reflection of the number of uninsured patients. The lack of insurance deters necessary and regular access to care and utilization of recommended services. These then result in delayed receipt of care, increased acuity and morbidity rates within the overall population. We are less likely to see a high concentration of providers, particularly specialty care providers, in communities with high uninsured rates or percentages of residents on Medicaid. As the ideas of expanding coverage and universal healthcare gain traction among policymakers, South LA serves as a reminder that improving health outcomes also requires concurrent efforts to improve employment opportunities, infrastructure, and reimbursement for quality care.

Approximately 218,000 (30.4%) of non-elderly adults in South LA are uninsured. For children 17 years and under, 46,000 or 10.7% do not have insurance. LA County has only 21.8% of the non-elderly adult population uninsured while West LA has an even smaller 11.8% uninsured. Children also fare better in West LA, with only 4.0% uninsured, and 8.3% uninsured throughout the county. In spite of Medi-Cal and the State Children's Health Insurance Program (SCHIP), or Healthy Families, an estimated 187,000 eligible people remain uninsured in LA County.

The disparity between South LA and West LA is consistent with the lack of economic opportunities, resulting disparities in unemployment and reliance on publicly-sponsored insurance. More than 13% of South LA residents are unemployed.

Table 5. Unemployment and Reliance on Public Insurance

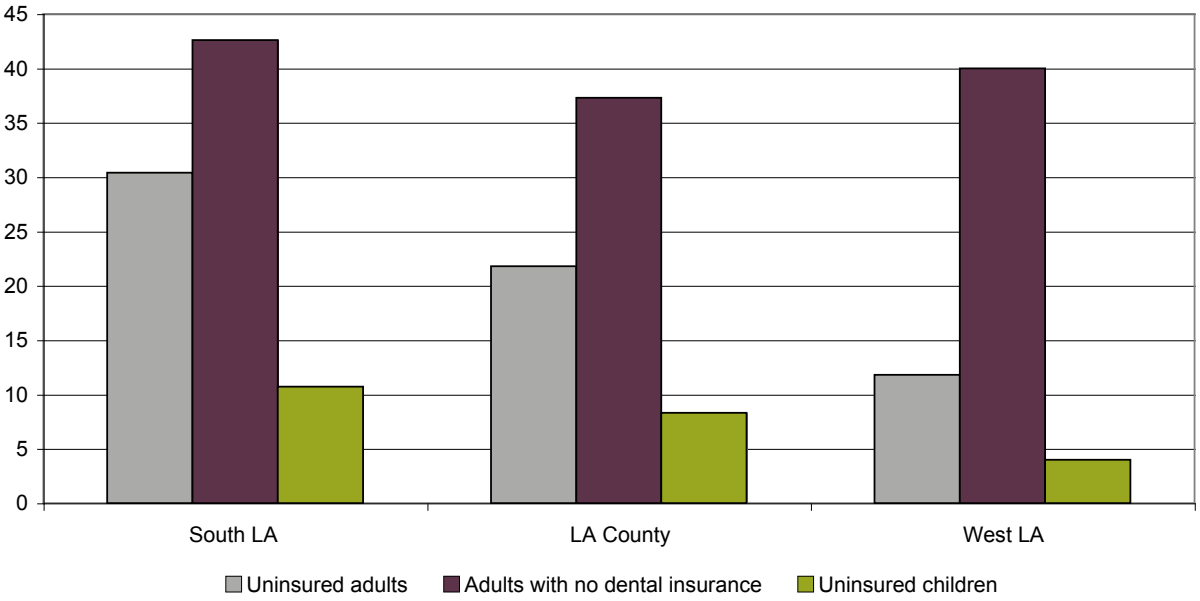
	SOUTH LA	LA COUNTY	WEST LA
Percent unemployed in civilian labor force	**14.1**	8.2	6.1
Percent of adults (18-64 years old) who reported having Medi-Cal	**26.2**	16.6	5.8*

*The estimate is statistically unstable (relative standard error ≥23%).

Sources: United Way Zip Code Data Book 2007; LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

The lack of healthcare coverage leaves these 264,000 residents of South LA exposed to higher risks of morbidity and mortality. Uninsured women, for example, are less likely to receive the recommended preventive cancer screenings for breast and cervical cancer than women who have insurance.[36] Lack of insurance is also associated with the prevalence of obesity in children and adolescents.[37] For adults with acute asthma, a lack of insurance leads to consistently poorer quality of care than patients who have coverage.[38]

Figure 14. Health and Dental Insurance



Source: Percent of uninsured non-elderly adults and children from the Los Angeles County Health Survey. Percent of non-elderly adults without dental insurance from California Health Interview Survey, 2003; data are for SPA 5 and 6.

Less disparity occurs, however, in the percent of adults who do not have dental insurance. In Service Planning Area 6 (South LA), 42.6% of adults do not have dental insurance. LA County and Service Planning Area 5 (West LA) respectively show 37.3% and 40.0% of the adult population without dental insurance. Experts surmise that there are several reasons for the high, but almost equal, levels of dentally uninsured adults between the two sub-county areas. Over the years, there has been a shrinking of employer-based coverage, either by eliminating some workers completely or removing dental and vision benefits. Because West LA has a high proportion of adults who rely on employer-based or private coverage (82.1%), the number of adults who pay out-of-pocket for dental care may have increased as benefits decreased. South LA adults, on the other hand, rely heavily on public insurance (26.2% covered by Medi-Cal), which includes dental benefits. Public dental insurance, however, does not ensure access to dental care because Denti-Cal providers are few and far between.

RECOMMENDATIONS

Though these indicators are primarily concerned with the lack of health insurance, there is also a slow dissipation underway in the options available to the low-income uninsured, underinsured, and even the publicly insured. The number is expected to grow larger as state and federal budget deficits allow a reduction in benefits and services for these programs. Nationally, SCHIP is set to expire in March 2009 and should this legislation be reauthorized by Congress, there is a good chance that funding will be decreased. Statewide, the low level of reimbursement for Medi-Cal discourages providers to accept publicly-insured patients, thus creating a barrier for the 30% of South LA adults who are beneficiaries.

Many counties, including Los Angeles, have established local coverage programs for children otherwise ineligible for Healthy Families and Medi-Cal. In Los Angeles County, the local program is Healthy Kids. However, Healthy Kids and similar programs throughout the state do not have sustainable funding sources and are now facing a cap or discontinuation of future enrollment, if not disenrollment, of children on the program today.

Los Angeles County *Healthy Kids* program was implemented in July 2003 with initial funding of $100 million from First 5 LA. There are currently 34,693 children enrolled in the program; of these, 6,133 are children living in SPA 6 (South LA). The program is coupled with funding for outreach and enrollment. Five community organizations are working in South LA to enroll eligible children in this and other publically-funded programs. The list of organizations includes: Community Health Councils, Crystal Stairs, St. Francis Medical Center, St. John's Well Child and Family Center, and Robert F. Kennedy Institute.

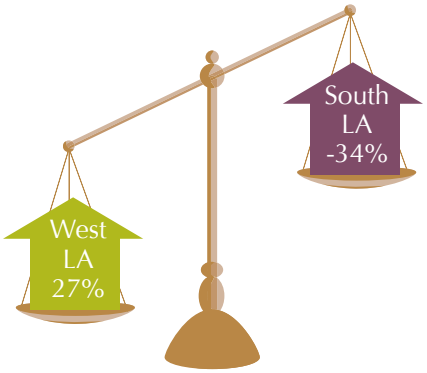
Los Angeles County currently receives funding through a Medicaid waiver and SB 1448 that expanded coverage for the low-income uninsured population, frequent users of the county healthcare system. Under this initiative, LA County would receive $54 million to improve care coordination and health outcomes for chronically ill and elderly, pre-Medicare patients. The funding allocation of the Coverage Initiative enacted by SB 1448, known locally as Healthy Way LA, unfortunately only designates 18,752 of eligible patients to SPA 6 (South LA), although the area has an estimated 185,000 uninsured adults. This translates into SPA 6 (South LA), with the second highest rate of uninsured adults in the county, receiving only the third highest funding allocation behind the Metro and San Fernando SPAs.

The uneven distribution of financial resources, the lack of options for the undocumented, and the consequent levels of poor health all argue that California, if not the nation, needs to expand publicly sponsored healthcare programs.

Below are recommendations that were developed during the *Scorecard Summit* in June 2008 that seek to reduce the number of uninsured for South LA in the absence of state or national health reform.

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Expand the enrollment criteria under the Coverage Initiative (Healthy Way LA) to maximize participation in the program and increase the number of visits allotted to SPA 6 appropriate to the need.	▪ Los Angeles County Board of Supervisors ▪ Los Angeles County Department of Health Services ▪ California Department of Health and Human Services
Streamline enrollment systems and financial eligibility categories to reduce enrollment barriers and the number of eligible but not enrolled children and families.	▪ California Department of Health Services/ MRMIB ▪ Los Angeles County Department of Health Services
Increase PPP dollars for dental, vision and mental health services for low-income uninsured populations.	▪ Los Angeles County Board of Supervisors ▪ Los Angeles County Department of Health Services
Expand eligibility for adults up to 133% FPL under Medi-Cal and Healthy Families.	▪ Los Angeles Congressional Delegation ▪ Governor Schwarzenegger ▪ Los Angeles County Board of Supervisors ▪ State of California Legislature
Maximize CHDP, emergency Medi-Cal and other funding streams to support children's coverage.	▪ California Department of Health Services

PRIMARY & PREVENTIVE CARE ACCESS



Experts agree that early prevention, care coordination, and continuity of care all contribute to a more efficient health system and, more importantly, better health outcomes.[39] The Institute of Medicine defines primary care as "the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community."[40] For the purposes of this study, 12 indicators are used to assess the availability and adherence to a series of basic recommended primary and preventive care services and screenings. However, many people, in particular the underserved and uninsured, obtain non-emergent, primary care in an emergency department because they lack access to a primary care physician.[41] Across the nation, approximately 11% of ambulatory care visits occur in the emergency room, most likely because of its extended hours for unscheduled care and the ability to treat a variety of symptoms.[42] As South LA already suffers from a lack of physicians and sites of medical care, undoubtedly the next and sometimes the preferred choice is the emergency room. We have therefore included two indicators related to emergency room care, although typically not considered an element of primary or preventive care.

Of the six indicators for access to primary and preventive care, the largest disparities within South LA compared to an LA County baseline are (1) the percentage of emergency-room hours spent on diversion per year and (2) the percent of households without a vehicle.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Percent of adults who reported having a regular source of care[xxvi]	**74.7**	80.2	84.8
Percent of adults who reported easily obtaining medical care[xxvi]	**57.3**	69.9	80.9
Percent of adults who could not afford dental care at least once in the past 12 months[xxvi]	**34.7**	25.6	20.3
Percent of households with no vehicle[xxvii]	**21.2**	12.6	8.1
Percent of total ER operation hours spent in diversion a year[xxviii]	**29.2**	15.4	7.1
ER visits that leave without being seen per 1,000 population[xxviii]	**10.2**	11.6	8.2

[xxvi] Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 8,468 Los Angeles County adults representative of the population in Los Angeles County.

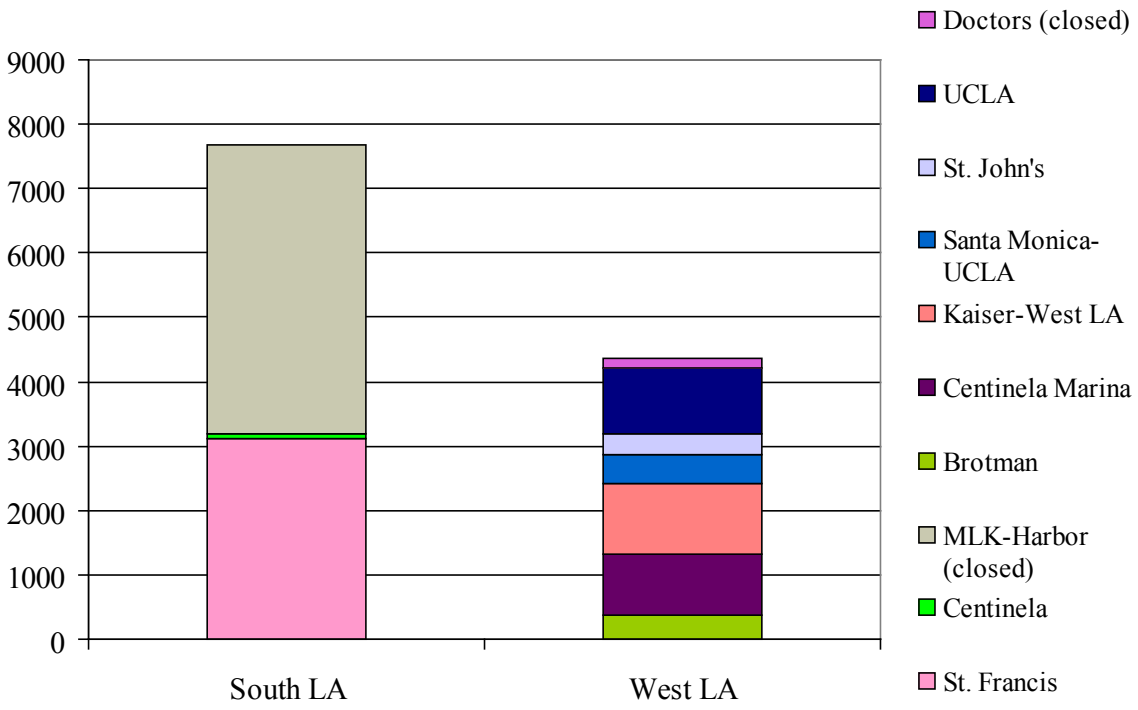
[xxvii] United States Census Bureau, Census 2000, Summary File 3.

[xxviii] Office of Statewide Health Planning and Development, Hospital Annual Utilization Profile Report, 2006.

Diversion status occurs when hospital emergency rooms are full beyond capacity and ambulances are re-directed to neighboring facilities. The time it takes for the patient to receive emergency care is presumably lengthened. South LA's three emergency rooms (St. Francis, Centinela Freeman, and MLK Medical Center before its closure) were on diversion 29.2% of their operating hours or on average 3,800 hours during 2006.[xxix] In contrast, West LA emergency rooms spent approximately 7.1% or on average 620 of their operating hours on diversion for the same year. South LA emergency rooms spent more time on diversion than the seven emergency rooms available to West LA residents.

Since the closure of MLK Medical Center, the closest county hospital (Harbor-UCLA Medical Center) has seen treatment time when the patient arrives to when the patient leaves the emergency department increase to 12 hours and 14 minutes. This is significantly longer than the 9 hours and 13 minutes at LAC+USC Medical Center, and the 10 hours and 14 minutes needed to treat ER patients at Olive View/ UCLA Medical Center.[43] In addition to overcrowding in the ER, ambulance diversion is also a symptom of a number of factors, including boarding patients in the ER due to a lack of inpatient beds, misuse of the emergency room, and a lack of necessary staffing.[44] With only two emergency rooms left in the area, one can assume that diversions will be more frequent and more patients will be re-routed to hospitals further away.

Figure 15. Emergency Room Operating Hours Spent on Diversion per Hospital



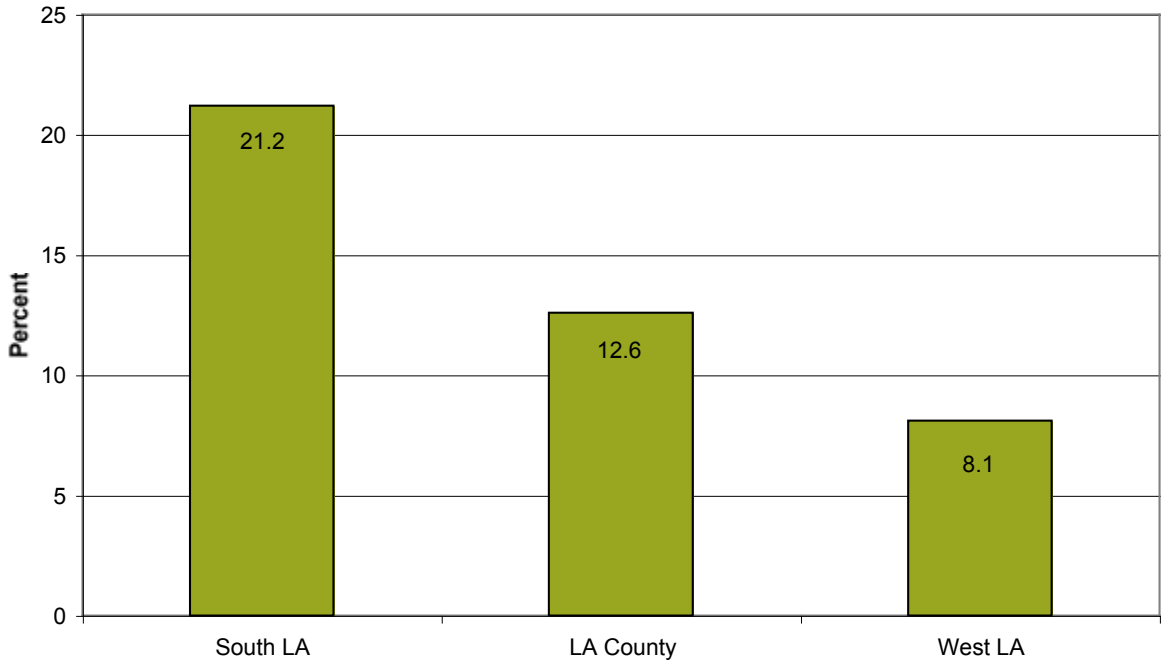
Source: Office of Statewide Health Planning and Development, Hospital Annual Utilization Report, 2006

[xxix] Office of Statewide Health Planning and Development, Hospital Annual Utilization Report, 2006. Yearly average does not include Centinela due to nondiversion status.

