POMONA VALLEY HOSPITAL
MEDICAL CENTER

Expert care with a personal touch

2019
Community Benefit Plan

and Implementation Strategy in Support of Pomona Valley Hospital Medical Center's 2018 Community Health Needs Assessment

Prepared by:
Leigh C. Cornell, FACHE
Courtney Greaux, MHA

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

TABLE OF CONTENTS

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 2015 CHNA and completed an Implementation Strategy to address the significant needs identified in our assessment. A summary of the 2015 CHNA and Implementation Strategy has been included in our 2018 Community Benefit Plan (report for fiscal year 2017) and PVHMC continuously monitors performance metrics to track progress and gauge the success of our outlined programs and strategies. Additionally, in accordance with these state and federal requirements, PVHMC is in the process of conducting our next triennial needs assessment for FY 2018.

Approval from a Governing Body

PVHMC's 2018 Community Health Needs Assessment (CHNA) and Implementation Strategy included in this report was adopted by the Board of Directors on May 7, 2018. As we proceed with 2019, PVHMC plans to continue supporting its varied community benefit activities and programs currently in place as described in this report, and develop new programs, when appropriate, to meet the needs of the community as identified in our most recent Community Health Needs Assessment.

Executive Summary

Pomona Valley Hospital Medical Center (PVHMC) is a 412-bed, fully accredited, acute care hospital serving eastern Los Angeles and western San Bernardino counties. For over a century, PVHMC has been committed to serving our community and plays an essential role as a safety-net provider and tertiary referral facility for the region.

A nationally recognized, not-for-profit facility, the Hospital's services include Centers of Excellence in Cancer Care, Cardiac and Vascular Care, Women's and Children's Services, and Trauma Care. Specialized services include centers for Breast Health, Sleep Disorders, a Neonatal ICU, a Perinatal Center, Physical Therapy/Sports Medicine, a Level II Trauma Center and Emergency Department which includes our Los Angeles County and San Bernardino County STEMI receiving center designation, Robotic Surgery, and the Family Medicine Residency Program affiliated with UCLA. Satellite Centers in Chino Hills, Claremont, Covina, La Verne and Pomona provide a wide range of outpatient services including physical therapy, urgent care, primary care, radiology and occupational health.

As a community hospital, we continuously reflect upon our responsibility to provide high-quality healthcare services, especially to our most vulnerable populations in need, and to renew our commitment while finding new ways to fulfill our charitable purpose. Part of that commitment is supporting advanced levels of technology and providing appropriate staffing, training, equipment, and facilities. PVHMC works vigorously to meet our role in maintaining a healthy community by identifying health-related problems and developing ways to address them.

In 2018, in compliance with California's Community Benefit Law and Section 501(r)(3) of the Internal Revenue Code, created by *The Patient Protection and Affordable Care Act* (2010), a Community Health Needs Assessment was completed. This assessment is intended to be a resource for PVHMC in the development of activities and programs that can help improve and enhance the health and well-being of the residents of Pomona Valley. In response to the assessment's findings, an Implementation Strategy was developed to operationalize the intent of PVHMC's Community Benefit Plan initiatives through documented goals, performance measures, and strategies.

PVHMC demonstrates its profound commitment to its local community and has welcomed this occasion to formalize our Community Benefit Plan and Implementation Strategy. Our community is central to us and it is represented in all of the work we do. PVHMC has served the Pomona Valley for 116 years, and we value maintaining the health of our community.

About Pomona Valley Hospital Medical Center

Our Mission

Pomona Valley Hospital Medical Center is dedicated to providing high-quality, cost-effective health care services to residents of the greater Pomona Valley. The Medical Center offers a full range of services from local primary acute care to highly specialized regional services. Selection of all services is based on community need, availability of financing and the organization's technical ability to provide high quality results. Basic to our mission is our commitment to strive continuously to improve the status of health by reaching out and serving the needs of our diverse ethnic, religious and cultural community.

Our Vision

PVHMC's vision is to:

- **Be the region's most respected and recognized Medical Center and market leader** in the delivery of quality health care services;
- **Be the Medical Center of choice for patients and families** because they know they will receive the highest quality care and services available anywhere;
- **Be the Medical Center where physicians prefer to practice** because they are valued customers and team members supported by expert health care professionals, the most advanced systems and state-of-the-art technology;
- **Be the Medical Center where health care workers choose to work** because PVHMC is recognized for excellence, initiative is rewarded, self-development is encouraged, and pride and enthusiasm in serving customers abounds;
- **Be the Medical Center buyers demand (employers, payors, etc.) for their health care services** because they know we are the provider of choice for their beneficiaries and they will receive the highest value for the benefit dollar; and,
- **Be the Medical Center that community leaders, volunteers and benefactors choose to support** because they gain satisfaction from promoting an institution that continuously strives to meet the health needs of our communities, now and in the future.

Our Values

C = Customer Satisfaction
H = Honor and Respect
A = Accountability: The Buck Stops Here
N = New Ideas!
G = Growing Continuously
E = Excellence: Do the Right Things Right!

Our Location

1798 N. Garey Avenue, Pomona, CA 91767

Our Organizational Structure

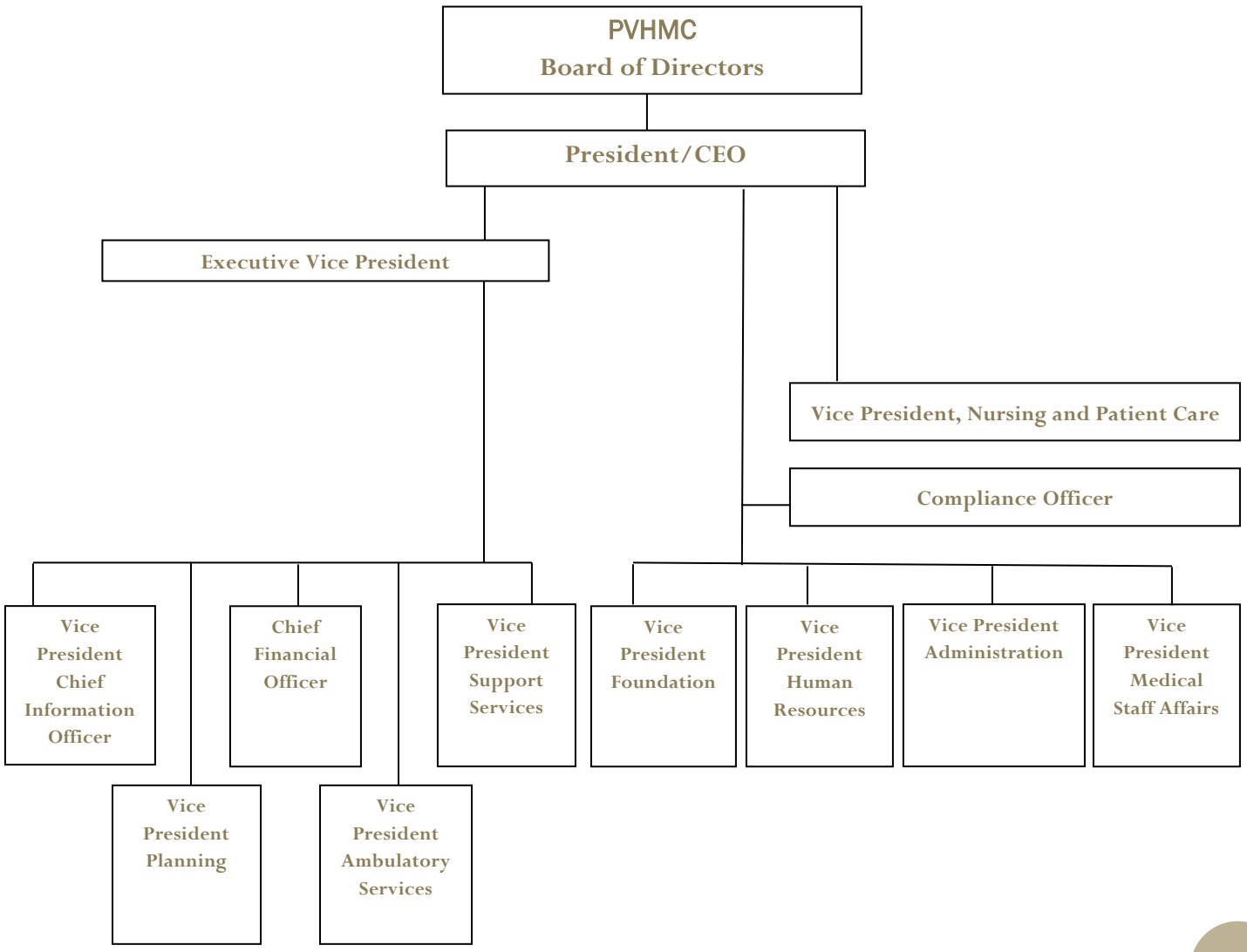
PVHMC is governed by a Board of Directors whose members are representative of the community, hospital and medical staff leadership. The Board of Directors has been integrally involved from the earliest days of the Senate Bill 697 process. The President/CEO is charged with the day-to-day administrative leadership of the organization and is assisted by an executive team of vice presidents who oversee specific departments.

President/Chief Executive Officer: Richard E. Yochum, FACHE

Chairman, Board of Directors: Richard Fass,PhD

Community Benefit Executive: Leigh C. Cornell,FACHE

Figure 1. Organization Chart



Unique Pomona Valley Hospital Medical Center Assets

PVHMC offers the following healthcare services and distinguished designations to our community:

Services

- **Emergency Care Services**
  - Level II Adult Trauma Center
  - EDAP – Emergency Department Approved Pediatrics
  - Los Angeles STEMI receiving Hospital
  - Comprehensive Stroke Center certified by The Joint Commission and LA County
  - Los Angeles County Disaster Resource Center
- **Adult Services**
  - General Medical and Surgical Services
  - Critical Care Services
  - Cardiac Cauterization and Surgery
- **Pediatric Services**
  - General Pediatric Medical and Surgical Services
  - Level IIIB Neonatal Intensive Care Unit
  - Neonatal Transportation Services
  - Pediatric Specialty Outpatient Clinic
- **Obstetric Services**
  - Perinatology
  - High Risk Obstetrics
  - Maternal/Fetal Transport Services
- **Ambulatory Services**
  - Radiation and Medical Oncology
  - GI Lab
  - Kidney and Urological Services
  - Sleep Disorders Center
  - Radiology
  - Rehabilitations Services including physical, occupational, speech and cardiovascular
- **Family Medicine Residency Program**
  - Affiliated with the David Geffen School of Medicine at UCLA

Awards and Designations

- Joint Commission Accredited Hospital and Laboratory
  - Certification for In-patient Diabetes, Orthopedic Joint Replacement, Palliative Care, and Perinatology
- Baby Friendly Designation
- American Heart Association / American Stroke Association Get with the Guidelines "Stroke Gold Plus Quality Achievement Award – Target: Stroke Elite Honor Roll
- American Heart Association / American Stroke Association Get with the Guidelines "Gold Plus Achievement Award for Treating Heart Failure
- American College of Cardiology Certification as a "Chest Pain" center
- Healthgrades Cardiac Surgery Excellence Award (Top 10% in the Nation two years in a row)
- Healthgrades 5-Stars for Carotid Surgery
- Healthgrades 5-Stars for Coronary Bypass Surgery
- Healthgrades 5-Stars for Back Surgery

- Los Angeles Regional Agency and City of Duarte "San Gabriel Valley Environmental Award"
- US News and World Report "High Performing Hospital in GI Surgery and Gastroenterology"
- Smart Care California Achievement award for achieving the Health People 2020 target for low-risk first-birth C-section rates.

Facts and Figures

Year PVHMC Established: **1903**

Number of Licensed Beds: **412**

Average Number of Associates: **3,363**

Number of Volunteers: **917**

Number of Volunteer Service Hours: **77,495**

Number of Active Physicians on Medical Staff: **457**

PVHMC Admission Statistics

	2016	2017	2018
Total Admissions	22,279	22,229	21,386
Percentage Direct Admit	46%	41%	41%
Overall Hospital Length of Stay	4.1	4.0	4.1
Average Daily Census (Acute)	247	245	243
Average Daily Census (Adult-Only)	203	2015	204
Emergency Visits (including LWBS and Admissions)	101,442	101,744	99,112
Hours on Diversion	451	166	288
Surgery			
Inpatient	3,247	3,595	3,749
Cardiac Surgery	192	175	168
Specialty Lab	5,566	5,058	5,071
Cath Lab Procedures			
Inpatient	1,967	2,238	2,310
Outpatient	2,851	2,519	2,275
Dialysis Treatments	3,343	3,479	3,634
Radiation Oncology	27,580	26,451	27,021
Deliveries	7,076	6,294	5,986
NICU Days	13,029	12,287	12,191
Ambulatory Visits	514,391	528,100	553,085
Sweet Success Visits	9,659	10,003	10,173
Respiratory	219,217	220,765	212,052

Our Community

Pomona Valley Hospital is located in Los Angeles County within Strategic Planning Area 3 (SPA 3) and closely borders San Bernardino County. Our community is defined by our primary service area, which encompasses the cities of Pomona, Claremont, Chino, Chino Hills, La Verne, Ontario, 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.

For the purposes of the California Community Benefit Law, the ACA, and the new federal requirement to conduct a triennial Community Health Needs Assessment and Implementation Strategy, 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).

Map 1: The Communities We Serve

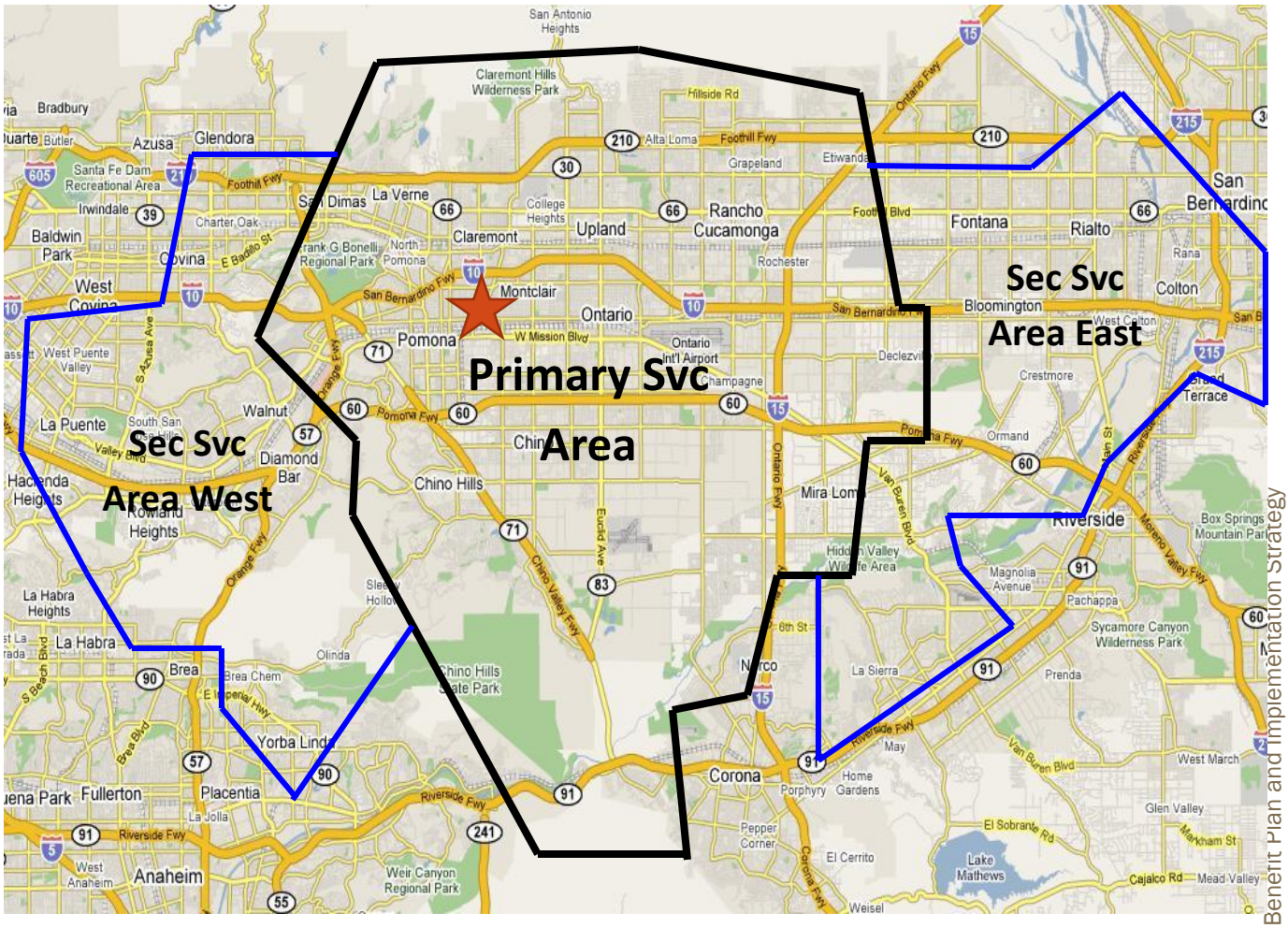


Table 1: PVHMC's Primary Service Area Population

City	County	2010 Population
Pomona	Los Angeles	149,058
Claremont	Los Angeles	34,926
La Verne	Los Angeles	31,063
Chino	San Bernardino	77,983
Chino Hills	San Bernardino	74,799
Ontario	San Bernardino	163,924
Upland	San Bernardino	73,732
Montclair	San Bernardino	36,664
San Dimas	Los Angeles	33,371
Rancho Cucamonga	San Bernardino	165,269
Alta Loma	San Bernardino	n/a[1]

Source: U.S. Census Bureau, 2010

[1]Alta Loma data were not available separately (included with Rancho Cucamonga data)

Table 2. Ethnic Diversity of Our Community 2010

City	White	Hispanic or Latino	Black/ African-American	American Indian	Asian	Hawaiian/ Pacific Islander	Other	Two or More Races
Pomona	48.0%	70.5%	7.3%	1.2%	8.5%	0.2%	30.3%	4.5%
Claremont	70.6%	19.8%	4.7%	0.5%	13.1%	0.1%	5.8%	5.2%
La Verne	74.2%	31.0%	3.4%	0.9%	7.7%	0.2%	9.1%	4.5%
Chino	56.4%	53.8%	6.2%	1.0%	10.5%	0.2%	21.2%	4.6%
Chino Hills	50.8%	29.1%	4.6%	0.5%	30.3%	0.2%	8.7%	4.9%
Ontario	51.0%	69.0%	6.4%	1.0%	5.2%	0.3%	31.3%	4.7%
Upland	65.6%	38.0%	7.3%	0.7%	8.4%	0.2%	12.9%	4.8%
Montclair	52.7%	70.2%	5.2%	1.2%	9.3%	0.2%	27.0%	4.4%
San Dimas	72.0%	31.4%	3.2%	0.7%	10.5%	0.1%	8.5%	4.9%
Rancho Cucamonga	62.0%	34.9%	9.2%	0.7%	10.4%	0.3%	12.0%	5.4%
Alta Loma[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Source: U.S. Census Bureau, 2010

[1]Alta Loma data were not available separately (included with Rancho Cucamonga data)

2018 Community Health Needs Assessment

Grounded in a longstanding commitment to address the health needs of our 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 complete 2018 CHNA process consisted of primary and secondary data collection, including valuable community, stakeholder, and public health input, that was examined to prioritize the most critical health needs of our community and serve as the basis for our Community Benefit Plan and Implementation Strategy.

Methodology

Primary data was collected via telephone survey and consisted of input from 319 from the eleven cities within PVHMC's service area, resulting in a 95 percent level of confidence and an accuracy of +/- 5.5%. A total of 26 out of 319 of the surveys (8.15% response) were conducted in Spanish.-In order to ensure that cell phone only households were well represented in the survey, IAR purchased "enhanced wireless" phone numbers which are based on the last known address of the cell phone owner.-The surveys were conducted between March 2 and March 12, 2018. Surveys were conducted on a variety of days and times (Monday- Friday from 3:00 p.m. to 9:00 p.m.; and Saturday 11:00 a.m. to 5:00 p.m. and Sunday 1:00 p.m. to 7:00 p.m.) in order to maximize the chances of completing a survey. The Principal Investigator was Barbara Sirotnik, PhD and the Project Coordinator was Lori Aldana, MBA. Primary data was obtained through IAR's executive interviews with Los Angeles Public Health official, Christin Mondy, on April 13, 2018, and with Dr. Maxwell Ohikhuare, San Bernardino County Public Health Dept. Health Officer, on April 18, 2018. Additional primary data were collected through two focus group meetings with 12 community-based organizations within PVHMC's primary and secondary service areas whose organizations serve and represent minority, low-income and medically underserved individuals. Secondary supporting data highlighting health status indicators and major health influencers was collected from several sources, and when appropriate, compared to Healthy People 2020 goals.

Every attempt was made to solicit primary, secondary, and health-related information relative to the communities we serve. In some instances, PVHMC's ability to assess the health needs was limited by lack of existing data at the city and county level. Additionally, in some instances, comparable health-related data was limited across both counties in which our primary service area encompasses.

Objectives

The objectives of the 2018 CHNA were consistent with those of previous CHNA's, in that PVHMC desired to: 1) objectively look at demographic and socioeconomic aspects of the community, health status, and barriers to receiving care, 2) identify opportunities for collaboration with other community based organizations 3) identify communities and groups that are experiencing health disparities, and 4) to assist PVHMC with the development of resources and programs that will improve and enhance the well-being of the residents of Pomona Valley.

Introduction

In the first phase of PVHMC's assessment process, **primary data** were collected via a telephone survey from residents within PVHMC's service area to determine their perceptions and needs regarding various health issues, and to see if there have been any changes since the previous studies. Specific issues and questions included:

- **Demographic profile (including self-reported health evaluation);**
- **Health insurance coverage:** insurance coverage, type of insurance, reason(s) for no coverage;
- **Barriers to receiving needed health services;**

- **Utilization of health care services for routine primary/preventative care:** how long since last physical, children's preventative care and immunizations; adult's routine health screening tests;
- **Need for specialty health care:** chronic or ongoing health problems, adequate help dealing with disease, unmet needs;
- History of getting **screened for cancer** (and reasons for not being screened), and **types of cancer** of greatest concern;
- Best **ways of providing information** about disease prevention;
- **Use of tobacco**; and
- **Experience with and evaluation of PVHMC:** reasons for selecting PVHMC, health care services, classes, support groups, and emergency room experience.

Secondary data were collected from a variety of sources regarding health status indicators and major health influencers for PVHMC's service area:

- **Health status indicators**: cardiovascular disease, diabetes, cancer, high blood pressure, obesity, leading cause of death. These indicators were compared to Healthy People 2020 goals at the SPA (Service Planning Area) 3 level, Los Angeles County level, and San Bernardino County level.
- **Major health influencers**: smoking/tobacco use, physical activity levels, health insurance coverage. These indicators were compared to Healthy People 2020 goals at the SPA 3 level, Los Angeles County level, and San Bernardino County level.

Third, IAR conducted **executive interviews** with officials 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;
- 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.

Finally, PVHMC conducted two **focus groups** with individuals representing various community based organizations in PVHMC's service area, including organizations serving low income, minority and medically underserved populations.

Primary Data Collection (Telephone Survey)

Methodology

Questionnaire Construction

In consultation with PVHMC, IAR reviewed and slightly modified the questionnaires used for the 2009, 2012, 2015 surveys to ensure that the 2018 questionnaire included all the items required for PVHMC's decision-making needs. Using similar questionnaires for these needs assessment reveals notable trends over time, but the few unique questions each year also provide information regarding new issues of interest to PVHMC.

The survey was designed to take, on average, no more than 10 minutes to complete since surveys exceeding that length tend to have high non-response rates.[1] 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 I.

Sampling methods

In order to generate the initial sampling frame (that is, the list of all residents within PVHMC's service area telephone numbers) for the remaining potential participants, all zip codes for this service area were identified. Next, a random sampling procedure was used within the selected zip codes to generate the sampling frame (the list of telephone numbers to appear in the sample). The numbers were then screened to eliminate business phones, fax machines, and non-working numbers.

Further, it is well known that more and more households are becoming "cell phone only" households. Indeed, in May of 2017, the Center for Disease Control's National Center for Health Statistics, reported that a majority of the U.S. population (50.8%) are now cell-phone only households. And 95% of Americans now own a cellphone of some kind (up from 35% in 2011). In order to ensure that cell phone only households were well represented in the survey, IAR purchased "enhanced wireless" phone numbers which are based on the last known address of the cell phone owner.

Finally, in order to ensure that some unlisted phone numbers were included in the sample, the original list was supplemented by using "working" telephone numbers as seed numbers from which others numbers were generated by adding a constant. To the extent possible, therefore, each resident within PVHMC's service area **with a telephone** had an equal chance of being included in the survey.

The following table lists PVHMC's primary service area by city, zip code and county:

Table 3: PVHMC's Primary Service Area by Zip Code

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

Telephone interviews were conducted by the Institute of Applied Research at California State University, San Bernardino using computer assisted telephone interviewing (CATI) equipment and software. The surveys were conducted between March 2 and March 12, 2018. Surveys were conducted on a variety of days and times (Monday- Friday from 3:00 p.m. to 9:00 p.m.; and Saturday 11:00 a.m. to 5:00 p.m. and Sunday 1:00 p.m. to 7:00 p.m.) in order to maximize the chances of completing a survey with the selected respondents. A total of 319 residents were surveyed from the eleven cities within PVHMC's service area, resulting in a 95 percent level of confidence and an accuracy of +/- 5.5%. A total of 26 out of 319 of the surveys (8.15%) were conducted in Spanish.

[1]. The amount of time to complete the survey actually exceeded 10 minutes this year. The median was 12 minutes, and the mean length of time was 12.6 minutes.

Highlights of telephone survey findings

Following are highlights of the major findings from the 2018 **PVHMC** telephone survey. In general, this section of the report is divided by conceptual categories (e.g. demographic profile, self-reported health evaluation and health behaviors, health insurance coverage, barriers to receiving needed health services, utilization of health care services for routine primary/preventative care, need for specialty health care, and experience with PVHMC and desires for classes/groups. **The reader is encouraged to view the full data display of the results in Appendix II.**

Demographic profile of respondents and self-reported health evaluation

As seen in the table below, approximately 41% (40.6%) of the survey respondents are male, and most (61.8%) are married. Nearly three quarters (74.6%) have at least some college education, with a relatively high median income. Approximately half of respondents (52.0%) identified themselves as Caucasian and 37.1% as Hispanic (with 39.1% indicating that they are of Hispanic or Latino origin)[2]. On average respondents are 56 years old, have lived in their community 24 years, and have 3 people living in the household. Most of them (65.7%) have no children under the age of 18 living in the household with them. Of those who ***do*** have children living in the household, most have one (39.4%) or two children (37.6%).

One brief note regarding the demographic profile of respondents: the table shows that the sample is somewhat skewed toward older, more affluent and educated individuals than would appear in the population. Further, Hispanics are slightly underrepresented. Sadly, as noted in a report by the Pew Research Center, this is a nationwide trend.[3] Overall response rates have been in decline since the late 1990's and have finally begun to stabilize, however young adults and Hispanics are still under-represented somewhat in most telephone surveys.

Relative to the age distribution: young adults are used to multi-tasking and responding via text messages or tweets, so they tend to be unwilling to take 10 minutes of their time for a survey unless it is of extreme relevance to them (which is not the case for a health needs survey). They also are more likely to live in cell-phone only households (which is the reason IAR ensured that cell phones were well represented in the sampling frame). The median age of adults (18+ years old) in Los Angeles and San Bernardino Counties is approximately 50 years old, thus the median of 56 years old is slightly elevated.

Relative to ethnicity: surveying Hispanics is known to be especially difficult due to concerns about confidentiality.[4] Further, sampling accuracy can suffer based on the Latino tendency to live in households with many family members, and the fact that "Hispanics are relatively heavy users of mobile technology"[5]. Our sample includes approximately 39% of people with Hispanic/Latino origin, whereas the population figure is approximately 49% in the two county area.

So what is the solution? One solution is to apply a weighting scheme to correct for potential bias based on demographics. The other solution – the one we use in this report and have used in the last three reports – is to analyze the data based on demographic subgroups to point out significant differences by subgroup (where they exist).

[2]. Ethnicity was a multiple response question.
[3]. http://www.pewresearch.org/2017/05/15/what-low-response-rates-mean-for-telephone-surveys/
[4]. http://www.pewresearch.org/2015/11/12/the-unique-challenges-of-surveying-u-s-latinos/
[5]. https://www.insightsassociation.org/article/challenges-finding-reliable-hispanic-consumer-insights

Table 4: Demographic Profile of Respondents

	2012	2015	2018
Gender			
Male	32.5%	42.3%	40.6%
Female	67.5%	57.4%	59.4%
Married	58.8%	55.8%	61.8%
Some College or College Degree	74.4%	67.8%	74.6%
Median Household Income Category	$50,000- $66,000	$50,000- $65,000	$65,000- $80,000
Ethnicity			
Caucasian	57.7%	51.3%	52.0%
Hispanic	26.1%	41.8%	37.1%
Average (Mean) Age	55	53	56
Average (Mean) # of Years Living in Community	23	20	24
Average (Mean) # of People Living in the Household	3	3	3
Those with No Children Living in the Household	57.2%	61.7%	65.7%
(Of those with Children): # of Children Living in the Household			
One	42.5%	44.1%	39.4%
Two	37.2%	25.2%	37.6%

When respondents were asked "would you say that in general your health is excellent, very good, fair or poor" (Question 25), the answer from most of the respondents (66.8% -- down slightly from 2015's 68.8%) was "excellent" or "very good". Only 3.9% said their health is "poor." These figures are not a significant shift from the health evaluations offered by respondents in previous surveys.

Table 5: Respondents' Rating of their Health

	2012	2015	2018
Excellent	16.4%	15.2%	15.4%
Very Good	51.4%	53.6%	51.4%
Fair	25.1%	27.9%	29.3%
Poor	4.3%	3.3%	3.9%

There are obviously many factors contributing to a person's overall health. One of those factors is good nutrition. As stated on the HHS.gov website: "Good nutrition is an important part of leading a healthy lifestyle. Combined with physical activity, your diet can help you to reach and maintain a healthy weight, reduce your risk of chronic diseases (like heart disease and cancer), and promote your overall health."[6]

Most evaluations of health status include a question such as Question 11 on the telephone survey: 'Do you typically find it difficult to eat healthy or maintain a healthy body weight?" In this 2018 survey, the majority of respondents (62.9%) indicated that they *do not find it difficult*, whereas 28.3% said "yes" and the remainder (8.8%) said that they "sometimes" find it difficult.

Those who reported finding it difficult (or somewhat 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?" None of the responses below will be surprising. Nearly 3 out of 10 people (29.7%) said they are simply too busy to exercise or prepare healthy meals.

[6]. https://www.hhs.gov/fitness/eat-healthy/importance-of-good-nutrition/index.html

This is consistent with statistics from the Centers for Disease Control and Prevention which indicates that nationwide, this is the most common 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, 4.81 hours per day on non-sports leisure activities (2.73 hours watching TV, 0.65 hours socializing and communicating, 0.32 hours relaxing and thinking, 0.41 hours playing games or using the computer for leisure, and 0.29 hours reading for personal interest).[7] 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", the difficulty of changing habits, and the cost of eating healthy. All of these themes can be used as PVHMC conducts its community classes.

Table 6. What would you say is the number "ONE" reason it is difficult?

	Responses		
	N	Percent	Percent of Cases
Too busy (to exercise or prepare healthy meals)	**35**	**29.2%**	**29.7%**
I like food too much	23	19.2%	19.5%
It's hard to change my eating and exercise habits	16	13.3%	13.6%
Cost of healthy food (fruits and vegetables)	13	10.8%	11.0%
Not sure how to cook/prepare healthy foods	3	2.5%	2.5%
Not sure what is considered "unhealthy"	3	2.5%	2.5%
I don't care about my weight	2	1.7%	1.7%
Other	19	15.8%	16.1%
Don't know	6	5.0%	5.1%
Total	120	100.0%	101.7%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

The 19 people who gave "other" reasons cited the temptations from fast food places and advertising; specific diet regimens required to deal with diabetes, the "lack of good teeth," injuries/ disabilities/ health concerns, stress and/or fatigue from school and work, and one interesting and poignant comment expressing frustration: "I am healthy and exercise and still don't lose weight!"

Failure to eat a healthy diet and maintain a healthy body weight are clearly factors contributing which diminish a person's health status, and smoking tobacco is another factor. 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, increase 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.[8]

A new question was placed on the survey this year asking whether anyone living in the house smokes tobacco -- cigarettes, cigars, or pipes (Q182018). Only 9.5% of respondents were willing to admit that someone in the house smokes tobacco.

[7]. https://www.bls.gov/charts/american-time-use/activity-leisure.htm
[8]. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm

It will be interesting to track this health behavior over time to determine whether all of the information on the negative effects of smoking have an effect on people's behaviors.

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. The question is: has the percentage of uninsured residents in the PVHMC service area also dropped?

Four survey questions dealt with health insurance coverage among respondents and their family members. First, IAR asked respondents to indicate how many **adults** (age 18 and above) living in the household are covered by health insurance (Question 5). Overall, the majority of respondents (87.9%) said that ***all*** of the adults in the household are covered by insurance, with another 10.2% saying that ***some*** of the adults are covered. Only 1.9% of them said that ***none*** of the adults are covered by health insurance. 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, and a significant jump from 2015 when 80.5% said that all were covered. For the most part, it appears that households with more adults tend to have a reduced likelihood that all will be covered by insurance. The exception to this trend is the households where there are 5 adults however there were so few households in that category (only 13) that this could be a statistical aberration and should not be a focus of analysis or interpretation. In addition, it is important to note that coverage is significantly increased across the board.

Table 7. Adults Covered by Health Insurance

Number of Adults Living in the Household	2012 Number and percent of households in which….				2015 Number and percent of households in which….				2018 Number and percent of households in which….			
	All are covered	Some are covered	None are covered		All are covered	Some are covered	None are covered		All are covered	Some are covered	None are covered	
1	65 94.2%	0 0.0%	4 5.8%	1	65 94.2%	0 0.0%	4 5.8%	1	65 94.2%	0 0.0%	4 5.8%	1
2	123 82.0%	14 9.3%	13 8.7%	2	123 82.0%	14 9.3%	13 8.7%	2	123 82.0%	14 9.3%	13 8.7%	2
3	38 54.3%	24 34.3%	8 11.4%	3	38 54.3%	24 34.3%	8 11.4%	3	38 54.3%	24 34.3%	8 11.4%	3
4	18 69.2%	7 26.9%	1 3.8%	4	18 69.2%	7 26.9%	1 3.8%	4	18 69.2%	7 26.9%	1 3.8%	4
5	2 40.0%	2 40.0%	1 20.0%	5	2 40.0%	2 40.0%	1 20.0%	5	2 40.0%	2 40.0%	1 20.0%	5
6 or more	0 0.0%	1 100%	0 0.0%	6 or more	0 0.0%	1 100%	0 0.0%	6 or more	0 0.0%	1 100%	0 0.0%	6 or more
Total	**246 76.6%**	**48 15.0%**	**27 8.4%**	**Total**	**246 76.6%**	**48 15.0%**	**27 8.4%**	**Total**	**246 76.6%**	**48 15.0%**	**27 8.4%**	**Total**

Table 8: Children Covered by Health Insurance

Number of Children Living in the Household	2012 Number and percent of households in which….				2015 Number and percent of households in which….				2018 Number and percent of households in which….			
	All are covered	Some are covered	None are covered		All are covered	Some are covered	None are covered		All are covered	Some are covered	None are covered	
1	46 95.8%	0 0.0%	2 4.2%	1	46 95.8%	0 0.0%	2 4.2%	1	46 95.8%	0 0.0%	2 4.2%	1
2	41 97.6%	0 0.0%	1 2.4%	2	41 97.6%	0 0.0%	1 2.4%	2	41 97.6%	0 0.0%	1 2.4%	2
3	18 100%	0 0.0%	0 0.0%	3	18 100%	0 0.0%	0 0.0%	3	18 100%	0 0.0%	0 0.0%	3
4	3 75.0%	0 0.0%	1 25.0%	4	3 75.0%	0 0.0%	1 25.0%	4	3 75.0%	0 0.0%	1 25.0%	4
5 or more	1 100%	0 0.0%	0 0.0%	5 or more	1 100%	0 0.0%	0 0.0%	5 or more	1 100%	0 0.0%	0 0.0%	5 or more
Total	**109 69.5%**	**0 0.0%**	**4 3.5%**	**Total**	**109 69.5%**	**0 0.0%**	**4 3.5%**	**Total**	**109 69.5%**	**0 0.0%**	**4 3.5%**	**Total**

IAR also asked how many **children** living in the household are covered by health insurance (Question 6), and the vast majority (98.1%, up from 95.2% in 2015) said that ***all*** of their children are covered. Only 1 person said that ***none*** of the children are covered, and another one said the some of the children are covered. Again, these figures are a significant improvement from previous reports (see Table 8 above).

In the 2015 report we noted that there were significant differences in health insurance coverage based on demographics such as age, ethnicity, income, or education. We reported that older people, as well as people with higher incomes and education, are the most likely to have households where all adults are covered. Further, in 2015, non-Hispanics were more likely than Hispanics to have coverage for all adults in the household. The 2018 data show similar trends, however the differences are no longer statistically significant. The "gap" is closing, probably due to the implementation of the Affordable Care Act.

Table 9. Number of Adults Covered by Health Insurance Selected Subgroup results

		% None Covered	% Some Covered	% All Covered	Pattern
Age	18 to 34	0%	14%	86%	Younger people are somewhat less likely to have all adults covered than older people
	35 to 54	3%	14%	83%	
	55 or older	1%	7%	92%	
Ethnicity	Hispanic	3%	14%	83%	Hispanics are somewhat less likely to have all adults covered than non-Hispanics
	Non-Hispanic	1%	8%	91%	
Income	Less than $35,000	3%	19%	78%	People with higher incomes are somewhat more likely to have all adults covered than those with lower incomes
	$35,000 to < $80,000	1%	11%	88%	
	$80,000 or more	1%	6%	93%	
Education	Some high school or less	4%	12%	84%	Those people with more education are most likely to report that all adults are covered
	Some college	1%	13%	86%	
	College degree	2%	10%	88%	

Finally, IAR asked respondents a multiple response question: "What type of health insurance covers people in your household?" (Question 7). 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 (72.1%). Another large group of people (20.7%) mentioned Medicare and 15.7% mentioned Medi-Cal.

Table 10. What type(s) of health insurance cover(s) people in your household?

	Responses		
	N	Percent	Percent of Cases
Have insurance, but don't know what type	6	1.5%	1.9%
Private insurance (either HMO or PPO)	**230**	**58.1%**	**72.1%**
Medi-Cal	**50**	**12.6%**	**15.7%**
Medicare	**66**	**16.7%**	**20.7%**
Veterans (VA)	4	1.0%	1.3%
Obamacare, covered California, ACA	6	1.5%	1.9%
Other government insurance (WIC, CHIP, ETC.)	5	1.3%	1.6%
Not covered (no insurance at all)	3	0.8%	0.9%
Don't know	21	5.3%	6.6%
Refused	5	1.3%	1.6%
Total	396	100.0%	124.1%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

As noted above, the vast majority of people said that at least some of the people in their household are covered by health insurance. Why are the few others not covered? The only comments were either that they had lost or changed jobs (2 people) or didn't really know (1 person).

