Pomona Valley Hospital Medical Center

2021 Community Needs Assessment Study

In cooperation with California State Unversity San Bernardino's
Institute of Applied Research

POMONA VALLEY HOSPITAL
MEDICAL CENTER

Expert care with a personal touch

Prepared in Compliance with
California's Community Benefit Law and Section 501(r)(3)
of the Internal Revenue Code

2021-2023

PREFACE

California's Community Benefit Law

California's Community Benefit Law, referred to as Senate Bill 697 (SB 697) is found in the California Health and Safety Code, section 127340-127365. A detailed description of the law may be found in the appendix. The law began in response to increasing interest from the community on contributions not-for-profit hospitals gave to their communities. The California Association of Catholic Hospitals and the California Healthcare Association co-sponsored SB 697 which was signed into law September, 1994.

Senate Bill 697 requires private not-for-profit hospitals in California to describe and document the full range of community benefits they provide to their communities. Hospitals are required to provide a written document describing the hospital's charitable activities to the community as a not-for-profit organization and submit this report annually. Every three years, hospitals conduct a community needs assessment and consequently develop a formal planning process addressing those issues. The goals and intent of SB 697 is that hospitals will collaborate with regional community partners to identify community needs and to work together in developing a plan to meet those needs.

Federal Requirements

Federal requirements in Section 501(r)(3) of the Internal Revenue Code, created by *The Patient Protection and Affordable Care Act* (2010), require not-for-profit hospitals and healthcare organizations to conduct a triennial Community Health Needs Assessment (CHNA) and complete a companion Implementation Strategy for addressing those identified community needs. These requirements are a provision to maintaining tax-exempt status under Section 501(c)(3). In compliance with these requirements, Pomona Valley Hospital Medical Center (PVHMC) conducted a 2018 CHNA and developed a Community Benefit Plan and Implementation Strategy to describe the actions PVHMC will take to address the significant needs identified in this assessment. PVHMC makes its Community Health Needs Assessment (CHNA), Community Benefit Report and Implementation Strategy widely available to the public at pvhmc.org.

Approval from a Governing Body

PVHMC's 2021 Community Health Needs Assessment (CHNA) included in this report was adopted by the Board of Directors on November 11, 2021.

EXECUTIVE SUMMARY

The Institute of Applied Research and Policy Analysis (IAR) at California State University, San Bernardino (a full-service consulting and applied research organization), has contributed to Pomona Valley Hospital Medical Center's (PVHMC's) every-three-year community needs assessment since 2009. IAR was pleased to be asked to participate once again in PVHMC's 2021 needs assessment.

This year IAR was charged with collecting secondary data regarding Los Angeles County, San Bernardino County, and SPA3 (San Gabriel Valley); primary data from 1,156 residents in PVHMC's service area; information from 26 representatives of low-income, minority, and medically underserved populations in PVHMC's service area; and input regarding the health needs of the community from two public health executives (one from Los Angeles County and one from San Bernardino County).

This executive summary highlights some of the most important findings of this year's community needs assessment. The reader is encouraged to carefully review the full report.

HIGHLIGHTS OF FINDINGS

Biggest (most significant) health care needs:

- **Access to affordable primary care/prevention services and screenings**, especially for low-income populations, communities of color, homeless, LGBTQ+, seniors, undocumented populations, and minority groups.
- **Mental health services/resources**, especially for marginalized communities (homeless and rural), BIPOC, Medicaid and uninsured populations, underrepresented minorities, youth and aging populations, people with special healthcare needs, and the severely mentally ill.
- More **community-wide partnerships, collaborations, and care coordination**, in particular to seniors, minority populations, people with low income and education, special needs patients, LGBTQ+, homeless, undocumented, and marginalized communities (homeless and rural). This issue is especially important relative to individuals suffering from chronic disease:
    - **Adult hypertension**
    - **Cardiovascular health**
    - **Diabetes**
    - **Obesity**

Major barriers to meeting health care needs:

- **Cost/financial issues**, e.g., inability to pay due to lack of insurance or underinsurance, lost income from having to leave work to see the physician during usual office hours, lack of transportation to get to a health appointment, etc.
- Lack of communication between the patient and his/her health care provider, either because of **language barriers**, providers who do not have an adequate understanding of culturally competent care, or fear/lack of trust in the healthcare system.
- **Social determinants of health (SDOH)**, e.g., healthcare access and quality, language and literacy, economic stability, neighborhood environment, food security and employment.
- Lack of access to healthcare due to an inadequate number of providers in outlying areas, lack of **transportation** to get to appointments, or a lack of understanding of how to navigate the healthcare system.
- Increasing food insecurity.
- Lack of patient **health literacy**, both general (e.g., the need for wellness appointments and screenings) and specific (relative to specific chronic disease conditions).

Identified strategies to address significant health needs:

- Increase the number of primary care providers in the region to improve access and reduce the waiting time to get an appointment for routine or specialty care.
- Provide education and resources that support care coordination, including resources that improve communication between patients and providers, procedures to address language barriers, and providing culturally competent care.
- Provide education opportunities for the community regarding issues such as obesity/weight loss, healthy lifestyle, nutrition, smoking cessation, need for health screening, importance of follow-up care and wellness checks, and advanced directives.
- Continue and increase the level of partnerships with CBOs and other community groups that can help reduce the equity gap in healthcare. Fund, support, and partner with organizations that offer health services as well as those offering services such as youth diversion and violence prevention programs.
- Increase availability of mental health resources, and work to communicate the availability of those (and other) resources to the community.
- Address Social Determinants of Health (SDOH) to build health equity, e.g. increase the diversity of the healthcare workforce, provide diversity, equity and inclusion (DEI) education to the workforce, provide services that promote health literacy and improve trust in the health care system, such as promotoras, and address economic and environment issues.

PRIORITZED HEALTH NEEDS

The following table shows the **prioritized health needs** and areas of focus for PVHMC in the 2021-2023 CHNA cycle.

Health needs identified in the CHNA were determined to be significant through a thorough evaluation of primary and secondary data. The identified health needs were prioritized based upon: (1) community respondents and key informants identified the need to be highly significant, or largely identified specific services that they believe would make a positive impact on the health of the community (2) feasibility of providing interventions for the unmet community needs identified, such that Pomona Valley Hospital Medical Center currently has, or has the current means of developing, the resources to meet the need within the next triennial CHNA cycle, and (3) alignment between the identified health need and Pomona Valley Hospital Medical Center's mission, vision, and strategic plan.

PRIORITY AREA	COMMUNITY HEALTH NEED PRIORITIES
Access to Care	**Access to affordable/no-cost preventative care** and **health screenings**.
	Access to **mental health services** and resources.
	Improved Awareness of Services/Resources and **Health Education**
Care Coordination	**Care coordination** and disease management, particularly for: • Diabetes • Hypertension/Cardiovascular Disease • Obesity

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I. INTRODUCTION

Grounded in a longstanding commitment to address the health needs of the community, Pomona Valley Hospital Medical Center (PVHMC) partnered with California State University San Bernardino's Institute of Applied Research (IAR) to conduct a formal Community Health Needs Assessment (CHNA). The Institute of Applied Research and Policy Analysis (IAR) at California State University, San Bernardino(CSUSB), a full-service consulting and applied research organization, has contributed to Pomona Valley Hospital Medical Center's (PVHMC's) every-three-year community needs assessment since 2009.

The complete 2021 CHNA process consisted of primary and secondary data collection, including valuable community, stakeholder, and public health input, ensuring that information regarding low-income, minority, and medically underserved populations is included in the study. The CHNA results are examined to prioritize the most critical health needs of our community and serve as the basis for our Community Benefit Plan and Implementation Strategy. The CHNA further includes resources potentially availabile in PVHMC's community to address the significant health needs identified in the CHNA and an evaluation of the impact of actions that PVHMC has taken to address the significant health needs indentified in PVHMC's immediately preceding CHNA report (2018).

PVHMC'S COMMUNITY

Pomona Valley Hospital Medical Center is located at 1798 N. Garey Avenue, Pomona, CA 91767. Pomona Valley Hospital is located in Los Angeles County within Strategic Planning Area 3 (SPA 3) and closely borders San Bernardino County. PVHMC's community is defined by a primary service area, which consists of seven cities in San Bernardino County and four in Los Angeles County –Pomona, Claremont, Chino, Chino Hills, La Verne, Ontario, Montclair, Rancho Cucamonga, Alta Loma, Upland, and San Dimas and make up a total population of 840, 789 (Source: U.S. Census Bureau, 2010). Our secondary service area includes additional surrounding cities in San Gabriel Valley and western San Bernardino County.

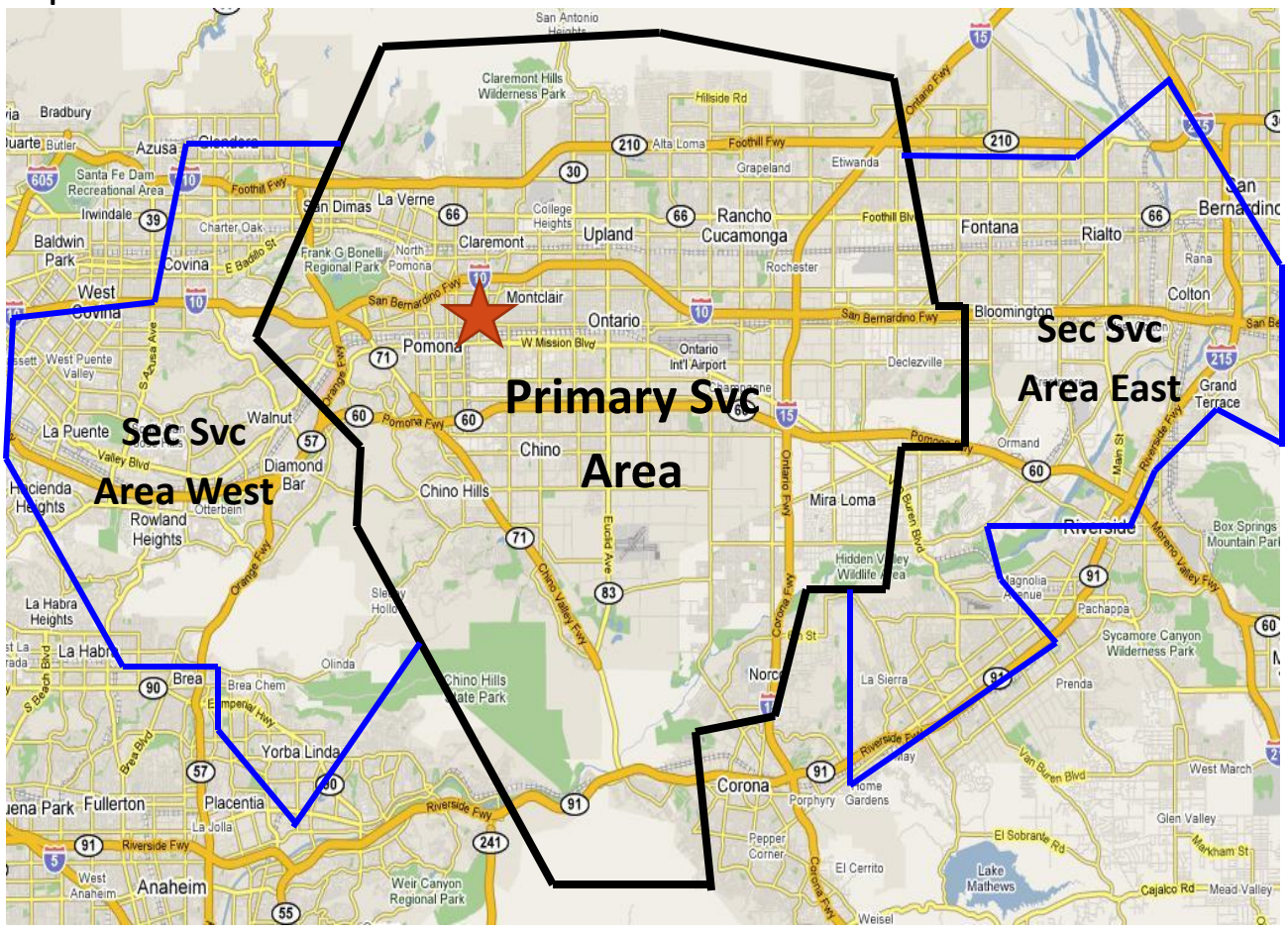
Our service area was determined and defined by analyzing inpatient admissions data and discharge data from the Office of Statewide Health Planning and Development (OSHPD).

Table 1.1: PVHMC's Service Area

City	County	Zip Codes
Alta Loma	San Bernardino	91701, 91737
Chino	San Bernardino	91708, 91710
Chino Hills	San Bernardino	91709
Claremont	Los Angeles	91711
La Verne	Los Angeles	91750
Montclair	San Bernardino	91763
Ontario	San Bernardino	91758, 91761, 91762, 91764
Pomona	Los Angeles	91766, 91767, 91768
Rancho Cucamonga	San Bernardino	91729, 91730
San Dimas	Los Angeles	91773
Upland	San Bernardino	91784, 91785, 91786

Source: https://censusreporter.org/

Map 1: **The Communities PVHMC Serves**



Demographic Profile of PVHMC's Service Area

The following tables list the demographic profile of cities in PVHMC's service area, with California, Los Angeles County, and SPA3 figures provided for comparison purposes.

Table 2.1: Population and Age

City/Region	Population	Median age	% Under 18 yrs old	% 18 to 64 yrs old	% 65+ yrs old
Chino	92,352	38.6	18%	69%	13%
Chino Hills	83,843	40.9	21%	65%	14%
Claremont	36,090	40.4	18%	62%	19%
La Verne	32,211	45.1	20%	60%	20%
Montclair	39,155	32.5	26%	63%	11%
Ontario	184,999	32.1	27%	64%	9%
Pomona	151,696	34.3	24%	64%	12%
Rancho Cucamonga (includes Alta Loma)	177,614	36.9	23%	63%	14%
San Dimas	34,048	41.3	21%	60%	19%
Upland	77,123	38.0	21%	65%	15%
California	39,512,223	37.0	23%	63%	15%
Los Angeles County	10,039,107	37.0	21%	65%	14%
San Bernardino County	2,180,085	33.8	26%	62%	12%
SPA3	1,790,000	32.0	22%	65%	13%

Sources: https://censusreporter.org/, The 2019 California Health Interview Survey, http://publichealth.lacounty.gov

Table 2.2: Gender and Ethnicity

City/Region	% Male	% White	% Black	% Asian	% Hispanic of any race
Chino	52%	24%	3%	15%	55%
Chino Hills	49%	29%	4%	35%	29%
Claremont	47%	49%	5%	14%	25%
La Verne	48%	50%	3%	9%	36%
Montclair	49%	13%	3%	10%	71%
Ontario	49%	15%	4%	7%	71%
Pomona	49%	11%	5%	10%	72%
Rancho Cucamonga (includes Alta Loma)	49%	35%	8%	14%	40%
San Dimas	46%	47%	2%	14%	34%
Upland	47%	35%	7%	9%	45%

California	50%	36%	6%	15%	39%
Los Angeles County	49%	26%	8%	15%	49%
San Bernardino County	50%	27%	8%	7%	54%
SPA3	46%	21%	4%	29%	47%

Sources: https://censusreporter.org/, The 2019 California Health Interview Survey, http://publichealth.lacounty.gov

The city-specific median household income figures range between $62,024 for Montclair and $103,473K for Chino Hills. The percent of persons below the poverty line exceeds 10% in three of the cities in PVHMC's service area (Montclair, Ontario, and Pomona).

Table 2.3: Median Household Income, Poverty, Education, and Foreign Born

City/Region	Median Household Income	Persons Below Poverty Line	High School Grad or Higher	Bachelor's Degree or Higher	Foreign Born
Chino	$ 87,090	6.7%	81.9%	27.1%	27.1%
Chino Hills	$103,473	3.6%	95.3%	52.4%	33.0%
Claremont	$101,420	6.6%	94.2%	56.0%	18.9%
La Verne	$ 88,131	7.8%	91.7%	38.0%	16.3%
Montclair	$ 62,024	14.6%	73.0%	16.3%	33.7%
Ontario	$ 75,266	11.8%	74.6%	17.6%	30.1%
Pomona	$ 67,202	13.1%	72.0%	18.6%	32.0%
Rancho Cucamonga (includes Alta Loma)	$ 92,773	7.5%	91.5%	36.2%	21.2%
San Dimas	$ 86,410	9.3%	93.4%	36.9%	20.1%
Upland	$ 82,426	7.3%	91.6%	32.1%	15.5%
California	$ 80,440	11.8%	84.0%	35.0%	26.8%
Los Angeles County	$ 72,797	13.4%	79.8%	33.8%	34.0%
San Bernardino County	$ 67,903	13.3%	80.7%	22.5%	21.0%
SPA3	$ 76,346	20.3%	80.2%	37.3%	37.8%

Sources: https://censusreporter.org/, The 2019 California Health Interview Survey, http://publichealth.lacounty.gov

Table 2.5: Language Spoken at Home

	English ONLY spoken at home, Children 5-17	Spanish spoken at home, Children 5 -17	English ONLY spoken at home, Adults 18+	Spanish spoken at home, Adults 18+
United States	77.4%	16.0%	78.2%	13.0%
California	57.0%	33.0%	55.2%	27.8%
Los Angeles County	45.2%	44.9%	42.8%	38.1%
SB County	61.9%	34.4%	55.3%	36.0%
SPA3	32.2%	28.7%	35.2%	24.2%

Sources: https://censusreporter.org/, The 2019 California Health Interview Survey, http://publichealth.lacounty.gov

Methodology

This year IAR was charged with collecting secondary data regarding Los Angeles County, San Bernardino County, and SPA3 (San Gabriel Valley); primary data from residents in PVHMC's service area; information from representatives of low-income, minority, and medically underserved populations in PVHMC's service area; and input regarding the health needs of the community from public health executives (one from Los Angeles County and one from San Bernardino County).

More specifically, **secondary data** were collected from a variety of sources regarding demographic profile of the region, health status indicators and major health influencers for PVHMC's service area:

- **Demographic profile of residents**: age, gender, language, race/ethnicity, income, poverty rate, education, foreign born, and language.
- **Health status indicators**: general health evaluation, rates of various diseases (cardiovascular disease, diabetes, cancer, high blood pressure, obesity), and leading causes of death.
- **Major health influencers**: health insurance coverage, tobacco and e-cigarette use, alcohol use, food and nutrition, physical activity levels, mental health issues, homelessness, and rates of domestic violence.

In addition, **primary data** were collected via an online survey of residents within PVHMC's service area to determine their perceptions and needs regarding various health

issues, and to see if there have been any significant changes since the previous studies. Specific issues and questions included:

- **Demographic profile of survey respondents:** city of residence, gender, marital status, education, income, ethnicity, age, years living in the community, number of people and number of children in the household;
- **Health status indicators:** Self-reported health evaluation, impact of the pandemic on overall health, chronic illnesses, other health issues (SODH), children's health conditions, and advanced directives;
- **Major health influencers:** healthy eating, use of tobacco and vaping (and follow-up health screening), health insurance coverage (and reasons for no coverage), barriers to receiving needed health services, utilization of health care services for routine primary/preventative care, safety (accidents, injuries, and other concerns), COVID-19 pandemic, experience with and evaluation of PVHMC; and
- **"Other" issues:** issues of DEI (diversity, equity, and inclusion), biggest health-related issue or service needed, and best ways of disseminating information about classes/support groups/events.

Some community members are unable to respond to an online survey, so IAR supplemented the primary data with a **modified Delphi process** in which representatives of low-income, minority, and medically underserved people were surveyed both in writing and through a focus group. The process addressed the health needs and health drivers in the community, specifically:

- Most significant **health needs** that have the greatest impact on overall health;
- **Most affected subgroups/populations** are most affected by unmet health needs;
- **Health services or health resources** that are lacking;
- **Barriers** keeping people from getting health care;
- **Positive and negative influences** on the health of people in the community;
- The most important thing hospitals can do **to improve the wellness** of the community; and
- Suggestions for **helping PVHMC meet the needs** of the community.

Finally, IAR was asked to conduct **executive interviews** with representatives of both the Los Angeles County and San Bernardino County Public Health offices in order to gain their perspectives of:

- Unmet needs in the community relative to **primary care and preventive care**;
- Unmet needs in the community relative to **support for patients and families** (e.g., support groups, classes, caregiver services);

- Unmet needs in the community relative to **chronic disease management**;
- **Health needs priorities** of the community;
- **Barriers** to receiving routine and urgent health care; and
- Ways in which PVHMC can help **improve the health and wellness** of the general community as well as the subgroups of low-income, minority, and medically underserved populations.

PVHMC is pleased to present this report including the results of its **2021 Community Needs Assessment,** which summarizes the findings from the secondary data collection, primary data collection, Delphi process, and the executive interviews. The report concludes with overall observations and recommendations.

II. SECONDARY DATA

Introduction

These secondaray data have been collected for Los Angeles County as a whole, San Bernardino County as a whole, and for SPA3 (Service Planning Area 3). Available city-specific secondary data for PVHMC's *primary* service area have also been collected. These figures are compared with Healthy People 2020 goals where appropriate. Where relevant, the data reported in the previous community health needs assessment are compared with the most current data collected. Together with the primary data from the online surveys, this information should help PVHMC create an action plan for improving the wellness of the community.

This section of the report presents secondary data regarding:

- **Demographic profile of residents**: age, gender, language, race/ethnicity, income, poverty rate, education, foreign born, and language.
- **Health status indicators**: general health evaluation, rates of various diseases (cardiovascular disease, diabetes, cancer, high blood pressure, obesity), and leading causes of death.
- **Major health influencers**: health insurance coverage, tobacco and e-cigarette use, alcohol use, food and nutrition, physical activity levels, mental health issues, homelessness, and rates of domestic violence.

The following table details the secondary data categories and sources used:

Table 2.4: Secondary Data Sources Used

Indicator Category	U.S. Census & Census Recorder	Los Angeles County Dept of Public Health	CA Health Interview Survey	Centers For Disease Control, CA	CA Dept of Public Health	Healthy People 2020 & 2030	Kids Data.org	CA Dept Of Justice Office Attorney General	CA Cancer Registry	CA EDD	Other Sources
Demographics	X	X									
Social & Economic Factors	X	X								X	
Access to Health Care	X		X								
Foreign Birth Place	X										
Mortality/Leading causes of Death		X		X	X						
Health Insurance	X	X	X			X	X	X	X		
Health Status & Chronic Disease			X						X		
Mental Health			X								X
Tobacco & Alcohol Use			X			X					X
Overweight & Obesity Rates			X			X					
Prevention Practices (exercise)			X			X					
Food & Nutrition			X	X							X
Domestic Violence								X			X
Homelessness											X

Health Status Indicators

Overall health self-assessment

Over half of the people from the two-county area of interest to PVHMC who responded to the 2019 California Health Interview Survey characterized their health as "excellent" or "very good," and those positive numbers have increased over time. In 2019, 58.8% of LA County residents (up from 51.3% in 2011/12), 60.9% of San Bernardino County residents (up from 54.2% in 2011/12), and 55.3% of SPA3 respondents (up from 51.9% in 2011/12) rated their health as "excellent" or "very good" (see Table 2.6: **bold** with grey highlighting). For the most part, that improvement is noted for both males and females (yellow highlighting below). However, the blue highlight shows a change for females in SPA3. In 2016, 56.6% of females evaluated their health as "excellent" or "very good," vs. only 49.4% in the 2019 data.

Finally, although the majority of residents report that their health status is at least "good," it is still important to note that in 2019, 12.5% of Los Angeles County residents, 15.4% of San Bernardino County residents, and 13.7% of SPA3 residents rated their health as only "fair" or "poor" (red highlighting).

Table 2.6: General Health of Children, Teens, and Adults

2011 - 2012 Data[1]

	LA County			SB County			San Gabriel Valley (SPA3)		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Excellent	24.6%	21.4%	**23.0%**	29.1%	18.4%	**23.8%**	22.6%	23.3%	**22.9%**
Very good	27.7%	28.8%	**28.3%**	30.2%	30.5%	**30.4%**	28.2%	29.8%	**29.0%**
Good	30.3%	29.6%	29.9%	25.8%	31.5%	28.7%	28.5%	28.5%	28.5%
Fair	14.5%	16.1%	15.3%	12.4%	14.1%	13.2%	17.6%	14.4%	15.9%
Poor	3.0%	4.1%	3.5%	2.5%	5.4%	4.0%	3.1%	4.0%	3.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

2016 Data

	LA County			SB County			San Gabriel Valley (SPA3)		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Excellent	24.0%	25.0%	**24.5%**	27.6%	21.3%	**24.7%**	24.3% *	27.1%	**25.8%**
Very good	26.6%	27.7%	**27.2%**	31.5%	20.4%	**26.5%**	24.3%	29.5%	**27.1%**
Good	30.0%	30.0%	30.0%	27.7%	31.6%	29.4%	39.0%	27.0%	32.7%
Fair	16.2%	14.7%	15.5%	8.5% *	21.5%	14.3%	9.7% *	14.4% *	12.2%
Poor	3.0%	2.7%	2.8%	4.8% *	5.2% *	5.0%	2.7% *	1.9% *	2.3% *
Total	99.8%	100.1%	100.0%	100.1%	100.0%	99.9%	100.0%	99.9%	100.1%

2019 Data

	LA County			SB County			San Gabriel Valley (SPA3)		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Excellent	26.6%	24.3%	**25.5%**	27.8%	22.6%	**25.1%**	21.3%	19.3%	**20.2%**
Very good	36.1%	30.5%	**33.3%**	34.9%	36.5%	**35.8%**	40.8%	30.1%	**35.1%**
Good	25.1%	32.1%	28.7%	23.2%	24.4%	23.8%	25.7%	35.6%	31.0%
Fair	10.2%	9.9%	10.0%	9.2%	15.3%	12.4%	10.9%	9.2%	10.0%
Poor	1.9%	3.1%	2.5%	4.9%	1.2%	3.0%	1.3%*	5.8%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Sources: Sources: 2011 – 2012, 2016, and 2019 California Health Interview Survey

* Statistically unstable

Table 2.7: shows that the cities with the highest percentages of adults rating their health as only "fair" or "poor" were Montclair, Ontario, and Pomona (red highlighting). Between 2014 and 2018 there have been sizable increases in those negative health ratings among adults in the

1. CHIS uses the coefficient of variation (CV) to express the sampling variance (or "sampling error") around an estimate. The CV indicates whether or not a point estimate (e.g., a mean, proportion, total) is statistically stable relative to its standard error, and shows the proportion of the estimate that reflects sampling variability. In AskCHIS, estimates with a CV greater than 30% are "flagged" as statistically unstable with an asterisk (*). Those figures should be interpreted with caution.

18 to 64 age group in the cities of Chino, La Verne, Ontario, Pomona, San Dimas, and Upland. Smaller increases over time in negative ratings were seen in most cities for the 65+ age group.

The results for the overall counties/region show that there were fewer individuals rating their health as “fair” or “poor” in 2019 than in 2016 (with the exception of SPA3, 18 to 64 age group).

Table 2.7:
% Rating Their Health as "Fair" or "Poor” by Age Group

City-Specific Figures

CITY	2014		2018	
	18 to 64 years old	65+ years old	18 to 64 years old	65+ years old
Chino	17.2%	30.5%	20.5%	32.6%
Chino Hills	15.3%	25.8%	14.1%	27.7%
Claremont	11.2%	21.5%	12.5%	21.2%
La Verne	11.9%	21.5%	16.7%	23.2%
Montclair	26.5%	N/A	26.7%	38.7%
Ontario	21.6%	35.7%	24.1%	36.0%
Pomona	23.7%	41.3%	27.7%	40.6%
Rancho Cucamonga	14.7%	25.7%	14.7%	26.3%
San Dimas	12.6%	23.2%	15.4%	24.5%
Upland	15.4%	23.0%	18.1%	24.2%

County/Region Figures

COUNTY/REGION	2016		2019	
	18 to 64 years old	65+ years old	18 to 64 years old	65+ years old
Los Angeles	19.9%	33.9%	13.5%	24.3%
San Bernardino	25.0%	29.0%	19.0%*	26.5%*
San Gabriel (SPA3)	15.2%	34.4%	15.6%*	24.3%*

Sources: 2016 and 2019 California Health Interview Survey, and 2014 and 2018 California Health Interview Survey (Neighborhood Edition)

Given the relatively high percentage of individuals rating their health as “fair” or “poor,” it is good news that in 2019 more San Bernardino County residents were getting their yearly physical exams than was the case in 2016. That number has decreased in Los Angeles County and SPA3.

Table 2.8: % Physical Exam at least in the past 12 months

COUNTY/REGION	2016	2017	2018	2019
Los Angeles County	75.0%	76.7%	75.3%	**69.7%**
San Bernardino County	70.3%	71.2%	70.2%	**72.9%**
SPA3	74.3%	78.1%	77.1%	**69.3%**

Source: 2016, 2017, 2018, 2019 California Health Interview Survey

*statistically unstable

Table 2.9: % Who Received a Physical Exam in the Past 12 months (by Age Group)

	2016		2019	
COUNTY/REGION	18 to 64 years old	65+ years old	18 to 64 years old	65+ years old
Los Angeles	72.8%	86.1%	65.1%	90.4%
San Bernardino	66.3%	93.7%	71.3%	80.6%
San Gabriel (SPA3)	70.9%	91.2%	64.3%	94.2%

Sources: 2016 and 2019 California Health Interview Survey

Prevalence of chronic diseases

Although the majority of individuals in each county/region rated their health as "excellent" or "very good", many people still battle conditions such as cardiovascular disease, diabetes, high blood pressure, cancer, and obesity. The following tables show the prevalence of those diseases, broken down by geographical region and gender. Tables for 2011/12 and 2016 are shown below for comparison purposes to 2019 data. In general, the rates of high blood pressure and obesity are the highest of the chronic diseases listed. Cancer rates appear to be dropping over time.

