Community Partnerships: Vulnerable Population

Partnerships

Innovations: For Improved Outcomes

Our Primary Aims

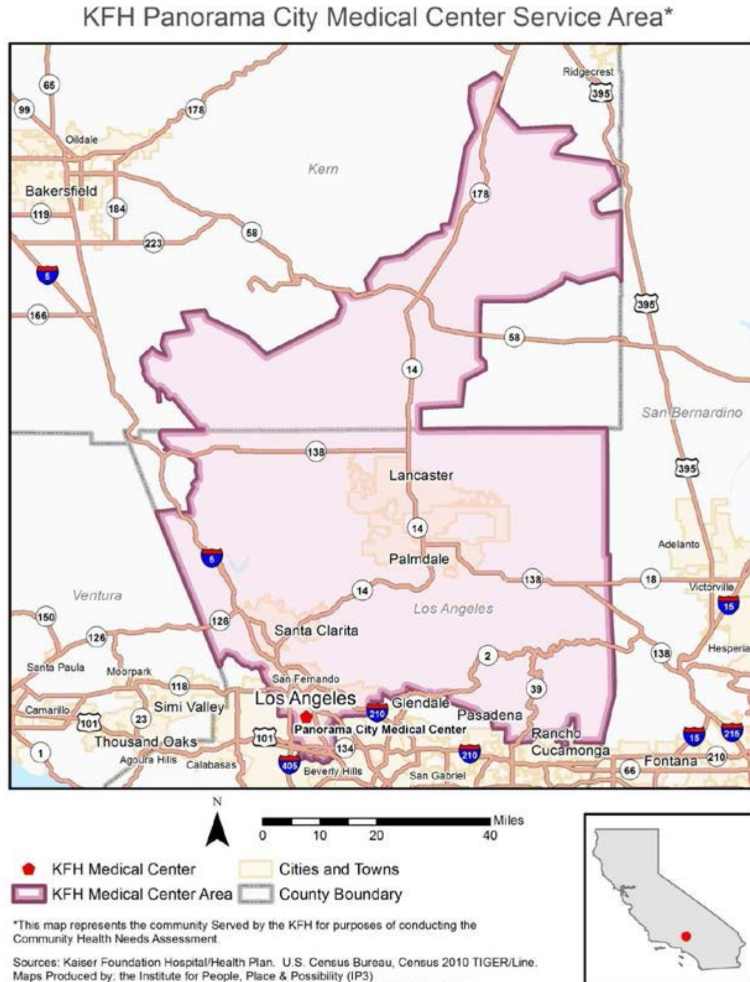
- Create community partnerships with major stakeholders of diverse community organizations to join forces and **pursue a shared interest in improving community health**
- Promote approaches that screen and target most **vulnerable populations** to reduce disproportionate disparities that drive poor health outcomes.
- **Leverage resources** to improve environment and community capacity in ways that are **sustainable** and produce **measurable health outcomes**

Challenges

Improve Outcomes: By Addressing Un-met Needs

- Identify high utilizers with poor outcomes
- Use Community Commons to target populations
- Use Community Health Needs Assessment (CHNA) combined with Individual Patient Needs Assessment
- Conduct Screening to Identify Needs: Incorporate Into Care Plan
- Community Partnerships and Outreach
- Address Un-met Needs; Align Resources with Needs
- Address Root Causes, Bridge Gaps: Improve Outcomes