One final comment: our data show that the percent of people covered by health insurance has increased (probably due to the advent of the Affordable Care Act). It is unclear whether that improvement will continue as the current administration takes steps to modify or dismantle the ACA.

Barriers to receiving needed health services

Next, respondents were asked if they or anyone in their family had needed any health services within the past year that they could not get (Question 8), and 9.9% (31 people) said "yes." As might be expected, income was strongly related to this question's responses: 20.6% of those making $35,000 a year or less reported that they had needed services that they couldn't get, as opposed to 11% of those making $35,000 up to $80,000, and 3.7% of those making $80,000 or more.

When asked what kept them from getting needed services (Question 8a), cost was the number one factor, with 35.5% (11 people) saying they are worried about the cost of services and/or co-payments. A total of 22.6% (7 people) cited lack of availability of services, and another 12.9% (4 people) said that their provider wouldn't accept their insurance.

Table 11. What kept you or your family members from getting the health services you needed?

	Responses		
	N	Percent	Percent of Cases
Worried about the cost of service/co-payments	11	26.8%	35.5%
Needed services weren't available	7	17.1%	22.6%
Provider wouldn't accept insurance	4	9.8%	12.9%
Didn't like the programs or services	3	7.3%	9.7%
No health insurance at all	3	7.3%	9.7%
Lacked transportation	2	4.9%	6.5%
Difficulty scheduling	2	4.9%	6.5%
Worried about cost of prescription	1	2.4%	3.2%
Pomona Valley Hosp Med Ctr. didn't have the services needed	1	2.4%	3.2%
Other	7	17.1%	22.6%
Total	41	100.0%	132.3%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

Respondents were also asked to indicate what services they were unable to get (Question 8b). The answers from the 31 people who responded were quite varied: 3 mentioned dental care and another 3 mentioned not being able to get the medications they needed. There was no consistency in the remainder of the comments.

Utilization of Health Care Services for Routine Primary / Preventative Care

Most respondents reported that they keep up with regular doctor visits. That is, 80.0% of them said they had visited their doctor for a general physical exam (as opposed to an exam for a specific injury, illness or condition) within the past year (Question 9). This figure has been relatively stable over the last three needs assessment reports.

Table 12: Length of Time since Respondent's Last Physical Exam

	2012 %	2015 %	2018 %
Within the past year	254 79.6%	261 80.3%	252 80.0%
Within the past 2 years	26 8.2%	28 8.6%	36 11.4%
Within the past 5 years	21 6.6%	17 5.2%	15 4.8%
More than 5 years ago	13 4.1%	13 4.0%	7 2.2%
Never	5 1.6%	6 1.8%	5 1.6%

The results for children are even more encouraging (Question 10). Most of the respondents with children said that all of their children had a preventative health care check-up within the past year (85.6% of respondents) and another 1.9% said that *some* of the children had a check-up. On the other hand, that still means that 12.5% said their children did NOT have

a health-care check-up within the past year. Clearly, the reason for the lack of check-ups was not a lack of health insurance since all of those families had earlier indicated that all of the children are covered by insurance.

A follow-up question (Question 10a) probed to see if the child(ren) had received all of the immunizations the doctor recommended. Almost all (93.3%) said that all of their children have received all of the immunizations the doctor has recommended, and another 1.0% said that *some* of the children had received all of their vaccinations. The rest (5.7%) said that not all vaccinations were given, however there wasn't a question on the survey asking for the reasons why, and so an opportunity exists to add this as a question to the next assessment cycle.

Table 13: Check-ups and Immunizations for Children

	2012 %	2015 %	2018 %
Q10: Number of families whose children all had preventative health care check-ups within the past year	95 85.6%	104 83.2%[9]	89 85.6%
Q10a: Number of families whose children have received all of the immunizations the doctor recommended	107 93.9%	119 94.4%	98 93.3%

The next series of questions (Questions 12b-e) 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. Thus direct comparisons over time cannot be made. Further, the Healthy People 2020 targets don't necessarily coincide with the time frames in the questions asked, thus comparisons must be made with caution. What CAN be concluded from the table below, however, is that there is still progress to be made before the data show that Healthy People 2020 targets are being reached.

Table 14. Percent of Respondents Who Said They or a Family Member Has Had a Health Screening

Health Screening Test	% "Yes" 2009	% "Yes" 2012	% "Yes" 2015	% "Yes" 2018	HP 2020 Targets
Pap smear in the past **year** (2009 & 2012) or **three years** (2015 and now 2018)	51.2%	49.8%	63.1%	**61.0%**	**93.0%** [a]
Mammogram in the past year	52.9%	53.9%	50.8%	**58.8%**	**81.1%** [b]
Blood test for cholesterol in the past year	75.5%	76.5%	79.6%	**84.8%**	**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%**	**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.

Considering that these screening tests have proven over time to be invaluable in detecting medical problems early, why did people choose to avoid them? The predominant reason cited in an open ended multiple response question was being too old or too young to need the test (47.5%). A much smaller percentage said they don't think the test is important or

[9]. This figure is a slight decrease from the 2012 statistics; however it is within the margin of error.

necessary (11.7%), the doctor has not recommended/told them to have the test (10.6%), the perception that "healthy people don't need it" (7.8%), or said that they are "too busy" to get the test (6.7%). Very few people cited a lack of insurance (2.8%) or a fear or dislike of the test (2.2%) as a rationale for not getting the screening(s).

Table 15: Reasons for not getting all cancer screenings

	Responses		
	N	Percent	Percent of Cases
No insurance	5	2.4%	2.8%
Financial the out of pocket cost even with insurance	4	1.9%	2.2%
Fear of the test/dislike of the test	4	1.9%	2.2%
Didn't think it is important or necessary [not broken don't fix]	**21**	**10.2%**	**11.7%**
Too old or too young to need the test	**85**	**41.3%**	**47.5%**
No transportation	2	1.0%	1.1%
No women in the household	5	2.4%	2.8%
No regular doctor	4	1.9%	2.2%
Healthy person	14	6.8%	7.8%
Doctor has not recommended or told me to have yet.	**19**	**9.2%**	**10.6%**
Hysterectomy	6	2.9%	3.4%
Appointment is made	6	2.9%	3.4%
No time, too busy	**12**	**5.8%**	**6.7%**
Doctor did not want to do the test	5	2.4%	2.8%
Other	14	6.8%	7.8%
Total	206	100.0%	115.1%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

Finally, an analysis shows that there are differences by various demographic factors in rates of being screened. Overall, older people had higher rates of receiving the screening tests (other than a pap smear). Hispanics received pap smears and mammograms more often than non-Hispanics, but were tested at lower rates for cholesterol and colon cancer (but the differences were not statistically significant. There were no statistically significant differences in rates of getting screened based on income, although we note that fewer low-income individuals received pap smears than did middle or high-income individuals (see bolded figures below). More people with advanced education (i.e. college degrees) got pap smears and colon cancer screenings than did those with lower levels of education (bolded).

Table 16. Percentage Who Received Screening Tests- Selected Subgroup results – FY 2015

		Pap Smear	Mammogram	Cholesterol	Colon Cancer
Age	18 to 34	**71%**	**26%**	**77%**	**21%**
	35 to 54	**74%**	**51%**	**65%**	**34%**
	55 or older	**50%**	**57%**	**90%**	**77%**
Ethnicity	Hispanic	61%	45%	**71%**	**38%**
	Non-Hispanic	65%	54%	**85%**	**62%**
Income	Less than $35,000	**54%**	**35%**	72%	**36%**
	$35,000 to < $80,000	**63%**	**47%**	75%	**53%**
	$80,000 or more	**77%**	**67%**	85%	**61%**
Education	Some high school or less	**58%**	48%	**71%**	**38%**
	Some college	**59%**	48%	**80%**	**55%**
	College degree	**73%**	56%	**88%**	**65%**

Table 17. Percentage Who Received Screening Tests- Selected Subgroup results - FY 2018

		Pap Smear	Mammogram	Cholesterol	Colon Cancer
Age	18 to 34	**81%**	**32%**	**66%**	**22%**
	35 to 54	**75%**	**54%**	**80%**	**41%**
	55 or older	**48%**	**68%**	**93%**	**83%**
Ethnicity	Hispanic	67%	63%	81%	54%
	Non-Hispanic	59%	56%	87%	66%
Income	Less than $35,000	54%	65%	83%	59%
	$35,000 to < $80,000	69%	56%	83%	63%
	$80,000 or more	64%	58%	89%	64%
Education	Some high school or less	**58%**	67%	81%	**47%**
	Some college	**53%**	57%	91%	**65%**
	College degree	**70%**	55%	83%	**66%**

Need for Specialty Health Care

In order to determine the community needs for "specialty" health care, the telephone interviewers read respondents a list of chronic/ongoing health conditions and were asked if they or any member of their family have the conditions (Question 13). Over a quarter (25.5%) of respondents said that they didn't have any of the conditions listed. The table below shows that high blood pressure is the major "specialty" health issues reported by our respondents, with diabetes, arthritis, high cholesterol, and obesity also mentioned by a large percentage of individuals. There has been a significant increase since the 2015 report in the incidence of diabetes and high blood pressure (yellow highlighting).

Table 18: Percent of Respondents Who Said They or a Family Member has a Chronic or Ongoing Health Condition[10]

Chronic or Ongoing Health Condition	% Who Said "Yes" 2009	% Who Said "Yes" 2012	% Who Said "Yes" 2015	%Who Said "Yes" 2018
Cancer	15.8%	9.0%	13.4%	11.7%
Diabetes	**32.1%**	**19.5%**	**25.9%**	**42.4%**
Asthma	25.0%	11.8%	16.5%	16.0%
High Blood Pressure	**51.5%**	**36.5%**	**42.7%**	**60.6%**
Obesity	17.3%	8.7%	21.6%	25.5%
Osteoporosis	13.3%	8.7%	10.7%	11.7%
Chronic Heart Failure	8.2%	3.4%	4.6%	5.2%
High cholesterol/arteriosclerosis*	--	--	**32.3%**	**36.8%**
Arthritis*	--	--	**29.9%**	**37.7%**

Most of the respondents (89.8%) said that they and/or their family member have received adequate help in managing the disease (Question 14). There were 23 people who made comments regarding help they were not able to get. Those comments reflected people's perceptions that they did not receive the proper medication, or help with meal planning and nutrition education, or access to a heath care professional that cares and was familiar enough with the person's case to provide needed services.

Cancer is not the top issue our respondents are dealing with, however many people still have concerns about cancer. This year respondents were asked: "Which type of cancer are you most concerned about?" (Question Q152018). Nearly a quarter (24.2%) said that they are not concerned about cancer at all. "Cancer in general" topped the list of concerns for those who ***are*** concerned about cancer, followed by breast cancer.

Table 19. Some people are concerned about cancer. Which type of cancer are you most concerned about?

	Responses		Percent of Cases
	N	Percent	
Breast cancer	**63**	**27.4%**	**31.3%**
Lung	21	9.1%	10.4%
Colorectal	31	13.5%	15.4%
Prostate	14	6.1%	7.0%
Skin Cancer	21	9.1%	10.4%
Cancer in general (all cancers)	**80**	**34.8%**	**39.8%**
Total	230	100.0%	114.4%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

This year, new questions were added regarding the best sources of information about diseases and disease prevention (Question Q162018).

[10]. "Other" responses (not read to the respondent or shown in the table) included allergies, COPD, Fibromyalgia, Kidney disease, chronic pain, gout, and a variety of other health issues.

Table 20. What are the best ways of providing you with information about disease prevention such as cancer, diabetes, heart disease, and stroke?

	Responses		
	N	Percent	Percent of Cases
Community events	31	7.2%	10.1%
Doctor's visits	**176**	**40.9%**	**57.1%**
TV or social media	78	18.1%	25.3%
Mail sent home	68	15.8%	22.1%
Calls/Calling	4	0.9%	1.3%
Classes	2	0.5%	0.6%
Email/Email Newsletter	20	4.7%	6.5%
From Insurance Companies	3	0.7%	1.0%
Internet/Online	20	4.7%	6.5%
Magazine/Articles	2	0.5%	0.6%
Newspaper	1	0.2%	0.3%
Pamphlets/flyers	2	0.5%	0.6%
YouTube	1	0.2%	0.3%
Not interested in the information	15	3.5%	4.9%
Other	7	1.6%	2.3%
Total	430	100.0%	139.6%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

The data in table 20 show that having a doctor provide information during an appointment is the best way of learning about disease prevention. TV or social media can also be effective, as can mail sent home, but these methods are not deemed to be as effective as doctor's visits.

A new follow-up question was also asked in this needs assessment (Q172018): "There are a number of places where people can learn more about diseases such as cancer, diabetes, and heart disease. **In addition to a doctor's office or hospital**, where else would you like to see the information being shared?" Not surprisingly, people mentioned the Internet as an information source (36.0%), in addition to public schools (27.5%) and community events (21.1%).

Table 21. In addition to a doctor's office or hospital, where else would you like to see information being shared about diseases such as cancer diabetes, and heart disease?

	Responses		
	N	Percent	Percent of Cases
Churches	35	8.1%	14.2%
Community colleges	29	6.7%	11.7%
Workplace	40	9.3%	16.2%
Libraries	25	5.8%	10.1%
Public Schools	**68**	**15.8%**	**27.5%**
Supermarkets	22	5.1%	8.9%
Community events	**52**	**12.1%**	**21.1%**
Internet	**89**	**20.7%**	**36.0%**
Billboards	2	0.5%	0.8%
Community Centers	3	0.7%	1.2%
Senior Centers	7	1.6%	2.8%
Magazines	4	0.9%	1.6%
Mailers to homes	9	2.1%	3.6%
Social Media	6	1.4%	2.4%
TV	10	2.3%	4.0%
Others	29	6.7%	11.7%
Total	430	100.0%	174.1%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

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

Slightly over half of the survey respondents (57.2%) reported that they had at some time gone to PVHMC for health care (Question 18). As in the past, the main reason(s) cited for choosing PVHMC for health care (Question 18a) were convenience/location (i.e. "close to home"), insurance, referral by a physician, and quality/reputation.

Table 22. Respondents Who Have Gone to PVHMC and the Reason(s) for choosing PVHMC

	Percent Who Said "Yes" 2009	Percent Who Said "Yes" 2012	Percent Who Said "Yes" 2015	Percent Who Said "Yes" 2018
Have you ever gone to PVHMC for health care?	**151 49.3%**	**169 52.6%**	**167 51.1%**	**179 57.2%**
Why did you Choose PVHMC?				
Close to home	74 49.3%	72 42.9%	75 44.9%	**78 43.6%**
Insurance	38 25.3%	30 17.9%	34 20.4%	**50 27.9%**
Referred by Physician	30 20.0%	31 18.5%	33 19.8%	**33 18.4%**
Services offered	21 14.0%	12 7.1%	24 14.4%	13 7.3%
Quality / reputation	16 10.7%	25 14.9%	32 19.2%	**23 12.8%**
Word of mouth (friend, neighbor, family, or co-worker)	4 2.7%	11 6.5%	7 4.2%	9 5.0%
My doctor is there				4 2.2%
Work site	5 3.3%	4 2.4%	2 1.2%	1 .6%
Community Presentation	--	--	--	2 1.1%
Other	7 4.7%	13 7.7%	5 3.0%	6 3.4%
Ambulance took me there, so there was no choice	--	--	16 9.6%	22 12.3%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

Whereas the above question dealt with choosing PVHMC for "health care" (whatever that meant to the respondent), the next question focused on the need for services at an emergency room. A large proportion of respondents (48.2%) said they *or a member of their household* had received services at PVHMC's emergency room (Question 23 – in 2018 the phrase "members of the household" was included in the question, whereas it hadn't been included in previous surveys). The predominant reason for the visit(s) was injury or accident (30.7%), followed by chest pain/heart attack (11.7%), breathing difficulties from sinus infections or this year's severe flu season (10.9%), gallbladder/kidney/appendix attacks (10.2%), and pain (10.2%).

Table 23. What was the reason emergency services were needed?

	Responses		
	N	Percent	Percent of Cases
Injury or accident	**42**	**27.8%**	**30.7%**
Chest pain/heart attack	**16**	**10.6%**	**11.7%**
Stroke	2	1.3%	1.5%
Breathing difficulties (flu, sinus infection,...)	**15**	**9.9%**	**10.9%**
Allergic Reaction	2	1.3%	1.5%
Asthma attacks	2	1.3%	1.5%
Diabetes issues	2	1.3%	1.5%
Gallbladder/kidney/appendix attacks	**14**	**9.3%**	**10.2%**
High blood pressure issues	2	1.3%	1.5%
Labor/miscarriage/pregnancy	5	3.3%	3.6%
Lightheaded/dizzy/passed out	4	2.6%	2.9%
Pain (Back, neck, leg, abdominal, throat)	**14**	**9.3%**	**10.2%**
Pneumonia, coughing blood, fever	4	2.6%	2.9%
Seizures	4	2.6%	2.9%
Other	23	15.2%	16.8%
Total	151	100.0%	110.2%

NOTE: This is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

The following table shows that although almost two-thirds (65.7%) of respondents and/or household members who went to the Emergency Room for services did not try to see the doctor before going to the Emergency Room (Question 24). That figure is a significant decrease from the 71.7% in 2015. As has been the case in years past, a large group of people indicated that their emergency was after doctor's office hours or on a weekend, thus they went to the ER for care. Another 40.9% simply said that it was an emergency situation and 26.1% said they were brought by ambulance, thus there was no opportunity to visit a doctor before going to the Emergency Room.

Table 24: Did you or the household member try to see the doctor before going to the Emergency Room?

	Percent Who Said "No" 2009	**Percent Who Said "No" 2012**	**Percent Who Said "No" 2015**	**Percent Who Said "No" 2018**
	78 72.2%	**99 73.3%**	**86 71.7%**	**94 65.7%**
Reasons for not visiting the doctor before going to the ER				
After office hours or on a weekend	26 33.3%	32 36.0%	33 39.8%	32 36.4%
Emergency situation	20 27.0%	22 24.7%	24 28.9%	36 40.9%
Brought by ambulance	12 16.2%	15 16.9%	22 26.5%	23 26.1%

* As noted above, in 2018 the phrase "members of the household" was included in the question, whereas it hadn't been included in previous surveys.
NOTE: Reasons for not visiting is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

In addition to these experiences with PVHMC, IAR also asked respondents if they have ever attended any of the classes offered by PVHMC (Question 19). This year 11.7% stated that they had (up from 6.6% in 2015), and 21.5% indicated that there are classes they would *like* PVHMC to offer.

Table 25: PVHMC Classes

	Percent Who Said "Yes" 2009	Percent Who Said "Yes" 2012	Percent Who Said "Yes" 2015	Percent Who Said "Yes" 2018
Q19: Have you attended any classes offered by PVHMC?	31 10.1%	35 10.9%	22 6.6%	36 11.7%
Q20: Are there any classes you'd like them to offer?	35 12.8%	41 15.0%	62 18.6%	56 21.5%

Upon probing, the most often mentioned class desired (by 23 of 56 people who chose to make suggestions) was something dealing with healthy eating and nutrition. Considering that cholesterol, high blood pressure, obesity, and diabetes were mentioned as ongoing health concerns for our respondents, it is encouraging that there appeared to be a call for education in these areas. In addition, 7 people asked for classes dealing with diabetes issues, 5 wanted CPR classes, and 4 wanted classes dealing with female health issues (pre-natal care, miscarriage support, lactation, etc.).

A follow-up question asked the respondents whether they or any member of their family had attended any health-related *support groups* in the past year (Question 21). The percentage of people answering in the affirmative was 11.6% -- virtually unchanged from 2015. Nearly half of respondents (42.9%) had no interest in such groups, but others mentioned an interest in groups focused on nutrition (33 people), diabetes (21 people), obesity and weight problems (15 people), cancer (17), high blood pressure (8), heart disease (7) or anything having to do with mental health, depression, or PSTD (16). Further, for the first time, people asked for grief and bereavement groups (9) or a caregiver support group (7). It is unclear whether people would actually translate their desires into behavior by attending such support groups, but there is clearly interest in the community for at least some of the groups mentioned.

Table 26: PVHMC Support Groups

	2009 %	2012 %	2015 %	2018 %
Q21: Have you or any member of your family attended any health-related support groups in the past year?	**43 14.0%**	**42 13.1%**	**33 10.1%**	**35 11.6%**
What Types of Support Groups Are you Interested in?				
Not interested in any groups	115 50.2%	82 37.4%	114 46.9%	102 42.9%
Nutrition	24 10.5%	19 8.7%	36 14.8%	33 13.9%
Diabetes	24 10.5%	16 7.3%	24 9.9%	21 8.8%
Obesity and Weight Loss	20 8.7%	14 6.4%	18 7.4%	15 6.3%
Heart Disease	6 2.6%	13 5.9%	3 1.2%	7 2.9%
Cancer	11 4.8%	12 5.5%	16 6.6%	17 7.1%
High Blood Pressure	11 4.8%	12 5.5%	14 5.8%	8 3.4%
Mental Health	--	--	--	10 4.2%
Depression/PTSD	--	--	--	6 2.5%
Grief and Bereavement	--	--	--	9 3.8%
Caregivers	--	--	--	7 2.9%

On previous needs assessment surveys, the last (and perhaps most important) substantive question was "Are there any health related services that you need that are not being provided in your community?" Typically there was little commonality of responses as to what specific health services were needed. This year the focus was changed to a question asking: "What is the biggest health related issue or service that ***the community*** needs to focus on? (Question Q262018). This was presented as an open-ended, multiple response question in order to elicit people's final comments about community needs. The numbers show that the most pressing issue on the minds of respondents was healthy lifestyle (e.g. obesity, nutrition and health eating, and exercise).

Table 27. What is the biggest health related issue or service that the community needs to focus on?

	Responses		
	N	Percent	Percent of Cases
Affordable Health Care/Free Screening	30	6.8%	11.5%
Housing for Homeless	33	7.5%	12.6%
Mental Services (Better advertising and Lower Cost)	41	9.3%	15.6%
Obesity/Nutrition/Exercise/Healthy Living	**93**	**21.0%**	**35.5%**
Preventive care	28	6.3%	10.7%
Place to buy healthy foods affordably	31	7.0%	11.8%
Services for diabetes	35	7.9%	13.4%
Heart Disease	12	2.7%	4.6%
Elderly care	7	1.6%	2.7%
Addiction treatment	22	5.0%	8.4%
Cancer cure/treatment	33	7.5%	12.6%
Affordable Medicine	25	5.7%	9.5%
Others	52	11.8%	19.8%
Total	442	100.0%	168.7%

NOTE: Reasons for not visiting is a multiple response question in which the respondent was able to indicate more than one response. "Percent of responses," therefore, sums to 100% but "Percent of cases" will not.

The table above includes a great many "others." Many of those comments were unhelpful in that they lacked specificity (e.g. "general health" or "focus on everything"). A few mentioned better doctors or services in the ER, and transportation issues. The complete variety of comments is available in the data display.

Secondary Data

For the purposes of this report, secondary data have been collected regarding:

- **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, smoking/tobacco use, alcohol use, food and nutrition, physical activity levels, and rates of domestic violence.

These data have been collected for SPA (Service Planning Area) 3, Los Angeles County as a whole, and San Bernardino County as a whole. Available city-specific secondary data for PVHMC's *primary* service area have also been collected. Secondary data sources at the local, state, and national levels included:

- www.HealthyPeople.gov
- 2011 – 2012 and 2016 California Health Interview Survey (CHIS)
- 2011 – 2012 and 2014 California Health Interview Survey (CHIS), Neighborhood Edition
- 2016 LA County Health Survey (http://publichealth.lacounty.gov)
- Centers for Disease Control and Prevention Leading Causes of Death in California (https://www.cdc.gov/nchs/pressroom/states/california/california.htm)

- California Department of Public Health, County Health Status Profiles
  https://www.cdph.ca.gov/Programs/CHSI/CDPH Document Library/CHSP-County Profiles 2018.pdf
- U.S. Dept of Health and Human Services
  https://www.healthdata.gov/dataset/leading-causes-death-zip-code-1999-current
- 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.
- Gallup-Healthways Well-Being Index
- State of California Dept. of Justice, Office of the Attorney General
  http://oag.ca.gov/crime/cjsc/stats/domestic-violence
- http://publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf
- https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use
- Centers for Disease Control and Prevention, http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

Before presenting the data, it is important to mention the "positives and negatives" of secondary data. On the positive side, such data are relatively inexpensive to gather, and the secondary data sources above include a rich database of information regarding residents of the geographic areas under study. Of course, secondary data are only as good as the research that produced them, however the above sources tend to be credible, providing accurate, valid, and reliable information. Unfortunately, however, these data are not as current as the primary data from the telephone survey presented earlier in this report. Indeed, most of the secondary data presented in this section of the report reflects a picture of the community in 2016 (countywide statistics) or 2014 (city-specific statistics) rather than 2017 (as would be desired). Further, it was often the case that the different data sources defined their data slightly differently (e.g. physical activity per *month* vs. *daily* physical activity, or age categories such as 13 – 17 in one source vs. 12 – 17 in another), thus making comparisons over time difficult.

With those caveats, we now present a snapshot of health status indicators and major health influencers for residents of Los Angeles County (as a whole), San Bernardino County (as a whole), and the San Gabriel Valley region (SPA3). These figures are compared with Healthy People 2020 goals where appropriate, and with city-specific data for PVHMC's primary service area. . 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 telephone survey, this information should help PVHMC create an action plan for improving the wellness of the community.

Health Status Indicators

Overall health self-assessment

In the 2014 report, approximately half of the people from the two county area of interest to PVHMC who responded to the 2011 – 2012 California Health Interview Survey characterized their health as "excellent" or "very good" (51.3% of LA County respondents, 54.2% of San Bernardino County respondents, and 51.9% of the respondents in SPA3 (San Gabriel Valley). The comparable figures in the 2016 survey are similar, with 51.7% of LA County respondents, 51.2% of San Bernardino County respondents, and 52.9% of SPA3 respondents reporting their health as "excellent" or "very good" (see bold figures in the table below).

These aggregate figures, however, mask the fact that in San Bernardino County, there has been a decrease in the percentage of "excellent" and "very good" evaluations for females since the last report. Whereas 30.5% of females rated their health as "very good" in 2011/12, that figure was only 20.4% in 2016. The combined percentages of "excellent" and

"very good" dropped from 48.9% to 41.7% (yellow highlighting). For males in SPA3, there was a significant increase in the percentage that listed their health as "good" (28.5% to 39.0%) and a decrease in only "fair" evaluations (17.6% to 9.7% -- blue highlighting)

Finally, although the majority of residents have health status that is at least "good," it is still important to note that 18.3% of Los Angeles County residents, 19.3% of San Bernardino County residents, and 15.4% of SPA3 residents rate their health as "fair" or "poor."

Table 28: General Health of Children, Teens, and Adults

2011 – 2012 Data

	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	100.1%	100.0%	100.1%	100.0%	99.9%	100.1%	100.0%	100.0%	99.9%

2016 Data[11]

	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%

Sources: 2011 – 2012 and 2016 California Health Interview Survey

* Statistically unstable

In the 2014 study, IAR gathered city-specific data from 2011 - 2012 regarding the percent of adults (18 – 64) who rated their health as "Fair" or "Poor." The most recent data from the Neighborhood Edition of the California health Interview Survey (2014 data) has added data from children/teens and senior citizens in its data displays at the city, zip code, or region level. The following table (next page) shows those data.

In 2011 – 2012 the cities with the highest percentages of adult results rating their health as only "fair" or "poor" were Montclair, Ontario, and Pomona (yellow highlighting).

There has been a significant decrease in those negative ratings over time in Montclair and Ontario. The not-so-good news, however, is that the figures for the other cities/regions did not show significant improvement (with changes

[11] 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.

remaining within the margin of error). Further, the table shows that Pomona and Ontario have high percentages of seniors (age 65+) in only fair or poor health (see blue highlighting). In the future, PVHMC will be able to view changes over time for all age groups.

Table 29. % Rating Their Health as "Fair" or "Poor" (City/Region Specific), by Age

CITY	2011-2012 %	2014 %		
	18 to 64 years old	0 - 17 years old	18 to 64 years old	65+ years old
Chino	20.9%	2.8%	17.2%	30.5%
Chino Hills	15.8%	2.3%	15.3%	25.8%
Claremont	12.1%	NA	11.2%	21.5%
La Verne	12.9%	1.8%	11.9%	21.5%
Montclair	31.5%	3.6%	26.5%	N/A
Ontario	27.0%	3.3%	21.6%	35.7%
Pomona	25.9%	2.9%	23.7%	41.3%
Rancho Cucamonga	18.8%	2.4%	14.7%	25.7%
San Dimas	13.5%	1.8%	12.6%	23.2%
Upland	19.7%	2.5%	15.4%	23.0%

COUNTY/REGION	2011-2012 %	2014 %		
	18 to 64 years old	0 - 17 years old	18 to 64 years old	65+ years old
Los Angeles	20.8%	4.8%	19.9%	33.9%
San Bernardino	21.8%	0.6%	25.0%	29.0%
San Gabriel (SPA3)	21.7%	0.5%	15.2%	34.4%

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

The above table focuses on residents of all ages (children, teens, and adults) and is not available at the city or zip code level. There is, however, available data at the city level for the percentage of adults 18 to 64 rating their health as "fair" or "poor."[12] The following table presents those data:

Prevalence of chronic diseases

Although the majority of individuals in each county/region rated their health as "excellent" or "very good", many people battle conditions such as cardiovascular disease, diabetes, cancer, high blood pressure, 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.

[12]. The city-specific data are not available for individuals ages 65 or older

Table 30: Percent of Adults Diagnosed With Various 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% *	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%

Source: 2011 – 2012 and 2016 California Health Interview Survey

* Statistically unstable

The yellow highlighting in the tables above show that the prevalence of obesity has increased significantly among both males and females in Los Angeles County, and San Bernardino County saw an increase for women. The incidence of high blood pressure dropped for residents of both counties and for the San Gabriel Valley region (green highlighting).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 31: % of Adults Diagnosed With Heart Disease, Diabetes, or Obesity (City-Specific)

CITY	% Heart Disease	% Diabetes	% Obese (BMI $\geq$ 30)
Chino	4.8%	10.1%	34.8%
Chino Hills	5.1%	9.8%	26.6%
Claremont	6.8%	8.4%	17.6%
La Verne	6.6%	8.2%	18.7%
Montclair	4.5%	13.1%	40.7%
Ontario	4.4%	11.5%	39.9%
Pomona	4.4%	11.2%	28.4%
Rancho Cucamonga	4.8%	8.9%	30.2%
San Dimas	6.4%	8.4%	19.4%
Upland	5.6%	9.5%	30.4%

Source: 2014 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, chronic lower respiratory diseases, stroke, and accidents. California data from 2016 show that leading causes of death include heart disease (rate = 143.1), cancer (rate = 139.7), stroke (rate = 36.9), Alzheimer's (rate = 36.2), chronic lower respiratory diseases (rate = 326), and accidents (rate = 32.0).[13]

Focusing on Los Angeles County, San Bernardino County, and SPA3: In the last community needs assessment, heart disease was the leading cause of death, followed by all cancers. The most current data for this report shows that cancer has now overtaken heart disease as the leading cause of death in Los Angeles and San Bernardino Counties, however heart disease is still the leading cause of death in the PVHMC region.

There are two different ways of presenting data on leading causes of death. The first method focuses on the number (or percentage) of deaths from a certain cause, and the second focuses on death rates per 100,000 population (crude and/or age-adjusted rate). The table below provides both percentages and rates for LA County and San Bernardino County, however the data for SPA3 is only available in terms of percentage of deaths.

Table 32: Leading Causes of Death

Cause of Death	LA County			SB County			PVHMC Region	HP 2020
	%	Crude Rate	Age-Adjusted	%	Crude Rate	Age-Adjusted	%	Target
All Cancers	**23.51%**	141.0	134.8	**21.97%**	138.9	157.6	**23.64%**	161.4
Heart Disease	**18.34%**	110.0	103.9	**13.66%**	86.3	106.5	**24.61%**	103.4
Stroke	5.76%	34.5	33.2	5.19%	32.8	40.5	5.55%	34.8
Chronic Lower Respiratory Disease (COPD)	4.84%	29.0	28.2	6.69%	42.3	52.1	6.09%	a
Alzheimer's Disease	5.83%	35.0	32.9	4.71%	29.8	40.0	6.23%	a
Unintentional injuries (accidents)	3.84%	23.0	22.2	4.12%	26.0	27.5	3.27%	36.4
Diabetes Mellitus	3.90%	23.4	22.3	4.61%	29.1	33.2	4.54%	b
Influenza and Pneumonia	3.41%	20.5	19.6	1.73%	11.0	13.2	2.08%	a
Chronic Liver Disease & Cirrhosis	2.35%	14.1	13.1	2.40%	15.2	15.5	2.24%	8.2

Sources include:
https://www.cdph.ca.gov/Programs/CHSI/CDPH Document Library/CHSP-County Profiles 2018.pdf
(data reflect average deaths 2014 – 2016)
https://www.healthdata.gov/dataset/leading-causes-death-zip-code-1999-current

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 deat

Major Health Influencers

[13] https://www.cdc.gov/nchs/pressroom/states/california/california.htm

In 1948, The World Health Organization (WHO) defined health as "*the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*"[14] Consistent with this concept, Healthy People 2020 has 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. This section of secondary data includes information about some of those factors, and we begin with a look at health insurance coverage.

The Los Angeles County, San Bernardino County, and SPA3 areas have shown similar increases, as noted in the table below. The Healthy People 2020 target has not yet been realized; however the counties are getting closer.

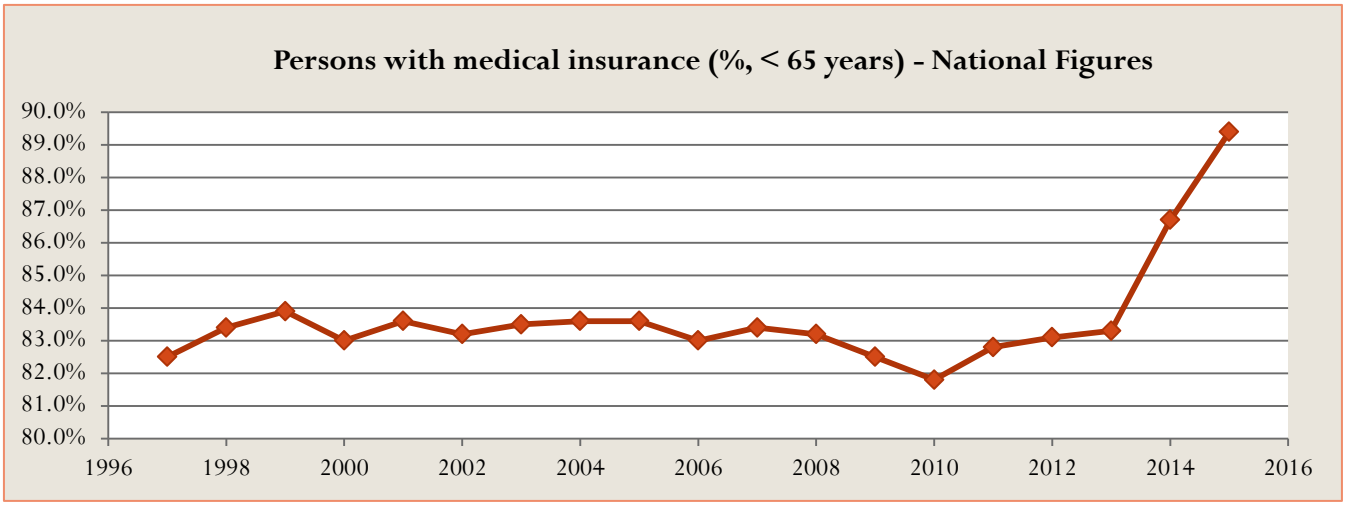


Table 33: Health Insurance Status

		LA County	SB County	SPA3
2011 – 2012 data	Adults with health insurance (18 – 64 years old)	74.9%	74.3%	75.7%
	Population with health insurance (all ages)	82.6%	83.7%	83.0%
2016 data	Adults with health insurance (18 – 64 years old)	86.3%	85.3% *	91.2% *
	Population with health insurance (all ages)	90.5%	89.6% *	94.3% *

Source: 2011 – 2012 and 2016 California Health Interview Survey
* Statistically unstable

It must be noted that the LA County Health Survey released in January 2017 (data for 2016) had slightly different estimates (but within the margin of error). That survey showed 88.3% of LA County adults with health insurance, and 88.7% of SPA3 adults with health insurance.[15]

Following are the city-specific data on insurance coverage. The yellow highlighting in the table below indicates that the lowest percentages of insured adults are in the cities of Montclair, Ontario, and Pomona.

[14]. http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf?ua=1
[15]. http://publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf
[15]. https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use

Table 34: % Insured (City-Specific)

	2011 - 2012		2016	
CITY	% children & teens	% adults (18 - 64)	% children & teens	% adults (18 - 64)
Chino	97.6%	73.9%	NA	78.5%
Chino Hills	97.9%	81.5%	97.7%	84.5%
Claremont	96.8%	83.2%	NA	86.3%
La Verne	96.2%	83.1%	NA	85.5%
Montclair	97.7%	68.4%	N/A	73.4%
Ontario	97.5%	69.8%	97.5%	74.8%
Pomona	94.8%	70.4%	94.4%	74.2%
Rancho Cucamonga	97.8%	78.8%	97.8%	82.6%
San Dimas	N/A	82.1%	N/A	84.6%
Upland	97.8%	78.1%	N/A	81.6%

Source: 2011 – 2012 and 2014 California Health Interview Surveys, Neighborhood Edition

Tobacco 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."[16]

The following table shows the percentage of people (of any age) who are current smokers, former smokers, or who never smoked. Over time there has been a slight decrease in the percentage of *current* smokers. The figure for *former* smokers in San Bernardino County increased significantly, as did the figure for "never smoked" in SPA3.

Table 35: Tobacco Use

		LA County	SB County	SPA3	HP2020 Target
2011 – 2012 data	Current smokers	13.9%	14.5%	13.7%	12.0%
	Former smokers	21.5%	21.2%	20.0%	---
	Never smoked	64.6%	64.3%	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%	---

The data from the LA County Department of Public Health survey conducted in 2016 and released in January 2017 indicate that 13.3% of LA County adults and 12.8% of San Gabriel (SPA3) adults are current smokers. These figures appear to be within the margin of error (or close to it) of the figures above, and are virtually unchanged from those in the report released in 2013.

[16]. https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use

City-specific figures follow:

Table 36: Tobacco Use Among Adults (City-Specific)

CITY	2011 – 2012 % Current Smokers	2014 % Current Smokers
Chino	13.7%	9.5%
Chino Hills	10.7%	9.6%
Claremont	14.0%	10.8%
La Verne	11.4%	11.0%
Montclair	15.5%	9.9%
Ontario	14.5%	9.3%
Pomona	15.5%	12.8%
Rancho Cucamonga	14.5%	10.7%
San Dimas	12.0%	11.1%
Upland	14.7%	10.2%

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

Alcohol Use

Excessive alcohol use has 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.[17] How does the CDC define "excessive" alcohol use? The definition includes **binge drinking** (for women, 4 or more drinks during a single occasion; for men, 5 or more drinks during a single occasion), **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 following data address binge drinking by adults and teens. Binge drinking among adults is slowly increasing.