Table 2.10: Percent of Adults (18 – 64) Diagnosed with Various Chronic Diseases (Male, Female, Total) 2011 – 2012 Data

	LA County			SB County			San Gabriel Valley		
	MALE	FEM.	TOT.	MALE	FEM.	TOT.	MALE	FEM.	TOT.
Cardio-vascular	6.2%	5.1%	5.6%	6.9%	5.8%	6.3%	7.3%	5.4%	6.3%
Diabetes	9.6%	7.7%	8.6%	9.2%	12.0%	10.6%	10.1%	6.1%	8.0%
High BP	26.0%	27.3%	26.7%	32.3%	33.2%	32.8%	29.7%	28.1%	28.9%
Cancer	5.9%	8.2%	7.1%	7.0%	9.4%	8.2%	4.2%	7.4%	5.9%
Obesity	25.9%	23.6%	24.7%	36.1%	30.4%	33.2%	25.1%	21.9%	23.4%

2016 Data

	LA County			SB County			San Gabriel Valley		
	MALE	FEM.	TOT.	MALE	FEM.	TOT.	MALE	FEM.	TOT.
Cardio-vascular	6.4%	4.9%	5.6%	6.6%*	9.8%*	8.2%*	5.4%*	7.0%*	6.3%*
Diabetes	6.0%	4.6%	5.3%	10.3%*	7.4%*	8.9%*	5.3%*	5.8%*	5.6%*
High BP	26.1%	17.1%	21.5%	25.7%	25.9%	25.8%	24.4%	10.1%*	16.5%
Cancer	3.3%	5.8%	4.5%	3.4%	7.0%	5.2%	2.8%	4.1%	3.5%
Obesity	32.0%	29.1%	30.5%	32.6%	42.8%	37.6%	29.5%	20.0%*	24.3%

2019 Data

	LA County			SB County			San Gabriel Valley		
	MALE	FEM.	TOT.	MALE	FEM.	TOT.	MALE	FEM.	TOT.
Cardio-vascular	7.6%	5.7%	6.7%	6.4%*	8.7%	7.6%	4.6%	5.7%*	5.2%
Diabetes**	10.9%	9.3%	10.1%	17.5%	11.0%	13.9%	9.5%	10.8%	10.2%
High BP (2018 data)	**29.6%**	**18.0%**	**23.7%**	**26.5%**	**20.1%**	**23.3%**	**27.5%**	**14.4%**	**21.3%**
High BP (2019, borderline BP included)**	**21.1%**	**14.9%**	**18.0%**	**35.2%**	**14.8%**	**24.1%**	**17.7%**	**21.1%**	**19.5%**
Cancer	3.7%	3.9%	3.7%	3.9%	4.0%	3.8%	N/A	N/A	N/A
Obesity***	**28.2%**	**28.%**	**28.1%**	**38.9%**	**30.1%**	**34.1%**	**20.7%**	**24.9%**	**22.9%**

Source: 2011 – 2012, 2016, 2018 and 2019 California Health Interview Survey

Source of most recent cancer data, 2014 – 2018: https://explorer.ccrcal.org/

* Statistically unstable

** Borderline diabetes included

*** Body Mass Index – 4, BMI 30.0 or higher

City-specific data are not available for most major chronic diseases, but they are available for diagnoses of heart disease, diabetes, and obesity (BMI $\geq$ 30).

Table 2.11:
% of Adults Diagnosed With Heart Disease, Diabetes, or Obesity (City-Specific)

	2014 %			2018 %		
CITY	% Heart Disease	% Diabetes	% Obese (BMI ≥ 30)	% Heart Disease	% Diabetes	% Obese (BMI ≥ 30)
Chino	4.8%	10.1%	34.8%	5.5%	12.5%	28.8%
Chino Hills	5.1%	9.8%	26.6%	5.8%	10.7%	21.6%
Claremont	6.8%	8.4%	17.6%	6.7%	6.8%	16.9%
La Verne	6.6%	8.2%	18.7%	7.2%	8.8%	20.1%
Montclair	4.5%	13.1%	40.7%	5.7%	14.6%	33.8%
Ontario	4.4%	11.5%	39.9%	5.4%	13.8%	33.3%
Pomona	4.4%	11.2%	28.4%	4.8%	11.1%	29.0%
Rancho Cucamonga	4.8%	8.9%	30.2%	6.2%	11.7%	26.9%
San Dimas	6.4%	8.4%	19.4%	6.9%	8.7%	20.2%
Upland	5.6%	9.5%	30.4%	6.8%	11.9%	26.8%

Source: 2014 and 2018 California Health Interview Survey, Neighborhood Edition

Leading causes of death

The reason that community health needs assessments include data on leading causes of death is that conditions with the highest mortality rates could be targeted for preventive action by health care organizations. Recent **nationwide** data indicate that the major causes of death are heart disease, cancer, accidents (unintentional injuries), chronic lower respiratory diseases, and stroke. **California** data from 2019 show that leading causes of death include heart disease (rate = 136.9), cancer (rate = 131.6), stroke (rate = 37.3), Alzheimer's (rate = 37.0), and accidents (rate = 35.9) and chronic lower respiratory diseases (rate = 29.0).[2]

Cancer and heart disease are the leading causes of death in Los Angeles County and San Bernardino County. The following table shows the available data for death rates per 100,000 population (crude and/or age-adjusted rate) in those 2 counties, and the age-adjusted rate in SPA3. It also includes California figures and HP2020 targets for comparison.

2. https://www.cdc.gov/nchs/pressroom/states/california/ca.htm

Table 2.12: Leading Causes of Death (2017 – 2019 average)

Cause of Death	LA County		SB County		SPA3	California		HP 2020
	Crude Rate	Age-Adjusted	Crude Rate	Age-Adjusted	Age-Adjusted	Crude Rate	Age-Adjusted	Age-Adjusted Target
All Cancers	**142.5**	**127.8**	**138.8**	**150.2**	N/A	**149.8**	**131.4**	161.4
Heart Disease	**109.2**	**95.0**	**90.0**	**102.0**	**106.6**	**94.0**	**80.6**	103.4
Stroke	36.7	32.4	36.0	41.2	33.5	41.6	35.9	34.8
Chronic Lower Respiratory Disease (COPD)	29.5	26.3	42.6	49.1	30.2	34.0	29.7	a
Alzheimer's Disease	41.3	35.2	33.5	40.2	24.2	41.6	35.2	a
Unintentional injuries (accidents)	26.6	25.3	37.6	38.5	N/A	36.1	34.1	36.4
Diabetes Mellitus	27.1	24.2	31.8	34.8	22.8	24.2	21.3	b
Influenza and Pneumonia	19.3	17.0	13.0	14.5	20.6	15.8	13.7	a
Chronic Liver Disease & Cirrhosis	13.9	12.4	16.5	16.6	N/A	13.6	12.1	8.2

Sources: https://www.cdph.ca.gov/Programs/CHSI/Pages/County-Health-Status-Profiles.aspx
http://publichealth.lacounty.gov/chs/SPA3/

a. HP2020 target not yet established

b. National Objective is based on both underlying and contributing cause of death, which requires use of multiple cause of death files. California's data excluded multiple/contributing causes of death

Major Health Influencers

According to the World Health Organization (WHO), "many factors combine together to affect the health of individuals and communities. Whether people are healthy or not is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact."[3]

Consistent with this concept, Healthy People 2020 and Healthy People 2030 have indicated that a person's health is influenced/determined by the interrelationships between multiple factors, including individual behaviors, policymaking, social factors, availability of health services, and biology and genetics.

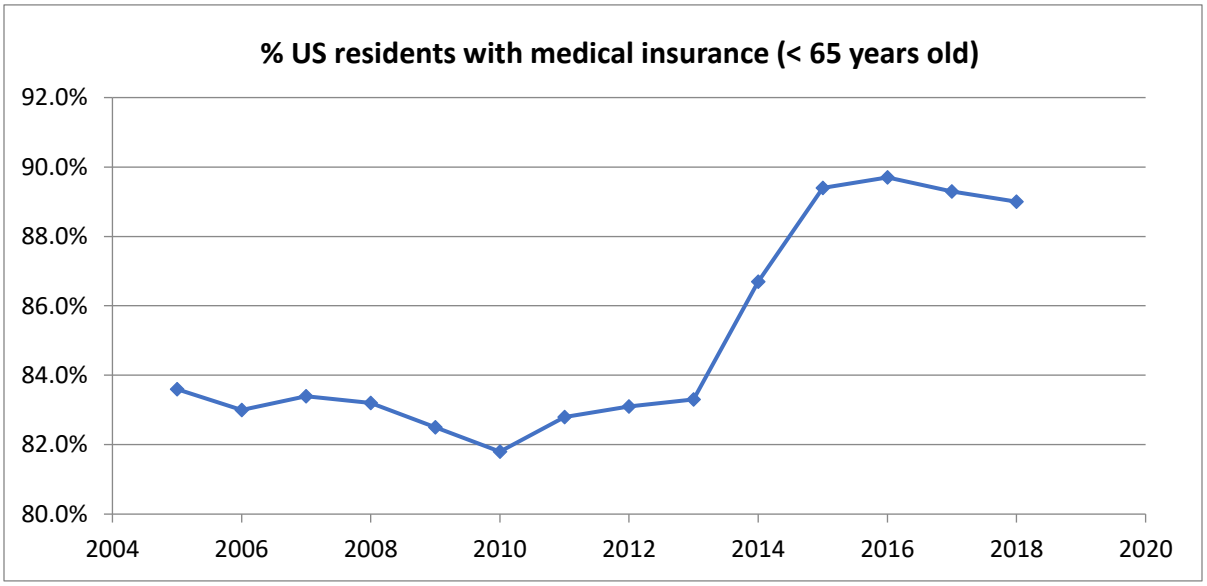
3. https://www.who.int/news-room/q-a-detail/determinants-of-health

This section of the report includes information about some of those factors, beginning with a look at health insurance coverage.

Insurance Coverage

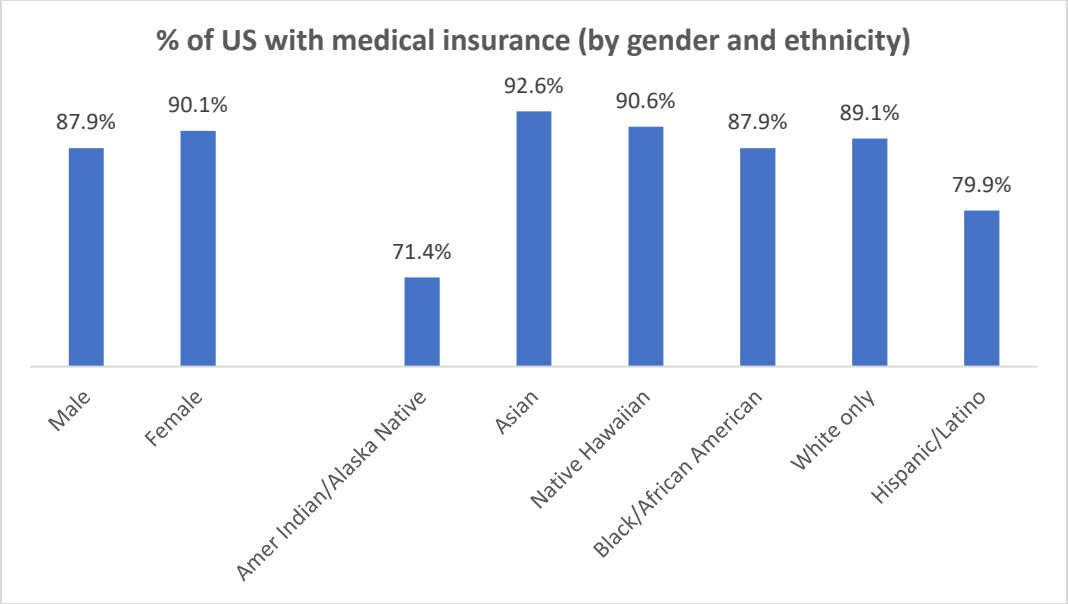
The Healthy People 2020 target for the proportion of people with medical insurance (individuals 65 years old and below) is 100%. The reason for such a high target is that those who are uninsured often do not have the funds to seek preventive health care, thus resulting in the need for treatment for diseases (and potentially poorer health outcomes).

Before 2013 the rates of insured residents nationwide hovered between 80% and 85%, with an increasing trend shown since 2013 (probably due to the requirement in the Affordable Care Act (ACA) that all Americans must have health insurance). But the data for 2017 and 2018 shows a slight decline, and as of 2018 (the last date with data on the HealthyPeople.gov website), 89.0% of the U.S. population reported having medical insurance. The National Center for Health Statistics quotes the 2019 figure to be 89.8% insured.



Source: https://www.healthypeople.gov/2020/data-search/Search-the-Data?topic-area=3495

Viewing the data for the U.S. as a whole masks some disparities in the data by gender and race/ethnicity. Nationwide, more females than males have medical insurance. The percentage insured for American Indian/Alaska Natives is quite low (71.4%), as is the rate for Hispanics/Latinos (79.9%).



Los Angeles County and San Bernardino County have seen overall increases in health insurance status over time, whereas the 2019 data for SPA3 shows a slight decrease. The Healthy People 2020 target has not yet been realized, but both Los Angeles and San Bernardino Counties are getting closer.

Table 2.13: Health Insurance Status (% Covered by Health Insurance)

		LA County	SB County	SPA3
2011 – 2012 data	Children and teens (0 – 17)	95.6%	97.7% *	94.6%*
	Adults (18 – 64)	75.4%	73.9%	75.9%
	Seniors (65+)	98.6% *	99.3% *	99.6% *
	All ages	83.1%	83.4%	83.0%
2016 data	Children and teens (0 – 17)	97.5% *	94.7% *	100.0% *
	Adults (18 – 64)	86.3%	85.3% *	91.2% *
	Seniors (65+)	99.4% *	100.0% *	100.0% *
	All ages	90.5%	89.6% *	94.3% *
2019 data	Children and teens (0 – 17)	98.0%*	98.0% *	95.5% *
	Adults (18 – 64)	86.2%	90.1%	85.8%
	Seniors (65+)	99.6% *	100.0% *	100.0% *
	All ages	90.7%	93.4%	89.7%

Source: 2019 California Health Interview Survey

* Statistically unstable

It must be noted that the LA County Health Survey released in 2018 had slightly different estimates. That survey showed 90.1% of LA County adults (ages 18 – 64) with health insurance, and 93.2% of SPA3 adults with health insurance.[4]

Following are the available city-specific data on insurance coverage. The good news is that the rate of adults with health insurance has increased from 2016 to 2018 in all of the cities in the PVHMC service area. The cities of Chino, Montclair, Ontario, and Pomona had the lowest percentages of insured adults in PVHMC's service area in 2018.

Table 2.14: % Insured (City-Specific)

	2012		2016		2018	
CITY	% children & teens	% adults (18 - 64)	% children & teens	% adults (18 - 64)	% children & teens	% adults (18 - 64)
Chino	97.6%	73.9%	NA	84.2%	Current data unavailable	85.2%
Chino Hills	97.9%	81.5%	97.7%	90.0%		88.9%
Claremont	96.8%	83.2%	NA	92.3%		92.1%
La Verne	96.2%	83.1%	NA	92.5%		91.7%
Montclair	97.7%	68.4%	N/A	77.1%		82.6%
Ontario	97.5%	69.8%	97.5%	79.6%		83.8%
Pomona	94.8%	70.4%	94.4%	84.1%		85.2%
Rancho Cucamonga	97.8%	78.8%	97.8%	87.7%		88.5%
San Dimas	N/A	82.1%	N/A	92.3%		90.8%
Upland	97.8%	78.1%	N/A	84.9%		88.2%

Source for adults: 2012, 2016, and 2018 California Health Interview Surveys, Neighborhood Edition
Source for children and teens ages (0 – 18): Kidsdata.org (data through 2016)

Tobacco and E-Cigarette Use

One of the Healthy People 2020 goals is to "reduce illness, disability, and death related to tobacco use and secondhand smoke exposure." The web site indicates that tobacco use (and secondhand smoke) causes cancer, heart disease, lung diseases, a variety of health issues for pregnant women, and health problems in infants and children. It is cited as the "single most preventable cause of death and disease in the United States."[5] In addition, the Healthy People 2030 objectives include reducing current tobacco use in adolescents and adults, reducing the

4. http://publichealth.lacounty.gov/ha/hasurveyintro.htm
5. https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use

use of flavored tobacco products in adolescents who use tobacco, reducing the proportion of adolescents exposed to tobacco marketing, and reducing the current use of smokeless tobacco products among adolescents.

The following table shows the percentage of people (of any age) who are current smokers, former smokers, or who never smoked tobacco. Over time there has been a significant decrease in the percentage of *current* adult smokers, and a significant increase in the percentage of adults who have never smoked. Also included in the table is 2019 data on e-cigarette use among adults.

Table 2.15: Tobacco Use and E-Cigarette Use Among Adults (18+)

		LA County	SB County	SPA3	HP2020 Target
2011 – 2012 data	Current smokers	13.9%	14.6%	13.8%	12.0%
	Former smokers	21.5%	22.3%	19.9%	---
	Never smoked	64.6%	63.2%	66.3%	---
2016 data	Current smokers	11.4%	11.4%	10.5%	12.0%
	Former smokers	20.1%	27.0%	17.1%	---
	Never smoked	68.5%	61.6%	72.5%	---
2019 data	Current smokers	6.0%	9.5%	3.7%	12.0%
	Former smokers	18.4%	16.3%	13.8%	---
	Never smoked	75.5%	74.2%	82.5%	---
2019 data	Current E-cig user	4.0%	4.6% *	3.5% *	---
	Former E-cig user	11.5%	11.9%	8.9%	---
	Never smoked E-cigarettes	84.5%	83.5%	87.6%	---

Sources: 2011 – 2012, 2016 and 2019 California Health Interview Survey (CHIS); healthypeople.gov
NOTE: "Current E-cig user" is a person who has used e-cigarettes at least once in the last 30 days, "Former E-cig user" is a person who has not used in the last 30 days

City-specific figures for tobacco and e-cigarette use among adults follow. The heaviest cigarette use is among adults in the cities of Chino, Montclair, and Ontario:

Table 2.16: Tobacco and E-Cigarette Use Among Adults 18+ (City-Specific)

CITY	2011 – 2012 % Current Smokers	2014 % Current Smokers	2018 % Current Smokers	2018 % Current E-cigarette User
Chino	13.7%	9.5%	13.2%	6.2%
Chino Hills	10.7%	9.6%	10.4%	6.3%
Claremont	14.0%	10.8%	7.9%	5.1%
La Verne	11.4%	11.0%	9.3%	4.7%
Montclair	15.5%	9.9%	13.6%	5.5%
Ontario	14.5%	9.3%	13.0%	6.0%
Pomona	15.5%	12.8%	11.1%	4.3%
Rancho Cucamonga	14.5%	10.7%	12.9%	6.4%
San Dimas	12.0%	11.1%	8.4%	4.5%
Upland	14.7%	10.2%	12.5%	6.0%

Sources: 2011 – 2012 and 2014 and 2018 California Health Interview Survey, Neighborhood Edition

Alcohol Use

Excessive alcohol use can result in a series of both short and long-term health risks. Short term risks include injuries from falls, drowning, burns, and vehicle crashes; violent behaviors; risky sexual behaviors, complications in pregnancy, and alcohol poisoning. Over time it can lead to a variety of chronic diseases and other serious issues such as high blood pressure, cancer, dementia, mental health problems, and social problems.[6]

How does the CDC define "excessive" alcohol use? The definition includes **binge drinking** (for women, 4 or more drinks in about 2 hours; for men, 5 or more drinks during a 2-hour period), or **Heavy Drinking** (for women, 8 or more drinks per week; for men, 15 or more drinks per week), or **any drinking by pregnant women or people younger than age 21**. The National Institute on Alcohol Abuse and Alcoholism adds that binge drinking is a pattern of drinking alcohol that brings blood alcohol concentration to .08 or higher.[7] They also note that in 2019, 25.8% percent of people nationwide ages 18 and older reported that they engaged in binge drinking in the past month, and 6.3% reported that they engaged in heavy alcohol use in the past month. These data can be used to compare to the rates in PVHMC's service area.

The following data address binge drinking by adults and teens in Los Angeles County, San Bernardino County, and SPA3.

6. Centers for Disease Control and Prevention, http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm
7. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics

Table 2.17: Alcohol Use

		LA County	SB County	SPA3
2011 – 2012 Data (pooling)	% ***adults*** binge drinking in the past *year*	29.9%	28.7%	28.5%
	% ***teens*** (12 – 17) binge drinking in the past *month*	5.1%	---	3.0% *
2015 data	% ***adults*** binge drinking in the past *year*	33.8%	33.6%	27.0%
2016 data	% ***teens*** (12 – 17) binge drinking in the past *month*	3.0% *	---	---
2019 data**	% ***teens*** (12 – 17) binge drinking in the past *month*	2.8%*	16.3%*	---

Sources: 2011 – 2012 and 2016 and 2019 California Health Interview Survey (CHIS); healthypeople.gov
* Statistically unstable
**CHIS no longer includes questions about binge drinking for adults. Rather, questions are asked about needing help for emotional/mental health problems or use of alcohol/drug (combined). This data cannot be included in this table.

Food and Nutrition

According to the CDC, poor nutrition is one of the main risk factors for preventable chronic diseases (along with tobacco use, lack of physical activity, and excessive alcohol use).[8] The web site indicates that fewer than 1 in 10 US adults and adolescents eat enough fruits and vegetables, and most adults and young people consume too many sugary drinks. In general, a diet high in added sugars, sodium and fat tends to contribute to several disease states, including heart disease, obesity, diabetes, some cancers, high cholesterol, and high blood pressure.[9] Yet a 2019 study showed that 46.3% of US individuals reported eating a balanced, healthy diet "always" or "very often."[10] That is good news, considering that healthy eating can play a major role in the prevention of such diseases.

The California Health Survey (published by the UCLA Center for Health Policy Research) includes a variety of measurements to determine the health behaviors of residents relative to food and nutrition. The following table is a snapshot of healthy (and not-so-healthy) eating patterns reported by respondents in Los Angeles County, San Bernardino County, and SPA3 in 2016 and 2018.

8. https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm
9. US Department of Agriculture and US Department of Health and Human Services. Dietary Guidelines for Americans, 2010. 7th edition. Washington, DC: US Government Printing Office; 2010.
10. https://www.statista.com/statistics/1085382/healthy-eating-in-the-us/#:~:text=From%20a%202019%20study%20conducted,food%20very%20often%20during%202019

Table 2.18: Food and Nutrition

		2016 data			2018/2019 data		
		LA County	**SB County**	**SPA3**	**LA County**	**SB County**	**SPA3**
Soda consumption	% **children &** ***teens*** who consumed ≥ 2 glasses of soda *yesterday*	3.4% *	3.4% *	7.5% *	9.3%	3.3%	16.3% *
	% ***children & teens*** who consumed ≥ 2 glasses of sugary drinks (other than soda) *yesterday*	12.2%	30.2% *	5.0% *	14.2%	12.7%*	11.4%*
Consumption fruits/vegs	% ***teens*** who ate ≥ 5 servings of fruits and vegetables daily	22.5%*	8.2%*	22.0%*	23.2%	16.8%*	18.1%*
	% ***teens*** who ate ≥ 2 servings of fruits and vegetables yesterday	69.5%	65.0%*	67.3%*	65.2%	57.0%	51.4%
Avail & cost of fruits/vegs	% **adults** who can *always* or *usually* **find** fresh fruits and vegs in neighborhood	86.7%	82.1% *	89.5%	87.1%	85.4%	92.6%
	% **adults** with fresh fruits/vegs *always* or *usually* **affordable** in neighborhood	75.6%	75.0%	82.1%	80.8%	81.9%	81.3%
Issues among the poverty population	% ***adults with income < 200% of federal poverty level*** (FPL) without the consistent ability to be able to afford enough food	43.1%	55.1%	34.8%	40.9%	46.4%	34.4%
	% of ***children/teens/ adults with income < 300% of FPL*** currently receiving food stamps	21.7%	27.8%	17.8% *	16.5%	23.1%	10.1% *

Source: 2016, 2018, and 2019 California Health Interview Survey

* Statistically unstable

Consumption of soda and sugary drinks (other than soda) by children and teens has increased over time in LA County and SPA3, but has decreased in San Bernardino County. The

percentage of teens reporting eating *at least 5 servings* of fruits and vegetables daily has increased significantly in San Bernardino County, but the percent who reported eating *at least 2 servings* yesterday decreased in all regions (especially SPA3). The vast majority of adults can apparently find fresh fruits and vegetables in their neighborhood; however fewer can find *affordable* fresh fruits and vegetables. But on a positive note, the percentage of adults without the consistent ability to be able to afford enough food has decreased (although it remains higher than would be desired). These findings (and others in the table above) may highlight areas that deserve focus by public health officials.

City-specific food insecurity data is shown below. Montclair has the highest percentage of low-income individuals who are unable to consistently buy food. Ontario and Pomona also have high rates of food insecurity.

Table 2.19: % of ALL Adults 18+ Unable to Consistently Buy Food (City-Specific)

CITY	2014 data	2016 data	2018 data
Chino	7.0%	8.2%	7.1%
Chino Hills	3.3%	4.1%	3.6%
Claremont	2.5%	2.4%	2.2%
La Verne	3.6%	3.7%	3.4%
Montclair	13.0%	12.0%	11.7%
Ontario	10.7%	11.0%	10.2%
Pomona	13.4%	11.2%	10.1%
Rancho Cucamonga	4.1%	4.9%	5.0%
San Dimas	3.9%	3.9%	3.1%
Upland	5.0%	5.4%	5.3%

Source: 2014, 2016, and 2018 California Health Interview Survey, Neighborhood Edition

One final note regarding food insecurity: As reported in August 2021, the Biden administration has moved to increase food stamp program benefits more than 25% from pre-pandemic levels. Once people in the program begin to receive this additional aid, it is hoped that the rates of food insecurity will decrease.

Physical Activity

Research shows that people who engage in regular physical activity have a lower risk for chronic diseases such as cardiovascular disease, cancer, diabetes, obesity, osteoporosis, depression, and a host of other illnesses. The following table outlines the level of physical

activity for adults, teens, and children in LA County and SPA3.[11] The figures for adults, although not "perfect," are higher than the HP 2020 figures. But the figures for children's exercise are relatively low and declining over time.

Table 2.20: Measures of Physical Activity

	2015 data		2018 data		
	LA County	SPA 3	LA County	SPA 3	HP 2020
Percent of ***adults*** who obtain recommended amount of aerobic exercise per week (≥150 minutes/week of moderate exercise or ≥75 min of vigorous exercise)	65.1%	64.2%	64.4%	63.4%	47.9%
Percent of ***adults*** who obtain recommended amount of muscle-strengthening (≥2 days/week)	41.3%	37.3%	43.1%	40.9%	24.1%
Percent of ***adults*** who obtain recommended amount of aerobic and muscle strengthening exercise per week	34.1%	31.3%	35.1%	33.4%	20.1%
Percent of ***children*** ages 6-17 who obtain recommended amount of aerobic exercise each week (≥60 min daily)	28.5%	28.4%	23.7%	22.4%	N/A
Percent of ***children*** ages 6-17 who obtain recommended amount of aerobic and muscle strengthening exercise per week	17.7%	15.7%	15.1%	12.2%	N/A

Sources: 2015 and 2018 LA County Health Survey; Healthypeople.gov

The California Health Interview Survey also includes questions regarding the amount of daily physical activity for children, teens, and adults; visits to parks/open spaces by teens; hours spent by children and teens on sedentary activities during weekdays and weekends; and walking for transportation and leisure for adults.

11. IAR was unable to find current similar data for San Bernardino County

Table 2.21: Other Measures of Physical Activity

	2016 data			Most current data		
	LA County	SB County	SPA3	LA County	SB County	SPA3
Percent ***children*** physically active ≥ 1 hour during at least 5 days in the past week	44.9%*	38.7*	12.2%*	49.9%* (2018)	31.1%* (2018)	30.5%* (2018)
Percent ***teens*** (12 – 17) who visited a park, playground, or open space in the last month	77.2%*	91.6%*	92.7%*	50.5% (2018)	61.5%* (2018)	42.5%* (2018)
≥ 5 hours spent by ***children and teens*** on sedentary activities on typical weekdays after school	14.0%*	16.2%*	29.8%*	15.8%* (2018)	21.9%* (2018)	16.5%* (2018)
≥ 5 hours spent by ***children and teens*** on sedentary activities on typical weekend days	22.6%*	9.5%*	34.8%*	17.6%* (2018)	24.2%* (2018)	20.0%* (2018)
				30.7%* (2019)	39.5% (2019)	28.6%* (2019)
Percent ***adults*** who regularly walked for transportation, fun, or exercise	38.5%	33.0%	37.8%	39.2% (2017)	33.3% (2017)	36.7% (2017)
Percent ***adults*** who are physically active at least 20 minutes at a time, ≥ 5 days a week	---	---	---	48.6% (2018)	51.9%* (2018)	51.2%* (2018)

Sources: 2016, 2017, 2018, 2019 California Health Interview Survey (CHIS)

* Statistically unstable. This table has some figures that are especially questionable where the confidence intervals are literally 0% – 100%. ***The results should be interpreted with caution.***

Overall, visits to parks, playgrounds, or open spaces by teens decreased significantly over time between 2016 and 2018. And the percent of children and teens spending at least 5 hours per weekend on sedentary activities *increased* sharply in Los Angeles County and San Bernardino County but *decreased* in SPA3.

Unfortunately, the California Health Interview Survey did not include city-specific physical activity data for 2018. Following is the available city-specific data for physical activity for 2014 and 2016 (the most current data available). The table shows that the physical activity

level of children and teens declined from 2014 to 2016 in nearly all cities, whereas the physical activity for adults has increased.

Table 2.22: City-Specific Physical Activity Measures

CITY	2014 Data		2016 Data	
	% 5 – 17 yr olds ≥ 1 hr of daily physical activity (excluding PE)	*% adults* who walked ≥ 150 minutes	*% 5 – 17 yr olds* ≥ 1 hr of daily physical activity (excluding PE)	*% adults* who walked ≥ 150 minutes
Chino	23.5%	30.6%	18.2%	32.8%
Chino Hills	22.1%	27.5%	20.5%	33.9%
Claremont	21.3%	32.2%	20.2%	36.8%
La Verne	21.4%	31.4%	20.4%	33.9%
Montclair	20.8%	29.6%	13.7%	35.8%
Ontario	21.5%	30.4%	15.9%	33.5%
Pomona	17.4%	31.9%	15.2%	34.9%
Rancho Cucamonga	25.2%	28.9%	20.9%	34.7%
San Dimas	20.5%	30.2%	21.4%	33.8%
Upland	24.8%	29.8%	18.6%	35.5%

Source: 2014 and 2016 California Health Interview Survey, Neighborhood Edition

Mental Health

The pandemic has had an immense effect on the mental health of adults and children in the US. A Kaiser Family Foundation (KFF) Health Tracking Poll of US adults from July 2020[12] showed the following effects on adults of worry and stress over COVID-19:

- 36% had difficulty sleeping
- 32% had difficulty eating
- 12% increased their alcohol consumption or substance use
- 12% experienced worsening chronic conditions

But as noted in the table below, residents in the region were experiencing increasing levels of mental health issues even before the pandemic. The following table includes several measures of mental and emotional health. The reader will note that the rate of mental health issues skyrocketed between 2016 and 2019, and the recent results of nationwide polls (such as

12. https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/

the ones by the Kaiser Family Foundation quoted above) would indicate that rates are most probably higher in 2020 and due to worries and stress associated with the pandemic.

