Innovative and Emerging Models of Chronic Disease Prevention

A Public Health Perspective

Monday, April 25, 2016

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Division of Chronic Disease and Injury Prevention
Los Angeles County Department of Public Health
Overview

• Burden of chronic disease/conditions (e.g., hypertension, prediabetes, diabetes, obesity, others)
• Approach to addressing this burden from a public health perspective
• Federal and local initiatives aligned with these emerging models and efforts
• Examples:
  i. Active Transportation
  ii. National Diabetes Prevention Program
  iii. CTSI’s Healthy Aging Initiative
Los Angeles County

The Landscape

• 4,000 square miles

• 10 million residents
  • 24% obese adults
  • 23% obese children
  • varies widely by region

• 88 cities

• 80 schools districts + LACOE

• Opportunity for broad reach
Burden of Chronic Diseases
## Trends in the Leading Causes of Death Los Angeles County, 2001-2010

Age-adjusted rate/100,000

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>2001</th>
<th>2010</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>220</td>
<td>138</td>
<td>-37%</td>
</tr>
<tr>
<td>Stroke</td>
<td>56</td>
<td>36</td>
<td>-36%</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>42</td>
<td>33</td>
<td>-21%</td>
</tr>
<tr>
<td>Emphysema</td>
<td>36</td>
<td>30</td>
<td>-17%</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>12</td>
<td>25</td>
<td>108%</td>
</tr>
<tr>
<td>Pneumonia &amp; influenza</td>
<td>32</td>
<td>22</td>
<td>-31%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>24</td>
<td>21</td>
<td>-13%</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>18</td>
<td>14</td>
<td>-22%</td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>12</td>
<td>12</td>
<td>0%</td>
</tr>
<tr>
<td>Breast cancer (female)</td>
<td>24</td>
<td>21</td>
<td>-13%</td>
</tr>
</tbody>
</table>

Source: Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health
# Leading Causes of Death by Race/Ethnicity, Los Angeles County, 2010

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Number of deaths</th>
<th>Age-adjusted death rate</th>
<th>#1 cause</th>
<th>#2 cause</th>
<th>#3 cause</th>
<th>#4 cause</th>
<th>#5 cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>28,738</td>
<td>667 per 100,000</td>
<td>Coronary heart disease 6,845</td>
<td>Emphysema/COPD 1,743</td>
<td>Lung cancer 1,655</td>
<td>Stroke 1,534</td>
<td>Alzheimer’s disease 1,509</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>151 per 100,000</td>
<td>40 per 100,000</td>
<td>40 per 100,000</td>
<td>34 per 100,000</td>
<td>31 per 100,000</td>
</tr>
<tr>
<td>Hispanic</td>
<td>13,751</td>
<td>529 per 100,000</td>
<td>Coronary heart disease 2,555</td>
<td>Stroke 780</td>
<td>Diabetes 690</td>
<td>Liver disease 587</td>
<td>Lung cancer 441</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>111 per 100,000</td>
<td>34 per 100,000</td>
<td>29 per 100,000</td>
<td>18 per 100,000</td>
<td>18 per 100,000</td>
</tr>
<tr>
<td>Black</td>
<td>7,438</td>
<td>891 per 100,000</td>
<td>Coronary heart disease 1,721</td>
<td>Stroke 446</td>
<td>Lung cancer 433</td>
<td>Diabetes 294</td>
<td>Emphysema/COPD 289</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>208 per 100,000</td>
<td>54 per 100,000</td>
<td>51 per 100,000</td>
<td>35 per 100,000</td>
<td>35 per 100,000</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>6,343</td>
<td>429 per 100,000</td>
<td>Coronary heart disease 1,451</td>
<td>Stroke 501</td>
<td>Lung cancer 400</td>
<td>Pneumonia/Influenza 296</td>
<td>Diabetes 237</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>98 per 100,000</td>
<td>34 per 100,000</td>
<td>26 per 100,000</td>
<td>21 per 100,000</td>
<td>16 per 100,000</td>
</tr>
<tr>
<td>Los Angeles County Total*</td>
<td>56,538</td>
<td>615 per 100,000</td>
<td>Coronary heart disease 12,635</td>
<td>Stroke 3,278</td>
<td>Lung cancer 2,941</td>
<td>Emphysema/COPD 2,622</td>
<td>Alzheimer’s disease 2,242</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>138 per 100,000</td>
<td>36 per 100,000</td>
<td>33 per 100,000</td>
<td>30 per 100,000</td>
<td>25 per 100,000</td>
</tr>
</tbody>
</table>