Additional disparities in access to primary and preventive care services reveal patients in South LA are:

- **Less likely to have access to ready transportation**: 21.2% of households in South LA do not have access to a vehicle, compared to 12.6% in all of LA County and 8.1% in West LA. Travel burden has already been linked to a number of health behaviors such as the use of mammography services, use of pharmacy services, and missed appointments.[45] This is further complicated by the noted deficiencies in LA County's public transportation system including overcrowding that must now be addressed under court order.[46]

Figure 16. Percent of Households with No Vehicle



Source: US Census 2000, Summary File 3

- **Less likely to have access to a medical home**: Only 74.7% of South LA adults reported having a regular source of care in contrast to 84.8% in West LA and 80.2% for overall LA County. Similarly, only 57.3% of South LA adults indicated they were able to easily obtain medical care while 81% of West LA adults and 70% of overall LA adult respondents reported ease in access to care. Most respondents identified financial barriers when asked why they did not have a regular source of care and what difficulties they had in obtaining medical care. Individuals with a medical home are more likely to receive preventive care.[47]
- **Less likely to afford dental care:** 34.7% of adults in South LA could not afford to see a dentist in the past 12 months. By contrast, only 20.3% of West LA adults and 25.6% of LA County adults reported financial barriers to receiving dental care. This is significant given the link between dental disease and other chronic illnesses including cardiovascular disease, for which mortality is again higher in South LA than in any other region of Los Angeles.[48]
- **More likely to leave the ER without treatment**: South LA's three emergency rooms, in addition to being on diversion status, had 10.2 visits per 1,000 people who registered but left before being treated. This rate is actually lower than the LA County baseline of 11.6 visits per 1,000, but significantly higher than the West LA rate of 8.2. The lack of timely medical care is a significant factor in the level and prevalence of illness and health outcomes.

RECOMMENDATIONS

In 1995, Los Angeles County applied for and received a Section 1115 Medicaid Waiver that called for a restructuring of the county's health services delivery system by shifting patient care out of financially-burdened hospitals and into community-based, outpatient care settings focused on primary and preventive services.[49] The crisis and bailout gave rise to the closure of a number of county clinics and in turn, the establishment of the Public Private Partnerships between the county and primary care safety-net providers.

> There are currently 57 PPP providers with over 100 different sites throughout LA County. Thirteen providers are located in South LA. Seven of these have formed the Southside Coalition of Community Health Centers. The Coalition clinics offer primary and specialty care services, including dental care, and conducted more than 300,000 patient visits in 2006.

Since then, the county has continued to reduce services in public settings and shift care for the uninsured into the private sector. In the summer of 2002, the Board of Supervisors approved a redesign of the health services system that included the closure of 11 county health centers and converted the High Desert Hospital in Antelope Valley into a Multi-service Ambulatory Care Center (MACC). This redesign was necessary in light of budget deficits that called for cost savings and better management of limited resources. More recently, the county has again proposed the idea of shifting all primary care services to the PPP clinics in order to provide a stable health services budget. This privatization plan is still under study with a public hearing scheduled for December 2008, with an updated plan scheduled for board action in January 2009.

Clearly, these service reductions, added to the barriers of poverty, culture, linguistics and transportation, present significant hurdles to the uninsured population in accessing recommended, regular preventive and primary care. In order to reduce the high rates of chronic illnesses, targeted expansion of primary and preventive care access for the uninsured is necessary.

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Expand access to and funding for urgent care centers including: ▪ Retain and allocate SB 474 funds and seek federal match ▪ Expand services at the MLK MACC and/or PPP clinics to provide 24hour/7day week service ▪ Increase PPP clinic funding.	▪ Los Angeles Congressional Delegation ▪ Los Angeles County Board of Supervisors ▪ California State Legislature
Expand funding for oral health education and prevention programs to: ▪ Increase number of patient advisors and interpreters ▪ Increase outreach and education at WIC, preschools and childcare settings ▪ Develop media campaigns by public health and community-based agencies ▪ Train pediatricians and general medicine to educate patients.	▪ California State Legislature ▪ California Department of Public Health ▪ Los Angeles Congressional Delegation ▪ LA County Public Health

PRIMARY & PREVENTIVE CARE UTILIZATION

Beyond physical structures and facility capacity, consumers often experience barriers to care that are best illustrated through an examination of utilization. To assess utilization we examined a number of the basic primary and prevention services including screening for cervical, breast and prostate cancer as well as recommended annual visits to the doctor, dentist and reliance on an ER for care.

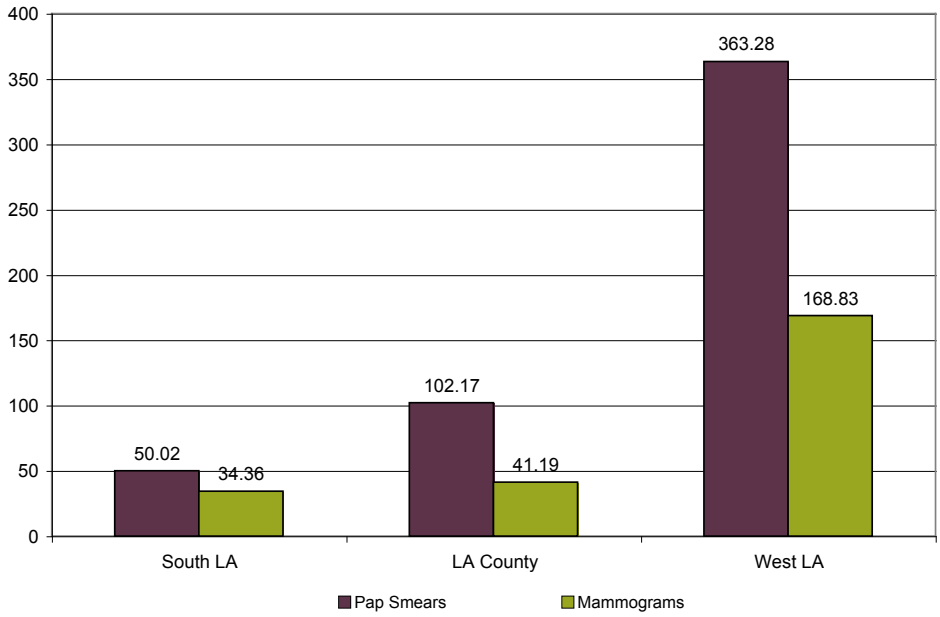
INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Percent of adults who reported ER use in the past 12 months[xxvi]	**25.9**	21.7	19.3
Number of pap smear screenings conducted by PPP clinics per 1,000 uninsured women[xxx]	**50.0**	102.2	363.3
Number of mammogram screenings conducted by PPP clinics per 1,000 uninsured women[xxx]	**34.4**	41.2	168.8
Percent of men over 40 years of age who have not had a PSA test[xxxi]	**63.8**	59.0	43.7
Percent of the population 2 years and over that has never been to a dentist[xxxi]	**7.8**	5.3	4.7
Percent of the population that saw a doctor at least once in the past year[xxxi]	**81.4**	82.8	84.3

The largest disparities within the utilization indicators were by far the number of pap smears and mammograms screened at PPP clinics per 1,000 uninsured women. Though PPP clinics are not the only sites where women can obtain these recommended screenings and residents of South LA may travel to other areas of the county for services, local PPP clinics are an obvious and available choice for *uninsured* women. For PPP clinics in South LA, only 50 pap smear and 34.4 mammography screenings were conducted per 1,000 uninsured women. West LA's rate was drastically higher at 363.3 pap smears and 168.8 mammography screenings per 1,000 uninsured women.

[xxx] Office of Statewide Health Planning and Development, Clinic Annual Utilization Report, 2006.

[xxxi] California Health Interview Survey, 2003. http://www.chis.ucla.edu/ Geographic areas are by SPA 5 and 6 boundaries.

Figure 17. Cancer Screenings Conducted by PPP Clinics per 1,000 Uninsured Women



Source: Office of Statewide Health Planning and Development, Clinic Annual Utilization Profile Report, 2006

The under utilization or non-compliance with recommended screenings is significant as South LA (SPA 6) ranks first in LA County for premature deaths due to breast cancer among women.[49] While cervical cancer rates or mortality are not available for the region, we can assume that they would be high as well given the high cancer rates in the population overall and the low rates of screening. One simple explanation for the lower rate of screening is that there are more uninsured women in South LA (125,000 uninsured women in South LA vs. 18,000 uninsured women in West LA) and thus fewer clinic resources to spread in a larger population. It may be more difficult for uninsured women in South LA to receive screenings as there is a higher demand. Currently, both South and West LA PPP clinics rely on a mobile mammography van that is on-site once a month for mammography services. This may result in months-long waiting lists and also deter women from making return appointments. Obviously, these measures require more study as to why the disparities between South and West LA are significantly higher.

Additional disparities in primary and preventive care utilization measures include:

- **Percent of adults who reported ER use:** Approximately 25.9% of South LA adults reported going to an emergency room within the past 12 months. Only 21.7% of LA County and 19.3% of West LA adults reported visiting an emergency room within the past 12 months. This would suggest less access to primary and urgent care services consistent with the higher level of acuity and illness in the population. The lack of access to primary care physicians during non-business hours drives people who do not have emergent conditions to seek care at emergency departments.
- **Percent of the population that has never been to a dentist:** 7.8% of the SPA 6 population 2 years and over has never been to a dentist. This again is high when compared to 5.3% of LA County and 4.7% of the population in SPA 5 or West LA that have not seen a dentist. Dental disease can result in higher risk for cardiovascular disease, higher school absenteeism, decreased school performance, and permanent disability.[50]
- **Percent of men over 40 who never had a Prostate-Specific Antigen (PSA) test:** 63.8% of men over 40 in South LA have not been tested for prostate cancer; in LA County the rate is 59.0% and in West LA 43.7%. South LA's prostate cancer mortality rate (41.79) is far higher than West LA (19.48) or LA County (21.86).

RECOMMENDATIONS

A lack of healthcare coverage and capacity notwithstanding, South LA residents face a number of additional obstacles to obtaining primary and preventive care services, thus complicating the effort of refocusing attention and utilization from costly specialty, inpatient and emergent care to primary and preventive care. Financial resources, language proficiency, personal and cultural beliefs and practices, and social networks have all been found to contribute to an individual's ready access and utilization of recommended medical services.[51] Similar to what occurred in 1995 following the announcement to close many county clinics, outpatient services at county run clinics in South LA have declined by 130,000 visits or 21% from 2002-03 to 2005-06 as a result of the MLK crisis. The 13,000 visit increase across all PPP clinics during the same time period was not nearly enough to make up the difference. [52] The healthcare system remains oriented toward more costly, tertiary care rather than primary, preventative care. Public and private payors cap or do not reimburse certain services or programs to prevent and manage chronic diseases. While public insurance and HMO coverage have helped to eliminate financial barriers to mammography, women 40–64 years with public coverage still lag behind their privately insured counterparts in using mammography and out-of-pocket costs remain a barrier to use for uninsured women.[53] In LA County, uninsured patients typically wait much longer than the insured to get referred for specialty care in the overwhelmed public healthcare system.

To combat the lack of primary and specialty care services at traditional healthcare providers, local community-based organizations have developed a wide-range of health education programs. Two examples are:

- Mothernet's *Take Charge!* chronic disease program in Compton incorporates family-focused in-home education and case management; healthcare coverage enrollment; and access services. No children participating in the program sought emergency treatment, compared to 80% in the year before being in the program. 87% of diabetic program participants adhered to treatment regimens including glucose monitoring, diet, stress reduction and standards of care.
- The *Best Babies Collaboratives* implement service plans in their community that are designed to reduce disparities and improve pregnancy and birth outcomes.

Many of South LA's hospital-based programs focusing on heart disease, diabetes and cancer have dwindled. South LA community clinics struggle to subsidize education programs through a patchwork of grants and patient reimbursement from other services. Federal commitment to community clinics, hampered by competing budget priorities and the economy, has not lived up to prior years' promise to make significant expansions. The current budget only contains a $27 million increase for community health centers (Section 330 program, etc).[54] The use of *promatoras* or community health workers serves as an alternative or complement to the traditional medical system of clinic and hospitals, yet credentialing and recognition by the mainstream health systems limit sustainability and expansion.

The recommendations listed below were developed during the *Scorecard Policy Summit* to address these disparities.

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Increase funding for community health clinics through federal Section 330 grant programming, etc.[xxxii] and the PPP program to reimburse screenings or to purchase screening equipment or hire staff for outreach to increase the number of patients who access screenings.	▪ Los Angeles Congressional Delegation ▪ Bureau of Primary Health Care
Strengthen systems for prevention, treatment, and management of chronic disease by: ▪ Basing provider rates through Medi-Cal, Healthy Families and other state contracts on the provision of "total care," or continuous, coordinated quality care including disease management, lifestyle education, etc. ▪ Providing incentives or higher reimbursement for number of screenings and extended office hours.	▪ California State Legislature ▪ California Department of Health Services/Public Health ▪ Los Angeles Congressional Delegation ▪ Los Angeles County Board of Supervisors ▪ LA County Public Health/Health Services
Expand the hours/days of mammography screenings at the MLK-MACC Women's Health Center and create a liaison position to connect to the community, PPPs and public health centers for referrals.	▪ Los Angeles County Board of Supervisors ▪ Los Angeles County Department of Health Services
Long-term investment in community health workers for health education and outreach by: ▪ Creating employment opportunities at all levels of the health system including public health agencies and healthcare providers ▪ Establishing reimbursement for CWH services under public and private payors ▪ Providing professional certification at universities and other educational institutions.	▪ Los Angeles Congressional Delegation ▪ Los Angeles County Department of Public Health ▪ University of California ▪ Private universities/community colleges ▪ Health plans

[xxxii] Section 330 of the Public Health Services Act provides for federal funding for public and private nonprofit entities that provide care to medically-underserved populations.

Scorecard Domain 2

Physical Environment Resources

PHYSICAL ENVIRONMENT RESOURCES

Physical Environment Resources Score

Environment is defined as the totality of physical conditions and context where people live, work, and play. It is a combination of the built environment or external physical resources and conditions—air, parks, schools, liquor stores, fast-food chains, housing—that affect and influence access, opportunity and human development. The environment contributes to major health outcomes, the prevalence of chronic diseases, and rates of mortality in significant ways. We know the emission of diesel fuel and exposure to cockroaches are associated with asthma; chemicals such as radon or particulate matter from air or land pollution lead to cancer and aggravate heart diseases.[55] We also know that legislative policy can help control the negative impact of the environment on health. Restricting the use of lead-based paint, for example, resulted in significant drops in childhood lead poisoning. Local, state and federal bodies now carefully monitor and control air quality and the water supply, thereby significantly improving population health status in the US.

In contrast, a study commissioned by the United Church of Christ on environmental justice first in 1987 and again in 2007 found that polluting industries are routinely located closer to racial and ethnic minority neighborhoods and that these communities are not equally protected by environmental laws. The 2007 report ranked Greater Los Angeles first among major urban areas with the most people living near hazardous waste facilities. The report found that the placement of these hazardous sites is the intentional result of local, state and federal land-use policies.

Given the inextricable relationship between the environment and health, the limited capacity of the healthcare system and the high number of uninsured in communities such as South LA, it is critical that the focus of early prevention shifts from individual behavior to the built environment and the policies that intentionally or unintentionally pollute neighborhoods. In this section of the *Scorecard* we examine the extent to which there are inequities in existing resources to support healthy life choices and environmental risk in South LA for 19 variables grouped into six categories:

- Nutrition
- Physical Activity
- Public Safety
- Housing
- Schools
- Air & Land Quality.

These indicators should not be seen as the full context of South LA's environment; they are a starting point to eliminating the regional factors that contribute to current health disparities. In the following sections, we analyze these and other findings by topic and provide policy recommendations to address South LA's environmental disparities. While the topics are addressed separately, they are in many cases interdependent.

NUTRITION

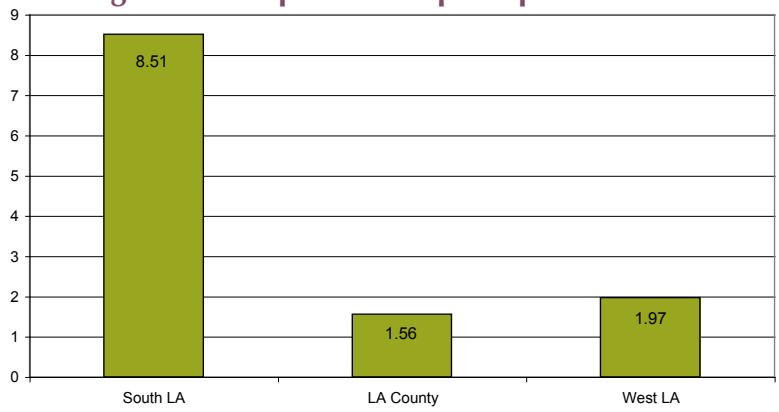
The largest disparities within the Environment section are found in nutrition. To assess the availability of South LA's healthful food options, we examined five nutrition measures including liquor retail stores, supermarkets, non-fast food restaurants, public health food facility ratings, and farmers' markets.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Liquor retail stores per sq. mi. [xxxiii]	**8.51**	1.56	1.97
Supermarkets (44,000+ sq. ft.) per sq. mi.	**0.10**	0.05	0.14
Percent limited service restaurants [xxxv]	**71.80**	47.70	40.80
Food facilities rated below "C" per sq. mi.	**0.21**	0.05	0.03
Farmers' markets per sq. mi. [xxxvii]	**0.06**	0.02	0.08

Nutritious, healthy food options are scarce in South LA. The area has a disproportionately high number of fast-food chains, liquor retail stores, and smaller convenience markets often selling processed, non-perishable items. The lack of healthy food options in South LA likely has a profound impact on the health of residents. Nutritious eating is a strong indicator of chronic disease and well-linked to the prevention of risk for chronic disease, especially diabetes, cardiovascular diseases and cancers.[56, 57] Further, the availability of healthy foods where we live has been shown to influence what we choose to eat and the prevalence of obesity and diabetes.[58,59, 60, 61]

The most striking disparity is the approximately 8.51 liquor retail stores per square mile in South LA; nearly four times the 1.97 per square mile in West LA and the 1.56 available in LA County overall.

Figure 18. Liquor Stores per Square Mile



Source: California Department of Alcoholic Beverage Control, State of California

[xxxiii] California Department of Alcoholic Beverage Control, State of California. http://www.abc.ca.gov/datport/LQSMenu.html accessed 30 January 2008.
[xxxiv] Reference USA, Info USA. http://www.referenceusa.com/ accessed 30 May 2008.
[xxxv] 2002 Economic Census, U.S. Census Bureau. http://www.census.gov/econ/census02/.
[xxxvi] Los Angeles County Department of Public Health Food Facility Rating, LA County Department of Public Health. http://www.lapublichealth.org/rating/ accessed 6 March 2008.
[xxxvii] California Certified Farmers' Markets, California Federation of Certified Farmers' Markets. http://www.cafarmersmarkets.com/find-market/index_html?county=Los+Angeles&submit=Go%21.