Table 2.23: Mental Health Issues

	2016 data			2019 data		
	LA County	**SB County**	**SPA3**	**LA County**	**SB County**	**SPA3**
Percent ***teens and adults*** who likely have had serous psychological distress during past year	7.4%	9.2%	5.8%*	15.1%	13.1%	13.5%
% teens only	1.3%*	0.9%*	---	37.3%	26.4%*	50.2%
% adults only	8.0%	10.5%	6.3%*	13.0%	11.3%	9.1%
Percent ***adults*** with moderate to severe **work impairment** past 12 months	11.9%	6.6%*	11.8%*	21.1%	13.8%	18.2%
Percent ***adults*** with moderate to severe **family life impairment** past 12 months	12.8%	16.0%	10.9%	20.8%	20.1%	17.5%
% **adults** needed help for emotional/mental health problems or use of alcohol/drugs	15.4%	15.2%	15.4%*	20.9%	16.5%	13.8%
% **teens** needed help for emotional/mental health problems	11.8%*	8.1%*	10.9%*	32.1%	29.7%*	30.7%*
% **adults** ever seriously thought about committing suicide	7.3%	6.9%	8.0%*	13.2%	12.2%	7.5%

Source: 2016, 2017, 2018, 2019 California Health Interview Survey
*statistically unstable

Table 2.24: 2018 City-Specific Mental Health Issues Over Past 12 Months

	% adults experiencing serious psychological distress	% adults whose emotions interfered with work performance	% adults with family life impairment	% adults who needed help for emotional/mental or alcohol/drug problems
Chino	11.0%	11.6%	16.9%	16.7%
Chino Hills	9.8%	10.1%	15.6%	15.8%
Claremont	12.6%	14.3%	18.1%	22.0%
La Verne	10.9%	11.0%	15.3%	19.2%
Montclair	10.9%	11.4%	16.2%	16.6%
Ontario	11.3%	11.7%	16.9%	17.3%
Pomona	12.3%	13.5%	16.9%	17.7%
Rancho Cucamonga	11.1%	11.7%	17.3%	19.4%
San Dimas	10.5%	10.7%	15.3%	18.4%
Upland	10.7%	11.2%	16.6%	19.1%

Source: 2018 California Health Interview Survey, Neighborhood Edition
*statistically unstable

Domestic Violence

Domestic violence is defined as "abuse committed against an adult or a minor who is a spouse, former spouse, cohabitant, former cohabitant, or person with whom the suspect has had a child or is having or has had a dating or engagement relationship."[13] Such abuse is clearly a "health influencer" for the 161,123 people nationwide who made domestic violence-related calls for assistance in 2019. Victims of domestic violence suffer immediate trauma. In addition, the violence can contribute to various chronic health problems (e.g. depression, substance abuse, and hypertension).

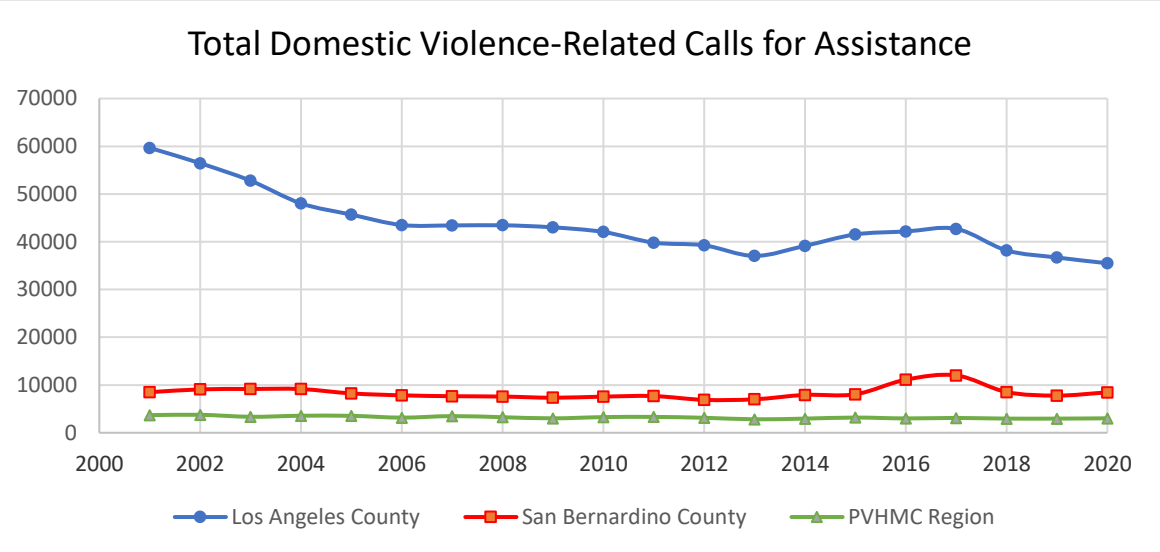
As the table and graph below demonstrate, domestic violence-related calls for assistance had been decreasing over time in LA County, SB County, and in PVHMC's primary service area until 2014. Between 2015 and 2017, that downward trend reversed (particularly as seen in the San Bernardino countywide data). The 2020 figure for Los Angeles County continued the downward trend, but for the San Bernardino County and PVHMC's primary service area increased.

13. https://openjustice.doj.ca.gov/data-stories/2019/domestic-violence-related-calls-assistance-reported-2010-2020

Table 2.25: Total Domestic Violence-Related Calls for Assistance

Year	LA County	SB County	PVHMC primary service area
2004	48041	9146	3558
2005	45684	8235	3538
2006	43508	7831	3167
2007	43416	7650	3484
2008	43458	7579	3246
2009	43014	7327	3015
2010	42052	7563	3269
2011	39817	7681	3317
2012	39253	6882	3131
2013	37038	7002	2815
2014	39145	7919	2958
2015	41534	8052	3175
2016	42148	11109	2998
2017	42702	12012	3097
2018	38190	8525	2959
2019	36707	7781	2960
2020	35498	8456	3017

Source: State of California Dept. of Justice, Office of the Attorney General
http://oag.ca.gov/crime/cjsc/stats/domestic-violence
https://openjustice.doj.ca.gov/data



Homelessness

According to the United States Interagency Council on Homelessness, "As of January 2020, California had an estimated 161,548 experiencing homelessness on any given day, as reported by Continuums of Care to the U.S. Department of Housing and Urban Development (HUD). Of that Total, 8,030 were family households, 11,401 were Veterans, 12,172 were unaccompanied young adults (aged 18-24), and 51,785 were individuals experiencing chronic homelessness."[14] At that time, California had 27.9% of the nation's homeless population. Those statistics undoubtedly got worse during the pandemic. But regardless of the reasons behind the epidemic of homelessness, policymakers must address the issue as a humanitarian and economic disaster with huge public health implications. As noted by the CDC: "Health problems among homeless persons result from various factors, such as barriers to care, lack of access to adequate food and protection, and limited resources and social services."[15]

The data in the table below show 'point-in-time' counts of people experiencing homelessness:

Table 2.26: Point-in-Time Homeless Counts

	2019 data			2020 data		
	LA County	SB County (2018)	SPA3	LA County	SB County	SPA3
# People who are homeless	56,257	2,118	4,489	63,706	2,607	4,555
% Sheltered	24.5%	31.9%	26.7%	27.7%	26.4%	33.5%
% Unsheltered	75.5%	68.1%	73.3%	72.3%	73.6%	66.5%

Sources: https://www.hudhdx.info/#hic
https://www.lahsa.org/news?article=557-2019-greater-los-angeles-homeless-count-results
https://www.lahsa.org/news?article=726-2020-greater-los-angeles-homeless-count-results
https://wp.sbcounty.gov/dbh/sbchp/wp-content/uploads/sites/2/2019/05/2019-homeless-count-and-survey-report.pdf
https://wp.sbcounty.gov/dbh/sbchp/wp-content/uploads/sites/2/2020/04/2020-SBC-Homeless-Count-Report.pdf

Final Comments Relative to Secondary Data

While gathering the data for the tables in this section of the report, IAR reviewed a large number of web sites which might be useful to PVHMC in the future. Following is a list of those sites:

Secondary data sources at the local, state, and national levels included:

14. https://www.usich.gov/homelessness-statistics/ca/
15. https://www.cdc.gov/phlp/publications/topic/resources/resources-homelessness.html

- United States Census Bureau
- California Health Interview Survey 2011-2012, 2014, 2016, 2018, 2019
- California Health Interview Survey (CHIS), Neighborhood Edition
- California Cancer Registry
- Department of Public Health County of Los Angeles
- Centers for Disease Control and Prevention Leading Causes of Death in California
- California Department of Public Health, County Health Status Profiles https://www.cdph.ca.gov/Programs/CHSI/CDPH Document Library/CHSP-County Profiles 2018.pdf
- Health People
- Kids Data
- State of California Dept. of Justice, Office of the Attorney General
- U.S. Census Bureau (2019) American Community Survey 5-year estimates. Retrieved from Census Reporter Profile (then using zip codes)
- Employment Development Department CA Latest News Releases
- Homelessness Data Exchange
- Los Angeles Homeless Services Authority
- 2020 Greater Los Angeles Homeless Count Results
- 2019 San Bernardino County Homeless Count and Subpopulation Survey Final Report https://wp.sbcounty.gov/dbh/sbchp/wp-content/uploads/sites/2/2019/05/2019-homeless-count-and-survey-report.pdf
- 2020 San Bernardino County Homeless Count and Subpopulation Survey Final Report https://wp.sbcounty.gov/dbh/sbchp/wp-content/uploads/sites/2/2020/04/2020-SBC-Homeless-Count-Report.pdf

Other links that PVHMC may find helpful:

- California Department of Public Health
- Census Bureau
- American Community Survey Five Year Estimates
- Healthy People 2020
- Center for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System
- Centers for Disease Control and Prevention, Leading Causes of Death
- California Health Interview Survey
- National Center for Health Statistics
- San Bernardino County Department of Behavioral Health
- California Department of Health Care Services
- National Institute of Mental Health. Suicide in the U.S.: Statistics and Prevention.
- The State of Obesity in California Data, Rates and Trends

- National Cancer Institute
- National Institute of Diabetes and Digestive and Kidney Diseases
- American Diabetes Association
- EDD Employment Development Department Newsroom
- EDD Labor Market Information
- American Cancer Society
- FBI Crime Statistics
- Bureau of Justice Statistics
- Domestic Violence Statistics
- U.S. Breast Cancer Statistics
- U.S. Health Resources and Services Administration Data Warehouse
- https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-treatment-and-survivorship-facts-and-figures/cancer-treatment-and-survivorship-facts-and-figures-2016-2017.pdf
- https://assessment.communitycommons.org/UserContents/CHNA_Contents/CHNA26296RPT_4.pdf
- http://www.dartmouthatlas.org/data/topic/
- http://www.dartmouthatlas.org/publications/
- Los Angeles County Department of Public Health (Key Health Indicators, Epidemiology, Data and Reports)
- California Office of Statewide Health Planning and Development (OSHPD)
- U.S. Department of Health & Human Services Preventions Surgeon General.gov Reports and Publications
- California Department of Education Physical Fitness Test, State, County, District Breakdowns
- CDC Youth Risk Behavior Surveillance System (YRBSS) 2019
- California Dream Index Los Angeles Region
- Opportunity Insights Economic Tracker impacts of COVID-19
- US Census Bureau Household Pulse Survey Data Tables
- US EPA
- United Way of California
- Careeronestop
- Employment Development Department CA Interactive Maps and Data Tools

III. PRIMARY DATA COLLECTION (ONLINE SURVEYS)

Process and Methodology Used

There are many ways of effectively and efficiently delivering a survey. Choice of a mode of delivery is typically determined based on a variety of factors such as the target population, time frame of a project, topic of interest, need for in-depth probing of respondents, and available budget. Each mode of delivery has its own advantages and disadvantages, and each allows the researcher to accomplish specific types of goals.

In the past, IAR has conducted a telephone survey of residents within PVHMC's service area. But over the past decade there has been a tremendous increase in the use of the internet and social media to communicate, gather information, provide an opportunity for community engagement, and enhance relationships. Not surprisingly, the use of online surveys has skyrocketed. Indeed, over the past few years of conducting survey research for public and private organizations in the Inland Empire, IAR has found that such surveys offer the advantages of speed, efficiency, community engagement, and lower costs of data collection.

To begin, IAR spent a great deal of time developing a new questionnaire (in consultation with PVHMC) to allow the community to provide their input regarding their healthcare behaviors and needs. Some of the questions had been used in the 2009, 2012, 2015, and 2018 community needs assessment surveys in order to reveal trends over time. Others addressed more current issues of interest to PVHMC (e.g. impact of COVID on health and employment, perceptions of diversity/equity in the community and among PVHMC staff, etc.). The online survey was designed to take, on average, no more than 15 minutes to complete. The initial questionnaire, after its approval by PVHMC staff, was then translated into Spanish and pretested in both languages. The questionnaire is attached as Appendix A.

Two distribution methods were prepared. First, IAR prepared a link to the online survey which was distributed by PVHMC's outreach team on dedicated websites, social media (Facebook, Instagram, Twitter), ads, patient outreach, community leader outreach, flyers, and internal communication outreach. In addition, IAR directed VuPoint Research to conduct the online survey using an established panel of individuals who have already agreed to take part in research of this type (and can be targeted by age, ethnicity, and gender). The two methods used together provided the broadest opportunity for people to respond to the online survey. PVHMC made links available in both English and Spanish on June 24, 2021, and VuPoint launched the survey on June 30, 2021. The surveys were available until August 1, 2021.

The surveys promoted by PVHMC's outreach team yielded a total of 819 residents from the eleven cities within PVHMC's service area, resulting in a 95 percent level of confidence and an accuracy of +/- 3.4%. Spanish-speaking individuals had the choice of completing the survey either in English or Spanish; 2.2% of the surveys were completed in Spanish. VuPoint's "panel" approach to the online survey yielded a total of 337 respondents in the service area (all of

whom responded to the English version of the survey), resulting in a 95 percent level of confidence and an accuracy of +/- 5.3%.

Sampling and Response Considerations

- PVHMC's outreach resulted in an abundance of respondents from the city of Pomona who have used PVHMC's services. Thus responses from the panel approach (VuPoint) may differ from that approach on certain questions (which are noted in the report).
- In order to correct for under-sampling of young people who are traditionally less likely than older people to respond to surveys, a weighting factor was applied to the data. The weighted results cited in this report are a more accurate representation of the opinions of the full population of residents in PVHMC's service area.
- Previous community needs assessment surveys were conducted using a telephone mode of delivery, thus differences noted over time may partially be due to switching the survey delivery mode to online. Indeed, research shows that females answer online surveys in much greater numbers than males, whereas telephone surveys have close to a 50/50 split between females and males. Hispanic participation tends to be higher in telephone surveys than in online surveys. Young people are more likely to respond to web surveys than telephone surveys (if they agree to participate at all), whereas older people are more likely to participate in phone surveys. And there is a higher rate of "longtime residents" among telephone survey respondents than in web surveys.[16]

The reader is encouraged to consider the above factors when interpreting the comparative analyses between the 2021 survey and previous surveys.

Online Survey Findings

The findings from the 2021 PVHMC online surveys are presented in sections, divided into conceptual categories (e.g., demographic profile of respondents, health status indicators, health influencers, and "other" issues). We begin with a brief profile of survey respondents.

Demographic profile of respondents

The following table shows the number of people from each city who responded to each version of the survey.

16.https://www.researchgate.net/publication/241589742_A_Comparison_of_Response_Characteristics_from_Web_and_Telephone_Surveys

Table 3.1: Respondent City of Residence

Cities	IAR Online		VuPoint Online	
	# in Sample	Percent	# in Sample	Percent
Alta Loma	37	4.5%	33	9.8%
Chino	53	6.5%	34	10.1%
Chino Hills	81	9.9%	34	10.1%
Claremont	138	16.8%	16	4.7%
La Verne	81	9.9%	15	4.5%
Montclair	19	2.3%	16	4.7%
Ontario	71	8.7%	51	15.1%
Pomona	212	25.9%	60	17.8%
Rancho Cucamonga	30	3.7%	28	8.3%
San Dimas	28	3.4%	12	3.6%
Upland	69	8.4%	38	11.3%
TOTAL	**819**	**100.0%**	**337**	**100.0%**

Table 3.2: Demographic Profile of Respondents

	IAR	VuPoint
Gender		
Male	20.0%	32.5%
Female	79.4%	64.2%
Married	49.5%	40.2%
Education		
High School Degree or Less	10.0%	23.3%
Some College or College Degree	90.0%	76.7%
Median Household Income Category	$65,000- $80,000	$50,000 - $65,000
Less than $35,000	23.5%	34.3%
$35,000 to < $80,000	32.0%	35.6%
$80,000 or more	44.5%	30.0%
Employment		
Working full-time for pay	42.6%	38.2%
Working < 30 hours a week for pay	11.0%	12.4%
Unemployed and looking for work	6.4%	10.9%
Ethnicity (multiple response question)		
Caucasian	49.4%	53.7%
Hispanic	36.8%	33.4%

Asian/Pacific Islander	12.6%	15.6%
Black/African American	6.3%	10.1%
Hispanic, Spanish, or Latino Origin	41.3%	36.2%
Average (Mean) Age	46	41
18 to 34 years old	34.0%	43.6%
35 to 54 years old	31.0%	27.7%
55 or older	35.0%	28.7%
Average (Mean) # of Years Living in Community	21	17
Average (Mean) # of People Living in the Household	3	3
Those with No Children Living in the Household	60.4%	65.0%
(Of those with Children): # of Children Living in the Household		
One	44.2%	44.9%
Two	39.8%	34.7%

Health Status Indicators

Self-reported health evaluation

When respondents were asked "*would you say that in general your health is excellent, good, fair or poor,*" the answer from the majority of the respondents was "excellent" or "good" (70.1% in the IAR survey and 66.2% in the VuPoint Survey), with the rest evaluating their health as "fair" or "poor." Given the toll COVID-19 has taken on people's physical and mental health in 2020 and 2021, one might have expected to see a significant increase in negative health ratings ("fair" or "poor"), but that was not the case. The health evaluations in the table below have not significantly changed over time. We note, however, that there are more negative health ratings from residents in PVHMC's service area than are reflected in Gallup survey results from November 2020[17] which show that approximately 20% of U.S. residents rated their health as "fair" or "poor." Finally, we note that there were no significant differences in health evaluation based on gender or ethnicity.

Table 3.3: Respondents' Rating of their Health

	2009	2012	2015	2018	2021 IAR	2021 VuPoint
Excellent	15.1%	16.4%	15.2%	15.4%	17.0%	14.5%
Very Good/Good	54.9%	51.4%	53.6%	51.4%	53.1%	49.7%
Fair	23.7%	25.1%	27.9%	29.3%	25.7%	30.3%
Poor	6.2%	4.3%	3.3%	3.9%	4.3%	4.5%

17. https://news.gallup.com/poll/1648/Personal-Health-Issues.aspx

A direct question was included on this year's survey about the impact of the pandemic on overall health: *"How has the pandemic impacted your overall health? Would you say that it has had a negative impact, or a positive impact, or not much impact?"* In response, over a third of respondents indicated that the pandemic had negatively affected their overall health, whereas about half indicated that the pandemic had not had much impact on their health.

Table 3.4: Impact of the Pandemic on Overall Health

	IAR	VuPoint
Negative impact	37.9%	34.2%
Positive impact	7.0%	9.1%
Not much impact	50.6%	52.4%
Don't know	4.5%	4.2%

As a follow-up question, those who had indicated that the pandemic had negatively impacted their health were asked to indicate the way(s) in which their health was impacted. The following table shows the results of that multiple response question. The main negative impact was the stress, anxiety, and depression that most likely came from isolation, job loss (and resulting loss of health insurance), financial difficulties, illness/death of family and friends, etc. Over half of the respondents reported gaining weight, and many reported being afraid to return to the "normal" life from going back to work and socializing.

Table 3.5: Ways the pandemic negatively impacted overall health

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
More stressed, anxious, and/or depressed	248	86.6%	82	73.9%
Gained weight	149	51.9%	65	58.6%
Afraid to go back to work or socialize	83	29.1%	40	36.0%
Stomach problems	71	24.8%	15	13.5%
Got COVID --still feeling fatigue, fogginess, pain, cough, difficulty breathing...	42	14.6%	22	19.8%
Drinking alcohol more	28	9.6%	21	18.9%
Lost job so couldn't pay for food	15	5.1%	21	18.9%
Smoking more	12	4.0%	18	16.2%

Missed primary/preventive care	8	2.9%	3	2.7%
Lost family member to COVID	3	1.1%	0	0.0%
Others	21	7.2%	7	6.3%
Total # responding to the question	286		111	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Chronic Illnesses

As noted in the secondary data analysis, high blood pressure, obesity, and diabetes are the most prevalent chronic diseases for residents of Los Angeles County, San Bernardino County, and SPA3. The table below reflecting the health problems of residents of PVHMC's service area shows a high prevalence of those diseases as well as issues of high cholesterol, arthritis, and asthma. We note that 17% of respondents in the IAR survey and 23% in the VuPoint survey indicated that they have NO chronic or ongoing health problems.

Table 3.6: Do you or any member of your family have any of the following chronic or ongoing health problems?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
High blood pressure	**335**	**55.7%**	**122**	**49.2%**
Obesity	**209**	**34.8%**	**67**	**27.0%**
Diabetes	**199**	**33.1%**	**76**	**30.6%**
High cholesterol or arteriosclerosis	**189**	**31.5%**	**69**	**27.8%**
Arthritis	**185**	**30.7%**	**62**	**25.0%**
Asthma	**165**	**27.4%**	**61**	**24.6%**
Cancer	76	12.6%	17	6.9%
Osteoporosis	65	10.8%	15	6.0%
Chronic Pain (back, fibromyalgia, neuropathy, migraine)	26	4.3%	3	1.2%
Chronic heart failure	21	3.4%	10	4.0%
Thyroid disease / disorder	19	3.2%	1	0.4%
Kidney disease / stones / issues	10	1.6%	2	0.8%
Immune Diseases	8	1.4%	2	0.8%
COPD	6	1.0%	2	0.8%
Lupus/Autoimmune Diseases	6	1.0%	3	1.2%
Sleep issues	6	0.9%	2	0.8%
SVT/AFIB	5	0.9%	3	1.2%

Gerd/Reflux Disease	3	0.5%	0	0.0%
Parkinson	3	0.4%	0	0.0%
Others	49	8.2%	12	4.8%
Don't know	26	4.3%	15	6.0%
Total # responding to the question	601		248	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

A few respondents mentioned chronic illnesses other than the ones in the above table, including chronic stress/anxiety, bronchitis, celiac disease, hernia, dementia, renal failure, depression/mental health issues, and Crohn's disease.

It is not enough for physicians to simply diagnose a chronic disease, tell patients what to do, and hope the patients will make the lifestyle choices necessary to live a healthy life. The literature would indicate that patients must be active, informed participants in the health care process. The American Academy of Family Physicians notes that the key to a successful health outcome "is the patient's level of involvement and responsibility for his or her own condition."[18]

Ongoing advice and support from doctors, support groups, or classes can help keep people on track. Respondents with chronic diseases were asked whether they feel they have received adequate help managing their disease from those sources. Only about three-quarters of respondents responded in the affirmative, and another small group indicated that they had received help for *some* of the illnesses.

Table 3.7: Do you feel you and your family have received adequate help managing the disease (from doctors or support groups or classes)?

	IAR		VuPoint	
	Count	Percent	Count	Percent
Yes	447	74.3	183	74.1%
No	80	13.3	39	15.8%
Only for some of the illnesses	30	5.0	4	1.6%
Don't know	44	7.4	21	8.5%
Total	602	100.0	247	100.0%

Those who indicated that they had not received adequate help were asked to specify what type of help they had not received. Many people specified that they needed help with obesity/weight loss, healthy lifestyle, nutrition, and diabetes education (16). There were also comments (12) revolving around the general need for more advice, information, and education

18. https://www.aafp.org/fpm/2000/0300/p47.html

regarding their disease without specifying exactly what type of information they were seeking. For example, one asked for "*accurate, reliable information*" and another said: "*doctors need to give education/teaching regarding the patient's diagnoses*." One said: "*I'm not always sure what I'm supposed to be doing for myself.*" A few people were specific, stating that they wanted information about the long-term effects of COVID and weight loss/healthy lifestyle information.

It must be noted that there were a great many comments complaining about a lack of compassion, caring, and listening from their health care provider, and about the need for better communication with patients. For example: "*The provider seems to want to only get tests done, and talks down to me*." "*The provider doesn't listen. Pain management is often overlooked since he treats me like I'm lying or my pain isn't that bad*." "*I had to switch providers because they never went over test results.*" "*The providers constantly focus on medication for treatment but never discuss how that illness can be managed in other ways.*"

Others (13) talked about not getting appointments in a timely manner ("*Scheduling was difficult*," and "*I was scheduled for a procedure but it was rescheduled three times due to the pandemic*"). Several talked about the lack of support groups or classes during the pandemic.

Other health issues reported by adults:

Social determinants of health are important to address when evaluating a community's quality of life. Issues such as substance abuse, mental health, domestic violence, poverty, and hunger have a major impact on people's health and well-being.

In an attempt to evaluate those social determinants of health, respondents were presented with a list of various issues and asked if they personally (or a child they care for) has experienced the health issues. Over half of respondents (52.4% of IAR survey respondents and 56.1% of VuPoint respondents) said that they had not experienced ANY of the health issues listed.

The top response given by those *with* experience was **mental health disease**. Clearly that is an issue that healthcare organizations need to address, particularly in light of stresses that have arisen during the pandemic. Unfortunately 36% in the IAR survey and 40% in the VuPoint survey indicated either that they are not aware (or not sure) that there are community resources to help if someone they know was experiencing a mental health crisis. That is a call for community outreach and education.

Although mental health was the most-often mentioned health issue, respondents also mentioned poverty/joblessness, "children falling behind in school," living in an unsafe neighborhood, and substance abuse.

Table 3.8: Following is a list of various health issues. Have you personally (or a child you care for) experienced any of these health issues? Please check all that apply.

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Mental health disease	**180**	**70.9%**	**64**	**49.6%**
Living in an unsafe neighborhood with gangs, gun violence, and crime	61	**24.0%**	24	18.6%
Substance abuse	46	18.3%	31	**24.0%**
Poverty/joblessness	45	17.7%	36	**27.9%**
Domestic violence	35	13.7%	22	17.1%
Malnutrition/hunger	35	13.7%	13	10.1%
Children falling behind in school	35	13.7%	35	**27.1%**
Intellectual disabilities	28	11.0%	8	6.2%
Homelessness	25	9.8%	20	15.5%
Incarceration for minor crimes	15	6.0%	11	8.5%
Total # responding to the question	254		129	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Children's Health Conditions

This year's survey asked some new questions about specific health conditions experienced by the children in the household. Respondents were asked: *"Have you been told by any of your children's doctors that they have any of the following conditions?"* The vast majority of respondents indicated that their children had NONE of the conditions noted. Asthma/breathing problems and weight issues were the main conditions reported by those respondents whose children DO have medical issues.

Table 3.9: Children's Medical Conditions

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Asthma or breathing problems	48	57.2%	21	44.7%
Overweight/obese	39	46.7%	25	53.2%
Diabetes	12	14.5%	7	14.9%
Seizures	1	1.2%	2	4.3%
Others	13	15.3%	3	6.4%
Total # responding to the question	84		47	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

"Other" conditions listed include:

- Attention deficit disorder (ADD)
- Attention deficit disorder without hyperactivity (ADHD) (2)
- Autism spectrum disorder (ASD)
- Anxiety
- Chronic Fatigue Syndrome
- Colitis
- Depression
- Eczema
- Gender identity issue
- Guillen-Barre Syndrome
- Oppositional defiant disorder (ODD)
- Rheumatoid arthritis
- Scoliosis
- Tourette Syndrome

Most of the respondents who have children with asthma/breathing problems or diabetes did not need to take them to the emergency room in the past year to deal with those issues.

Table 3.10: How many times during the past 12 months did you visit the emergency room because of your child's…

	Asthma/Breathing		Diabetes	
	IAR	VuPoint	IAR	VuPoint
Zero Visits	35 78.4%	11 52.4%	9 90.0%	2 28.6%
1 visit	8 17.7%	4 19.0%	1 10.0%	3 42.9%
2 visits	1 1.7%	5 23.8%	0 0.0%	1 14.3%
3 visits	0 0.0%	1 4.8%	0 0.0%	1 14.3%
>3 visits	1 2.2%	0 0.0%	0 0.0%	0 0.0%
Total # responses	45	21	10	7
Average # visits	.34 visits	0.81 visits	.10 visits	1.14 visits

Relatively few respondents reported having trouble finding pediatric specialists for their children (16 in the IAR sample and 9 in the VuPoint sample). Those 25 respondents were then given a follow-up question asking: "*What specialists couldn't you find for your child(ren)*?" Nineteen (19) of those individuals chose to provide a response.

Table 3.11. What specialists couldn't you find for your child(ren)?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Diabetes specialist	2	18.2%	1	14.3%
Bone or joint specialist	2	18.2%	1	14.3%
Cancer specialist	0	0.0%	0	0.0%
Heart specialist	0	0.0%	1	12.5%
Lung or breathing specialist	0	0.0%	3	42.9%
Brain health specialist (i.e. neurologist)	0	0.0%	1	14.3%
Others	7	63.6%	2	28.6%
Total # responding to the question	11		8	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Responses from the 9 people who answered "other" included herbalist, mental health professional/psychologist/therapist, pediatric neurologist, pediatric ENT, urologist, physical therapist, and thyroid specialist/endocrinologist.

The following table shows reasons offered for not being able to see a specialist.

Table 3.12: What difficulties did you have getting in to see a specialist for the child?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Couldn't get a timely appointment	4	19.0%	5	62.5%
Couldn't find this type of specialist locally	5	23.8%	2	25.0%
No transportation to get to the office	0	0.0%	0	0.0%
Couldn't go during hours of operation	1	4.8%	2	25.0%
Didn't know how to find this type of specialist	1	4.8%	1	12.5%
Specialist is not in the health network	2	9.5%	4	44.4%
No health insurance/couldn't afford it	1	4.8%	1	12.5%
Specialist was not seeing new patients	4	19.0%	1	12.5%
Others	3	14.3%	0	0.0%
Total # responding to the question	11		8	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

The "other" responses were predominantly statements that their insurance wouldn't cover the cost of the visit and/or procedure.