*Total includes persons of other or unknown race/ethnicity.
Percent of Adults Diagnosed with Hypertension by Age Group, Los Angeles County, 2011

Source: Los Angeles County Health Survey, 2011
Potential Decrease in Cases of Hypertension and Annual Savings in Hypertension Treatment Costs from Reducing Sodium Consumption in LA County

<table>
<thead>
<tr>
<th>Scenario: Percent Reduction in Population Sodium Intake</th>
<th>Average Systolic Blood Pressure Reduction (mm Hg)</th>
<th>Percent Decrease in the Frequency of Hypertension</th>
<th>Decrease in the Number Cases of Hypertension</th>
<th>Potential Annual Cost Savings [in 2014 dollars] ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% (344 mg)</td>
<td>0.71</td>
<td>1.7%</td>
<td>31,953</td>
<td>69.5 million</td>
</tr>
<tr>
<td>20% (687 mg)</td>
<td>1.41</td>
<td>2.8%</td>
<td>52,629</td>
<td>114.3 million</td>
</tr>
<tr>
<td>30% (1,031 mg)</td>
<td>2.11</td>
<td>4.2%</td>
<td>78,944</td>
<td>171.5 million</td>
</tr>
<tr>
<td>40% (1,374 mg)</td>
<td>2.82</td>
<td>5.3%</td>
<td>99,619</td>
<td>216.3 million</td>
</tr>
<tr>
<td>50% (1,718 mg)</td>
<td>3.52</td>
<td>6.8%</td>
<td>127,814</td>
<td>276.9 million</td>
</tr>
</tbody>
</table>

Number and Percentage of U.S. Population with Diagnosed Diabetes, 1958-2009

Source: CDC’s Division of Diabetes Translation. National Diabetes Surveillance System
Prevalence of Obesity and Diabetes Among Adults in Los Angeles County, 1997-2011

Source: Los Angeles County Health Survey
Combined Treatment Expenditures and Lost Productivity (in billions), by Chronic Disease, U.S.

<table>
<thead>
<tr>
<th>Chronic Disease</th>
<th>Treatment Expenditure</th>
<th>Productivity Losses</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancers</td>
<td>$48</td>
<td>$271</td>
<td>$319</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$27</td>
<td>$105</td>
<td>$132</td>
</tr>
<tr>
<td>Heart disease</td>
<td>$65</td>
<td>$105</td>
<td>$170</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$33</td>
<td>$280</td>
<td>$313</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>$46</td>
<td>$171</td>
<td>$217</td>
</tr>
<tr>
<td>Pulmonary conditions</td>
<td>$45</td>
<td>$94</td>
<td>$139</td>
</tr>
<tr>
<td>Stroke</td>
<td>$14</td>
<td>$22</td>
<td>$36</td>
</tr>
</tbody>
</table>

Preliminary Findings: Diabetes Costs in Los Angeles County, 2007 and 2030

<table>
<thead>
<tr>
<th>Type</th>
<th>Estimated Population</th>
<th>LA County Total Cost</th>
<th>In the U.S. Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2007</td>
<td>2030</td>
</tr>
<tr>
<td>Diabetes</td>
<td>642,000</td>
<td>780,214</td>
<td>$6.4 bil</td>
</tr>
<tr>
<td>Pre-Diabetes*</td>
<td>116,000</td>
<td>141,857</td>
<td>$51.4 mil</td>
</tr>
</tbody>
</table>

Projected population growth in LA County: 10.2 million (2007) to 11.7 million (2030); 7.4 million adults in 2007 vs. 8.9 million adults in 2030. Population projections accounted for migration, mortality, fertility trends, no natural catastrophes, etc.