Table 37: Alcohol Use

		LA County	SB County	SPA3
2011 – 2012 data	% ***adults*** binge drinking in the past *year*	30.1%	29.6%	28.6%
	% ***teens*** (12 – 17) binge drinking in the past *month*	4.4%	1.3%	3.3%
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*	1.2% *	0.0% *	0.0% *

Sources: 2011 – 2012 and 2016 California Health Interview Survey (CHIS); healthypeople.gov

* Statistically unstable

Food and Nutrition

Poor diet (eating too little or too much, not having enough fruits and vegetables in the diet, and not having a varied diet) tends to contribute to several disease states, including heart disease, obesity, diabetes, some cancers, high cholesterol, and

[17]. Centers for Disease Control and Prevention, http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

high blood pressure.[18] In contrast, 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. Some of the definitions of those measurements/variables have changed since the last PVHMC Community Health Needs Assessment so comparisons over time cannot be made for all variables.

The following table is a snapshot of healthy (and not-so-healthy) eating patterns. In 2011-2012, the percentage of children and teens who ate fast food in the past week was recorded as 72.6% in LA County, 76.8% in SB County, and 70.0% in SPA3. Those figures have risen significantly since the last needs assessment (yellow highlighting). The rest of the figures in the tables are only slightly changed from the previous report. One specific figure in the table below warrants comment: the percent of teens in San Bernardino County who ate five or more services of fruits and vegetables daily was only 8.2% (in contrast to 22.5% for Los Angeles County teens and 22.0% of SPA3 teens. This may be an area that deserves focus by public health officials, particularly when this figure is considered in concert with the 86.3% of San Bernardino County children and teens who ate fast food in the past week, and the 55.1% of adults without the consistent ability to afford enough food (green highlighting below).

Table 38: Food and Nutrition

	LA County	SB County	SPA3
% ***all residents*** (children, teen, adult) who ate fast food in the past week	72.5%	78.7%	71.6%
% ***adults*** who ate fast food in the past week	71.7%	76.1%	71.8%
% ***children & teens*** who ate fast food in the past week	79.7%	86.3% *	75.3% *
Average weekly consumption of soda by adults (% ***adults*** who consume 1 or more sodas per *week)*	43.4%	51.2%	38.6%
% **children &** ***teens*** who consumed ≥ 2 glasses of soda yesterday	3.4%	3.4%	7.5%
% ***children & teens*** who consumed ≥ 2 glasses of sugary drinks (other than soda) *yesterday*	12.2%	30.2%	5.0%
% ***teens*** who ate ≥ 5 servings of fruits and vegetables daily	22.5%	8.2%	22.0%
% ***teens*** who ate ≥ 2 servings of fruits and vegetables yesterday	69.5%	65.0%	67.3%
% ***adults with income < 200% of federal poverty level*** without the consistent ability to be able to afford enough food	43.1%	55.1%	34.8%
% of ***all adults*** without the consistent ability to be able to afford enough food	9.9%	8.5%	N/A

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

* Statistically unstable…see footnote 6 above.

City-specific food insecurity data is shown below. The reader will note that the survey question was only asked of adults ages 18+ with an income < 200% federal poverty level, however those not asked were considered/assumed to be food secure.

[18]. 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.

Table 39: Food Insecurity (adults 18+) (City-Specific)

CITY	% Unable to Consistently Buy Food
Chino	7.0%
Chino Hills	3.3%
Claremont	2.5%
La Verne	3.6%
Montclair	13.0%
Ontario	10.7%
Pomona	13.4%
Rancho Cucamonga	4.1%
San Dimas	3.9%
Upland	5.0%

Source: 2014 California Health Interview Survey, Neighborhood Edition

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.[19]

Table 40: Measures of Physical Activity

	LA County	SPA 3	HP 2020
Percent of ***adults*** who obtain recommended amount of aerobic exercise per week (≥150 minutes/week, moderate exercise or ≥75 min vigorous exercise)	65.1%	64.2%	47.9%
Percent of ***adults*** who obtain recommended amount of muscle-strengthening (≥2 days/week)	41.3%	37.3%	24.1%
Percent of ***adults*** who obtain recommended amount of aerobic and muscle strengthening exercise per week	34.1%	31.3%	20.1%
Percent of ***children*** ages 6-17 who obtain recommended amount of aerobic exercise each week (≥60 min daily)	28.5%	28.4%	N/A

Sources: 2016 LA County Health Survey; Healthypeople.gov

The California Health Interview Survey asked slightly different questions, and therefore the information from that source relevant to physical activity does not match the data above. The following table shows the 2016 CHIS data about physical activity. The reader will note that the questionnaire only included items about daily physical activity for children and teens, and walking for transportation and leisure for adults:

[19]. IAR was unable to find current similar data for San Bernardino County

Table 41: Other Measures of Physical Activity

	LA County	SB County	SPA3
Percent ***children*** physically active ≥ 1 hour during at least 5 days in the past week	44.9% *	48.3% *	20.3% *
Percent ***teens*** physically active ≥ 1 hour during at least 5 days in the past week	31.0% *	64.9% *	53.6% *
Percent ***children and teens*** (5 – 17) who visited a park, playground, or open space in the last month	87.2%	89.9% *	91.8% *
≥ 5 hours spent by ***children and teens*** on sedentary activities on typical weekdays after school	14.0% *	16.2% *	29.8% *
≥ 5 hours spent by ***children and teens*** on sedentary activities on typical weekend days	22.6% *	9.5% *	34.8% *
Percent ***adults*** who regularly walked for transportation, fun, or exercise	38.5%	33.0%	37.8%

Sources: 2016 California Health Interview Survey (CHIS)

* Statistically unstable, see Footnote 6 above. This table has some figures that are especially questionable where the confidence intervals are literally 0% – 100%. ***The results should be interpreted with caution.***

Following is the available city-specific data for physical activity in the past week.

Table 42: Physical Activity in the Past Week

CITY	*% 5 – 17 yr olds* ≥ 1 hr of daily physical activity (excluding PE)	*% adults* who walked ≥ 150 minutes
Chino	23.5%	30.6%
Chino Hills	22.1%	27.5%
Claremont	21.3%	32.2%
La Verne	21.4%	31.4%
Montclair	20.8%	29.6%
Ontario	21.5%	30.4%
Pomona	17.4%	31.9%
Rancho Cucamonga	25.2%	28.9%
San Dimas	20.5%	30.2%
Upland	24.8%	29.8%

Source: 2014 California Health Interview Survey, Neighborhood Edition

Domestic Violence

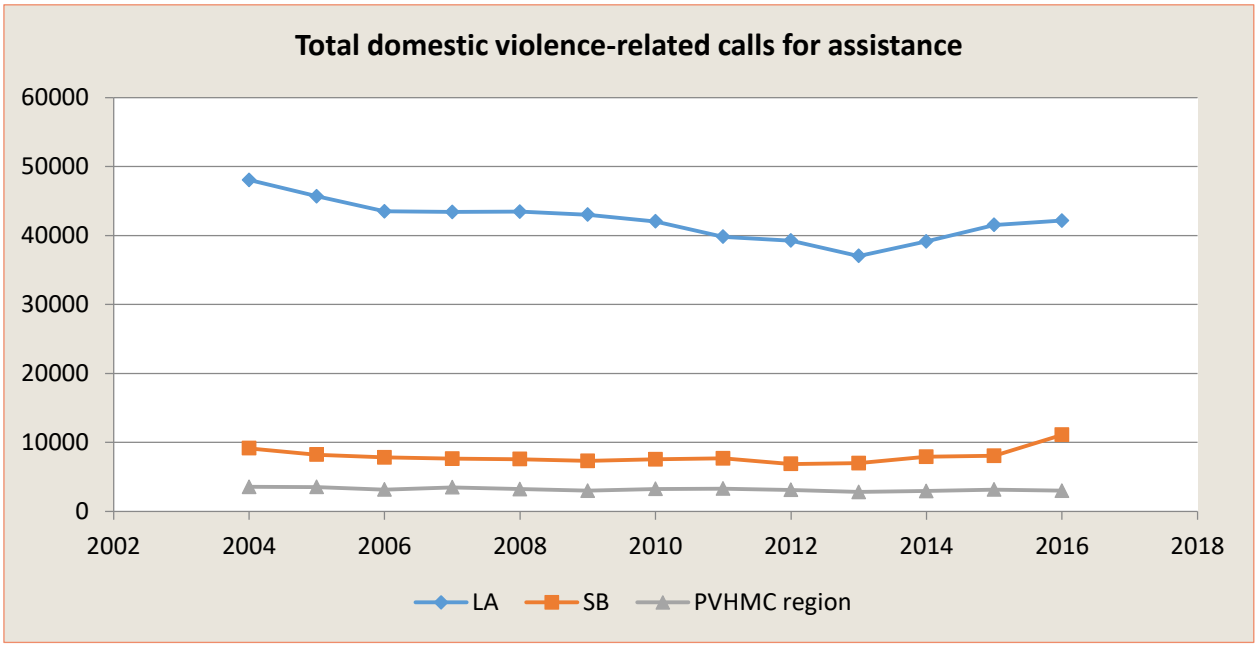
As noted in the introduction to this section of the report, the definition of "health" includes being in a state of physical, social, and mental well-being. Victims of domestic violence suffer immediate trauma, but in addition, the violence can contribute to various chronic health problems (e.g. depression, substance abuse, and hypertension).

As the table below demonstrates, 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. In 2015 and 2016, that downward trend reversed, particularly in San Bernardino County.

Table 43: 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

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



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:

- California Department of Public Health (www.cdph.ca.gov)
- Census Bureau (www.census.gov)
- American Community Survey Five Year Estimates
  http://www.census.gov/acs/www/data_documentation/data_main/

- Healthy People 2020 (https://www.healthypeople.gov/)
- Center for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity (https://www.cdc.gov/nccdphp/dnpao/)
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (http://www.cdc.gov/brfss/)
- Centers for Disease Control and Prevention, Leading Causes of Death (http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm)
- California Health Interview Survey (www.chis.ucla.edu)
- National Center for Health Statistics (https://www.cdc.gov/nchs/fastats/health-care-and-insurance.htm)
- San Bernardino County Department of Behavioral Health (http://wp.sbcounty.gov/dbh/about-dbh/)
- California Department of Health Care Services (http://www.dhcs.ca.gov/provgovpart/Pages/CalOMSPv.aspx)
- National Institute of Mental Health. Suicide in the U.S.: Statistics and Prevention. http://www.nimh.nih.gov/health/statistics/suicide/index.shtml
- The State of Obesity in California Data, Rates and Trends (http://stateofobesity.org/)
- National Cancer Institute (http://www.cancer.gov/)
- Diabetes and Digestive and Kidney Diseases (NIDDK) (http://www.niddk.nih.gov/health-information/health-statistics/Pages/default.aspx)
- American Diabetes Association (http://www.diabetes.org/diabetes-basics/statistics/)
- Cancer Treatment and Survivorship Facts & Figures: 2016-2017 (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)
- American Cancer Society. (http://www.cancer.org/cancer/breastcancer/detailedguide/breast-cancer-key-statistics)
- U.S. Breast Cancer Statistics. (http://www.breastcancer.org/symptoms/understand_bc/statistics)
- Healthy San Bernardino County. Demographics, Statistics, and Tracking
- (https://assessment.communitycommons.org/UserContents/CHNA_Contents/CHNA26296RPT_4.pdf)
- U.S. Health Resources and Services Administration Data Warehouse
- (https://datawarehouse.hrsa.gov/)
- Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality
- (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)
- (http://publichealth.lacounty.gov/gsearch/?cof=FORID%3A11&cx=012881317483563061371%3Avdhgk7yx4bk&q=health+assessment&sa=Go)
- California Office of Statewide Health Planning and Development (OSHPD)
- (http://www.oshpd.ca.gov/HID/)
- FBI Crime Statistics (http://www.fbi.gov/stats-services/crimestats/)
- Bureau of Justice Statistics (http://www.bjs.gov/)
- Domestic Violence Statistics http://domesticviolencestatistics.org/domestic-violence-statistics/

- U.S. Department of Health & Human Services Preventions Surgeon General.gov Reports and Publications (http://www.surgeongeneral.gov/library/reports/index.html)
- California Department of Education Physical Fitness Test, State, County, District Breakdowns (http://www.cde.ca.gov/ta/tg/pf/)
- Youth Risk Behavior Surveillance System (YRBSS) – 2017 data are results are due to be released on June 14, 2018. http://www.cdc.gov/healthyyouth/yrbs/pdf/trends/us_tobacco_trend_yrbs.pdf

Summary of Public Health Executive Interviews

The third component of PVHMC's FY 2018 Community Health Needs Assessment includes interviews of public health officials in both Los Angeles and San Bernardino Counties. IAR conducted an in-depth telephone interview with Ms. Christin Mondy (Los Angeles County SPA3 and SPA4 Public Health Officer) on April 13, 2018, and with Dr. Dr. Maxwell Ohikhuare, San Bernardino County Public Health Dept. Health Officer, on April 18, 2018. The interviews consisted of questions regarding the 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.).

Respondents were asked to identify unmet needs in the community relative to those health need categories, and also indicate which populations are most affected. In addition, they were asked to provide suggestions for meeting the needs of the community.

FINDINGS

Overall, 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.

Support for patients and families (education, support groups, etc.)

One of the ways people can lift themselves out of poverty is education. Hospitals need to **work with educational institutions** to increase high school graduation rates (particularly in terms of low-performing schools). That begins at the elementary school level (improving reading) and continues at the upper levels via vocational training for high paying jobs that don't necessarily require a college education. Hospitals are well-positioned to offer internships and vocational training.

In addition, a huge unmet need for **affordable housing.** The issues of poverty and homelessness need to be addressed through partnerships between legislatures, city leaders, and community based organizations.

NOTE: both of these upstream determinants of health were mentioned throughout the interviews relative to each of the health need categories addressed.

Primary care and preventative health services

Issues in this category included:

- Increase the number of primary care providers in the region. This is a problem for populations across the board, but it especially affects the poverty population, Hispanics and African Americans, the uninsured or underinsured. In addition, immigrants and the undocumented are strongly affected. Suggestions: Bring in more primary care providers, and provide training for primary care providers on providing "culturally sensitive" care. Provide language interpretation services. Conduct outreach to communities of color and immigrant communities, the homeless population, and the undocumented population.
- Expand efforts at getting help for the homeless. Be sure the hospital is involved in partnerships dealing with the issue. Suggestions: do targeted outreach to communities of color and immigrant communities, the homeless population, and the undocumented population.
- Address the rising incidence of sexually transmitted infections (especially among youth). Suggestion: Partner with school districts to offer STD education.
- Address the high incidence of TB due to the large percentage of foreign born and homeless individuals in the area. Suggestions: Provide education and training for medical providers on diagnostic treatment. Work to improve the completion rate for TB preventive treatment so that active TB will decrease.
- Address teen pregnancy. Suggestions: Improve access to family planning for teens, support educational programs in schools, and engage patients to improve preventative care.
- Address poverty. The poverty population is dealing with competing priorities. They work long hours to earn enough money to pay for food and housing, so unless they are extremely sick they won't go to the doctor. Suggestion: Work with other organizations to address poverty.

Chronic disease management

Unmet needs exist for the following diseases:

- Coronary heart disease: The rate has decreased over time, but it is still the leading cause of death. Pomona has high rates of coronary heart disease.
- Obesity (especially for Latinos and African Americans): Pomona has a high rate, both for adults and children.
- Diabetes: The diabetes rate is higher than the rest of LA County (age adjusted rate per 100,000 of 45.3 in SPA3 vs. 21.9 in LA County as a whole)
- Hypertension

Suggestions:

- Use the model of the "LA Partnership." For example, there is a diabetes work group that would be a good group to work with. Best practices/experiences are shared.
- Work with other organizations to address poverty. The more upward mobility a person has, the more able he or she is to be able to deal with (and control) chronic disease.
- Improve preventative care to avoid chronic diseases. People need to "know their numbers." By the time a disease is diagnosed it's too late.

Wellness

Nutrition is a big issue, especially on the east end of the county. The food environment index is really bad (the ratio of healthy food stores to liquor stores, etc.). The population in poverty is the population most affected. People in poverty will eat what they can *afford* (e.g. McDonald's) rather than what is *healthiest*.

Suggestions:

- City leaders should encourage stores that carry healthy foods (at a reasonable price) to locate in neighborhoods where nutrition is an issue.
- Hospitals should promote the fact that people need to pay attention to what they eat (i.e., decrease salt and oil intake). Train people to look at healthy alternatives. Train them to be able to cook some of their favorite ethnic foods in a way that will taste similar but will be healthy. In other words, education is the key! Hospitals can do outreach (i.e. run workshops, cooking classes, etc.) to educate people about healthy eating.
- Hospitals should promote exercise as a bigger component of people's lives. Stress physical activity and reinforce that people don't need to join a gym to exercise. People can walk around the block. Partner with schools to open their fields to the community after hours so that people can come to exercise in a safe environment. Reach out to city planning divisions that are now incorporating healthy places to exercise in their plans (i.e. physical spaces that people can go to walk and exercise).

In terms of smoking: a lot of progress has been made at the national and state levels, but there is still more that can be done. Where possible, work with cities to control tobacco use in public (example, have "smoke-free" parks). Raise the awareness in the community of the dangers of tobacco. Ask, advise, and refer. Take a look at FDA approved cessation services.

It is still unknown what the effects of new legislation on marijuana will be.

Barriers to health

Both respondents noted the following barriers:

- Socioeconomic Barriers; poverty, homelessness
- Undocumented immigrants have difficulty and mistrust; therefore, they are less likely to take care of health, especially preventative health. They will go to clinics to get health care, but they are afraid to go to a hospital due to the perception that they will be at risk if the hospital gets information about their status. This fear makes them delay needed medical treatment. They are able to get outpatient care, but not inpatient care.
- 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

Focus Groups

Introduction

As part of 2018 Community Health Needs Assessment process, two DrPH students at Claremont Graduate University (CGU) were asked to facilitate two focus groups with individuals who work with minority and medically underserved populations and are aware of their unique healthcare needs of these populations. The purpose of the focus group is to gather information from local health leaders regarding the health needs of the community in PVHMC's primary service

area. The focus group environment is designated to create a space where community health leaders can help identify priority health areas. The focus groups generate discussion of health needs of the community including but not limited to primary care and preventative care, support for patients and families, chronic disease management, and wellness. Discussions also included barriers to receiving both routine and urgent health care. The input of these health care leaders helps PVHMC to better understand the unique health needs of those living in PVHMC's service area and seeks to improve the quality of health services available in the region.

Methodology

Design

Based on the previous needs assessment and information received from PVHMC, we created an outreach list based off the hospital's Primary Service area that spans mainly from Pomona, Claremont, Upland, Rancho Cucamonga, and Chino Hills. We searched for organization leaders from CEOs to Directors of Departments. (Please refer to Appendix- Figure 1 for PHVMC Primary Service Area).

Two groups of emails were sent out to the interest groups in this Primary Service area with the invitation letter (refer to Appendix Figure 2). Two sets of mailings were sent out to interest groups whose email contact could not be found. Responses to attend one of the focus groups were mainly received through email although 1 participant confirmed by phone. Reminder emails with logistical information were sent out to each focus group participant several days prior to the focus group meeting to ensure attendance or answer any questions.

Participating Organizations

- Inland Empire Health Plan
- Community Senior Services
- Pilgrim Place
- House of Ruth
- San Gabriel/Pomona Regional Center
- Tri City Mental Health Services
- ParkTree Community Health Center
- Inter Valley Health Plan
- Project Sister
- Upland New Health Center
- PHFE WIC
- City of Montclair- Human Services

Summary of Focus Group Design

PVHMC offered two focus groups in order to accommodate various work schedules. The focus groups were conducted in the evenings of April 5, 2018 and April 12, 2018 at Pomona Valley Hospital Medical Center. The sessions ran for approximately 90 minutes, and participants discussed the health needs of the community--primary care and preventative care, support for patients and family, chronic disease management, and wellness. An additional discussion sought to explore barriers to receiving both routine and urgent health care. On April

5, 2018, PVHMC and the CGU-DrPH students had the opportunity to meet with eight community leaders and on April 12th they met with six community leaders. Combined, a total of 14 community leaders represented the homeless, low income, youth and adults, disability and seniors, and domestic violence victims. Each organization provides direct services and resources such as; health education, nutrition, and wellness programs for the youth and seniors; primary care services; acupuncture services; comprehensive healthcare for individuals of all ages; comprehensive services for seniors' emergency food and shelter; working with victims of emotional and physical trauma in need of counseling intervention, shelter, transitional housing, and anger management services; and medical and Medicare enrollment.

Before the focus group began, each participant was provided with a packet that included a Consent Form (Refer to Appendix), Survey Instrument (Refer to appendix), list of questions, and a ranking exercise.

Summary of Focus Group Findings

The following is a brief summary of themes and responses to the two focus groups:

Question 1 Responses (Support for Patients and Families):

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

- There is a need for more gerontologists to understand the needs of the senior population
- There is a need for more case management regarding senior services, especially regarding discharge protocol
- The use of promotoras would be useful to better communicate health care to families of different cultural backgrounds
- Having a patient advocate accompany individuals who need help navigating their care would be beneficial
- Trauma patients may not respond well to support group settings
- Connections and awareness of resources available in the community is needed
- Knowing your community and that education is a "rich man's sport"
- Educate people where they are already at (grocery store, library, government agency, etc.)
- Health education may not be a priority of community members given social circumstances (education level, need to work or care for family members

Question 2 Responses (Primary Care and Preventative Health Services):

2. In the area of primary care and preventative health services in our community, can you identify any unmet needs in the community?

    A. Which populations do you believe are most affected?
    B. Do you have any suggestions on how to meet the needs of our community in this area?

- Educate and walk patients through the process of their medical care in language and terms they can understand; forms in large print for senior population
- Informal or Formal partnerships can generate liaisons on patient advisory to serve and work with the hospital.
- Create informal partnerships for patients of particular needs (ie: sexual assault). A trained staff member could help navigate sensitivity in their care
- Generate resources lists of community based organizations surrounding the hospital and follow-up with sites if services/resources provided
- Increase the promotion of screenings to help people become more comfortable with medical services.
- Trust Building in the Community for health services through community programs, health fairs, and farmer's market.
- Telemedicine
- Bring back better vision/ hearing screenings at schools
- Address the dilemma with the opioid crisis and individuals who come in just to get their prescription drugs
- There is a need for mental health urgent care for behavioral health
- Need more psychologists, more psychiatrists, and medication management specialists
- Need more addiction recovery specialists
- Address issues with referral agencies needing patients to fully transfer over to them
- There are a low number of child beds at health centers in the local area
- Create incentives for low income communities to come get these preventive screenings (ie. Parktree gave gift cards during holidays to come get pap smears)
- Enhance continuity and continuum of care; dashboard of resources and services received for the patients

Question 3 Responses (chronic disease management):

3. In the area of chronic disease management, can you identify any unmet needs in our community?

   A. Which population are most affected?
   B. Do you have any suggestions on how to meet the needs of our community in this area?

- Incorporate follow-up phone calls for seniors to check on their health and well-being
- Homeless populations at risk for chronic disease, but may feel stigmatized to come in for care
- Educate police and fire departments of what to look for regarding health issues related to chronic disease
- Be aware of the health needs of domestic violence survivors such as fibromyalgia or neurological trauma
- Awareness of LGBTQ health needs and action taken to address
- Broaden the definition of chronic diseases to bring in the topic of mental health and addiction

- Be aware of the social determinants such as transportation and the effort and time it takes a someone without a vehicle to get around on public transportation to get to a variety of appointments (and if they have kids with them too)
- Access to healthy foods and the struggle with farmers markets that are often too expensive for small amounts of food

Question 4 Responses (wellness):

4. In the area of wellness (nutrition, physical activity, smoking, etc.) can you identify any unmet needs in our community?

A. Which populations do you believe are the most affected?
B. Do you have any suggestions on how to meet the needs of our community in this area?

- EBT cards often cover more fast food and unhealthy products making healthy eating difficult for low-income adults and families
- Promotion of local food pantries/ farms for low-income residents
- Free cooking classes for low-income communities with ingredients they could actually afford
- A "How to Shop" course at food pantries
- Use community health workers to promote wellness in low-income populations and paying them
- Utilize health education classes to promote positive mental health (coloring classes, Zumba, and physical activity classes)
- Pomona Farmers Market 1st/2nd Saturdays in June 7:30am-11:30am where those on WIC receive $20 for fruits/vegetables (WIC partnership with First 5)
- Acupuncture as an alternative method to smoking cessation

Question 5 Responses (any other unmet health-related needs):

5. Can you identify any other unmet health-related needs in our community that we did not mention?

- Health needs of undocumented citizens who are nervous and distrust their names being in any system due to ICE (instances of people coming to organizations and hospital to have their name cleared from system)
- Creating best policies and practices that all community health organizations strive to work by so that the same message is being echoed throughout the community
- Educating via radio which is popular among Spanish communities
- Protecting patients from Medicare fraud
- Sex workers in Pomona and the STI issue it presents to the workers and the community

Barriers to Health Responses

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?

- Trust
  - Current political climate
- Education
- Transportation
- Knowledge of resources
- Homelessness
  - Move around
  - criminalization
- Language Barriers
- Cultural Understanding
- Motivation
- Money
- Underlying causes
  - Low income; poverty
  - Health not a priority
- Keep primary care out of ED
- Coordinate with FQHC
- Have Urgent Cares open longer (have the right types of care open at the appropriate hours)

Suggestions and Additional Comments:

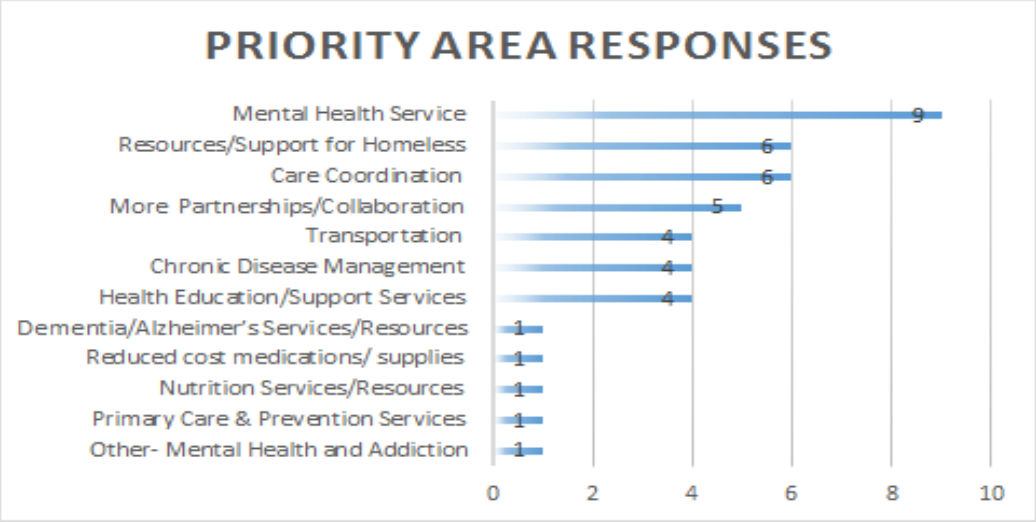
Do you have suggestions from other agencies in which PVHMC can work with to meet the needs of our community? Other Comments?

- Investing more in afterschool programs
- Creating a PVHMC cookbook for healthy food options
- Influences of the current political climate
- More attention on helping the homeless populations
- Constant trainings to ensure vulnerable population medical information remains private
- Host Community Organization meetings at hospital site for networking and awareness of services and resources
- Hospital to attend community partner meetings
- Resource/service guide

Ranking Exercise

Out of 24 possible choices for the ranking exercise with options to add open ended comments, the focus groups selected 12 that they considered a ***significant unmet need and should be considered a priority***. The chart below illustrates the top priority choices and number of responses from the focus group participants for each priority area.

Priority Area Responses from Focus Group Participants.



After tabulating the top 3 priorities for the focus groups as a whole, the findings were as follows:

1. 64.3% reported Mental Health as a priority
2. 42.3% reported Care Coordination and Resources/Support for Homeless Populations as a priority
3. 35.7% reported more Community Wide Partnerships/Collaboration as a priority

Conclusion

The focus groups conducted contributed to a better understanding of the specific needs that these local community health organizations have. Each focused group was comprised of members from health plans, senior services, sexual assault, social services, mental health, and disabilities. This diverse group allowed different community perspectives to be shared for each of the questions. Representatives had the opportunity to brainstorm solutions and to network with each other. The focus group facilitators were able to record and take notes on these discussions to examine the top themes. The most common themes in both discussions were 1) **chronic disease management in terms of mental health**, 2) **access to care in terms of homeless, low income and medically underserved populations**, and 3) **health education and support services through increased community-wide partnerships and collaboration**. With this information, PCHMC is better informed and prepared to better utilize the available resources in the community.

Summary of 2018 Needs Assessment Findings

Overall, nearly two-thirds of telephone survey respondents rate their health as "excellent" or "good." This figure has remained relatively stable over time. As IAR has recommended in the past, PVHMC may want to increase its outreach efforts to the community in an effort to improve the health and wellness of residents in its service area. Secondary data shows that the percent of 18 to 64-year olds rating their health as "fair" or "poor" has decreased in Montclair and Ontario

(cities which had the highest rates of poor health in 2011-2012). That is encouraging, and hopefully the hospital (in cooperation with CBOs and primary care providers) can continue and expand upon these successes.

The telephone survey revealed that as might be expected (given the Affordable Care Act), more people are now covered by health insurance than was the case in the 2009, 2012, and 2015 surveys. That said, many people are still concerned about the cost of health care, and the survey indicates that cost remains the number one barrier to receiving needed health services. And secondary data show that the percentage of insured adults is lowest in the cities of Montclair, Ontario, and Pomona, so special attention should be placed on those areas.

One of the big takeaways from this community needs assessment was the need to focus on obesity, nutrition, exercise, and "healthy living." For example, the phone survey revealed that there is interest in support groups and/or classes dealing with healthy eating and nutrition. Considering that cholesterol, high blood pressure, obesity, and diabetes were also mentioned by phone survey respondents as ongoing health concerns, it is encouraging that there appeared to be a call for education in these areas – something that PVHMC can easily provide. To validate these results, secondary data show that the incidence of obesity has significantly increased (especially in San Bernardino County) since 2011-2012. The data also show high proportions of individuals who ate fast food in the past week. And in San Bernardino County, the percent of teens who ate the recommended number of daily servings of fruits and vegetables is extremely low while the percent of adults without the consistent ability to be able to afford food is quite high (especially in Montclair, Ontario, and Pomona). All of these issues were reinforced during the executive interviews. The executive interviews also highlighted the need to focus on the social determinants of health and health equity.

Prioritized Health Needs

PVHMC's Community Benefit Committee reviewed the 2018 Community Needs Assessment and through analysis of primary, secondary, focus group and public health input received, **the following were identified as significant health needs in PVHMC's primary service area:**

- Mental Health
- Care Coordination Services/Patient Navigators
- Resources/Support/Outreach for Homeless
- Chronic Disease
    - Diabetes
    - High Blood Pressure; Cardiovascular Disease
    - Mental Health
- Disease Prevention & Education
- Obesity & Weight Management
- Nutrition Education and Support Groups
- Physical Activity Programs
- Access to Affordable Preventative and Specialty Healthcare Services/Access to No-Cost Screenings
- Primary Care, Psychiatry, and Gerontology Providers
- Awareness of Available Resources in the Community

Major Influencers of Health Identified (Social-Determinants of Health):

- Health Insurance Status (city-specific)
- Cost of Healthy Food/Access to Healthy Food (city-specific)
- Poverty/Economic standing
- Education level
- Language and Cultural Barriers as Influencers of Trust

Input was solicited through 1) primary data collection: 319 community-member telephone survey, two focus groups, and two executive interviews with Los Angeles and San Bernardino County public health departments, and 2) secondary data from a multitude of local, state and national resources. All solicited feedback and data was assessed in detail and used by PVHMC in identifying significant community needs and setting priorities.

The identified needs above were prioritized and grouped into the three overarching areas:

- *Chronic Disease*
- *Obesity*
- *Access to Care*

Table 44, below, shows Pomona Valley Hospital Medical Center's prioritized health needs:

PRIORITY AREA	COMMUNITY HEALTH NEED PRIORITIES
1. **Chronic Disease**	Diabetes High Blood Pressure Mental Health
2. **Obesity**	Free Classes & Support Groups targeting Nutrition, Weight Management, and Physical Activity Affordable, Healthy Food Access
3. **Access to Care**	Access to Primary Care, Specialty Care, & Mental Health Providers Improved Awareness of Services & Resources Care Coordination/Patient Navigation Services Homeless Outreach

Prioritization Process

Health needs identified in our CHNA were determined to be significant through evaluation of primary and secondary data, whereby those identified health needs were prioritized based upon: (1) community respondents and key informants identified the need to be significant, or largely requested specific services that they would like to see Pomona Valley Hospital Medical Center provide in the community (2) feasibility of providing interventions for the unmet need identified in the community, in 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.

Implementation Strategy

In support of PVHMC's 2018 Community Health Needs Assessment (CHNA), and ongoing Community Benefit Plan initiatives, Pomona Valley Hospital Medical Center's FY2018 – FY2020 Implementation Strategy documents the priority health needs for which PVHMC will address in the community and translates our CHNA data and research into actual strategies and objectives that can be carried out to improve health outcomes. PVHMC determined a broad, flexible approach was best as strategies and programs for community benefit are budgeted annually and may be adjusted as new programs are developed. Accordingly, the Implementation Strategy will be continuously monitored for progress in addressing our community's health needs and will serve as a tool around which our community benefit programs will be tailored.

Priority Area 1: Chronic Disease Management

Identified Community Need: High Blood Pressure, Diabetes, Mental Health

Strategies to address this need:

- Provide glucose screenings at health fairs and events (local and on-campus)
- Provide free or low cost diabetes, weight management and nutrition education classes and resources
- Provide education to promote cardiovascular health and risk reduction
- Offer blood pressure screenings at health fairs and events (in-community and on-campus)

- Publish information on stroke, cardiovascular health, diabetes, cancer treatment, and available resources to address these conditions
- Provide 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
- Provide Cancer Care Patient Coordinators (Navigators) and Social Services to guide patients with making appointments, receiving financial assistance, and enrolling in support groups

Anticipated Impact: Through the above strategies, PVHMC anticipates the following improvements in community health over time: 1) reduced prevalence rate of targeted chronic diseases, 2) increased awareness about self-management tools, and 3) increased awareness of risk factors associated with targeted chronic diseases, and 4) improved community-wide program collaboration to address health needs

Metrics and/or Methods of Evaluation:

- Number in attendance at health fairs and events in which PVHMC participates; number of screenings performed
- Number of publications distributed; number or sources and avenues in which PVHMC promotes what is offered to the community
- Number of participants in cardiovascular, diabetic, and cancer classes, support groups, and lectures provided by PVHMC

Priority Area 2: Obesity

Identified Community Need: Education, Classes and Support Groups targeting Nutrition, Weight Loss/Management and Physical Activity

Strategies to address this need:

- Collaborate with community partners and participate in community-wide initiatives centered around obesity, diabetes, and food/nutrition
- Develop free or low-cost education, resources, and/or classes that promotes healthy eating, disease prevention, and weight loss/management

Anticipated Impact: Through the above strategies, PVHMC anticipates the following improvements in the health of our community: 1) increased awareness of disease-specific risk factors, early intervention, and prevention strategies, and 2) improved awareness of community benefit programs offered at PVHMC and throughout the community

Metrics and/or Methods of Evaluation:

- Number of classes, workshops, and support groups and other designated community benefit programs PVHMC provides to the community
- Number of community participants in attendance *or aware* of the programs that are available to them
- Community feedback

Priority Area 3: Access to Care

Identified Community Need: Access to Primary and Specialty Care, Access to Mental Health Services, Care Coordination/Patient Navigation

Strategies to address this need:

- 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
- Continue to increase PVHMC's capacity to care for patients needing emergency treatment, trauma services, surgery, and primary care
- Continue providing enrollment assistance in appropriate health plans for our community's vulnerable populations

Anticipated Impact: Through the above strategies, PVHMC anticipates the following improvements in community health: 1) increased access to emergency, specialty, and primary care, 2) increased awareness of established resources available in the community to meet health needs, and 3) increased insurance coverage

Metrics and/or Methods of Evaluation:

- Number of patient encounters among general, specialty, and community outreach services
- Number of new and recurring community partnerships established
- Number of immunizations and screenings provided in the community
- Amount of transportation services provided; Amount of medical device and medication assistance provided

Evaluation of the Impact of Actions Taken to Address Needs - 2018

As a non-profit organization, Pomona Valley Hospital Medical Center takes pride in our commitment to continuously strive to improve the status of health of our community. Even so, PVHMC's vast efforts in promoting community health, and dedication to providing *"Expert Care with a Personal Touch"* serves as an opportunity to examine some of our current programs, strategies, and successes. Taking a close look at specific actions that PVHMC has taken to address priority health needs identified in prior Community Health Needs Assessments, PHVMC's brief evaluation of the anticipated impact is documented here.

Although this list is *not* comprehensive and a more complete listing of all of PVHMC's actions and services can be found in PVHMC's Community Benefit Report and Implementation Strategy on our website (pvhmc.org), the following list summarizes PVHMC's actions since our previous CHNA:

- Education both verbal and in print at various health fairs and within PVHMC's community classes to raise awareness about cardiovascular health, diabetes, cancer, emergencies (CPR) including risk reduction.
- Diabetes Program Outreach, specifically, collaboration with the UniHealth Foundation, Claremont Graduate University and ParkTree (federally-qualified health center) to research prevalence of diabetes and pre-diabetes in the community, providing education and screenings(500 blood tests in 2017) at the following:
    - Cardenas Health Fair
    - Hilda Solis Health & Wellness Fair
    - PVHMC Stroke Awareness Day
    - PVHMC Charity Car Show & Health Fair
    - San Gabriel Regional Health Fair
    - Women's Health Fair, hosted by Assemblymember Freddie Rodriguez
    - Pomona Diabetes Month Health and Wellness Fair-Lyons Club
    - Mount San Antonio Gardens – Diabetes Evening Lecture for all Residents
- Stroke Program outreach to local community, providing in-community education about signs and symptoms of stroke emergencies, what-to-do in an emergency, and risk reduction. Community outreach included:
    - Glendora After Stroke Program
    - LA County Fair
    - Side walk CPR
    - Community Nursing Homes
    - Community Senior Services
    - Community Caregiver Day
    - Engage Local Schools in Primary Prevention
    - High Schools
    - Elementary Schools
    - Community events
    - Concerts in the park
    - "Children's Art for Heart" with local schools
    - "Power of Red" Event
    - AHA Heart Walk
- Cancer Care Program outreach, including cancer care navigators, multiple programs and support groups offered to meet the needs of the community and to aid them through cancer diagnosis, treatment, and recovery. Programs offered:
    - Women with Cancer
    - Look Good…Feel Better Support Group
    - Pomona Valley Ostomy Association
    - Leukemia/Lymphoma Support Group
    - Bereavement/Loss Support Group
    - When Cancer Enters Your Life
    - Cancer Treatment Fatigue.
    - Integrated Wellness Arts
    - Stretch and Yoga
    - No cost Wig Program

- Clinical research trials are currently in progress in the areas of Breast Cancer, Gastrointestinal Cancers, Head and Neck Cancers, Lung Cancer, Symptom Management, and Prostate Cancer. Additionally in 2017, a 19 person research study began, looking at Gene Expression, Meditative Movement and Emotional Distress. Background and Objectives:
- Cardiac Rehab and Fitness Gym
- Maternal Fetal Transport Program (Access to Specialized Care)
- Wellness Farmers Markets in PVHMC's parking lot
- Hospital tours to local schools, students and community-based organizations
- Sports Medicine Evening Clinic; Pre-sports physicals that raise money for local high school sports programs
- Community blood drives
- No cost car seats and infant clothing for new moms in need
- No cost flu shots in a mobile community setting
- In-kind support to ParkTree FQHC for startup dental service needs.
- Homeless Recuperative Care Program
- Women's and Children's Services no-cost classes open to public including breastfeeding support, CPR, sibling support and preparation, new father support and "boot camp training",
- As part of our Trauma Center designation, PVHMC is expanding its injury prevention program to decrease the incidence of trauma. Programs in development include fall prevention for the elderly, violence outreach and prevention, and pedestrian safety and distracted driving, for example. PVHMC already participates in a program to reduce drunk driving in the teenage population, and we provide car seat safety information to new mothers and families. Improving safety throughout the community is a very important part of our Trauma Center's role.