Community Coalition, a local South LA CBO, has long-championed a reduction in the 200 liquor stores within South LA to reduce crime near stores. Working with the city to target the closing of individual stores is a long process and requires continuous community pressure to accomplish.[62]

The negative health effects of alcohol are numerous. Consuming alcohol, particularly large amounts, harms all facets of the body's nutritional process, which may lead to hypoglycemia and increased risk of liver disease and impaired brain function from the organs being malnourished.[63, 64] Risky sexual behavior, infant mortality, unintentional injuries and violence are also associated with too much alcohol consumption.[65] Studies have shown a significant relationship between the physical availability of alcohol and alcohol problems. Even small increases in the availability of alcohol lead to increased use; alcohol use has been associated with violence.[66] Because research has linked increased availability of alcohol to higher sales, the World Health Organization supports limiting alcohol outlets to reduce negative outcomes.[67]

Many studies have shown that regularly eating fast food can lead to higher body-mass index scores. Limited service or fast-food restaurants comprise 71.8 percent of the restaurants in South LA, compared to 40.8% of West LA restaurants and 47.7% of LA County restaurants. The rate of obesity among children in South LA is 28.8% compared to 17.6% obesity among children in West LA and 23.3% for all children in the county.[xxxviii] To curb the proliferation of fast food, the LA City Council adopted an interim ordinance placing a moratorium on new fast-food restaurants in South LA to provide an opportunity to attract more sit-down restaurants.[68] Fast-food restaurants frequently offer high calorie menus and bargain priced large portions. Research has shown that consumers presented with menu labeling at the point of service make healthier food choices. California passed a law in 2008 requiring menu labeling in chain restaurants.

Retail food outlets and grocery stores tell an equally alarming story. Research has found that the presence of a supermarket in a neighborhood is linked to higher fruit and vegetable consumption.[69] For each additional supermarket, the likelihood of residents meeting nutritional guidelines increases by one-third.[70] The number of quality food retailers falls short of the community health need. We examined large stores—44,000 square feet or larger—as a proxy for access to a larger variety of fresh food products. However, of the 0.10 supermarkets per square mile that are over 44,000 square feet in size, many in South LA are value warehouses. West LA, with 0.14 supermarkets per square mile, has a larger selection of stores offering organic foods and healthier products. A study conducted by CHC of food retailers found fewer markets serve more people in South Los Angeles: 5,957 persons per store in South LA vs 3,763 persons per store in West LA.[71] The study examined 261 local food retailers in South LA and 69 stores in West LA, documenting notable differences in the availability of health-supporting foods. Fresh produce, whole grain bread, and nonfat milk were less likely to be found in South LA than in the West LA community.[72]

[xxxviii] Los Angeles County Health Survey, LACHS 1999 & 2005 Surveys, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. 1999 estimates are based on self-reported data by a random sample of 8,354 Los Angeles County adults representative of the population in Los Angeles County.

In a community with limited healthy food options, farmers' markets can help fill some of the void. A recent study found that low-income women purchase a greater number of fruits and vegetables at farmers' markets than at supermarkets.[73] However, we found:

- **Fewer farmers' markets are available across South LA**. Only 6 farmers' markets are available in South LA compared to 16 in West LA. To maximize access to farmers' markets in under-resourced areas, experts recommend subsidies, community organizing, a focus on selling basic, affordable foods, hiring residents to be sales staff, and providing transportation. [74]

The Los Angeles County Health Department gives a letter grade to restaurants based on how they score on proper food storage and temperature, adequate cooking of food, cleanliness of equipment and facilities as well as safe food handling/hygiene.[75] For the healthy food options that do exist, South LA retailers are more likely to offer products under unhealthy conditions.

- **A rating of "C" or lower among food facilities is the second highest nutrition disparity**. Data show that 21% of food facilities subject to monitoring under the LA DPH food ratings program receive a grade of "C" or below in South LA—much higher than the 3% in West LA and the 5% in the county overall. Experts surmise that West LA's strong tourist economy is partially responsible for this; there are several areas colloquially known as "restaurant rows" where tourists will seek out dining venues. Though the facility rating system is not a national program, the familiarity of the A-F grading scale allows for global understanding of the scoring system and its meaning, and is quickly adapted by tourists. As a means of remaining competitive, anecdotal evidence suggests that West LA restaurant owners are tying the restaurant grade to employee performance measures and offering financial bonuses to restaurant managers.

Monitoring food retail/grocery stores is another matter and crosses several jurisdictions. Federal regulation and oversight are generally limited to the processing of food before it reaches stores. Both the US Department of Agriculture (USDA) and the Food and Drug Administration (FDA) regulate the products that are sold in stores. The USDA provides grading standards for produce, meat, poultry and other meat products. It also regulates the labels and contents of most products that contain meats. There are no standards for produce or meat that a store offers. Similarly, the FDA regulates the labels and contents of non-meat containing food products. Unfortunately, expiration dates on food products are not a federal mandate. In fact, it is up to the manufacturer of the food to provide the expiration of a product and the responsibility of the store to ensure that their shelves do not still contain these "expired" foods.

At the state and local levels, the Health Department is responsible for enforcing state laws associated with food safety standards. These standards are commonly associated with cleanliness, food preparation, temperatures for perishable foods and sanitary practices. Although any retail establishment that maintains a certain amount of food products (e.g., 10 square feet in Los Angeles County) falls under its purview, the Health Department does not evaluate the quality of the food sold in grocery stores. It is up to individual stores to ensure the safety and quality of food.

RECOMMENDATIONS

To bring South LA's nutritional assets into greater balance with the county and better resourced, healthy areas, we turn to public policy in three key areas: (1) planning and land use; (2) economic development; and (3) public health. The objective must be not simply to improve access, but also to enrich the quality of the existing food resource environment. Given the limited number and size of parcels for new development, local government must play a more active and creative role in providing incentives and planning for access to healthy resources in underserved communities. A number of cities in California have addressed the issue of nutritional resources in their redevelopment activities and general plans, which provide a blueprint for zoning, development and land use decisions in cities. The City of Los Angeles is currently updating 12 of its 35 community plans. Three of these plans are part of the South Los Angeles region, including West Adams-Baldwin Hills-Leimert, Southeast, and South Los Angeles. West Adams-Baldwin Hills-Leimert is expected to be completed in Fall 2009, followed by Southeast and South LA in March 2010. Placing a limit on the number of fast-food outlets and other nuisance businesses either through the plan update or area-specific zoning ordinances can provide the physical space and economic opportunity for the development of healthy food outlets in communities that are "food deserts" such as South LA. Redevelopment funds can be used to ensure that healthy food resources are incorporated in new projects.

Existing license, permit and health surveillance provisions should be strengthened and expanded to increase access to healthy food in communities. Current state policy regulating the number of liquor outlets is based on population. As South LA's population has grown, new alcohol outlets have been allowed to open without exceeding the threshold. Reevaluating this policy and establishing limits based on geography may be more effective. While the state has the authority to license liquor stores, local governments have responsibility for appropriate use including the sale of liquor through the building permit process for new outlets and the alteration or expansion of existing stores. LA County has adopted a restaurant rating program; however, there is very little regulation of food retail outlets.

The Nutrition Workgroup analyzed the data and these policy opportunities during the *Scorecard Policy Summit* in June 2008 and developed the following policy recommendations to address disparities in healthy food access and liquor outlets.

POLICY RECOMMENDATIONS	ACCOUNTABLE AGENCY
Provide grants and below-market rate micro-loans to transform liquor stores and convenience stores and to develop new retail supermarkets through the use of block grants, targeted tax credits, redevelopment funding and other financing vehicles based on fresh food products as a specific percentage of the product line or square footage of retail space.	▪ Los Angeles City Council and other city councils (Compton, Inglewood, Hawthorne, etc.) ▪ Community Development Departments
Utilize state and local regulatory authority to limit alcohol sales by: ▪ Re-evaluating state policy to place limits on the number of liquor stores based on the size of the geographic area to account for population density ▪ Developing city zoning regulations and limits on the total number and density of liquor stores in South Los Angeles ▪ Adopting city standards regarding location and hours and conditions of liquor store operation through zoning tools or conditional use permits.	▪ City councils ▪ California Department of Alcoholic Beverage Control
Extend the South LA "Fast-Food" moratorium limiting the number of fast-food restaurants until an ordinance and land use policy that supports investment in South LA by healthier food resources is adopted.	▪ City councils
Establish a centralized position within the city to help streamline and expedite the permit process for the private sector and other entities to establish supermarkets based on their ability to meet a set of criteria and standards of quality.	▪ City councils
Enhance the role and authority of local health departments to regulate and enforce the quality and condition of food in local markets.	▪ Los Angeles County Board of Supervisors ▪ Los Angeles County Department of Public Health

PHYSICAL ACTIVITY

Three measures were scored that represent capacity and access to physical activity options. These measures are (1) children whose parents report easy access to a safe place to play; (2) amount of green space; and (3) miles of bicycle lanes.

South LA does not have equal access to physical activity options, making this the second highest environmental health disparity. The lack of green space or parks is clear evidence of this disparity.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Percent of children (1-17 years old) whose parents reported they could easily get to a park, playground or other safe place to play[xxxix]	**74.7**	83.1	85.1
Acres of green space / recreation areas per 1,000 population[xl]	**1.2**	97.2	70.1
Miles of county bicycle lanes per 100,000 population[xli]	**0.42**	0.97	1.92

The LA County Health Survey results indicate only three-quarters of the population have access to a safe place for children to play, compared to 85% and 83% in West LA and LA County respectively. When asked about the frequency of physical activity, 61.9% in West LA and 51.8% reported vigorous to moderate activity. Only 45.9% in South LA met the criteria for being physically active.[76] Safe routes can reduce reliance on cars and encourage walking or biking that promotes health. Cities must address safety to create safe passage for children to get to school. The National Center for Safe Routes to School calls for paved sidewalks, lighting scaled to pedestrians, bicycle facilities, separate paths, and connected roadways.[77]

South LA's physical activity options contribute to lower health status and the low levels of exercise reported. Lack of physical activity and poor nutrition are the second leading causes of preventable death in the US and are the primary culprits in the obesity epidemic facing South LA and the rest of the nation. Being overweight or obese reduces life expectancy. Among children, overweight increases risk for a number of health problems including asthma, depression, diabetes, or bone problems. Physical activity is a key indicator of chronic disease prevention and mental health. Increased physical activity is also positively associated with school outcomes and negatively associated with delinquency.[78]

[xxxix] Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 6,032 parents/guardians of children 0-17 years representative of the population in Los Angeles County.

[xl] GreenInfo Network, 2007.

[xli] LA County Department of Public Works, Programs Development Division, 2007.

The environment within the community can significantly influence a child's risk of obesity and how frequently individuals exercise. A recent LA County Public Health report ranked 128 cities and communities in LA County according to child obesity rates. The study also ranked the same areas on economic hardship indicators and park area per capita to determine their relationship to child obesity and found that park area was associated with child obesity. [79]

FUNDING OPPORTUNITIES

- **Proposition K**: a park-bond measure passed in 1996 by voters in the City of LA to address the inadequacies and deterioration of the city's "youth infrastructure"—parks and recreation centers—and the currently unmet need for park, recreation, childcare, and community facilities in the city. Proposition K generates $25 million per year for 30 years for acquisition, improvement, construction, and maintenance of city parks and recreational facilities.
- **Quimby Act**: a state law designed to generate funding for park development that requires developers to either pay in-lieu funds or set aside land for park and recreational uses within, or in the immediate vicinity of, new subdivisions.
- **Proposition 40:** a park and environmental bond measure passed in 2002 by California voters that includes $832.5 million for the acquisition and development of state and local parks including grants for local assistance programs to develop parks and recreation areas and facilities.

Other features of the physical environment, including access to facilities, aesthetics of the facilities/ neighborhoods and land use mix, affect the amount of physical activity as well.[80] CHC conducted a community assessment in 2001 that both inventoried and examined the capacity of a wide variety of physical activity resources in South LA in comparison to West Los Angeles. The assessment concluded that far more of the facilities in South LA were publicly owned (72%) than in West LA (52%). While both areas have relatively similar basic services for older adolescents, adults in South LA have fewer resources and choices. The imbalance towards public facilities in South LA suggests the vulnerability of the community to budgetary problems and also points to the important role that cities play in ensuring access to recreational resources in underserved communities. The recreational facilities in West LA were much more likely to offer a wide range of programs for adults and, in keeping with the public-private nature of the resource environment, open more days and longer each day. In return, West LA residents were more likely to pay a fee (62% versus 20%) for their physical activity services than residents in South LA. Other studies have shown that while use of parks is most intense in areas of low accessibility, access to adequate recreational opportunities is dependent upon proximity to parkland, available modes of transportation and hours of operation.[81]

City Controller Laura Chick conducted an audit of the City Department of Recreation and Parks in 2006 citing "inequity regarding access to recreational opportunities and the diversity of services provided." The study found inequities in the manner in which the department allocated staffing resources and that "less affluent communities are more dependent on Department subsidized programs and are less likely to offer as many programs." The audit called for the development of a five-year strategic plan, appropriate performance standards and measurements along with the completion of a community assessment every five years.

Compounding the inequitable distribution of parks, "park poor" communities such as South LA receive disproportionately less public funding. On February 21, 2008 the Los Angeles City Controller released an "Audit of Quimby Fee Collection and Uses." The audit identified over $129 million in unspent Quimby funding that could have otherwise been used to support the development of parks. The audit concluded that current Quimby ordinances, such as the requirement that funds can only be allocated for projects within a two-mile radius from the development that generated the fees, contributed to the failure of the Quimby program. Other studies have concluded since subdivision projects are disproportionately "suburban," older inner city neighborhoods receive little in the way of Quimby resources.[82]

Additional economic factors work against the development of new parks. There is an inherent financial conflict in the development of parks, particularly when cities face budget shortfalls. Not only do parks represent ongoing operating costs or liabilities to the city, but they also do not generate the tax dollars that come from private development.

RECOMMENDATIONS

The need for more parks and physical activity options to combat the rising rates of childhood obesity and chronic disease, particularly in low-income areas, is clear. Growing research demonstrates that creating or enhancing access to places for physical activities can result in a 25% increase in the percent of persons who exercise at least the recommended 3 times a week.[83] The CDC's review of the evidence finds high economic benefit for environmental and policy approaches to increasing access.[84] Policy instruments such as building codes, circulation and design standards and zoning ordinances must be utilized by cities and the county to improve the walkability, promotion and accessibility of physical activity options. Planning and development should include strategies such as locating schools, work, and shopping near homes; incorporating parks and requirements for open space in new developments; and adopting joint use agreements for shared use of parks and school facilities to ensure better equity in physical activity. Policies and interventions that involve street-scale urban design and land-use policies that support physical activity on a neighborhood level also resulted in average increases of 35% in physical activity. These interventions can include improved street lighting, infrastructure projects to increase safety of street crossings, use of traffic calming approaches (e.g., speed humps, traffic circles), enhanced street landscaping, parkways, trails and improved safety at parks and public facilities as well as school routes. The City of LA is currently working on its transportation plan and should ensure strategies to increase physical activity opportunities such as sidewalk improvements, pedestrian-friendly streets, bike/pedestrian pathways, and adequate bike racks at public parks, shopping centers, and workplaces.

Several residential areas in South Los Angeles represented innovations in urban design for their time and provide examples of what is good about the community and needs to be restored or built upon. Two examples are Leimert Park and Village Green.

Leimert Park was designed by the Olmsted brothers, an influential landscape design company that completed numerous high-profile projects, including the United States Capitol, New York's Central Park, and entire park systems in cities such as Seattle, Boston, and Louisville. Leimert Park was one of the first comprehensively planned communities in Southern California designed for low- and middle-income families. It was considered a model of urban planning: automobile traffic near schools and churches was minimized, utility wires were buried or hidden from view in alleys, and densely planted trees lined its streets.

The Baldwin Hills Village, commonly called "The Village Green," was constructed during the 1940s. It was the first experimental apartment complex with no through-streets. Apartment units, connected by extensive parkways surround a village green-like open space located in the center of the project. In the 1960s, these units were converted to condominiums and remain so today.

The challenges in urban communities such as South LA are at least twofold: (1) equitable funding; and (2) land use prioritization. Two years after the city audit, major recommendations have yet to be implemented. Tax dollars designated for park expansion and maintenance must be allocated to remedy the inequity in open space across communities. Public policies such as Quimby need to be reevaluated to ensure the goal of more parks is achieved in the neglected low-income areas that are rarely infused with new developments to generate Quimby funds. State funding, such as Proposition 84, a bond measure that contains $400 million for competitive grants for local and regional park improvement, needs to be targeted for "park-poor" communities. Abandoned industrial land must be restored, repurposed and include open space. Community involvement has proven successful in increasing access to parks and open space in South Los Angeles over further development.[85]

The Physical Activity Workgroup examined the data and arrived at the following policy recommendations to reduce disparities in physical activity resources.

POLICY RECOMMENDATIONS	ACCOUNTABLE AGENCY
Incorporate health into local government planning including the general plan, redevelopment and transportation.	▪ City/county planning agencies ▪ Los Angeles Metropolitan Transportation Authority
Fully implement the recommendations from the City Controller audit including the development of a citywide strategic plan for parks.	▪ Los Angeles City Council and other city councils ▪ Los Angeles County Board of Supervisors
Allocate city, county, and state revenues from taxes and designated bonds to address the current inequities in park development and maintenance and ensure a system of parks, schools, and recreation centers that provide equal access to physical activity for all South LA.	▪ Los Angeles Unified School District and other school districts: Inglewood, Hawthorne, Lennox etc. ▪ Los Angeles Department of Parks & Recreation and other city parks agencies ▪ Los Angeles County Parks & Recreation ▪ California Department of Parks and Recreation
Increase the number of joint community use agreements between schools, parks and recreation departments to allow use of school property and facilities after hours for physical activity.	▪ City/county planning agencies ▪ Los Angeles Metropolitan Transportation Authority
Establish safe routes to school and improve the safety of parks and streets.	▪ City/county planning agencies ▪ Los Angeles Metropolitan Transportation Authority

PUBLIC SAFETY

We examined three indicators of public safety: adult perception of neighborhood safety, traffic accidents, and crime rates.