Medical Center: Health Determinants



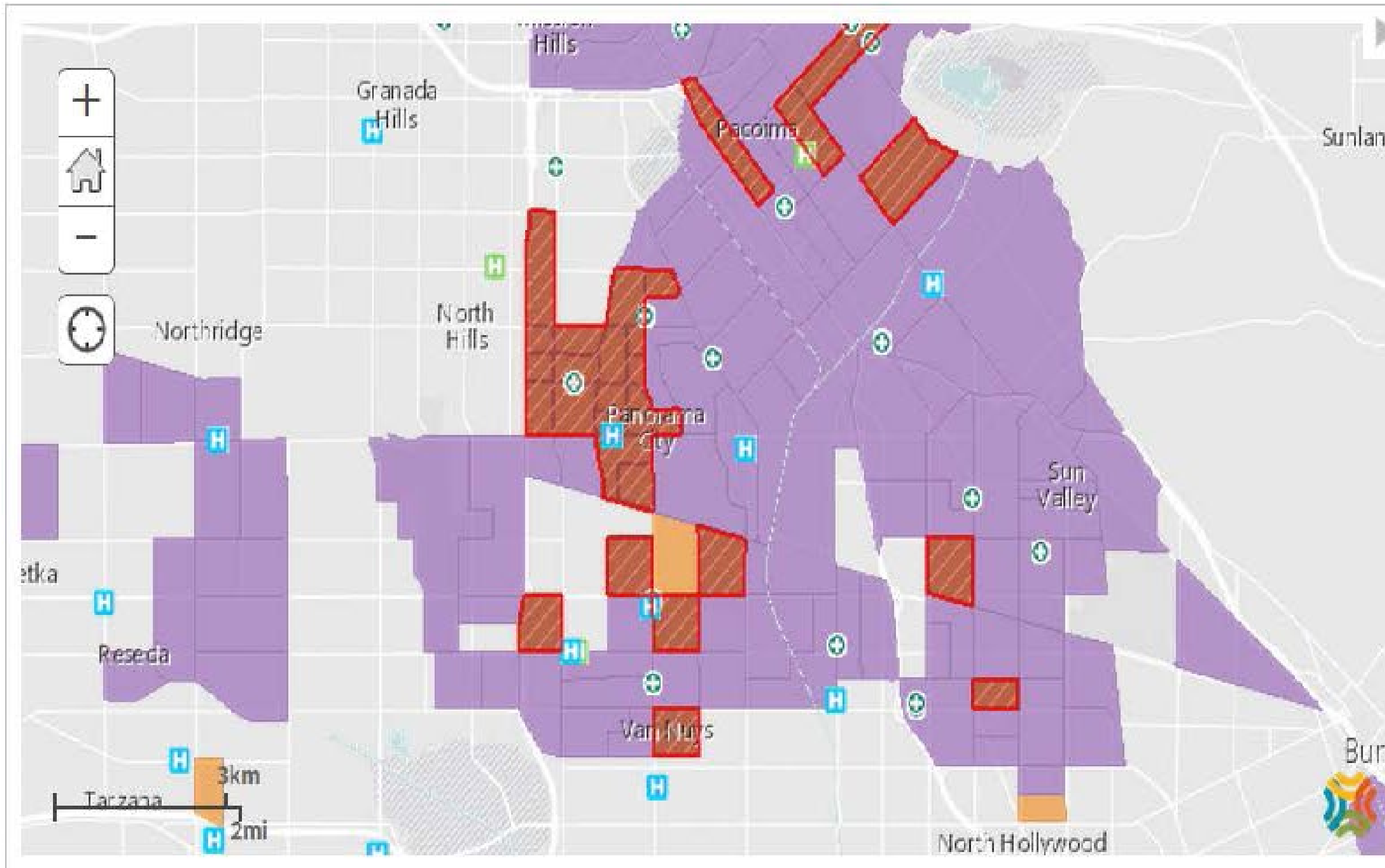
Population

- Several zip-codes within service area are identified by Center for Disease Control (CDC) as “vulnerable population”
- Having disproportionate disparities for chronic disease burden and social health determinant

Evidence: Challenges- Vulnerable Census Tracts in Panorama City Area

Vulnerable Populations Footprint Tools

Share Export Map Help



Panorama City

Map Layers

Vulnerable Populations Footprint, ACS 2008-12

- Above all thresholds (Footprint)
- Above the poverty threshold
- Above the education threshold

Vulnerability Thresholds

Population Below Poverty Level 30%

Population Less Than High School 25%

Vulnerable Populations Footprint Tools

Priority Intervention Area Tools

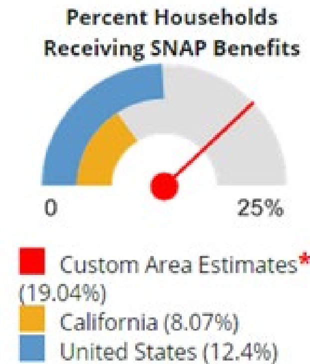
Households Receiving **SNAP** in Panorama City Area

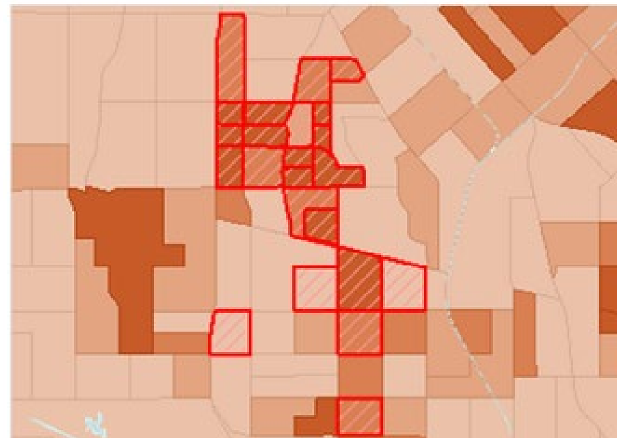
This indicator reports the estimated percentage of households receiving the Supplemental Nutrition Assistance Program (SNAP) benefits. This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrolment.