* Includes only medical costs and not lost productivity.
# Health Policy Brief

**Prediabetes in California: Nearly Half of California Adults on Path to Diabetes**

## Supplemental Tables

<table>
<thead>
<tr>
<th>Los Angeles County Service Planning Area (SPA)</th>
<th>18-39</th>
<th>40-54</th>
<th>55-69</th>
<th>70+</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>(95% CI)</td>
<td>%</td>
<td>(95% CI)</td>
<td>%</td>
</tr>
<tr>
<td>Antelope Valley (SPA 1)</td>
<td>30%</td>
<td>(24.3 - 34.7)</td>
<td>50%</td>
<td>(39.9 - 60.7)</td>
<td>59%</td>
</tr>
<tr>
<td>San Fernando (SPA 2)</td>
<td>32%</td>
<td>(29.4 - 34.9)</td>
<td>49%</td>
<td>(44.2 - 53.0)</td>
<td>61%</td>
</tr>
<tr>
<td>San Gabriel (SPA 3)</td>
<td>35%</td>
<td>(31.3 - 38.0)</td>
<td>48%</td>
<td>(43.1 - 53.7)</td>
<td>55%</td>
</tr>
<tr>
<td>Metro (SPA 4)</td>
<td>36%</td>
<td>(32.3 - 39.1)</td>
<td>50%</td>
<td>(42.9 - 58.0)</td>
<td>50%</td>
</tr>
<tr>
<td>West (SPA 5)</td>
<td>29%</td>
<td>(25.1 - 33.5)</td>
<td>50%</td>
<td>(44.6 - 56.3)</td>
<td>60%</td>
</tr>
<tr>
<td>South (SPA 6)</td>
<td>36%</td>
<td>(31.6 - 39.8)</td>
<td>49%</td>
<td>(39.4 - 59.1)</td>
<td>60%</td>
</tr>
<tr>
<td>East (SPA 7)</td>
<td>35%</td>
<td>(31.0 - 38.5)</td>
<td>50%</td>
<td>(43.6 - 56.4)</td>
<td>57%</td>
</tr>
<tr>
<td>South Bay (SPA 8)</td>
<td>31%</td>
<td>(27.2 - 34.2)</td>
<td>44%</td>
<td>(38.0 - 50.1)</td>
<td>55%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>33%</td>
<td>(31.9 - 34.8)</td>
<td>48%</td>
<td>(45.9 - 50.9)</td>
<td>57%</td>
</tr>
</tbody>
</table>

Source: 2013-14 California Health Interview Survey

Note: Estimates of prediabetes are based on predictive models developed using 2009-2012 NHANES data and applied to CHIS 2013-14 data. Prediabetes estimates include adults with undiagnosed diabetes. Nationally, approximately 3.9 percent of adults have undiagnosed diabetes.
Impact of Alzheimer’s Disease

• Healthcare costs – medical care; hospitalizations; skilled nursing; home care; long term care costs often lead to depletion of patient’s personal savings and assets
• Personal costs – disease progression with memory loss, wandering, behavioral problems, injuries, depression
• Caregiving – caregiver stress, caregiver illness, paid and unpaid costs of caregiving
• Costs to businesses – absenteeism due to caregiving, etc.
Public Health Framework for Chronic Disease Prevention in Los Angeles
Growing Choose Health LA

**Early:** September 2010-March 2011
- Research & Development

**1st Year:** October 2011
- Launched “Sugar Pack” campaign
- “Eat, Move, Live LA” TV series
- Continued

**2nd Year:** October 2012
- Launched “Choose Less, Weigh Less” campaign
- Launched Healthy Holiday Tips campaign
- Created Nutrition Education Catalog

**3rd Year:**
- Will launch Restaurant program
- Will re-launch website
- Continue to Grow, Develop and Expand
Health Factors

All Determinants of Health Matters

Programs and Policies

Mortality (50%)

Morbidity (50%)

Health behaviors (30%)

Clinical care (20%)

Social & economic factors (40%)

Physical environment (10%)

Tobacco use

Diet & exercise

Alcohol use

Unsafe sex

Access to care

Quality of care

Education

Employment

Income

Family & social support

Community safety

Environmental quality

Built environment
Reducing the risk of diabetes and metabolic syndrome

- Regular physical activity
- Healthy diet
- Blood pressure control
- Increased cardiovascular strength
- Decreased cholesterol
- Decreased blood pressure
- Decreased obesity

Factors to consider:

- Regular doctor visits and age appropriate preventive screenings
- Access to lifestyle change programs and community resources (e.g., National Diabetes Prevention Program)
- Social support groups and services
- Workplace wellness programs
- Community screening and MTM programs
- Health consumer information and protection (e.g., self-management resources, home BP monitoring)
- Increased green space and walkability
- Active transportation
- Safer and more walkable communities
- Depression screening and treatment
- Smoking cessation programs
- Alcohol and drug abuse detection and brief intervention
- Community resource database, 211 LA County
- NDPP Providers
- Local farmer’s Markets, purchasing cooperatives
- Community screening and MTM programs
- Menu labeling, behavioral economics
- Healthym Food Environments
- Workplace wellness programs
Framework for Action: General Model of Health & Improvement Strategies

Federal and Local Initiatives
**State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke**

**Inputs:** Funding, guidance and support from DDT, DHDSP, DNPAO

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>SHORT-TERM OUTCOMES</th>
<th>INTERMEDIATE OUTCOMES</th>
<th>LONG-TERM OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMPONENT 1</strong> Environmental strategies to promote health and support and reinforce healthful behaviors</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
  - Implement food and beverage guidelines including sodium standards (i.e., food service guidelines for cafeterias and vending) in public institutions, worksites and other key locations such as hospitals |
  - Strengthen healthier food access and sales in retail venues (e.g., grocery stores, supermarkets, chain restaurants, and markets) and community venues (e.g., food banks) through increased availability (e.g., fruit and vegetables and more low/no sodium options), improved pricing, placement, and promotion |
  - Strengthen community promotion of physical activity though signage, worksite policies, social support, and joint-use agreements |
  - Develop and/or implement transportation and community plans that promote walking Strategies to build support for lifestyle change, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts |
  - Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change. Implement evidence-based engagement strategies (e.g., tailored communications, incentives, etc.) to build support for lifestyle change |
  - Increase coverage for evidence-based supports for lifestyle change by working with network partners |
| **COMPONENT 2** Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities |
  - Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance (e.g., implement advanced Meaningful Use data strategies to identify patient populations who experience CVD-related disparities) |
  - Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities) |
  - Increase engagement of non-physician team members (i.e., nurses, pharmacists, nutritionists, physical therapists and patient navigators/community health workers) in hypertension management in community health care systems |
  - Increase use of self-measured blood pressure monitoring tied with clinical support |
  - Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes |
| **Community clinical linkage strategies to support heart disease and stroke and diabetes prevention efforts** |
  - Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or at high risk for type 2 diabetes |
  - Increase engagement of community pharmacists in the provision of medication/self-management for adults with high blood pressure |
  - Implement systems to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs (e.g., EHRs, 800 numbers, 211 referral systems, etc.) |
| **Increased community and large city environments that promote and reinforce healthful behaviors and practices related to obesity, diabetes prevention, cardiovascular health, including key settings that support physical activity and healthful foods and beverages.** |
| **Increased engagement in lifestyle change** |
| **Increased use and reach of strategies to build support for lifestyle change** |
| **Reduced death and disability due to diabetes, heart disease and stroke by 3% in the implementation area** |

**Page 6**
In fall 2014, the Los Angeles County Department of Public Health was awarded the 1422: State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke cooperative agreement from the Centers for Disease Control and Prevention (CDC).

This federal funding was used to develop the 4-year Chronic Disease Prevention Strategy in Los Angeles (CDPS) project. The initiative intends to implement community and health systems strategies to prevent and control chronic conditions such as hypertension and prediabetes. CDPS supports a comprehensive model of systems and environmental strategies that will improve the health of the entire Los Angeles population and subgroups with disproportionate risk of chronic disease. Program strategies include: shared use agreements between schools and communities to promote physical activity (e.g., Joint Use Moving People to Play Task Force); increasing healthy food options in a variety of environments; community plans to promote active transportation (e.g., the City of Los Angeles Mayor’s Great Streets Initiative and Vision Zero); and health system strategies to increase meaningful use of electronic health records, decision support tools, and coordination of clinical and community resources. Together, these strategies aim to reduce adult obesity and other chronic disease risk factors that can lead to death and disability from heart disease, stroke, and type 2 diabetes. Using a multidisciplinary approach, CDPS is bringing the vision of a healthy Los Angeles to reality. Key strategies and programs under CDPS are highlighted below.

**OFFICE OF WOMEN’S HEALTH**

The Los Angeles County Office of Women’s Health Appointment and Referral Hotline is a multi-lingual hotline providing a variety of health resources including heart disease, diabetes, and blood pressure risk assessments. Operators speak English, Spanish, Armenian, Korean, Mandarin, Cantonese, and Vietnamese.