Perception of neighborhood safety is the largest contributor to the differences in South LA and West LA safety with only 62% of South LA adults believing their neighborhood is safe. The low perception of neighborhood safety is validated by statistics that report high rates of crime in South LA. There were 11.86 violent crimes per 1,000 population in South LA, compared to 3.57 per 1,000 population in West LA and 6.58 for LA County overall. The disparity in violence extends beyond the immediate physical danger to longer-term health risks. Continual exposure to violent crime and other hazards has been shown to provoke physiological stress and has been associated with cardiovascular disease.[86] Exposure to violence impacts both fears of crime as well as changes or restrictions in lifestyle such as physical activity level or illegal purchase and possession of guns by minors.[87, 88]

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Percent of adults (18+ years old) who believe their neighborhoods are safe [xlii]	**61.5**	80.9	89.6
Traffic accidents per 1,000 population[xliii]	**14.7**	12.5	11.7
Crimes per 1,000 population[xliv]	**19.0**	17.5	16.8
Violent crimes (homicide, rape, robbery, aggravated assault) per 1,000 population	**11.9**	6.6	3.6
Property crimes (burglary, car theft, larceny) per 1,000 population	**26.2**	28.4	30.1

[xlii] Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 8,648 Los Angeles County adults, representative of the population in Los Angeles County.

[xliii] Statistical Digest, 2005. Los Angeles Police Department, Information Technology Division, Management Report Unit.

[xliv] Office of the Attorney General, State of California, Department of Justice, Criminal Justice Statistics Center, 2005. http://ag.ca.gov/cjsc/statisticsdatatabs/CrimeCity.php. Numbers for the City of Los Angeles from the Los Angeles Police Department.

No one factor contributes to crime but rather multiple, often interrelated issues ranging from unemployment to difficulty in school to family support and substance abuse play a role. The findings for South LA reinforce this claim. The unemployment rate in South LA stands at 14.1% or 131% higher than West LA and 72% higher than the overall county. The "achievement gap" for students attending public schools in South LA has been documented extensively. In SPA 6 (South LA), a mere 13.7% of public school third graders were reading at or above the national average and only 33.7% were doing math at or above the national average. Public high school graduation rates in SPA 6 (South LA) are the lowest in the county, with only 62.4% of students graduating.[xlv] The increasing number of single parent households strains the family support system. Zoning and planning codes and enforcement may also inadvertently result in unsafe facilities being built, and property owners and architects are not likely familiar with designing to prevent crime.[89]

The **Summer Night Lights** is a public/private collaboration to keep parks and recreation centers in eight high crime districts in Los Angeles City open until midnight four nights each week from July through September beginning in 2008. The program was designed to provide a safe and constructive environment for children, youth and families and deter crime. In the reporting districts that the SNL programs served, there was an 86% decrease in homicides, 23% reduction in aggravated assaults, 32% reduction in shots fired, and a 17% reduction in gang related crime. The most significant reduction was in the reporting districts served by Jim Gilliam SNL, where there was a 32% reduction in gang related crime and zero homicides as compared to 6 for the same time period in 2007. The project provided $250,000 in youth jobs, $40,000 in coaches and officials, $81,000 in artist fees, $63,000 spent with local vendors and $70,000 in intervention jobs. All these jobs went to residents of the SNL neighborhoods.

Other results are as follows:

- **The disparity in total combined Part 1 offenses did not vary widely**. Part 1 offensives include violent and property crimes. South LA had 19.0 crimes per 1,000 population, with West LA's rate slightly lower at 16.8 and LA County between the two at a rate of 17.5 during the study period.
- **Violent crimes in South LA are 2-3 times higher than in West LA and LA County**. While South LA had a higher rate of violent crime than West LA, West LA showed a higher rate of property crime at 30.1 per 1,000 population. In South LA, there were 26.2 property crimes per 1,000 population in 2006.

Traffic accidents are also a significant disparity in South LA. Traffic accidents contribute to motor vehicle deaths and are the third leading cause of premature death in SPA 6.[90] In the City of Los Angeles, 16% of all traffic accidents occurred in south LA City, at a rate of 14.7 accidents per 1,000 population.[xlvi] In west LA City, only 11% of LA City traffic accidents occurred locally at a rate of 11.7 accidents per 1,000 populations. The City of Los Angeles had an overall rate of 12.5 accidents per 1,000 population. This disparity also affects other environmental indicators. For example, traffic conditions have also been associated with levels of physical activity.[91]

[xlv] Los Angeles County Children's Planning Council, Los Angeles County 2006 Children's Scorecard.

[xlvi] Data only available for City of LA communities. See Appendix for more details.

RECOMMENDATIONS

Public safety is a public health issue, and the level of violence is a public health crisis. The issue of public safety goes beyond suppression and must be addressed through a multi-disciplinary approach that includes prevention strategies aimed at changing the socioeconomic, behavioral and environment factors that lead to violence and traffic accidents. Mentoring programs, Job Corps and early intervention programs such as Healthy Start have been shown successful in preventing crime among participants. After school programming including recreation and tutoring is needed outside the classroom to support student achievement. A "safer communities" approach, or community policing, which focuses on direct problem solving as well as the underlying social and economic factors that contribute to crime is a best practice among law enforcement. Improvements in the physical design and condition of neighborhoods, the use of streetscapes and architectural design features are also useful tools in improving the safety of communities.

There are a number of opportunities to build upon successful program models. The City of Los Angeles has recently released $168 million in funding for gang prevention, intervention and reduction services in an attempt to address gang violence with a comprehensive, coordinated strategy. This citywide strategy is based upon the promising results of a federally-funded local initiative, the Gang Reduction Program, which saw a 44% reduction in gang-related crime in the Boyle Heights neighborhood.[92] Statewide, California voters passed Proposition 36 in 2000, which required that those convicted of a non-violent, drug-related offense be offered probation and community-based drug treatment in lieu of a prison sentence. First and second year implementation studies and evaluations have shown that, while there is room for improvement in the program, there was a significant benefit in cost-savings to state and local governments.[93]

To prevent injuries from motor vehicle occupant injury, the CDC recommends ensuring adherence to existing policies for DUI, child safety seats and safety belts. The creation of safety zones in areas with high incidence of accidents or heavy traffic should utilize lane restriping, traffic signs, signal optimization, and increased education and enforcement of safety laws. Creating more bike lanes, traffic islands and single-lane roundabouts can create safer passage for motor vehicles, bikes and pedestrians and lower reliance on motor vehicles.

The Public Safety Workgroup analyzed these public safety indicators and recommends the following policy focuses:

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Increase funding and access to prevention programs for youth with a focus on academic remediation, school retention and job training.	▪ City Council ▪ Community Development Agency ▪ School District
Increase funding for multi-disciplinary gang prevention and expand community safety partnerships between schools, law enforcement, neighborhood associations and other key stakeholders.	▪ City Council ▪ Law Enforcement ▪ School District
Create safety corridors on South LA roadways.	▪ Department of Transportation ▪ Law Enforcement ▪ City Planning

HOUSING

Quality, affordable housing is essential to the quality of life and health in any community. Housing in the South LA region has changed dramatically in the last few years with rising prices placing pressure on residents to preserve the integrity of their neighborhood, followed by a high number of foreclosures and falling prices stemming from the national credit crisis.

Substandard housing conditions, which are more likely to be found in low-income areas, contribute to a multitude of poor health outcomes including asthma, lead poisoning and unintentional injuries. Long-term studies find children living in poor housing conditions may later develop chronic diseases, become disabled or die younger.[94] In this section, three housing measures are presented as affecting health including housing stock built before 1939, owner-occupied housing, and overcrowded housing.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Percent of housing structures built before 1939[xlvii]	**18.1**	12.9	13.3
Percent of occupied housing units that are overcrowded (1.0 or more occupants per room)[xlvii]	**36.8**	22.9	7.9
Percent of owner-occupied housing units[xlviii]	**38.1**	47.4	40.2

For all three indicators, South LA experiences a deficit compared to West LA and to LA County for percent of housing structures built before 1939 and percent of housing units that are overcrowded. The greatest disparity within housing occurs in overcrowded housing—approximately 37% of occupied housing units in South LA are overcrowded. This is more than four and a half times the 8% of West LA housing that is overcrowded and sixty percent higher than the 23% overcrowding in LA County. Overcrowded housing represents a potential health threat and has historically been associated with the spread of infectious diseases such as tuberculosis and influenza.[xlix]

Age of housing is a concern for lead paint exposure, which was not banned until 1978 for its adverse health effects from intellectual and behavioral deficits, seizures or death in children to hypertension and kidney disease in adults. While older housing stock does not always equate with substandard housing (there are many historic neighborhoods in LA County), in low-income areas this is the case more often than not.[95] The median year in which LA County housing units were built was 1961, with 13% of homes built before 1939. In comparison, South LA reports 18% of pre-1939 housing and 13% in West LA.

[xlvii] United States Census Bureau, Census 2000. Summary File 3.
[xlviii] United Way of Greater Los Angeles, Center for Community Research and Solutions. 2007 Zip Code Databook.
[xlix] The definition of overcrowded housing is adopted from Census guidelines and includes occupied housing units with 1.0 or more occupants per room.

The third measure provides an indication of the number of families that rent their homes as opposed to own their homes. Renter status is another housing characteristic associated with elevated blood lead levels in children. One recent study found that the variables of owner-occupied housing and age of housing were linked to the rate of pediatric injury requiring hospitalization.[96] The percentage of residents in South LA who are renters and do not own their home is slightly higher than in West LA and almost 10 percentage points higher than LA County overall. 38% of occupied housing units in South LA are owned, comparable to the 40% of owner-occupied units in West LA and the 47% reported for LA County.

A home also represents individual and family life savings and, historically, an opportunity for upward mobility. However, the recent mortgage crisis has resulted in a rapid decline in home values and increased foreclosures. Despite the higher percentage of renters, South LA has among the highest rate of foreclosures as low-income families that may not have previously qualified for mortgage loans were caught in sub-prime mortgage schemes.

South LA includes five out of 15 of the large public housing developments and 29 of the 47 scattered public housing sites owned and managed by the Housing Authority of the City of Los Angeles (HACLA).[1] Many of these projects are isolated from basic services creating high concentrations of poverty and violence. Cities across the country have replaced overcrowded and now substandard public housing with new mixed-income and mixed-use construction to provide opportunities for ownership and to diversify the economic profile of the area. The City of Los Angeles now confronts the need to replace several of its housing projects. This creates an important opportunity to change the profile of poverty in Los Angeles.

Overcrowding, exposure to lead paint and substandard housing are simply symptoms or outcomes of a much greater and fundamental problem**.** The problems associated with housing arise largely from residential segregation and discrimination.[97] Racial segregation concentrates poverty and excludes and isolates communities of color from the basic and quality resources needed for socio-economic equality and health. The City of LA created an affordable trust fund in 2000 to leverage housing funds. Voters rejected a measure in 2006 that would have created $1 billion in bonds for housing for the homeless and low-income families. In 2007, the Mayor of LA proposed requiring affordable housing in new developments, but other policymakers recommended changes to prevent razing current more affordable housing. Innovation, leadership and greater public and political will are required to break this stranglehold and pattern of housing segregation**.**

[1] The Housing Authority of the City of Los Angeles, accessed September 30, 2008.

RECOMMENDATIONS

Research suggests that helping individuals who live in high concentrations of poverty relocate to lower poverty neighborhoods can improve health outcomes. Portable rent vouchers and tenant-based assistance have been the most common housing mobility strategies. There must also be legal efforts that challenge residential and school segregation and target development of affordable housing in high opportunity areas. The most effective approach to address poor housing and health is arguably a focus on quality, affordable housing for all as well as improving overall human/social capitol.[98] As part of its public housing reconstruction effort, the Seattle Housing Authority has created High Point, a mixed-income community that doubles the number of units and also seeks to reduce health disparities through a walkable and "green" design.

Reporting on housing quality and resident satisfaction with housing can provide a basis not only for policy change but also for residents and advocates to improve housing in their community.[99] Additional public policy, such as the lead abatement program, is needed to reduce health risk associated with older housing stock with financial aid to property owners for upgrades. The EPA recently announced new regulations for housing contractors renovating homes built before 1978. After analyzing the data, the Housing Workgroup developed four policy recommendations to close the gaps in the indicators.

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Review and revise existing housing codes to reduce environmental health risks associated with ventilation, moisture, carpeting, molds, injury hazards, exposure to toxic substances, privacy, noise, lighting and other factors, particularly in subsidized housing.	▪ LA Housing Authority ▪ LA Building/Safety ▪ CRA ▪ City Councils ▪ Planning Departments ▪ County Environmental Health
Strengthen and enhance the role, monitoring and reporting by public health agencies to assess the quality of public housing and resident satisfaction.	▪ LA County Public Health ▪ LA City Council
Develop a strategic plan to leverage and maximize local, state and federal funding to increase funding to maintain and build affordable housing.	▪ Housing Departments ▪ Housing Authority of the County of Los Angeles ▪ Housing Authority of the City of Los Angeles ▪ City Councils
Establish policy and a citywide plan to provide for equitable geographic distribution of affordable housing through mixed use, particularly in rebuilding public housing.	▪ LA Housing Authority ▪ LA Building/Safety ▪ CRA ▪ City Councils ▪ Planning Departments

SCHOOLS

Education figures strongly in the immediate and long-term health of children. In South LA, 33.5% of the population is under 18 years of age. Only 62.4% of the population enrolled in SPA 6 (South LA) public high schools graduate, compared to 78.6% in West LA and 79.4% countywide.[xlv] In contrast, the percentage of the population in South LA that possesses a high school diploma (18.9%) is relatively similar to the overall county rate (19.9%). But while the data on educational achievement is compelling, it only tells part of the story. The school environment represents an equally potential risk to the development and educational achievement of children. For this reason, we go beyond the academic performance measures and examine the health and safety of school facilities.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Schools with substandard facilities (Williams schools) per total schools in the area[li]	**0.64**	0.30	0.08
LAUSD schools within 500 feet of a freeway per total schools in area[lii]	**0.06**	0.08	0.04

To assess the quality of a school, we applied the Williams schools designation. This designation is the result of a May 2000 class-action lawsuit filed against the State of California and the California Department of Education that contended these agencies failed to provide the basic educational resources of instructional materials, qualified teachers, and safe and decent school facilities. Under the settlement agreement reached in August 2004, some 2,200 public schools in California were deemed in violation of the basic standards codified in the Williams legislation and are subject to yearly monitoring.[100]

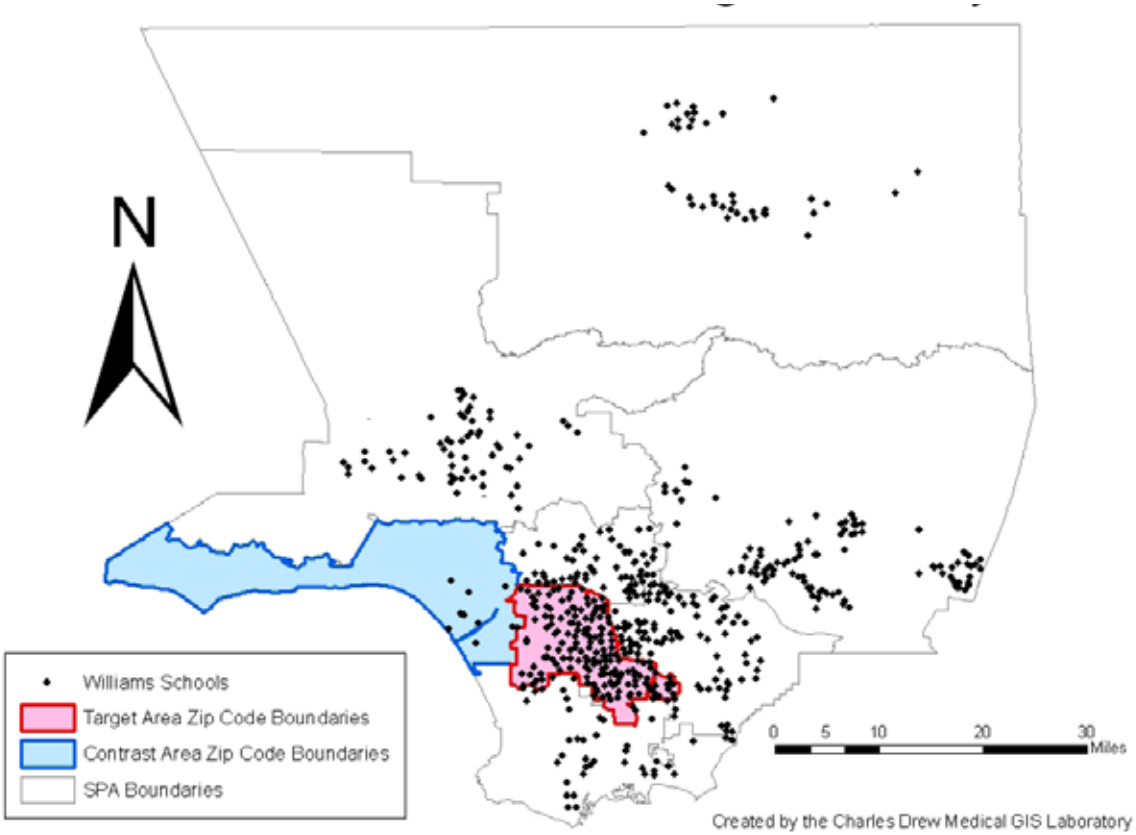
In LA County, 594 schools were identified in violation of Williams standards, with 176 or 30% of the schools located in the South LA area. West LA, by comparison, had only eight schools that were designated. As a percentage of total schools in each area, non-compliant schools comprise 64% of schools in South LA, 8% in West LA, and 30% in LA County overall, leading to a 111% difference between South LA and LA County and a 73% difference between West LA and LA County.

The state of South LA's schools contributes to less academic success and in turn bad health among residents. Low literacy, for example, which is concentrated among those with less education, may lead to ineffective communication with healthcare providers and lower quality of care. It has also been associated with negative health outcomes.[101] The link between health education attainment and poorer health status and outcomes is also well established. And, as noted previously in the report, education plays a role in preventing crime.

[li] Los Angeles County Office of Education, 2007 Reports of Williams Legislation Monitoring.

[lii] Schools in Proximity to Freeways, Presentation to the Facilities Committee. Los Angeles Unified School District Office of Environmental Health and Safety. 8 November 2007.

Figure19. Williams Schools in Los Angeles County



Beyond the ability of South LA schools to meet student educational requirements, the health of the physical environment of the school can trigger illness among students that inhibits learning. Asthma is one of the leading causes of school absenteeism. Studies show a link between residential proximity to traffic and freeways and children's health outcomes such as wheezing, asthma, and lung-function growth.[102,103,104] Based on this knowledge, state law now prohibits new schools from being built within 500 feet of a freeway although several loopholes exist. The number of schools within 500 feet of a freeway is 6% for schools in South LA, more than the 4% in West LA but less than the 8% for all LAUSD schools.