Safety (Accidents, injuries, and other concerns)

According to the Society of Trauma Nurses, "Injury is the leading cause of death for people between the ages of 1 to 44 years old representing 59 percent of all death in the United States. According to the Center for Disease Control and Prevention (SDC), each year, approximately 214,000 people die from unintentional and violence related injury. The number of those that are injured and survive range into the millions. The impact of injury can have long reaching effects such as lifelong disability, mental health disorders and cause financial instability."[19]

19. https://www.traumanurses.org/2021-national-trauma-awareness-month

Respondents were asked: "*In the past 2 years, have you or has anyone in your household experienced a traumatic injury like a work accident, car accident, or sports injury*?" Approximately 1 in 6 families answered in the affirmative. It is quite possible that the number of people reporting injuries would have been higher if the pandemic in 2020 and 2021 had not kept many people isolating at home without the opportunity to play sports or drive the number of miles they had driven in the past.

Table 3.13: In the past 2 years, have you or has anyone in your household experienced a traumatic injury like a work accident, car accident, or sports injury?

	IAR		VuPoint	
	Count	Percent	Count	Percent
Yes	128	17.3%	54	16.7%
No	608	82.7%	270	83.3%
Total	736	100.0%	324	100.0%

As noted in the table above, the vast majority of respondents had not experienced a traumatic injury in the recent past. But did they feel *safe*? Safety (i.e. a low crime rate) is a big component of quality of life in a community. If an area is *perceived* to be unsafe, the community's attractiveness as a place to live and work suffers. Healthy behaviors such as exercising and socializing outdoors diminish, stress increases, residents and visitors begin to abandon the area, and businesses often follow that exodus.

Respondents were asked: "*Do you feel safe in your neighborhood*?" Most respondents (65.2% in the IAR survey and 60.1% in the VuPoint survey) said that they feel safe "all the time," and another large group indicated that they feel safe only at certain times of the day.

Table 3.14: Do you feel safe in your neighborhood…?

	IAR		VuPoint	
	Count	Percent	Count	Percent
All the time	483	65.2%	196	60.1%
At certain times of the day but not others	223	30.2%	112	34.4%
Never	12	1.6%	13	4.0%
Don't know	23	3.1%	5	1.5%
Total	740	100.0%	326	100.0%

But the above question focused on the feelings of safety for the adult respondents, not the children in the community. Those respondents with at least one child were asked to indicate what safety concerns they have for their children. As noted in the table below,

concerns about crime and violence ranked at the top of the list, followed by bullying. Potential lack of safety while children walk home from school was also a concern for more than a third of respondents.

Table 3.15: The safety of our children is an important part of our community. What safety concerns do you have for your children?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Crime/violence	**131**	**46.2%**	**64**	**56.6%**
Bullying	**97**	**34.2%**	**57**	**50.4%**
Children walking home from school	**95**	**33.6%**	**43**	**38.1%**
Swimming/pool safety	81	28.5%	32	28.3%
No particular worries	65	23.1%	11	9.7%
Children riding a bike	54	19.0%	22	19.5%
Riding in a car	47	16.7%	24	21.2%
Car seat safety	41	14.6%	26	23.0%
Safety playing a sport	36	12.8%	22	19.5%
Don't know	23	8.2%	3	2.7%
Other (please specify)	15	5.4%	4	3.5%
Total # responding to the question	283	100.0%	113	100.0%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

To place these results in context, we offer some statistics from a national sample of parents asked to rate the top health concerns for US children and teens.[20] The major concerns cited in that study are:

1. Overuse of social media/screen time (72%)
2. Bullying/cyberbullying (62%)
3. Internet safety (62%)
4. Unhealthy eating (59%)
5. Depression/suicide (54%)
6. Lack of physical activity (54%)
7. Stress/anxiety (54%)
8. Smoking/vaping (52%)
9. Drinking or using drugs (50%)
10. COVID (48%)

20. https://mottpoll.org/reports/top-health-concerns-kids-2020-during-pandemic

Advanced directives

Given the prevalence of chronic illnesses and other health issues, the need for advanced directives is clear. Yet, less than half of respondents indicated that they have designated someone to make health decisions for them if they are unable to do so themselves. As might be expected, older people were much more likely to have an advanced directive than younger people. In fact in the IAR survey, nearly 70% of respondents in the 55 or older age group have an advanced directive, vs. 32% in the 18 to 34 year old age group. The same trend holds in the VuPoint survey.

Table 3.16: Have you designated someone to make healthcare decisions for you should you be unable to do so on your own? In other words, do you have an advanced directive?

	IAR		VuPoint	
	Count	Percent	Count	Percent
Yes	336	47.4%	125	37.9%
No	356	50.1%	180	54.5%
Don't know/don't remember	17	2.4%	25	7.6%
Total	709	100.0%	330	100.0%

Major Health Influencers

Healthy eating

There are obviously many factors contributing to a person's overall health. One of those factors is good nutrition. As noted on the health.gov website, "The foods and beverages that people consume have a profound impact on their health. The scientific connection between food and health has been well documented for many decades, with substantial and increasingly robust evidence showing that a healthy lifestyle—including following a healthy dietary pattern—can help people achieve and maintain good health and reduce the risk of chronic diseases throughout all stages of the lifespan: infancy and toddlerhood, childhood and adolescence, adulthood, pregnancy and lactation, and older adulthood. The core elements of a healthy dietary pattern are remarkably consistent across the lifespan and across health outcomes."[21]

Most health need surveys such as this one include a question such as: "*Do you typically find it difficult to eat healthy or maintain a healthy body weight*?" Approximately 1/3 of respondents indicated that it is NOT difficult to do so (down from nearly 2/3 in 2018). Another

21. https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

large group of respondents (25.8% IAR and 27.0% VuPoint) said it IS difficult, and 15% said that it isn't *typically* difficult however the pandemic changed their eating and exercise habits.

Table 3.17: Difficulty eating healthy or maintaining a healthy body weight

	2018	2021 IAR	2021 VuPoint
Yes	28.3%	25.8%	27.0%
No, it is not difficult	62.9%	33.0%	26.1%
Sometimes difficult	8.8%	26.1%	31.5%
Not usually, but my eating and exercise habits changed during the pandemic	---	15.0%	15.5%

Those who reported that they **typically** find it difficult (or sometimes difficult) to eat healthy or maintain a healthy body weight were then asked a follow-up question: *"What would you say is the NUMBER ONE reason it is difficult?"* Approximately 3 out of 10 people (30.7% in IAR survey and 27.2% in VuPoint) simply said that "it's hard to change my eating and exercise habits" -- a significant increase from the 13.6% who provided that reason in the 2018 survey.

In the 2018 survey, 29.7% said that maintaining a healthy weight is difficult because "I'm too busy to exercise or prepare healthy meals." In the 2021 surveys the number of people providing that response declined, and was only given by 16.3% of IAR and 14.7% of VuPoint survey respondents. The CDC website lists "lack of time" as a major reason cited for not exercising. Yet the "too busy" rationale may be more of an issue of "failure to prioritize," considering that data show that Americans 15 years old and older spend, on average, 2.81 hours watching TV, 0.64 hours socializing and communicating, 0.31 hours relaxing and thinking, 0.43 hours playing games or using the computer for leisure, and 0.27 hours reading for personal interest).[22] In short, most people have the time to exercise and prepare healthy meals if they wish to make those activities a priority. Other reasons for finding it difficult to eat healthy or maintain a healthy body weight include "liking food too much" and the cost of eating healthy. One interesting and poignant comment came from a person expressing what may be a common frustration: "We eat very healthy but cannot lose weight." All of these themes can be used as PVHMC conducts its community classes.

22. https://www.bls.gov/charts/american-time-use/activity-leisure.htm

Table 3.18:

Number "ONE" reason it is difficult to eat healthy and maintain a healthy body weight

	IAR		VuPoint	
	Count	Percent	Count	Percent
It's hard to change my eating & exercise habits	**122**	**30.7%**	**52**	**27.2%**
Cost of healthy food (fruits and vegetables)	75	**18.9%**	21	11.0%
Too busy to exercise or prepare healthy meals	**65**	**16.3%**	**28**	**14.7%**
I like food too much	38	9.6%	34	**17.8%**
Not sure how to cook/prepare health foods	22	5.6%	5	2.6%
The pandemic changed my eating habits	20	5.1%	20	10.5%
Lazy / stressed / anxiety	5	1.3%	0	0.0%
Menopause	3	0.7%	0	0.0%
Not sure what is considered "unhealthy"	1	0.4%	11	5.8%
I don't care about my weight	1	0.2%	8	4.2%
Others	28	7.0%	5	2.6%
Don't know	17	4.3%	7	3.7%
Total	398	100.1%	191	100.1%

Use of tobacco or vaping

Smoking or being in the same house as someone who smokes, is another factor which can negatively affect a person's health status. Indeed, the Centers for Disease Control and Prevention notes that "smokers are more likely than nonsmokers to develop heart disease, stroke, and lung cancer. Estimates show that smoking increases the risk for coronary heart disease by 2 to 4 times, increases the risk for stroke by 2 to 4 times, and increases the risk of developing lung cancer by 25 times for men and 25.7 times for women. It diminishes overall health, increases absenteeism from work, and increases health care utilization and cost.[23]

Some people are tempted to turn to electronic cigarettes to help them stop smoking. Vaping is perceived as a "safer alternative" which exposes people to fewer toxic chemicals than tobacco. Yet there have been lung injuries and deaths associated with vaping, and although little is known about the long-term effects of vaping, the most current data suggests that there are links to chronic lung disease and asthma.[24]

23. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm
24. https://www.hopkinsmedicine.org/health/wellness-and-prevention/5-truths-you-need-to-know-about-vaping

In 2018 a new question was placed on the survey asking, *"Does anyone living in the house smoke (cigarettes, cigars, or pipes)"?* At that time, only 9.5% of respondents were willing to admit that someone in the house smokes tobacco. That question was modified for the 2021 survey by including an additional category regarding vaping. A total of 14.2% of the IAR sample and 33.9% of the VuPoint sample reported that someone in the house either smokes tobacco, or vapes, or both smokes AND vapes.

Table 3.19: Does anyone living in the house smoke tobacco or vape?

	IAR 2021		VuPoint 2021	
	Count	**Percent**	**Count**	**Percent**
Yes, either cigarettes, cigars, or a pipe	57	7.7%	56	17.4%
Yes, vapes	25	3.5%	38	11.8%
Yes, both smoke AND vape	22	3.0%	15	4.7%
No one in the house smokes or vapes	629	85.8%	212	66.0%
Total response to the question	733	100.0%	321	100.0%

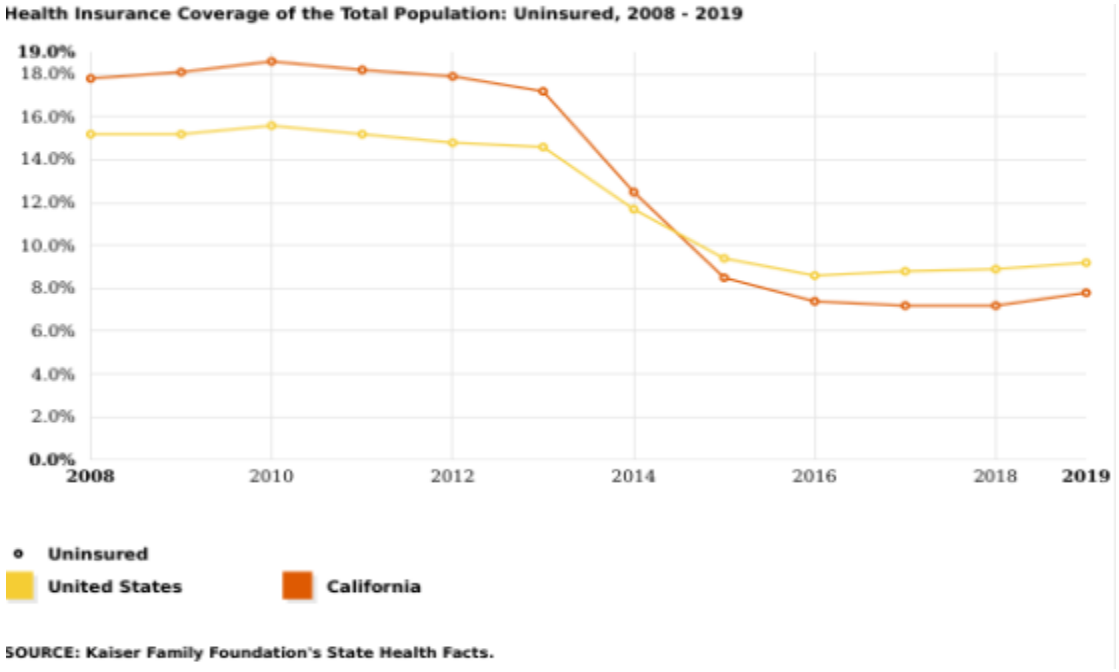
Respondents living with someone who smokes and/or vapes were then asked whether that household member who smokes or vapes has ever had a lung cancer screening." Only 11.4% of the IAR sample (11.2% of VuPoint) said "yes" and another 10.8% (10.3% of VuPoint) didn't know, thus over three quarters of each sample reported that the person who smokes or vapes has never had a lung cancer screening. This may be something that PVHMC would like to include in its educational outreach.

Health insurance coverage

The Affordable Care Act (ACA) signed into law in 2010 was designed to provide an opportunity for all Americans access to affordable, quality health insurance (the HealthyPeople 2020 target is that 100% of all Americans should have some form of health insurance). The major provisions of the ACA came into force in 2014, and by 2016 the proportion of the population without health insurance had been cut approximately in half. But the proportion of uninsured US residents may be on the rise again. According to Wallethub, that proportion was 9.2% in 2019, compared to 8.9% in 2018. But a 2021 survey by Commonwealth Fund Health Care Coverage found that 10% of all US adults 18 – 64 were uninsured as of June 2021, a rate *below* the 2020 rate. But The question of whether the rate is rising or falling is somewhat inconclusive, but what ***is*** clear is the disparity in uninsured rates by ethnicity: the data for the US shows that the 2021 rate was 20% uninsured for Latinx/Hispanics, 11% Black, 7% White, and

3% Asian/Pacific Islanders. And the rate for low-income (<138% FPL) was 16%.[25]

At the state level, 7.8% of the total California population was uninsured in 2019. That was a slight increase from 7.2% in 2018 and 2019.[26]



Four questions on the Community Health Needs survey dealt with health insurance coverage among respondents and their family members in PVHMC's service area: number of adults in the household covered by medical insurance, number of children in the household covered by medical insurance, type(s) of health insurance covering household members, and reasons why the uninsured members of the household (if any) do not have insurance.

The vast majority of households show full insurance coverage of the adults in the household (88.3% in the IAR survey and 83.7% in the VuPoint version). This is a significant improvement from 2012 when only 76.6% of respondents said that all of the adults in the household were covered by insurance, however it is still far from the desired 100%. For the most part, it appears that households with more adults tend to have a reduced likelihood that all will be covered by insurance.

25. https://www.commonwealthfund.org/publications/issue-briefs/2021/jul/as-pandemic-eases-what-is-state-coverage-affordability-survey

26. https://www.kff.org/other/state-indicator/total-population/

Table 3.20: Adults Covered by Health Insurance

Number of Adults Living in the Household	2021 IAR Number and % of households in which….				2021 VuPoint Number and % of households in which….			
	All are covered	Some are covered	None are covered	Total	All are covered	Some are covered	None are covered	Total
1	121 96.0%	0 0.0%	5 4.0%	**126**	57 82.6%	0 0.0%	12 17.4%	**69**
2	338 89.4%	23 6.1%	17 4.5%	**378**	118 88.7%	6 4.5%	9 6.8%	**133**
3	158 88.8%	16 9.0%	4 2.2%	**178**	59 83.1%	9 12.7%	3 4.2%	**71**
4	81 83.5%	16 16.5%	0 0.0%	**97**	34 82.9%	6 14.7%	1 2.4%	**41**
5	19 79.2%	5 20.8%	0 0.0%	**24**	8 57.1%	5 35.7%	1 7.1%	**14**
6 or more	5 33.3%	10 66.7	0 0.0%	**15**	6 66.7%	1 11.1%	2 22.2%	**9**
Total	**722 88.3%**	**70 8.5%**	**26 3.2%**	**818**	**282 83.7%**	**27 8.0%**	**28 8.3%**	**337**

Table 3.21: Trends in Adult Insurance Coverage, Community Health Needs Assessment

	% of households in which all are covered	% of households in which some are covered	% of households in which none are covered
2012	76.6%	15.0%	8.4%
2015	80.5%	14.0%	5.5%
2018	87.9%	10.2%	1.9%
2021 IAR	88.3%	8.5%	3.2%
2021 VuPoint	83.7%	8.0%	8.3%

According to a study by the Georgetown University Health Policy Institute (Center for Child and Families), “After reaching a historic low of 4.7 percent in 2016, the child uninsured rate in the US began to increase in 2017, and as of 2019 jumped back up to 5.7 percent.” The report also presents the state-by-state figures, and California’s child uninsured rate in 2019 was

3.6%.[27] Table 3.22 below shows the data from the PVHMC region based on the 2021 Community Needs Assessment, and Table 3.23 shows the trend over time (and the fact that full coverage for children has decreased since the 2018 community needs assessment.

Table 3.22: Children Covered by Health Insurance

Number of Children Living in the Household	IAR 2021 Number and % of households in which….				2021 VuPoint Number and % of households in which….			
	All are covered	Some are covered	None are covered	Total	All are covered	Some are covered	None are covered	Total
1	135 94.4%	0 0.0%	8 5.6%	**143**	52 98.1%	0 0.0%	1 1.9%	**53**
2	120 96.0%	2 1.6%	3 2.4%	**125**	38 92.7%	1 2.4%	2 4.9%	**41**
3	34 97.1%	1 2.9%	0 0.0%	**35**	17 100.0%	0 0.0%	0 0.0%	**17**
4	12 100.0%	0 0.0%	0 0.0%	**12**	4 80.0%	1 20.0%	0 0.0%	**5**
5 or more	5 100.0%	0 0.0%	0 0.0%	**5**	2 100%	0 0.0%	0 0.0%	**2**
Total	**306 95.6%**	**3 0.9%**	**11 3.4%**	**320**	**113 95.8%**	**2 1.7%**	**3 2.5%**	**118**

Table 3.23: Trends in Children's Insurance Coverage, Community Health Needs Assessment

	% of households in which all are covered	% of households in which some are covered	% of households in which none are covered
2012	69.5%	0.0%	3.5%
2015	95.2%	2.4%	2.4%
2018	98.1%	0.9%	0.9%
2021 IAR	95.6%	0.9%	3.4%
2021 VuPoint	95.8%	1.7%	2.5%

We looked for significant differences in health insurance coverage for adults based on demographics such as age, ethnicity, income, and education. The data show that family income

27. https://ccf.georgetown.edu/2020/10/08/childrens-uninsured-rate-rises-by-largest-annual-jump-in-more-than-a-decade-2/

and education are associated with insurance coverage. Specifically, people with higher incomes and education are the most likely to have households where all adults are covered. Further, non-Hispanics were more likely than Hispanics to have coverage for all adults in the household. There is also some indication (although not statistically significant) that older people are more likely to have all adults covered than younger people.

Table 3.24: Number of Adults Covered by Health Insurance
Selected Subgroup results
(NOTE: *IAR data is in* ***bold****, whereas VuPoint data is underlined*)

	IAR Black, **bold** VuPoint Blue, underlined	None Covered	Some Covered	All Covered	Pattern
Age	18 to 34	**4%** 9%	**14%** 12%	**83%** 80%	Younger people are somewhat less likely to have all adults covered than older people (n.s.)
	35 to 54	**3%** 9%	**7%** 6%	**90%** 85%	
	55 or older	**3%** 6%	**7%** 3%	**90%** 91%	
Ethnicity	Hispanic Origin	**5%** 11%	**12%** 13%	**83%** 76%	Hispanics are less likely to have all adults covered than non-Hispanics
	Non-Hispanic	**2%** 7%	**5%** 5%	**93%** 89%	
Income	Less than $35,000	**9%** 12%	**10%** 14%	**81%** 75%	People with higher incomes are more likely to have all adults covered than those with lower incomes
	$35,000 to < $80,000	**3%** 6%	**10%** 5%	**87%** 89%	
	$80,000 or more	**2%** 4%	**5%** 4%	**93%** 91%	
Education	High school degree or less	**6%** 17%	**15%** 14%	**79%** 69%	Those people with more education are most likely to report that all adults are covered
	Some college	**5%** 4%	**7%** 8%	**88%** 88%	
	College degree +	**2%** 6%	**6%** 5%	**92%** 89%	

NOTE: n.s. means not a statistically significant difference

Finally, IAR asked respondents a multiple response question: "What type of health insurance covers people in your household?". The largest group of individuals named "private insurance" (either HMO or PPO) as the type of insurance coverage for at least some of the family members. Another large group of people mentioned Medi-Cal and/or Medicare.

Table 3.25: What type(s) of health insurance cover(s) people in your household?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Private insurance (either HMO or PPO)	**541**	**66.9%**	**162**	**49.5%**
Medi-Cal	**232**	**28.7%**	**74**	**22.6%**
Medicare	**191**	**23.6%**	**71**	**21.7%**
Obamacare, covered California, ACA	44	5.4%	23	7.0%
Have insurance but don't know the type	20	2.5%	32	9.8%
Not covered (no insurance at all)	15	1.8%	13	4.0%
Veterans (VA)	14	1.7%	4	1.2%
Other Government Insurance (WIC, CHIP, ETC.)	2	0.3%	3	0.9%
Total	808		327	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

As noted earlier, relatively few respondents said that at least some of the people in their household are uninsured. Those respondents were asked to indicate the main reason(s) that they and/or their family members don't have health insurance. Between the IAR and VuPoint versions of the survey, only 24 people responded to the question. The majority of the comments were either that they couldn't afford premiums (11), their employer doesn't offer (or stopped offering) coverage (5), they lost or changed jobs (5), became in eligible because of age or leaving school (3).

Barriers to receiving needed health services

Another series of survey questions dealt with the barriers to receiving needed health services. Respondents were first asked if they or anyone in their family had needed any health services within the past year that they could not get. Over a quarter of IAR respondents (26.0%) and 20.2% of VuPoint respondents answered in the affirmative. Respondents in the IAR version of the survey who indicated that they are of Hispanic/Spanish/Latino origin were significantly more likely than non-Hispanics to report that they were not able to get services (26.7% vs 19.5% in the IAR version of the survey. As might be expected, income was strongly related to this question's responses: 27.1% of those making less than $25,000 reported that they had needed services that they couldn't get vs 21.7% of those making $80,000 to $110,000. And 30.0% of young people (age 18 – 29) reported that they were not able to get needed health

services, vs. 17.5% of those age 60 – 69 and 12.9% of those age 70 – 79. The same trends held in the VuPoint version of the survey.

Findings from the 2020 Commonwealth Fund Biennial Health Insurance Survey indicate that insurance status (being uninsured, underinsured, or having coverage with significant cost sharing) is the most important barrier to accessing care in the U.S.[28] Yet that was not the predominant reason expressed by our respondents for the lack of services. Our respondents cited difficulty scheduling the services (possibly due to the pandemic), lack of availability of services, unwillingness to "leave the house during the pandemic," and to a lesser extent, worry about the cost of service/co-payments.

Table 3.26. What kept you or your family members from getting the health services you needed?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Difficulty scheduling	**100**	**49.2%**	**28**	**42.4%**
The needed services weren't available	**81**	**39.6%**	**17**	**25.8%**
Didn't want to leave the house during the pandemic	**53**	**25.8%**	**15**	**22.7%**
Worried about cost of service/co-payments	**47**	**23.0%**	**9**	**13.6%**
Didn't know where to find the services	25	12.1%	6	9.1%
Hours were not convenient	24	11.8%	**11**	**16.7%**
The medical technology wasn't available in the area	18	8.9%	2	3.0%
Appointments/Procedures/Testing cancelled due to Covid	17	8.3%	3	4.5%
Provider wouldn't accept my insurance	16	7.9%	8	12.1%
PVHMC didn't have the services needed	16	7.7%	4	6.1%
Worried about cost of prescription(s)	12	6.0%	**10**	**15.2%**
Had problems with the English language	12	5.7%	4	6.1%

28. https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial

No health insurance	8	3.8%	7	10.6%
Lacked childcare/babysitter	8	3.7%	4	6.1%
Lacked transportation	7	3.3%	3	4.5%
Didn't like the programs or services	4	2.0%	3	4.5%
Others	21	10.3%	1	1.5%
Don't know	1	0.3%	0	0.0%
Total # responding to the question	204		66	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Following are a few of the illustrative "other" comments made regarding reasons for not getting the needed health services

- Unable to get provider approval.
- Too many patients were waiting, and emergency was backed up.
- Access to specialists whose hours were severely limited. The appointment was 4 months out!
- Kaiser overwhelmed.
- Was not able to take time away from work.
- ER too crowded from COVID-19.
- Couldn't get a referral to a specialist.
- Medical would not refer me to an orthodontist or school dentistry.

Respondents were also asked to indicate what services they were unable to get. The answers from the people who responded were quite varied. The most often mentioned service was dental care, with another large group mentioning surgery, prescriptions (not being able to get the medications they needed), and vision care.

Table 3.27: What services couldn't you get? Please check all that apply.

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Dental care	**64**	**35.2%**	**25**	**40.3%**
Surgery	**46**	**25.3%**	13	21.0%
Prescriptions or medication needed	**31**	**16.8%**	**17**	**27.4%**
Vision care	**28**	**15.4%**	**20**	**32.3%**
ER Care / Medical Procedures / See Specialist	25	13.9%	2	3.2%
Preventive Care / Screenings/ Annuals	20	11.1%	7	11.3%
Therapy Physical/Occupational/Mental	13	7.0%	2	3.2%
Medical equipment (walkers, wheelchairs, special medical equipment)	12	6.6%	6	9.7%
MRI CT Radiology	10	5.5%	2	3.2%
Others	9	5.0%	4	6.5%
Total # responding to the question	183		62	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

"Other" comments on services the respondents were unable to get included:

- Programs that help children with special needs
- I have blood reflux in my legs and need to have a stent placed in my leg arteries.
- Covid testing - Dr. visit. (did not go to ER.)
- Q & A for Guillain Barre Syndrome
- See my PCP to get a PT referral
- Learning disability assessment for child
- Help for pain management
- Timely appointments
- Therapist for anxiety
- Foot care and dermatologist
- Pain relief from osteo-arthritis
- Diabetic shoes
- Epidural
- Mental Health

Utilization of Health Care Services for Routine Primary /Preventative Care

In the last three Community Needs Assessment reports (2012, 2015, and 2018), the surveys showed that approximately 80% of respondents had visited a doctor for a general physical exam (as opposed to an exam for a specific injury, illness, or condition) in the previous year. That has changed (possibly due to COVID). The 2021 surveys showed a significant drop in respondents being able to get the general physical exams which could detect possible diseases so they could be treated early, identify issues that could cause medical concerns in the future, and build a relationship with the primary care physician. We hypothesize that the reasons for the drop are predominantly COVID-based, including physician's offices being closed during the "stay-at-home orders," patients' fears of contracting COVID during their visit to a medical office, and hearing advice indicating that patients should **only** come to doctor offices, urgent care, and ER for emergencies.

Table 3.28: Length of Time since Respondent's Last General Physical Exam

	IAR		VuPoint	
	Count	**Percent**	**Count**	**Percent**
Within the past year	507	63.2%	168	51.5%
Within the past 2 years	211	26.3%	85	26.1%
Within the past 5 years	52	6.5%	46	14.1%
More than 5 years ago	10	1.2%	17	5.2%
Never	5	0.6%	5	1.5%
Don't know/don't remember	18	2.2%	5	1.5%

It is unclear whether this decline in yearly physician's visits will be permanent post-pandemic. As noted in an editorial from the American Journal of Medicine: "Minimal use of the physical examination will soon become standard practice. This change was already occurring but is now being accelerated. And, it will be here to stay; the numbers of individuals that have the ability to train others in advanced examination techniques will decrease as they age…It is now becoming acceptable to see and bill patients virtually with no actual patient contact or in person with very limited examination."[29]

Telehealth services grew exponentially during the pandemic, but will those services continue (and perhaps grow) post-pandemic? Much of the current literature on the subject would indicate that the answer is a qualified "yes." The literature notes that telehealth services will require additional regulatory changes in the future to deal with issues such as patient confidentiality, data security, and dealing with patients who are not tech-savvy." Articles from

29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7674965/

2020 also show that although patients find telehealth services to be convenient and "intimate," only 76% of patients would recommend a video visit following a telemedicine visit.[30]

To assess the feelings of residents in the PVHMC region, respondents were asked: "*In the past year, have you used telehealth services where you do a video chat with a healthcare provider using a mobile device or computer?"*. A follow-up question was included asking respondents' preferences for in-office physician visits or telehealth treatment.

Table 3.29:
In the Past Year Have You Used Telehealth Services?

	IAR		VuPoint	
	Count	**Percent**	**Count**	**Percent**
Yes	484	60.2%	168	51.4%
No	320	39.8%	159	48.6%

Overall, do you prefer having in-office physician visits or telehealth treatment?
(asked only of those who had used the services)

Didn't like telehealth treatment – prefer in-office physician visits	211	43.6%	48	28.6%
Liked telehealth services – would use them in the future	141	29.3%	84	50.0%
No preference	121	25.1%	35	20.8%
Don't know	10	2.0%	1	0.6%

The reader will note that there are significant differences in the responses of the IAR and VuPoint surveys, with the VuPoint version showing similar numbers to the Harvard Business Review article cited above.

The next series of questions were designed to determine whether or not the respondent or any member of his/her household has had recommended health screenings recently. The reader will note that the recommended frequency of pap smears changed since the 2012 report from every year to every ***three*** years, and the recommended frequency of colon cancer screening changed from every five years to every ***ten*** years. Further, the Healthy People 2020 targets don't necessarily coincide with the time frames.