Anticipated Impact

Through PVHMC's efforts and strategy to meet the growing health needs of our community, we have previously anticipated, and continue to anticipate through current actions, the following impact on the health of the community:

- reduced prevalence rate of targeted chronic diseases,
- increased awareness of risk factors associated with targeted chronic diseases,
- increased awareness of early intervention and prevention strategies,
- increased access to emergency, specialty, and primary care, and
- increased awareness of resources available in the community to meet health needs

Evaluation of Impact

Evaluating primary and secondary data in our most recent Community Needs Assessment, including public health and focus group input, compared to previous needs assessments, findings indicate the following areas of health improvement in the community:

- The percentage of community members who have received cholesterol testing, mammograms and colon cancer screenings has increased since PVHMC's last assessment. Among those that had not received all recommended screenings within recommended time periods, the predominant reason was being too old/too young for the test, no time or too busy, or didn't think it was important or necessary. Additionally, the 2018 needs assessment revealed that Hispanics received pap smears and mammograms more often than non-Hispanics, but were tested at lower rates for cholesterol and colon-cancer. PVHMC will continue to

seek out ways to further increase the numbers of community members receiving preventative health screenings and providing education on the importance of regular recommended screenings.

- Most respondents reported that they keep up with regular doctor visits. That is, 80.0% of them said they had visited their doctor for a general physical exam (as opposed to an exam for a specific injury, illness or condition) within the past year, a figure that has been relatively stable across the last few CHNAs. Another 11.4% had received a physical exam within the past two years, an increase from 8.6% in 2015. Furthermore, the percentage of people who had a physical exam within 5 years or more than five years ago has decreased from 2015 to 2018, an encouraging figure.
- In the 2015 report we noted that there were significant differences in health insurance coverage based on demographics such as age, ethnicity, income, or education. We reported that older people, as well as people with higher incomes and education, are the most likely to have households where all adults are covered. Further, in 2015, non-Hispanics were more likely than Hispanics to have coverage for all adults in the household. The 2018 data show similar trends; however, the differences are no longer statistically significant. The "gap" is closing, probably due to the implementation of the Affordable Care Act. Through PVHMC's participation in the hospital presumptive eligibility program and the trained Covered California representatives in place at the hospital, we will continue our work and efforts to further increase insurance coverage in our community, which in turn will provide residents better access to established primary care and hospital services.

The needs assessment demonstrates areas in which there remain unmet needs:

- Although the assessment indicates an increase in the percentage of community members who have received mammograms, cholesterol testing, and colon cancer screenings since PVHMC's last assessment these percentages are currently below recommended Healthy People 2020 targets, and demonstrates there is still a need for promoting the benefit and availability of health screening tests.
- Percentage of respondents who said they or a family member diabetes or high blood pressure increased significantly from 2015 to 2018. PVHMC has taken significant actions to address Diabetes and Cardiovascular Health and Stroke in the community, and combined with the increase in health insurance coverage, PVHMC believes the significant increase in respondents reporting diabetes and high blood pressure is likely related to the increase in reported recommended screenings and physical exams. Thus, respondents who likely were unaware they were living with these conditions may now be aware. Even so, these figures demonstrate a significant need for services, classes, and partnerships with local non-profits to address Diabetes and High Blood pressure needs as well as raise awareness about prevention.
- More than 40% of respondents believe the best way to provide information about disease prevention is through doctor's office visits. In addition to doctor's office or hospital, respondents reported the public schools, community events, and through internet are the best locations and/or sources to share disease prevention information. This provides PVHMC with some ideas about how to best address the need of "raising awareness about services" and "disease prevention education."
- 40% of respondents would like to see PVHMC offer classes related to healthy eating and nutrition, followed by diabetes, weight management, cancer, high blood pressure, and mental health or depression. Considering that cholesterol, high blood pressure, obesity, and diabetes were mentioned as top health concerns, it is encouraging to see that the community has a desire for education in these areas.

Our evaluation of the anticipated impact of our actions and strategies further looked at both successes as well as areas in which the Hospital might consider future strategies to meet additional needs. The conclusion of the evaluation was as follows:

PVHMC will –

- continue providing free and partial payment hospital services for those without the ability to pay or limited financial resources
- continue reaching out to our local schools and community groups on the importance of healthy living
- continue providing medical services in underserved areas through free and community based clinical services
- continue providing yearly vaccinations and screenings to children and the elderly
- continue training health professionals like Family Medicine residents and nursing students in order to meet the needs of the future, especially in medically underserved areas
- participate in continuous review of PVHMC's Implementation Strategy to gauge the success of community benefit strategies
- continue working collaboratively with other community groups (i.e. local public health departments, community based clinics) to optimize PVHMC's outreach efforts,
- seek to identify where gaps in services exist and identify opportunities for additional partnerships
- continue to meet with community groups and stakeholders to gather input that will be helpful in outlining PVHMC's Community Benefit programs and activities
- consider future community benefit programs in the areas of Alzheimer's/Dementia, health literacy, financial and insurance education, transportation, and other programs identified as a need or suggested by community members and stakeholders

Consideration of Comments from Previous CHNA and Implementation Strategy:
PVHMC widely published its previous CHNA (FY 2015) both in print and on the PVHMC website. Although PVHMC did receive requests for copies of the CHNA and provided those at no cost upon request, PVHMC did not receive written public comments/questions related to the previous Needs Assessment or Implementation Strategy.

Community Partners

Pomona Valley Hospital Medical Center invests in partnerships with community organizations that share our mission and vision for serving the diverse ethnic and cultural needs of our community. It is essential to work closely to help strengthen our community and create solutions. We are very fortunate to have partnered with the following organizations over the years to address the health needs of our community:

- American Cancer Association
- American Heart Association
- American Stroke Association
- American Health Journal
- American Red Cross
- Auxiliary of PVHMC
- Bright Prospect
- Boys and Girls Club of Pomona
- CAHHS Volunteer Services
- Cal Poly Pomona
- Casa Colina Hospital for Rehab Medicine
- Chaffey College
- Chino Kiwanis
- Chino Hills Chamber of Commerce
- Chino Valley Unified School District
- Chino Valley YMCA
- Claremont Chamber of Commerce
- Claremont Hospice Home
- Community Senior Services Board
- Firefighters Quest for Burn Victims
- IEHP
- International Association for Human Values
- InterValley Health Plan
- Kids Come First Community Clinic
- Ladies Plastic Golf Association
- Loma Linda University

- Meals on Wheels
- Mount San Antonio College
- National Health Foundation
- Pomona Chamber of Commerce
- Pomona Host Lions Club
- Pomona Rotary
- Pomona Unified School District
- Pomona Valley YMCA
- Project Sister
- St. Lucy's Benedictine Guild
- The Learning Centers at Pomona Fairplex
- Upland Kiwanis
- Western University of Health Sciences
- YMCA of San Gabriel Valley

Additional resources and organizations PVHMC has identified to potentially address the health needs of the community:

- East Valley Community Health Center
- Mission City Community Clinic, Pomona
- Planned Parenthood, Pomona
- Chino Valley Medical Center
- Montclair Hospital
- San Antonio Community Hospital
- Community Hospital of San Bernardino
- Kaiser Permanente, Baldwin Park and Fontana
- House of Ruth
- Prototypes
- Pomona Valley Health Center, Chino
- Pomona Valley Health Center, Chino Hills
- Pomona Valley Health Center, Claremont
- Family Health Center, Pomona
- Pomona Community Health Center
- Arrowhead Regional Hospital
- Loma Linda University Medical Center
- St. Bernardine Medical Center
- San Dimas Community Hospital
- Citrus Valley Health Partners

ADDITIONAL RESOURCES THAT PVHMC HAS IDENTIFIED TO POTENTIALLY ADDRESS THE HEALTH NEEDS OF THE COMMUNITY CAN BE FOUND IN APPENDIX D

FY 2018 Focus Study and Progress Report

As a non-profit organization, Pomona Valley Hospital Medical Center (PVHMC) takes pride in our commitment to continuously strive to improve the status of health in our community, reaching out to meet health needs by:

- Providing free and partial payment hospital services for those without the ability to pay or limited financial resources
- Reaching out to local community groups on the importance of healthy living
- Providing medical services in underserved areas through free and community based clinical services
- Training health professionals like Family Medicine residents and nursing students in order to meet the needs of the future

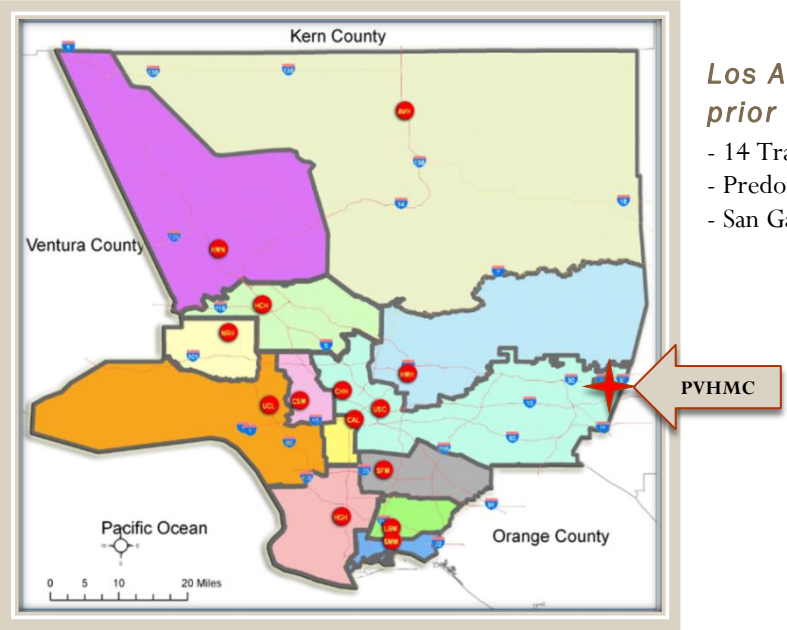
Pomona Valley Hospital Medical Center's vast efforts in promoting community health and dedication to providing ***"Expert Care with a Personal Touch"*** serves as an opportunity to evaluate some of our programs and identify our successes in meeting the needs of our community this past year. While the Implementation Strategy and Community Benefit Report provides a comprehensive overview of the array of programs and services PVHMC provides to address the health needs of the community, specific programs PVHMC has chosen to recognize and highlight in the 2018 Community Benefit Plan, demonstrating our dedicated work in addressing key priority areas, are:

- Trauma Services – Priority Area 3 (Access to Care)
- Stroke Care – Priority Areas 1 & 3 (Chronic Disease & Access to Care)
- Diabetes Care – Priority Area 1, 2, & 3 (Chronic Disease, Obesity & Access to Care)

Trauma Services

Responding to the Needs of our Community

For more than two decades, the eastern Los Angeles County region has lacked a trauma center — at its peak in 1985, the county's trauma center network included 22 hospitals spread strategically throughout the county. But many hospitals shut down their centers because of funding problems, leaving only 14 to treat more than 25,000 patients a year. A state audit found that the closure of trauma centers in the 1980s left parts of the county, including Malibu, the eastern San Gabriel Valley, and large portions of the Antelope Valley without nearby trauma centers. The audit specifically recommended That Los Angeles County (LAC) increase efforts to open a trauma center in the eastern San Gabriel Valley. With a clear lack of coverage in the geographic region and the political will in response to the state audit, the county issued a request-for-proposal with a competitive bidding process. PVHMC, as a nationally recognized Hospital, confident in our ability to provide a strong service and committed to our mission to meet the needs of the communities we serve, submitted a bid. After a thorough evaluation, PVHMC's application was selected and the Hospital was invited to join LAC Trauma Network. PVHMC's Trauma Center has served a total of 3,835 since its opening in 2017.



Los Angeles County Trauma Network, prior to PVHMC's designation:

- 14 Trauma Centers in LAC (PVHMC is now the 15th)
- Predominately placed in the west side of LAC
- San Gabriel Valley was uncovered:
  - 30 miles west to LAC USC
  - 30 miles south to UCI
  - 30 miles east to Arrowhead

What is a Trauma Center?

Trauma centers are equipped to treat life-threatening injuries 24- hours per day, seven days a week. Unlike regular hospital emergency departments, trauma centers must meet many rigorous standards established by the American College of Surgeons (ACS). That includes having a specially trained trauma surgeon at the hospital around the clock. PVHMC has eight trauma surgeons who are double-board certified in general surgery and surgical critical care. They are supported by elite orthopedic surgeons, neurosurgeons, and anesthesia coverage. PVHMC also has:

- Immediately available operating rooms
- Staffed and available CT scanners
- Trauma-trained nurses and technicians
- Surgical critical care capabilities
- Around-the-clock blood bank operations

Community Programs and Services

In preparation for our Trauma Center designation, we created nearly 200 new healthcare jobs, including specialty trained Trauma, Orthopedic, Neuro, and Maxillofacial surgeons along with nurses and other specialty trained service Associates. We have invested nearly $100 million in major capital improvements and new technology, including an expanded Emergency Department, a Trauma Intensive Care Unit, and a helipad for aerial transports. The Hospital's Trauma designation and community programs are a tremendous achievement and benefit to the community.

To target motor vehicle accidents:

- **HAM Program:** This is a Driver under the Influence (DUI) court-ordered program that is in collaboration with PVHMC and the Coroner's office to reduce recidivism in DUI convictions. Classes are offered monthly at PVHMC. Classes are two 8 hour days; one spent in class at PVHMC and the other is a trip to the LA county Coroner's office. Between August 2017 and December 2018, a total of 217 individuals participated in this program.

- **Every 15 Minutes:** In an additional effort to further reduce motor vehicle accidents and DUI's PVHMC facilitates and hosts this drinking and driving demonstration for local high schools to educate students on the dangerous effects and consequences of driving while under the influence and promote safe driving practices. This demonstration begins when an auto-accident is staged offsite, then students are then transported to the hospital for education and discussion, and the program concludes with a visit to the hospital morgue.

To prevent death from over-bleeding:

Stop the Bleed Program: In collaboration with local schools and police, the Stop the Bleed program is designed to train community members on how to use tourniquets (bands that help control bleeding) to prevent deaths from life-threatening bleeding wounds. Initiated after Sandy Hook in 2012, and the Hartford Consensus, this program prepares community members to respond, and helps those wounded, in the event of an active shooter or emergency event. Since the start of the program in 2018 a total of 220 individuals have been trained by the trauma service

Future:

Upcoming programs include the Matter of Balance program for fall prevention for the elderly, violence outreach and prevention, and pedestrian safety and distracted driving, for example. Improving safety throughout the community is a very important part of our Trauma Center's role.

Stroke Care

Along with our improvements in providing access to emergency care, Pomona Valley Hospital Medical Center (PVHMC) has a long history as a regional leader in innovative stroke treatment. The Stead Heart and Vascular Center at PVHMC is committed to providing advanced clinical care for patients and families in the midst of a health crisis. Our care has been nationally recognized for saving lives by the American Heart Association of Cardiovascular Pulmonary Rehabilitation, American Stroke Association, HealthGrades, and several other independent national organizations.

Recognizing that stroke is the 5th leading cause of death in the United States and the 2nd leading cause of death in Los Angeles County[1], it is clear why cardiovascular health appeared as a priority health need in PVHMC's 2018 Community Health Needs Assessment. In response to these findings, PVHMC's Stead Heart and Vascular Center embarked on a project to address this critical need and made a commitment to proactively fight stroke with education, coordinated care, and rapid-response treatment.

Beginning in 2009, the Los Angeles County EMS Agency established a "Primary Stroke Center" approach to transporting patients, directing EMS providers to bypass local community hospitals and take stroke victims to Primary Stroke Centers. This meant that the residents of Pomona Valley experiencing a stroke would be transported more than thirty miles west of the Pomona Valley, with transport times during peak commute traffic of more than 60 minutes. The coordination of care for San Bernardino County Stroke victims was even more dismal with very limited services spread across the largest county in America. Understanding that the catchment area between primary stroke centers includes a population of approximately 1.8 million people, PVHMC recognized that the residents of Pomona Valley were significantly underserved and burdened by the threat of traveling such distance to receive treatment.

Seeking to reduce the prevalence of stroke in our community, and recognizing the value of *accountability* to our patients, PVHMC developed numerous quality improvements in regard to stroke care, and in 2018, received the Gold Seal of Approval[1] and certification by the Joint Commission as a Comprehensive Stroke Center. Comprehensive Stroke Center certification reflects PVHMC's commitment to meeting the health needs of our community, and means our patients can rely on us to provide them with high-quality stroke care, coordinated from the first point of contact.

Achieving comprehensive regional stroke certification included efforts by PVHMC to expedite stroke treatment, improve processes in care, enhance education, and provide outreach services to the community. PVHMC's Stroke Program developed algorithms to provide the best coordinated care pathway for our patients, from the moment of arrival to the moment of discharge.

Our multidisciplinary approach to stroke care includes:

- Communication between the ambulance and PVHMC before the patient arrives at the Emergency Room
- Advancements of the "Stroke-Alert" announcement have been made throughout the hospital, whereby a dedicated team – including a stroke nurse – is sent to the emergency room to facilitated rapid stroke care and ensure that the patient is immediately taken to the CT scan and lab results are completed within 45 minutes
- A multidisciplinary team of highly trained medical professionals, including ED Physicians, specially trained Nurses, Neurologists, Phlebotomists, Therapists, Radiologists, and other respond quickly to the needs of a stroke patient. PVHMC holds the perspective that everyone is part of the team and has an equally critical role in our stroke patients' care
- A minimum of 8 annual specialized training hours for nursing associates in stroke units and the Emergency Department

- In the incidence of ischemic stroke, administration of thrombolytic medication (intravenous tPA) to restore blood flow to the brain, administered within 60 minutes of arrival. Administering tPA (tissue plasminogen activator) within the first 4.5 hours of the onset of stroke symptoms can significantly minimize death or disability
- Thrombectomy: Prior to 2018, the standard guidelines for the treatment of stroke recommended the clot busting drug for patients arriving within 3-4.5 hours of symptom onset as well as the potential for thrombectomy (clot removal) for patients arriving within six hours of stroke onset. A monumental research study published in 2017 however changed this time line and drastically improved the odds for stroke patients presenting to our hospital after 6 hours of stroke symptom onset. The DAWN trial demonstrated that blood clot removal from the brain up to 24 hours after stroke led to improved outcomes and reduced disability for selected stroke patients. PVHMC implemented this evidenced-based care early in 2018 with the advent of Stroke Alert Level I for patients presenting within 3-4.5 hours of symptom on set and Stroke Alert Level II for those patients presenting between 6 and 24 hours of stroke symptom on set
- "The right care at the right time"; a dedicated Stroke Coordinator meets with the patient daily after admission to the hospital, helps the patient navigate health needs, discuss level of care and rehabilitation, and follows up with the patient after discharge
- Stroke rehabilitation within 24 hours after treatment can prevent stroke-related complications and improve health outcomes. The Case Managers assist with discharge planning for the patient and provide support and resources for families and recovering patients are offered access to PVHMC's Wellness Gym
- Life after Stroke New Beginnings; a group for stroke survivors and those who care for and about them. Having a stroke is a life altering experience. Support groups are a great way to meet other stroke survivors and care partners who understand what you are going through. Our mission is to enhance the lives of survivors and care partners through self-help education and supportive discussions
- Community education and risk reduction

Although PVHMC is not obligated to do so, we choose to report our outcomes in the national Get With the Guidelines® Stroke Database, whereby PVHMC continuously adheres to the latest scientific treatment recommendations. Our participation on a national level, comparing ourselves against other Primary Stroke Centers across the United States, speaks to the integrity of our program.

2018 Stroke Program Progress Report

In addition to neuro-interventional services, the Hospital provides 24-hour, 7-day a week, 365-day a year coordinated stroke services that includes emergent and acute neurology and neurosurgical care. We offer stroke rehabilitation, stroke education and a regionally recognized stroke support group. PVHMC is the first Hospital in our region to be designated as a Comprehensive Stroke Center by LA County and just one of 169 hospitals out of the 5,500 hospitals across the nation.

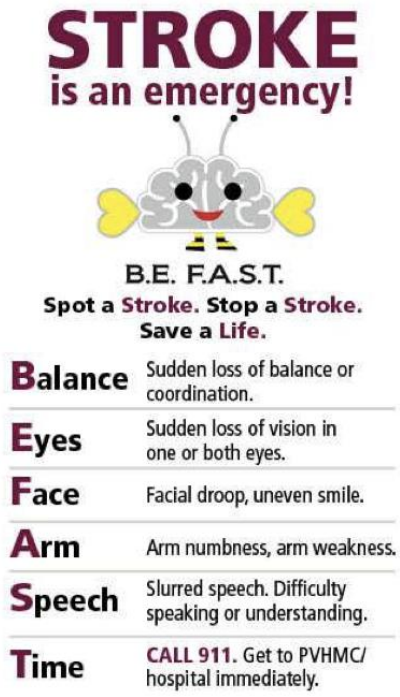
Emergency Medical Systems Collaboration

PVHMC works with the San Bernardino County Fire Department, Los Angeles County Fire Department, and other local fire departments as a synchronized team to save lives. As a specialty receiving center for stroke and heart attack patients, paramedics will call PVHMC and talk to a specialty nurse in the Emergency Department who is designated to take their calls. The paramedics describe the injuries and the nurse provides treatment instructions and activates the stroke alert team at the

The Joint Commission
American Heart Association
American Stroke Association
CERTIFICATION
Meets standards for
Comprehensive Stroke Center

2018 GET WITH THE GUIDELINES STROKE
GOLD PLUS

PVHMC. Once treatment is rendered, patients are cared for in a stroke designated united with specialized training nursing staff to future provide care to this unique population. The role and collaboration with the Emergency Medical System (EMS) responders and the PVHMC Emergency Department (ED) is a crucial element of the PVHMC's stroke program. EMS and ED providers have representative membership on PVHMC's Neuroscience Committee and PVHMC also has a designated Pre-Hospital Coordinator Registered Nurse to provide EMS/paramedic education.



Education and collaborative outreach includes:

- Base station meetings
- Paramedic training
- Firehouse visits/in-services
- Annual EMS breakfast; sharing outcomes, celebrating success
- Community-based events
- Local hospital/EMS transfer/transport contracts

Patient and Caregiver Education

Education and risk reduction outreach are part of our commitment to preventing future strokes and improving the health of the community. Education includes multilingual education publications, free monthly education support groups, and hosting community events to conduct screenings and raise stroke awareness. Specific patient and caregiver education in 2018 included:

- *Stroke Discharge Education Tool*
  - Stroke packet available in 4 different languages
- *Support Groups*
  - New Beginnings: "Life After Stroke"
  - Support for care partners and stroke survivors
  - Meets twice a month
- *Biannual Celebration of Health*
  - Held in the summer and winter
- *Primary Prevention*
  - Risk assessment
  - Screening
  - Stroke Survivor Day: "Many Faces of Stroke"
- *New Beginnings Newsletter*
- *Promotion of Stroke Awareness Month*

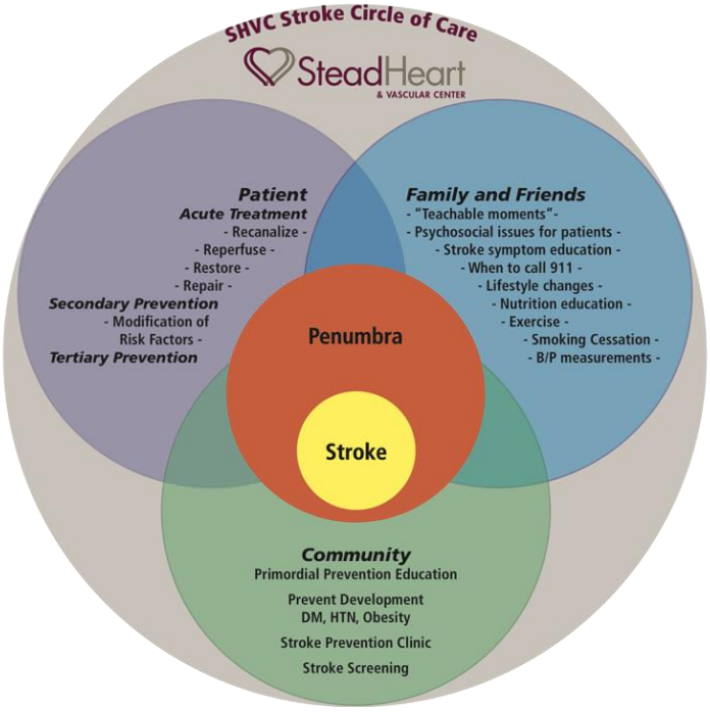
Community Education

The PVHMC Stroke Program team also reaches out to the local community and provides in-community education about signs and symptoms of stroke emergencies, what-to-do in an emergency, and risk reduction. Community outreach included:

- Glendora After Stroke Program
- San Gabriel Valley Chinese Cultural Center
- LA County Fair
- Community Nursing Homes
- Community Senior Services
- Engaged Local Schools in Primary Prevention
- Community events
- Cardiovascular Rehab and Fitness Gym with balance training, occupational therapy, speech therapy, and physical therapy
- PVHMC's Education Campaign that helps the community spots the signs of stroke "BE FAST"

Sharing our Program:

- Hospital website
- Hospital publications
- Staff bulletin boards
- Electronic physician newsletter
- Management meetings
- Department meetings
- Medical staff meetings
- PICC meetings
- Board meetings
- Auxiliary meetings
- Foundation meetings
- HealthCares magazine
- 3rd Annual Neuro Symposium "Above and Beyond Stroke Care"



POMONA VALLEY HOSPITAL MEDICAL CENTER

3RD ANNUAL NEURO SYMPOSIUM

Above and Beyond in Comprehensive Stroke Care

Saturday, October 27, 2018
8:00 am to 12:30 pm

DoubleTree by Hilton Ontario Airport
Grove Ballroom

POMONA VALLEY HOSPITAL
MEDICAL CENTER
STEAD HEART & VASCULAR CENTER

Life AFTER STROKE
New Beginnings

A group for stroke survivors and those who care for and about them

Having a stroke is a life altering experience. Support groups are a great way to meet other stroke survivors and care partners who understand what you are going through. Our mission is to enhance the lives of survivors and care partners through self-help education and supportive discussions.

WHEN?
Every second and fourth Thursday of the month from 10 to 11:30 am

WHERE?
Pomona Valley Health Center

WHO?
All stroke survivors, care partners and families are invited to attend.

Pomona Valley Health Center
1601 N. Monte Vista Avenue, Claremont 91711
For more information call
909.865.9823

POMONA VALLEY HOSPITAL
MEDICAL CENTER
STEAD HEART & VASCULAR CENTER
pvhmc.org

POMONA VALLEY HOSPITAL MEDICAL CENTER

Join Us!

2018 Stroke Awareness Day

Celebrating The Many Faces of Stroke

- Blood Pressure Screenings
- Stroke Risk Assessments
- Signs and Symptoms of Stroke and What To Do
- Showcasing the Newest Technology in Stroke Diagnostics
- Recreational Adaptive Equipment
- Support and Resources for Caregivers
- After Stroke Care Programs
- Light Refreshments and Nutritional Information

This day offers stroke survivors, families, caregivers and our community a day of celebration, education, awareness and fun with our knowledgeable and dedicated stroke team

Sat., May 19, 2018
9:00 to Noon
PITZER AUDITORIUM

Please RSVP by calling 909.865.9983

Pomona Valley Hospital Medical Center's Stroke Program is certified as a Primary Stroke Center by The Joint Commission the foremost accrediting body in healthcare in the United States. Awarded to centers that pass a rigorous on-site review and a thorough examination of the program and patient care, the certification recognizes the center's commitment to following national standards and guidelines that can significantly improve outcomes for stroke patients.

POMONA VALLEY HOSPITAL
MEDICAL CENTER
STEAD HEART & VASCULAR CENTER
Expert care with a personal touch
pvhmc.org

POMONA VALLEY HOSPITAL MEDICAL CENTER 2018

MAY IS Stroke Awareness Month

May 1 **Celebrate "Comprehensive Stroke Center" Certification with Ice Cream**
2:00 pm to 4:00 pm Days / 9:00 pm to 11:00 pm Nights
Pitzer Auditorium

May 1 **Dr. Desai presents at Tuesday Noon CME - Stroke Program Update**
12:00 Lunch • 12:30 Presentation
Pitzer Auditorium

May 15 **Stroke Education Day**
Stroke Program Coordinators will visit the Stroke Units to test your stroke knowledge. Join the game, win a prize

May 19 **Annual Stroke Awareness Day**
This ***free*** community events provides Stroke Education not only for the Stroke Survivors—it is also for the family and friends of those that have experienced a stroke and their Caregivers.
9:00 am to Noon • For more information or to RSVP call 909.865.9983
Pitzer Auditorium

May 22 **Nursing Symposium**
Neurological Assessment by Dr. Srinath Samudrala, Neurosurgery
Deficit and Disability in Acute Ischemic Stroke by Christy Casper, MSN, ANP, AG-ACNP
Register on "My Net Learning"
7:30 am Registration / Breakfast
8:00 am Lecture
10:00 am Conclusion

May 30 **Wear Your Brain Hat Day**
Are you creative, artistic, musical, logical?
Wear your hat, test your knowledge with those around you. Treats for those we see wearing their Brain Hat.

The Joint Commission · American Heart Association · American Stroke Association
CERTIFICATION
Comprehensive Stroke Center

pvhmc.org

For more information call
909.865.9983

POMONA VALLEY HOSPITAL
MEDICAL CENTER
STEAD HEART & VASCULAR CENTER
Expert care with a personal touch

Diabetes Care 2015- 2018

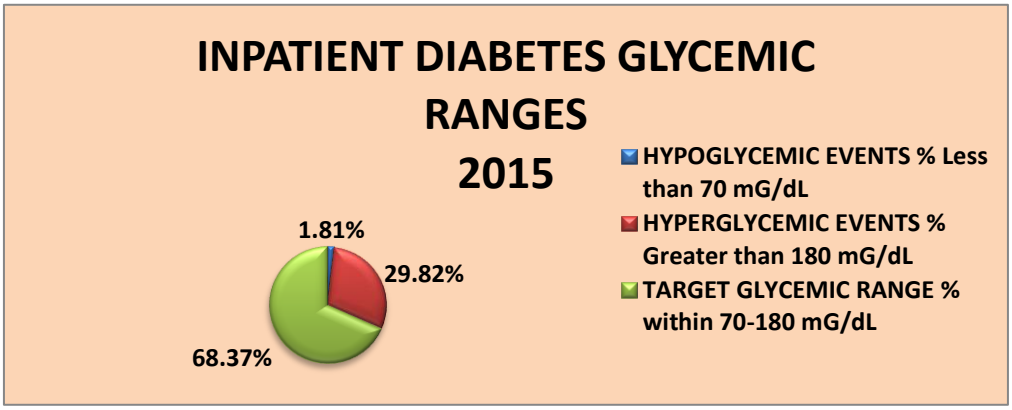
Stopping Diabetes in its Tracks (SDIT)

Type 2 Diabetes (T2D) is a growing problem. It has tripled over the last decade and it is anticipated to triple over the next several decades (CDC, 2015). Approximately 9.3% of Americans have diabetes; 90-95% of which is T2D. This equates to 21 million individuals diagnosed with Diabetes (CDC 2014 Report Card on DM). More so, it is estimated that 8.1 million individuals are undiagnosed (CDC 2014 Report Card on DM). This is a staggering number, and prediabetes diagnoses are also on the rapid rise.

Furthermore, in PVHMC's 2015 Community Health Needs Assessment, approximately 25.9% said that they or a family member were living with a diagnosis of either Type 1 or Type II Diabetes. This percentage is in alignment with estimates of the prevalence of diabetes within the patients discharged from PVHMC with an existing or new diagnosis of Diabetes (average of 25% of patients discharged from PVHMC). We know, however, this is likely to be an underestimate given that until now there has been no routine screening for diabetes across hospital services. Most of the known T2D cases also suffer from comorbidities, including especially cardiovascular disease. The incidence of high blood pressure (42%), obesity (21%, likely a low estimate), and arteriosclerosis (32%), were also significant in our community responses. Such data paints a poor prognosis for the residents of Pomona and the surrounding communities. It is for the reasons above that PVHMC identified Diabetes as a priority area to address in the community.

To further explore the need to manage and prevent Diabetes and take actionable steps to improve the health of our Community, PVHMC in partnership with the Pomona Community Health Center (PCHC), implemented diabetes screenings for patients. Although data on prediabetes and diabetes in hospital, clinic, and community populations in Pomona Valley are sparse and fragmented given the lack of routine screenings in any of those settings until now, we present here the best data available. Out of 1673 adult patients seen in the Pomona Community Health Center in the 6-month period January 6 – July 6, 2015, 28.3% were diabetic. On June 17th of 2015, we began testing/collecting A1C values on all adult admissions to medical-surgical and telemetry units of PVHMC. Since that date, 395 tests were performed on this population. Of the 395 tests performed, 207 patients had a value range between 5.7-6.4, approximately 53% of those tested. However, although in partnership we were able to effectively screen and educate more than 2000 residents, no ***community-based*** general diabetes screenings have been carried out in Pomona region communities to date. Community based prediabetes screenings in a similar population in nearby communities of Riverside County revealed a prediabetes rate of 34.1% in adults, increasing with age, and a combined overweight/obesity rate of 85% regardless of age, further supported PVHMC's decision to make Diabetes management a priority for our Community.

Figure 1. PVHMC Inpatient Diabetes Glycemic Ranges 2015



Stemming from our 2015 CHNA, PVHMC's Implementation Strategy highlighted actionable strategies to address Diabetes and other chronic diseases such as high blood pressure and heart disease in the community. These strategies included, but not limited to, providing free glucose screenings on campus and out in the community, providing free or low cost diabetes education, weight management and nutrition education, providing cardiovascular education and risk reduction resources. Working with our Community Partners, we will be able to make this strategy a reality.

Through the collaborative efforts of PVHMC, the Pomona Community Health Center (PCHC), Claremont Graduate University (CGU) and the Community Translational Research Institute (CTRI), we will examine the feasibility of population-based screenings for three different patient populations of interest to the intervention(s) we are planning—(1) individuals who meet the criteria for prediabetes (A1C = 5.7-6.4 for adults, and two or more of obesity, familial risk, and A1C (5.3-5.8) for children), 2) individuals who have undiagnosed T2D (A1C above 6.5 for adults and 5.8 for children), and 3) individuals already diagnosed with diabetes who exhibit poor adherence in the management of their disease (A1C >9.0). These screenings will help us understand the true prevalence of the disease at three critical stages (pre-, early-, and advanced/uncontrolled T2D) in each of the three populations (hospital, clinic, and community), and guide the design of the interventions we will propose for each population and disease stage. Once implemented, the intervention designed during this planning phase will: a) prevent and delay progression from prediabetes to T2D, b) prevent/delay progression from early stage diabetes to advanced stages with co-morbidities, and c) improve the control of advanced cases of diabetes in the patient populations of Pomona Valley Hospital Medical Center (PVHMC), its related Pomona Community Health Center (PCHC), and the communities they serve. There will be a lifespan approach concentrating first on adults at risk of disease progression, and second on children and adolescents at high risk of developing T2D in the short and long term. The unique inclusion of children and adolescents in our pilot testing and screening (and as-needed interventions) addresses one of our greatest hopes, extrapolating a goal from our project title, "Stopping Diabetes in its Tracks."

With additional support from the UniHealth Foundation, PVHMC and its partners have begun the planning process to develop and test this data-driven, integrated and sustainable 3-level prediabetes and diabetes-screening program which will lead to developing an intervention that translates evidence-based approaches to obesity and diabetes prevention and control into effective and sustainable programs. During the 9-month period we will undergo extensive planning efforts that help to set the stage for effective and efficient implementation of an intervention that addresses important health needs within the community of Pomona. To achieve these ends, we will develop the leadership structure, team organization, and operational procedures necessary to achieve the screening, intervention, and evaluation objectives during the implementation phase. In an effort to develop the most cutting-edge and effective intervention for this community context, our team will also translate existing evidence-based approaches to obesity and diabetes prevention and control into the final intervention we propose for implementation. This novel, approach will facilitate the identification of an intervention that is carefully tailored to the community of interest and capable of identifying and empowering individuals who face the greatest risk and have the greatest need for an effective approach at managing diabetes.

Key activities of our planning process are to:

a. Develop a structure and process of program leadership and organization

b. Identify team functions and form collaborative teams integrating key personnel from the participating organizations: PVHMC, PVHC, PCHC, CGU, and CTRI. These teams are:

- Leadership team
- Screening team
- Intervention team
- Evaluation team

c. Explore additional community resources that may be needed for effective screenings and program implementation (e.g., community centers, churches, schools that have facilities in which the team can perform screenings as well as facilities such as kitchens and recreational facilities that will help to support other key intervention components)

d. Carry out a pilot test of population screenings to assess feasibility in hospital, clinic, and community settings, and do a preliminary assessment of the prevalence of prediabetes and T2D in the populations of those settings.

e. Conduct screenings of at least 100 adults in each – the Hospital, the Health Center, and in community settings, and at least 50 children at PCHC. Actual numbers of persons screened could be much higher in the hospital and clinic, at least for adults.

f. Perform a process evaluation specifically examining the participation rate in the screening pilot and reasons for high/low participation.

g. Scan clinic and hospital data to quantify the number of individuals who have been previously diagnosed with diabetes and persons with other risk factors and co-morbidities, including obesity and hypertension.

h. Use Geographic Information Systems to identify "hotspots" and "cold spots," and consider using smart phones to communicate with patients in order to encourage behaviors that should lead to better outcomes. Hotspots would be of two types: large clusters of fast food and conveniences stores that might lead to unhealthy eating and clusters of areas in which people live that have a high concentration of individuals with diabetes and prediabetes. Cold spots include clusters of locations such as: (1) farmer's markets and other healthy eating venues and (2) places where individuals can exercise.

i. Develop a plan to meet the objectives of the ultimate program we will propose to the UniHealth Foundation and prepare a grant proposal accordingly.

j. Develop an evaluation plan - Utilize the general approach outlined in the *CDC Framework for Program Evaluation in Public Health* (1999) to develop an evaluation plan. Engage team and other stakeholders (as appropriate) in describing the intervention, its intended outcomes, and causal pathways. Specifically:

    - Delineate the intended outcomes of the intervention. This includes performing a literature review and hosting discussions with principal investigators of similar intervention approaches to understand what types of outcomes we would anticipate arising as a result of our efforts and the timing of such outcomes (e.g., do they occur 1 month, 6 months, 1 year after intervention exposure).