LAUSD is undergoing an unprecedented $19 billion effort to build new schools and modernize and repair existing facilities, resulting in 150 new schools and 70 school additions.[105] The district must confront the challenge of adhering to the 500 feet law when there is limited undeveloped land or the choice of potentially displacing families whose children attend the school.

RECOMMENDATIONS

The conditions and disparities in inner city schools are not intractable but require vigilant monitoring and reporting. On April 30, 2008, KNBC's investigation found 30 percent of the LAUSD schools tested (9 out of 30) had water with lead levels above what the government says is safe. To reduce these environmental risks, new school construction or modernization and repair projects for South LA Williams schools should be prioritized under the various school bond initiatives.

Primary prevention policies to address child asthma should focus on retrofitting school buses and diesel trucks, reducing vehicle emissions, increasing public transportation use, building bicycle and walking paths, and preventing idling of school buses. Secondary prevention approaches should include conditioning or filtering air in schools, limiting vehicles near schools, separating schools from roadways.[106] In line with its core design principles, local school districts should make every attempt to find alternatives to building near freeways and other pollutants such as industrial facilities or in places where air quality risk standards are exceeded.

POLICY RECOMMENDATION	ACCOUNTABLE AGENCY
Mandate completion of structural (retrofitting) improvements to comply with regulations related to indoor/outdoor air quality of all schools by a designated time.	▪ California Department of Education ▪ California State Legislature
Increase enforcement of the school-freeway distance with an extended public review period and mitigation measures if a school district requests an exception under the law.	▪ State Department of Education
Reduce the number of Williams Decile 1-3 South LA schools in the next 3 years by at least 33%.	▪ Los Angeles Unified School District and other City School Districts ▪ Los Angeles County Office of Education
Conduct state legislative hearings to examine status of corrective action, examine critical Williams schools issues and provide greater public accountability.	▪ California Department of Education ▪ California State Legislature

AIR & LAND QUALITY

Rail systems, freeways and air traffic from LAX airport crisscross South LA. The community is bordered by one of the largest urban oil fields (Baldwin Hills/ Inglewood Oil Field), refineries, LAX airport and peppered with an over-abundance of abandoned industrial sites, recycling centers, automotive body and repair shops and transportation depots. These characteristics influence the quality and safety of the region's land and air. Clean air, water and hazard free land are vital to an individual's and the community's health. To assess air and land quality, we examined the amount of industrialized/manufacturing zones, toxic waste sites ("brownfields"), and EPA-regulated facilities in South LA.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
Percent of industrial/manufacturing land by LA City region[liii]	**7.34**	6.21	1.97
Number of toxic waste (DTSC) sites per 100,000 population[liv]	**5.45**	5.82	3.23
Number of EPA-regulated (TRI) facilities per 1,000 population[lv]	**1.33**	1.83	1.77

Industrial or manufacturing-zoned land makes up the largest disparity in air and land quality. The following six classifications, taken from the Community General Plan Land Use Report, were used to define the percentage of industrial/manufacturing land by region: commercial manufacturing, limited manufacturing, limited industrial, light manufacturing, light industrial, and heavy manufacturing.[lvi] These areas include land that is zoned specifically for industrial purposes, as opposed to the other zoning categories of residential, commercial, and public facilities. The data for this measure are limited to LA City Planning Department Community Areas and exclude cities outside Los Angeles. The industrial-zoned land in South LA city planning areas is three times the area of West LA and slightly less than the overall city. In 2005, Los Angeles Mayor Antonio Villaraigosa issued a directive to the city planning department asking for recommendations to protect the city's limited industrial zones while balancing the need for affordable housing and alternative land uses. Currently, the City of Los Angeles has approximately 19,000 acres—or eight percent of total city land—zoned for industrial uses (excluding the Port of Los Angeles and Los Angeles International Airport).[107] Of this 8%, approximately 6% is reserved for manufacturing purposes and is heavily concentrated in the greater downtown Los Angeles city area.

The higher percentage of industrial/manufacturing land may speak to the historical concentration of heavy industrial and manufacturing businesses in South LA along Slauson Boulevard and other main arteries and does not accurately reflect current use. Several large industrial areas continue to exist, but are not in use or used for purposes other than previously zoned.

[liii] Community General Plan Land Use Report, Los Angeles City Planning Department, January 2008.

[liv] EnviroStor Database, California Department of Toxic Substances Control. http://www.envirostor.dtsc.ca.gov/public/ accessed June 20, 2008.

[lv] Envirofacts Data Warehouse, Environmental Protection Agency. http://www.epa.gov/enviro/ accessed June 20, 2008.

[lvi] City of Los Angeles Department of Planning and the Community Redevelopment Agency. Los Angeles' Industrial Land: Sustaining a Dynamic City Economy. December 2007.

Heavy manufacturing plants are one of the sources known to contribute to outdoor air pollution and potentially release toxic chemicals during production. Air pollution is known or suspected to cause cancer and is associated with other serious health conditions such as birth defects and asthma.[108] The effects of exposure to toxic chemicals released into air or land can be acute or accumulate over time, and many are known to cause cancer.[109] High temperature operations at industrial sources also contribute to nitrogen oxide, and short- and long-term air exposure is linked to respiratory illness.[110] Heavier industry, such as oil field production, uses equipment that releases a variety of pollutants from particulate matter to sulfur dioxide.[111]

Many other sources including vehicles and planes, dry cleaners and gas stations add to the list of pollutants in South LA.[112] To assess these sources and to identify more specifically the presence of toxic release among industry, we gathered data from state and federal regulatory databases for the county and the two study areas. The California Department of Toxic Substances' (DTSC) EnviroStor database tracks and identifies sites known to have contamination or sites that may need further investigation. It also identifies facilities that are permitted to handle hazardous waste. [lvii] In addition, because state and federal guidelines have differing threshold levels for reporting businesses, we also analyzed the EPA's Envirofacts database for facility information from a variety of environmental databases, including those tracking toxic chemical release sites, water discharge permit compliance, hazardous waste handling processes, and air emission estimates. [lviii] Though there may be some overlap between the two databases (DTSC EnviroStor and EPA Envirofacts), because California environmental policies establish higher thresholds than the federal EPA, many of the businesses that report to DTSC are not required to report to EPA.

Liberty Hill Foundation is working with researchers, environmental groups and local community residents in South LA, Pacoima, Van Nuys, the Figueroa corridor downtown, Boyle Heights, Maywood, Commerce and Wilmington to inventory potentially toxic and hazardous sites in neighborhoods. The effort, known as "ground truthing," is designed to provide an accurate picture of toxic and hazardous sites and how they affect the health of nearby communities.

The rate of DTSC sites per 100,000 population in South LA (5.45) is consistent, but slightly lower than LA County (5.82) overall. It is, however, almost twice the rate of West LA (3.23 per 100,000). There is a precipitous and somewhat contradictory drop for South LA in the number of less stringently federally-reported sites. This may be attributed either to under-reporting and or the decline in related businesses in the area. Further research is needed to validate this data.

[lvii] Department of Toxic Substances Control, EnviroStor Frequently Asked Questions and Answers.

[lviii] Environmental Protection Agency, Envirofacts Multi-system Query.

RECOMMENDATIONS

A number of state and federal agencies are responsible for monitoring environmental standards including the South Coast Air Quality Management District, State Water Resources Control Board and the EPA. More stringent regulation and policy changes at the federal and state levels have allowed better control and reduction of air and land pollutants.[113] This includes improved technology for garbage sites, industry and others to prevent release of contaminants. The EPA now stringently regulates and addresses land quality through the Superfund or CERCLA, which provides for the evaluation and cleanup of hazardous waste sites. While it is not yet clearly demonstrated that living near an industrial area is linked to adverse health outcomes because of the variances in each place, the potential risk is present and the City of LA has attempted to buffer residents with lighter industrial zones. However, this is not always possible where industry precedes a housing development. The Baldwin Hills community is organizing for a Community Standards District to regulate the planned expansion of oil drilling and production by the oil company PXP on land adjacent to the community as part of the environmental impact study required under the California Environmental Quality Act. The law was put in place to protect the environment in communities by allowing alternatives or mitigation through the EIR, but projects can still move forward even if specific hardships are demonstrated.[114] The public often is not aware of these processes and public hearings may go unnoticed or unattended.

Of equal concern is the lack of coordination by city agencies for the significant number of current projects and developments. This includes planning for transit corridors by MTA and DOT (Crenshaw-Prairie); mixed use and retail development within the nine South LA Redevelopment Project areas; the City of Los Angeles Department of Parks and Recreation strategic planning; and Baldwin Hills Park Master Plan, to name a few. Greater coordination or consolidation of the planning and redevelopment function may facilitate a more cohesive plan balancing economic and community health priorities. The community plan update through the planning departments should be used to strengthen existing standards and set limits on the occurrence of potentially hazardous sites on a geographic basis, including light manufacturing and repair shops subject to DTSC reporting.

Greater coordination is needed among the city planning departments of neighboring cities to provide uniform standards, measures and reporting of land use. Reporting of current land use should be improved at all levels of government with limits placed on local variances. As the need for more affordable housing and responsible mixed-use development encroaches upon industrially-zoned areas, design standards must be more strictly enforced.

POLICY RECOMMENDATIONS	ACCOUNTABLE AGENCY
Strengthen adherence to planning and design requirements for buffering and clean-up of heavy and light industrial use.	▪ LA City Planning and Zoning Administrator ▪ LA City Council ▪ LA City Redevelopment Agency
Establish a fund similar to the federal CERCLA or Superfund that imposes fees on businesses to be used for removal or other corrective responses.	▪ Los Angeles County Board of Supervisors ▪ California State Legislature
Strengthen coordination between responsible city departments to ensure more cohesive regional planning for parks, transportation, zoning, redevelopment and housing.	▪ LA City Planning and Zoning Administrator ▪ LA City Redevelopment Agency
Develop and implement a system to gather data and provide a set of indicators that accurately reflects air and land quality.	▪ AQMD ▪ California Department of Toxic Substances ▪ Environmental Protection Agency

NEXT STEPS

Although the disparities highlighted in the *South LA Health Equity Scorecard* are not new, national attention on the need for healthcare reform and the existence of several current local initiatives provide an opportunity "to get it right." More than any single finding documented in this report, the *Scorecard* is designed to demonstrate that the health of a community is not the sole responsibility or authority of the county or the healthcare sector. Rather, just as the health of the population is influenced by multiple factors in both the healthcare environment and the physical environment, so must the response to poor health outcomes address the universe of these influences.

Even agencies that don't typically see health as their responsibility have a powerful decision-making role that contributes to or diminishes health at a neighborhood, community and regional level. Local public health agencies across the country are starting to partner with urban planners, schools, businesses, and municipalities to focus on neighborhoods or "places" where many of the exposures to social determinants of health occur. Initiatives include, for example, rebuilding and expanding public housing to include recreational space such as bike paths and parks and increasing the number of affordable housing units throughout a community.

In the face of the current national economic crisis, greater attention must be given to the needs of the inner city as part of any economic stimulus or recovery plan if we are to avoid exacerbating inequities and prevent further erosion of the health of whole populations. These factors—highlighted by the *Scorecard* results—leave no doubt that the time for coordinated leadership and a comprehensive agenda for policy change is now. The recommendations outlined in this report are more than just the output of a project; they are a call for leadership and provide blueprints for an actionable agenda.

Success will require vision and forward thinking by policymakers and responsible agencies, along with a recognition that what works in one place may not work in another. The Mayor of Los Angeles recently released a South LA Strategic Initiative that opens a process of coordination among the various city departments to expedite a number of outstanding redevelopment projects and to support job creation. In cities such as Inglewood and Compton, as well as elsewhere in the region, there is increased development. However, the old political argument that "something, albeit inferior, is better than nothing" can no longer be tolerated. It is no longer in the best interests of the health of communities such as South LA to allow development or redevelopment in the absence or outside of a strategic plan for building a healthy community and sustainable economy. Job creation alone does not result in better access to quality services or community economic development. A job is not a job—part-time minimum wage jobs at fast-food restaurants or big box retailers do little to stimulate the re-entry of quality food retailers, better schools or to lift families out of poverty. An economic strategy is needed that not only stops the "leakage" of consumer spending but also results in the recirculation and reinvestment of dollars back into the community. Plans calling for higher housing density must be tempered by well-designed communities that support physical activity and disperse low-income housing in a rational and equitable manner.

This requires collaborative and strategic planning beyond any immediate project or sector initiative. The transportation agenda must support housing development; housing development must be supported and complemented by economic development and job creation. With redevelopment and increased density must come new opportunities for open space, improved infrastructure and additional support for education. The funding and resources are in place, but they need to be better aligned and leveraged with the benefit of the community foremost.

The process begins with a commitment to health equity. Health equity does not take away from one community to improve the condition of another. Health equity is the targeted reinvestment of economic, political and social capital in underserved communities to achieve parity. It is the dismantling of intentional, unintentional or absence of public, economic and institutional policies that isolate whole segments of the population from access and opportunity as we see in South LA. It is the proactive creation of access and opportunity by decision makers and the community.

The inequality in the health of South LA is a "condition" that goes beyond the limits of any single city and necessitates collaboration and cooperation at every level of government and across jurisdictions. County and city elected officials and their respective agencies must develop a joint power agreement that outlines a comprehensive plan to address the economic, social and political hurdles and that identifies benchmarks and performance standards for public accountability. There must be a targeted and strategic commitment of resources insulated from fluctuations in the budget process.

The efforts to achieve health equity must extend beyond the walls of City Hall and include the active participation of community, business and faith-based leadership. A great deal can be done at the community level. Despite a history of economic, social and political obstacles, the residents of South LA have demonstrated creativity, resilience and a great capacity for creating a community rich in assets in a desert of equitable public and private investment. The many coalitions, outstanding community- and faith-based organizations, and the network of neighborhood councils and associations should be tapped and engaged in this effort.

The Coalition for Health & Justice and the Disparities in Healthcare Advisory Committee have already agreed to push forward on the recommendations in the Scorecard pertaining to Primary and Preventive Care Access and Utilization. Having discussed and expanded the recommendations in great detail, these coalitions are mobilizing on a number of action items, such as a postcard campaign for an increase of county funding for safety-net clinics, a future partnership with health-educator training programs, and the publication of a South LA Health Resources Guide. These action items were carefully chosen and developed to improve one or more of the 12 indicators of South LA's deficient access to and utilization of primary and preventive care services. Both coalitions will be moving on these actions—and more—during the next year.

Much like the members of the Coalition for Health & Justice and the Disparities in Healthcare Advisory Committee, others attending the Policy Summit expressed interest in partnering with leaders working to eliminate disparities, either by conducting research or establishing connections for recommendations that lack an advocate. CHC is working with a number of the coalitions and groups through the publication of the *Scorecard* and establishment of a website to help provide greater public accountability and engagement. Our hope is that this report is only the beginning of a collaborative process, with every intention that in forthcoming editions the data will demonstrate progress achieved and thus a discernible improvement in the health of the South LA community.

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Scorecard Advisors:

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Marqueece Dawson, *Community Coalition*
Gloria Davis, *Girl's Club*
Angela Young-Brinn, *Healthy African American Families*
Janice French, *LA Best Babies*
Tonya Gorham, *LA Best Babies*
Jacquelyn Wilcoxen, *Los Angeles County Department of Mental Health*
Martina Travis, *Los Angeles County Department of Public Health*—SPA 6
Nicole Vick, *Los Angeles County Department of Public Health*—SPA 6
Dr. Ricky Bluthenthal, *RAND Corporation: Urban Community Research Center /Cal-State Dominquez Hills*
Genevieve Filmardirossian, *South Central Family Health Center*
Nina Vacarro, *Southside Coalition of Community Health Centers*
Jennifer Ito, *Strategic Concepts in Organizing and Policy Education*
T.H.E. Clinic
Alison Herrmann, *UCLA Center to Eliminate Health Disparities*
David Sloane, *USC School of Policy Planning and Development*
Dr. Roderick Seamster, *Watts Healthcare Corporation*

Data Collection:

California Department of Alcoholic Beverage Control
California Department of Toxic Substance Control
California Health Interview Survey
California Office of the Attorney General
California School Health Centers Association
Environmental Protection Agency
GreenInfo Network
Healthy City
LA City Planning Department
Los Angeles Police Department
LA County Department of Health Services
LA County Department of Mental Health
LA County Department of Public Health
LA County Department of Public Works
Los Angeles County Office of Education
Los Angeles Unified School District
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Charles Drew University

Editor: Janice Taylor, Communications Director, Community Health Councils
Data: Jonathan Nomachi, CHC; Photography: Korie Flournoy, CHC, and Robin Gilliam; Research: Sadio Woods, CHC
Interns: Anne Ferree, Lauren Frank, Jessica Jew, Ming Li, Katherine Mack, Nkechi Obioha
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APPENDIX 1: Data Sources, Notes and Known Limitations

As with all data collection and uses, limitations occur within this study. The *South Los Angeles Health Equity Scorecard* incorporates multiple data sources ranging from the widely-known US Census, LA County Health Survey, California Health Interview Survey, and Office of Statewide Health Planning and Development to specific data sets gathered from schools, planning departments, health service delivery agencies, state licensing bodies, etc. General data limitations that should be acknowledged include:

- **Scorecard data reflect multiple years and different methods of collection.** Every attempt was made to collect data across like years. However, the report incorporates data from multiple repositories with different data collection periods and methods. We could not utilize the same year on every indicator, nor can we assure consistency in the ways in which data were gathered.
- **Scorecard data in some cases are not available for the equivalent geographic area.** The boundaries of the study area were determined through zip codes, but much of the data was only available under other geographic boundaries such as cities or Service Planning Areas. In several cases, indicators and their data are for different geographic boundaries than the specified *Scorecard* target and contrast areas. One example of this is school proximity to freeways. Data were collected only from LAUSD; therefore data from other LA County school districts were excluded. Geographic boundaries are noted by indicator in Appendix 1.
- **Scorecard data are not computed for statistical significance and should not be represented as such.** Some data are statistically unreliable and noted accordingly**.**
- **Some data are duplicated among indicators.** For example, the supply of licensed acute psychiatric beds is the maximum number of psychiatric beds a hospital is licensed to operate at any time. Hospitals may be licensed to operate a certain number of beds, but this does not necessarily mean they have the physical and staff resources to occupy those beds with patients. The supply of licensed available beds represents the number of beds that can be staffed, equipped, and ready for use by a patient within 24 hours. Licensed available bed supply includes beds for all specialty services. Because of this, the supply of licensed acute psychiatric beds is included among the data. In these instances, data were averaged or weighted in an effort to offset duplication.