Download Data

Report Area	Total Households	Households Receiving SNAP Benefits	Percent Households Receiving SNAP Benefits
Custom Area Estimates*	24,981	4,757	19.04%
Los Angeles County, CA	3,230,383	251,947	7.8%
California	12,542,460	1,012,610	8.07%
United States	115,610,216	14,339,330	12.4%

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, American Community Survey. Source geography: Tract





Households Receiving SNAP Benefits, Percent by Tract, ACS 2009-13

- Over 19.0%
- 14.1 - 19.0%
- 9.1 - 14.0%
- Under 9.1%
- No Data or Data Suppressed

- Report Area

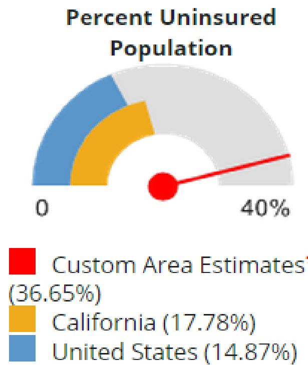
Uninsured Population in Panorama City Area

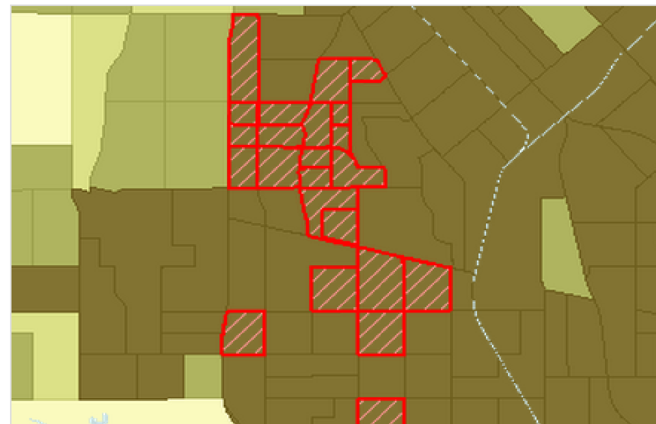
This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Download Data

Report Area	Total Population (For Whom Insurance Status is Determined)	Total Uninsured Population	Percent Uninsured Population
Custom Area Estimates*	96,121	35,225	**36.65%**
Los Angeles County, CA	9,820,180	2,177,718	**22.18%**
California	37,130,876	6,601,519	17.78%
United States	306,448,480	45,569,668	14.87%

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, American Community Survey. Source geography: Tract





Uninsured Population, Percent by Tract, ACS 2009-13

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Report Area

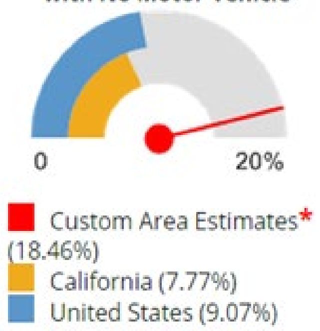
Households with No Motor Vehicle

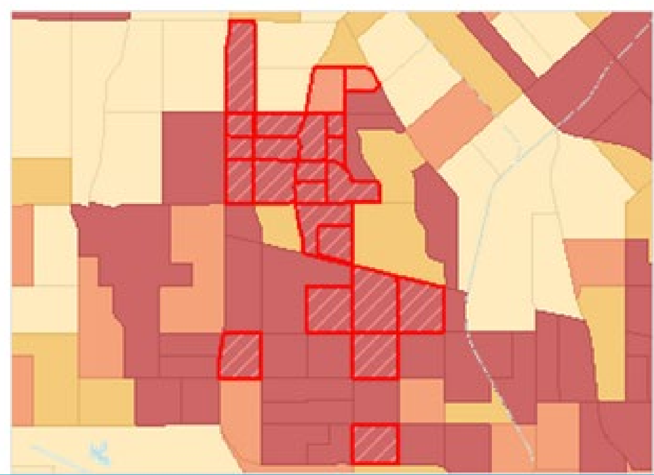
This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates.