    - In collaboration with the planning team and other stakeholders (as appropriate), delineate the hypothesized causal pathways between intervention implementation and outcomes. Similar to the identification of outcomes, this step will also leverage information already available for similar evidence-based interventions regarding presumed causal pathways.

Ultimately, the aim of the planning grant period is to design a program that will significantly reduce the prevalence and severity of untreated TD2 though an integrated screening, intervention and adherence program, specifically develop an intervention that will lead to the following:

- Active and sustained patient participation in an integrated program of classes, coaching and technology to reduce risk through lifestyle modification, leading to
- Reduction in BMI
- Reduction in A1C
- Reduction in Blood Pressure
- Reduction in medication(s) to manage DM
- Improved Kidney function
- Lipid reduction
- Reduction in prevalence of T2D in the hospital, clinic, and community populations (measureable in the long run if not within the period of this grant funding)

Specific health-related needs being met by this project include:

a. Identification of adults (over age 21) who are pre-diabetic by A1C (5.7-6.4%) criteria and introduction of prevention interventions to forestall the development of T2D.

b. Identification of children and adolescents (ages 5-21) who exhibit high levels of known risk factors for T2D, including two or more of obesity, A1C=5.3-5.8, and at least one parent who is known to be diabetic or prediabetic

c. Identification of previously unknown cases of T2D (adult A1C>6.4, child A1C>5.8).

d. Identification of individuals with poorly controlled T2D (A1C > 9.0)

e. Reduction of cardiac and neurological risks through improved glycemic control, weight loss and lipid reduction.

f. Recruitment of identified prediabetics and diabetics into an evidence based program for diabetes prevention and control

g. Reduction in the use and cost of services including fewer inpatient hospitalizations, fewer emergency room visits.

h. Reduction and/or better control of comorbidities.

i. Improved adherence to medication management and lifestyle changes. Benefits include: reduced risk of heart attack and stroke, the development of cardiovascular and kidney disease and the development of autonomic neuropathy disorders.

Type 2 Diabetes is preventable, primarily by control of body weight as evidenced by trials in the U.S., Finland, and China. There is evidence that the risk of T2D can be reduced as well by effective blood pressure and lipid control, and by reduction of exposure to environmental pollutants, especially tobacco smoke. In addition to our efforts to address Diabetes, as described above, we will adapt the best evidence based strategies for obesity control for all, and for BP, lipid, and tobacco smoke exposure where appropriate. Our screenings will add the important component of identifying the impact that the above have on adults as well as children and adolescents and address the other Chronic Disease risk factors and causes that give diabetes a foothold.

2016-2017 Progress

Through the support of the UniHealth Foundation, this consortium of healthcare organizations and academic institutions, further supported by two affiliated organizations, has completed a successful feasibility study and planning process to pave the way for a comprehensive and integrated (community, clinic, hospital) program. This ambitious plan is to prevent and control obesity and type-2 diabetes in a high risk, underserved population. Although created for Pomona, the program is designed to be scalable and replicable for other communities. Toward these ends, the consortium successfully met all of the proposed *Planning Grant* objectives fully or in large measure.

The consortium established strong inter-institutional working relationships and developed an evidence base to support the need for, and approach to, the goal of improved population health outcomes through reduced risk and prevalence of type 2 diabetes. The team is poised to produce the full grant proposal to UHF in March that will describe the outreach and intervention implementation project designed for 2017-2020.

What follows in this 2016 summary update is a description of the challenges faced, an explanation of what was accomplished in the *Planning Grant,* and a framework of what we plan to propose for moving forward. This summary highlights the accomplishments realized through productive inter-institutional collaboration in the face of a number of expected and some unanticipated challenges. The capacity of the consortium for carrying out a full implementation program is greatly enhanced by its proven ability to adapt to a variety of challenges, solve problems in a collaborative way, and find creative solutions that take mutual advantage of the resources found at the member institutions.

Planning and Collaboration

Beginning June 2016, general meetings were replaced by the Implementation and Assessment Team (IAT) meetings to develop implementation and measurement protocols and monitor coordinate the demonstration screenings. Sub-teams, consisting of community, clinic, hospital and evaluation teams, met and carried out work specific to their individual objectives in the interim periods between IAT and General Meetings. Graduate students and staff from CTRI and CGU filled out the Community and Evaluation teams, and medical, nursing and administrative staff filled out the Hospital and Clinic teams. The IAT, then, became the organizational structure for the inter-institutional collaboration that led to the successful feasibility demonstrations and planning for a full program implementation.

Assessment and Screening

Geographic Information Systems (GIS) and an Environmental Scan (ES) were completed in 2016 as part of the general assessment of the Pomona community; both maps were used in combination to better understand resources and possible barriers to health for Pomona residents. In order to accomplish this, CTRI used ArcGIS to construct a map using publicly available administrative data (e.g. Business census). The map included several categories of data, such as grocery stores, fast food outlets, restaurants, Federally Qualified Health Centers, pharmacies, schools, parks, smoke/vape shops, and bars. A 5-minute drive-time analysis was conducted for the two screening sites to ascertain the geographic area in which residents in our targeted community would be most likely to purchase food or receive relevant services. As seen in prior efforts in GIS mapping, administrative databases do not always accurately reflect the current landscape. This is where an Environmental Scan becomes an important tool to "Ground truth" onto what is displayed in a GIS map derived from archival data, by verifying the archival data against new data points derived from direct observations in the field. Furthermore, mapping in this way can be useful for intervention development and evaluation by informing potential interventions in regards to food and recreational access and barriers, and availability of related community resources.

After receiving approval of the Pomona Valley Hospital Medical Center (PVHMC) IRB to conduct screenings, each of the screening teams (PVHMC, Pomona Community Health Center (PCHC), and community) initiated their respective

trainings and screenings. Development of the screening and research protocols were built upon protocols developed previously by CTRI and were collaborative among the community, clinic, and hospital teams.

The hospital followed the general format of the community screening protocol, but was unique in many ways. Same with the clinic, the hospital did not need to identify screening sites; instead, PVHMC patients were the target population. The hospital setting allows for first hand encounter of those suffering from the catastrophic physiologic and financial effects of diabetes and how a collaborative team can affect change for the future of those at risk for diabetes.

Findings

The hospital A1C reports from Jan. 1 – Dec. 10, 2016 had total A1C readings for 11,292. From these patients, 31.8% were prediabetic (A1C=5.7-6.4%) and 24.6% were diabetic (A1C>6.4%). From the prediabetic patients, 100 of them consented to participate in the study. Participants' measurements were collected from their medical chart, and were surveyed. Majority of this participants were male (56%), while 46% were female. The mean age was 56.8 (Std. Dev.=14.1), with ages ranging from 24 -88 years old. This population of participants consisted mostly of Latino or Hispanic people (54%), while 31% were White. Majority of participants were married (35%), and had a high school degree (33%). The ADA risk score and a 10-item survey were administered. Eighty three percent of participants scored equal or higher than 5; which indicates a higher risk for type-2 diabetes. From the 10-item survey, 35% did not engage in moderate physical activities, and 20% currently smoke. From the physical measurements, calculated Body mass index (BMI) among our participants showed that 26% were overweight (BMI=25-29.9), and 49% were obese (BMI≥30) and 22% were hypertensive.

At the Pomona Community Health Center (PCHC), a total of 102 adults and 26 children were screened. For adults, 63.7% were female and 36.3% were male. Participants age ranged from 18-71 years old with a mean age of 41.8 (Std. Dev.=11.7). This population of participants consisted mostly of Latino or Hispanic people (78.4%), while 13.7% were White. Majority of participants were married (40.2%), and had a high school degree (34.3%). The ADA risk score and a 10-item survey were also administered. Almost 68% of participants scored equal or higher than 5; which indicates a higher risk for type 2 diabetes. From the 10-item survey, the majority (35.3%) engaged in moderate physical activities 4-6 days a week and 15.7% currently smoke. From the physical measurements, calculated Body mass index (BMI) was obtained and we found that 36.6% were overweight (BMI=24-29.9) and 48% were obese (BMI≥30). A1C levels were also collected where 17.6% were prediabetic (A1C=5.7-6.4%) and 3.9% were diabetic (A1C>6.4%). Blood pressure measured 13.7% of our samples were hypertensive.

A total of 26 children were also screened at PCHC and only physical measurements (weight, height, blood pressure, and A1C levels) were collected. The age range of children screened was 5-17 years old, 53.8% were male and 46.2% were female. BMI criteria indicated that 15.4% were overweight and 23.1% were considered obese. A1C levels showed that 7.7% of children screened were prediabetic (A1C=5.7-6.4%).

Finally, in the community, two screening sites were selected: (1) Renaciamiento Community Center, a highly populated area surrounded by multiple apartment complexes located in the Angela and Chanslor streets; and (2) Philadelphia Elementary School (Pre K-6 grade). A total of 40 participants were screened in the community where 72.5% were female and 27.5% were male. Age of these participants ranged from 19 to 74 years old, with an average age of 47.4 (Std. Dev. = 13.2). Our sample was predominantly Latino or Hispanic (92.3%), 53.8% were married, 46.2% had a high school degree and 53.9% were below 100% of the Federal Poverty Level (FPL). Information on insurance coverage was also collected and we found that 33.3% had Medi-Cal and 35.7% were uninsured. Anthropometric measures, A1C and cholesterol levels were also collected and we found that 35.9% were overweight (BMI= 25-29.9), 48.7% were obese (BMI≥30), 67.5% were obese using waist circumference (WC) criteria (WC>35" for females, and WC>40" for males).

From the A1C tests we found that 17.5% were newly diagnosed prediabetic (A1C=5.7-6.4%), and 7.5% were newly diagnosed diabetic (A1C>6.4%), and 32.5% of the participants were hypertensive. Readings for total cholesterol (TC) showed that 40% had borderline high levels of TC (200-239mg/dL), 60% had low High-density lipoprotein (HDL <40mg/dL), 37.5% had high levels of triglycerides (200-499mg/dL). Furthermore, glucose levels showed that 57.1% of the participants were within the 100-125mg/dL range indicating an increased risk for diabetes.

Developing an Intervention Plan

After thorough research and discussion with biweekly meetings regarding the various interventions to be instituted for diabetes prevention and diabetes management, the partners favored the Centers for Disease Control and Prevention program, National Diabetes Prevention Program (NDPP), in particular, the new PreventT2 curriculum launched in March 2016 that expands on the original 2002 Diabetes Prevention Program (DPP) trial and follow-up studies for the prevention of type 2 diabetes (T2). This new curriculum promotes modest weight loss (5%-7% of current weight if overweight or obese) and increased physical activity through a 12-month lifestyle change program and is ideal for the Pomona Community. The curriculum also reflects new literature on self-efficacy, physical activity, and diet.

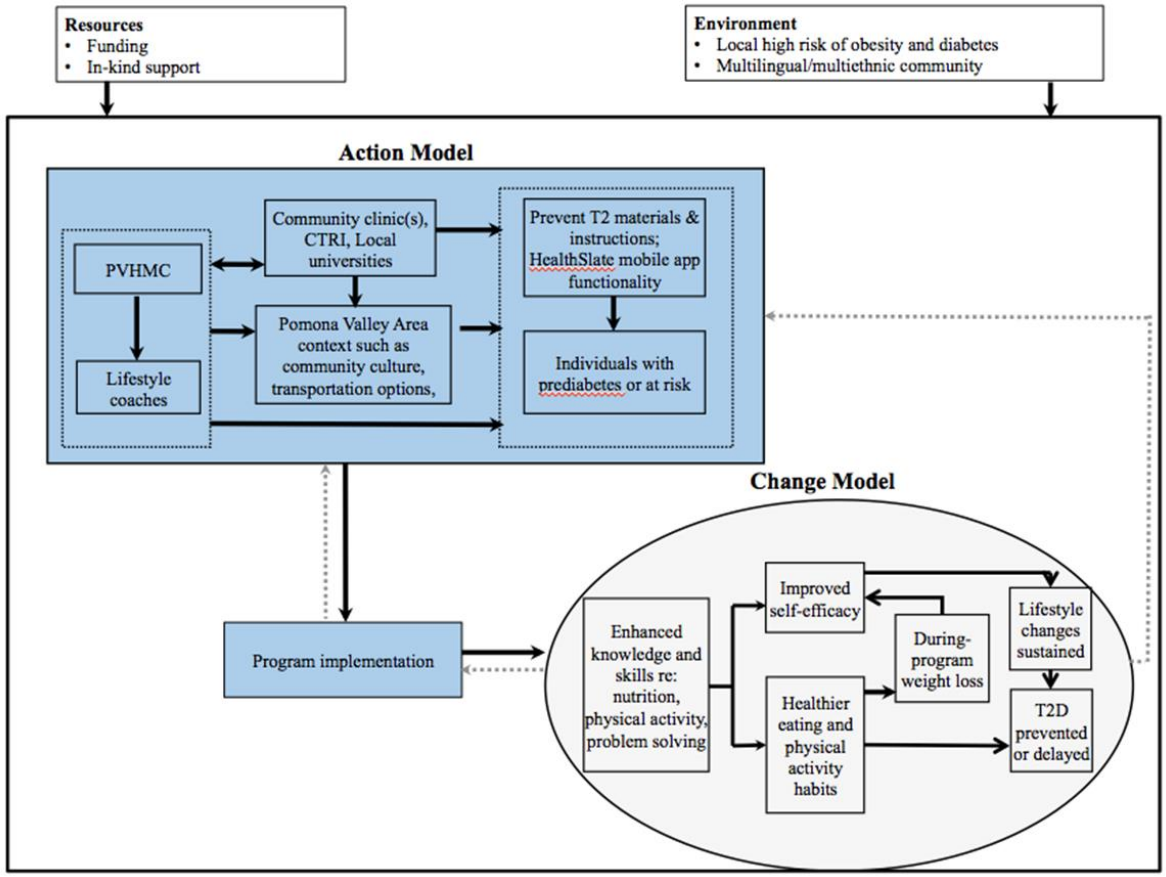
Because culture plays an integral role in people's food choices and lifestyle decisions, lessons will be tailored to the Pomona population. Spanish language curriculum will be available and the interventions modified to meet the needs of the interventional group. As well, witnessing the success of the nearby Diabetes Free Riverside Intervention (DeFeR), we plan to take these lessons learned and basic program components and translate the intervention to the Pomona Community with modifications. Our program will utilize a partnership between community members, hospital and clinic staff, as well as volunteers, as educators and health coaches.

Our goal is to personalize the program based on participant needs, desires, and cultural preferences. As well, adding a more structured exercise component utilizing exercise tracking wearable technology, applications, and additional exercises courses for participants. In the past we have used community volunteers to provide group exercise classes to community members to coordinate with in-class NDPP sessions. Utilizing the process used in our screening protocol, described above, we will refer and enroll eligible and willing participants in a 1-year program consisting of a minimum of

20 courses including diet and lifestyle intervention modules, taken in a group setting. In addition to the traditional in-person courses, the intervention assessment team is also exploring alternative meeting locations including virtual classrooms and application-based programming which utilizes the NDPP via smart phone applications.

In-line with CDC Diabetes Prevention Recognition Program guidelines and with agreement of the intervention team, we will supplement existing NDPP T2 curriculum to fit our audience and cover topics of specific importance to diabetes prevention and overall health. The T2 curriculum addresses one of our concerns by decreasing somewhat the heavy emphasis on dietary fat intake. Additional agreed upon enhancements include information about the basic principle of glycemic load and introduction of a tool for choosing lower glycemic foods over higher glycemic index foods, discussion on intuitive eating, recognizing the 'why' of food choice and mood versus hunger, the use of activity tracking devices to enhance and encourage physical activity as well as virtual and/or in-person activity sessions, use of local food market tours, and limited virtual home-visits to provide feedback on the home food environment.

The Change Model, depicted below describes some of the presumed changes that will occur within the participants as a result of engaging in the intervention.



Evaluation

The evaluation as envisioned will consist of two phases. The first phase focuses on providing valuable insights to the project team on how to improve upon initial implementation efforts. Every intervention, irrespective of previous evidence supporting its effectiveness, requires program implementer's take extensive efforts to tailor it appropriately within the current context. As such, the first year of the implementation process is envisioned in essence as a "pilot" phase

during which time the project team can continue to learn how to integrate the proposed intervention into Pomona successfully.

The second phase of the evaluation focuses on answering questions that relate to the effectiveness of the intervention as implemented in Pomona and the costs relative to benefits imparted through this intervention. During the first phase of the evaluation, the team will focus on putting into place the data collection activities required to obtain high-quality data for use in the effectiveness and cost analyses.

2018 Diabetes Progress Update

Stopping Diabetes in Its Tracks (SDIT) – Pomona

What follows in this 2018 summary is an update of the progress made including progress towards achieving goals, objectives, and outcomes of the project. The summary also briefly highlights some of the challenges encountered and how they were resolved, any changes made during the course of the project, and the expected and unanticipated outcomes.

The SDIT Consortium began its first year by acknowledging that it is imperative to treat Pomona residents with utmost respect by providing clinical services and by rigorously following research protocol, including protection of the participant's rights, welfare, and wellbeing.

The Consortium has adopted a systems-engineering approach which has created six subsystems representing six of the project elements guided by a roadmap and a set if critical pathways. Each subsystem is assigned a taskforce made up of members from across the SDIT partner institutions and from a variety of academic and clinical disciplines, and membership overlaps across the teams. Task forces work in parallel and collaborate with one another to contribute to the achievement of project objectives. Each task force meets weekly or bi-weekly and reports to the leadership team on its activities, progress, and questions. The six subsystems created are:

- The Research and Development Subsystem managed and staffed by the Measurement, Evaluation and Intervention Task Force
- The Clinical Subsystem managed and staffed by the Clinical Task Force
- The Community Subsystem managed and staffed by the Community Task Force
- The Navigation Subsystem managed and staffed by the Navigation Task Force
- The Data Subsystem managed and staffed by the electronic Tracking System Task Force
- The Human Subjects Protection Subsystem managed and staffed by the IRB Task Force.

The SDIT Leadership Team carries out the oversight of the entire SDIT System and integration of the subsystems.

Progress towards Achieving Goals, Objectives, and Outcomes of the SDIT Project

- Two leadership teams were created
- A systems-engineering plan and personalized ecological conceptual framework was created to guide the program development.
- Six operational task forces were created to address the requirements of the subsystems essential to successful realization of the SDIT mission
- Additional collaborating institutions: Western University of Health Sciences' College of Graduate Nursing and Scripps College Post-Baccalaureate Premedical (PBPM) Program were integrated with the USC School of Social Work and Keck Graduate Institute's PBPM program in navigation and community screening.

- Development, pilot testing, and operationalization of measurement systems and Electronic Tracking System
- Navigation System was created
- Pilot testing of the DSME program
- Initiation of screenings and identification of sufficient numbers of eligible persons form community, clinics, and hospital to initiate Diabetes Prevention Program (DPP) and Diabetes Self-Management Education and Support Program (DSME) interventions in early 2019.

Community-Based Glucose Screenings - 2018

Date	Event/Location	Staff (# of Nurses)	Total Screenings
February 10, 2018	PVHC La Verne - Grand Opening	11	150
April 28, 2018	Lemon Festival	10	81
April 28, 2018	HNM Festival	4	30
May 19, 2018	Stroke Awareness Festival	6	65
May 25, 2018	Hillcrest Retirement Community	7	128
June 22, 2018	My Sweet & Healthy Community	5	33
July 13, 2018	2nd Annual LA Veterans Resource Expo	7	94
July 28, 2018	4th Annual Family Day – Wingstop	4	28
August 31, 2018	LA County Fair	4	26
September 5, 2018	LA County Fair	7	47
September 23, 2018	HNM Health and Wellness Event	7	114
October 20, 2018	2nd Annual Charity Car Show at PVHMC	5	47
November 7, 2018	National Diabetes Awareness Month – Diabetes Health Fair	8	55

Other Activities and Community Events

Beginning in October 2018, PVHMC began hosting a Free Diabetes 101 class with the Clinical Diabetes Specialist from the Diabetes Clinical Resource Team. The class is held every 2nd Tuesday of the month with two classes delivered at 4pm for our Spanish community members and another at 6pm for class delivered in English. On average, the classes have hosted a range of 5-12 participants. The classes are 1.5 hours in which community members are invited to learn about the best steps to take in living and managing their diabetes successfully. Examples of topics include:

- General diabetes information
- What glucose levels mean
- How episodes of high and low sugar are treated

- How to check blood sugar
- Diabetes medications and their side effects
- How to prevent complications and lifestyle modifications like diet and exercise and how it can positively affect health.

The class is intended for those with both Type 1 and Type 2 diabetes. The classes are held in the Community Room of the Robert and Beverly Lewis Family Cancer Care Center.

In November, the Diabetes Clinical Resources Team at PVHMC celebrated National Diabetes Awareness Month with a number of events to spread awareness to prevent diabetes and help those with the disease better manage their symptoms and lifestyles.

- November 7, 2018: A Diabetes Health Fair was held in front of the Robert and Beverly Lewis Outpatient Pavilion where the community could come by for a quick and free blood glucose screening from our Diabetes Clinical Resource Team. Clinical Diabetes Specialists were available to provide free education on risk factors, symptoms management and more.
- November 11, 2018: Community members were invited to join the Diabetes Clinical Resource Team with family and friends on a brisk **2.5 mile walk/hike on the Eucalyptus Loop Trail** in Chino Hills. Information was shared about diabetes/prediabetes and why walking is good for health.
- November 13, 2018: The Diabetes Clinical Resource Team hosted a **Diabetes 101** Class in the Community Room of the Robert and Beverly Lewis Family Cancer Care Center. It is a free class for community members with both Type 1 and Type 2 diabetes. The class helped participants gain a better understanding of living well with diabetes, including what diabetes is, how to check sugars, lifestyle modifications and more. Two classes were held, one in Spanish followed by another class in English.
- November 14, 2018: The Diabetes Clinical Resource Team hosted a World Diabetes Day event in the cafeteria where the community could take a free risk assessment test and learn about diabetes.

Sweet Success Program

The Sweet Success Program is a California State Diabetes and Pregnancy Education Program affiliate at PVHMC that that began in 1993. Offered along with other Women's and Children's Services at PVHMC, the program helps pregnant women with diabetes or gestational diabetes deliver healthy babies. The program consists of dietary counseling, education and blood glucose monitoring for the duration of a woman's pregnancy and six weeks after delivery.

Healthy in Pomona

Healthy in Pomona (HiP) is one of five initiatives of ***Pomona's Promise***, which is an outline for a community-based approach to linking services and programs, providing resources, and identifying gaps to support youth and family services in the City of Pomona. Members represent various youth and family serving entities, including education, government, faith based and, non-profit agencies along with Pomona residents. The group meets to share information and work towards a common goal of better coordination of youth and family services in the City of Pomona. The collaborative group of residents and organizations that form HiP are dedicated to improving the health of Pomona by championing the HEAL (Healthy Eating Active Living) Resolutions.

Healthy in Pomona began in the spring of 2014 and have been active in implementing the Collective Impact Process. In January 2015, a nine-month community-focused needs assessment was completed and the results disseminated in the spring of 2015. The process included an extensive review of available public health data, a Community Needs Assessment from PVHMC and input from Pomona residents via two community forums, community surveys and focus groups. A total of ten themes emerged as health priorities for Pomona which includes:

- Public Safety
- Economic Security
- Access to Healthy Food
- Exercise
- Access to Health Care
- Family Activities
- Healthy Environment
- Caring for Each Other

In 2016, HiP began forming workgroups to focus on specific areas. Three workgroups were formed: Homeless Advisory Committee which dissolved and became the Continuum of Care Coalition, Healthy Eating and Active Living and Violence Prevention and Intervention group which became the Care Coordination Workgroup. Members of PVHMC Diabetes Clinical Resource Team as well our partners in the SDIT project take part in HiP collaborations.

In 2018, quarterly meetings were held with PVHMC representation to discuss multiple agenda items. For example, the Healthy Eating and Active Living Workgroup have identified the need to prioritize parks and activating open spaces as means for addressing obesity and its related diseases (e.g. diabetes), as well as having an impact on deviant behavior in the community.

Community Benefit Activities and Programs

Measuring outcomes of community benefit activities and programs may not always tell the true story of community benefits; its purpose, however, is doing something that makes a difference in the lives of the people in our community. We have organized our Hospital's comprehensive listing of community benefit activities and programs into five different areas:

Emergency Services

Women's and Children's Services

Ambulatory Services

Ancillary Services

Outreach Services

Within each of these areas, the following major categories were used based on the new Schedule H of the Internal Revenue Service (IRS) Form 990:

1. **Community Health Improvement Services:** community health education, community based clinical services, health care support services

2. **Health Training (Education) Programs**: physicians/medical students, nurses/nursing students, other health professions education

3. **Scholarships/funding for professional education**

4. **Subsidized Health Services**: emergency services, subsidized continuing care

5. **Research**

6. **Financial and In-Kind Contributions**

7. **Community Building Activities**: community support, environmental improvements, coalition building, and workforce development

The examples you will find in this report will serve to highlight what we believe are our true successes in addressing the identified needs of our community, whether they affected hundreds of residents or impacted only one; whether they required thousands of dollars, or were free of cost – they are insights into an organization and a community actively involved in improving the health status of residents living in the Pomona Valley and in the communities beyond.

Emergency Services

The Emergency Department (ED) at Pomona Valley Hospital Medical Center (PVHMC) is a 24-hour, 7-day a week, full service department offering immediate and effective evaluation and treatment. The department's dedicated Associates are specifically trained in emergency medicine to offer prompt and accurate diagnoses and skilled medical treatment. The medical team includes board-certified emergency Physicians and nationally certified Nurses, Physician Assistants, Emergency Medical Technicians and Respiratory Therapists along with other support staff.

The Emergency Services team is committed to provide technologically advanced, lifesaving medical services with compassionate care. Although regular, on-going medical care for non-life-threatening conditions is best provided in a private physician's office or urgent care setting, emergencies do arise when immediate medical care is needed. Regardless of insurance coverage, all patients are treated and stabilized in our Emergency Department, per federal guidelines.

The following are some of the community benefits and activities within Emergency Services:

Subsidized Health Services

Physician On-Call Coverage: PVHMC provides physician coverage in the Emergency Department in the following specialties: Adult Medicine; Cardiology; Ear, Nose, and Throat (ENT); General Surgery; Neonatal Intensive Care Unit-Ophthalmology; Neurosurgery; Ophthalmology; Orthopedic Surgery; Urology; Vascular Surgery; and Trauma Surgery.

Paramedic Base Station: As a part of the PVHMC mission to provide quality comprehensive care to our community, we operate one of the 20 remaining Paramedic Base Stations in Los Angeles County. The PVHMC Base Station operates under the regulatory control of the Los Angeles County Emergency Medical Services Agency and is manned by specially trained nurses called Mobile Intensive Care Nurses (MICNs), certified by Los Angeles County. As a paramedic base station, we provide services to our surrounding communities including: Pomona, Claremont, La Verne, San Dimas, Diamond Bar and parts of Walnut. PVHMC has been a base station since July, 1979.

This vital component of patient care provides emergency care givers in the field (Paramedics and Emergency Medical Technicians) with a direct link to the ED, allowing direct contact with the nurse, and if necessary the ED Physician. The ED staff is better prepared for the imminent arrival of a critically ill or injured patient, recognizing potential problems early or redirecting the paramedics if necessary to a closer or more appropriate facility.

Ambulance Transports: Working with Case Management, the PVHMC Emergency Department provides appropriate level ambulance transports home or to another acute care facility or skilled nursing facility in an effort to meet the indigent or underinsured patient's continuing medical needs. In 2017, PVHMC provided this service to 133 persons.

Community Building Activities

Every 15 Minutes: This program educates high school students of the dangers of drunk driving. It involves local fire and police departments, ambulances, schools, students, families and Pomona Valley Hospital Medical Center. A drunk-driving accident is simulated outside of a high school's premises with a teenage driver and students acting injured and killed. The Grim reaper enters the classroom every 15 minutes and escorts a student out. This symbolizes the fact that every 15 minutes someone is killed by a drunk driver.

Emergency Department Approved for Pediatrics: Designated by Los Angeles County as an ED Approved for Pediatrics (EDAP), our Emergency Department provides specialized emergency care that can greatly improve outcomes for young patients. EDAP (Emergency Department Approved for Pediatrics) is a component of the Los Angeles County Emergency Medical System, which indicates the designation to receive 911-ambulance traffic of pediatric patients. There are currently 40 **EDAP hospitals** in Los Angeles County. To qualify as an **EDAP**, a hospital emergency department must meet specific criteria, including requirements for pediatric equipment, physician coverage, ongoing pediatric education and policies as well as having a designated Pediatric Liaison Nurse (PdLN). Our Pediatric Transport Unit stands ready 24-hours-a-day to transport critically ill or injured children to PVHMC for care in our ED or in our Pediatric Care Unit.

Safe Surrender: The Safe Surrender program began in August, 1996 by a woman named Debi Faris who obtained permission to take custody of the remains of abandoned and unwanted newborns by giving them a name and a dignified burial. This place became known as the "Garden of Angels" and to date, 46 markers symbolize the work of Ms. Faris. From this beginning, Ms. Faris realized there was a crisis in our society that deserved immediate attention. Senator James Brulte was approached and immediately the Senator created a bill, Senate Bill 1368, which became known as the Newborn Abandonment Prevention Law. This law became effective in California on January 1, 2001. The law states that a parent of a newborn less than 72 hours of age can relinquish their baby anonymously and without the fear of criminal prosecution, to an employee at any hospital emergency department within the state of California. To date, Pomona Valley Hospital Medical Center has had three (3) newborns surrendered and we continue to prepare ourselves for future opportunities to save a life, which is basic to our mission and vision. The program has been shared with local schools and community programs; however, the need to increase awareness is crucial to the ongoing success of the program.

Disaster Resource Centers (DRC): As a participant in the National Bioterrorism Hospital Preparedness Program (NBHPP), Pomona Valley Hospital Medical Center is a one of 13 designated Disaster Resource Centers (DRC) in Los Angeles County, prepared to be a resource to our community in the event of a declared disaster. As the DRC for the region, PVHMC is responsible for twelve (12) 'umbrella hospitals' and annually coordinates drills, training, and sharing of plans to bring together the community and our resources for disaster preparedness.

Women's and Children's Services

Pomona Valley Hospital Medical Center (PVHMC) was built as state-of-the-art medical facility in the 1990s in response to the growing healthcare needs of women and children in the eastern Los Angeles, San Bernardino and Inland Empire region. In 2014, PVHMC became the largest birthing hospital in California to receive the ***Baby-Friendly*** designation from the World Health Organization and UNICEF. Currently, PVHMC is ranked 5th in California for the number of deliveries, 6,246, according to most recent data from the Office of Statewide Health Planning and Development (OSHPD).

Women's and Children's Services at PVHMC offers extensive and continuously expanding services tailored to meet a variety of special needs. In addition to obstetrics, pediatrics, and infant care, PVHMC offers complete care for women throughout all stages of life. Community health improvement services are offered through our Family Education Resource Center and provides resources for childbirth, breastfeeding, parenting, CPR, babysitting, and support for bereaved parents. Specialized classes and support are offered for expectant and new mothers, including: *Childbirth Preparation*, *Baby Express*, and the *Sweet Success Program*. Classes and support are also offered for expectant and new fathers, including: *Boot Camp for Dads* and *Dadvice*.

Pomona Valley Hospital Medical Center (PVHMC) offers both a *Breastfeeding Class* and *Breastfeeding Clinic* for expectant and new parents to receive current information and education about breastfeeding that adheres to the evidence based on *Ten Steps to Successful Breastfeeding*. These guidelines include helping and teaching mothers to initiate bonding and breastfeeding immediately after birth, showing mothers how to maintain lactation, and offering mothers the information, skills, and support needed to successfully continue breastfeeding upon their return home. The Women's Center at PVHMC provides personalized, home-like single birthing and postpartum rooms, making PVHMC the hospital of choice for expectant mothers. PVHMC offers "rooming-in" that allows mothers and infants to remain together 24-hours a day.

As one of the most advanced maternal and neonatal providers in Southern California, PVHMC has a Maternal-Fetal Medicine program, an advanced Labor and Delivery program, and a 53-bed, Level IIIB Neonatal Intensive Care Unit (NICU). Each of these programs confirms PVHMC's commitment to providing life-saving care to patients and demonstrates the range and depth of community benefit programs and commitment to the health of women and children. PVHMC also provides complete pediatric services especially designed to meet the needs of both the child and his/her family. Using advanced technology and procedures, PVHMC highly skilled staff is prepared for even the most complicated pediatric cases. From accepting and transporting neonatal intensive care patients to follow up care and specialty clinics, all pediatric care is done in a compassionate, supportive and nurturing environment.

In addition to the program's clinical services and specialized training, PVHMC has active involvement with our referring facilities. We offer formal and informal educational opportunities for staff and physicians regularly at their site location at no cost to the requesting facility. PVHMC's specialized team of Maternal-Fetal Medicine Associates offer classes in OB Emergencies, Obesity in Pregnancy, Prolapsed Cord/Breech/Shoulder Dystocia Deliveries, The Art of Perinatal Care, Labor Management, Pain Management, Induction, Breastfeeding, Stroke and Pregnancy, Newborn Assessment, Cultural Care & Perinatal Loss, Review of the New NRP Guidelines, Diabetes in the Perinatal Period, Bleeding/Hemorrhage/Shock/DIC in Pregnancy, and High-Risk Pregnancies.

PVHMC programs for High-Risk moms and their babies that include:

- Sweet Success-Diabetes and Pregnancy
- Inpatient and Outpatient breastfeeding support programs

- Perinatal and Neonatal Bereavement Support Programs - "Helping Hands" & "Care Connect"
- California Children's Services (CCS) Provider
- Complete Pediatric Sub-Specialty Care

PVHMC services for care of the newborn include, but are not limited to:

- Medical Care
- High frequency ventilation
- Surfactant replacement therapy
- Genetic screening
- Sub-specialty consultations
- Surgical Care
- Cardiothoracic: PDA and diaphragmatic hernia
- Gastrointestinal: Hernia, fundoplications, gastrostomy tube, bowel
- obstructions, intussusception, ileostomy, colostomy, pyloromyotomy, imperforate anus, omphalocele, and gastroschesis.
- Neurosurgery: VP shunt and ventriculostomy

The following is a list of Women's and Children's Programs and activities provided to the community in 2018:

Subsidized Health Services

In-House Obstetrics Coverage: PVHMC has hospital-based Obstetrics and Gynecology Physicians that provide 24-hours a day/7 days per week coverage for deliveries.

Baby Express: Designed to help parents get ready for the new baby experience, Baby Express education includes baby care, health, safety, and the "Happiest Baby" class which aims to teach new parents techniques to calm and soothe a baby. In 2018, 188 persons were served.

Big Brother/Big Sister: Children, three to six years of age are prepared for their first meeting with the new baby in the hospital and learn to help care for him/her at home. In 2018, 43 persons were served.

Boot Camp for Dads: A unique workshop designed to provide education to new dads. Boot camp veterans return with their 2-3 months old infant and give soon-to-be dads tips and support to head in the right direction with their new family. In 2018, 133 persons were served.

Breastfeeding Class: Expectant parents receive current information and education about breastfeeding. In 2018, 139 persons were served.

Breastfeeding Clinic: Our free 4 day-a-week clinic is open to breastfeeding mothers and provides education, emotional support, pump rentals, and problem-solving techniques for successful breastfeeding. A lactation consultant is on hand to assist with their need. In 2018, 700 persons were served.

Cesarean Birth Preparation: Question and answer sessions provide information to prepare families for what to expect during their special delivery. In 2018, 7 persons were served.

Childbirth Preparation Class: Offered in a 5-week series or a one-day course, our Childbirth Preparation Class provides community education on the physical and emotional aspects of the labor process. This class is designed to

prepare the parent with hands on learning, comfort and breathing techniques, parenting, CPR, and the role of the support person. In 2018, 380 persons were served.

Every Woman's Journey: Women's education lecture series with topics appropriately changing monthly to encourage a healthy lifestyle. In 2018, 173 persons were served.

Infant/Child CPR: This class provides infant/child Cardiopulmonary Resuscitation (CPR) skills for parents, grandparents and babysitters. Additional education provided on choking prevention how to handle other emergencies; also available in Spanish. In 2018, 86 persons were served.

Maternity Orientation: A tour and orientation expectant parents to help them get acquainted with our labor, delivery, recovery, and postpartum units. Tours are also offered in Spanish and Chinese. In 2018, 1936 persons received tours in English, 232 persons received tours in Spanish, and 698 persons received tours in Chinese.

Memorial Wall and Garden: For those families who lose an infant or child, The Memorial Wall offers a way to give lasting tribute by having a child's name permanently etched on one of the wall's granite tiles.

Safesitter Class: Safesitter is a class to teach adolescents safe babysitting techniques. Students receive hands on practice in basic lifesaving techniques and education is provided on child development and age-appropriate activities. In 2018, 113 persons were served.

The Caring Connection: A support network for parents and families while their babies are in the Neonatal Intensive Care Unit (NICU), and even after they have gone home. Trained nurses and social workers offer parents emotional support, guidance, information and community resource referrals. This group is also offered in Spanish.

Walk to Remember: Each October during National Perinatal Bereavement Month, PVHMC invites families who have experienced the loss of an infant or child to participate in a "Walk to Remember". The evening includes an inspirational program of sharing, a memorial service and a candlelight walk. In 2018, 260 persons were served.

Dadvice: This group is for dads who may be experiencing or living with someone experiencing stress, depression, anxiety or other issues related to pregnancy, birth and the postpartum period. In 2018, 20 persons were served.

Health Professions Education

Perinatal Symposium: Labor and Delivery and Neonatal education for the medical community (physicians and nurses). Education topics include management of various clinical situations that arise in practice with emphasis on optimizing the outcome for mother and infant. In 2018, 836 persons were served.

Women's Conference: This health awareness and resource "day of learning" is open to all women in our community and provides informational speakers on health and wellness as well as fun and entertaining topics. Vendors fill the room with community resources, health screenings, food and music.

Maternal-Fetal Transport Program

Due to quality outcomes and access-to-care needs, the **Maternal-Fetal Transport Program** was established in 1994 and was first and the only one of its kind in California. By 2000, PVHMC was only 1 of 3 hospitals providing this type of benefit in the state. Since establishing this program, more than 26 hospitals in Imperial, Inyo, Kings, Los Angeles, Mono, Riverside, and San Bernardino Counties have requested PVHMC's maternal-fetal transport assistance. PVHMC Maternal-Fetal Transport Team also provides training and education to healthcare providers on this specialty service.

Pregnant women who experience complications often require special attention and need rapid medical care during their pregnancy. The PVHMC Maternal-Fetal Transport Unit is equipped to handle any emergency when high-risk expectant mothers need to be quickly and safely transported to PVHMC from other nearby hospitals. The unit provides a mobile intensive care environment for pregnant patients en route to the hospital, transferring more than 150 high-risk pregnant women safely and quickly each year regardless of their diagnosis, race, ethnicity or financial status. This program is truly a testament to PVHMC's thoughtful, purposeful and strategic approach to community-wide health – beginning with health in the womb.