It was anticipated that the screening rate for cancer might have dropped in the 2021 needs assessment. In fact, the National Cancer Opinion Survey conducted in 2020[31] showed

30. https://hbr.org/2020/12/what-patients-like-and-dislike-about-telemedicine
31. https://www.asco.org/research-data/reports-studies/national-cancer-opinion-survey

that 24% of adults delayed or cancelled routine screening tests because of the pandemic, and 63% of those who delayed/cancelled their tests were *concerned* about being behind on the screenings. Those who cancelled or delayed the tests may have believed that concerns about the pandemic were more important than concerns about missing the cancer screenings, or they may have simply been unable to get to the screenings due to lack of transportation or unwillingness to miss work in order to have the tests.

Table 3.30: Percent of Respondents Who Said They or a Family Member Has Had a Health Screening (% Yes)

Health Screening Test	2009	2012	2015	2018	IAR 2021	VuPoint 2021	HP 2020 Targets
Pap smear in the past **year** (2009 & 2012) or **three years** (2015, 2018, and 2021)	51.2%	49.8%	63.1%	61.0%	**62.2%**	**47.8%**	**93.0%** [a]
Mammogram in the past year (or "typically" every year)	52.9%	53.9%	50.8%	58.8%	**61.6%**	**35.6%**	**81.1%** [b]
Blood test for cholesterol in the past year	75.5%	76.5%	79.6%	84.8%	**76.1%**	**58.6%**	**82.1%** [c]
Screened for colon cancer in the past ***five*** years (2009 & 2012) or ***ten*** years (2015)	46.6%	49.8%	52.9%	61.2%	**62.0%**	**40.3%**	**70.5%** [d]

NOTES:

a. The HP 2020 target for cervical cancer screening is age adjusted, 21 – 65 years, and refers to receiving a Pap test within the past ***3 years.***
b. The HP 2020 target for mammograms refers to the past ***2 years***, not the past year, and is age adjusted for ages 50 – 74.
c. The HP 2020 target for having their blood cholesterol checked is an age-adjusted percentage for the preceding ***5 years***, NOT the past year.
d. No time element is given for the colon cancer screenings in HP 2020.

In our surveys, the only significant decrease in screenings was in blood tests for cholesterol. The main conclusion that can be drawn from the table above is that there is still progress to be made before the data show that Healthy People 2020 targets are being reached.

Typically respondents justify the fact that they haven't received the screenings by listing reasons such as being "too old or too young to need the test", or "fear or dislike" of the test, or the perception that "healthy people don't need it," or the feeling that the tests are not important or necessary (especially for people who say they are healthy). Those reasons are still listed in large numbers in the table below, but this year a large group of respondents also mentioned not wanting to leave the house during the pandemic.

Table 3.31: Reasons for not getting the cancer screenings (Pap, Mammogram, Colon Cancer)

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Too old or too young to need test	**136**	**38.2%**	**51**	**27.1%**
I didn't want to leave the house during the pandemic	58	16.2%	42	22.3%
Fear of the test/dislike of the test	**48**	**13.4%**	**24**	**12.8%**
I am healthy (so don't need it)	**38**	**10.5%**	**44**	**23.4%**
Didn't think it is important or necessary	**22**	**6.1%**	**31**	**16.5%**
Fear of the results	21	6.0%	13	6.9%
Financial issues -- the out-of-pocket cost is high, even with insurance	18	5.1%	14	7.4%
Had some done (just not all)	17	4.7%	3	1.6%
No insurance	16	4.5%	11	5.9%
No regular doctor	13	3.8%	16	8.5%
No females in the household	12	3.4%	2	1.1%
Body part has been removed	8	2.2%	6	3.2%
Lack of child care	8	2.1%	8	4.3%
No transportation to get to a test	2	0.7%	3	1.6%
Other (please specify)	34	9.6%	7	3.7%
Total # responding to the question	356		188	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

There were a large variety of "other" reasons offered, mostly focusing around three issues:

- Don't have time/Too lazy/Forgot
- Dealing with other personal issues
- Scheduling is hard with my job…can't get away during office hours, and not paid when work is missed

COVID-19 Pandemic

Since March of 2020, Covid-19 has touched virtually every person in the United States and beyond, either through a personal/familial physical health crisis, mental health crisis, job loss (and the resulting economic fallout), lifestyle changes, etc. It has caused turmoil, hardship,

and interruptions to our everyday "normal" life, with differential effects based on gender, race/ethnicity, education, and occupation. The population in PVHMC's service area includes a large group of low-wage workers, the elderly, those with chronic health conditions, and those living in close quarters – the most likely to be effected by COVID in some way. Thus it was logical to include COVID questions on this year's community needs assessment survey.

The first COVID question asked whether the respondent had received at least one dose of the COVID-19 vaccine when the survey was conducted in July, 2021. The vast majority of respondents indicated that they had, indeed, been vaccinated.

Table 3.32: Have you received at least one dose of the COVID-19 vaccine?

	IAR		VuPoint	
	Count	**Percent**	**Count**	**Percent**
Yes	641	82.7%	248	77.0%
No	134	17.3%	74	23.0%
Total	775	100.0%	322	100.0%

There were clear and statistically significant differences in vaccination rates based on age, Hispanic origin, income, and education.

Table 3.33: Vaccination Rates by Subgroup

	IAR	VuPoint	Pattern: There is a higher rate of vaccination among…
Age:			
18 – 34 year olds	68%	76%	Older people
35 to 54 year olds	80%	73%	
55 +	95%	85%	
Hispanic Origin:			
Hispanic	82%	76%	Non-Hispanics
Not Hispanic	91%	78%	
Income:			
< $35,000	77%	73%	Higher income respondents
$35,000 to < $80,000	86%	77%	
$80,000 or more	92%	87%	
Education:			
High school grad or less	73%	76%	More educated respondents
Some college	83%	74%	
College degree +	93%	82%	

The survey respondents who said they had not been vaccinated were then asked how quickly (if at all) they planned to get the vaccine for COVID-19.

Table 3.34: How quickly, if at all, do you think you will get the vaccine for COVID-19 now that it is available?

	IAR		VuPoint	
	Count	Percent	Count	Percent
Planning to receive the vaccine soon	19	15.4%	13	18.6%
Waiting **a month or two** to see what the short-term effects are on others	4	3.7%	8	11.4%
Waiting **several months** to see what the longer-term effects are on others	21	17.4%	10	14.3%
Waiting **a year or so** to see if a better version of the vaccine is developed	9	7.5%	4	5.7%
Do not plan to get the vaccine at all	**51**	**42.0%**	**27**	**38.6%**
Don't know	17	2.1%	8	11.4%
Total	121	100.0%	70	100.0%

The survey also included a question regarding possible employment status changes during the pandemic "stay at home order." As of July 2021, over half of respondents reported no change in employment status.

Table 3.35: Did your employment status change during the pandemic "stay-at-home" order?

	IAR		VuPoint	
	Count	**Percent**	**Count**	**Percent**
No change in employment status	**452**	**57.4%**	**165**	**51.6%**
Same workplace but working reduced hours	50	6.3%	24	7.5%
Now working from home full time	48	6.1%	34	10.6%
Now working from home at least part of the time	49	6.2%	28	8.8%
Lost job due to Covid	65	8.3%	48	15.0%
Had to quit job to take care of children, parents, etc.	30	3.8%	7	2.2%
Retired	68	8.7%	8	2.5%
Other (please specify)	24	3.1%	6	1.9%
Total	787	100.0%	320	100.0%

"Other" comments made about employment status changes:

- Laid off for 4 months then rehired part-time for 5 months, then full time.
- I was able to obtain a better paying job, due to the lack of people wanting to work.
- One job increased; second job decreased hours.
- Due to cancellation of medical appointments and procedures, I was unable to gain employment due to poor health.
- Afraid to find job in public.
- Do what I can to make money to survive.
- Struggled for several months but we are slowly coming back on track.
- Work hours increased
- On disability during pandemic
- One works from home, and one works three days home and two days at workplace.
- FMLA and disability due to illness (covid)
- Disabled

Experiences With Pomona Valley Hospital Medical Center and Desires for Classes/Groups

88.8% of IAR respondents and 51.6% of the VuPoint respondents reported having gone to PVHMC *at some pint in time* for health care. As in the past, the main reason(s) cited for choosing PVHMC for health care were convenience/location (i.e. "close to home"), insurance, referral by a physician, and quality/reputation. Although the percentages were different for the two survey modalities, the main reasons for choosing PVHMC were the same in both surveys.

Table 3.36: Why did you Choose PVHMC for your health care?

	2009	2012	2015	2018	IAR 2021	VuPoint 2021
Close to home	74 49.3%	72 42.9%	75 44.9%	78 43.6%	**428** **65.7%**	**95** **57.2%**
Insurance	38 25.3%	30 17.9%	34 20.4%	50 27.9%	**363** **55.7%**	**62** **37.3%**
Referred by Physician	30 20.0%	31 18.5%	33 19.8%	33 18.4%	**256** **39.4%**	**52** **31.3%**
Quality / reputation	16 10.7%	25 14.9%	32 19.2%	23 12.8%	**202** **31.1%**	**24** **14.5%**
Types of Services offered	21 14.0%	12 7.1%	24 14.4%	13 7.3%	153 23.5%	14 8.4%
Word of mouth (friend, neighbor, family, or co-worker)	4 2.7%	11 6.5%	7 4.2%	9 5.0%	67 10.4%	15 9.0%
Ambulance took me there, so there was no choice	--	--	16 9.6%	22 12.3%	52 7.9%	10 6.0%
Current/Past Employee of PVHMC	--	--	--	--	28 4.3%	2 1.2%
Community Presentation	--	--	--	2 1.1%	24 3.7%	3 1.8%
Internet	--	--	--	--	4 0.6%	7 4.2%
Newspaper, radio, or television	--	--	--	--	3 0.5%	4 2.4%
Other	7 4.7%	13 7.7%	5 3.0%	6 3.4%	18 2.8%	0 0.0%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

The needs assessment questionnaire also queried respondents about whether they have attended any classes offered by PVHMC. This is an important question since according to a

study in the Journal of the American Osteopathic Association, "Just 45 minutes of patient education can improve outcomes for patients with chronic diseases."[32]

Over time there has been increasing interest in classes offered by PVHMC.

Table 3.37: Experience with and interest in classes offered by PVHMC

	% Yes 2009	% Yes 2012	% Yes 2015	% Yes 2018	% Yes IAR 2021	% Yes VuPoint 2021
Have you attended any classes offered by PVHMC?	31 10.1%	35 10.9%	22 6.6%	36 11.7%	156 21.5%	30 9.3%
Are there any classes you'd like them to offer?	35 12.8%	41 15.0%	62 18.6%	56 21.5%	168 47.7%	40 26.0%

Those who had said that there are classes they would like PVHMC to offer were then asked to specify the type of classes they desire. By far, the classes most desired were those dealing with healthy eating and nutrition, followed by exercise/fitness classes or a gym. CPR classes and female health classes were also mentioned in significant numbers.

32. https://www.modernhealthcare.com/article/20181119/NEWS/181119936/study-finds-45-minutes-of-patient-education-improves-chronic-disease-management

Table 3.38: What type of classes would you like PVHMC to offer?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Healthy eating, nutrition classes	**127**	**77.0%**	**25**	**62.5%**
Exercise/fitness classes or a gym	**103**	**62.2%**	**17**	**42.5%**
CPR classes	76	45.7%	18	45.0%
Female health classes (prenatal, miscarriage, lactation, etc.)	67	40.4%	14	35.0%
Diabetes prevention	50	30.5%	13	32.5%
Alzheimer's classes, support groups	39	23.6%	10	25.0%
Counseling Mental/Stress/Grief	9	5.5%	0	0.0%
Others	21	12.5%	3	7.5%
Total # responding to the question	166		40	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Support groups are another way to reach out to help people by bringing together people experiencing the same life difficulty, e.g. a chronic illness, lack of overall health and well-being, or emotional problems or life transitions. In previous needs assessments, between 10% and 14% of respondents have said that someone in the family had attended health-related support groups in the past year. This year's figures were 6.1% in the IAR survey and 13.7% in the VuPoint survey.

Regardless of whether they had previous experience with support groups, respondents were asked if they had any interest in attending such groups. Nearly a quarter of respondents said they are not interested. Consistent with the above table dealing with classes, respondents expressed the most interest in support groups dealing with nutrition, obesity, and weight problems. In addition, sleep disorders might be a good candidate for a support group, as would grief and bereavement. It is unclear whether people would actually translate their desires into behavior by attending such support groups (and/or others in the table below), but there is clearly interest in the community for at least some of the groups mentioned.

Table 3.39: What kind of support groups might you or someone else in your family be interested in?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents answering the question
Nutrition	**206**	**40.1%**	**88**	**33.2%**
Obesity and weight problems	**142**	**27.6%**	**66**	**24.9%**
Sleep apnea/sleep disorders	111	21.6%	48	18.1%
Grief and bereavement	105	20.4%	32	12.1%
High blood pressure	98	19.1%	47	17.7%
Diabetes	96	18.7%	42	15.8%
Arthritis	66	12.8%	24	9.1%
Living with a disability	66	12.8%	34	12.8%
Caregivers	59	11.6%	23	8.7%
Pregnancy/new moms/new dads	59	11.5%	21	7.9%
Asthma	53	10.3%	28	10.6%
Heart disease	53	10.2%	14	5.3%
Cancer	41	8.0%	24	9.1%
Stroke	30	5.7%	10	3.8%
Child/elder abuse	27	5.2%	8	3.0%
Homelessness	22	4.3%	10	3.8%
Smoking cessation / stop smoking	15	3.0%	25	9.4%
Mental Health / Depression / Anxiety	15	2.9%	4	1.5%
Others	36	6.9%	8	3.0%
Don't know	91	17.8%	37	14.0%
Total # responding to the question	514		265	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Next on the survey were questions dealing specifically with the emergency room at PVHMC. As in the past, the predominant reason for visits to the emergency room was injury or accident, following by chest pain/heart attack, and symptoms of either the regular flu, sinus infection, or COVID-19.

Table 3.40: What was the reason emergency services were needed?

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Injury or accident	**175**	**36.4%**	**53**	**47.7%**
Chest pain/heart attack	81	16.8%	12	10.8%
COVID-19	45	9.4%	9	8.1%
Breathing difficulties from the "regular" flu or a sinus infection	42	8.7%	19	17.1%
Pain (back, neck, leg, abdominal)	28	5.8%	4	3.6%
Gallbladder / kidney / appendix attacks	25	5.3%	0	0.0%
Stroke	24	5.1%	9	8.1%
Labor / miscarriage / pregnancy	14	3.0%	7	6.3%
Lightheaded / dizzy / passed out / Vertigo	10	2.1%	3	2.7%
Vomiting / fever/ stomach issues	7	1.4%	0	0.0%
Urinary issues/concerns	7	1.4%	1	0.9%
Bowel issues/ problems / obstructions	6	1.3%	0	0.0%
Cancer problems	5	1.0%	1	0.9%
Seizures	5	1.0%	0	0.0%
High blood pressure issues	3	0.7%	0	0.0%
Others	133	27.5%	15	13.5%
Total # responding to the question	509		119	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.
NOTE: "other" category covered so many different reasons that they could not be coded.

In previous community needs assessments, 34% or fewer respondents who had sought help in PVHMC's emergency room reported that they had tried to see their doctor before going to the emergency room. This year's datasets are consistent with those figures.

Table 3.41: Did you or the household member try to see your doctor before going to the emergency room?

	IAR		VuPoint	
	Count	Percent	Count	Percent
Yes	175	34.3%	35	28.7%
No	320	62.6%	82	67.2%
Don't know/don't remember	15	3.0%	5	4.1%
Total	510	100.0%	122	100.0%

Nearly half of respondents who reported that they did not try to see their doctor before going to the emergency room said "it was a true emergency" or the patient was "brought by ambulance," thus there was no opportunity to visit a doctor before going to the Emergency Room. Another large group of respondents said that their emergency occurred after office hours. A few of those who had "other" comments indicated that they had visited Urgent Care first and were told to go to the ER, or were told by their doctor that if the issue occurred again they should go to the ER.

Table 3.42: What was the reason you didn't try to see your doctor before going to the emergency room? Please check all that apply.

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
It was a true emergency	**150**	**47.2%**	**59**	**49.2%**
It was after office hours	**141**	**44.2%**	**38**	**31.7%**
Brought by ambulance	78	24.5%	27	22.5%
Don't have a regular doctor	24	7.4%	10	8.3%
Doctor was too busy to fit me in	20	6.4%	9	7.5%
Don't remember	8	2.6%	6	5.0%
Others	15	4.7%	0	0.0%
Total # responding to the question	319		120	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Diversity, Equity and Inclusion

Diversity, Equity, and Inclusion (DEI)

A core value and an important component to organizations today is DEI: diversity, equity, and inclusion. Organizations seek to ensure that all of the constituents (employees, customers, clients, and the broader community) experience equal access and unbiased treatment.

Three "Likert" questions were included on the survey. First: respondents agreed or strongly agreed that the PVHMC staff reflects the diversity of the community. This means that they believe PVHMC staff are aware of the social, cultural, and linguistic needs of their patients which often leads to better treatment and increased patient satisfaction.

Table 3.43: "Based on my experience at Pomona Valley Hospital Medical Center, the staff reflect the diversity of the community."

	IAR		VuPoint	
	Count	**Percent**	**Count**	**Percent**
Strongly agree	**184**	**28.2%**	**41**	**21.4%**
Agree	**249**	**38.1%**	**84**	**43.8%**
Neither agree nor disagree	117	18.0%	32	16.7%
Disagree	21	3.2%	13	6.8%
Strongly disagree	18	2.8%	2	1.0%
Don't know	63	9.7%	20	10.4%
Total	653	100.0%	192	100.0%

At this point in time, however, the results of the two surveys are mixed as to whether all community residents have equal access to resources.

Table 3.44: "All community residents have equal access to community resources"

	IAR		VuPoint	
	Count	Percent	Count	Percent
Strongly agree	91	12.7%	**54**	**16.3%**
Agree	133	18.6%	**91**	**27.5%**
Neither agree nor disagree	102	14.2%	64	19.3%
Disagree	**230**	**32.2%**	66	19.9%
Strongly disagree	**105**	**14.7%**	38	11.5%
Don't know	55	7.7%	18	5.4%
Total	715	100.0%	331	100.0%

Table 3.45: "Lack of equity (equality) or inclusion in healthcare has negatively impacted my ability to receive the best care."

	IAR		VuPoint	
	Count	Percent	Count	Percent
Strongly agree	50	7.1%	17	8.9%
Agree	82	11.7%	31	16.1%
Neither agree nor disagree	156	22.2%	48	25.0%
Disagree	**213**	**30.4%**	**50**	**26.0%**
Strongly disagree	**144**	**20.5%**	**36**	**18.8%**
Don’t know	56	8.0%	10	5.2%
Total	701	100.0%	192	100.0%

As a final DEI item, respondents were asked an open-ended question regarding the most important thing PVHMC could do to enhance diversity and inclusion in the community. Responses included:

- Ensure everyone has an equal access to healthcare
- Develop better communication with patients
- Treat all human beings equally, care about them, and treat them as we all wish to be treated
- Provide DEI training and education for staff at all levels
- Hire people of diverse cultures to reflect the community served

Biggest health-related issue or service needed

The bottom-line question of this needs assessment is: “*What is the biggest health related issue or service that people in the community need*?” The question was asked as a multiple response item on which people were able to check all needs that apply. **Priority 1**

appears to be increasing access to care – specifically “affordable health care/free screenings.” A close second (**Priority 2**) was mental health services – specifically availability, cost, and letting community know about the services.

Table 3.46: What is the biggest health-related issue or service that people in your community need? Please check all that apply.

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Affordable/free health care/ screenings	**475**	**70.7%**	**140**	**48.3%**
Mental health services	**441**	**65.7%**	**133**	**45.9%**
Affordable medicine/prescriptions	372	55.4%	128	44.1%
Housing for the homeless	327	48.8%	102	35.2%
Preventive care	324	48.2%	82	28.3%
Place to buy healthy foods affordably	249	37.1%	88	30.3%
Obesity	241	36.0%	67	23.1%
Addiction treatment	171	25.5%	83	28.6%
Services for diabetes	160	23.8%	28	9.7%
Cancer cure/treatment	160	23.8%	41	14.1%
COVID-19 treatment	92	13.6%	59	20.3%
Safety	2	0.3%	0	0.0%
Affordable housing (low income)	1	0.2%	0	0.0%
Others	31	4.6%	6	2.1%
Total # responding to the question	671		290	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

Information Sources

Throughout this report the data have shown that respondents are looking to PVHMC for more community outreach, collaboration, and health education. But what are the best ways to let the community know about the health fairs, classes, events, disease prevention education, etc.?

In previous health needs assessments, "doctor's visits" were the information channel preferred by most respondents. That was not the case in this year's survey where over half of respondents indicated that mail sent home is one of the best ways of providing information about disease or injury prevention (see next page). Doctor's visits were a close second, and perhaps slipped from "first place" since during the pandemic many people isolated at home, avoiding seeing their physician unless they had a specific health concern to deal with. Community events were also mentioned by people as an information source.

Table 3.47: What are the best ways of providing you with information about community health and safety education (that is, disease or injury prevention)? Please check all that apply.

	IAR		VuPoint	
	# of mentions	% of respondents who answered	# of mentions	% of respondents who answered
Mail sent home	**354**	**53.4%**	**152**	**51.9%**
Doctor's visits	**343**	**51.7%**	**139**	**47.4%**
Community events	314	47.3%	97	33.1%
TV or social media	283	42.6%	134	45.7%
Workplace	172	25.9%	56	19.1%
Public schools	167	25.1%	79	27.0%
Email	26	3.9%	2	0.7%
Newspaper	3	0.4%	0	0.0%
Others	16	2.5%	0	0.0%
Total # responding to the question	664		293	

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of respondents who answered the question," therefore, does not sum to 100%.

IV. DELPHI GROUP FINDINGS

Representatives of Low Income/Minority/Medically Underserved

INTRODUCTION

Data sources for hospital Community Needs Assessments often include focus groups consisting of representatives of low-income, minority, and medically underserved populations – people on the front lines providing needed health care services. This year, IAR used a modified Delphi process with participants selected from the membership of the San Gabriel Valley Health Consortium and other regional community groups to collect input for PVHMC's assessment.

Potential participants were first contacted by PVHMC staff to describe the needs assessment study and inform them that IAR would be contacting them to request their participation. On June 26, 2021, IAR sent each participating individual a link to an online survey. The survey introduction described the study process and obtained the participant's consent to participate (per IRB protocol).

The survey covered the following topics (see Appendix B for the semi-structured survey form):

- The top 3 most significant health needs that have the greatest impact on overall health in the community;
- Community subgroups/populations that are most affected by those unmet health needs;
- Health services or resources that are lacking;
- Barriers to receiving health care, especially for the minority and medically underserved populations;
- Positive and negative influences on the health of people in the community;
- The most important thing that hospitals in the region can do to improve the health and wellness of the community, especially minorities and medically underserved populations; and
- Suggestions for helping PVHMC meet the needs of the community.

In total, 26 people participated in the study. The following table shows the participating organizations and the populations they serve:

Table 4.1: Participating Organizations and Populations They Serve

Organization	Low Income	Home-less	Minorities	Children	Seniors	Women	Victims Domestic Violence	Language Barriers	Other
AgingNext	X		X		X				
Alzheimer's Association					X				
Bonita USD				X					
Bright Prospect	X	X	X	X		X		X	
Dept of Public Health, SB County	X	X	X	X	X	X	X	X	Correctional Institutions
Foothill AIDS Project	X	X	X			X		X	HIV/AIDS
Foothill Family Shelter	X	X	X	X		X		X	
House of Ruth	X	X	X	X	X	X	X	X	LGBTQI+
Inland Valley Hope Partners	X	X		X		X			
Pomona Pride Center									LGBTQI+
Pomona USD	X	X	X	X				X	
Project Sister Family Services	X		X	X		X			Victims of Sexual Violence & Sex Trafficking
Tri-City Mental Health	X	X	X	X	X	X	X	X	LGBTQ+, 0-5
Western University of Health Sciences*	X	X	X	X	X	X	X	X	Intellectual/ developmental disabilities
Youth & Family Club of Pomona Valley	X		X	X					

*NOTE: there were 12 representatives from Western University who responded to the survey. The 12 individuals included: (1) administrators who were able to discuss the health needs of the community at large, (2) professors of optometry who were able to focus on primary care as well as eye care, and (3) an individual in charge of community partnerships and access to care.

IAR then compiled the data and sent the highlights of findings back to participants. Participants were offered an opportunity to provide further written input regarding any gaps in the findings, and were invited to attend an online/"virtual" focus group using Zoom where IAR could briefly review the findings of the open-ended surveys and engage the group in a discussion of community health needs. The virtual focus group was held on August 11, 2021.

Following is a brief summary of responses to the survey questions and virtual focus group discussion. Where possible, responses are summarized under general themes. All direct quotes from participants are shown in *italics*.

What types of services does your organization offer?

As shown in the table above, the organizations that provided input predominantly serve children, low-income individuals, and minorities. Following are respondents' descriptions of services offered:

- Academic institution with a clinic serving low-income, underserved populations from pediatric to adolescents to the aging population.
- College access and college completion program working with middle school and high school students at Pomona Unified School District public schools. College readiness programming, one-on-one coaching, academic tutoring support, college application assistance, financial assistance and ongoing mentoring from peers and professionals through college graduation.
- Comprehensive dental services.
- Comprehensive domestic violence services including a 24-hr crisis hotline, emergency and transitional residential shelter, case management, trauma-informed counseling for both adults and children, legal advocacy, support groups, domestic violence educational classes, housing programs with wraparound services.
- Dental Care.
- Those with special health care needs (e.g. intellectual or physical disabilities).
- Education.
- Eye care from routine exams to medical eye care (e.g. Specialty Eye care services, Pediatric Optometry, Vision Therapy, Neuro Optometric Rehabilitation, Low Vision, Primary Care Optometry, Specialty Contact lens, glaucoma management, seniors, ocular disease treatment and learning related vision problems).
- Groups, individual therapy, case management, care coordination, crisis support, co-occurring, psychiatry, medication management, rehabilitation services.
- Health care: primary care, endocrinology, rheumatology, dentistry, optometry, pharmacy, podiatry.
- HIV/AIDS wrap around services: Mental Health and Substance abuse counseling, food, transportation, housing/financial assistance, case management, early intervention services, linkage to care, medical case management, nutrition, psychosocial support case management.

- Non-Medical Programs for Older Adults aging in their own homes which includes, transportation, caregiver support, volunteers, Village Model, support groups, information and resources.
- Programs to enhance and sustain the well-being of the LGBTQ+ and allied communities by providing vital social, emotional and support services, educational and arts programs, and advocacy.
- Health screenings, balance & strength assessment, assist with navigation of health care system, vision screen, fitness/wellness assessment, health education, behavioral health screening, & sports physicals. Healthy eating/planting with elementary & community partners and reading to children.
- 24/7 helpline for those affected with Alzheimer's and related dementias and their caregivers. Free classes and support groups. Respite care. Collaborations with CBOs and health systems to reach more families.
- We offer crisis intervention, advocacy, emotional support at a forensic medical exam, counseling, and community education/prevention.
- Transitional housing and monthly services such as food bags/hygiene kits/feminine hygiene kits/diaper's/wipes/etc.
- Emergency food and shelter/RRH (rapid re-housing) services for families and single women experiencing homelessness. Homeless prevention rental assistance when funding is available.
- Youth Development Programs and activities.

Following is a list of health needs and health drivers. What are the most significant health needs that have the greatest impact on overall health in the community? Please check what you believe are the *top 3 most significant health needs* (where the most significant unmet needs and drivers should be considered a priority).

The table below shows the results of this multiple response question. First, the unweighted percent of the 26 respondents checking each health need is shown. We also provide a *weighted* percent which scales/adjusts the responses to remove potential bias of having multiple people with similar perspectives responding to the question. Based on the weighted figures, the most significant health needs were judged to be: (1) Primary care and prevention services, (2) mental health services/resources, and (3) more community-wide partnerships/collaboration. Care coordination was also mentioned by a sizable number of respondents.

Table 4.2: Most Significant Health Needs (respondents were asked to choose up to 3)		
	Percent of respondents	***Weighted* percent of respondents**
Primary care & prevention services (i.e. Primary physicians, community clinics, wellness visits, screenings, prenatal care)	**53.8%**	**48.6%**
Care coordination	**38.5%**	25.0%
Mental Health services/resources	**30.8%**	**41.7%**
More community-wide partnerships/ collaboration	**30.8%**	**34.7%**
Health education/Support Groups (e.g. fitness, nutrition, disease management, navigation of resources, prevention with health lifestyle, coping with terminal diseases)	19.2%	16.0%
Chronic disease management		
Heart disease/heart failure	11.5%	9.0%
Strokes	3.8%	6.3%
Diabetes	23.1%	16.7%
Asthma	0.0%	0.0%
Other	0.0%	0.0%
Reduced cost medications or medical supplies	15.4%	8.3%
Resources/support for homeless populations	11.5%	18.8%
Nutrition services/resources	11.5%	18.8%
Transportation*	11.5%	7.6%
Physical Activity services/resources	7.7%	12.5%
Substance abuse services/resources	7.7%	12.5%
Dental services	7.7%	4.2%
Dementia/Alzheimer's services and resources	3.8%	6.3%
Day treatment/adult day care services	3.8%	6.3%
Physical therapy/rehabilitation services	0.0%	0.0%
Palliative care	0.0%	0.0%
Cancer support/treatment/resources	0.0%	0.0%
Home health services	0.0%	0.0%

* NOTE: based on the focus group and executive interviews, lack of transportation may be of higher importance than is reflected in this table.