Download Data

Report Area	Total Occupied Households	Households with No Motor Vehicle	Percentage of Households with No Motor Vehicle
Custom Area Estimates*	24,981	4,612	18.46%
Los Angeles County, CA	3,230,383	313,430	9.7%
California	12,542,460	973,952	7.77%
United States	115,610,216	10,483,077	9.07%

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, American Community Survey. Source geography: Tract





Households with No Vehicle, Percent by Tract, ACS 2009-13

- Over 8.0%
- 6.1 - 8.0%
- 4.1 - 6.0%
- Under 4.1%
- No Data or Data Suppressed
- Report Area

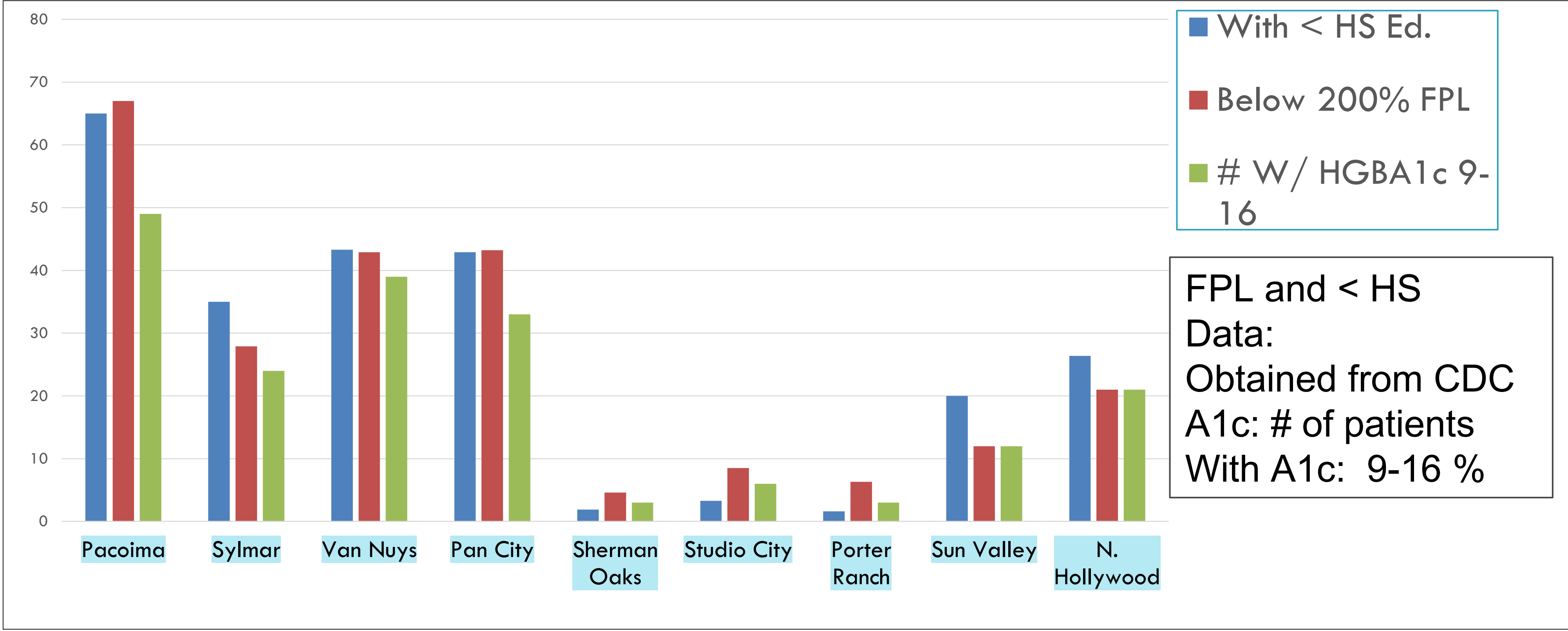
Community Health Needs Assessment

Community Context Indicators that Compound to Diminish Health Opportunities:

- Vulnerable populations (Poverty and Education)
- Linguistic Isolation (non-English speaker/ESL/do not speak English well)
- Housing Cost Burden (>30% of Income)
- Households with No Vehicle (Transportation Challenges)
- Households Receiving SNAP (Supplemental Nutritional Assistance)