The tables below provide a full list of indicators, their data, and the scoring used for this *Scorecard*. Notations and explanations regarding the source, collection and limitations of specific indicators are at the end of the tables.

HEALTHCARE RESOURCES

Healthcare Facilities

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
General acute care hospitals per 100,000 population[1]	0.45	0.90	1.23	-0.45	0.33	-50%	36%
Emergency medical treatment stations per 100,000 population[2]	6.66	14.95	20.43	-8.29	5.48	-55%	37%
Bed supply per 1,000 population (averaged)	0.68	1.23	1.83	-0.55	0.60	-45%	49%
Licensed available bed supply per 1,000 population[3]	1.14	2.21	3.22				
Acute psychiatric bed supply per 1,000 population[4]	0.22	0.24	0.43				
Community clinic supply (DHS and PPP) per 1,000 uninsured population[5]	0.09	0.10	0.12	-0.01	0.03	-9%	28%
School-based health centers per 1,000 uninsured child population[6]	0.11	0.17	0.50	-0.06	0.33	-35%	201%
Mental health agencies per 100,000 population[7]	5.75	4.26	6.91	1.49	2.65	35%	62%
Pharmacies per 100,000 population[8]	7.72	15.14	21.81	-7.42	6.68	-49%	44%
Agencies that offer HIV/STD screenings per 100,000 population[9]	1.14	1.39	1.54	-0.25	0.15	-18%	11%
					AVERAGE	**-28%**	**59%**

Healthcare Workforce

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
General physicians' supply per 1,000 population[10]	0.12	0.54	1.27	-0.42	0.73	-78%	135%
Key specialists' supply per 100,000 population[10]	1.61	6.26	19.46	-4.65	13.19	-74%	211%
Oncologists per 100,000 population	0.08	1.37	4.92				
Cardiologists per 100,000 population	1.59	5.64	19.97				
OB/GYN supply per 100,000 population	3.18	11.79	33.49				
Pediatricians per 100,000 children[10]	11.06	57.24	193.05	-46.18	135.81	-81%	237%
General practice dentists per 100,000 population[10]	16.20	59.79	147.15	-43.60	87.36	-73%	146%
					AVERAGE	**-76%**	**182%**

Healthcare Financing

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
PPP dollars per uninsured person[11]	$27.12	$34.05	$65.36	-6.93	31.31	-20%	92%
Hospital uncompensated care per adjusted patient day[12]	$3338.94	$1008.66	$1024.87	-$2330.28	-$16.21	-231%	-2%
Hospital net revenue per adjusted patient day[13]	$1970.19	$1914.01	$2592.16	$56.18	$678.15	3%	35%
Hospital operating expense per adjusted patient day[13]	$2350.91	$2082.84	$2903.84	-$268.65	-$821.56	-13%	-39%
					AVERAGE	**-65%**	**22%**

Healthcare Coverage

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Percent of adults (18-64) who reported having no insurance (40%)[14]	30.4	21.8	11.8	-8.6	10.0	-39%	46%
Percent of children (0-17) who reported having no insurance (40%)[15]	10.7	8.3	4.0	-2.4	4.3	-29%	52%
Percent of adults (18-64) who do not have dental insurance (20%)[16]	42.6	37.3	40.0	-5.3	-2.7	-14%	-7%
					AVERAGE	**-30%**	**38%**

Primary and Preventive Care Access

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Percent of adults who reported having a regular source of care[14]	74.7	80.2	84.8	-5.5	4.6	-7%	6%
Percent of adults who reported easily obtaining medical care[14]	57.3	69.9	80.9	-12.6	11.0	-18%	16%
Percent of adults who could not afford dental care at least once in the past 12 months[14]	34.7	25.6	20.3	-9.1	5.3	-36%	21%
Percent of households with no vehicle[17]	21.2	12.6	8.1	-8.6	4.5	-68%	36%
Percent of ER hours spent in diversion a year[18]	29.2	15.4	7.1	-13.8	8.3	-90%	54%
ER visits that leave without being seen per 1,000 population[18]	10.2	11.6	8.2	1.36	3.4	12%	29%
					AVERAGE	**-34%**	**27%**

Primary and Preventive Care Utilization

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Percent of adults who reported ER use in the past 12 months[14]	25.9	21.7	19.3	-4.2	2.4	-19%	11%
Number of pap smears by PPP clinics per 1,000 uninsured adult women[19]	50.0	102.2	363.3	-52.1	261.1	-51%	256%
Number of mammograms by PPP clinics per 1,000 uninsured adult women[19]	34.4	41.2	168.8	-6.8	127.6	-17%	310%
Percent of men 40+ years who have never had a PSA test[16]	63.8	59.0	43.7	-4.8	15.3	-8%	26%
Percent of people 2+ years who have never been to a dentist[16]	7.8	5.3	4.7	-2.5	0.6	-47%	11%
Percent of population that saw a doctor at least once within the past year[16]	81.4	82.8	84.3	-1.4	1.5	-2%	2%
					AVERAGE	**-24%**	**103%**

HEALTHCARE ENVIRONMENT RESOURCES

	South LA	West LA
Healthcare Facilities	-28%	59%
Healthcare Workforce	-76%	182%
Healthcare Financing	-65%	22%
Healthcare Coverage	-30%	38%
Primary and Preventive Care Access	-34%	27%
Primary and Preventive Care Utilization	-24%	103%
TOTAL SCORE	**-43%**	**72%**

PHYSICAL ENVIRONMENT RESOURCES

Nutrition

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Liquor retail stores per sq. mi.[20]	8.51	1.56	1.97	-6.94	-0.41	-445%	-26%
Supermarkets (44,000+ sq. ft.) per sq. mi.[21]	0.10	0.05	0.14	0.04	0.09	86%	178%
Percent limited service restaurants[22]	71.80	47.70	40.80	-24.10	6.90	-51%	14%
Food facilities rated below "C" per sq. mi.[23]	0.21	0.05	0.03	-0.16	0.02	-320%	40%
Farmers' markets per sq. mi.[24]	0.06	0.02	0.08	0.04	0.06	200%	300%
					AVERAGE	**-106%**	**101%**

Physical Activity

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Percent of children whose parents reported they could easily get to a safe place to play[15]	74.7	83.1	85.1	-8.4	2.0	-10%	2%
Acres of green space / recreation areas per 1,000 population[25]	1.2	97.2	70.1	-95.93	-27.05	-99%	-28%
Miles of county bicycle lanes per 100,000 population[26]	0.42	0.97	1.92	-0.55	0.95	-56%	97%
					AVERAGE	**-55%**	**24%**

Public Safety

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Percent of adults who believe their neighborhoods are safe[14]	61.5	80.9	89.6	-19.4	8.7	-24%	11%
Traffic accidents per 1,000 population[27]	14.7	12.5	11.7	-2.2	0.9	-18%	7%
Crimes per 1,000 population[28]	19.0	17.5	16.8	-1.54	0.7	-9%	4%
Violent crimes (homicide, rape, robbery, aggravated assault) per 1,000 population	11.9	6.6	3.6				
Property crimes (burglary, car theft, larceny) per 1,000 population	26.2	28.4	30.1				
					AVERAGE	**-17%**	**7%**

Housing

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Percent of housing structures built before 1939[17]	18.1	12.9	13.3	-5.2	-0.4	-40%	-3%
Percent of occupied housing units that are overcrowded (1.0 or more occupants per room)[17]	36.8	22.9	7.9	-13.8	15.1	-60%	66%
Percent of owner-occupied housing units[29]	38.1	47.4	40.2	-9.3	-7.2	-20%	-15%
					AVERAGE	**-40%**	**16%**

Schools

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Schools with substandard facilities (Decile 1-3 Williams schools) per total schools in the area[30]	.64	0.30	0.08	-0.34	.22	-111%	73%
LAUSD schools within 500 ft. of a freeway per total schools in area[31]	0.06	0.08	0.04	0.02	0.04	25%	53%
					AVERAGE	**-43%**	**63%**

Air and Land Quality

	South LA	LA County	West LA	South LA Difference	West LA Difference	South LA Percent Difference	West LA Percent Difference
Percent of industrial/manufacturing zoned land by LA City region[32]	7.34	6.21	1.97	-1.13	4.24	-18%	68%
Number of toxic waste (DTSC) sites per 100,000 population[33]	5.45	5.82	3.23	0.37	2.59	6%	44%
Number of EPA-regulated facilities per 1,000 population[34]	1.33	1.83	1.77	0.50	0.06	27%	3%
					AVERAGE	**5%**	**39%**

PHYSICAL ENVIRONMENT RESOURCES

	South LA	West LA
Nutrition	-106%	101%
Physical Activity Options	-55%	24%
Public Safety	-17%	7%
Housing	-40%	16%
Schools	-43%	63%
Air and Land Quality	5%	39%
TOTAL SCORE	**-43%**	**42%**

Footnotes to Appendix 1

1 Office of Statewide Health Planning and Development (OSHPD), Hospital Listings, 2006. Only general acute care hospitals located in South LA zip codes and West LA zip codes were included.
2 OSHPD Hospital Annual Utilization Profile Report, 2006. EMS treatment station supply queried by hospitals located in South and West LA zip codes. LA County EMS treatment supply excludes non-reporting hospitals.
3 OSHPD Hospital Annual Financial Report, 2006. Available beds are the average daily complement of beds (excluding nursery bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Excludes beds placed in suspense or in nursing units converted to non-patient care uses which cannot be placed into services within 24 hours. Available bed supply queried by hospitals located in the South and West LA zip codes. LA County bed supply excludes non-reporting hospitals. Available bed supply in South LA excludes Promise Hospital of East Los Angeles-Suburban Campus due to non-comparable reporting.
4 OSHPD Hospital Annual Utilization Profile Report, 2006. Acute psychiatric beds are beds licensed specifically for psychiatric patients. Licensed acute psychiatric bed supply queried by hospitals located in the South and West LA zip codes.
5 Los Angeles County Department of Health Services (LADHS), Office of Planning and Analysis, 2007. Community clinic supply includes all PPP clinic sites and DHS health centers and comprehensive health centers located in the South and West LA zip codes.
6 California School Health Centers Association, 2007. School-based health centers queried by South and West LA zip codes.
7 Los Angeles County Department of Mental Health (LADMH), Planning Division, 2007. Mental health agencies include DMH facilities and DMH-contracted facilities. Numbers are for Service Planning Areas (SPA) 6 and 5.
8 Personal research of Arleen F. Brown, UCLA Department of Medicine, Division of General Internal Medicine and Health Services Research, 2007. South LA numbers are for SPA 6 and the additional zip codes for Hawthorne (90250) and Inglewood (90301, 90302, 90303, 90304, 90305). West LA numbers are for SPA 5.
9 HIV LA Consumer Director, Office of Aids Program and Policy. http://www.hivla.org/search.cfm. Accessed March 4, 2008. Queried by South and West LA zip codes.
10 Medical Marketing Services, Inc., 2007. General practice physicians' supply includes family practice, general practice, general preventive medicine, and internal medicine. OB/GYN supply includes gynecology, obstetrics, and obstetrics and gynecology. Physician and dentist supply queried by office- and hospital-based physicians and dentists located in South and West LA zip codes.
11 LADHS Office of Planning and Analysis, 2007. PPP dollars are for Fiscal Year 2006-2007.
12 OSHPD Hospital Annual Financial Profile Report, 2006. Uncompensated care costs include charity care, county indigent program care, and bad debt care. Uncompensated care costs exclude Promise Hospital of East Los Angeles-Suburban campus in South LA and Kaiser Foundation Hospital-West LA in West LA due to non-comparable reporting. Costs aggregated by hospitals located in South and West LA zip codes. LA County costs exclude non-reporting hospitals.
13 OSHPD Hospital Annual Financial Profile Report, 2006. Net revenue and operating expenses queried by hospitals located in South and West LA zip codes. Excludes Promise Hospital of East Los Angeles-Suburban Campus in South LA and Kaiser Foundation Hospital-West LA in West LA due to non-comparable reporting. LA County excludes non-reporting hospitals.
14 Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 8,648 Los Angeles County adults, representative of the population in Los Angeles County. South LA numbers are for SPA 6 and the additional zip codes for Hawthorne (90250) and Inglewood (90301, 90302, 90303, 90304, 90305). West LA numbers are for SPA 5.
15 Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 6,032 parents/guardians of children 0-17 years representative of the population in Los Angeles County. South LA numbers are for SPA 6 and the additional zip codes for Hawthorne (90250) and Inglewood (90301, 90302, 90303, 90304, 90305). West LA numbers are for SPA 5.
16 California Health Interview Survey, 2003. http://www.chis.ucla.edu/. Data are for SPA 5 and 6 boundaries.
17 United States Census Bureau, Census 2000, Summary File 3. Households queried by zip codes in South and West LA.
18 OSHPD Hospital Annual Utilization Profile Report, 2006. ER diversion hours and visits that leave without being seen queried by hospitals located in South and West LA zip codes. LA County excludes non-reporting hospitals.
19 OSHPD Clinic Annual Utilization Profile Report, 2006. Pap smears and mammograms queried by the PPP clinics located in South and West LA zip codes. All areas exclude non-reporting clinics.
20 License Query System – Reports. Sacramento, CA: California Department of Alcoholic Beverage Control; 2007. http://www.abc.ca.gov/datport/AHCountyZIP.asp//. Accessed October 2007. Licenses queried by South and West LA zip codes.
21 ReferenceUSA Business Database. Omaha, NE: ReferenceUSA; 2007. http://www.referenceusa.com/. Accessed March 30, 2008. Business listings queried by South and West LA zip codes.
22 United States Census Bureau, 2002 Economic Census Data. Limited service restaurants queried by South and West LA zip codes.
23 Food Facility Rating List. Baldwin Park, CA; Los Angeles County Department of Public Health, Environmental Health; 2007. http://www.lapublichealth.org/rating/. Accessed November 15, 2007. Food facilities queried by South and West LA zip codes.
24 Certified Farmers' Markets in Los Angeles County. Hollywood, CA: See-LA, 2008. http://www.farmernet.com/events/cfms. Accessed November 7, 2007. Farmers' markets queried by South and West LA zip codes.

25 GreenInfo Network, 2008. Includes parks, open space, recreation areas, green space. Information queried by South and West LA zip codes.
26 LA County Department of Public Works, Programs Development Division, 2007. Includes Class I, II and III bicycle lanes maintained by the County of Los Angeles and queried by South and West LA zip codes.
27 2005 Statistical Digest. Los Angeles Police Department, Information Technology Division, Management Report Unit. Data are for the City of Los Angeles. South LA City accidents queried by Newton, Southwest, and 77th Street Community Police Stations; west LA City accidents queried by West LA and Pacific Community Police Stations.
28 2005 Criminal Justice Profile. California Department of Justice, Criminal Justice Statistics Center. Data queried by jurisdiction. LA City data queried by Community Police Stations (see reference 27) from the 2005 Statistical Digest. These numbers are reported to the Criminal Justice Statistics Center.
29 United Way of Greater Los Angeles, Zip Code Data Book Service Planning Area 5, 6 and 8. May 2007. Data queried by zip codes for South and West LA.
30 Williams Settlement Legislation 2007 Annual Report. Los Angeles County Office of Education. Decile 1-3 Williams schools queried by South and West LA zip codes. Total schools in South and West LA zip codes from the National Center for Education Statistics, http://nces.edu.gov/index.asp. Accessed June 2008.
31 Schools in Proximity to Freeways, November 2007. Los Angeles Unified School District Office of Environmental Health and Safety. Schools queried by South and West LA zip codes. Data are for LAUSD schools only.
32 Community General Plan Land Use Report, January 2008. Los Angeles City Planning Department. Zones include commercial manufacturing, limited manufacturing, limited industrial, light manufacturing, light industrial and heavy manufacturing. South and west LA City regions include Community Plan Areas South Los Angeles, Southeast Los Angeles, and West Adams-Baldwin Hills-Leimert for south LA City; Bel Air-Beverly Crest, Brentwood-Pacific Palisades, Palms-Mar Vista-Del Rey, Venice, West Los Angeles, Westchester-Playa del Rey, and Westwood for west LA City.
33 EnviroStor Database. California Department of Toxic Substance Control. http://www.envirostore.dtsc.ca.gov/public/. Accessed November 7, 2007. Toxic sites queried by South and West LA zip codes.
34 Envirofacts Database. Environment Protection Agency. http://www.epa.gov/enviro/html/multisystem.html. Accessed January 11, 2008. Envirofacts sites queried by South and West LA zip codes.

Appendix 2: Scoring Methodology

The data for this *Scorecard* are organized into two domains: Healthcare Environment Resources and Physical Environment Resources. Each domain consists of six sub-domains with several indicators (see Appendix 1 for a complete list). Each indicator is scored based on the percent difference between the target area (South LA) and the LA County baseline. For comparison, we also provide the percent difference between a contrast area (West LA) and the LA County baseline.

Each indicator was first identified as a positive or negative factor. Positive indicators are those seen as assets to the community; we would like to see an increase in those areas. Negative indicators are those that hurt the community and should be reduced. For example, within the housing sub-domain, the percent of owner-occupied housing units is seen as positive: home ownership is a sign of economic investment and long-term wealth. The percent of overcrowded housing units, however, is seen as a negative, and in the future we hope to decrease this number.

In calculating the distance of the target and contrast areas to the LA County baseline, we needed to address the mixture of positive and negative indicators in our *Scorecard*. We did this by calculating the difference so that the higher number is always better.

For example, in South LA, 38.1% of housing units are occupied by their owners. In West LA, 40.2% of housing units are occupied by their owners. LA County overall has the highest number of owner-occupied housing units at 47.4%. Hence the county is performing better than the target and contrast areas. The calculation is executed by subtracting LA County from South and West LA.

PERCENT OF OWNER-OCCUPIED HOUSING UNITS

		South LA		LA County Baseline		
South LA Difference	=	38.1	—	47.4	=	-9.3
		West LA		LA County Baseline		
West LA Difference	=	40.2	—	47.4	=	-7.2

For negative indicators, the score is calculated by subtracting South LA/West LA from the LA County baseline.