Respondents were then asked to explain ***why*** they believe the selected health needs are the most significant, and what factors and conditions contribute to those health needs. Their responses are categorized under the health need selected:

Primary care and prevention services

- *"There are many patients that need preventative and primary care, but this is difficult for some due to the hours that are offered for these services. Many people need to take time off work or use vacation time or cannot make appointments due to the use of public transportation. Offering more availability on "off-hours" would allow many other options for these populations to receive their care without sacrificing income."*
- *"Diabetes and Heart disease are primarily lifestyle driven and preventable with better primary care and prevention services."*
- *"Our patient population exhibits a high rate of uncontrolled diabetes, hypertension, and unmet dental needs."*
- *"We need all of the items listed, as they truly are the Social Determinants of Health, but longitudinal, preventive Primary Care is critical, linked to Behavioral medicine"*

Mental health services/resources

- *"Mental health issues have been observed growing especially in the youth, increasing in anxiety, depression, and other mental illnesses."*
- *"The mental health system is non-existent or completely inefficient and ineffective to provide the kind of support our most vulnerable population."*
- *"Mental health is still stigmatized and has limited resources."*
- *"The lack of integration between primary care and mental health has led to reduced lifespan and poorer health outcomes."*

More community-wide partnerships/collaboration

- *"Education & collaborations/partnerships are the foundation to addressing all the other health needs listed above."*
- *"Partnerships with other community organizations will strengthen one another and will serve the better good of the community and last health education keeps us all aware of how to remain safe."*
- *"You need to change the culture in order to have a long-term impact in public health, you achieve this with education and awareness. Having more collaboration among community partners is the only way to achieve a health care system that will focus on the patient, not on the disease."*
- *"There needs to be a website listing community organizations and partners. If an organization wants to partner with someone, they can find people on the website. Events can be advertised. There can be a listserve to trigger e-mails sent to all partners. Part of building trust is learning about each other's agency…this is one way to do it."*

Care Coordination

- *"Care coordination is a MUST as there are too many specialized areas (silos) in today's medicine. A patient typically needs multiple providers for their comprehensive care and putting the onus on each provider to keep track of and manage the communication of*

every one of their patients is unmanageable for the provider. There needs to be integrated care coordinators that are knowledgeable and take on this responsibility to minimize, and hopefully completely mitigate, any miscommunications, lost referrals/communications, and delays in healthcare. Delays in care and improper coordination need to be minimized, and hopefully eradicated, in modern medicine where information flows nearly instantly over any distance."

- *"Having a resource list that allows for care coordination among the different health professions would be ideal in order to refer appropriately or have warm hand-off to partners."*
- *"The majority of our patients are in the Pomona area and we constantly encounter patients who are in need of basic health care services, in need of coordination of their care, in need of transportation to be able to get to appointments."*
- *"Our clients are low-income or unhoused. A growing number are senior citizens who are struggling to pay their medical bills/medicines and therefore need our emergency food assistance. We also see many clients who have developed diabetes, partially due to a poor diet and stress of a food insecure household. Finally, we see homeless individuals who have been released from the hospital with nowhere to go and who still clearly need some care. Also, some of the homeless we work with have chronic issues that need treatment. Lack of care causes their condition to worsen until it constitutes a real emergency."*

Other interesting quotes

- *"Based on an overlapping "dental desert map" created by LAC DPH, East LA County has a definite need for dental services, specific to those who have Medicaid dental or are uninsured."*
- *"Health Education/Support Groups need to be accessible in language and to the community in public spaces. Getting to a PVHMC site can be difficult, especially when dates and topics are not publicly announced to residents."*
- *"There is a large stigma around the homeless population and their ability to communicate. It would be beneficial to have mobile services and outreach to the areas with homeless individuals. Not necessarily the encampments but also the hotels/motels they reside in."*
- *"Less than 50% of those affected by Alzheimer's disease have been formally diagnosed by their provider. Only 25% of those affected by this disease know that they have it. There is a huge problem with getting a timely diagnosis of Alzheimer's. In California Alzheimer's is the 3rd leading cause of death. However, funding to find a cure is significantly lower than heart disease and cancer."*
- *"Most of our clients are low income, some uninsured and undocumented. Their access to health care is limited. Having community clinics to address healthcare needs would be beneficial. Having additional resources for mental health support would be good"*
- *"A special item of concern: Substance use disorder, especially with the influx of Fentanyl into our communities."*

A final probe asked: **Which community subgroups/populations** are the most affected by those unmet health needs? The following table shows the health needs from the above table, along with the populations most affected.

Health Need	**Populations most affected**
Health education/Support Groups	LGBTQ+, seniors, homeless, undocumented, low-income, marginalized communities (homeless and rural), BIPOC (black, indigenous, and other people of color), low education, special needs patients
Care coordination	Undocumented, homeless, low income, minority groups, Medicaid and uninsured populations, underrepresented minorities, youth and aging population, people with special healthcare needs
Chronic disease management: Heart disease/heart failure	BIPOC, older adult, and lower socio-economic individuals, Hispanic and African American, low income, minorities
Chronic disease management: Strokes	Low income, minorities
Chronic disease management: Diabetes	Low-income families/individuals, homeless, low education, special needs patients, BIPOC, older adult, and lower socio-economic individuals, Hispanic and African American
Primary care & prevention services (i.e. Primary physicians, community clinics, wellness visits, screenings, prenatal care)	Low-income populations, communities of color, homeless, Hispanic, visually impaired, LGBTQ+, seniors, undocumented, minority groups
Resources/support for homeless populations	Undocumented, low-income, homeless populations
Nutrition services/resources	Females who identify as Hispanic or Latina, low income
Physical Activity services/resources	Low-income populations, females who identify as Hispanic or Latina
Substance abuse services/resources	Low-income individuals, homeless, severely mentally ill, communities of color

Mental Health services/resources	Marginalized communities (homeless and rural), BIPOC, Medicaid and uninsured populations, underrepresented minorities, youth and aging population, special healthcare needs, low-income, undocumented, minority groups, females who identify as Hispanic or Latina, severely mentally ill
Transportation	Hispanic, homeless, visually impaired, low-income individuals, severely mentally ill
More community-wide partnerships/ collaboration	Seniors, minority populations, low income, low education, special needs patients, LGBTQ+, homeless, undocumented, marginalized communities (homeless and rural), BIPOC
Reduced cost medications or medical supplies	Any person receiving health care will be affected by this, but especially low-income families/individuals, the homeless, Hispanic, visually impaired
Dementia/Alzheimer's services and resources	Seniors and especially minority populations. African Americans have twice the risk of developing Alzheimer's and other dementias when compared to Whites, and Latinos/Latinas have 1.5 times greater risk of developing Alzheimer's and other dementias when compared to Whites.
Day treatment/adult day care services	Seniors and especially minority populations
Dental services	Medicaid and uninsured populations, underrepresented minorities, youth and aging population, special healthcare needs, persons experiencing homelessness.

What *health services or health resources* are lacking for you and/or the people you serve and work with? What services or resources are needed in the community (i.e. primary care, specialty care, prenatal care, dental care, vision care, mental health services, community outreach, classes, support groups, community clinics, etc.)?

Respondents were asked in an open-ended question to indicate what services or resources are needed in the community. The follow table reflects IAR's coding of those responses (both as unweighted and weighted percentages, as described earlier).

As the table shows, primary care, mental health services, and specialty care are considered the most important health services or resources that are lacking. In addition, a sizable group mentioned the need for more partnerships to provide care/outreach, and for education to make the community aware of resources.

Table 4.3 Health services or health resources that are lacking (Coded from open-ended comments)

	Percent of respondents
Specialty care (including vision, dental)	**50.0%**
Primary care/prenatal care	**36.4%**
Mental health services	**31.8%**
Partnerships to provide care/outreach	22.7%
Education to make the community aware of resources	27.3%
Access to care/community clinics	13.6%
Support groups	9.1%
Culturally competent education and care	4.5%

The following direct quotes provide context and further details (where available) regarding the services or resources that are lacking:

Primary care/prenatal care

- *"More primary care"*
- *"Primary care and preventative care is a significant need. From there it spans all healthcare services. . ."*
- *"Primary care and prenatal care are the most needed."*

Mental health

- *"Care Management Mental Health"*
- *"Lack of mental health workforce"*
- *"Mental health services"*

Specialty care

- *"Ability to access specialty services in a timely manner when we identify issues in our primary exams"*
- *"Follow up to complex eye and vision problems"*
- *"Hospital affiliation to allow for affiliated dental faculty to perform general sedation for medically complex and/or special healthcare needs patients that are unable to receive dental treatment under other circumstances"*
- *"I think access to vision care is lacking. The availability of these services greatly impedes patients from receiving care as these services are typically offered during regular business hours and not after ~5pm on weekdays or to the same capacity on weekends"*
- *"Ocular surgical option with support from optometry"*
- *"Reproductive health screenings and education. Medical care including vision and dental"*
- *"Geriatric support services"*

Partnerships/Outreach/Awareness

- *"I think we are lacking building partnerships with all community-based organizations.*
- *"Community outreach - may need to go out to neighborhoods to help let people know what is available"*
- *"We need to work more closely with health systems (Primary care, specialty care, hospitals) to share information about our programs and services"*
- *"I think community outreach is very important to make people aware of the services offered, when those services are offered, and where they are offered"*
- *"Education"*
- *"Community outreach with a proactive approach. Need education campaigns as many services might be available but patients are not aware"*
- *"In general, all communities need help with more awareness of the help that is out there"*
- *"One of the main programs we have is the need to increase awareness about Alzheimer's and the programs we provide, because many caregivers feel alone and they don't know we are here to support them. Also, we need to work more closely with health systems (Primary care, specialty care, hospitals) to share information about our programs and services."*

Access to care/community clinics

- *"Community clinics that are easily accessible "*
- *"More funding and/or access to care"*
- *"Community Health Workers would be invaluable, as would Harm Reduction services"*

We all know there are *barriers to receiving health care*, especially for the minority and medically underserved populations. From your experience, what is keeping people from getting the health care they need?

Several respondents mentioned **cost/financial issues** as a barrier receiving health care for the minority and medically underserved populations. Respondents indicated that some patients simply do not have the money to seek health care, or there is a fear of large medical bills. Others mentioned a lack of knowledge of what is covered versus not covered under the patient's insurance. Consider the following quotes from respondents:

- *"The minority population I work with frequently do not have and cannot afford health insurance. They also typically hold jobs that do not offer frequent paid time-off and cannot afford to take a day off for a mid-day appointment. If they take the day off, they not only lose the income, but are also paying for the expensive care they are receiving so it is a very costly situation for them. This can easily lead to cancelling or not showing up for appointments, or additional stress from their financial situation."*
- *"Some families qualify for health care for their children but not a deep enough subsidy for their own health insurance. In order to pay the bills, the parents forego their own health care needs."*

- *"The health and mental health systems are not designed to provide the best services but to maximize profit. Patients needing mental health wrap around services are seen once every few months and are left without support."*
- *"Fear of large medical bills."*
- *"Economic limitations (uninsured, underinsured)."*

Lack of communication is another barrier. The literature has shown that communication between a patient and his/her health care provider is key to delivering high quality health care resulting in improved patient outcomes. Therefore, it is not surprising that the lack of communication would be mentioned as a significant barrier to receiving health care. Language barriers reduce the likelihood of creating the necessary linkages between hospital care and primary care. Respondents said:

- *"A barrier exists because of a lack of knowledge about the population's cultural beliefs, values, and traditions"*
- *"Language barriers and cultural barriers. Some normal and regular health screenings or visits are avoided because it is not practiced in their homelands or cultures. So education on the importance and why physicals, pap smears, mammograms, etc. are needed."*

A related barrier mentioned was **lack of trust** in the health care system, either because of previous bad experiences, unclear communication, immigration status, lack of knowledge, stigma, or misinformation on social media. For example:

- *"Some of our families are undocumented and don't know what they can access without compromising their position"*
- *"Fear of immigration reporting"*
- *"Fear of being judged"*

As one might expect, **access to health care** was considered to be a huge barrier. Availability of needed healthcare is part of that barrier, as is a lack of transportation to get to a clinic and a lack of digital connectivity to access online information and services. And as one person said, *"it is difficult to navigate the healthcare system."*

A final barrier that arose in the comments of several respondents was the **lack of health literacy** and the resulting need for education: education about healthcare resources available in the community and patient education of their healthcare needs.

What aspects in our community can positively influence people's health? In other words, what are some ways to improve the health of people in our community? Also, what negatively influences (impacts) people's health in our community?

Suggested ways to improve the health of people:

There are many models of good community health care that focus on positive actions that can improve the health of people.

One respondent suggestion that people need to be educated about practices to ensure **mental health care** (e.g. mindful meditation, breathing practices, "yoga for the healthier you"). "*It's all how you market it*." "*Make the sessions interesting but focused on how to live a balanced life, and how to manage stress. Then people might want to try them out."*

Education/outreach such as the specific strategy noted above was mentioned by several people as a way of improving community health. Respondents noted that massive awareness campaigns should be conducted in different languages, using different delivery methods. The campaigns would include regular and open conversations with the community about available resources and services. Outreach events and health fairs are possible venues for such conversations. Several people felt that patient education is key, especially classes focusing on nutrition and healthy diet (which would be available at no cost).

Related to the need for education/outreach is the need to help people make **better lifestyle choices**. As noted by one person: *"People can change their lifestyle to reduce their risk. Studies show that exercise, nutrition, social engagement and cognitive activity can reduce health risks."* A campaign to encourage healthier habits to avoid chronic diseases would be helpful. But such lifestyle changes are often difficult or impossible for low-income adults who have limited options for affordably obtaining healthy food (e.g. fruits/vegetables), accessing clinical care, or finding adequate and safe spaces to exercise. They may not be able to afford health insurance, healthy food, or medications. As one person noted: "*There are large systemic issues that need to be addressed."* Sustained **financial assistance to community clinics** was suggested, perhaps through more grants to enable them to serve those in need.

Increasing the diversity of the healthcare workforce through community partnerships is another key to creating a positive environment conducive to community health. Specifically, one person noted that *"a positive influence can be partnership with community organizations that are providing culturally competent services to this population."* For example, previous needs assessments have noted the importance of enlisting the help of **promatoras**, lay Hispanic/Latino community members who would be able to mitigate somewhat the issues of lack of trust, lack of understanding of culture, language barriers, and the fear factor which exists among some undocumented residents. Creating partnerships with nonprofits to increase the diversity of healthcare delivery workforce would be a positive. These partnerships would help with "healthcare hot spotting" (going to the need).

Finally, an important component of positively influencing health is **addressing the SDOH** (social determinants of health) to build health equity among those most in need. As one respondent commented, this includes "*working with the county and city for optimizing public transportation, collaborating further with grassroots organizations in care coordination,*

developing outreach programs that integrate multiple professions to care for the person, and re-building any trust lost during the pandemic."

Negative influences (impacts) on health in our community:

Most of the negative influences mentioned are the "flip side" of the positive factors listed above: lack of early intervention, insufficient education/outreach, unhealthy lifestyle choices, limited access to culturally competent care, and insufficient focus on the social determinants of health. In addition, one comment addressed a COVID-related concern – the social isolation that has resulted from public schools and businesses being closed. Following are a few direct quotes about negative influences on health:

- *"Limited access to affordable, healthy food. Too easy access to unhealthy, fast foods and desserts. Again, the lack of financial resources, transportation, and understanding/ navigating the healthcare system."*
- *"Lack of culturally competent care"*
- *"Lack of green spaces, food deserts, community violence"*
- *"Passiveness, lack of awareness, late diagnosis of many conditions, the time it takes to get an appointment to specialty services, lack of inter-professional and intra-professional collaboration"*
- *"Fear (undocumented individuals) and lack of continuity/follow up"*
- *"Easy access to drugs. Homelessness, depression, suicidal ideation, mental health conditions. A street team with quicker response time would be good. Pomona PD has a homeless liaison and Tri-City has the PET team. The demand is so big in Pomona, it causes the response time to be very delayed."*
- *"Too many advertisements in the community promoting junk food with lower prices"*
- *"Lack of early intervention, lack of health education, support, and a very complicated system of care."*
- *"It's difficult to navigate the system and find a comparison of systems (i.e. fee for service vs. HMO) so that good decisions can be made. We need neutral parties to provide information – community navigators/ambassadors.*

What is the one most important thing that *hospitals* in this region can do improve the health and wellness of the community, especially minorities and medically underserved populations in this region?

In previous PVHMC needs assessments, IAR's data gathering process has revealed that hospitals becoming more active in the community, forming linkages with area CBOs, reaching out with education and services, and improving discharge planning and linkages to primary care for follow-up would significantly improve the health and wellness of the community. In addition, those assessments mentioned the need for education regarding disease prevention, wellness, being healthy, and getting early intervention.

Responses to the survey for the 2021 needs assessment were quite similar. **All of the above** suggestions appeared in the responses to this question. In addition, there was increased focus on **equity of health care**: Comments included having individuals that speak same language available when health care is being provided, addressing implicit bias, having diverse leadership, and training promotoras and community health workers who are directly from the community.

Service availability was also mentioned by multiple people. One summarized the issue nicely as follows: *"The simple fact that it takes about 2-3 months to get an appointment for a routine exam is mind-blowing. The PCP is the entry point for many into the healthcare system, and typically acts as the central hub for any referrals and/or coordination of care. This simply has to change for there to be a positive change in the health of any of the communities. The availability affects every population."*

Most hospitals already work in partnership with community organizations that can provide support and help meet community needs. However, respondents suggested **increased collaboration** with partnering organizations that can resolve existing barriers to improved community health (both in terms of primary care and behavioral health).

Ensuring **adequate transition from the hospital to follow-up services** was mentioned as an important thing for hospitals to do. *"Make sure the patients have the resources they need before being discharged. Lack of knowledge around resources is a big issue in the underserved populations."* One respondent noted that primary care physicians, specialty care physicians, and hospital staff need to be aware of the resources available in the community in order to better help their patients. "*I hear many families who say they were given a diagnosis, but they were not referred to resources."*

One respondent called for for more **cost-effective** ways to provide care, and one suggested that hospitals increase the number and scope of grants in order to help the underserved. Others suggested increasing **community outreach and** "**motivational education."**

What suggestions can you offer to help PVHMC meet the needs of the community (i.e. new activities or strategies, new community education/presentations on specific topics, new partnerships, specific services, needed resources, etc.)? Please explain.

The overall themes of the responses to this question match the themes above: equity, availability, cost effectiveness, community outreach, partnerships, and **education**. Following are the direct quotes which focus on the specific suggestions made:

- *"Starting with collaborations with other health care providers in private practice or community clinics as well as educational institutions. Having these effective and comprehensive networks would help reach sooner and more efficiently the common objectives in the different domains."*
- *"Community Clinics and opportunities for primary care. Community Health workers for outreach. Food services. Local transportation."*
- *"Continue to strengthen the Pomona Violence Prevention Network. Offer more Youth Mental Health classes, support. Offer inclusive sex education classes and STI education for youth."*
- *"Continued advocacy for underserved populations with local/state government entities."*
- *"Early intervention in schools; church outreach as regular health partners."*
- *"Hosting grand rounds for the community, community learning for both providers and the general public through case presentation, use of non- traditional health care workers, making service access a low barrier."*
- *"A partnership/collaboration with youth groups and community groups to provide on-going education and dialogue in community settings."*
- *"Partner with organizations in the community to simplify the referral process."*
- *"Partner with Western University of Health Sciences, especially in the delivery of eye care with an underutilized resource of optometry."*
- *"Patient education - collaboration with other healthcare providers - obtaining funding for these activities (grants etc.)".*
- *"Provide low-cost options up-front to patients seeking care at PVHMC."*
- *"Provide specific services for those who are chronically homeless free of charge. Maybe a simple check-up and blood work that needs to be done so that they are aware of what is going on with their health."*
- *"There can be presentations and hands on trainings at organizations"*
- *"They can work with the Alzheimer's Association to provide education to their patients and provide referrals."*
- *"Utilize student support from WesternU in all professions. Work in collaboration to build education to community (new partnerships). Develop teams for specific groups/areas to maintain consistency & build trust. Utilize community group leaders as champions."*
- *"You are welcome to access our families through our schools to address needs."*
- *"Create or utilize programs like Pomona Promise to link services and programs."*
- *"Building that trust, learning more about each other's agencies."*

V. INTERVIEWS WITH PUBLIC HEALTH OFFICIALS

INTRODUCTION

The final component of PVHMC's Community Health Needs Assessment consisted of eliciting the views of public health officials in both Los Angeles and San Bernardino Counties. Ms. Jocelyn Estiandan, Los Angeles County Sr. Public Health Analyst SPA3 chose to provide her comments in writing. She submitted them on July 22, 2021. In addition, IAR conducted an in-depth zoom interview with four representatives of the San Bernardino Department of Public Health on August 2, 2021. Participants included Ms. Jennifer Baptiste Smith (Chief of Clinical Health and Prevention Services), Ms. Monique Amis (Chief of Community and Family Health), and two Clinic Supervisors/nurses from the Department of Maternal, Child & Adolescent Health.

The interviews consisted of questions regarding the unmet health needs of the community in the areas of:

- Support for patients and families (education, support groups, etc.),
- Primary care and preventative health services,
- Chronic disease management, and
- Wellness (nutrition, physical activity, smoking, etc.).

In addition, respondents were asked to offer their opinions on the barriers to meeting the health needs of the community, and were provided an opportunity to make additional comments regarding the most important things that hospitals in the region can do to improve the health and wellness of the community. See Appendix C for the interview guide.

Overall, comments from the executive interviews focused heavily on the social determinants of health and health equity. In short, if people live in poor conditions, they have limited access to health care. Respondents were clear that the lack of access to education, good health care, housing, and opportunities to improve economic standing had far-reaching effects on the health of the community. However, these are issues which can only be solved by fostering collaboration/ partnerships between hospitals, community-based organizations, and government organizations.

Following is an overview of respondent comments for each of the health need categories noted above.

FINDINGS

1. Unmet needs in the area of support for patients and families (education, support groups, etc.)

One of the interviews focused on five types of unmet needs in the category of support for patients and families: (1) **trauma prevention and violence prevention services**, (2) **maternal**

mental health and infant health services, (3) **support services for gender minorities**, (4) access to **services for immigrants**, and (5) **food security**. **Suggestions for PVHMC**:

- Screen patients for food insecurity and connect patients-in-need to food and nutrition services;
- Offer lactation services and allow doulas to fully support people giving birth, especially Black women and families;
- Connect Black women and families to other local supportive services (e.g., Prototypes);
- Connect patients (youth and families) to mental health services; and
- Work closely with gang violence intervention workers to connect victims of violence to supportive services.

The other interview was quite different, focusing on the need for **transportation services** (especially for the low-income population). Public transportation is quite limited in outlying areas and runs only limited hours, so people have trouble getting to medical appointments.

In addition, people often focus on meeting immediate health needs, but they are **unaware of available resources** for other (more long-term) needs. Even people providing resources don't know what other providers are doing. There is little **linkage** between the agencies/partners. **Suggestions**: The health care system needs to do better with communication and linkages. It was suggested that the patients/clients should be asked about the best way for them to get needed information about resources, then agencies should act on the patients'/clients' suggestions about the best ways to "advertise" the resources. But it is also important to "close the loop." That is, once the "advertising campaign" has commenced, ask people whether they *found* the resources, and whether the resources *met their needs*.

2. Unmet needs in the area of primary care and preventative health services

Identified needs in the area of primary care and preventative health services include:

- **Patients who fail to follow up after hospitalization and/or keep scheduled medical appointments** (wellness visits and follow-up appointments). This is a problem for populations across the board, but it especially affects the low-income population, people living in rural areas, women with children, young adults who don't know how to navigate the system, and seniors afraid to use busses. In addition, immigrants and the undocumented are strongly affected. **Suggestions**: Increase the number of primary care providers in the region (especially for wellness care). Provide training for primary care providers on providing "culturally sensitive" care. Provide incentives for providers to work in outlying areas where few providers want to work. Make appointments a "memorable experience" by training the medical team to "connect" with the patient.
- **Lack of equity in health care.** This issue was raised in the context of disparities in COVID

vaccinations (Black/African Americans and the Latinx population having significantly lower vaccination rates when compared with Caucasians). This especially affects low-income populations, people of color, and youth 12+. **Suggestions**: Partner with CBOs and other community groups to provide pop-up vaccination clinics targeting the hard-to-reach populations, and develop or engage in existing vaccination education campaigns in partnership with community groups, the Department of Public Health, and the Pomona Unified School District.

- **Lack of patient education and motivation to seek health care.** The Department of Public Health is trying to use methods such as texts and electronic processes to remind people of appointments, but there is lack of self-motivation and urgency to keep appointments. **Suggestions**: It is important to educate the patients about "why it is important to keep appointments." Otherwise, kids don't get their follow-up care, providers' schedules get messed up, and physicians who have been moved from other locations to provide care in outlying clinics experience no-shows.

3. Unmet needs in the area of chronic disease management

Low-income individuals often have no **"medical home"** and **insufficient education** about their condition. They often need to change providers and they don't always keep appointments, so their chronic issues are hard to treat. This issue is especially important relative to:

- Asthma in children
- Mental health in adolescents (stress, depression) – this is especially important for minorities
- Adult hypertension
- Cardiovascular health
- Diabetes
- Obesity

Suggestions for PVHMC and other physicians/clinics include:

- Make off-hour appointments for people who can't leave work to seek medical care.
- Provide copies of medical records to the patient at no cost so that they can be available to other providers.
- Doctors need to help patients understand what their responsibility is to take care of themselves. Chronic illness does not happen overnight. It happens over time and needs to be addressed over time.
- Provide culturally sensitive health care. Ask patients the reasons WHY don't want to take the medication prescribed, or follow up on appointments, or are non-compliant with physician's advice. Remove the US vs THEM philosophy. It should be US ***with*** THEM (working together).
- Educate people to become activists for their own health.

4. Unmet needs in the area of wellness nutrition, physical activity, smoking, etc.),

Food insecurity, particularly access to low cost or free fresh fruit and vegetables, is a major unmet need. According to the LA County respondent, 1 in 10 households experienced substantially higher rates of food insecurity from April – July 2020 than pre-pandemic levels. The San Gabriel Valley region had the 2nd highest percentage of households with food insecurity. Vulnerable populations include low-income people/families; black, indigenous, and other people of color; people with chronic conditions; and unemployed individuals. **Suggestions:** (1) Educate and empower physicians of patients with chronic conditions to refer to farmer's markets and produce distributions. (2) Work with City leaders to encourage stores that carry healthy foods (at a reasonable price) to locate in neighborhoods where nutrition is an issue. Encourage City leaders not to give business permits unless they agree to cut down on fast food places and increase the number of stores which carry healthy food and a good selection of brands (e.g. feminine needs products). "Point out to officials the differences in stores in various parts of the city, because it is not on their radar right now." (3) Educate people on exercise, portion size, and healthy eating.

Safety/security is also a major component of wellness. There needs to be increased focus on prevention of serious violent crimes which include aggravated assaults, robbery, rape, and homicide as well as assault-related trauma center visits, which has been increasing since 2016 (Los Angeles County Emergency Medical Services Agency). Gang prevention, gang interventions, gang violence prevention, and youth diversion programs are important for vulnerable populations such as: at-risk youth, youth involved in the criminal justice system, low-income households, and minorities. **Suggestions:** Fund, support, and partner with CBOs that offer youth diversion programs, and gang violence prevention programs.

5. "Other" unmet needs

There is a need for **homelessness services** for low-income households, people experiencing homelessness, minorities, and immigrants. **Suggestion**: collaborate with community partners to ensure a "No Wrong Door" approach to service delivery and referrals to resources.

In addition, there is a current spike in the need for **mental health support for Asian** populations. **Suggestion**: collaborate with community partners to provide mental health support and address the increase in Asian hate crimes.

6. Barriers to meeting the health needs of the community

The following barriers were mentioned by respondents:

- Institutional racism

    - Persons of color, specifically African American communities, face higher levels of toxic stress due to institutionalized racism and bias. Toxic stress is a contributor to pre-term births and low birth-weight infants.
    - Black people have higher rates of heart disease, hypertension, diabetes, lung disease, asthma and obesity, among other illnesses.
    - Disproportional rates of Black and Brown people in the criminal justice system lead to poor health outcomes.
- Socioeconomic Barriers; poverty, homelessness.
- Rise in Asian hate crimes.
- Rise in food insecurity.
- Rise in violence and gang violence.
- Rise in unemployment.
- Undocumented immigrants have difficulty and mistrust; therefore, less likely to take care of health, especially preventative health.
- Language and cultural barriers -- if providers don't understand "culturally competent services," it is hard to convince patients to live healthy lives.
- Lack of awareness of the need for preventative health.

7. In order of ranking, what do you believe are the top three or more barriers to meeting the health needs of our community?

Identified Health Need Priorities and Barriers
1. Mental health
2. Transportation
3. Education
4. Food insecurity/healthy food
5. More medical providers
6. Improve retention and recruitment of nurses and paraprofessionals

8. Other suggestions and additional comments for ways hospitals can improve the health and wellness of the community in collaboration with other agencies:

- **Collaboration** with all agencies is key. The patient is not only a "hospital patient"… he/she is a concern of other agencies as well once the patient leaves the hospital. Example of a disconnect: a pregnant woman was working with child services in San Bernardino and was known by those staff. She had to deliver in Riverside County, and there was no collaboration between counties to have health providers understand her full situation.
- **Support and fund** local agencies that work in the areas of gang and violence prevention, homelessness, African American health, mental health, and food insecurity.

- The County Department of Public Health works with hospitals, but the communication doesn't always work well. Have a **single liaison**, one central person to communicate with so that everyone can be linked effectively.
- While **recruiting** new nurses and physicians: ask if they have ever had experience working with low-income populations.

9. Suggestions for agencies with which PVHMC can work to meet the health needs of the community:

- Soledad Enrichment Action (SEA)
  Contact Johnny "JT" Torres: jtorres@seaprograms.org
- San Gabriel Valley Hospital Collaborative
  Contact Deborah Silver: healthsgv@gmail.com
- Tri-City Mental Health and Pomona's Promise – Health Access Committee
  Contact Toni (Antonette) Navarro: anavarro@tricitymhs.org
- San Gabriel Valley Consortium on Homelessness
  Contact Scott Chamberlain: scott@sgvc.org
- San Gabriel Valley African American Infant and Maternal Mortality Prevention Initiative
  Contact Annette Trejo: atrejo@ph.lacounty.gov
- Protoypes (Pomona Women's Center)
  Contact Michelle Rosamond: mrosemond@prototypes.org
- Pomona Unified School District:
  Contact Mark Maine: Mark.Maine@pomona.k12.ca.us

VI. EVALUATION OF IMPACT

As a non-profit organization, Pomona Valley Hospital Medical Center is committed to continuously strive to improve the status of health of the community. Taking a close look at specific actions that PVHMC has taken to address priority health needs identified in prior Community Health Needs Assessment (2018), PHVMC's brief evaluation of PVHMC's impact and accomplishments has been documented here.

Although this list is not comprehensive and a more complete listing of all of PVHMC's actions and community benefit services can be found in PVHMC's Community Benefit Report and Implementation Strategy on the website (pvhmc.org), the following provides a summarized evaluation of PVHMC's strategies and accomplishments across FY 2019-2021.