Correlation Between:
Poverty, Low Education & Poor Diabetes Control

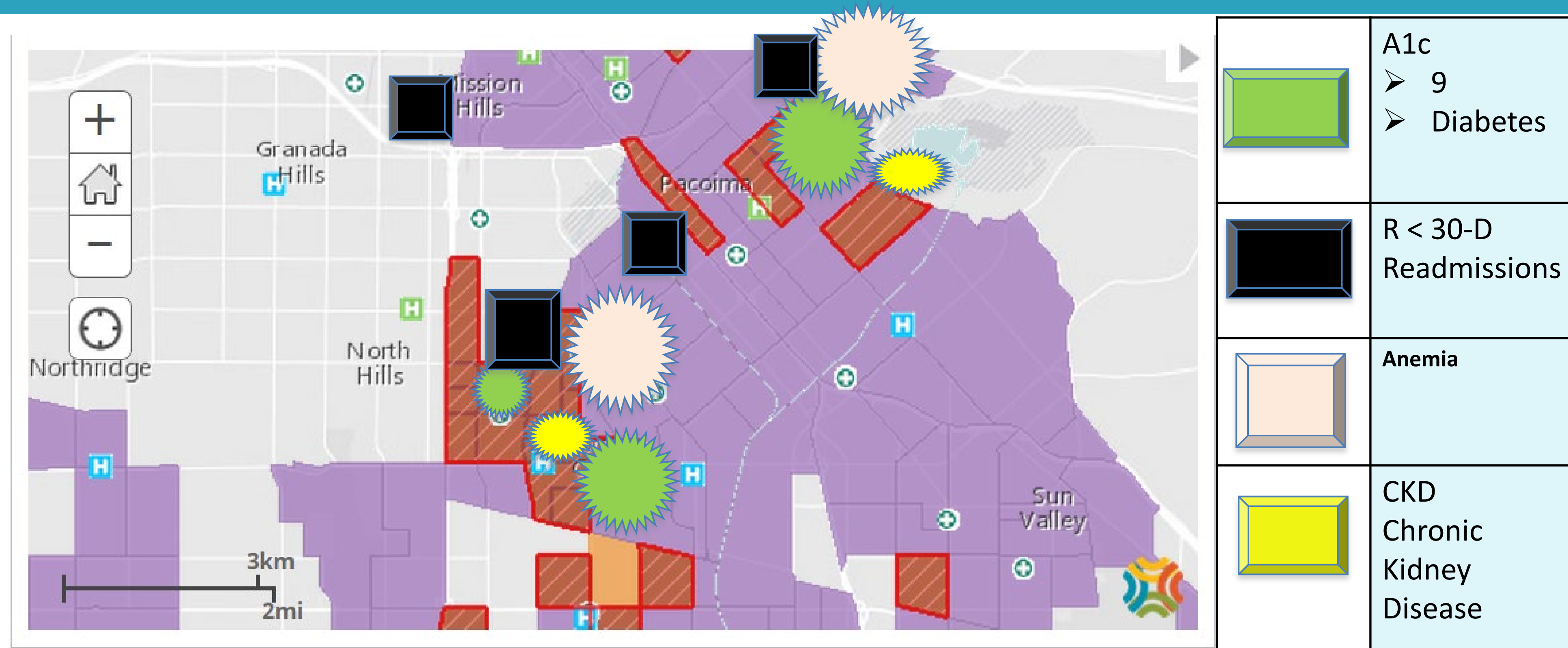
Health Determinants as Percentage, A1c # of pts.



FPL and < HS Data:
Obtained from CDC
A1c: # of patients With A1c: 9-16 %

Geographic Location by Zip-code (FPL = Federal Poverty Level)

Hospital 30-Day Readmissions, Chronic Disease Mapped to Zip Codes and SDOH



NOTE: Chronic Disease Correlates to the Same Regions as Vulnerable Populations

Recommendations: Best Practices

- Build community initiatives on a platform of governance, management, and adequate stable financing that assures continuity and sustainability.
- Focus on disease prevention, early detection, treatment, and evaluation, by creating a Culture of Health within the community.
- Engage community stakeholders in partnerships, support initiatives that engage in significant community development, and that have the potential to influence the known determinants of health disparities (e.g. housing, safety, education, civic engagement).
- Embody the kind of community initiatives and support, that is necessary for sustainable long-term results.

DCRC MODEL: PATIENT PATHWAY