The goals of the Maternal-Fetal Transport Program include serving the needs of expectant mothers in seven outlying counties, providing maternal-fetal ambulance and air transport for mothers needing emergency maternal services. The IIIB Neonatal Intensive Care Unit (NICU) is on-site and provides fully trained labor & delivery RNs to assist with emergency care and transport. This program is unique because it meets patients where they are, 24 hours/day, and deploys within 30 minutes of accepting a transport.

The unit team includes Maternal-Fetal Medicine Physicians, Obstetricians, Physician Sub-specialists, Registered Nurses and Respiratory Therapists who can quickly access and stabilize the patient's condition during mobile transport. During transport, our unit team maintains communication with our Maternal-Fetal Medicine Physicians, and is specially trained to care for the full range of maternal medical emergencies in the field, including but not limited to:

- Bleeding after 20 weeks
- Hypertensive disorders
- Preterm Rupture of Membranes
- Preterm labor
- Multiple gestation (twins, triplets, etc.)
- Diabetes
- Fetal Anomalies
- Medical Complications of Pregnancy

Neonatal Intensive Care Unit

Pomona Valley Hospital Medical Center (PVHMC) has a state-of-the-art 53 bed level-3 NICU facility for the treatment of sick or premature babies from the surrounding area of Pomona, Chino Hills, Corona, Claremont, Eastvale, Diamond Bar, and throughout the San Bernardino and Los Angeles County area. The IIIB Neonatal Intensive Care Unit offers specialized care for critically ill infants and is designated as a level IIIB unit, since it is equipped and trained to care for infants born at less than 32 weeks' gestation or weighing less than 1500 grams. Every member of the Neonatal Intensive Care Unit (NICU) team has been specially trained to care for newborns needing advanced medical service and functions as a multi-disciplinary team. The team is headed by a pediatric physician specialist (neonatologist), additional physician specialists from fields such as cardiology and neurology, registered nurses and respiratory care therapists, pharmacists, developmental therapists, dieticians and medical social workers.

Established in 1994, the Neonatal Transport Team at PVHMC is a highly skilled group of registered nurses and respiratory therapists working with Board Certified Neonatologists to provide safe and efficient ground transport of sick newborns to a level IIIB intensive care unit. The associated costs of the program's training, coordinating, travel-time and

hands-on specialized care in the field by our mobile team is provided to the patient at no cost. The patient and requesting facility can be confident that PVHMC will be available 24-hours a day, 7-days a week to meet their access-to-care needs, regardless of ability to pay.

Children's Services

The pediatric services unit at PVHMC offers a caring environment that encourages the participation of parents in the health care of their children. We host a special pre-admitting program in which the child and family are introduced to their own case manager, who coordinates care throughout their stay. Medical social workers and discharge planners are available to address any concerns, should they arise. They will also help coordinate post-hospital care; provide community care referrals and emotional support for the family.

At PVHMC, pediatricians and nurses who specialize in the care of children, use the most advanced technology available to ensure a calm and healing environment. To help ease children's fears of treatment and technologically advanced machines, a colorful jungle theme has been incorporated into the pediatric unit. Hand painted by a PVHMC Pediatric nurse, it is very welcoming to our small patients. To help add a measure of comfort, sleep chairs are included in each room allowing parents to be with their child during overnight stays.

The pediatric services unit provides diagnostic and treatment services for a variety of medical conditions, including:

- Gastrointestinal disorders
- Infectious diseases
- Orthopedic disorders and injuries
- Respiratory diseases
- Sleep disorders

Pomona Valley Hospital Medical Center is one of the region's premier medical centers, our outstanding doctors and caring nurses and staff have met the expectations of parents for more than 100 years with excellent maternity care. With more than 5,000 babies born here each year, PVHMC is dedicated to providing a gratifying family experience.

Ambulatory Services

At Pomona Valley Hospital Medical Center (PVHMC), we strive to balance the best in medical technology with the best in truly personalized, family-centered care. Our ambulatory services provide the highest level of care in the areas of cancer, cardiovascular health, and kidney health, as well as primary and specialty services to meet the unique needs of our residents in every stage of life. PVHMC's ambulatory services include:

- *The Robert and Beverly Lewis Family Cancer Care Center*
- *Pomona Valley Health Center - Chino Hills*
- *Pomona Valley Health Center – Crossroads*
- *Pomona Valley Health Center – Claremont*
- *Pomona Valley Health Center – La Verne*
- *Sleep Disorders Center*
- *Stead Heart and Vascular Center*
- *Family Health Center*

The Robert and Beverly Lewis Family Cancer Care Center

The Robert and Beverly Lewis Family Cancer Care Center, a part of PVHMC, has been helping our community battle cancer since 1993, and is dedicated to education, prevention, diagnosis, treatment, support and recovery. Located one block northeast of the Hospital's main campus, our Cancer Care Center is home to the Breast Health Center, Radiation Oncology, Medical Oncology, Patient Care Coordinators, a Social Worker, and our Community Library. Outpatient services include education classes, diagnostic tests and screenings, chemotherapy, radiation oncology, wellness programs, counseling and more. Cancer specialists, trained to provide the most sophisticated, technologically advanced cancer care available in a non-threatening, homelike atmosphere, tailor care to each person's individual situation. We make every effort to keep our patients fully informed so that they are involved every step of the way. We never forget that we are dealing with people – not just a disease.

Community Health Improvement Services

Living Well After Cancer: This exercise program for cancer survivors involves the staff of the Cancer Care Center, PVHMC's Physical Therapy Department, and the Claremont Club. *Living Well After Cancer* is targeted to aid in rehabilitation after cancer treatment and to improve fitness levels to live a better quality of life. In 2018, 71 persons served.

Health and Wellness Fairs, Forums and Events, Speaking Engagements, and Celebrations (e.g. Survivor's Day): About 1,400 persons served in 2018.

Patient Workshops: A Patient workshop provided nutrition education to help improve the quality of life of our cancer patients with 37 persons served.

Patient and Community Library: Books, periodicals, pamphlets, and videos/DVD's/CD's on cancer-related topics are available to patients and family members at this library, as well as internet access. Approximately 500 people visit annually.

Publications: The Cancer Program Annual Report provides updates on diagnosis and treatments and includes statistics and survival data comparing PVHMC to the National Cancer Database. Annually, 250 copies are published and distributed to our community. In addition, a quarterly newsletter provides information and education to the public regarding availability and access to social and health services.

Breast Prosthesis Display: For women seeking information on breast prostheses, bras and lingerie, this activity is made available with the support of the American Cancer Society.

Cancer Care Classes and Support Groups: Multiple programs and support groups are offered to meet the needs of the community and to aid them through cancer diagnosis, treatment, and recovery. In 2017, 3,141 persons were served through the following cancer care support:

- **Women with Cancer:** A support group for all women with all types of cancer meets to address their needs.
- **Look Good…Feel Better Support Group:** The focus is on the personal appearance of women who have experienced radiation or chemotherapy. Skin care and makeup techniques are presented along with a free makeup kit. Sponsored by The American Cancer Society.
- **Pomona Valley Ostomy Association:** Education and mutual support for "ostomates."
- **Leukemia/Lymphoma Support Group:** Support and education for people with leukemia, Hodgkin's disease, lymphoma, and multiple myeloma.
- **Bereavement/Loss Support Group:** This support group is for anyone who has suffered the loss of a loved one and is experiencing the grieving process; open to family members and friends.
- **When Cancer Enters Your Life:** A sharing support group for everyone - a cancer patient, a relative, friend, loved one, or co-worker- who has been affected by someone with cancer.

Wellness Programs:

- **Integrated Wellness Arts:** Each meeting focuses on the creative journaling to aid in healing.
- **Stretch and Yoga:** Opened to the community to become more flexible, to gain strength and to improve circulation, and fitness level, especially for patients recovering from cancer treatment.

Research

The Robert and Beverly Lewis Family Cancer Care Center advances medical science while offering the community cutting-edge therapy. The center's physicians are able to offer patients the most current treatment available through participation in various types of clinical research studies. Clinical research trials are currently in progress in the areas of Breast Cancer, Head and Neck Cancers, Lung Cancer, Gyn, and Prostate Cancer. Additionally in 2018, we enrolled 7 people into a research study looking at Gene Expression, Meditative Movement and Emotional Distress.

Background and Objectives:

Breast cancer survivors (BCS) often report decrements in cognitive functioning. Cognitive impairment (CI) is generally understood as resulting from chemotherapy, radiation, or other cancer treatments, but may also be a sequela of stress and emotional issues experienced by breast cancer patients and survivors. This study will consider emotional issues experienced by breast cancer patients and survivors as Emotional Distress (ED). Meditation and exercise are both known to reduce stress, with growing evidence for the potential of each to also improve cognitive functioning in cancer patients and survivors, but these have been less tested in the context of exploring the mechanisms of action that may produce these improvements. A Meditative Movement (MM) program (Qigong/Tai Chi Easy) offers the potential of combining both benefits of meditation and exercise for breast cancer survivors. This is a pilot study to test the MM program to effect changes in cognitive functioning and associated symptoms/conditions, and to examine the potential of gene expression factors associated with ED to provide a better understanding of mechanisms of CI change.

- Aim 1 will examine the potential of Meditative Movement (MM) program to improve cognitive function and associated symptoms.
- Aim 2 will examine if/how MM may influence up-regulation of BDNF (learning & memory) gene expression and its potential correlation with NF-kB (stress & inflammation) and TP53 (tumor suppressor) gene expression.
- Aim 3 will explore relations among the self-reported cognitive function and tests of cognitive performance with changes in gene expression."

Cash and In-Kind Contributions to Community

Wig Program: Wigs are available, free of charge, for women who have lost their hair as a result of cancer treatment. In 2018, 96 persons served.

Pomona Valley Health Centers

Pomona Valley Health Centers believes no one should have to sacrifice quality for convenience, or pay higher costs for compassionate, personalized care. All health centers provide patients with access to the top medical services in the region. They are equipped with state-of-the-art medical equipment and staffed by highly experienced, compassionate physicians, nurses, and other caregivers. Pomona Valley Health Centers are the region's leading centers of patient care, enhancing the quality of life for years to come.

Pomona Valley Health Center-Chino Hills (PVHC-CH) and Crossroads (PVHC-CR)

- Family Medicine, Physical Therapy, Digital Mammography, and more
- Licensed Urgent Care Center and Family Practice

Pomona Valley Health Center-Claremont

- Urgent Care, Family Medicine, Occupational Medicine, Radiology, Physical Therapy, Sleep Disorders, Sports Medicine, and Milestones Center for Child Development

Pomona Valley Health Center-La Verne

- Recently opened its doors in 2018 to serve families who live and work in La Verne and surrounding communities
- Urgent Care, Family Medicine, Radiology, Occupational Medicine, and Physical Therapy

Sleep Disorders Center

As an Accredited Member of the American Academy of Sleep Medicine (AASM) for more than twenty years, our Sleep Disorders Center located in the Pomona Valley Health Center at Claremont is a multi-disciplinary specialty clinic that provides diagnosis and treatment for people of all ages experiencing problems with poor sleep. We take a comprehensive approach to treating all sleep problems, including snoring, sleep apnea, insomnia, restless legs, narcolepsy, fatigue, excessive daytime sleepiness, sleep behaviors such as sleep walking and adjustment to shift work.

The Center provides both in-lab and at-home sleep study services for the diagnosis and monitoring of sleep-related disorders. An in-lab sleep study involves an overnight stay in one of our eight, comfortable and specially equipped patient rooms. The patient is closely monitored during the night and discharged early the next day.

In addition to comprehensive diagnostic services, PVHMC's Sleep Disorders Center offers the most advanced treatment modalities available. Treatment for sleep disorders may include: Continuous Positive Airway Pressure (CPAP), drug therapy, the use of dental prostheses, testing of oral appliance efficacy with the use of specialized mandibular advancement titration test, and surgical referrals, among other procedures and therapies. We also offer sleep disorder support groups that provide ongoing emotional support and educational services for patients and their families.

Stead Heart and Vascular Center

Since 1986, Pomona Valley Hospital Medical Center's Stead Heart Center has been a leader in innovative cardiovascular care, earning the confidence and respect of the surrounding communities and beyond. In 2006, the center expanded to become the first designated heart and vascular center in the region.

As a comprehensive cardiovascular program we offer the patient exceptional care, with the most complete lines of cardiac, vascular and stroke services in Los Angeles and San Bernardino Counties, providing access to pre-eminent diagnostic, treatment and rehabilitation services. With this access, the SHVC's umbrella of Physicians, Specialists, Nurses, Technicians and Therapists work together to provide the region with the finest treatment options. The following is a listing of some of the nationally recognized services that our SHVC advanced clinical care team provides:

- Diagnostic Cardiac, Vascular and Neuro Procedures
- Interventional Cardiac, Vascular and Neuro Procedures
- Electrophysiology/Pacemaker Program
- Heart and Vascular Surgical Treatment Procedures
- Endovascular repair of Aortic Aneurysm
- Trans catheter Aortic Valve Replacement
- Left Atrial Appendage Closure
- Patent Foramen Ovale Closure
- Cardiac, Vascular and Neuro Rehabilitation
- Heart Failure and Diabetes Education

As important as knowing the causes and risk factors of heart disease and stroke, it is also important to know where to go for the best treatment. In the past two years we've been recognized by objective organizations such as American Heart Association (AHA)®, American Stroke Association (ASA)®, Blue Cross®, Blue Shield®, HealthGrades®, California Coronary Artery Bypass Graft Outcomes Reporting Program (CCORP), Society of Thoracic Surgeons, and American College of Cardiology. Our recognitions include:

- First acute heart attack (STEMI) Receiving Center with dual county designation.
- Currently ranked in the top-ten among Los Angeles County's 34-hospital STEMI Receiving Center system for STEMI treatment times (LA County – Emergency Medical Services Agency)
- Top 5% nationally for STEMI treatment times (American College of Cardiology)
- Top 5% nationally for Stroke Treatment (HealthGrades)
- Top 5% nationally for Heart Failure Treatment (HealthGrades)
- Top 10% nationally for cardiac surgery outcomes (Society of Thoracic Surgeons)
- GOLD – American Heart Association/American Stroke Association Get With The Guidelines for Heart Failure
- Healthgrades "Top 100" Hospital in America for Cardiac Care, Cardiac Surgery, and Coronary Intervention
- Healthgrades Cardiac Services Excellence Awards- 2017

PVHMC's Stead Heart and Vascular Center takes pride in its more than 20-year history as the regional leader for innovative treatments. Throughout the years this leadership, along with honoring our values, has allowed us to become a Trusted Source™ in the community.

Community Health Improvement Services

Community Education Group Lectures: Chronic disease education is provided through lectures presented in the community; topics include: heart disease, vascular disease, diabetes, exercise, weight management, stress management and healthy lifestyles. Individuals were served at a variety of locations in the community, including local nursing homes, local chambers, and middle schools.

Community Education Events: Several events are offered in the community to raise awareness about cardiovascular health and to provide education and access to resources.

- ***Power of Red:*** This American Heart Association approved event - hosted in part by the Stead Heart and Vascular Center - celebrates the power that women have to fight against stroke and heart disease. Women, dress in red and learn about risk factors and how to make heart-healthy choices. The Power of Red event also celebrates attending heart attack survivors.
- ***Stead Heart for Women Outreach and Education*:** Provides education, support, and resources for women's health, especially regarding heart disease, stroke prevention, and making healthy nutrition choices. Built on the concept of the TV show, "Paint Night", the 2017 event consisted of panel speakers who shared with the female audience about risk of heart disease and how to manage their risk.
- ***Stroke Awareness Day:*** Pomona Valley Hospital Medical Center (PVHMC) gave stroke survivors and community members a chance to engage in free screenings and education as part of our stroke rehabilitation program. *The Many Faces of Stroke* was the 2018 theme, and PVHMC Associates offered blood pressure screenings, stroke risk assessments, education on signs and symptoms of stroke, showcasing newest tech in

stroke diagnostics, recreational adaptive equipment, support and resources for caregivers, after stroke care programs, light refreshments & nutritional information.

- ***New Beginnings Support Group*** where patients and their care partners can meet other survivors share experiences and learn to reduce their risk factors. We offer New Beginning Support Groups for Stroke survivors and Heart Failure patients.

***Cardiovascular Education Series*:** A key component to risk factor modification is education. It is very important for all of our patients to attend our classes and support groups. Patients and community members wanting to learn more about heart health, or talk with others in a welcoming setting, are encouraged to attend. Classes are offered weekly. Risk reduction education is focused on the following:

- EXERCISE – Participants are taught training principles, the components of an exercise program, how to improve each component, and the benefits of regular exercise.
- NUTRITION – Members learn about heart healthy eating, how fat and cholesterol impact the heart and vessels, planning a balanced meal, and what the major nutrients do for the body and why they should consume them.
- HEART DISEASE – Most of the classes explain the major risk factors for heart disease, which risk factors are modifiable, and how to decrease specific factors.
- HYPERTENSION – This class educates those with hypertension and those at risk for developing hypertension; topics include pathophysiology, diagnosis, and treatment of high blood pressure. In addition, members receive instruction regarding stroke - the causes, signs/symptoms, and the methods of diagnosis and treatment of a stroke.
- STRESS MANAGEMENT – The importance of stress management in the primary and secondary prevention of coronary heart disease is taught in this class. Participants learn what stress does to the entire body, both physically and psychologically, and are given numerous tips on how to decrease and manage stress.
- WEIGHT MANAGEMENT – Attendees learn the importance of consuming a variety of nutrients, how to lose weight safely, and are instructed in behavior therapy and altering the environment in which they live.
- CARDIAC SUPPORT GROUP – This class allows adults with cardiac disease, and at risk of cardiac disease, to share their feelings, needs, and concerns with other cardiac patients who have experienced the same events. This is a proven therapeutic model for coping and achieving a faster recovery.
- OPEN FORUM WITH PHYSICIAN – Patients at risk of cardiac disease are able to freely ask questions regarding heart disease pathophysiology, diagnosis, treatment, medications and cardiac rehabilitation.

Ancillary Services

Pomona Valley Hospital Medical Center's Ancillary Services include:

- *Case Management*
- *Social Services*
- *Chaplain Services*
- *Education*
- *Epidemiology and Infection Control*
- *Administration/Human Resources*
- *Marketing and Public Relations*
- *Patient Relations and Risk Management*
- *Pharmacy*
- *Laboratory*
- *Food and Nutrition Services*
- *Physical Therapy*
- *Respiratory*
- *Volunteers Services*
- *Medical Staff and Family Medicine Residency Program*

Administration and Human Resources

Pomona Valley Hospital Medical Center (PVHMC) Administration and Human Resources Departments actively work to support local community organizations that share our mission and vision for a healthy community. Donations are made to organizations that provide community support services such as assistance to victims of domestic violence, sexual assault crisis and prevention services, healthcare support services, social service, socio-economic development, and child development.

Cash Donations and In-Kind Contributions

In 2018, Pomona Valley donated over $190,000 to local community organizations that support the needs of our broader community and our most vulnerable populations. Such organizations include:

- Boys Republic
- Bright Prospect
- Casa Colina Health Foundation
- Fairplex Child Development Center
- Community Senior Services
- Hillcrest Senior Center
- Inland Valley Hope Partners
- Inland Valley Recovery
- Kiwanis Club
- Morrow Pancreatic Health Foundation
- Namiwalk Los Angeles
- National Health Foundation
- Partners in Care
- ParkTree Community Health Clinic
- Project Sister
- Shoes that Fit
- The Learning Centers
- Youth and Family Club

Community Building Activities

Coalition Building: Participation in community health groups such as the Health Consortium of the Greater San Gabriel Valley (formerly known as Los Angeles County Service Planning Area (SPA) 3 Health Planning Group).
Physician Assistance Program: This program provides loans to new physicians in specialties identified as a need, to help them with starting their practices in our community. Pomona is a designated Medically Underserved Area (MUA) and PVHMC recruits physicians to fill the shortage and actively address the needed medical care to many of our Medi-Cal and indigent patients**.**

In 2018 PVHMC recruited the following specialties:

- Orthopedic Surgery
- OB/GYN
- Cardiology
- Laborist

Career Day: PVHMC Human Resources annually attends Pomona Valley Unified School District to speak to high school students about careers in healthcare. In 2018, PVHMC also participated in a Community-wide career day at Ganesha Park to provide information about healthcare careers, as well as Pomona Adult School. In 2018, approximately 300 individuals were served.

Case Management, Social Services, and Chaplain Services

Subsidized Health Services

Home Medications: This service provides oral or parenteral medications as prescribed by the physician for home, and ensures the continuing healthcare needs of the indigent and underinsured patients are met post discharge.

Durable Medical Equipment: Provides equipment such as walkers, wheelchairs, oxygen, glucometers, apnea monitors, beds, wound VACs (Vacuum Assisted Closure) or other durable medical equipment ordered by the physician. This benefit assists in the indigent or underinsured patient's recovery course at home.

Home Health Visits: Provides a visiting nurse to the indigent or underinsured patient's home to administer a service ordered by the physician. This service is able to provide treatment, medication, and assessment of physical condition, and would allow patients to continue their treatment at home - especially when their illness prevents them from getting care outside of that environment.

Community Health Improvement Services

Social Services: Discharge planning and community resources for underinsured and uninsured persons beyond routine discharge planning; planning includes, but is not limited to, skilled board and care placement and referral for homeless and mental health and substance abuse treatment.

Clothing Donation: Provides clothing to our homeless and indigent patients before discharge.

Homeless Recuperative Care Program: Housing for homeless while recovering (Recuperative Care program). Also contributes to providing clothing for homeless patients.

Health Professions Education

Social Services Internships: PVHMC partners with the University of Southern California (USC) and California State University, Long Beach (CSULB) to provide onsite training for Masters of Social Work (MSW) students. Also, educational in-services offered to health professionals on mental health topics in the community.

Education Department

Pomona Valley Hospital Medical Center's Education Department provides both in-house and community education services and training.

Community Health Improvement Services

Hands-Only CPR: The Hands Only CPR program is a one-day event that provides basic hands-on Cardio-Pulmonary Resuscitation (CPR) training to individuals in the community. Using the American Heart Association's Family & Friends CPR Anytime kit - which includes a demonstration manikin and training video –PVHMC's Education and Emergency Department collaborate with local fire departments and spend the day at various locations in the community teaching the layperson life-saving CPR. About 475 persons served in 2018.

Health Professions Education

Nursing Student Preceptorship: Senior nursing students work clinically with staff nurses in Medical/Surgical and Telemetry units. 120 students served in 2018.

Clinical Nursing Experience: The Education Department offers clinical experience for nursing students from community colleges, and universities (public and private). Instructors from the Education Department are oriented on how to competently supervise in clinical areas and assist in orienting these nursing students.

Nursing Advisory Board: The Education Department serves on Nursing Advisory Boards as advisors to local schools (e.g., Chaffey College, Western University of Health Sciences, Mount San Antonio College, Citrus College), to assist in meeting requirements for their Nursing programs.

Food and Nutrition Services

Community Health Improvement Services

Community Nutrition Education: Support for community through nutrition education such as senior nutrition, prostate cancer forum, diabetes workshop, healthy eating, and Ostomy support. Approximately 68 persons served in 2018. Wellness Markets offered in collaboration with Cal Poly Pomona

Health Professions Training

Dietetic Internships: PVHMC is a clinical and management site for Dietetic student interns from California State Polytechnic University, Pomona (CPP) and California State University, Los Angeles.

Food and Nutrition Regional Opportunity Program (ROP): Training for high school students enrolled in an ROP program. 4 students served in 2018.

Cash and In-Kind Contributions

Meals on Wheels: Meals are provided to homebound members of our community. In 2018, 6,583 persons served.

Marketing and Public Relations

Marketing and Public Relations participates in the community by attending several yearly activities to inform and educate.

Community Health Improvement Services

Community Health Fairs and Events: A wide variety of health information is provided to participants. Some events teach "Hands-Only CPR" that can save lives in the future. Other events provide health risk assessments and/or screenings (diabetes, blood pressure, etc.). Included in this category is the LA County Half-Marathon where health information is provided to thousands of walkers/runners over the two day event. We also were present at the Modern Pentathlon also held at the Fairplex. In 2018, we did our first annual "Jump Rope" activity at a local elementary school to demonstrate the importance of exercise on heart and vascular health. Over 4,000 persons in our primary and secondary service areas benefited from these events.

Speakers Bureau: Physicians, clinicians, dietitians and other healthcare providers speak to community groups (i.e. Kiwanis, Rotary, retirement communities, employer-based audiences, etc.) on a multitude of health topics.

American Health Journal Segments and Programs: Televised on PBS nationally, interviews with community Physicians on health topics of interest. In 2018, in addition to the viewing of the segments, a programs was created featuring physicians from The Robert and Beverly Lewis Family Cancer Care Center.

Hospital Information: Essential Hospital information is provided to all who enter the Hospital via the "Patient Guide." This guide includes all state and federal required patient rights and responsibilities along with how and where to find services (i.e. Food Court, visitor guidelines, etc.)

Hospital Website: The website is designed to inform the public of all services, programs, classes and special events that take place at PVHMC. The community can access information 24/7, and provides a place to submit requests for additional information that is sent directly to Associates to reply.

Hospital Tours: Tours can be scheduled for community residents and schools interested in learning more about the Hospital and what services are available.

Cash and In-Kind Contributions

Annual Tree Lighting: PVHMC holds an annual event where the community is invited to see the lighting of the Christmas tree atop of the main Hospital. Free photos with Santa, children's activities, entertainment and refreshments make for a festive holiday event.

Clothing Donation Drive for the Homeless: Associates donated warm clothing and blankets to the homeless shelter in downtown Pomona and were delivered before Christmas.

Medical Staff Office and Family Medicine Residency Program

Health Professions Education

Medical Student Clerkships: Inpatient clerkships for medical students from Western University of Health Sciences and Family Health Center clerkships for medical students from the David Geffen School of Medicine at the University of California, Los Angeles (UCLA).

Nurse Practitioner Training: Training at the Pomona Family Health Center to Nurse Practitioner students from Western University of Health Sciences and other colleges.

Medical Library: All types of library services, including printing and online resources, reference and research assistance, guidance and instruction on research skills, and evaluation of information, are available to the community and to students in health-related programs, as well as to affiliated physicians and other health care providers.

Continuing Medical Education (CME): Pomona Valley Hospital Medical Center is accredited by the Institute for Medical Quality, and the California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. CME courses are provided at PVHMC to increase the knowledge, performance, and competence of our physicians, residents, and associates. The most frequently attended CME activity is the Tuesday Noon Conference which Medical Staff members, Hospital associates and any other interested physicians in the community are welcome to attend; physicians do not have to be on staff with PVHMC. Most of our CME events, with the exception of several full- and half-day seminars, are provided free of charge.

Family-Medicine Residency Program

Caring for the Community

Many physicians, especially those who practice Family Medicine, stay in areas where they complete their residency. Through affiliation with the David Geffen School of Medicine at UCLA and academic relationship with Western University of Health Sciences, College of Osteopathic Medicine of the Pacific, PVHMC provides a Family Medicine Residency program that aims at keeping physicians in the Pomona Valley region.

The program, which currently has 24 residents and has graduated over 120 residents in the past 20 years, is committed to developing compassionate physicians with strong clinical and communication skills to care for our community. Our belief is that the clinical and academic goals of residents are best achieved working alongside experienced family physicians in a facility dedicated to the care of patients and families. Residents function in a team environment emphasizing creativity, innovation, integrity, and the care of patients and families from the beginning to the end of life. Recognizing the cultural richness and ethnic diversity of our community, we select residents and faculty who mirror that diversity and share a common set of values and commitment to caring for this population.

Adjacent to the hospital, the program is centered at our Family Health Center (FHC). The center is staffed by faculty, resident physicians, and a nurse practitioner. The FHC offers comprehensive care through the continuum of life; this includes: adult and well child care, complete maternity care, specialty gynecologic, dermatologic, and musculoskeletal procedures. Our physicians also care for the elderly in the community at skilled nursing facilities and hospice. Our residents are trained in underserved medicine through a Federally Qualified Health Center (FQHC) system in the community.

In addition, the program offers a Family Medicine Residency Clerkship, offering medical students the opportunity to accompany residents and faculty in an inpatient and ambulatory setting. The clerkship integrates concepts of resource utilization, continuous quality improvement and clinical effectiveness into the curriculum. Based upon our community's demographic profile, issues related to minority and underserved populations are our highest priorities. In 2017, the family medicine residency program offered over a dozen family medicine rotations to medical students in their third and fourth year of training. Over two hundred medical students from varying specialties were processed and oriented to the hospital through the Department of Academic Affairs, an administrative role served by the staff of the family medicine residency program.

Track System

Specialized tracks to augment learning in geriatrics, sport's medicine, women's health, and care of the underserved are available in the second and third year of training. These tracks are coordinated by faculty with added qualifications in geriatrics, palliative and hospice medicine, sports medicine as well as fellowship training in obstetrics. All tracks include academic faculty development and additional conference stipend. Track residents are selected based on their interest and good academic standing at the end of first year of residency.

Geriatrics

The Geriatrics Track is an opportunity for those residents considering a geriatrics fellowship, inpatient work or caring for the elderly with a strong interest in internal medicine and/or end of life issues to pursue a more intense geriatric experience.

Obstetrics and Women's Health

Obstetrics and Women's Health are vital components of Family Medicine. The OB and Women's Health track was instituted to provide interested residents with greater exposure, training, and mentoring in this area.

Sports Medicine

The sports medicine track trains residents to be competent in management of musculoskeletal health. The curriculum provides the resident with a solid foundation for care of individuals with athletic injuries.

Medically Underserved Health

The Medically Underserved Health track was instituted to provide interested residents with greater exposure, training, and mentoring in health care disparities, the patient-centered medical home and community clinics.

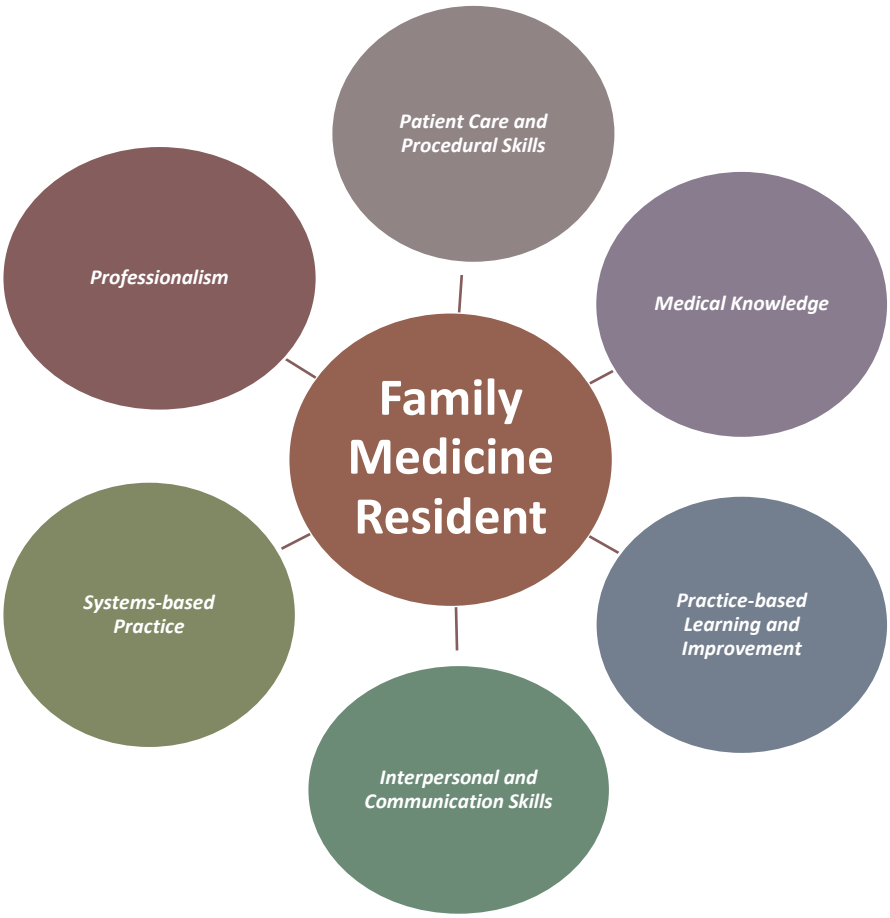
Employment Opportunities for Graduates

Post training employment opportunities are available within Premier Family Medicine Associates and with Pomona Valley Hospital Medical Center. These include but are not limited to, the PVHMC Family Medicine Residency Program, PVHMC hospitalist group, outpatient practices, urgent care, or FQHCs and other clinics in the community.

Twenty Years of Preparing Physicians to Serve Our Community

Started in 1997 with 10 residents, 6 clinical physician faculty, and 1 continuity clinic, we now have 24 residents, 25 faculty, and 2 sites for continuity clinic. As of June of 2018, we graduated a total of 116 Family Medicine Physicians from our residency program. The majority of our graduates go on to practice Primary Care and many stay in the local community and enjoy working with the underserved, while some move on to become academic physicians or continue their education by completing a specialty fellowship. Alumni have established various practice types, from academic, urgent care, FQHC, private practice, small group practice, HMO, Veterans Affairs, corporate, and hospitalist roles. This is a tremendous achievement and puts us well on our way to accomplishing the original mission of the residency; to populate the Inland Empire and our community with young, well-trained family physicians. Over the next 20 years, we

will continue to provide our community with the highest quality physicians who provide the best in-patient care and display qualities in line with our values.



PVHMC's Residency Program journey has been and continues to be informed by our values:

Commitment to Community is pivotal as community is at the center; all else flows from it.

Commitment to Ethical Principles of honesty, integrity, humility and empathy;

Commitment to Diversity and Cultural Competency ideal for patient and family centered care;

Commitment to Patient Advocacy to ensure appropriateness of care;

Commitment to Physician Wellness to ensure the sustainability of a healthy community;

Commitment to Excellence in patient care with a strong foundation in evidence based medicine.

PVHMC Family-Medicine Residency Timeline	
Year	
1997	Family Health Center – Pomona opens
	Family Medicine Residency Program begins with 10 residents
1999	Graduation of first class
	3 residents graduate
2000	Establishment of PVHMC Satellite Division - first PVHC clinic opens in Chino Hills
	1 graduate establishes practice at Chino Hills clinic
	2 graduates establish private practice in Pomona
	Introductions of specialty tracks: Sports Medicine & Women's Health
2002	Pomona Clinic Coalition - focus on underserved population
	1 graduate establishes practice at Pomona Clinic Coalition
2003	Introduction of Geriatric Track
	Pomona Valley Health Center – Grand Avenue, Chino Hills opens
	3 graduates establish practice at new PVHC site
2005	First graduate accepted into a Sports Medicine Fellowship
	Since 2005, 3 graduates have completed a Sports Medicine Fellowship
2006	First graduate accepted into a Geriatric Fellowship
	Since 2006, 5 graduates have completed a Geriatric Fellowship
2007	Pomona Valley Health Center - Crossroads, Chino Hills opens
	4 graduates establish practice at new PVHC site
2008	Introduction of technology (Electronic Practice Management/Electronic Health Record)
2010	Pomona Valley Health Center - Claremont opens
	2 academic faculty establish practice at new PVHC site
2012	Residents begin leading PVHMC Rapid Response team
	Federally Qualified Health Center (FQHC) - designation
	3 graduates establish practice at the FQHC
2014	Introduction of the Underserved Track
	First graduate accepted into Sleep Medicine Fellowship
2015	ACGME approval to expand from 6-6-6 program to 7-7-7 program
	Establishment of Urgent Care fellowship at PVHMC
	1 graduate to date; working with Premier Medical Group Urgent Care
	First graduate named as Associate Program Director
2016	Resident graduate/faculty member completes Academic fellowship
	2 faculty have completed Academic Fellowship to date
2017	PVHC - La Verne location projected to open
	4 graduates are scheduled to establish their practice at the new site
2018	ACGME approval to expand from 7-7-7 program to 8-8-8 program
	8 graduates have completed fellowship
	Addition of Fellowship Trained Family Medicine Obstetrics and Geriatrician to Faculty

Patient Relations and Risk Management

Community Health Improvement Services

Transportation Services: Provides taxi vouchers to needy patients and families to assist with transportation to home and/or other facilities. Approximately 1,332 persons served in 2018.

Pharmacy

Community Health Improvement Services

Medications for those unable to pay: A transition supply of medications is provided for patients who cannot pay or who are uninsured, particularly children and the homeless in the Emergency Department (ED).

Physical Therapy and Rehabilitation Services

Rehabilitation Services

The Charles M. Magistro Physical Therapy and Rehabilitation Center, home to PVHMC's Rehabilitation Services Department, was established 1954 by its namesake, Charles Magistro, PT, a pioneering physical therapist and innovative icon in the profession who led the development and expansion of the department and served as its director for 35 years. Since then, the department continues to lead the way in the field of rehabilitative healthcare.

Today, we are located on the first floor of the Robert and Beverly Lewis Outpatient Pavilion at PVHMC. In addition to our Pomona location, we offer convenient outpatient rehabilitation services 5-6 days a week at our clinics in Claremont, Chino Hills, Covina, and La Verne and at our Milestones Centers for Child Development in Chino Hills and Claremont. We also provide inpatient services at PVHMC seven days a week.

We employ over 60 licensed therapists, including a Certified Hand Therapist (CHT). Many others hold board certified credentials from the American Physical Therapy Association (APTA) naming them as clinical specialists in the fields of Orthopedics (OCS), Neurology (NCS), Geriatrics (GCS), and Pediatrics (PCS). Our staff is committed to continuing education. In fact, many serve as clinical instructors and frequently speak to athletic teams, fitness, clubs, universities and other organizations.

We have long been a trusted and successful provider of the region's most comprehensive rehabilitation services. Each and every one of our services is designed to meet the needs of our community. Whether our patient's daily activities are performed at home, at work, or on the athletic field, our qualified therapists will address their condition and help them get back to doing what they love.

Our services range from physical therapy, to occupational and speech therapy, to cardiovascular and pulmonary rehabilitation – all with customized treatment plans to meet the exact needs of the patient. The scope and specialization of our services provide diagnostic specific therapy programs that improve quality and efficiency. Utilizing evidence-based practice guidelines, our seventeen specialized "Get Well" programs are led by therapists with advanced certification.

Rehabilitation at PVHMC extends from the routine to the highly specialized, offering expertise ranging from neonates, to geriatrics, to injured workers, to weekend warriors through our outpatient clinics, acute care units, Sports Medicine Center, Wound Care Center, Milestones Center for Child Development and Stead Wellness Center.

Community Health Improvement Services

Living Well After Cancer: Performed at The Claremont Club, the *Living Well After Cancer* program includes physical screenings for individuals following their cancer treatment. PVHMC Physical Therapists offer recommendations on appropriate gym exercises as well as precautions. In 2018, 40 persons were served.

Community Balance and Fall Reduction Lectures: PowerPoint lectures with question & answer sessions offer information on common balance and vestibular problems to senior citizen residents. Approximately 80 persons served in 2018.

Sports Medicine Center: As one of the first hospital-based Sports Medicine Programs in the area, the Sports Medicine Center (SMC) at Pomona Valley Hospital Medical Center (PVHMC) has consistently set the pace in the education, prevention, treatment, and rehabilitation of injuries for local athletes of all ages and skill levels since 1983. Today our affiliation with Premier Family Medicine and the PVHMC Family Medicine Residency Program expands our services with further medical expertise and innovative programs. Providing support, education, service, and assessment to local students and schools for over three decades has made us one of the leading sports medicine centers in the region.