Priority Health Needs Identified in PVHMC's **2018** Community Health Needs Assessment and addressed in **FY 2019-2021:** **1. Chronic Disease** **2. Access to Care** **3. Obesity/Nutrition**	
Strategies	• Provide Diabetes Outreach and Education, including activities centered around obesity and food/nutrition. • Provide Cancer Care Patient Coordinators (Navigators) and Social Services to guide patients with making appointments, receiving financial assistance, and enrolling in support groups. • Provide Stroke Prevention and Rehabilitation Outreach and Education. • Provide Cancer Care Programs and Support Groups. • Free or low-cost education, resources, and/or classes that promotes healthy eating, disease prevention, and weight loss/management. • Provide on-site enrollment assistance and for appropriate health insurance plans; participation in the hospital presumptive eligibility program. • Promote community awareness about health services offered, wellness classes, and support groups. • Provide discharge transportation for vulnerable patients who are otherwise unable to get home.

	• Provide free, low-cost or reduced-cost health services, medications, and medical devices. • Provide free or reduced cost screenings and immunizations at local health fairs. • Collaborate with primary care providers and clinics to improve access to preventative and specialty care. • Continue working with PVHMC's Family Medicine Residency Program through UCLA to increase the number of primary care physicians in the region. • Increase PVHMC's capacity to care for patients needing emergency treatment, trauma services, surgery, and primary care.
Impact and Accomplishments	• Provided free glucose screenings at health fairs and events (local and on-campus). • Provided free or low cost diabetes, weight management and nutrition education classes and resources. • Provided education to promote cardiovascular health and risk reduction. • Offered free blood pressure screenings at health fairs and events (in-community and on-campus). • Published information on stroke, cardiovascular health, diabetes, cancer treatment, and available resources to address these conditions. • Provided care coordination services that seek to assure patients are positioned for a safe discharge home, with positive health outcomes and increased awareness and understanding of their healthcare needs after discharge. • Provided Cancer Care Patient Coordinators (Navigators) and Social Services to guide patients with making appointments, receiving financial assistance, and enrolling in support groups. • Provided free preventative health screenings and health education in community based settings. Highlights include: • Care Harbor Clinic (partnership with Fairplex) offering free medical, dental and vision services and matching attendees with local primary and specialty care providers.

	• IEHP Employee Health Fair • Latino Family Symposium • Los Angeles County Fair (Fairplex) • Community Health Fairs hosted by Supervisor Hilda Solis, Councilmember Nora Garcia, and Assemblymember Freddie Rodriguez • Community Health Fairs in the cities of La Verne, Claremont, Azusa, West Covina, Diamond Bar, Chino, Chino Hills, and Pomona • Provided Fiscal and In-Kind Support for ParkTree in the development of Dental Care services at three clinic locations: Pomona and Ontario (2) • Provided Behavioral Health and Substance Use Support to patients entering Emergency Room for treatment, including establishing designated ER Navigators to provide focused support to our patients experiencing a behavioral health or substance use crisis; identify, appropriately treat, refer to treatment and provide follow-up for patients presenting in the ED (in partnership with IEHP). • Health Bridges Program (in partnership with Claremont College Volunteers) to assist patients with limited English to navigate health care system and link to resources. • Provided Cancer, Stroke and Diabetes Navigators to provide enhanced care coordination and guide patients to receiving follow-up care, making appointments, and managing their disease. • Provided Cancer Care Classes and Support Groups to aid in diagnosis, treatment, recovery, and overall psycho-social wellness. • Established a Postpartum Depression Support Group. • Provided Mobile Phlebotomy Services (Mt. San Antonio Gardens). • Offered medication, transportation and medical equipment assistance for uninsured and/or low-income patients at discharge.

	• Hosted a recurring Sports Medicine Evening Clinic and provided High School Sports Physicals to raise money for sports programs (partnership with local school districts).
	• Hosted Drive-Thru Flu Clinics (partnership with Western University and Fairplex).
	• COVID-19 Vaccination Clinic serving more than 28,000 community members.
	• Provided enhanced COVID-19 Treatment, and Education, Rehabilitation services, including:
	  • Post-COVID recovery program – PVHMC PT/Rehab
	  • Screening/early identification: purchased testing in-house with purchase of FDA approved rapid-test analyzers.
	  • Provided Monoclonal Antibodies/Convalescent Plasma and community education about available treatment and how to donate.
	  • Provided in-kind medical equipment donations of to other hospitals to other hospitals during the pandemic.
	• Diabetes Self-Management Education (DSME) Classes – one of only 3 in 25 mile radius of PVHMC.
	• Participated in the "*Stopping Diabetes in its Tracks*" Initiative (collaboration with ParkTree, Pomona Valley Health Center, Claremont Graduate University, Community Translational Institute, and UniHealth)
	• Provided Heart Failure, Cardiovascular Disease and Stroke Support Groups, Education and Events, including:
	  • Stroke Awareness Day
	  • Power of Red
	  • Stead Heart for Women
	  • Cardiovascular Education Series and New Beginnings Support Groups
	• Offered Aquatic Wellness and Rehabilitation Gym access for patients managing chronic heart and pulmonary related conditions.

	• Hosted Speakers Bureau Events open to community and patients (topics include heart health, women's health, cancer, and nutrition).
	• Hosted CCC Patient Workshops, Support Groups, and Early Detection/Prevention Speaking Engagements.
	• Provided Nutrition Education with focus on Diabetes, Cardiovascular, Cancer and General Nutrition, including:
	  • Healthy Eating for Diabetes (community class)
	  • Nutrition strategies for Cancer during treatment (CCC)
	  • Nutrition for the Heart (Central Baptist Church)
	  • Nutrition for Ostomy Patients (CCC – Ostomy Support Group)
	• Distributed Fresh Produce Boxes to our Local Community (Partnership with Sunrise Produce and God's Pantry)
	• Provided Meals on Wheels (2018-2019) and Food Finders Program (2020) to support food insecure community members.
	• Provided Marathon Sponsorships and health/injury support to runners, including:
	  • Heart Walk
	  • LA County Half-Marathon
	  • Holiday Half-Marathon
	• Attended and Supported
	Pomona's Promise Community Safety Workgroup – Trauma Program; Pomona's Promise Healthcare Group – Lisa Diaz, RN (Diabetes)
	• Offered Injury Prevention-HAM (Hospital and Morgue) Class (DUI program) and PVHMC's Trauma Department "*Stop the Bleed*" Class to provide safety and injury prevention education.
	• Hosted Childbirth and Parenting Classes/Support Groups and Breastfeeding Clinic open to all community members.
	• Provided Hands-Only CPR Classes in community-based settings (partner with local police and fire departments).
	• Provided Health Professions Education:
	  • Neuro, Stroke, Cardiac and Perinatal Symposiums.

	• Family Medicine Residency Program in partnership with UCLA • Internships for nursing, respiratory, radiology, food/nutrition, social services students. • Participated in STEA2M Fair for kids (Fairplex) to inspire students from grades K-12 to explore and pursue learning and careers in the areas of Science, Technology, Engineering, Arts and Agriculture, and Math. • Supported community building, education and large-scale disaster preparedness and training activities (partnership with city, police, fire, and more than a dozen hospitals in the region) • Provided Financial and In-Kind Donations to dozens of local organizations meeting the needs of our community.
Valuation	❖ More than **390,000** individuals benefited from PVHMC's Community Benefit outreach and programs. ❖ More than **$3 million** in community benefits dedicated to community outreach, screenings, and education in addressing the 2018 priority health needs in the last three years. ❖ Additionally, more than **$100 million** in unreimbursed care and charity-care was provided for our most vulnerable PVHMC patients between 2018-2020.

Appendix A

Online Survey Instrument

PVHMC Online for FINAL APPROVAL – 6/17/21 (with small revisions 6/22)

Here is the anonymous link in English:
http://csusb.az1.qualtrics.com/jfe/form/SV_7V3ToRP6u9wKLum

And here is the anonymous link in Spanish (still reviewing the translation as of 6/17/21):

http://csusb.az1.qualtrics.com/jfe/form/SV_7V3ToRP6u9wKLum?Q_Language=ES

NOTE: question "numbers" are in bold. They will not show up to the respondent.
NOTE: IAR wishes to be clear that this survey is VERY long, and completion rate may suffer somewhat.

POMONA VALLEY HOSPITAL MEDICAL CENTER
Expert care with a personal touch

CALIFORNIA STATE UNIVERSITY SAN BERNARDINO
Institute of Applied Research and Policy Analysis

INTRO
Thank you for accessing this Community Health Needs Assessment regarding the community's health-related needs. This assessment is being conducted by the Institute of Applied Research at Cal State San Bernardino, on behalf of Pomona Valley Hospital Medical Center (PVHMC). Please note that we need your input, ***even if you have never been to PVHMC***. Your input will help decision-makers better understand the health needs of the community so that they can help improve the quality of health services available in the region.

This survey takes about 15 minutes to complete, and your answers may be used by hospital officials to better meet the health needs of the community. Your identity and your responses will remain completely confidential, and of course, you are free to decline to answer any particular survey question after the initial screening questions. We hope you can respond by **July 30, 2021**.

If you have content-related or technical questions related to this survey, please contact Dr. Barbara Sirotnik at bsirotni@csusb.edu, or call 909.537.5729.

By clicking below, you acknowledge that you are ***18 years old or older***, ***have been informed*** of and understand the purpose of the study, and ***freely consent*** to participate. Please indicate this acknowledgement by selecting "Agree to participate." Selecting "Disagree" will end the survey.

○ Agree to participate. Continue with the survey.

- ○ Disagree (end survey)

Q1CityZip

This survey is designed for residents of Pomona Valley Hospital Medical Center's service area. To make sure you are in the area, what is the city and zip code where you live?

- ○ 91701 Alta Loma
- ○ 91737 Alta Loma
- ○ 91708 Chino
- ○ 91710 Chino
- ○ 91709 Chino Hills
- ○ 91711 Claremont
- ○ 91750 La Verne
- ○ 91763 Montclair
- ○ 91758 Ontario
- ○ 91761 Ontario
- ○ 91762 Ontario
- ○ 91764 Ontario
- ○ 91766 Pomona
- ○ 91767 Pomona
- ○ 91768 Pomona
- ○ 91729 Rancho Cucamonga
- ○ 91730 Rancho Cucamonga
- ○ 91773 San Dimas
- ○ 91784 Upland
- ○ 91785 Upland

○ 91786 Upland

○ Other (Please specify) _____

Q2NumPeople
Including YOURSELF, how many people live in your household? Please type a NUMBER.
_____

Display This Question only if more than 1 person lives in the household

Q3NumKids
How many children ages 0 - 17 live in your household? Please type a NUMBER._ _____

Q4NumInsured
How many persons in your household AGES 18 AND ABOVE are covered by medical insurance? Please type a NUMBER. _____

Display This Question if # of children > 0

Q5NumKidsInsured
How many children in your household AGE 0 - 17 are covered by medical insurance? Please type a NUMBER. _____

Q6InsuranceType
What type of health insurance covers people in your household? Please check all that apply. NOTE: If you have Blue Cross, Blue Shield, IEHP, United Healthcare, AETNA, etc. click the second box: "I have private insurance"

☐ I have insurance but don't know the type

☐ I have private insurance (either HMO or PPO)

☐ Medi-Cal

☐ Medicare

☐ Veterans (VA)

☐ ObamaCare, Covered California, Affordable Care Act Insurance

☐ Other Government Insurance (WIC, CHIP, ETC.)

- [ ] Other (Please specify) _____
- [ ] Not covered, no insurance at all
- [ ] Prefer not to answer

Display This Question if have no insurance

Q7WhyNoIns

What are the main reasons you and/or your family members don't have health insurance? Please check all that apply.

- [ ] I am (we are) healthy
- [ ] Don't need insurance
- [ ] Did not understand plans well enough to buy insurance
- [ ] Lost job or changed job
- [ ] Person with primary policy (spouse or parent) lost or changed job
- [ ] Divorce or separation
- [ ] Person with policy died
- [ ] Became ineligible because of age or left school
- [ ] Employer doesn't offer or stopped offering coverage
- [ ] Cut back to part-time or became a temp employee
- [ ] Couldn't afford premiums
- [ ] Insurance company refused coverage (due to pre-existing condition)
- [ ] Lost Medicaid or Medi-Cal assistance eligibility
- [ ] Other (Please specify) _____
- [ ] Don't know
- [ ] Prefer not to answer

Q8Covid1a
The next few questions deal with your experiences with COVID-19 and the pandemic. First, have you received at least one dose of the COVID-19 vaccine?

- ○ Yes
- ○ No
- ○ Prefer not to answer

Display This Question if haven't been vaccinated

Q9Covid1b
Which of the following statements best describes how quickly, if at all, you think you will get the vaccine for COVID-19 now that it is available? Are you…

- ○ Planning to receive the vaccine soon?
- ○ Waiting a month or two to see what the short-term effects are on others?
- ○ Waiting several months to see what the longer-term effects are on others?
- ○ Waiting a year or so to see if a better version of the vaccine is developed?
- ○ Do not plan to get the vaccine at all
- ○ Don't know
- ○ Prefer not to answer

Q11Covid3a
How has the pandemic impacted your overall health? Would you say that it has had a negative impact, or a positive impact, or not much impact?

- ○ Negative impact
- ○ Positive impact
- ○ Not much impact
- ○ Don't know
- ○ Prefer not to answer

Display This Question if negative impact

Q12Covid3b

In what ways has the pandemic negatively impacted your overall health? Please check all that apply.

- [ ] More stressed, anxious, and/or depressed
- [ ] Gained weight
- [ ] Got COVID --still feeling fatigue, fogginess, pain, cough, difficulty breathing...
- [ ] Stomach problems
- [ ] Afraid to go back to work or socialize
- [ ] Smoking more
- [ ] Drinking alcohol more
- [ ] Lost job so couldn't pay for food
- [ ] Other (please specify) _____
- [ ] Prefer not to answer

Q14Covid4b

Did your employment status change during the pandemic "stay-at-home" order?

- ○ No change in employment status
- ○ Same workplace but working reduced hours
- ○ Now working from home full time
- ○ Now working from home at least part of the time
- ○ Lost job due to Covid
- ○ Had to quit job to take care of children, parents, etc.
- ○ Other (Please specify _____
- ○ Prefer not to answer

Q15Telehealth1
In the past year, have you used telehealth services where you do a video chat with a healthcare provider using a mobile device or computer?

- ○ Yes
- ○ No
- ○ Prefer not to answer

Display This Question if have used telehealth services

Q16Telehealth2
Overall, do you prefer having in-office physician visits or telehealth treatment?

- ○ Didn't like telehealth treatment -- prefer in-office physician visits
- ○ Liked telehealth services -- would use it in the future
- ○ No preference for in-office vs telehealth -- it doesn't matter either way
- ○ Don't know
- ○ Prefer not to answer

Q17NoServices
In the past year, have you or any members of your household needed any health services that you could not get?

- ○ Yes
- ○ No
- ○ Don't recall
- ○ Prefer not to answer

Display This Question if someone needed health services they couldn't get

Q18WhyNoServices
What kept you or your family members from getting the health services you needed? Please check all that apply.

- ☐ Worried about cost of service/co-payments

- [ ] Worried about cost of prescription(s)
- [ ] Lacked transportation
- [ ] Lacked child care/babysitter
- [ ] Had problems with the English language
- [ ] Hours were not convenient
- [ ] Difficulty scheduling
- [ ] The needed services weren't available
- [ ] Didn't know where to find the services
- [ ] Pomona Valley Hospital Medical Center didn't have the services needed
- [ ] Didn't like the programs or services
- [ ] Provider wouldn't accept my insurance
- [ ] The medical technology wasn't available in the area
- [ ] No health insurance
- [ ] Didn't want to leave the house during the pandemic
- [ ] Other (Please specify) _____
- [ ] Don't know
- [ ] Prefer not to answer

Display This Question if someone needed health services they couldn't get

Q19WhatServices

What services couldn't you get?

- [ ] Dental care
- [ ] Vision care
- [ ] Prescriptions or medication needed

- [ ] Surgery
- [ ] Medical equipment (walkers, wheelchairs, special medical equipment)
- [ ] Other (please specify)
- [ ] Prefer not to answer

Q20GeneralPhys
About how long has it been since you visited a doctor for a general physical exam, as opposed to an exam for a specific injury, illness, or condition.

- ○ Within the past year (1-12 months ago)
- ○ Within the past 2 years (13 months to 2 years)
- ○ Within the past 5 years (25 months to 5 years ago)
- ○ More than 5 years ago
- ○ Never had a general physical exam
- ○ Don't know
- ○ Prefer not to answer

Display This Question if respondent has at least one child

Q23Kidcondition
Have you been told by any of your children's doctors that they have any of the following conditions? Please check all that apply.

- [ ] Asthma or breathing problems
- [ ] Diabetes
- [ ] Overweight/obese
- [ ] Seizures
- [ ] Other (please specify) _____
- [ ] NONE

☐ Prefer not to answer

Display This Question if child has asthma or breathing problems

Q24Asthma

How many times during the past 12 months did you visit the emergency room because of your child's **asthma or breathing problems**? Please type a NUMBER. _____

Display This Question if child has diabetes

Q25Diabetes

How many times during the past 12 months did you visit the emergency room because of your child's **diabetes**? Please type a NUMBER. _____

Display This Question if respondent has at least one child

Q26Specialist1

Have you had any trouble finding pediatric specialists for any of your children?

○ Yes

○ No

○ Don't recall

○ Prefer not to answer

Display This Question if had trouble finding pediatric specialists for any of your children

Q27Specialist2

What specialists couldn't you find for your child(ren)? Please check all that apply.

☐ Bone or joint specialist

☐ Cancer specialist

☐ Diabetes specialist

☐ Heart specialist

☐ Lung or breathing specialist

☐ Brain health specialist (i.e. neurologist)

- [ ] Other (Please specify) _____
- [ ] Don't know/don't recall
- [ ] Prefer not to answer

Display This Question if had trouble finding pediatric specialists for any of your children

Q28Specialist3

What difficulties have you had getting in to see a specialist for your child? Please check all that apply.

- [ ] Couldn't get a timely appointment
- [ ] Couldn't find this type of specialist locally
- [ ] No transportation to get to the office (e.g., no car)
- [ ] Couldn't get to the office during their hours of operation
- [ ] Don't know how to find this type of specialist
- [ ] Specialist is not in my health network
- [ ] No health insurance/couldn't afford it
- [ ] Specialist I wanted for my child was not seeing new patients
- [ ] Other (please specify) _____
- [ ] Don't know
- [ ] Prefer not to answer

Q29Weight

Changing subjects now...do you **typically** find it difficult to eat healthy or maintain a healthy body weight?

- ○ Yes
- ○ No
- ○ Sometimes

○ Not usually, but my eating and exercise habits changed as a result of the COVID-19 pandemic/quarantine

○ Don't know

○ Prefer not to answer

Display This Question if said "yes" or "sometimes" they typically find it difficult to eat healthy or maintain a healthy body weight

Q30HardWeight

What would you say is the NUMBER ONE reason it is difficult to eat healthy or maintain a healthy body weight?

○ Cost of healthy food (fruits and vegetables)

○ Not sure how to cook/prepare healthy foods

○ Not sure what is considered "unhealthy"

○ It's hard to change my eating and exercise habits

○ I like food too much

○ I don't care about my weight

○ Too busy to exercise or prepare healthy meals

○ The pandemic changed my eating habits

○ Other (Please specify) _____

○ Don't know

○ Prefer not to answer

Q31Pap

Now moving on to health prevention tests. Has any member of your household had a Pap Smear within the past three years?

○ Yes

○ No

- ○ No female in household
- ○ Don't know
- ○ Prefer not to answer

Skip To: Q34Cholesterol If No female in household

Q32Mammogram

Typically, how often do you or members of your household get a mammogram?

- ○ Every year
- ○ Every two years
- ○ Every three years or less often
- ○ DOESN'T APPLY -- TOO YOUNG TO NEED THE TEST
- ○ Don't know
- ○ Prefer not to answer

Q34Cholesterol

Has anyone in the household had a blood test for cholesterol in the PAST YEAR?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

Q35Colon

Has anyone in your household had a screening test for colon cancer in the past TEN years?

- ○ Yes
- ○ No
- ○ DOESN'T APPLY -- TOO YOUNG TO NEED THE TEST
- ○ Don't know

- ○ Prefer not to answer

Display This Question if "no" to pap smear or colonoscopy or every three years or less often for mammogram

Q36WhyNoScreening

May I ask why people in your household haven't had all of the cancer screenings stated above? (Pap, Mammogram, colon cancer) Please check all that apply.

- ☐ No insurance
- ☐ Financial issues -- the out of pocket cost is high, even with insurance
- ☐ Fear of the test/dislike of the test
- ☐ Didn't think it is important or necessary
- ☐ Lack of child care
- ☐ Fear of the results
- ☐ Too old or too young to need the test
- ☐ No transportation to get to a test
- ☐ No females in the household
- ☐ No regular doctor
- ☐ I am a healthy person
- ☐ I didn't want to leave the house during the pandemic
- ☐ Other (Please specify) _____
- ☐ Don't know
- ☐ Prefer not to answer

Q37Chronic

Do you or any member of your family have any of the following chronic or ongoing health problems? Please check all that apply.

- [ ] Cancer
- [ ] Diabetes
- [ ] Asthma
- [ ] High blood pressure
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Chronic heart failure
- [ ] High cholesterol or arteriosclerosis
- [ ] Arthritis
- [ ] Are there any other chronic conditions? If so, please specify. _____
- [ ] NO CHRONIC OR ONGOING HEALTH PROBLEMS
- [ ] Don't know
- [ ] Prefer not to answer

Skip To: Q42Smoke If NO CHRONIC OR ONGOING HEALTH PROBLEMS

Q38Help

Do you feel you and your family have received adequate help managing the disease (from doctors or support groups or classes)?

- ○ Yes
- ○ No
- ○ Only for some of the illnesses (please specify which ones) _____
- ○ Don't know
- ○ Prefer not to answer

Display This Question if didn't get adequate help, or only for some of the illnesses

Q39Help

What help did you need that you didn't get? Please explain.

_____

Q42Smoke
Does anyone living in the house smoke (cigarettes, cigars, or pipes) or vape?

- ○ Yes, either cigarettes, cigars, or a pipe
- ○ Yes, vape
- ○ Yes, both smoke AND vape
- ○ No one in the house smokes or vapes
- ○ Don't know
- ○ Prefer not to answer

Display This Question if smoke or vape. It should be displayed if any of the top 3 options are mentioned – either cigarettes/cigars/pipe, or vape, or both smoke AND vape

Q43LungScreen
Has the household member who smokes or vapes ever had a lung cancer screening?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

Q44Injury
In the past 2 years, have you or has anyone in your household experienced a **traumatic injury** like a work accident, car accident, or sports injury?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

Display This Question if respondent has at least one child

Q21Worry

The safety of our children is an important part of our community. What safety concerns do you have for your children? Please check all that apply.

- ☐ No particular worries
- ☐ Children walking home from school
- ☐ Children riding a bike
- ☐ Car seat safety
- ☐ Safety playing a sport
- ☐ Swimming/pool safety
- ☐ Riding in a car
- ☐ Bullying
- ☐ Crime/violence
- ☐ Other (please specify) _____
- ☐ Don't know
- ☐ Prefer not to answer

Q45Safety

Do you feel safe in your neighborhood…?

- ○ All the time,
- ○ At certain times of the day but not others, or
- ○ Never?
- ○ Don’t know
- ○ Prefer not to answer

Q46GoToPVHMC
The next few questions focus on Pomona Valley Hospital Medical Center (PVHMC). Have you ever gone there for health care?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

Display This Question if have gone to PVHMC

Q48WhyChoose
Why did you choose Pomona Valley Hospital Medical Center? Please check all that apply.

- ☐ Close to home (convenience/location)
- ☐ Insurance
- ☐ Referred by my physician
- ☐ Types of services offered
- ☐ Quality/reputation
- ☐ Word of mouth (from a friend, neighbor, family member, co-worker)
- ☐ Internet
- ☐ Newspaper, radio, or television
- ☐ Community presentation
- ☐ Other (Please specify) _____
- ☐ Taken there by ambulance in an emergency, so there was no choice
- ☐ Don't know
- ☐ Prefer not to answer

Q49Classes

Have you attended any classes offered by Pomona Valley Hospital Medical Center?

- ○ Yes
- ○ No
- ○ Don't know/don't remember
- ○ Prefer not to answer

Q50WantClasses
Are there classes you'd like them to offer?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

Display This Question if there are classes you'd like them to offer

Q51TypeClasses
What type of classes? Please check all that apply.

- ☐ Healthy eating, nutrition classes
- ☐ Diabetes prevention
- ☐ Alzheimer's classes, support groups
- ☐ Exercise/fitness classes or a gym
- ☐ CPR classes
- ☐ Female health classes (prenatal, miscarriage, lactation, etc.)
- ☐ Other (Please specify) _____
- ☐ Don't know
- ☐ Prefer not to answer

Q52Support
Have you or any member of your family attended any health-related support groups in the past year?

- ○ Yes
- ○ No
- ○ Don't know/ don't remember
- ○ Prefer not to answer

Q53TypeSupport
What kind of support groups might you or someone else in your family be interested in? Please check all that apply.

- ☐ NOT INTERESTED AT ALL
- ☐ Smoking cessation / stop smoking
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Cancer
- ☐ Nutrition
- ☐ Pregnancy/new moms/new dads
- ☐ Heart disease
- ☐ Asthma
- ☐ Arthritis
- ☐ Stroke
- ☐ Grief and bereavement
- ☐ Sleep apnea/sleep disorders
- ☐ Living with a disability

- [ ] Obesity and weight problems
- [ ] Caregivers
- [ ] Homelessness
- [ ] Child/elder abuse
- [ ] OTHER (Please specify) _____
- [ ] Don't know
- [ ] Prefer not to answer

Q54EmergencyRoom
The next few questions deal with the **emergency room** at Pomona Valley Hospital Medical Center. Have you or a member of your household received services there?

- ○ Yes
- ○ No
- ○ Don't remember/don't know
- ○ Prefer not to answer

Display This Question if have received services at PVHMC emergency room

Q55WhyER
What was the reason emergency services were needed? Please check all that apply.

- [ ] Injury or accident
- [ ] Chest pain/heart attack
- [ ] Stroke
- [ ] Breathing difficulties from the "regular" flu or a sinus infection
- [ ] COVID-19
- [ ] Other (Please specify) _____

- [ ] Don't remember
- [ ] Prefer not to answer

Display This Question if have received services at PVHMC emergency room

Q56SeeDRfirst

Did you or the household member try to see your doctor before going to the emergency room?

- ○ Yes
- ○ No
- ○ Don't know/don't remember
- ○ Prefer not to answer

Display This Question if have received services at PVHMC emergency room

Q57ReasonWhyNoDr

What was the reason you didn't try to see your doctor before going to the emergency room? Please check all that apply.

- [ ] Don't have a regular doctor
- [ ] It was after office hours
- [ ] Brought by ambulance
- [ ] Doctor was too busy to fit me in
- [ ] It was a true emergency
- [ ] Other (Please specify) _____
- [ ] Don't remember
- [ ] Prefer not to answer

Q58HealthStatus

Would you say that in general your health is excellent, good, fair, or poor?

- ○ Excellent

- ○ Good
- ○ Fair
- ○ Poor
- ○ Don't know
- ○ Prefer not to answer

Q59MentalHealth
Are you aware that there are community resources to help if someone you know was experiencing a mental health crisis?

- ○ Yes
- ○ No
- ○ Not sure
- ○ Prefer not to answer

Q60BigNeed
The survey is almost done. What is the biggest health-related issue or service that people in your community need? Please check all that apply.

- ☐ Affordable health care/free screenings
- ☐ Housing for the homeless
- ☐ Mental health services (availability, cost, letting community know about the services)
- ☐ Obesity
- ☐ Preventive care
- ☐ Place to buy healthy foods at affordable cost
- ☐ Services for diabetes
- ☐ Affordable medicine/prescriptions

- [ ] Addiction treatment
- [ ] Cancer cure/treatment
- [ ] COVID-19 treatment
- [ ] Other (Please specify) _____
- [ ] Don't know
- [ ] Prefer not to answer

Q61Designate
Have you designated someone to make healthcare decisions for you should you be unable to do so on your own? In other words, do you have an advanced directive?

- ○ Yes
- ○ No
- ○ Don't know/don't remember
- ○ Prefer not to answer

Q62HealthIssues
Following is a list of various health issues. Have you personally (or a child you care for) experienced any of these health issues? Please check all that apply.

- [ ] Substance abuse
- [ ] Mental health disease
- [ ] Intellectual disabilities
- [ ] Homelessness
- [ ] Domestic violence
- [ ] Living in an unsafe neighborhood with gangs, gun violence, and crime
- [ ] Malnutrition/hunger

- [ ] Incarceration for minor crimes
- [ ] Poverty/joblessness
- [ ] Children falling behind in school
- [ ] NONE OF THESE HEALTH ISSUES
- [ ] Prefer not to answer

Q40info
What are the best ways of providing you with information about community health and safety education (that is, disease or injury prevention)? Please check all that apply.
THESE SHOULD BE MULTIPLE RESPONSE

- ○ Community events
- ○ Doctor's visits
- ○ TV or social media
- ○ Mail sent home
- ○ Workplace
- ○ Public schools
- ○ Other (please specify) _____
- ○ NOT INTERESTED IN THE INFORMATION
- ○ Don't know
- ○ Prefer not to answer

Q64DEI2
Please indicate your level of agreement with the following statements: "All community residents have equal access to community resources"

- ○ Strongly agree
- ○ Agree

- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree
- ○ Don't know
- ○ Prefer not to answer

Display This Question if have either gone to PVHMC or attended classes or went to the ER

Q65DEI3

"Based on my experience at Pomona Valley Hospital Medical Center, the staff reflect the diversity of the community."

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree
- ○ Don’t know
- ○ Prefer not to answer

Q67DEI5

"Lack of equity (equality) or inclusion in healthcare has negatively impacted my ability to receive the best care."

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree
- ○ Don’t know

- ○ Prefer not to answer

Q68DEIsuggest
Next, what is the most important thing Pomona Valley Hospital Medical Center could do to enhance diversity and inclusion in your community?

_____
_____

Q69educ
FINALLY, please answer a few questions about you and your background.
What was the last grade of school that you completed?

- ○ Some high school or less
- ○ High school graduate
- ○ Some college
- ○ College graduate (bachelor's degree)
- ○ Some graduate work
- ○ Post-graduate degree (Master's, Ph.D., MD, JD, etc.)
- ○ Don't know
- ○ Prefer not to answer

Q70Marital
Which of the following best describes your marital status?