Clients can call 1-800-793-8090 for personalized assistance.
Chronic Disease Prevention Strategy (1422)

- A four year initiative to implement community and health system strategies to prevent and control chronic conditions such as hypertension and diabetes.

- Programs include:
  - Shared use agreement between schools and communities
  - Increasing health food options
  - Community plans to promote active transportation
  - Health system strategies – EHRs, meaningful use of electronic data, CHWs/Health Navigators, Pharmacist Strategies, community-clinical linkages, team-based care
Key Strategies and Programs – Early Stages

- Office of Women’s Health Appointment and Referral Hotline
- The Wellness Center
- National Diabetes Prevention Program
- Undiagnosed or undertreated hypertension
- Choose Health LA Restaurants
- Promoting Healthier Food & Beverages
Active Transportation – local efforts through multi-sector partnerships
Vision Zero Los Angeles: The Facts

**Collison Landscape in Los Angeles**
- 95 collisions occur per day on our streets. That is more than 30,000 per year.
- 950+ people sustained severe injuries in 2013 from collisions.
- 200+ people die every year from collisions.
- 44% of all deaths and severe injuries involve people walking or bicycling.
- 30% of all people killed or severely injured while walking or bicycling are youth and older adults.

**What is Vision Zero**
- Vision Zero is a traffic safety policy that ensures mistakes on our roadway do not result in severe injury or death.
- Strategies for achieving our Vision Zero goals center on engineering, enforcement, education, evaluation, and equity.
- The Vision Zero concept originated in Sweden, where it was adopted as a national strategy in 1997. Since then, despite increased traffic volumes, the number of traffic deaths has dropped over 30 percent.

**Vehicle Speed**
- Speed is a fundamental predictor of crash survival. Research shows that increasing vehicle speeds from 20 mph to 40 mph increases the likelihood of a pedestrian death when hit by a vehicle from 10 percent to 80 percent.
- Slower speeds also increase a driver’s field of vision and allow for more time to react to unexpected situations on the roadway.

**High Injury Network**
- The City of Los Angeles Department of Transportation (LADOT) has identified a network of streets called the High Injury Network (HIN), with a higher incidence of severe and fatal collisions. Strategic investments along the HIN will have the biggest impact in reducing severe injury and death.
- Many of the areas burdened with the poorest health outcomes also have a disproportional amount of severe and fatal injuries from collisions. Nearly half of the HIN falls within our most vulnerable communities.

**Who will be involved**
- A Vision Zero Executive Steering Committee, comprised of the Mayor’s Office, LADOT, the Los Angeles Department of Police, Public Works and Fire, and the County Department of Public Health will oversee the Vision Zero initiative.
- As we continue to identify areas in the City with the most need, we will partner with our communities to make safety improvements at the neighborhood level.

Source: City of Los Angeles

And the Great Streets initiative
2012 – BOS mandated interdepartmental task force to increase physical activity and improve health through planning, designing and building healthier environments

*Develop and structure cross-sector relationships*
Scale and Spread of Evidence-Based Programming (e.g., the National Diabetes Prevention Program)
The National Diabetes Prevention Program: Landscape in Los Angeles

- Group-based medical model
- Community-based model
- Employer-based model
- Internet-based model
Los Angeles County Department of Public Health

Partners working to scale the National Diabetes Prevention Program in Los Angeles

- YMCA
- Black Women for Wellness (BWW)
- AltaMed Health Services Corporation
- Northeast Valley Health Corporation
- Los Angeles Department of Health Services (DHS)
- The LAC+USC Wellness Center at the Historic General Hospital in Boyle Heights
DPPs February 2016

Map data ©2016 Google
Community Advisory Board

- Coalition formed in 2014 to help scale the National Diabetes Prevention Program in Los Angeles

**Coalition Mission**
- To scale the NDPP in Los Angeles
- To build the case for coverage of NDPP in Los Angeles and nationally
- To convene local stakeholders to educate community and providers about NDPP

**Member Groups**
- Health Systems
- Community-based organizations
- Academic Partners
- Health sector practitioners (i.e. health educators, social workers)
What Health Systems and the Provider Community Can Do to Aid Diabetes Prevention Efforts