PERCENT OF OVERCROWDED HOUSING UNITS

		LA County Baseline		South LA		
South LA Difference	=	23.0	—	36.8	=	-13.8
		LA County Baseline		West LA		
West LA Difference	=	23.0	—	7.9	=	15.1

Each indicator was then divided by the LA County baseline to find the percent difference.

PERCENT OF OWNER-OCCUPIED HOUSING UNITS

		South LA Difference		LA County Baseline		
South LA Percent Difference	=	-9.3	÷	47.4	=	-19.6%
		West LA Difference		LA County Baseline		
West LA Percent Difference	=	-7.2	÷	47.4	=	-15.2%

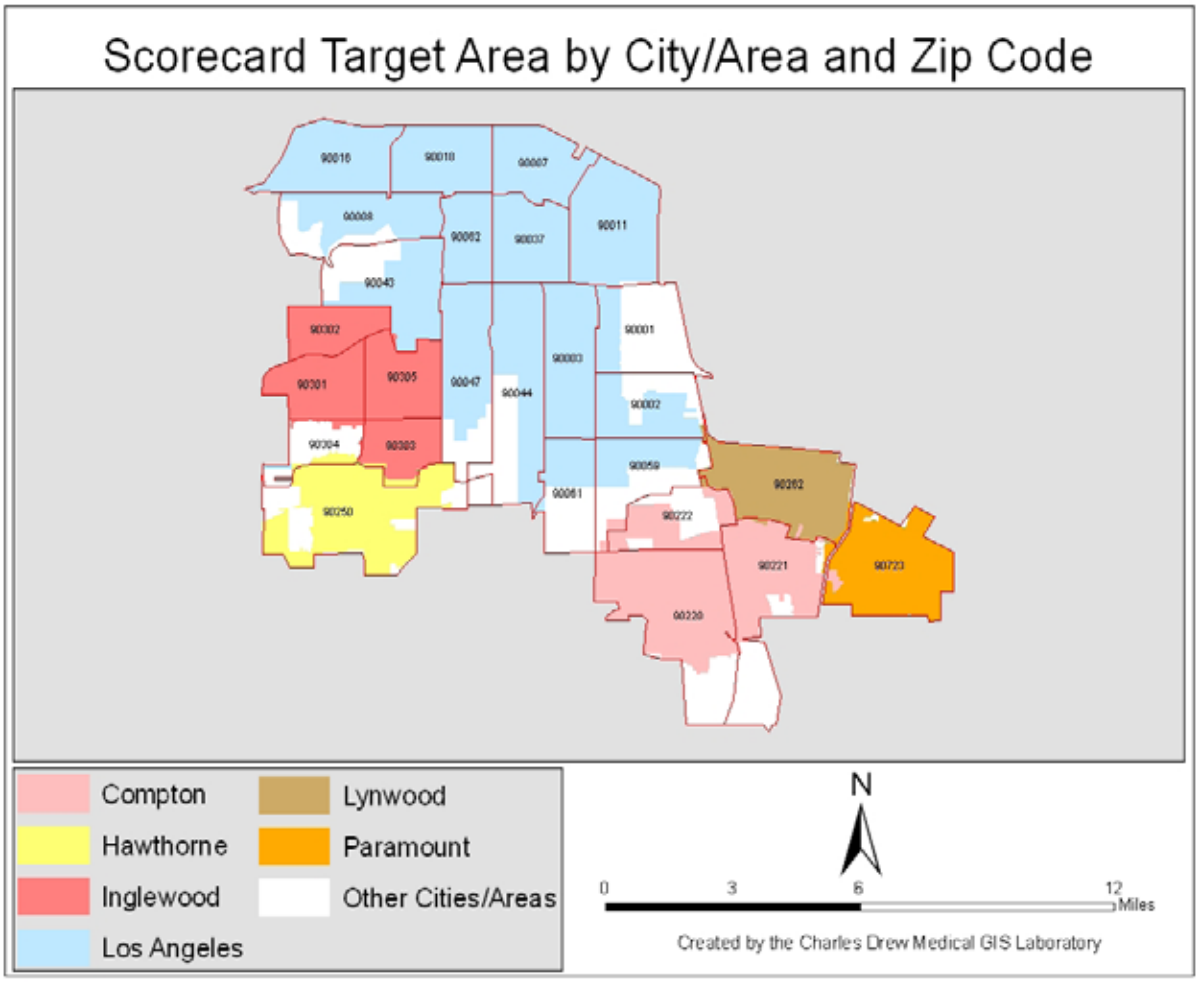
PERCENT OF OVERCROWDED HOUSING UNITS

		South LA Difference		LA County Baseline		
South LA Percent Difference	=	-13.8	÷	23.0	=	-60%
		West LA Difference		LA County Baseline		
West LA Percent Difference	=	15.1	÷	23.0	=	65.6%

To provide equal significance to each indicator and offset data limitations, indicators were weighted in several different ways. In some cases, weighting occurred before the percent difference was calculated. With the supply of hospital beds, for example, the number of licensed available beds overlaps the number of licensed acute psychiatric beds. For that reason, we averaged the results of the two indicators and used that average to calculate the percent difference. In other cases, weighting was done after the percent differences were calculated. Within the Healthcare Coverage sub-domain, we weighted the percent of uninsured adults and the percent of uninsured children as twice that of the percent of adults without dental insurance. While we agree that dental insurance and the resulting oral health are critical to overall health, our priorities lie with expanding comprehensive benefits (including mental health, vision, dental coverage) under healthcare coverage.

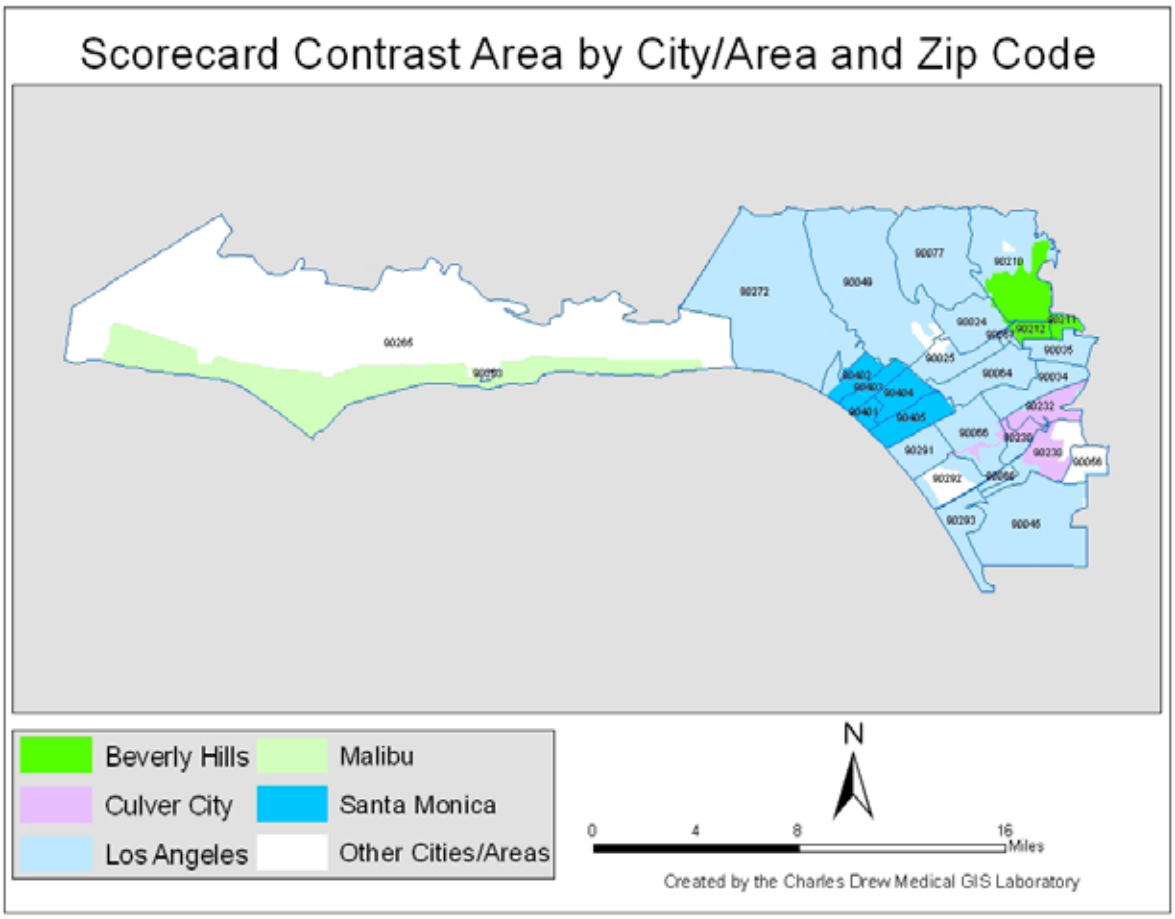
Each of the percent differences was averaged to obtain sub-domain scores, and then averaged once again to find a total domain score for both Healthcare Environment Resources and Physical Environment Resources. These scores are presented in the *Scorecard* report.

Appendix 3: Maps and Zip Codes of Study Areas



South LA Zip Codes, Cities and Communities[1]

90001 – South Central LA/Co.
90002 – South Central LA/Co.
90003 – South Central LA
90007 – University LA
90008 – Crenshaw LA/Co.
90011 – University LA
90016 – Crenshaw LA
90018 – University LA
90037 – University LA
90043 – Crenshaw LA/Co.
90044 – South Central LA/Co.
90047 – South Central LA/Co.
90059 – South Central LA/Co.
90061 – West Compton LA/Co.
90062 – University LA
90220 – Compton
90221 – Compton
90222 – Compton
90262 – Lynwood
90723 – Paramount
90301 – Inglewood
90302 – Inglewood
90303 – Inglewood
90304 – Inglewood (Lennox)
90305 – Inglewood
90250 – Hawthorne



West LA Zip Codes, Cities and Communities[1]

90024 – West L.A. LA
90025 – West L.A. LA
90034 – West L.A. LA
90035 – West L.A. LA
90045 – Westchester LA
90049 – Brentwood LA
90056 – Culver City/Ladera
90064 – West L.A. LA
90066 – Venice/Mar Vista LA
90067 – West L.A. LA
90077 – Bel Air LA
90210 – Beverly Hills
90211 – Beverly Hills
90212 – Beverly Hills
90230 – Culver City/Ladera
90232 – Culver City/Ladera
90263 – Malibu
90265 – Malibu
90272 – Pacific Palisades LA
90291 – Venice/Mar Vista LA
90292 – Venice/Mar Vista LA/Co.
90293 – Playa del Rey LA
90401 – Santa Monica
90402 – Santa Monica
90403 – Santa Monica
90404 – Santa Monica
90405 – Santa Monica

1 Communities in the City of Los Angeles are followed by "LA" and areas that include portions of the City of Los Angeles and unincorporated County areas are followed by "LA/Co." Other incorporated cities and unincorporated communities are identified by name. See United Way Zip Code Data Book.

Appendix 4: Table of Community Profile Measures

	SOUTH LA		LA COUNTY		WEST LA	
	2000	2005	2000	2005	2000	2005
Total Population[1]	1,241,699	1,321,180	9,518,361	10,088,274	621,338	651,084
Population density – persons per sq. mi.[1]	11,759	13,996	2,332	2,472	2,775	3,087
Population growth	--	6.4%	--	6.0%	--	4.8%
Median age[1]	n/a	n/a	32.0	n/a	n/a	n/a
Race – Percent White[1]	3.8	3.3	31.1	28.9	62.3	61.3
Race – Percent Latino[1]	57.4	62.4	44.6	47.0	16.1	16.6
Race – Percent Black[1]	35.2	31.0	9.5	9.0	6.8	7.0
Race – Percent American Indian[1]	0.2	0.2	0.3	0.3	0.2	0.2
Race – Percent Asian/Pacific Islander[1]	2.0	1.9	12.1	12.5	10.7	11.4
Race- Percent Other[1]	0.2	0.2	0.2	0.2	0.4	0.4
Race- Percent Two or more[1]	1.2	1.0	2.3	2.0	3.5	3.1
Nativity - Percent Foreign born[1]	35.6	n/a	36.2	n/a	28.2	n/a
Home language – Percent English[1]	43.4	43.2	45.9	45.8	65.3	65.2
Median household income[1]	$27,303†	n/a	$42,189	$48,248	$60,464†	n/a
Percent unemployment in civilian labor force[1]	14.1†	n/a	8.2	n/a	6.1†	n/a
Percent with high school degree/ equivalency[1]	19.8	19.7	18.8	18.8	12.3	12.3
Percent with a Bachelor's degree[1]	5.7	7.3	16.1	15.9	29.8	29.8
Percent families below 200% FPL[2]	61.5	60.0	37.7	36.8	26.5	25.3

†Denotes that data are for Service Planning Areas 5 and 6.

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1 United Way of Greater Los Angeles, Zip Code Data Book Service Planning Area 5, 6 and 8. February 2003 and May 2007. Data aggregated by zip codes for South and West LA.

2 Los Angeles County Department of Public Health. Extracted from July 1, 2005 Population Estimates prepared by Walter R. McDonald & Associates, Inc. (WRMA) for Urban Research, LA County CEO, released 5/18/2007.

Appendix 5: Table of Health Status Outcomes

MEASURE	INDICATOR	SOUTH LA		LA COUNTY		WEST LA	
		2000	2005	2000	2005	2000	2005
PRENATAL HEALTH	Percent of live births by mothers who received late or no prenatal care[1]	14.7	11.7	12.5	9.2	6.3	4.2
	Percent of low birth-weight live births[1]	7.4	8.1	6.4	7.3	6.8	7.7
	Rate of live births by mothers ages 15-19 years per 1,000 live births[1]	151.4	135.4	105.5	92.8	29.2	19.0
	Rate of infant mortality per 1,000 live births[1]	6.9	5.7	4.9	5.0	1.9	2.6
CHILDHOOD HEALTH	Number of children 5 years and under with elevated blood lead levels per 1,000 child population[2]	n/a	1.3	n/a	0.6	n/a	0.4
	Percent of children ages 0-17 years with asthma[3]	n/a	8.6	n/a	8.8	n/a	4.9*
SEXUALLY TRANSMITTED DISEASE	Incidence of AIDS (newly diagnosed cases) per 100,000 population[4]	20.2	15.1	18.5	12.0	10.8	7.0
	Rate of chlamydia (per 100,000 population)[5]	n/a	929.1	n/a	413.4	n/a	198.6
SEXUALLY TRANSMITTED DISEASE	Rate of gonorrhea (per 100,000 population)[5]	n/a	308.2	n/a	108.0	n/a	69.8
	Rate of early syphilis (per 100,000 population)[5]	n/a	17.4	n/a	15.9	n/a	10.8
OBESITY	Percent of obese adults[6]	23.1	28.9	16.7	20.9	10.9	14.1
	Percent of obese children[7]	25.1	28.8	20.4	23.3	17.0	17.6
DIABETES	Percent of adults diagnosed with diabetes[6]	8.1	11.1	6.7	8.1	4.7	4.5
	Diabetes death rate (age-adjusted per 100,000 population)[8]	39.5	42.7	24.0	26.5	12.0	14.0
LIVER DISEASE	Liver disease death rate (age-adjusted per 100,000 population)[8]	17.8	13.9	14.0	11.3	9.0	5.8
CARDIOVASCULAR DISEASE	Percent of adults diagnosed with hypertension[6]	20.6	28.2	19.1	23.4	15.0	16.8
	Coronary heart disease death rate (age-adjusted per 100,000 population)[8]	274.5	214.4	220.0	173.7	179.0	127.7
	Stroke death rate (age-adjusted per 100,000 population)[8]	78.2	56.9	57.0	43.4	53.0	43.0
CANCER	Lung cancer death rate (age-adjusted per 100,000 population)[8]	49.9	43.7	41.0	35.5	35.0	31.0
	Breast cancer death rate (age-adjusted per 100,000 population)[8]	26.6	27.8	24.0	23.3	25.0	25.1
	Prostate cancer death rate (age-adjusted per 100,000 population)[8]	39.6	40.2	24.9	23.4	21.5	22.2
	Cancer death rate (age-adjusted per 100,000 population)[8]	206.8	185.7	169.8	158.2	159.0	151.9

MEASURE	INDICATOR	SOUTH LA		LA COUNTY		WEST LA	
		2000	2005	2000	2005	2000	2005
VIOLENCE AND ACCIDENTS	Crude mortality rate from homicide in persons 15-44 years per 100,000 population[8]	53.5	59.6	17.9	19.5	*	8.2
	Motor vehicle crash death rate (age-adjusted per 100,000 population)[8]	10.1	9.6	9.0	9.3	7.0	5.7
MENTAL ILLNESS	Percent of adults diagnosed with depression[6]	7.2	11.8	8.8	12.9	8.8	16.6
ACUITY OF ILLNESS	Average length of stay at a hospital[9]	5.5	10.7	5.0	4.9	12.1	9.9
BEHAVIORAL RISK FACTORS	Percent of adults who reported consuming 5+ fruits and vegetables a day[6]	9.4	11.2	11.6	14.6	13.2	19.4
	Percent of adults who reported being physically active[6]	n/a	45.9	n/a	51.8	n/a	61.9
	Percent of adults who smoke cigarettes[6]	20.0	17.1	18.1	14.6	19.2	13.3
	Percent of adults who reported binge drinking in the past month[6]	9.3	14.0	8.7	17.3	10.6	17.4

*Data is statistically unstable.

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1 California Department of Health Services, Center for Health Statistics, Vital Statistics, 1999-2005. Received from the Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

2 Number of children 5 years and under with elevated blood lead levels received from the Los Angeles County Department of Public Health, Childhood Lead Poisoning Prevention Program, 2005. Population estimates for children 5 years and under from 2005 Los Angeles County Health Survey, Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Estimates are based on self-reported data by a random sample of 6,032 parents/guardians of children 0-17 years, representative of the population in Los Angeles County. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

3 Los Angeles County Health Survey, LACHS 2005 Survey, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Estimates are based on self-reported data by a random sample of 6,032 parents/guardians of children 0-17 years, representative of the population in Los Angeles County. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

4 Los Angeles County Department of Public Health, HIV Epidemiology Program, 2005. Population estimates from the Zip Code Data Book, United Way of Greater Los Angeles, 2007. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

5 Los Angeles County Department of Public Health, Sexually Transmitted Disease Program, 2006 Sexually Transmitted Disease Morbidity Report, Vol. 2: Service Planning Areas. Data for South and West LA are for SPA 5 and 6.