- ○ Single, never married
- ○ Married
- ○ Divorced
- ○ Widowed
- ○ Separated
- ○ Single, living with partner

- ○ Other (Please specify) _____
- ○ Prefer not to answer

Q71Hisp
Are you of Hispanic, Spanish, or Latino origin?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

Q72Race
How would you describe your race or ethnicity? Please check all that apply.

- ☐ Asian or Pacific Islander
- ☐ Black or African American
- ☐ Caucasian or White
- ☐ Hispanic
- ☐ Other (Please specify) _____
- ☐ Don't know
- ☐ Prefer not to answer

Q73Age
What was your age at YOUR LAST birthday? Please type a NUMBER. _____

Q13Covid4a
Which of the following best describes your current employment status? Are you...

- ○ Working full-time for pay

- ○ Self employed working full-time
- ○ Working less than 30 hours a week for pay
- ○ Self employed working part time
- ○ Full-time student
- ○ Full-time homemaker, parent or caregiver
- ○ Unemployed and looking for work
- ○ Retired
- ○ Disabled and not able to work
- ○ OTHER (PLEASE SPECIFY) _____
- ○ Prefer not to answer

Q74longevity
How long (in years) have you lived in your community? Please type a NUMBER. _____

Q75Income
Which of the following categories best describes your total household or family income before taxes, from all sources, for 2020?

- ○ Less than $25,000
- ○ $25,000 to less than $35,000
- ○ $35,000 to less than $50,000
- ○ $50,000 to less than $65,000
- ○ $65,000 to less than $80,000
- ○ $80,000 to $110,000
- ○ Over $110,000
- ○ Don't know
- ○ Prefer not to answer

Q76Gender
What is your gender identity?

- ○ Female
- ○ Male
- ○ Non-binary
- ○ Prefer to self-describe: _____
- ○ Prefer not to answer

Appendix B

Delphi Instrument

Delphi Survey for FINAL APPROVAL – 6/17/21

Each person will have their own unique link when it is sent out on June 28. The anonymous link (for testing) is: http://csusb.az1.qualtrics.com/jfe/form/SV_38UMJBxsphJd8KW

NOTE: question "numbers" are in bold. They will not show up to the respondent.

POMONA VALLEY HOSPITAL MEDICAL CENTER

Expert care with a personal touch

CALIFORNIA STATE UNIVERSITY SAN BERNARDINO

Institute of Applied Research and Policy Analysis

Q1Intro

CSUSB's Institute of Applied Research is conducting the data gathering effort for Pomona Valley Hospital Medical Center's (PVHMC's) 2021 Community Health Needs Assessment. As part of that effort, we need to elicit the input of people who work with minority and medically underserved populations in PVHMC's service area. We need your help! You are receiving this short survey because you have first-hand in-depth knowledge of the health care needs of these populations.

The survey deals with various health needs of the community – primary care and preventative care, support for patients and family, chronic disease management, and wellness. It also deals with other health-related issues such as homelessness, domestic violence, educational barriers, etc. But most importantly, it deals with your ideas about ways to overcome the barriers people face in terms of accessing both routine and urgent health care. Your input will help decision-makers better understand the health needs of those who live in PVHMC's service area and will hopefully help create the foundation for improving the quality of health services available in the region.

The survey should only take about 10 minutes to complete. If you are interrupted while responding you can use the same link to get you back into the survey. We would appreciate it if you could complete it by July 9, 2021. If you have any questions or would like additional information about the survey, feel free to contact Dr. Barbara Sirotnik, bsirotni@csusb.edu. Thank you, in advance, for your help!

By clicking below, you acknowledge that you ***have been informed*** of and understand the purpose of the study, and ***freely consent*** to participate. Please indicate this acknowledgement by selecting "Agree to participate." Selecting "Disagree" will end the survey.

- ○ Agree to participate

○ Disagree (end survey)

Q2RespInfo
First, in order to place your responses in context, please tell us just a little bit about yourself and your organization.

○ Name: _____

○ Organization you work for: _____

○ What is your position? _____

Q3Populations
What populations does your organization primarily serve? Please check all that apply:

☐ Children

☐ Senior citizens

☐ Homeless

☐ Victims of domestic violence

☐ Women

☐ Low income

☐ Minorities

☐ People with language barriers

☐ Other (please specify) _____

Q4services
What types of services does your organization offer?

_____
_____

Q5healthPriorities
Following is a list of health needs and health drivers. What are the most significant health needs that have the greatest impact on overall health in the community? Please check what you believe are the **top 3 most significant health needs** (where the most significant unmet needs and drivers should be considered a priority).

- ☐ Health education/Support Groups (please list topics) _____
- ☐ Care coordination
- ☐ Chronic disease management -- heart disease/heart failure
- ☐ Chronic disease management -- strokes
- ☐ Chronic disease management -- diabetes
- ☐ Chronic disease management -- asthma
- ☐ Chronic disease management -- other (please specify) _____
- ☐ Cancer support/treatment/resources
- ☐ Primary care & prevention services (i.e. Primary physicians, community clinics, wellness visits, screenings, prenatal care)
- ☐ Resources/support for homeless populations
- ☐ Nutrition services/resources
- ☐ Physical Activity services/resources
- ☐ Substance abuse services/resources
- ☐ Mental Health services/resources
- ☐ Transportation

- [ ] More community-wide partnerships/collaboration
- [ ] Palliative care
- [ ] Home health services
- [ ] Reduced cost medications or medical supplies
- [ ] Dementia/Alzheimer's services and resources (20)
- [ ] Day treatment/adult day care services (21)
- [ ] Physical therapy/rehabilitation services (22)
- [ ] Dental services

Q6WhyPriorities
Please briefly explain why you believe the three priorities/health needs you've selected are the most significant. What factors and conditions contribute to these health needs?

_____
_____

Q7Populations
Which community subgroups/populations are the most affected by those unmet health needs?

_____
_____

Q8Services
What **health services** or **health resources** are lacking for you and/or the people you serve and work with? What services or resources are needed in the community (i.e. primary care, specialty care, prenatal care, dental care, vision care, mental health services, community outreach, classes, support groups, community clinics, etc.)?

_____
_____

Q9barriers
We all know there are **barriers to receiving health care**, especially for the minority and medically underserved populations we are focusing on. From your experience, what is keeping

people from getting the health care they need?

_____
_____

Q10influence
What aspects in our community can positively influence people's health? In other words, what are some ways to improve the health of people in our community? Also, what negatively influences (impacts) people's health in our community?

_____
_____

Q11mostImportant
What is the **one** most important thing that ***hospitals*** in this region can do improve the health and wellness of the community, especially minorities and medically underserved populations in this region?

_____
_____

Q12suggestions
What suggestions can you offer to help PVHMC meet the needs of the community (i.e. new activities or strategies, new community education/presentations on specific topics, new partnerships, specific services, needed resources, etc.)? Please explain.

_____
_____

Q13attend
Once we receive all responses we will be summarizing the opinions of all participants and either sending them back to you for comment or inviting you to a brief zoom meeting to discuss commonalities of response or significant differences. Are you willing to attend such a meeting?

- ○ Yes
- ○ No

Display This Question if willing to attend

Q14timeOfDay
What time of day would be best for you to attend a short (maximum 1 hour) zoom meeting?

- [ ] 8 AM
- [ ] Noon
- [ ] 4 PM
- [ ] 5 PM
- [ ] 6 PM
- [ ] Other (please specify) _____

Display This Question if willing to attend

Q15day

Some people are especially busy certain days of the week, so attending a zoom meeting could be difficult. What day(s) are BEST for you?

- [ ] Monday
- [ ] Tuesday
- [ ] Wednesday
- [ ] Thursday
- [ ] Friday
- [ ] Doesn't matter

Thanks

Thank you for your input! We really appreciate your help and will be back in touch.

Appendix C

Executive Interview Instrument

Community Health Needs Assessment 2021
Executive Interview

Part I. About your Agency

Date of Interview:

Agency:

Part II. Health Needs of Our Community.

We would like to ask your views on health needs of the community:

a. In the area of ***support for patients and families*** (education, support groups, etc.), can you identify any unmet needs in our community? Which populations are most affected? Do you have any suggestions for meeting the needs of our community in this area?

Identified Need in the Community

b. In the area of ***primary care and preventative health services*** in our community, can you identify any unmet needs in our community? Which populations do you believe are most affected? Do you have any suggestions on how to meet the needs of our community in this area?

Identified Need in the Community

c. In the area of ***chronic disease management***, can you identify any unmet needs in our community? Which populations are most affected? Do you have any suggestions on how to meet the needs of our community in this area?

Identified Need in the Community

d. In the area of ***wellness*** (nutrition, physical activity, smoking, etc.), can you identify any unmet needs in our community? Which populations do you believe are most affected? Do you have any suggestions for meeting the needs of our community in this area?

Identified Need in the Community

e. Can you identify any **other** unmet health-related needs in our community that we did not mention? For example, some people have focused on homeless services, or substance abuse, or mental health, transportation, reduced cost medications, dementia services, or education.

Identified Need in the Community

Part III. Barriers to Health

Please provide your opinion on the types of barriers to meeting the needs of our community. For example, some people have talked about:

- Socioeconomic Barriers; poverty, homelessness
- Undocumented Immigrants have difficulty and mistrust; therefore, less likely to take care of health, especially preventative health.
- Language and cultural barriers

In order of ranking, what do you believe are the *top three or more barriers* to meeting the health needs of our community? Which health needs do you believe are top priorities to improve the health and wellness in our community?

Identified Health Need Priorities and Barriers
1.
2.
3.
4.

Part V. Suggestions and Additional Comments

Bottom line: What is the one most important thing that hospitals in the region can do to improve the health and wellness of the community?

Do you have suggestions for other agencies with which PVHMC can work to meet the needs of our community? Other comments?

Appendix D

Community Resources

POMONA COMMUNITY LINKS AND ASSISTANCE REFERENCE

The following is a comprehensive list of programs and organizations that PVHMC has identified through this needs assessment process that are possibly able to meet the health needs of the communities we serve.

Adult Education Center
Pomona Unified School District
1515 W. Mission Blvd.
Pomona, CA 91766
(909) 397-4800
www. pusd.org
Adult education services: High school diploma;
General Education Development (GED); job training, referral and placement; English as a Second Language (ESL) Parent Education; community courses.

Employment Development

Employment Development Department (EDD)
264 E. Monterey Avenue
Pomona, CA 91769
(909) 242-7999
Unemployment and Employment services

Los Angeles Urban Assistance League
264 E. Monterey Avenue
Pomona, CA 91767
(909) 242-7999
Employment and vocation training services.

Food Pantry's

Fountain of Love Church
Community Development Center
188 W. Orange Grove Ave.
Pomona, CA
(909) 629-0447
Resources and referral for homeless. Food can be picked up.

Helping Hands Caring Hearts Ministry
250 E Center St,
Pomona, CA
(626) 426-3356
Sunday Dinner @ 3:45
Pantry 3:30-5:30
Sunday Dinner and clothing available

Inland Valley Hope Partners
Program Center
1753 N Park Ave,
Pomona, CA 91768
(909) 622-3806
First time and every 30 days after that
applicants will receive 5 days-worth of food
(15 meals).

Inland Valley Hope Partners
1753 N. Park Ave.,
Pomona, CA 91768
(909) 622-3806
Certified Farmers Market Garey Ave. and Pearl Street, Pomona, CA. Fresh fruits and vegetables; accepting food stamps, and WIC

Inter City Volunteers
260 E Holt Ave,
Pomona, CA 91769
909-865-8853
Food assistance. Provides hot meals to
homeless individuals and families living in motels.

New Life Community Church
275 E. Foothill Blvd
Pomona, CA 91767
(909) 593-5000
Food distribution

Pomona First Baptist Church
601 N Garey Ave,
Pomona, CA 91767

909-629-5277
Fourth Saturday of the month dinner on this
day only. Haircuts available at this time.
Portable Wellness Clinic-$5 to see doctor.
First Wednesday of each mo.

Pomona Neighborhood Center
999 W. Holt Ave., Pomona
(909) 620-7691
Emergency food/shelter, Educational counseling, job development, placement.

Pomona Valley Christian Ministry
1006 S. Garey Ave
Pomona, Ca. 91768
(909) 868-1920
Meals, clothes, provide resources
and refer to other agencies. Food Pantry 4th
Thursday of each month.

Trinity United Methodist Church
676 N. Gibbs St.,
Pomona, CA 91767
909-629-9748
Food pantry

The Treasure Box
www.thetreasurebox.org
Orders via Online
$30.00 box of food valued at 75.00-100.00
program available to everyone

WIC Program
Women, Infant and Children
888-942-2229
Food and nutritional assistance for women
with children up to age 5, or women who are
pregnant. Service based on income level.

Helping Hands Pantry
1455 E 3rd St.,
San Bernardino, CA 92415
(909) 796-4222
Helping Hands Pantry provides many services to the hungry and needy, with a food bank, college and grad student food assistance, help with feeding pets, pantry gardens, a program for the homeless, and more.

Chino Neighborhood House
13130 6th St,
Chino, CA 91710
(909) 628-5608
Social services organization that works to ensure that families and seniors in our community have food on their table enabling their students to be more successful at school and allowing seniors to live a healthy lifestyle.

Mary's Mercy Center
641 Roberds Ave. N,
San Bernardino, CA 92411
(909) 889-2558
Serves balanced hot meals six days a week at noontime and provides free showers for women on Mondays and Wednesdays and free showers for men on Tuesdays and Thursdays.

Feeding America
2950 Jefferson St. B.,
Riverside, CA 92504
(951) 359-4757
Food Bank in the Inland Empire serving Riverside and San Bernardino Counties.

Meals on Wheels
845 E. Bonita Avenue
Pomona, Ca. 91768
909-593-6907
Provides home delivered meals to homebound individuals.

Hospice Care and Senior Services

Inland Hospice
233 W. Harrison, Claremont, CA 91711
(909) 399-3289
Bereavement groups for persons who have lost a friend or family member – call for a schedule of meeting for both adults and children.

Interlink Hospice
2001 N. Garey Pomona, Ca. 91767
(909) 784-3600
Hospice provides comfort care for terminally ill patients. Hospice caregivers can help with the patient's daily activities and medical needs and also help the patient and family deal with the psychological and spiritual needs when facing the end of life. Hospice care can be received at home or in a facility. Services include nursing, social work, etc.

Community Senior Services
2120 Foothill Blvd. Ste 115
La Verne, CA 91750
Provides several program assisting seniors. Their programs include: Get About Transportation, Retired and Senior Volunteers, In-Home Respite, Senior Poor Counseling and the Senior Resource director.

Oakmont of Chino Hills
14837 Peyton Dr,
Chino Hills, CA 91709
Retirement Community

Pacifica Senior Living Chino Hills
6500 Butterfield Ranch Rd.,
Chino Hills, CA 91709
Assisted Living Facility

Community Extended Care of Montclair
9620 Fremont Ave.,
Montclair, CA 91763
(909) 621-4751
Nursing home

Health Centers

East Valley Community Health Center
1555 Garey Ave.,
Pomona, CA 9176
(909) 620-8088
Medical Services: primary health care, pediatrics, free immunization, OB-GYN, pregnancy testing and counseling, contraception, AIDS/HIV testing and counseling, TB screening. Teen outreach.

Pomona Valley Health Centers – Pomona
1770 N. Orange Grove Ave., Suite 101
Pomona, CA 91767
(909) 469-9494

Medical Services: Full primary care services for adults and children. Health benefits application assistance.

Pomona Valley Health Centers – La Verne
2333 Foothill Blvd.
La Verne, CA 91750
(909) 392-6501
Medical Services: Full primary care services for adults and children; Urgent Care; Radiology; Physical Therapy. Health benefits application assistance.

Pomona Valley Health Centers – Claremont
1601 Monte Vista Avenue
Claremont, CA 91711
(909) 630-7938
Medical Services: Full primary care services for adults and children; Urgent Care; Radiology; Physical Therapy. Health benefits application assistance.

Pomona Valley Health Centers – Chino Hills
3110 Chino Avenue
Chino Hills, CA 91709
(909) 630-7490
Medical Services: Full primary care services for adults and children; Urgent Care; Radiology; Occupational Medicine. Health benefits application assistance.

Pomona Valley Health Centers – Chino Hills
2140 Grand Ave
Chino Hills, CA 91709
(909) 630-7875
Medical Services: Full primary care services for adults and children; Radiology; Physical Therapy; Milestones Center for Child Development. Health benefits application assistance.

Planned Parenthood
1550 North Garey Ave, Pomona, CA
(909) 620-4268 Emergency Line: 800-328-2826
Pregnancy counseling, family planning,
prenatal services, STD and HIV/AIDs testing.
Abortion and sterilization services.

Western University Health Clinic
887 E. 21st St. Suite C., Pomona, CA
(909) 865-2565

Medical Services: Full primary care services for adults and children.

Foothill Aids Project
233 W. Harrison Ave, Claremont, CA
(909) 482-2066
HIV/AIDs services: referrals, case management, counseling, support groups, prevention, bilingual services, Housing assistance, housing case management, substance abuse counseling and mental health counseling. and outreach education.

ParkTree Community Health Center - Pomona
1450 E. Holt Ave
Pomona, CA 91767
Medical Services: Adults and Children; Dental Services; Diabetes Care; Behavioral Health; Optometry

ParkTree Community Health Center - Pomona
750 S. Park Ave. Pomona, CA
(909) 630-7196
Medical Services: Adults and Children; Behavioral Health

ParkTree Community Health Center - Ontario
2680 E. Riverside Drive
Ontario, CA 91761
(909) 469-9016
Medical Services: Adults and Children; Dental Care (all ages)

ParkTree Community Health Center - Ontario
1556 S. Sultana Ave.
Ontario, CA 91761
(909) 469-9018
Medical Services: Adults and Children; Dental Care (all ages)

Bienestar Human Services
180 E Mission Blvd.
Pomona, CA 91766
HIV Prevention Center and Health Center.

Pomona Free Clinic
502 W Holt Ave
Pomona, CA 91768
Free Health Clinic

Central City Community Health Center, Inc.
268 N McArthur Way Suite A,
Upland, CA 91786
(909) 406-5353
Medical Center

Mental Health, Disability Services and Support Groups

Fresh Start Housing Program Tri-City Mental Health Center
2008 N. Garey Avenue
Pomona, Ca. 91767
(909) 623-6131
Transitional housing for adults with psychiatric disabilities.

National Alliance on Mental Illness (NAMI)
3115 N Garey Ave,
Pomona, CA 91767
(909) 399-0305
Offering education and support to people whose lives are affected by serious mental illness – family members and clients alike.

Ability First, Claremont Center
480 S. Indian Hill Blvd.
Claremont, CA 91711
(909) 621-4727
www.abilityfirst.org
Programs designed to help children and adults with physical and developmental disabilities after school programs, recreation aquatic exercise.

San Gabriel/Pomona Regional Center
75 Rancho Camino Drive,
Pomona, CA 91768
800-822-7504
Diagnostic and evaluation, information and referral, case management, advocacy and education to develop mentally disable persons and their families.

Services for Independent Living, Inc.
107 S Spring St,
Claremont, CA 91711

(909) 621-6722
Disability information, referral and advocacy; disability counseling, benefits assistance, housing search assistance, sign language interpretation, attendance registry. Transitional Housing Programs for homeless men with disabilities. Motel and food vouchers.

Tri-City Mental Health Center
2008 N Garey Ave.,
Pomona, CA 91766
(909) 623-6131
Assistance for children, adolescent and adults.

Pomona First Baptist Church
586 N. Main St.
Pomona, CA 91767
909-629-5277
Support groups: Divorce Care and Divorce Care 4 Kids, Women's Cancer Support, Parenting classes, Caregiver's Support Group, Celebrate Recover, Griefshare, AA.

Ennis W. Cosby Child and Family Services Friendmobile
300 West Second St., Pomona, CA
(909) 869-3799
Free counseling services to children, families and adults.

Pomona Adult Day Health Care Center
324 N. Palomar Dr.
Pomona, CA
(909) 623-7000
Designed to serve the frail elderly and those individuals eighteen years of age and older coping with a physical, cognitive or developmental disability.

Mental Health Systems
316 East E Street,
Ontario, CA 91764
(909) 986-9710
Provide mental health and drug and alcohol rehabilitation services in an innovative and cost-effective manner.

Rehab and Recovery Organizations

American Recovery Center

2180 W. Valley Blvd.
Pomona, CA
(909) 865-2336
Chemical dependency recovery: Provide inpatient detox, inpatient and outpatient

Crossroads, INC.
250 W 1st St #254
Claremont, CA 91711
(909) 626-7847
Home for female parolees re-entering the community.

Total Restoration Ministries
420 N. Reservoir
Pomona, Ca. 91767
909.620.7838
Sober Living- offers a 24-hour Resident Director,
Regular Drug/Alcohol testing, 12-step meetings at house weekly, meals prepared daily, structured, schedule implemented by a caring and trained staff which eases the transition to a new way of life.

AEGIS MedicalSystems, INC.
1050 N. Garey Avenue,
Pomona
(909) 623-6391
Drug diversion / Drug treatment

American Recovery Center
2180 W. Valley Blvd.
Pomona, CA
(909) 865-2336
Chemical dependency recovery: Provide inpatient detox, inpatient and outpatient services.

Pacific Clinic
790 East Bonita Avenue
Pomona, CA 91767
(909) 625-7207
(626) 254-5000
Pacific Clinics provides substance abuse prevention and education groups on-site to youth and adults ages 12 and up. They provide relapse prevention services, domestic violence services, anger management, and drug testing. The program duration is at least one year

Pomona Open Door
259 S. East End Ave.
Pomona, CA
(909) 622-8225
Services include outpatient therapy, alcohol/drug treatment, marriage/family counseling,

National Council on Alcoholism and Drug Dependence
656 N Park Ave,
Pomona, CA 91768
(909) 629-4084
Provides parenting classes, family re-unification, drug testing, one-on one counseling, and self-help meetings.

Shelters and Housing for Homeless

Foothill Family Shelter
1501 W. 9th Street, Ste D
Upland, Ca. 91786
(909) 920-5568
Assistance to families with children; geared towards temporary housing up to 120 days.

HPRP Pomona Plus
248 Monterey
Pomona, Ca. 91767
909.622.2091
Provides financial assistance and services to either prevent individuals and families from becoming homeless or to help those who are experiencing homelessness to be quickly rehoused and stabilized.

Pomona Homeless Outreach
2040 N. Garey Ave
Pomona, Ca. 91767
(909) 593-4796
Resource and referral for social services

Pomona Neighborhood Center, Inc.
999 West Holt Blvd.
Pomona, CA
(909) 620-7691

Provides general needs assistance to homeless individuals and families. Clothing, direct emergency assistance and community referral.

Pomona Plus Link-up Service
248 Monterey
Pomona, Ca. 91766
(909) 620-2571
Housing relocation and stabilization, house search and placement, legal services, credit repair.

Inland Valley Hope Partners
Our House Shelter
1753 N. Park Ave.,
Pomona, CA 91768
909-622-3806, x234
Provides up to 90 days of residential emergency shelter to single women and families. Services include room and board, case management, individual counseling, support groups, parenting classes, savings program, assistance with job and housing search, tutoring and homework assistance for the children.

Mercy House
905 E. Holt Blvd.
Ontario, Ca. 91764
(909) 391-2630
Motel vouchers, Food Vouchers, Hygiene kits
Diapers, Laundry detergent, feminine hygiene products, Bus Passes for employment or medical appointments. Use of telephone, and referrals of reemployment, shelter, food, housing.

Salvation Army
490 E. La Verne Ave.
Pomona, CA 91767
909-623-1579
909-620-6232 fax
www.salvationarmysocal.org
Can assist with meal vouchers and/or motel vouchers

San Gabriel Valley Center
11046 Valley Mall
El Monte, Ca. 91731
(626) 575-5431

Outreach, intake and assessment services for homeless persons. On site supportive services include intake/assessment, case mgmt., housing assistance, employment assistance, veterans' services, mental health services, life skills training, benefits advocacy, parenting classes, medical services and referrals 08/01/2011 Page 6

Foothill Family Shelter Inc.
1501 W 9th St D,
Upland, CA 91786
(909) 920-5568
Organization that houses homeless adults and children for a period of up to 120 days, free of rent and utility charges. The organization also provides one-year transitional housing as well as extended housing.

Walden Family Services
3576 Arlington Ave,
Riverside, CA 92506
(951) 788-5905
Provides foster care and adoption, as well as transitional housing plus foster care program, for children and youth in Riverside and San Bernardino Counties.

Union Rescue Mission
545 San Pedro St.,
Los Angeles, CA 90013
(213) 347-6300
Located in the heart of Skid Row, Union Rescue Mission is a refuge of help and hope. A safe haven where men, women, and children can get the guidance and support they need to live a life transformed.

Option House, Inc.
813 N D St. A,
San Bernardino, CA 92401
(909) 383-1602
Provides 24-hour crisis intervention shelter, transitional housing, outreach services, legal services, information, education and awareness to family violence victims to stop the cycle of abuse.

Arrowhead United Way
646 North D Street,
San Bernardino, CA 92401
(909) 884-9441
Organization that focuses on building blocks for a good life such as health, education, and financial stability for families.

Social Services and Helplines

Los Angeles Information Line
(800) 339-6993 TDD (800) 660-4026
Services in Los Angeles County including emergency shelter, disability ,welfare, emergency food, legal referrals, senior services, rehabilitation, and many more.

DPSS (CalWORKs & GAIN Programs)
2040 W. Holt Ave
Pomona, Ca. 91768
DPSS Eligibility Worker
(909) 865-5315
GAIN Career Center
(909) 392-3032
Counseling/rehabilitation, Case management, Housing Links, Employment Resources, School/Education, Training Links, Skills Building (budget, saving, etc.)

Inland Empire United Way
9644 Hermosa Ave.
Rancho Cucamonga
(909) 980-2857
www.unitedwayla.org
Resource and referral for social services

Dept. of Public and
Social Services
12860 Crossroads Parkway South
City of Industry, CA 91746
(562) 908-8400
Provided services to residences in need of financial assistance to meet their basic needs for food housing, childcare, in-home care, and/or medical assistance

Pomona District Office
2040 W. Holt Ave.,
Pomona CA 91768
(909) 865-5210
www.co.la.ca.us/dpss
Able-bodied adults are provided a variety of services to help them become employed and achieve economic self-sufficiency as quickly as possible

Social Security Office
960 W. Mission Blvd.
Pomona, CA 91766
(888) 808-5486
www.ssa.gov
Benefits assistance-Social Security and Medicare benefits, Social Security card, Social Security disability, Supplemental Security Income (SSI).

Family Resources
Pomona Unified School District
800 S Garey Ave,
Pomona, CA 91766
909-397-4800
Medical referral, Health Family application, childcare referral available, information, and resource referral. Will assist the children of homeless families. No Fee.

Friends Outside Hospitality
14901 Central Ave.
Chino, CA 91710
(209) 955-0701
Social Services Organization

Organizations that helps families, children and incarcerated individuals cope with the trauma of arrest and incarceration, find a new direction, and move forward with their lives.

Inland Empire Community Outreach Center
363 W 6th St. #4,
San Bernardino, CA 92401
(909) 269-9403
Organizations whose mission is to heal broken families, individuals, and homeless individuals through a variety of resources and services in the areas of drug and alcohol counseling, hunger, digital literacy, and homelessness.

Transportation Services

Dial-a-Ride
(909) 623-0183

Foothill Transit
Pomona Regional Transit Center
100 W. Commercial St. Pomona, CA
800-743-3463

www.foothilltransit.org

Metropolitan Transportation Authority (MTA)
MetroLink
800-371-5465
Public Transportation

Veterans Organizations

LA County
Dept. of Military and Veterans Affairs
1427 W. Covina Parkway
West Covina, CA 91790
626-813-3402
Counsels veterans, their dependents and survivors
regarding federal and state benefits such as compensation, pensions, disability, education, hospitalization, home loans, etc., and provides referrals concerning drug and alcohol abuse and post-traumatic stress disorders.

St. Anne's Transitional Home For Soldiers
23833 Palomino Dr.
Diamond Bar, CA 91765
(909) 612-1197
Provides supportive housing and support for male homeless Veterans and obtain residential stability skills.

Veteran's Benefit Information and Assistance
1-800-827-1000
Resource and referral for veterans

Women and Children Shelters- Crisis Services

House of Ruth
599 N Main St
Pomona, CA 91768
(909) 623-4364
(909) 988-5559 Hotline
Call the 24-hourhotline for crisis intervention, shelter intake, information and referral. Provides emergency shelter and transitional housing for women and children who are victims of domestic violence.

Chicana Service Action Center,
Chicano Family Services
151 East Second St. Pomona, CA 91766
(909) 620-0383
800-548-2722 – 24-hour hotline
Provides crisis assistance and placement for women and families of domestic violence.

Prototypes Women's Center Residential Program
845 E. Arrow Hwy
Pomona, CA 91767
(909) 624-1233
www.prototypes.org
Substance abuse treatment facility for women and their children offering comprehensive residential, outpatient and day treatment programs. Mental health and HIV/AIDS services available.

Women MedCare
160 E Artesia St #150,
Pomona, CA 91767
Woman's Health Clinic

University Homeless Women Center
1450 University f127, Riverside, CA 92507
(951) 224-9438
Homeless shelter for women.

Time for Change Foundation
2164 N Mountain Ave,
San Bernardino, CA 92405
(909) 886-2994
Provides assistance to homeless women and children to achieve self-sufficiency by providing housing and necessary supportive services.

Youth Development

Boys and Girls Club of
Pomona Valley
1420 S. Garey Ave
Pomona, CA 91769
(909) 623-8538
Offers various activities such as swimming, summer

leagues, basketball, indoor soccer, arts and crafts,
woodshop, tournaments and other special events.

Goodwill GoodGuides Youth Mentoring Program
264 East Monterey Ave
Pomona, Ca. 91767
(909) 973-9915
Mentoring Careers, leadership skills, Vision opportunities.

Pomona Valley 4-H club
Condit Elementary School
1759 N. Mountain Ave.
Claremont, CA 91771
(909) 374-8342
4-H is open for boys and girls ages 5-19 years of age. 4-H emphasizes leadership, community services and life skills.

Youth Crisis Hotline
(909) 448-4663
Runaway Switchboard
(800) 621-4000

Wilene's Re-Growth Center
637 N. Park Ave
Pomona, CA
(909) 469-6757
The Center hopes to reduce the number of youth who upon separating from group homes or foster families at age 18 have no place to live. Services include counseling, housing placements, job training, employment assistance, referrals and support to homeless families.

YMCA
350 N. Garey Ave
Pomona, CA
(909) 623-6433
Offers shower passes to organizations and individuals at a low cost.