• Champion or integrate practice protocols or reminder systems in the clinical setting to help refer patients to quality NDPP in the community
• Establish peer workgroups/expert panels in the parent health system to tailor best or expected practices for managing prediabetes in particular or across the system’s hospitals, ED, clinics/health centers, etc.
• Make framework for diabetes prevention as part of the continuum in diabetes care (prevention to management, not siloed programming)
• Develop team care approaches that can be used for diabetes prevention
• QA/QI for referral or bi-directional referral processes
CTSI Healthy Aging Initiative
Healthy Aging Initiative (HAI)

“Big Audacious Goal” for improving health in Los Angeles County

- County-Wide Program to Promote Healthy Aging in Los Angeles
- UCLA Clinical and Translational Science Institute (CTSI) Community Engagement and Research Program (CERP) convened meetings with leadership of Los Angeles County Department of Health Services (Mitchell Katz) and Department of Public Health (Jonathan Fielding)
- LAC DPH and DHS leadership proposed the goal of Healthy Aging in Los Angeles related to physical, emotional, and social health
- Domains to be addressed include social isolation, poor nutrition and lack of health food options, physical activity, mental health, substance abuse, prescription medication misuse, chronic disease management, built and social environment, etc.
- Invited USC Investigators, the USC CTSI, and the LAC DMH to participate
Healthy Aging in Los Angeles County
Long Term Goals

- Develop and support a **network of resources** that provide expertise on the implementation and impact of evidence-based interventions to improve the health of adults ages 50 years and older in Los Angeles County.

- Support existing **implementation and evaluation** of the interventions, with **measurement of synergistic impact** at multiple levels (individual, family, community, city, and county).

- Develop **common set of meaningful, measurable metrics** across interventions.
# UCLA-USC Healthy Aging Projects

<table>
<thead>
<tr>
<th>Investigators</th>
<th>Project Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria P. Aranda (PI), Fuentes, Mack, Kuo, Villa, Childs-Seagle</td>
<td>Bringing Evidence-based Programs to Historically Underrepresented Older Minorities</td>
</tr>
<tr>
<td>Steven P. Wallace (PI), Kietzman, Duru, Vaccaro</td>
<td>Healthy Aging Partnerships in Prevention Initiative (HAPPI)</td>
</tr>
<tr>
<td>William Vega (PI), Lloyd, Kuo, Wu, Shapiro</td>
<td>The Los Angeles Healthy Aging Indicator Project</td>
</tr>
<tr>
<td>Catherine Sarkisian (PI), Trejo, Simmons, Kuo</td>
<td>Measuring Feasibility of a Community-based “Wellness Pathway” Model</td>
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<tr>
<td>Arleen Brown (PI), Seeman, Ward, Kuo, Simmons</td>
<td>Evidence-based Healthy Aging Programs in High-Risk Communities in LA County</td>
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Next Steps

Stakeholders Convene: (April 13, 2016)*
- LAACHA

Report out Recommendations

CTSA Convene: (May 2016)
- SC CTSI
- UCLA

HAI Convening #2 Intervention Development (Summer 2016)

*Attendees:
Cynthia Banks,
Phyllis Willis,
Tony Kuo, Ellen Eidem, Alex Li and Laura Trejo
As “Baby Boomers” begin utilizing the health care and social services system more strategically in the ACA era

— Promote age-appropriate screenings (e.g. colonoscopies, osteoporosis, depression and isolation) and services (e.g. evidence-based health promotion programs)

— Improve consumer health literacy and consumer protection

— Bolster cultural competencies of providers and allied health professionals

— Ensure adequate professional capacity to meet demand
Challenges and Opportunities
To impact health outcomes in the right direction...

— Strengthen programs, services and policies that prevent chronic disease, to go beyond just co-location but community investments and development (*by design*);

— Prioritize vulnerable populations – contribute to the evidence base;

— Strive for safe and healthy communities;

— Encourage social cohesion and engagement;

— Advocate for improvements to public education, public housing, job training and job creation – social services needs are relevant across all groups (*economic insecurity, food insecurity, housing*, etc.)
Q&A and Resources

Los Angeles Geo Hub, including Vision Zero and other initiatives
http://geohub.lacity.gov

Public education resources
www.choosehealthla.com

Division of Chronic Disease and Injury Prevention
http://publichealth.lacounty.gov/chronic/