6 Los Angeles County Health Survey, LACHS 1999 & 2005 Surveys, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. 1999 estimates are based on self-reported data by a random sample of 8,354 Los Angeles County adults, representative of the population in Los Angeles County. 2005 estimates are based on self-reported data by a random sample of 8,648 Los Angeles County adults, representative of the population in Los Angeles County. 1999 estimates are used for the year 2000 in the data tables. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

7 Los Angeles County public schoolchildren, grades 5, 7, and 9. Prepared by Los Angeles County Department of Public Health, the Office of Health Assessment and Epidemiology, Epidemiology Unit, from data obtained from the 1999 and 2005 California Physical Fitness Testing Program, respectively, California Department of Education. 1999 estimates are used for the year 2000 in the data tables. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

8 1999-2005 Linked Mortality Files for Los Angeles County from the California Death Statistical Master Files, compiled by Data Collection and Analysis Unit, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. Data for South LA include SPA 6 plus selected zip codes (90250, 90301, 90302, 90303, 90304, 90305). Data for West LA are for SPA 5.

9 Office of Statewide Health Planning and Development, Hospital Annual Utilization Profile Report, 2006. Only general acute care hospitals located in South LA zip codes and West LA Zip codes were included.

Appendix 6: Bibliography

1 Diabetes: Disabling Disease to Double by 2050. *At a Glance*. US Department of Health and Human Services, Centers for Disease Control and Prevention. September 2008.

2 Diabetes on the Rise in Los Angeles County Adults. *LA Health Trends*. Los Angeles County Department of Public Health. August 2007.

3 Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press. 2003.

4 NCHS Data Warehouse. Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention; 2008. http://www.cdc.gov/nchs/datawh.htm. Accessed August 2008.

5 The Uninsured and the Difference Health Insurance Makes. *Key Facts*. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, September 2008.

6 Hospital Closures in California 1996 to Present as of September 2006. California Hospital Association. http://www.calhealth.org/public/press/Article%5C107%5CHospitalclosures.pdf. Accessed September 2008.

7 Career Guide to Industries. US Department of Labor, Bureau of Labor Statistics. http://www.bls.gov/oco/cg/cgs035.htm. Accessed October 8, 2008.

8 Wennberg J, Cooper M. *The Dartmouth Atlas of Health Care in the United States.* The Center for Evaluative Sciences, Dartmouth Medical School. 1998.

9 Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: Assessing the evidence. *Health Affairs*. 2005; W5-97 – W5-107.

10 Bazzoli G, Brewster G, Liu G, Kuo S. Does US hospital capacity need to be expanded? *Health Affairs*. 2005; 22(6): 40-54.

11 Andrulis D, Duchon L. The changing landscape of hospital capacity in large cities and suburbs: Implications for the safety net in metropolitan America. *Journal of Urban Health*. 2007; 84(3): 400-414.

12 Guo JJ, Jang R, Keller KN et al. Impact of school-based health centers on children with asthma. *Journal of Adolescent Health.* 2005; (37): 266-274.

13 Webber MP, Carpiniello KE, Oruwariye T et al. Burden of asthma in inner-city elementary schoolchildren: Do school-based health centers make a difference? *Archives of Pediatrics and Adolescent Medicine*. 2003; (157): 125-127.

14 Choe HM, Mitrovich S, Dubay D et al. Proactive case management of high-risk patients with Type 2 diabetes mellitus by a clinical pharmacist: A randomized controlled trial. *The American Journal of Managed Care*. 2005; 11(4): 253-260.

15 Knapp K, Ray M, Law A, Okamoto M, Chang P. The Role of Community Pharmacies in Diabetes Care: Eight Case Studies. California HealthCare Foundation. 2005.

16 Penfil B, Mertz E. *The Pharmacy Safety Net in California.* The Center for Health Professions, University of California, San Francisco. 2005.

17 Hadley J, Cunningham P. Availability of safety net provider and access to care of uninsured person. *Health Services Research.* 2004; 39(5): 1527-1547.

18 Miranda J, McGuire T, Williams D, Wang P. Mental health in the context of health disparities. *Am J Psychiatry*. 2008; 165(9): 1102-1108.

19 Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas. Council on Graduate Medical Education, 1998.

20 Althouse L, Stockman, J. Pediatric workforce: A look at general pediatrics data from the American Board of Pediatrics. *Journal of Pediatrics*. 2005; (48): 166-169.

21 Shi L, Macinko J, Starfield B et al. The relationship between primary care, income inequality and mortality in United States, 1980-1995. *Journal of the American Board of Family Practice*. 2003; 16(5): 412-422.

22 Kim J, Amar S. Periodontal disease and systemic conditions: A bidirectional relationship. *Odontology.* 2006; 94(1): 10-21.

23 Pourat N. Haves and Have-Nots; A Look at Children's Use of Dental Care in California. California HealthCare Foundation. 2008.

24 Ko M, Heslin K, Edelstein R, Grumbach K. The role of medical education in reducing health care disparities: The first ten years of the UCLA/Drew Education Program. *Journal of General Internal Medicine*. 2007; 22:625-631.

25 LA Health Action, http://lahealthaction.org/index.php/collaborative/committees/C82/. Accessed October 2008.

26 The Financial Health of California Hospitals, California HealthCare Foundation, 2007.

27 King-Harbor Closure Hospital Inpatient Impact Analysis. National Health Foundation, Hospital Association of Southern California. 2008.

28 Medicaid Payments per Enrollee, FY2005 http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4&sub=47&yr=28&typ=4&o=d&rgnhl=6

29 California Medical Assistance Commission, Annual Report to the Legislature 2003.

30 Public-Private Partnership Allocation Formula Working Group Report and Recommendations, LA County Chief Executive Office Memorandum to the Board of Supervisors, April 17, 2008.

31 DeNavas-Walt C, Proctor B, Smith J. US Census Bureau, Current Population Reports, P60-235, Income, Poverty, and Health Insurance Coverage in the United States: 2007. US Government Printing Office, Washington, DC. 2008.

32 Current Population Survey, 2007 and 2008 Annual Social Economic Supplements. US Census Bureau.

33 Insuring America's Health: Principles and Recommendations. Institute of Medicine, Committee on the Consequences of Uninsurance. 2004.

34 Dying for Coverage in California. Families USA. 2008.

35 Fronstin P. Sources of Health Insurance and Characteristics of the Uninsured : Analysis of the March 2006 Current Population Survey. Employee Benefit Research Institute Issue Brief #298. 2006.

36 Makuc D, Freid V, Parsons PE. Health insurance and cancer screening among women. National Center for Health Statistics, Center for Disease Control and Prevention. 1994.

37 Haas J, Lee L, Kaplan C et al. The association of race, socioeconomic status, and health insurance status with the prevalence of overweight among children and adolescents. *American Journal of Public Health*. 2003; 93(12): 2105-2110.

38 Ferris T, Blumenthal D, Woodruff P, Clark S, Camargo C. Insurance and quality of care for adults with acute asthma. *Journal of General Internal Medicine*. 2002; 17: 905-913.

39 Primary Care Professionals: Recent Supply Trends, Projections and Valuations of Services. Testimony of A. Bruce Steinwald before the Committee on Health, Education, Labor and Pensions, United States Senate. US Government Accountability Office, GAO-08-472T. 2008.

40 Donaldson M, Yordy K, Lohr K, Vanselow N. Primary Care: America's Health in a New Era, Committee on Future of Primary Care, Institute of Medicine. National Academies Press. 1996.

41 Overuse of Emergency Departments Among Insured Californians. California HealthCare Foundation. 2006.

42 Pitts S, Niska R, Xu J, Burt C. National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary, National Health Statistics Reports, No. 7. Hyattsville, MD: National Center for Health Statistics. 2008.

43 Update on the emergency department at Harbor-UCLA Medical Center, Memorandum to the Board of Supervisors. February 19, 2008.

44 Burt C, McCaig L. Staffing, capacity and ambulance diversion in emergency departments: United States, 2003-04. Advance Data From Vital and Health Statistics. 2006.

45 Probst J, Laditka S, Wang J, Johnson A. Effects of resident and race on burden of travel for care: cross sectional analysis of the 2001 US National household Travel Survey. *Health Services Research*. 2007; 7(40).

46 Consent Decree Compliance Campaign: Overview and Demands. Bus Riders Union. Accessed at http://www.busridersunion.org/engli/Campaigs/consentdecreeoverview.htm. on September 2008.

47 Devoe J, Fryer G, Phillips R, Green L. Receipt of preventive care among adults: Insurance status and usual source of care. *American Journal of Public Health*. 2003; 95(5):786-791.

48 Key Indicators of Health. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. April 2007.

49 Zuckerman S, Lutzky A. The Medicaid Demonstration Project in Los Angeles County, 1995-2000: Progress, but Room for Improvement. The Urban Institute. 2001.

50 Geerts S, Nys M, Patrick D et al. Systemic release of endotoxins induced by gentle mastication: Association with periodontitis severity. *Journal of Periodontology*. 2002; 73(1): 73-78.

51 Diamante A, Hays R, Morales L et al. Delays and unmet need for health care among adult primary care patients in a restructured urban public health setting. *American Journal of Public Health*. 2004; 95(5): 783-789.

52 LA Health Action, Examining County-funded Outpatient Service Declines in South Los Angeles. March 2008.

53 Makuc D et al. Financial barriers to mammography: who pays out-of-pocket? *Journal of Women's Health* 2007, 16(3): 349-360.

54 National Association of Community Health Centers. Federal Policy Issues http://www.nachc.org/appropriations.cfm Accessed October 2008.

55 Report on the Environment (Final Report). U.S. Environmental Protection Agency, Washington, DC, EPA/600/R-07/045F. 2008.

56 Diabetes Prevention Program Research Group. The diabetes prevention program design and methods for a clinical trial in the prevention of type 2 diabetes. *Diabetes Care*. 1999; 22: 623-34.

57 The Diabetes Prevention Program. Baseline characteristics of the randomized cohort. *Diabetes Care*. 2000; 23: 1619–29.

58 Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes. California Center for Public Health Advocacy, PolicyLink, and the UCLA Center for Health Policy Research. April 2008.

59 L. Lewis et al. African Americans' Access to Healthy Food Options in South Los Angeles Restaurants. *American Journal of Public Health.* 2005; 95(4): 668-673.

60 B. Fisher and D. Strogatz. Community measures of low-fat milk consumption: comparing store shelves with households. *American Journal of Public Health*. 1999; 89 (2): 235-237.

61 K. Cullen et al. Effect of a la carte and snack bar foods at school on children's intake of fruits and vegetables. *Journal of American Diet Association*. 2000; 100(12): 1482-6.

62 M. Aboelata. *The Built Environment and Health: 11 Profiles of Neighborhood* Transformation. 2004; Prevention Institute.

63 *Alcohol Alert*. National Institute on Alcohol Abuse and Alcoholism No. 22 PH 346 October 1993.

64 Accessed on August 26, 2008 CDC http://www.cdc.gov/alcohol/index.htm.

65 As cited in Quick Stats General Information on Alcohol Use accessed on August 28, 2008 at http://www.cdc.gov/alcohol/quickstats/general_info.htm.

66 Ashe et al. Land use planning and the control of alcohol, tobacco, firearms and fast food restaurants. *American Journal of Public Health.* 2003; 93(9): 1404-1408.

67 *WHO expert committee on problems related to alcohol us*e. Second Report. WHO Technical Series 944. World Health Organization, Geneva, 2007.

68 M. Hennessey and D. Zahniser, Council bans new fast food outlets in South L.A., LA Times, July 20, 2008.

69 S. Inagami, You are where you shop: grocery store locations, weight and neighborhoods. *American Journal of Preventative Medicine.*. 2006; 31(1): 10-17.

70 K. Morland et al., The contextual effect of the local food environment on resident's diet. *American Journal of Public Health*. 2002; 92 (11): 1761-1768.

71 Sloane, D. Improving the nutritional resource environment for healthy living through community-based participatory research. *Journal of General Internal Medicine.* 2003; 18: 568-575.

72 Ibid

73 D. Herman , G. Harrison, A. Afifi, E.Jenks. Effect of a targeted subsidy on intake of fruits and vegetables among low-income women in the Special Supplemental Nutrition Program for Women, Infants, and Children. *American Journal of Public Health*. 2008; 98(1): 98-105.

74 A. Fisher. Hot peppers and parking lot peaches: evaluating farmer's markets in low-income communities. Community Food Security Coalition. January 1999.

75 County of Los Angeles Environmental Health. Retail food inspection guide. Revised 7/07.

76 Los Angeles County Health Survey, LACHS 1999 & 2005 Surveys Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. 1999 estimates are based on self-reported data by a random sample of 8,354 Los Angeles County adults, representative of the population in Los Angeles County.

77 http://www.saferoutesinfo.org/askaquestion/answer.cfm?id=178 accessed on NCSRTS site 8/27/08.

78 R. Garcia, E. Flores, & S. Chang. Healthy Children, Healthy Communities: Schools, Parks, Recreation and Regional Planning. 31 Fordham Urban Law Journal 101. Center for Law in the Public Interest Policy report. 2004.

79 *Preventing Childhood Obesity: The Need to Create Healthy Places. A Cities and Communities Report.* Los Angeles County Department of Public Health, Office of Assessment Epidemiology. October 2007.

80 A. Deshpande, E. Baker, and R. Brownson. Environmental correlates of physical activity among individuals with diabetes in the rural Midwest. *Diabetes Care.* 2005; 28: 1012-1018.

81 A. Loukaitou-Sideris; Children in Los Angeles Parks: A Study of Equity, Quality and Children's Satisfaction with Neighborhood Parks. University of California at Los Angeles. 2002.

82 J. Wolch, J. Wilson. Park and Park Funding in Los Angeles: An Equity-Mapping Analysis*, Urban Geography*. 2005; 26(1): 4–35.

83 Creating or Improving Access to Places for Physical Activity Is Recommended to Increase Physical Activity. *Guide to Community Preventive Services*. Centers for Disease Control and Prevention. 2002.

84 Physical Activity: Economic Evidence, Guide to Community Preventative Services. Centers for Disease Control and Prevention. 2002.

85 R. Garcia, A. White. Healthy Parks, Schools and Communities: Mapping Green Access and Equity in the Los Angeles Region, The City Project. 2002.

86 T. Augustin, T. Glass, B. James, and B. Schwartz. Neighborhood psychosocial hazards and cardiovascular disease: The Baltimore memory study, *American Journal of Public Health*. 2008; 98(9): 1664-1670.

87 J. Freedy & S. Hobfoll. *Traumatic Stress*, Freedy & Hobfoll, Springer. 1995.

88 Reducing Gun Violence: Community Problem Solving in Atlanta. U.S. Department of Justice, National Institute for Justice. 2006.

89 M. Smith. Crime Prevention Through Environmental Design in Parking Facilities. NIJ Research in Brief, US Department of Justice. 1996.

90 Mortality in Los Angeles County 2005: Leading causes of death and premature death. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. July 2008.

91 McGinn et al. Exploring associations between physical activity and perceived and objective measures of the built environment. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. 2007; 84(2): 162-184.

92 Gang Reduction Strategy. City of Los Angeles, Office of Mayor Antonio Villaraigosa. April 2007.

93 D. Longshore, A.Hawken, D. Urada, M. Anglin. Evaluation of the Substance Abuse and Crime Prevention Act. UCLA Integrated Substance Abuse Programs. March 2003.

94 J. Krieger & D. Higgins. Housing and health: Time Again for Public health Action. *American Journal of Public Health*. 2002; 92(5): 758-768.

95 Jacobs et al. Prevalence of lead-based paint in US Housing. *Environmental Health Perspectives*. 2002 110(10).

96 E. Shenassa, S. Stubbendick, and M. Brown. Social disparities in housing and related pediatric injury: A multi-level study. *American Journal of Public Health*. 2004; 94(4): 633-639.

97 D.R. Williams & C. Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 Pub. Health Rep. 2001*;* 405-16.

98 Saegert et al. Healthy housing: A structured review of published evaluations of US interventions to improve health by modifying housing in the United States, 1990–2001. *American Journal of Public Health.* 2003; 93(9): 1471-1477.

99 J. Krieger & D. Higgins. Housing and health: time again for public health action. *American Journal of Public Health*. 2002; 92(5): 758-768.

100 CA Department of Education, http://www.cde.ca.gov/eo/ce/wc/.

101 Literacy and Health Outcomes: A Summary Evidence Report/Technology Assessment: Number 87, Agency for Healthy Quality & Research.

102 R. McConnell et al. Traffic, susceptibility, and childhood asthma. *Environmental Health Perspectives.* 2006; 114(5): 766-772.

103 W. J. Gauderman et al. Childhood asthma and exposure to traffic and nitrogen dioxide. *Epidemiology.* 2005; 16(6): 1-7.

104 W. J. Gauderman et al. Effect of exposure to traffic on lung development from 10 to 18 years of age: a cohort study. *Lancet*. 2007; 369: 571-77.

105 Growth spurt at LAUSD. *Buildings Magazine*. July 2006.

106 Künzli et al. Breathless in Los Angeles: The exhausting search for clean air, *American Journal of Public Health*. 2003; 93(9): 1494-1499.

107 Los Angeles' Industrial Land: Sustaining a Dynamic City Economy. Department of City Planning and the Community Redevelopment Agency of the City of Los Angeles. 2007.

108 U.S. EPA's 2008 Report on the Environment (Final Report). U.S. Environmental Protection Agency, Washington, DC, EPA/600/R-07/045F.

109 U.S. Department of Health and Human Services. 2005. *Report on carcinogens*. Eleventh edition. Washington, DC: Public Health Service, National Toxicology Program.

110 U.S. EPA. 2003. National air quality and emissions trends report—2003 special studies edition. EPA/454/R-03/005. Research Triangle Park, NC.

111 Oil and Gas Pollution Fact Sheet, Earthworks at http://www.earthworksaction.org/pubs/Oilandgaspollution.pdf accessed August 28, 2008.

112 U.S. EPA's 2008 Report on the Environment (Final Report). U.S. Environmental Protection Agency, Washington, DC, EPA/600/R-07/045F.

113 Ibid

114 California Public Resources Code Division 13 Environmental Protection Chapter 1 Policy. http://ceres.ca.gov/ceqa/stat/Ch_1.html accessed on August 28, 2008.

Community Health Councils
3731 Stocker Street, Suite 201
Los Angeles, CA 90008

323.295.9372 fax 323.295.9467
email: info@chc-inc.org
www.chc-inc.org