- SUPPORT of local athletic trainers who need additional assistance with event coverage are provided through the SMC's network of Physicians and Physical Therapists, including on field physician game coverage during football season.
- EDUCATION is provided by the SMC on many levels. Resident physicians in the PVHMC Family Medicine Residency Program-Sports Medicine Track receive training as part of our weekly Sports Medicine clinic. High school sports medicine students are taught to assist with blood pressure and vision checks during sports physicals. High school athletic trainers and sports medicine club students are offered opportunities to assist the SMC at community athletic events.
- SERVICE to the local athletic community is provided through the SMC's performance enhancement, injury prevention and pre-participation sports physicals available to all local athletes. Partnering with local schools (Bonita High School, Charter Oak High School, Claremont High School, Damien High School, San Dimas High School, St. Lucy's Priory High School) to provide group sports physicals at PVHMC's SMC clinic, offers fundraising opportunities for the schools' athletics programs. In 2018, a total of $13,290 was raised, and donated back, to 6 local high schools.
- ASSESSMENT of sports injuries are provided free of charge in our Sports Medicine Center Evening Clinic. Continuing our long tradition of providing free expert, timely, cost-effective treatment for all athletes in the community, the SMC clinic offers free injury assessment performed by a sports trained physician who is often assisted by family medicine residents. When needed, the screening also includes free Physical Therapy consultation, free x-rays, and free referrals to other medical specialists. In 2018, 234 sports injury screenings and 39 x-rays were provided at no cost to individuals in need.

Over a past decade, SMC and PT staff have provided medical coverage for the Holiday 5K and Half Marathon. This year there were 1,080 participants in the 5K held on Saturday, December 8th. On Sunday, December 9, 2018 the Holiday Half Marathon had 4,925 finishers, many of which were high school students from throughout Los Angeles and were participating in their first half marathon. We had 40 volunteers on our Medical Team, including 8 physicians, 6 local athletic trainers and 5 physical therapists, along with high school and college PT and ATC students. This year, we are pleased to report no serious medical emergencies. We treated approximately 50 runners for conditions ranging from dehydration, dizziness, nausea/vomiting, shortness of breath, abrasions, blisters, cramps, muscle spasms and miscellaneous joint pain.

Wellness and Aftercare Programs: Different from formal rehabilitation, our four "Stay Well" programs focus on general health and fitness. Supervised by our rehabilitation staff at our clinics, these Wellness and Aftercare programs are designed to help former patients as they transition to independent exercise. Each program is offered for a small fee and participation is open to the community. Our Wellness programs include:

- **Aquatic Wellness:** Supervised group classes allow participants to work independently on aquatic exercises in warm water indoor pools. Benefits include: decreased impact on weight bearing joints while exercising, increased endurance and strength, improved balance, maintenance and development of muscle tone, and weight management.
- **Cardio-Pulmonary Wellness**: Independent exercisers can work out in a medically supervised fitness gym located at PVHMC, staffed with clinical Exercise Physiologists who provide pre-participation health screening and risk stratification, blood pressure assessments, and individually tailored exercise regimens. This program is structured to assist those in need of managing heart and pulmonary-related conditions.
- **Massage Wellness:** A choice of several massages are performed in a private room by a medically trained and experienced Certified Massage Therapist (CMT). Benefits of this service include: relieves tired and aching muscles, cramps, spasms, low back pain, stiff neck pain, and frequent headache. Massage can also soften scar tissue, reduce chronic pain, increase flexibility and circulation, and provide general relaxation.
- **Gym Wellness:** Participants utilize the equipment in our rehabilitative gym to perform an independent exercise routine. Our rehab Associates monitor participant's safety and are available to answer questions. Benefits include: building strength and flexibility in a safe, non-intimidating environment; excellent transition for former patients as they regain their independence.

Health Professions Education

Clinical Experience for Rehab (PT, OT, SLP) Students: Provides orientation and training for Physical Therapy, Occupational Therapy, and Speech-Language Pathology Students in clinical areas.

Family Practice Residency Training: Orientation of resident Physicians to physical therapy services and how to order appropriately. Residents also receive musculoskeletal assessment training and/or wound care observation.

Community Building Activities

High School Career Day: Provides lectures and education to students regarding a career in Physical Therapy.

Laboratory

The Clinical Laboratory at Pomona Valley Hospital Medical Center (PVHMC) provides comprehensive, state-of-the-art clinical and anatomical testing services to inpatients and outpatients. The Laboratory is fully accredited with Clinical Laboratory Improvement Amendments (CLIA), The Joint Commission, AABB and the State of California. A total of 6 blood drives were hosted by PVHMC in 2018.

Health Professions Training

Clinical Experience for Phlebotomy Students: Phlebotomy externships for students from Chaffey College and Health Staff Training. 40 students served in 2018.

Clinical Experience for Histology Students: Histology externships for students from Mount San Antonio College. 8 students served in 2018.

Radiology

The Radiology Department at PVHMC provides comprehensive radiology services to the physicians and patients within our region 24 hours per day, 7 days per week. The services provided include General Radiology, CT Scanning, Ultrasound, MRI, Nuclear Medicine, PET/CT, Mammography, Dexa and Interventional Radiology. Radiology Services are provided at the main hospital campus and at 6 satellite facilities located in our surrounding communities of Pomona, Chino, Chino Hills, La Verne, and Claremont. In addition, our Breast Health Center is located within The Robert & Beverly Lewis Cancer Center.

Health Professions Education

Radiology Technologist Internship: PVHMC is a training facility for Radiology students from Chaffey College.

Ultrasound, Nuclear Medicine, CT and MRI Training: PVHMC is a training facility for Ultrasound, Nuclear Medicine, CT and MRI students from Loma Linda University.

Respiratory Services

Community Health Improvement Services

Smoking Cessation: Smoking Cessation: Respiratory provides free support for inpatients who wish to be "smoke-free". Education and brochures are provided at bedside, and Therapists work collaboratively with physicians to obtain orders that support patients while they are in the hospital and when they are discharged for long term success.

Health Professions Education

Mount San Antonio College Students: PVHMC's adult Intensive Care Unit (ICU) is a hospital-based training location for students enrolled in the Respiratory Program at Mount San Antonio College; 6 students served in 2018.

San Joaquin Valley College Students: PVHMC is a clinic site for respiratory students from San Joaquin Valley College; 18 Respiratory students served in 2018.

NICU Student Rotation: Respiratory Therapy students are provided with a Neonatal Intensive Care Unit (NICU) rotation with clinical education relating to the diagnosis, assessment, and treatment of respiratory diseases in the neonatal population; 16 students served in 2018.

Volunteer Services

Volunteers at PVHMC help make a difference in the lives of our patients and their families. We had a total of **917** Volunteers (adults, college and high school students) in 2018 totaling **77,495** hours of service. This translates to an estimated value of more than $2.25 million for the Hospital based on a California rate (Source: Independent Sector). We are proud of our Volunteers and the invaluable service they provide to our community.

Volunteers may choose to participate in direct patient care services or in non-patient care services. Programs and activities provided through our volunteer services include:

Community Health Improvement Services

Flu Clinic: Free flu shots were given to visitors of the Auxiliary's Charity Classic Car Show. 35 persons served in 2018.

Community Safety Training Services

Community Disaster Drill: Following attacks throughout the country such as the Route 91 Harvest Festival shooting and the Orlando nightclub shooting, agencies throughout the San Gabriel Valley, including PVHMC, joined forces to conduct a full emergency drill. The drill was an active shooter simulation held at the LA County Fairplex grandstands. PVHMC Volunteers were used to assess the transportation, EMT, S.W.A.T., Hospital, etc. response needs in an active shooter situation. 35 PVHMC Volunteers assisted with this simulation.

Cash and In-Kind Contributions

Children's Services: The Volunteer Services Department provides comfort items to children (patients, visitors, siblings) including blankets, plush toys, games, pediatric toy box items, crayons, and coloring books. With the addition of a Child Life Specialist to the Pediatric Department, more age and ability specific requests have been fulfilled by the Volunteer Department in 2018. Additionally, children's items are donated to community agencies such as local Adopt-A-Family programs, Santa Claus Incorporated, and local churches for holiday toy drives in our community; approximately 1,000 persons served in 2018.

Scholarships: The Auxiliary of PVHMC grants scholarships to high school and college Volunteers that are pursuing careers in the medical field. In 2018, 11 students were rewarded $9,500 in scholarships.

Infant Layette Sets: Infant layette sets are given to families in need for their new baby, including clothing and blankets; 130 persons served in 2018.

Car Seats: A safety rated infant car seat is provided to low income and needy families with a newborn infant; 12 families served in 2018.

NICU Parent Transportation Assistance: PVHMC's NICU serves many low-income families; a percent of this population is unable to afford regular trips to and from PVHMC to visit their babies. The Auxiliary of PVHMC provides

gas cards for distribution as seen fit by the assigned social worker to assist with the cost of transportation to and from the NICU. Sixty $20 cards were distributed to NICU families in 2018.

In addition to the gas cards, the Auxiliary provides Van transportation from the High Desert to the Hospital for families who do not have other modes of transportation available. The Care-A-Van service provided multiple rides for two families in 2018, an expense of $2,754.61.

School Supply Collection: In 2018, the Volunteer Department ran a school supply collection drive to benefit local Palomares Academy of Health Sciences, a local high school in Pomona, CA. The drive collected and donated (among other miscellaneous items):

Pens	490	Colored Pencils	30 (12 packs)
Highlighters	71	Markers	4 (10 packs)
Erasers	257	Crayons	10 (12 packs)
Glue (sticks and craft)	94	Notebooks	98
Index Cards	27 (100 each)	Lined Notebook Paper	8 Reams
Pencils	1,119	Binders	10

Outreach Services

A part of PVHMC's mission is our dedication to "continuously strive to improve the status of health by reaching out and serving the needs of our diverse ethnic, religious and cultural community." PVHMC has partnered in initiatives like the ParkTree Community Health Center, formerly known as the Pomona Community Health Center (PCHC), that allow the Hospital to reach out to the medically underserved local community.

ParkTree Community Health Center (*Formerly Pomona Community Health Center)*

Initially founded by Pomona Valley Hospital Medical Center in August1995, in response to the high volume of emergency care services sought by the most vulnerable members of our community, ParkTree Community Health Center (PCHC) provides comprehensive primary care services and medication at no or reduced cost.

In March, 2007, under the stewardship of PVHMC Family Medicine Residency Program graduate, Dr. Jamie Garcia, the original 2-exam room clinic in the Department of Public Health achieved Federally Qualified Health Center (FQHC) status and re-located to a new 12 room exam clinic in the Village complex located on Indian Hill and Holt Avenues. The Village was visited by Barack Obama in 2008 and recognized for its innovative "one stop - wrap around social services" for the homeless and working poor.

Today there are five locations situated in the cities of Pomona and Ontario to better serve the needs of Pomona Valley and San Bernardino residents, offering:

- Primary healthcare including diagnosis, treatment, medications, and laboratory tests
- Pediatric care such as well child visits, immunizations, and WIC health screenings
- Prenatal care/obstetrics
- Reproductive healthcare for men and women including contraceptive services, screening and treatment of sexually transmitted infections, and cancer detection
- Teen services
- Homeless healthcare and case management
- Chronic disease management for diabetes, asthma, and other illnesses
- Dental services for children and adults
- Medi-Cal and Covered California enrollment assistance
- Mental health services

The mission of the PCHC is to provide preventive and primary care services to the needy in the community. Accomplishing this mission depends on the generous support of a number of foundations, corporations, and caring individuals. PCHC collaborates with Pomona Valley Hospital Medical Center, Blue Shield of California Foundation, California Community Foundation, LA Care Health Plan, IEHP, Kaiser Permanente, The Ahmanson Foundation, The Rose Hills Foundation, The UniHealth Foundation, and the Valley Academics Foundation. Additional Information, including locations and hours, can be found by visiting PVHMC's website (pvhmc.org) or the Pomona Community Health Center website (www.PomonaCHC.org).

PVHMC continues to provide visionary support and in-kind support to ParkTree including Information Technology, Maintenance, Marketing, Financial Advisement, and Grant Writing services.

Summary of Key Services

The following table provides a summary of key Community Benefit programs and activities provided by PVHMC to address the health needs of our community, identified in our most recent Community Health Needs Assessment (CHNA). It is organized according to categories on Schedule H of the Internal Revenue Service (IRS) 990 form.

PVHMC Programs Addressing Priority Need		**Chronic Disease Management**	**Health Education / Wellness**	**Access to Care**	**Broader Community**	**Vulnerable Population**
Community Health Improvement Services	Cancer Education, Events, Wellness Programs and Support Groups	✓	✓		✓	✓
	Cardiac Education, Events and Support Groups	✓	✓		✓	✓
	Family Birth Services Education, Events, and Support Groups	✓	✓		✓	✓
	Recuperative Care Program	✓	✓	✓		✓
	Hands-Only CPR in Community		✓		✓	
	Health Fairs, Community Events, Immunization Clinic	✓	✓	✓	✓	✓
	Sports Medicine Center		✓	✓	✓	
	Maternal-Fetal Transport Program			✓	✓	✓
	Family Medicine Residency Program			✓	✓	✓
	Hospital Food Drive					✓
	Meals on Wheels	✓	✓		✓	✓

PVHMC Programs Addressing Priority Need		Chronic Disease Management	Health Education / Wellness	Access to Care	Broader Community	Vulnerable Population
	Speakers Bureau	✓	✓		✓	
	Community Blood Pressure Screenings	✓	✓	✓	✓	✓
	Hands-Only CPR		✓		✓	
	Women's Conference	✓	✓		✓	
	Diabetes Research and Community Screenings	✓	✓	✓	✓	✓
Health Professions Education	Physicians, Residents, Nurses and other professions; training and education	✓	✓	✓	✓	
	Perinatal Symposium	✓	✓		✓	
	High School Career Day		✓		✓	
Subsidized Health Services	Paramedic Base Station			✓	✓	
	Ambulance and Transportation			✓		✓
	Medications and Durable Medical Equipment		✓	✓		✓
	Home Health Visits	✓	✓	✓	✓	✓
Research	Cancer Care & SHVC Clinical Trials	✓		✓	✓	✓
Cash and In-Kind Contributions	Wig Program		✓		✓	✓
	Administration,		✓		✓	✓

PVHMC Programs Addressing Priority Need		Chronic Disease Management	Health Education / Wellness	Access to Care	Broader Community	Vulnerable Population
	Human Resources and Facilities Donations					
	ParkTree Center Support			✓		✓
	Medical Coverage for Los Angeles County Marathon		✓	✓	✓	
Community Building Activities	Coalition Building	✓	✓	✓	✓	✓
	Nursing Advisory Committee and Senior Services Board	✓	✓		✓	
	Physician Assistance Program	✓	✓	✓	✓	✓
	High School & Veterans Career Days		✓		✓	✓

Valuation of Community Benefits

For 2018, PVHMC's total value of community benefits came to **$88,190,022** (Schedule H (Form 990) Part I.7.k.). The amounts for Charity Care, Means-Tested Government Programs, and Other Benefits are shown.

Table 12. Economic Valuation of Community Benefit in 2018.

Charity Care and Means-Tested Government Programs	
Charity Care	$4,325,953
Medicaid[1]	$68,342,646
Total Unreimbursed Care and Charity Care	**$72,668,599**
Other Benefits	
Community Health Improvement Services and Community Benefit Operations	$2,777,978
Health Professions Education	$5,547,027
Subsidized Health Services	$6,778,385
Research	$103,168
Cash and In-kind Contributions to Community Groups	$314,865
Total Other Benefits	**$15,521,423**
Total Community Benefits for 2018[2]	**$88,190,022**

[1]Inpatient is the net unreimbursed cost (equivalent to Unreimbursed Cost less the Disproportionate Share Payment); Outpatient is net unreimbursed cost

[2]The value of Community Building Activities is an additional $329,516

The process for determining the economic value of the documented community benefits was as follows:

- Uncompensated care was valued in the same manner that such services were reported in the Hospital's annual report to OSHPD
- Charity care was valued by computing the estimated cost of charges (including charity care donations)
- Other services were valued by estimating the costs of providing the services and subtracting any revenues received for such services. Costs were determined by estimating staff and supervision hours involved in providing the services. Other direct costs such as supplies and professional services were also estimated. Any offsets, such as corporate sponsorship, attendance fees, or other income contributed or generated were subtracted from the costs reported

Plans for Public Review

As we proceed with 2019, PVHMC plans to continue supporting its varied community benefit activities and programs currently in place as described in this report, and develop new programs, when appropriate, to meet the needs of the community as identified in our 2018 Community Needs Assessment. PVHMC's next steps include:

- Continuous review of the current Implementation Strategy to track performance measures to gauge the success of strategies and programs in place
- Continue working collaboratively with other community groups (i.e. local public health departments, community based clinics) to optimize PVHMC's outreach efforts, identify where gaps exist, and identify opportunities for additional partnerships
- Continue to meet with community groups and stakeholders to gather input that will be helpful in outlining PVHMC's community benefit programs and activities; PVHMC openly welcomes comments and feedback on our current publications

The Community Benefit Plan, Implementation Strategy, and Community Health Needs Assessment (CHNA) are made widely available to all interested members in both electronic and paper format. The cost of production and distribution of these reports will be absorbed by the Hospital.

To access the Community Benefit Plan Implementation Strategy and CHNA on our website, please visit pvhmc.org and navigate to the Community Benefit Plan Outreach tab under the About Us section on our home page. The direct link is https://www.pvhmc.org/About-Us/Community-Services.aspx

Requests for a paper copies can be made by phone, in person, by email, or by mail, by contacting:

Courtney Greaux
Administrative Services Coordinator
Pomona Valley Hospital Medical Center
courtney.greaux@pvhmc.org
1798 North Garey Avenue
Pomona, CA 91767
(909)630-7398

In addition, the following methods will be utilized to reach members of the community with this information.

- Distribution through our local community collaboratives
- Distribution to city councils within our defined community
- Copies supplied to libraries and community centers within our community
- Copies provided to any agency or business within our community upon request
- Copies supplied to individual members of our community upon request
- Distributed to Hospital managers and staff upon request, with review of goals and objectives

Appendices

- **Appendix A.** 2018 Community Health Needs Assessment – Telephone Survey Questionnaire
- **Appendix B.** 2018 Community Health Needs Assessment Focus Group guides
- **Appendix C.** Secondary Data Resources
- **Appendix D.** Community Resource Directory
- **Appendix E.** California Health and Safety Codes Section 127340-127365
- **Appendix F.** Patient Financial Assistance Program Policy; Full Charity Care and Discount Partial Charity Care Policies

APPENDIX A
TELEPHONE QUESTIONNAIRE

Pomona Valley Hospital Medical Center

2018 Community Needs Assessment

Items in capital letters are not read to the respondent

SHELLO

Hello, I am calling from the Institute of Applied Research at Cal State San Bernardino. Have I reached [READ PHONE # FROM SCREEN]? We're conducting a scientific study of residents' health-related needs for Pomona Valley Hospital Medical Center and we need the input of the head of the household or his or her partner.

1. CONTINUE
2. DISPOSITION SCREEN

SHELLO2 (used only to complete a survey already started)

Have I reached [READ PHONE NUMBER]? Hello, this is _____, calling from the Institute of Applied Research at CSU San Bernardino. Recently, we started an interview with the [MALE/FEMALE] head of the household and I'm calling back to complete that interview. Is that person available?

INTERVIEWER: PRESS '1' TO CONTINUE

SPAN

INTERVIEWER: PLEASE CODE WHICH LANGUAGE THE INTERVIEW WILL BE CONDUCTED IN

1. ENGLISH
2. SPANISH

SHEAD

Are you that person?

1. YES

2. NO

8. DON'T KNOW/NO RESPONSE

9. REFUSED

IF (SHEAD = 1) SKIPTO INTRO

SHEAD2

Is there an adult resident at home?

1. YES

2. NO

8. DON'T KNOW/NO RESPONSE

9. REFUSED

IF (SHEAD2 = 1) SKIPTO INTRO

CALLBK

Is there a better time I could call back to reach an adult resident?

1. YES (SCHEDULE CALL BACK)

2. NO

IF (CALLBK = 2) END SURVEY

INTRO

This survey takes about 10 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.

I should also mention that this call may be monitored by my supervisor for quality control purposes only. Is it alright to ask you these questions now?

1. YES

2. NO

IF (ANS = 2) SKIPTO APPT

AGEQAL

First, I'd like to verify that you are at least 18 years of age.

1. YES

2. NO

IF (ANS > 1) SKIPTO QSORRY

IF (ANS = 1) SKIPTO BEGIN

QSORRY

I'm sorry, but currently we are interviewing people 18 years of age and older.

Is here anyone else at home that I could speak with?

[PRESS ANY KEY TO TERMINATE INTERVIEW OR BACK 2 TIMES]

APPT

Is it possible to make an appointment to ask you the survey questions at a more convenient time?

[HOURS MON-FRI 3-9 PM]

[SAT 11-5 SUN 1-7]

1. YES

2. NO

IF (APPT = 2) END SURVEY

BEGIN

I'd like to begin by asking you some general questions.

[INTERVIEWER: PRESS ANY KEY TO CONTINUE]

Q1

First, what city do you live in?

1. ALTA LOMA

2. CHINO

3. CHINO HILLS

4. CLAREMONT

5. LA VERNE

6. MONTCLAIR

7. ONTARIO

8. POMONA

9. RANCHO CUCAMONGA

10. SAN DIMAS

11. UPLAND

12. OTHER (SPECIFY)

13. OUT OF GEOGRAPHICAL REGION

98. DON'T KNOW

99. REFUSED

IF (ANS = 13) SKIPTO QSORRY2

Q2

What is your zip code in (CITY NAME SHOWS FROM SELECTED Q1)

1. 91701 ALTA LOMA
2. 91737 ALTA LOMA
3. 91708 CHINO
4. 91710 CHINO
5. 91709 CHINO HILLS
6. 91711 CLAREMONT
7. 91750 LA VERNE
8. 91763 MONTCLAIR
9. 91758 ONTARIO
10. 91761 ONTARIO
11. 91762 ONTARIO
12. 91764 ONTARIO

13. 91766 POMONA

14. 91767 POMONA

15. 91768 POMONA

16. 91729 RANCHO CUCAMONGA

17. 91730 RANCHO CUCAMONGA

18. 91773 SAN DIMAS

19. 91784 UPLAND

20. 91785 UPLAND

21. 91786 UPLAND

22. OTHER (SPECIFY)

98. DON'T KNOW

99. REFUSED

Q3

Including yourself, how many people live in your household?

REFUSED [ENTER 999]

Q4

How many children ages 0 - 17 years old live in your household?

REFUSED [ENTER 999]

IF (Q3 = 1) SKIPTO Q4

Q5

How many persons in your household AGES 18 AND ABOVE are covered by Medical Insurance?

REFUSED [ENTER 999]

Q6

How many children in your household AGE 0-17 YEARS are covered by medical insurance?

REFUSED [ENTER 999]

IF (Q4 = 0) SKIPTO Q7

Q7

What type of health insurance covers people in your household?

[INTERVIEWER IF NO INSURANCE CHECK 97 AND MOVE ON. CHECK ALL THAT APPLY]

1. HAVE INSURANCE BUT DON'T KNOW WHAT TYPE
2. PRIVATE INSURANCE (EITHER HMO OR PPO)
3. MEDI-CAL
4. MEDICARE
5. VETERANS (VA)
6. OBAMA CARE, COVERED CALIFORNIA, AFFORDABLE CARE ACT INS
7. OTHER GOVERNMENT INSURANCE (WIC, CHIP, ETC.)
8. OTHER (PLEASE SPECIFY)

97. NOT COVERED (NO INSURANCE AT ALL)

98. DON'T KNOW

99. REFUSED

IF NO INSURANCE AND SOMETHING ELSE CLICK 97 AND CONTROL "N" WE NEED 97 AND A NOTE OF THE OTHER INSURANCE…

IF (ANS not = 97) SKIPTO ACCESS

NOTES:

- IF BLUE CROSS, BLUE SHIELD, IEHP, UNITED HEALTHCARE, AETNA, ETC CHECK PRIVATE INSURANCE NUMBER 2
- WIC = WOMAN, INFANT & CHILDREN PROGRAM
- CHIP = CHILDREN'S HEALTH INSURANCE PROGRAM
- IF UNSURE, CLICK "OTHER " AND WRITE IT IN

Q7a

What is the main reason you or your family members don't have health insurance?

[INTERVIEWER CHECK ALL THAT APPLY]

1. I AM HEALTHY

2. I DON'T NEED INSURANCE

3. DID NOT UNDERSTAND PLANS WELL ENOUGH TO BUY INSURANCE

4. LOST JOB OR CHANGED JOB

5. PERSON WITH PRIMARY POLICY (SPOUSE OR PARENT) LOST OR

   CHANGED JOBS

6. DIVORCE OR SEPARATION
7. PERSON WITH POLICY DIED
8. BECAME INELIGIBLE BECAUSE OF AGE OR LEFT SCHOOL
9. EMPLOYER DOESN'T OFFER OR STOPPED OFFERING COVERGE
10. CUT BACK TO PART-TIME OR BECAME TEMP EMPLOYEE
11. COULDN'T AFFORD PREMIUMS
12. INSURANCE COMPANY REFUSED COVERGE (DUE TO A PRE-EXISTING CONDITION)
13. LOST MEDICAID OR MEDI-CAL ASSISTANCE ELIGIBILITY
14. OTHER (SPECIFY)_____
98. DON'T KNOW
99. REFUSED

ACCESS

Now I want to ask you a few questions about your health care experiences.

[INTERVIEWER: PRESS ANY KEY TO CONTINUE]

Q8

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

1. YES
2. NO
8. DON'T KNOW
9. REFUSED

IF (ANS > 1) SKIPTO Q9

Q8a

What kept you or your family members FROM GETTING the health services you needed?

[DO NOT READ---CHECK ALL THAT APPLY]

1. WORRIED ABOUT COST OF SERVICE/CO-PAYMENTS

2. WORRIED ABOUT COST OF PRESCRIPTION
3. LACKED TRANSPORTATION
4. LACKED CHILD CARE/BABY SITTER
5. HAD PROBLEMS WITH THE ENGLISH LANGUAGE
6. HOURS WERE NOT CONVENIENT
7. DIFFICULTY SCHEDULING
8. NEEDED SERVICES WEREN'T AVAILABLE
9. DIDN'T KNOW WHERE TO FIND THE SERVICES
10. POMONA VALLEY HOSP. MED. CTR. DIDN'T HAVE THE SERVICES NEEDED
11. DIDN'T LIKE THE PROGRAMS OR SERVICES
12. PROVIDER WOULDN'T ACCEPT INSURANCE
13. MEDICAL TECHNOLOGY WASN'T AVAILABLE IN THE AREA
14. OTHER (SPECIFY) _____
15. NO HEALTH INSURANCE AT ALL
98. DON'T KNOW
99. REFUSED

Q8b

What SERVICES couldn't you get?

Q9

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.

1. WITHIN PAST YEAR (1-12 months ago)
2. WITHIN PAST 2 YEARS (13 months to 2 years)
3. WITHIN PAST 5 YEARS (25 months to 5 years ago)
4. MORE THAN 5 YEARS AGO
5. NEVER
8. DON'T KNOW

9. REFUSED

IF (Q4 = 0) SKIPTO Q11

Q10

[Has your child] / [Have your children] had a preventative health care check-up within the past year?

1. YES
2. NO
3. SOME OF THE CHILDREN HAVE
8. DON'T KNOW
9. REFUSED

IF (Q4 = 1)

SHOW "Has your child had"

IF (Q4 > 1)

Show "Have your children had" 5 5

B10a

[Has your child] / [Have your children] received all of the immunizations the doctor recommended?

1. YES
2. NO-NOT ALL VACCINATIONS GIVEN
3. SOME (NOT ALL) KIDS HAVE GOTTEN ALL VACCINATIONS
8. DON'T KNOW
9. REFUSED

IF (Q4 = 1)

SHOW "Has your child"

IF (Q4 > 1)

SHOW "Have your children" 5 5

Q112018

Changing subjects now… Do you typically find it difficult to eat healthy or maintain a healthy body weight?

1. YES
2. NO [SKIP TO Q12B]
3. SOMETIMES
8. DON'T KNOW [SKIP TO Q12B]
9. REFUSED [SKIP TO Q12B]

Q11A: What would you say is the NUMBER ONE reason it is difficult?

[INTERVIEWER—ONE ANSWER ONLY]

1. COST OF HEALTHY FOOD (FRUITS AND VEGETABLES)
2. NOT SURE HOW TO COOK/PREPARE HEALTHY FOODS
3. NOT SURE WHAT IS CONSIDERED "UNHEALTHY"
4. IT'S HARD TO CHANGE MY EATING AND EXERCISE HABITS
5. I LIKE FOOD TOO MUCH
6. I DON'T CARE ABOUT MY WEIGHT
7. TOO BUSY (TO EXERCISE OR PREPARE HEALTHY MEALS)
8. OTHER (SPECIFY)
98. DON'T KNOW
99. REFUSED

Q12B

Has any member of your household had a Pap Smear within the past three years?

1. YES
2. NO
7. NO FEMALE IN HOUSEHOLD **[SKIP TO Q12D]**
8. DON'T KNOW
9. REFUSED

Q12C – DISPLAY ONLY IF Q12b IS NOT 7

In the past YEAR, have you or any members of your household had a mammogram?

1. YES

2. NO

7. NO FEMALE IN HOUSEHOLD **[SKIP TO Q12D]**

8. DON'T KNOW

9. REFUSED

Q12D

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

1. YES

2. NO

8. DON'T KNOW

9. REFUSED

Q12E

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

1. YES

2. NO

8. DON'T KNOW

9. REFUSED

Q12ADD DISPLAY ONLY IF 12B, C, *OR* E IS "NO"

May I ask why people in your household haven't had all of the cancer screenings I mentioned?

[PAP, MAMMOGRAM, COLON] [DON'T READ--CHECK ALL THAT APPLY]

1. NO INSURANCE

2. FINANCIAL THE OUT OF POCKET COST EVEN WITH INSURANCE

3. FEAR OF THE TEST/DISLIKE OF THE TEST

4. DIDN'T THINK IT IS IMPORTANT OR NECESSARY

5. LACK OF CHILD CARE

6. FEAR OF THE RESULTS

7. TOO OLD OR TOO YOUNG TO NEED THE TEST

8. NO TRANSPORTATION
9. NO WOMEN IN THE HOUSEHOLD
10. NO REGULAR DOCTOR
11. HEALTHY PERSON
12. OTHER (SPECIFY) _____
98. DON'T KNOW
99. REFUSED

Q12COMNT

USE THIS BOX ONLY IF PEOPLE HAD AN EXTRA CLARIFICATION COMMENT ON Q12ADD SUCH AS: 'I DIDN'T GET THE COLON CANCER TEST BECAUSE I HATE IT, AND DIDN'T HAVE THE MONEY FOR THE MAMMOGRAM'. EXPLAIN IF THEY HAD DIFFERENT REASONS FOR DIFFERENT CANCER SCREENINGS. OTHERWISE LEAVE BLANK---CLICK ANY KEY AND MOVE ON.

Q13

Do you or any member of your family have any of the following chronic or ongoing health problems: [READ THE OPTIONS AND CHECK ALL THAT APPLY]

1. Cancer
2. Diabetes
3. Asthma
4. High Blood Pressure
5. Obesity
6. Osteoporosis
7. Chronic Heart Failure
8. High Cholesterol/Arteriosclerosis [ahr-teer-ee-oh-skluh-roh-sis]
9. Arthritis
10. Are there any other chronic conditions (specify) _____
11. NONE
98. DON'T KNOW
99. REFUSED

IF (answer > 10) SKIPTO Q152018

Q14

Do you feel you and your family have received adequate help managing the disease?

[IF THEY DON'T KNOW WHAT WE ARE ASKING…"help from doctors, or support groups, classes"

1. YES
2. NO
3. ONLY FOR SOME OF THE ILLNESSES
8. DON'T KNOW
9. REFUSED

IF (ANS = 1) SKIPTO Q152018

IF (ANS > 7) SKIPTO Q152018

Q14a

What HELP did you need that you didn't get?

Q152018

Some people are concerned about cancer? Which type of cancer are you most concerned about? [DON'T READ…CHECK ALL THAT APPLY]

1. BREAST CANCER
2. LUNG
3. COLORECTAL
4. PROSTATE
5. SKIN CANCER
6. CANCER IN GENERAL (ALL CANCERS)
7. NOT CONCERNED ABOUT CANCER
8. OTHER (PLEASE SPECIFY)

98. DON'T KNOW

99. REFUSED

Q162018

What are the best ways of providing you with information about DISEASE PREVENTION such as cancer, diabetes, heart disease, and stroke? [READ AND CHECK ALL THAT APPLY]

1. Community events

2. Doctor's visits

3. TV or social media

4. Mail sent home

5. Other (PLEASE SPECIFY)

7. NOT INTERESTED IN THE INFORMATION

8. DON'T KNOW

9. REFUSED

Q172018

There are a number of places where people can learn more about diseases such as cancer, diabetes, and heart disease. In addition to a doctor's office or hospital, where else would you like to see the information being shared? [DON'T READ… CHECK ALL THAT APPLY, IF THEY DON'T KNOW READ… "for example, places like church, public schools, or supermarkets."]

1. CHURCHES

2. COMMUNITY COLLEGES

3. WORKPLACE

4. LIBRARIES

5. PUBLIC SCHOOLS

6. SUPERMARKETS

7. COMMUNITY EVENTS

8. OTHER (SPECIFY) _____

9. INTERNET

98. DON'T KNOW

99. REFUSED

Q182018

Does anyone living in the house smoke tobacco? [CIGARETTES, CIGARS, OR PIPES]

1. YES
2. NO
3. NO, BUT SOME VISITORS TO THE HOUSE SMOKE IN OUR HOUSE
4. NO, BUT JUST VAPING
5. ON OCCASION/SOMETIMES ONLY
8. DON'T KNOW
9. REFUSED

Q18

Have YOU ever gone to Pomona Valley Hospital Medical Center for health care?

1. YES
2. NO
8. DON'T KNOW
9. REFUSED

IF (ANS > 1) SKIPTO Q19

Q18a

Why did you choose Pomona Valley Hospital Medical Center?

[DON'T READ--CHECK ALL THAT APPLY]

1. CLOSE TO HOME (CONVENIENCE/LOCATION)
2. INSURANCE
3. REFERRED BY MY PHYSICIAN
4. SERVICES OFFERED
5. QUALITY/REPUTATION
6. WORD OF MOUTH (FRIEND, NEIGHBOR, FAMILY, CO-WORKER)

7. LOOKED IN THE PHONE BOOK
8. INTERNET
9. NEWSPAPER
10. RADIO
11. TELEVISION
12. WORK SITE
13. COMMUNITY PRESENTATION
14. OTHER (SPECIFY)
15. 911/EMERGENCY/AMBULANCE/SENT THERE/NO CHOICE
98. DON'T KNOW
99. REFUSED

Q19

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

1. YES
2. NO
8. DON'T KNOW/DON'T REMEMBER
9. REFUSED

Q20

Are there classes you'd like them to offer?

1. YES
2. NO
8. DON'T KNOW
9. REFUSED

IF (ANS >1) SKIPTO Q21

Q20a

What type of classes?

Q21

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

1. YES
2. NO
8. DON'T KNOW /DON'T REMEMBER
9. REFUSED

Q22

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

[DON'T READ… CHECK ALL THAT APPLY]

1. NOT INTERESTED AT ALL
2. SMOKING CESSATION / STOP SMOKING
3. DIABETES
4. HIGH BLOOD PRESSURE
5. CANCER
6. NUTRITION
7. PREGNANCY/NEW MOMS/NEW DADS
8. HEART DISEASE
9. ASTHMA
10. ARTHRITIS
11. STROKE
12. GRIEF AND BEREAVEMENT
13. SLEEP APNEA/SLEEP DISORDERS
14. LIVING WITH A DISABILITY
15. OBESITY AND WEIGHT PROBLEMS
16. CAREGIVERS
17. HOMELESSNESS
18. CHILD/ELDER ABUSE

19. OTHER (SPECIFY)_____

98. DON'T KNOW

99. REFUSED

TRANSER

And now just a few questions about the emergency room at Pomona Valley Hospital Medical Center.

[INTERVIEWER: PRESS ANY KEY TO CONTINUE]

Q23

Have you or a member of your household received services at Pomona Valley's emergency room?

1. YES

2. NO

8. DON'T REMEMBER/DON'T KNOW

9. REFUSED

IF (ANS > 1) SKIPTO Q25

Q23A

What was the reason emergency services were needed?

[DON'T READ… CHECK ALL THAT APPLY]

1. INJURY OR ACCIDENT
2. CHEST PAIN/HEART ATTACK
3. STROKE
4. BREATHING DIFFICULTIES (FLU, SINUS INFECTION, …)
5. OTHER (SPECIFY)
8. DON'T REMEMBER
9. REFUSED

Q24

Did you or the household member try to see your doctor before going to the Emergency Room?

1. YES

2. NO

8. DON'T KNOW /DON'T REMEMBER

9. REFUSED

IF (ANS = 1) SKIPTO Q25

IF (ANS > 2) SKIPTO Q25

Q24a

May I ask why not? [DON'T READ --CHECK ALL THAT APPLY]

1. DON'T HAVE A REGULAR DOCTOR

2. AFTER OFFICE HOURS

3. BROUGHT BY AMBULANCE

4. DOCTOR TOO BUSY TO FIT ME IN

5. OTHER (SPECIFY) _____

8. DON'T REMEMBER

9. REFUSED

Q25

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

1. EXCELLENT

2. VERY GOOD

3. FAIR

4. POOR

8. DON'T KNOW

9. REFUSED

Q262018

What is the biggest health related issue or service that the community needs to focus on? [OPEN ENDED, MULTIPLE RESPONSE.]

1. AFFORDABLE HEALTH CARE/FREE SCREENINGS
2. HOUSING FOR HOMELESS
3. MENTAL SERVICES (BETTER ADVERTISING AND LOWER COST)

4. OBESITY
5. PREVENTIVE CARE
6. PLACE TO BUY HEALTHY FOODS AFFORDABLY
7. SERVICES FOR DIABETES
8. OTHER (PLEASE SPECIFY, GET WORD FOR WORD)
9. AFFORDABLE MEDICINE
10. ADDICTION TREATMENT
11. CANCER CURE/TREATMENT

98. DON'T KNOW

99. NO COMMENT/REFUSED

DEMOGRAPHIC QUESTIONS

And finally I'd like to ask a few questions about you and your background…

[INTERVIEWER: PRESS ANY KEY TO CONTINUE]

D1

What was the last grade of school that you completed?

1. SOME HIGH SCHOOL OR LESS
2. HIGH SCHOOL GRADUATE
3. SOME COLLEGE
4. COLLEGE GRADUATE (BACHELOR'S DEGREE)
5. SOME GRADUATE WORK
6. POST-GRADUATE DEGREE
8. DON'T KNOW
9. REFUSED

D2

Which of the following best describes your marital status? …

1. Single, never married
2. Married
3. Divorced
4. Widowed

5. Separated, or
6. Single, living with partner
7. OTHER (SPECIFY)
9. REFUSED

D3

Are you of Hispanic, Spanish, or Latino origin?

1. YES
2. NO
8. DON'T KNOW
9. REFUSED

D4

How would you describe your race or ethnicity?

[DON'T READ…. CHECK ALL THAT APPLY]

1. ASIAN (SPECIFY)
2. BLACK OR AFRICAN AMERICAN
3. CAUCASIAN OR WHITE
4. HISPANIC
5. OTHER (SPECIFY)
8. DON'T KNOW
9. REFUSED

D5

What was your age at YOUR LAST birthday?

GAVE YOU A YEAR [ENTER 997 THEN, CONTROL "n" and type in the year for me.]

DON'T KNOW [ENTER 998]

REFUSED [ENTER 999]

D6

How long have you lived in your community?

[OVER 6 MONTHS…ROUND UP]

JUST MOVED HERE 6 MONTHS OR LESS [ENTER 997]

DON'T KNOW [ENTER 998]

REFUSED [ENTER 999]

D7

Which of the following categories best describes your total household or family income before taxes, from all sources, for 2017? Let me know when I get to the correct category.

1. Less than $25,000
2. $25,000 to less than $35,000
3. $35,000 to less than $50,000
4. $50,000 to less than $65,000
5. $65,000 to less than $80,000
6. $80,000 to $110,000
7. Over $110,000
8. DON'T KNOW
9. REFUSED

END

Well, that's it. Thank you very much for your time - we appreciate it.

Question Gender

The respondent was…

1. Male
2. Female
3. Couldn't tell

Question Coop

How cooperative was the respondent?

1. Cooperative
2. Uncooperative
3. Very Uncooperative

Question Undstd

How well did the respondent understand the questions?

1. Very easily
2. Easily
3. Some difficulty
4. Great deal of difficulty

Question Lng

In what language was the interview conducted?

1. English
2. Spanish

QSORRY2

I'm sorry, but we are only surveying people from Pomona Valley Medical Center Region at this time.

Thank you for your cooperation.

INTERVIEWER: PRESS '1' TO CONTINUE

POMONA VALLEY HOSPITAL
MEDICAL CENTER

Expert care with a personal touch

Focus Group Consent Form

Introduction: Pomona Valley Hospital Medical Center (PVHMC) is in the process of gathering information for its 2018 Community Health Needs Assessment. You have been invited to take part in this focus group because you are an individual who works in the community health field and have access to working with minority and medically underserved populations and are aware of their unique healthcare needs.

Purpose: The purpose of the focus group is to gather information from local health leaders regarding the the health needs of the community in PVHMC's primary service area. The focus group environment is designated to create a space where community health leaders can help identify priority health areas.

Participation: As a participant of this focus group you will be asked about the health needs of the community--primary care and preventative care, support for patients and family, chronic disease management, and wellness. We will also discuss barriers to receiving both routine and urgent health care. Your input will help create the foundation for improving the quality of health services available in the region.

Risk & Benefits: The risks associated with this focus group are minimal. However, you may feel uncomfortable answering some of the questions at this given setting. You are free to skip any question that makes you feel uncomfortable or refuse to answer any item. Please ask questions about anything that you do not understand. You may not benefit from participating in this research directly. You are free to send the research team further information after the focus group that you forgot to mention or felt uncomfortable mentioning in the focus group at that given time.

- This session will be audio recorded for the purpose of reviewing statements that will be vital for the Pomona Valley Hospital Medical Center Report.

Confidentiality: All of your responses to the interview will be private and confidential. The focus group session will be audio recorded the purpose of reviewing statements that will be vital for the Pomona Valley Hospital Medical Center Report. Every effort will be made to keep any information collected about you confidential by PVHMC and CGU students. We will not include your name or any identifiable information in written notes or reports of the focus group. Your privacy is important and this is the reason for having rules which control who can use or see your information. Your responses will be password protected, and kept under lock and key by the CGU students.

If you have any questions or would like additional information about this research, please contact:

Courtney Greaux: courtney.greaux@pvhmc.org

Agreement: By signing this consent form you indicate that you have read the form and agree to voluntarily participate in the focus group. If you agree to take part, you are free to withdraw from the study at any time. If you choose not to take part, no penalty or consequence will occur.

I _____, understand the above information and voluntarily give my informed consent to participate in this study.

The research project and consent form was explained to:

_____ _____

Signature of Participant Date

The person who provided consent confirmed that all of their questions had been answered and they agreed to participate in this research project. They verbally authorized their participation into this research project. They agreed to have Claremont Graduate University use their responses from the focus group for research purposes.

FOCUS GROUP SEMI-STRUCTURED GUIDE

PVHMC FOCUS GROUPS

April 5, 2018

April 12, 2018

POMONA VALLEY HOSPITAL MEDICAL CENTER

Expert care with a personal touch

Part I.

Introductions- Skylar & Devin

a. Explain agenda & purpose of today's FG

Introductions of Attendees

b. Brief background of attendee's role and organization

Part II a.

Thank you for agreeing to participate in this focus group!. Your input will be invaluable in helping 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. Please be assured that your individual responses to this survey (and your contribution to the focus group discussion) will remain anonymous.

1) Name:_____

2) Organization:_____

3) Job Title and role in the organization?

4) What populations do you primarily serve?

5) Briefly, what experience do you have working with minority and medically underserved populations in PVHMC's service area?

6) What types of services does your organization offer?

7) What is the most important thing PVHMC can do to improve the health and wellness of minorities and medically underserved populations in its region?

OPEN DISCUSSION

On the following topic areas

Part II b. Health Needs of the Community:

1. 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?
2. In the area of primary care and preventative health services in our community, can you identify any unmet needs in the 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?
3. In the area of chronic disease management, can you identify any unmet needs in our community? Which population are most affected? Do you have any suggestions on how to meet the needs of our community in this area?
4. 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 the most affected? Do you have any suggestions on how to meet the needs of our community in this area?
5. Can you identify any other unmet health-related needs in our community that we did not mention?

Part III. Barriers to Health

Please provide your opinion on the types of barriers to meeting the needs of our community:

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?

Part IV. Suggestions and Additional Comments

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

Part V. Ranking Exercise

Please see listing of health needs and health drivers below. In order of ranking, **please leave a checkmark on what you believe are the top 3 priorities** most significant unmet needs and should be considered a priority and requires more discussion.

- ❑ Health Education/Support Groups
- ❑ Care Coordination
- ❑ Chronic Disease Management
  - ❑ Heart Disease/Heart Failure
  - ❑ Stroke
  - ❑ Diabetes
  - ❑ Asthma
  - ❑ Other:
- ❑ Cancer Support/Treatment/Resources
- ❑ Primary Care & Prevention Services
- ❑ 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/Resources
- ❑ Day Treatment/Adult Day Care services
- ❑ Physical Therapy/Rehabilitation Services
- ❑ Dental Services

APPENDIX C
RESOURCES FOR SECONDARY DATA

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:

California Department of Public Health (www.cdph.ca.gov)

Census Bureau (www.census.gov)

American Community Survey Five Year Estimates http://www.census.gov/acs/www/data_documentation/data_main/

Healthy People 2020 (https://www.healthypeople.gov/)

Center for Disease Control and Prevention, Pediatric Nutrition Surveillance System http://www.cdc.gov/pednss/pdfs/PedNSS_2010_Summary.pdf

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System http://www.cdc.gov/brfss/

California Health Interview Survey (www.chis.ucls.edu)

National Center for Health Statistics (www.cd.gov/nchs/fastats/hinsure.htm)

San Bernardino County CalOMS dataset (http://www.sbcounty.gov/dbh/calohms.asp)

Centers for Disease Control and Prevention (http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm)

National Institute of Mental Health. Suicide in the U.S.: Statistics and Prevention. http://www.nimh.nih.gov/health/statistics/suicide/index.shtml

The State of Obesity in California Data, Rates and Trends: http://stateofobesity.org/

National Cancer Institute. http://www.cancer.gov/

Diabetes and Digestive and Kidney Diseases (NIDDK) http://www.niddk.nih.gov/health-information/health-statistics/Pages/default.aspx

American Diabetes Association. http://www.diabetes.org/diabetes-basics/statistics/

Cancer Treatment and Survivorship Facts & Figures:2014-2015 http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-042801.pdf

American Cancer Society. http://www.cancer.org/cancer/breastcancer/detailedguide/breast-cancer-key-statistics

U.S. Breast Cancer Statistics. http://www.breastcancer.org/symptoms/understand_bc/statistics

Healthy San Bernardino County. Demographics, Statistics, and Tracking 2020http://www.healthysanbernardinocounty.org/index.php?module=DemographicData&type=user&func=qfview&varset=1

U.S. Health Resources and Services Administration Area Resource http://datawarehouse.hrsa.gov/looking/data.aspx

http://datawarehouse.hrsa.gov/resources/relatedSites.aspx

Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality

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)

http://publichealth.lacounty.gov/gsearch/?cof=FORID%3A11&cx=012881317483563061371%3Avdhgk7yx4bk&q=health+assessment&sa=Go

California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data, Long Care Facilities, Hospitalizations, etc. http://www.oshpd.ca.gov/HID/DataFlow/index.html

http://data.ca.gov/category/by-agency/office-of-statewide-health-planning-and-development/

A lot of data on this site

Nielsen Claritas SiteReports, Consumer Spending Patterns (purchased program) Alcoholic Beverage Spending, Soft Drink Tobacco, Junk Food Healthcare spending (medical services, prescription drugs, medical supplies)

http://www.claritas.com/sitereports/default.jsp

Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-46 58. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

http://www.oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.pdf

California Office of Traffic Safety http://www.ots.ca.gov/Media_and_Research/Data_and_Statistics.asp

State Indicator on Fruits and Vegetables 2013 http://www.cdc.gov/nutrition/downloads/State-Indicator-Report-Fruits-Vegetables-2013.pdf

United States Department of Agriculture Fruit and Vegetable Pricing, http://ers.usda.gov/data-products/fruit-and-vegetable-prices.aspx#33646

Food Intakes Converted to Retail Commodities Data http://ers.usda.gov/data-products/commodity-consumption-by-population-characteristics.aspx

United States Census Health and Nutrition
http://www.census.gov/compendia/statab/cats/health_nutrition/food_consumption_and_nutrition.html

Food Research & Action Center Building Health Communities http://frac.org/pdf/food_ag_policy_collab_brochure.pdf

Gallup 2013 Study Fast Food Still Major Part of U. S. Diet http://www.gallup.com/poll/163868/fast-food-major-part-diet.aspx

Gallup Released January 7, 2015. In U.S., Uninsured Rate Sinks to 12.9% Gallup
http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx

Pew Research Center ACA at Age 4: More Disapproval than Approval But Most Opponents Want Politicians to Make Law Work http://www.people-press.org/2014/03/20/aca-at-age-4-more-disapproval-than-approval/2/

FBI Crime Statistics http://www.fbi.gov/stats-services/crimestats/

Bureau of Justice Statistics http://www.bjs.gov/

Domestic Violence Statistics http://domesticviolencestatistics.org/domestic-violence-statistics/

Center for Disease Control and Prevention Injury Prevention & Control: Division of Violence Prevention
http://www.cdc.gov/ViolencePrevention/youthviolence/stats_at-a_glance/index.html

Law Center to Prevent Gun Violence http://smartgunlaws.org/category/gun-studies-statistics/gun-violence-statistics/

National Institute of Justice http://www.nij.gov/topics/crime/gun-violence/pages/welcome.aspx

And so much more crimes and prevention, drugs & crime

Center for Disease Control and Prevention, Physical Inactivity Estimates, by County

http://www.cdc.gov/Features/dsPhysicalInactivity/

U.S. Department of Health & Human Services Preventions Surgeon General.gov Reports and Publications
http://www.surgeongeneral.gov/library/reports/index.html

California Department of Education Physical Fitness Test, State, County, District Breakdowns
http://www.cde.ca.gov/ta/tg/pf/

APPENDIX D
IDENTIFIED COMMUNITY RESOURCES TO ADDRESS HEALTH NEEDS

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.

Source:

http://www.ci.pomona.ca.us/mm/comdev/pdf/Community_Resource_Directory_Vol12.2__2014.pdf

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.)

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.

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

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.

Catholic Charities
248 E. Monterey Ave
Pomona, CA 91768
(909) 629-0472
www.catholiccharitiesa.org
Utility assistance and Motel Vouchers

Foothill Family Shelter
1501 W. 9th Street, Ste D
Upland, Ca. 91786
(909) 920-0453
Assistance to families with children; geared towards temporary housing up to 120 days.

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.

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
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

West Covina Access Center
415 S. Glendora, Ste F
West Covina, Ca. 91790
(626) 814-2421
A drop-in center where homeless persons can access a wide variety of services.

W.E.W.I.N/For Christ's Sake
727 W. 12th Street
Pomona, Ca. 91766
(909) 622-0094
(909) 721-2915
Provide non-Perishable food, clothing, small appliances, bedding, etc.

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

Crossroads, INC.
P.O. Box 15, Claremont
(909) 626-7847
Home for female parolees re-entering the community.

Foothill Family Shelter
1501 W. 9th Street, Ste D
Upland, Ca. 91786
(909) 920-0453
Must call for an appointment to apply
for shelter. Assistance to families with children; temporary housing up to 90 days.

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.

House of Ruth
Address Confidential
(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.

HPRP
Pomona Plus
248 Monterey
Pomona, Ca. 91767
909.622.2091
Fax 909.629.0328

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.

Mercy House/Trinity House
2040 N. Garey Ave
Pomona, CA 91767
(909) 593-4281
This is a transitional living shelter for single homeless men 18 and older. Participants must be employed or willing to find employment and have no history of violent or sexual crime. This program provides one-on-one evaluation process to set
goals

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.

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.

Fountain of Love Church
Community Development Center
188 W. Orange Grove Ave.
Pomona, CA
Resources and referral for homeless. Food can be picked up. resources.

Helping Hands Caring Hearts Ministry
New Harvest Church
480 W. Monterey St.
Pomona, Ca.
Sunday Dinner @ 3:45
Pantry 3:30-5:30
Sunday Dinner and clothing available

Inland Valley Hope Partners Beta
Program Center
1095 W. Grand Ave.
Pomona, CA 91766
909-622-7278
First time and every 30 days after that applicants will receive 5 days-worth of food (15 meals).

Inland Valley Hope Partners
Certified Farmers Market Garey Ave. and Pearl Street, Pomona, CA
Fresh fruits and vegetables; accepting food stamps, and WIC

Inter City Volunteers
P.O. Box 209
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
909-620-8137
Food distribution

Pomona First Baptist Church
586 N. Main St.
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
(951) 212-2031
Meals, clothes, provide resources and refer to other agencies. Food Pantry 4th Thursday of each month.

Trinity 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.

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
909-772-1213
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
1690 S. White Ave.
Pomona, CA 91766
909-397-5045
Medical referral, Health Family application, childcare referral available, information, and resource referral. Will assist the children of homeless families. No Fee.

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.

Adult Education Center
Pomona Unified School District
1515 W. Mission Blvd.
Pomona, CA 91766
(909) 469-2333
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 Department (EDD)
264 E. Monterey Avenue
Pomona, CA 91769
(909) 392-2659
Unemployment and Employment services

Los Angeles Urban Assistance League
264 E. Monterey Avenue
Pomona, CA 91767
(909) 623-9741
Employment and vocation training services.

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.

Pomona Community Crisis Center
240 E. Monterey, Pomona
(909) 623-1588
Offers outpatient drug rehabilitation including individual, group and family counseling; youth counseling for ages 7-21; drug screening; and drug and domestic violence diversion

Project Sister Sexual Assault Crisis Services
303 S. Park Ave., Ste. 303,Pomona
(909) 623-1619
(909) 626-HELP / 24-HourHotline
Project Sister is a sexual assault crisis service dedicated to reducing the incidence and trauma of sexual assault in the West San Gabriel and Pomona Valleys. Provides support groups, individual counseling, and self-defense classes.

The Butterfly Club
6921 Edison Avenue
Chino, Ca. 91710
(909) 597-8570
Healing for victims of Sexual Assault/Trauma

Victim's Witness Assistance Program
400 Civic Center Plaza, Room 201, Pomona
(909) 620-3381
Assists victims of crimes in obtaining reimbursement for medical expenses, loss of income/support, therapy and funeral expenses.

St. Anne's Transitional Home For Soldiers
(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

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.

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

Meals on Wheels
845 E. Bonita Avenue
Pomona, Ca. 91768
909-593-6907
Provides home delivered meals to homebound seniors and persons with disabilities.

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

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
160 E. Holt, Suite 101, Pomona
(909) 629-4084
Provides parenting classes, family re-unification, drug testing, one-on one counseling, and self-help meetings.

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.

Casa Colina Centers for Rehabilitation
2850 N. Garey Ave.
Pomona, CA 91769
(909) 596-7733
This organization has many programs to address rehabilitation; Vocational and transitional living programs are also available.

National Alliance on Mental Illness (NAMI)
1111 N. Mountain Ave.
Claremont, CA 91711
(909) 399-0305
Offering education and support to people whose lives are affected by serious mental illness – family members and clients alike.

San Gabriel/Pomona Regional Center
761 Corporate Center 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.
P. O. Box 1296, 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
2112 S. Garey Ave., Suite C
Pomona, CA 91766
(909) 591-6773
Assistance for children, adolescent and adults.

East Valley Community Health Center
Pomona. CA
(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.

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.

Family Health Center
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 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.

Pomona Health Center/LA County Health Center
750 S. Park Ave. Pomona, CA
(909) 868-0235
Medical Services: Vaccinations and STD Immunizations for children (0-18); Primary Care Services and prescriptions at no or low cost

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

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.

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.

Dial-a-Ride
(909) 623-0183
Transportation services

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

Metropolitan Transportation Authority (MTA)
Information: 800-COM-MUTE
MetroLink
800-371-5465
Public Transportation

APPENDIX E
CALIFORNIA HEALTH AND SAFETY CODES SECTION 127340-127365

SB 697 (Chapter 812, Statutes of 1994)

Health and Safety Code Sections 127340-127365

Article 2. Hospitals: Community Benefits

127340. The Legislature finds and declares all of the following:

(a) Private not-for-profit hospitals meet certain needs of their communities through the provision of essential health care and other services. Public recognition of their unique status has led to favorable tax treatment by the government. In exchange, nonprofit hospitals assume a social obligation to provide community benefits in the public interest.

(b) Hospitals and the environment in which they operate have undergone dramatic changes. The pace of change will accelerate in response to health care reform. In light of this, significant public benefit would be derived if private not-for-profit hospitals reviewed and reaffirmed periodically their commitment to assist in meeting their communities' health care needs by identifying and documenting benefits provided to the communities which they serve.

(c) California's private not-for-profit hospitals provide a wide range of benefits to their communities in addition to those reflected in the financial data reported to the state.

(d) Unreported community benefits that are often provided but not otherwise reported include, but are not limited to, all of the following:

(1) Community-oriented wellness and health promotion.

(2) Prevention services, including, but not limited to, health screening, immunizations, school examinations, and disease counseling and education.

(3) Adult day care.

(4) Child care.

(5) Medical research.

(6) Medical education.

(7) Nursing and other professional training.

(8) Home-delivered meals to the homebound.

(9) Sponsorship of free food, shelter, and clothing to the homeless.

(10) Outreach clinics in socioeconomically depressed areas.

(e) Direct provision of goods and services, as well as preventive programs, should be emphasized by hospitals in the development of community benefit plans.

127345. As used in this article, the following terms have the following meanings:

(a) "Community benefits plan" means the written document prepared for annual submission to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community.

(b) "Community" means the service areas or patient populations for which the hospital provides health care services.

(c) Solely for the planning and reporting purposes of this article, "community benefit" means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:

(1) Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs.

(2) The unreimbursed cost of services included in subdivision (d) of Section 127340.

(3) Financial or in-kind support of public health programs.

(4) Donation of funds, property, or other resources that contribute to a community priority.

(5) Health care cost containment.

(6) Enhancement of access to health care or related services that contribute to a healthier community.

(7) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services.

(8) Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

(d) "Community needs assessment" means the process by which the hospital identifies, for its primary service area as determined by the hospital, unmet community needs.

(e) "Community needs" means those requisites for improvement or maintenance of health status in the community.

(f) "Hospital" means a private not-for-profit acute hospital licensed under subdivision (a), (b), or (f) of Section 1250 and is owned by a corporation that has been determined to be exempt from taxation under the United States Internal Revenue Code. "Hospital" does not mean any of the following:

(1) Hospitals that are dedicated to serving children and that do not receive direct payment for services to any patient.

(2) Small and rural hospitals as defined in Section 124840.

(g) "Mission statement" means a hospital's primary objectives for operation as adopted by its governing body.

(h) "Vulnerable populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs.

127350. Each hospital shall do all of the following:

(a) By July 1, 1995, reaffirm its mission statement that requires its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization.

(b) By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years.

(c) By April 1, 1996, and annually thereafter adopt and update a community benefits plan for providing community benefits either alone, in conjunction with other health care providers, or through other organizational arrangements.

(d) Annually submit its community benefits plan, including, but not limited to, the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity to the Office of Statewide Health Planning and Development. The hospital shall, to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan. Effective with hospital fiscal years, beginning on or after January 1, 1996, each hospital shall file a copy of the plan with the office not later than 150 days after the hospital's fiscal year ends. The reports filed by the hospitals shall be made available to the public by the office. Hospitals under the common control of a single corporation or another entity may file a consolidated report.

127355. The hospital shall include all of the following elements in its community benefits plan:

(a) Mechanisms to evaluate the plan's effectiveness including, but not limited to, a method for soliciting the views of the community served by the hospital and identification of community groups and local government officials consulted during the development of the plan.

(b) Measurable objectives to be achieved within specified timeframes.

(c) Community benefits categorized into the following framework:

(1) Medical care services.

(2) Other benefits for vulnerable populations.

(3) Other benefits for the broader community.

(4) Health research, education, and training programs.

(5) Nonquantifiable benefits.

127360. Nothing in this article shall be construed to authorize or require specific formats for hospital needs assessments, community benefit plans, or reports until recommendations pursuant to Section 127365 are considered and enacted by the Legislature.

Nothing in this article shall be used to justify the tax-exempt status of a hospital under state law. Nothing in this article shall preclude the office from requiring hospitals to directly report their charity activities.

127365. The Office of Statewide Health Planning and Development shall prepare and submit a report to the Legislature by October 1, 1997, including all of the following:

(a) The identification of all hospitals that did not file plans on a timely basis.

(b) A statement regarding the most prevalent characteristics of plans in terms of identifying and emphasizing community needs.

(c) Recommendations for standardization of plan formats, and recommendations regarding community benefits and community priorities that should be emphasized. These recommendations shall be developed after consultation with representatives of the hospitals, local governments, and communities. http://www.leginfo.ca.gov/bilinfo.html

APPENDIX F

PATIENT FINANCIAL ASSISTANCE PROGRAM POLICY; FULL CHARITY CARE AND DISCOUNT PARTIAL CHARITY CARE POLICIES

Policy Name: Patient Financial Assistance Program Policy **#:** HW#1A.200
Division: Manual: Hospital Wide Policy
Origination Date: 12/31/2007 **Revised Date:** 07/01/2017

SUBJECT: Patient Financial Assistance Program Policy
Full Charity Care and Discount Partial Charity Care Policies

Purpose:
Pomona Valley Hospital Medical Center (PVHMC) serves all persons in the Pomona Valley and greater Inland Empire community. As a community hospital provider, Pomona Valley Hospital Medical Center strives to provide healthcare services within a high quality and customer service oriented environment. Providing patients with opportunities for financial assistance coverage for healthcare services is an essential element of fulfilling the Pomona Valley Hospital Medical Center mission. This policy defines the PVHMC Financial Assistance Program including its criteria, systems, and methods.

Nonprofit acute care hospitals must comply with the California Hospital Fair Pricing Act (codified in California's Health & Safety Code Sections 127400 et seq.), and with Section 501(r) of the Internal Revenue Code requiring written policies providing discounts and charity care to financially qualified patients. This policy provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the Pomona Valley Hospital Medical Center Financial Assistance Program.

The Finance Department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at PVHMC. Patient Access and Business Office staff are responsible for assisting the patient with the financial assistance application as needed to include handling of patient accounting transactions in a manner that supports the mission and operational goals of Pomona Valley Hospital Medical Center. PVHMC's Board of Directors is responsible for approving this policy.

Policy:
It is the policy of Pomona Valley Hospital Medical Center to offer financial assistance to patients who are unable to pay their hospital bills due to a financial inability to pay. Designated management will review individual cases to determine a patient's eligibility for financial assistance and determine the discount for which the patient qualifies.

All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy. This policy will be applied to financial assistance applications approved on or after November 1, 2017.

Introduction
Pomona Valley Hospital Medical Center strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. PVHMC is committed to providing access to financial assistance programs when patients are uninsured or underinsured and need help paying their hospital bill. These programs include state- and county-sponsored coverage programs and charity care as defined herein. This policy focuses on charity care for which eligibility for financial assistance and qualification for a discount is determined solely by the patient's and/or patient's family's ability to pay.

The Hospital makes every effort to inform its patients of the Hospital's Financial Assistance Program. Specifically:

- Every registered patient receives a written notice of the Hospital's Financial Assistance Policy written in plain language per IRC 501(r);
- Upon request, paper copies of the Financial Assistance Policy, the Financial Assistance application form and the plain language summary of the Financial Assistance Policy are made available free of charge . These documents are also available on the Hospital's website;
- Whenever possible, during the registration process, uninsured patients are screened for eligibility with government -sponsored programs and/or the Hospital's Financial Assistance Program;
- Public notices are posted throughout the Hospital notifying the public of financial assistance for those who qualify (See "Reporting & Billing: Public Notice" within this policy for more information);
- Guarantor billing statements contain information to assist patients in obtaining government –sponsored coverage and/or financial assistance provided by the Hospital (See "Reporting & Billing: Billing Statements" within this policy for more information);
- The hospital will provide patients with a referral to a local consumer assistance center housed in a legal services office;
- In an effort to widely publicize the Hospital's Financial Assistance Policy, the Hospital has collaborated with several community clinics to provide Financial Assistance literature for clinic patients.

This policy addresses the following:

Definitions

Financial Assistance Eligibility Criteria

Financial Assistance Discount Qualification Criteria

Application Submission and Review Process

Reporting & Billing

General Provisions

DEFINITIONS

Amounts Generally Billed (AGB): The amount generally billed by the hospital for emergency and other medically necessary services to patients who have health insurance. This amount does not represent the Hospital's usual and customary charge. It represents the amounts generally paid by a third-party payer as defined herein.

Essential living expenses: Expenses for any of the following: rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child and spousal support, transportation and automobile expenses (including insurance, fuel and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.

Full Charity: A discount representing 100% of a patient's liability. A full charity discount is equivalent to 100% of billed charges when the patient is uninsured and equivalent to the patient's unmet deductible, coinsurance and/or copay when the patient is insured.

High Medical Costs: An insured patient with "High Medical Costs" means:
A person whose family income does not exceed 350% of the federal poverty level if the individual does not receive a discounted rate from the hospital as a result of third-party coverage, and any of the following:

- Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10% of the patient's family income in the prior 12 months,
- Annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months

- A lower level determined by the hospital in accordance with the hospital's charge care policy

Income: The sum of all the wages, salaries, profits, interests payments, rents and other forms of earnings received by all members of a patient's family during a one year period of time. This includes gross receipts less cost of goods sold for self-employed family members.
Local Consumer Assistance Center: An agency designed to provide consumers with information about health care coverage and services. In California, The Health Consumer Alliance (HCA) was designated as the CCI/CalMediconnect Ombudsprogram effective April 1, 2014. More information regarding HCA can be found at http://healthconsumer.org. Consumers may call 888-804-3536 for routing to the correct consumer center.

Monetary Assets: Assets that are readily convertible to cash, such as bank accounts and publicly traded stock but not assets that are illiquid, such as real property and/or the following assets:

- Retirement funds and accounts;
- Deferred compensation plans qualified under the Internal Revenue Code;
- Nonqualified deferred compensation plans;
- The first $10,000 of qualified monetary assets;
- 50% of monetary assets after the first $10,000.

Necessary Services: Inpatient, outpatient or emergency medical care that is deemed medically necessary by a physician. Necessary services would not include purely elective services for patient comfort and/or convenience, including but not limited to a cosmetic lens implanted during cataract surgery.

Patient's Family Size: is dependent on the age of the patient as defined below -
1) For patients 18 years of age and older, the patient's family includes the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not;

2) For patients under 18 years of age, the patient's family includes the patient's parent(s), caretaker relatives and other children less than 21 years of age

PROCEDURE FOR FINANCIAL ASSISTANCE

FINANCIAL ASSISTANCE ELIGIBILITY

Financial assistance eligibility is based upon the patient's ability to pay as determined by the Patient's Family income relative to the current Federal Poverty Level.

The primary eligibility categories are:

- Patient is uninsured AND Patient's Family Income is at or less than 400% of the Federal Poverty Level designated for the patient's family size
- Patient is insured AND Patient's Family Income is at or less than 400% of the Federal Poverty Level designated for the patient's family size AND patient meets the definition of a "High Cost Medical" patient

The following conditions must also be satisfied:

- If the patient is insured, the patient's liability is NOT a Medicaid share of cost or unmet deductible, coinsurance and/or copay related to subsidized coverage provided through a Covered CA qualified health plan or similar plan;
- Patient does not qualify for other income-based/means test government-sponsored coverage;
    - A pending application for another health coverage program shall not preclude eligibility for financial assistance under this policy, however, final approval of financial assistance may be deferred until the pending application is processed and eligibility is determined

- Patient completes and submits a Financial Assistance Application;
- Patient submits all required and requested documents and responds to any questions that arise from the Financial Assistance Application.

A patient who is deemed eligible for financial assistance will not be charged for emergency or other medically necessary care more than amounts generally billed (AGB) to individuals who have insurance covering such care.
Physicians providing emergency services in the hospital are required to provide discounts to uninsured and high medical cost patients whose incomes are at or below 350 percent of the Federal Poverty Level. The discounts by physicians providing emergency services in the hospital are not included in the Hospital's Financial Assistance Policy. These discounts are administered independently by the physician, physician's medical group and/or the physician billing agent. Eligible patients are offered a reasonable, extended payment plan. If an agreement is not reached, a reasonable payment formula similar to the hospital's payment formula defined in the "Payment Plans" section within this policy must be used in determining the monthly payment. See Addendum A for a complete list of emergency providers.

FINANCIAL ASSISTANCE DISCOUNT QUALIFICATION CRITERIA

Once eligibility is established, the discounted amount and/or discounted balance is determined as defined in the following section of this policy depending upon:

- The Patient's eligibility category;
- The Patient's Family income;
- The Patient's Family Monetary Assets;

Full Charity Discount Criteria
The following chart summarizes the criteria that must be satisfied for a patient to qualify for full charity care:

ELIGIBILITY CATEGORY	INCOME	ASSETS
Uninsured	<400% FPL	<$10,000
Insured with High Medical Costs	<400% FPL	<$10,000

All patients who are eligible for financial assistance within this policy will receive full charity when the patient's family income is at or less than 400% of the Federal Poverty Level and their monetary assets are less than $10,000. To qualify for this level of discount, the patient will apply for and submit the documentation required for full charity within this policy.

Dates of Service included in Application
When the hospital determines that a patient qualifies for Financial Assistance, that determination will apply to the specific services and service dates for which the patient or the patient's family representative submitted the application. In cases of continuing care relating to a patient diagnosis that requires ongoing, related services, the hospital will treat continuing care as a single case for which qualification applies to all related ongoing services provided by the hospital. Management may, based on its review, determine that other pre-existing patient account balances outstanding at the time of qualification may be eligible for write- off. Generally, a patient will re-apply for financial assistance eligibility at least every 180 days, but management has the discretion to not require further application(s) for subsequent services following an initial application approval.

Other Eligible Circumstances qualifying for Charity: Medi-Cal Payment Denials
PVHMC deems those patients that are eligible for government -sponsored low-income assistance programs (e.g. Medi-Cal/Medicaid, California Children's Services and any other applicable state or local low-income program) to be indigent. Therefore such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP and CCS)), where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage limited to the amount the payer denied instead of paid. Consistent with Medicare cost reporting guidance for the calculation of the Hospital's low income percentage for

Medi-Cal DSH, non-covered services and all other denied services provided to eligible Medicaid beneficiaries will be reported as "Uncompensated Care" for cost reporting purposes without requiring a FAP application from each patient. Specifically included as Uncompensated Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care.

The patient is NOT eligible for financial assistance on Medi-Cal share of cost or a patient's subsidized or discounted out-of-pocket expenses determined by Covered California or any other state or federal government insurance exchange. A patient's unsubsidized out of pocket expense may qualify for a discount as defined within this policy.

Other Eligible Circumstances qualifying for Charity: Medicare Deductibles and Coinsurance Denials
Patients whose primary coverage is Medicare and secondary coverage is Medi-Cal are eligible for financial assistance and may qualify for full charity. The amount qualifying for full charity is limited to the Medicare coinsurance and deductible amounts unreimbursed by any other payer including Medi-Cal/Medicaid, and which is not reimbursed by Medicare as a bad debt, if:

1) The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low income patients; or

2) The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low income patients; or

Other Eligible Circumstances qualifying for Charity: Reassignment from Bad Debt to Charity
Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care.

Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

Criteria for Re-Assignment from Bad Debt to Charity Care:
All outside collection agencies contracted with PVHMC to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to charity care:

1) Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers);
2) The patient or family representative has not made a payment within 150 days of assignment to the collection agency;
3) The patient's credit & behavior score is within the lowest 25th percentile as of November 2007, PVHMC's secondary agency has determined the credit and behavior score representing the lowest 25th percentile is 547 or lower as reported by Transunion;);
4) The collection agency has determined that the patient/family representative is unable to pay; and/or
5) The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

Prompt Pay Discount
A patient is not eligible for financial assistance when the patient's family income is greater than 400% of the established Federal Poverty Level. Instead, uninsured patients qualify for a prompt pay discount, which shall apply to all necessary

inpatient, outpatient and emergency services provided by PVHMC. The discounted balance is dependent on the type of service provided:

1) For outpatient services, the discounted balance represents the average commercial HMO/PPO collection rate on outpatient services, not to exceed established cash prices
2) For inpatient services, the discounted balance represents the MediCal APR DRG amount for obstetrics and pediatric services and the Medicare DRG amount for all other acute inpatient services, not to exceed established cash prices.

The standard term for a prompt payment discount is 30 days. However, the term may be negotiated per the Payment Plans guidelines below.

Payment Plans
When a discount has been made by the hospital, the patient shall have the option to pay any or all outstanding amounts due in one lump sum payment, or through a scheduled term payment plan.

The hospital will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be negotiated between the hospital and patient based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. If the patient and the hospital are unable to agree on negotiated payment terms, the hospital shall offer the patient the default payment plan. Under the default payment plan, the patient's monthly payment shall not exceed 10% of a patient's family income for one month, excluding deductions for "essential living expenses" as defined herein above.

Limitation on Charges: Amounts Generally Billed ("ABG") Patients below 400% of the current Federal Poverty Level, who meet all eligibility and qualification criteria, will not pay more than Medicare (or the applicable MediCal APR DRG as defined below) would typically pay for a similar episode of service as defined by the "Prospective" method per Section 501(r) of the Internal Revenue Code ("IRC"). The applicable MediCal APR DRG reimbursement applies to obstetrics, newborns, neonatal intensive care and pediatrics. The Medicare DRG and respective outpatient rates applies to all other services. A deposit collected from a patient for scheduled services will be limited to Amounts Generally Billed as defined herein. At the time a patient is determined to qualify and be eligible for financial assistance, the amount billed to the patient will be limited to the Amount Generally Billed. Prior to submitting an application for financial assistance, the amounts billed will represent full billed charges consistent with the Hospital's usual and customary charges.

Collection Efforts
The Hospital's Business Office is responsible for billing a patient's guarantor unpaid copays, coinsurance, deductibles, balances covered under a payment arrangement and charges not covered by insurance. Guarantor statements are mailed to the guarantor's address on file.

Guarantor balances are due and payable within 30 days from the date of the first patient billing. The business office will send the guarantor a minimum of three cycle statements. A collection letter will be sent to the guarantor if the balance remains unpaid after three cycle statements.

Guarantor balances are considered past due after 30 days from the date of the first billing and may be advanced to a collection agency after 120 days from the date of first billing and after a minimum of three cycle statements have been sent to the guarantor. A guarantor balance may be advanced to a collection agency prior to these standard timelines if it is determined the patient or guarantor provided fraudulent or inaccurate demographic or billing information.

Guarantor balances will not be forwarded to a collection agency when the guarantor makes reasonable efforts to communication with the business office and makes good faith efforts to resolve the outstanding balance including but not limited to applying for government insurance coverage, applying for a discount under the Hospital's Financial Assistance Policy, submitting regular partial payments of a reasonable amount or negotiating a payment plan with the business office.

If the Hospital uses a collection agency, it will obtain a written agreement that the agency will abide by the hospital's standards and scope of practice.

Prior to commencing collection activities, the hospital will provide the patient with a clear and conspicuous written notice containing information regarding the patient's rights under applicable laws, certain patient rights and related information.

The Hospital will not engage in extraordinary collection activities ("ECAs"), either directly or indirectly through any purchaser of debt, collection agency or other party to which the hospital facility has referred the individual debt relating to seeking payment for care covered by the Hospital's Financial Assistance Policy including but not limited to:
1) Placing a lien on an individual's property
2) Foreclosing on real property
3) Attaching or seizing an individual's bank account or other personal property
4) Commencing a civil action against an individual
5) Causing an individual's arrest or writ of body attachment for civil contempt
6) Garnishing an individual's wages

For a patient that lacks coverage or has high medical costs, the hospital or its agent shall not report adverse information to a credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing. Prior to authorizing any extraordinary collections activities, the Hospital will ensure a Financial Assistance Application is mailed to the guarantor's current address on file allowing the guarantor no less than 30 days to respond or inform the business office of the interest to pursue financial assistance. The Director of Patient Financial Services will ensure all reasonable efforts are taken to determine if a patient is eligible for financial assistance under this policy before engaging in Extraordinary Collection Activities. All collection efforts will be suspended while a guarantor is actively participating in the Financial Assistance Application process.

APPLICATION SUBMISSION & REVIEW PROCESS

Single, Unified Application

The financial assistance application provides patient information necessary for determining patient qualification and such information will be used to qualify the patient or family representative for maximum coverage under the PVHMC Financial Assistance Program. The financial assistance application should be completed as soon as there is an indication that the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. Financial counselors, eligibility services liaisons and/or patient account representatives are available to provide guidance over the phone or meet in person.

The application will cover all outstanding guarantor balances at the time the application is completed. Patients may be required to re-apply for financial assistance at least every 180 days.

Required Documentation

Eligible patients may qualify for the PVHMC Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the PVHMC Financial Assistance Program. To determine eligibility and to maximize the qualifying assistance/discount amount, the following documentation is required when applicable:
1) Completed & signed financial assistance application;
2) Current pay stubs from the last two pay periods or if self-employed, current year-to-date profit & loss statement to determine current income;
3) Award letters for social security, SSI, Disability, Unemployment, General Relief, Alimony, etc.;

4) Last calendar year's filed tax return with all required schedules to determine income generating assets including monetary assets;
5) Last two months' bank, brokerage & investment statements;
6) Copies of prior year's 1099 for interest income, dividends, capital gains, etc.

Completion of a financial assistance application provides:

- Information necessary for the hospital to determine if the patient has income sufficient to pay for services;
- Documentation useful in determining qualification for financial assistance; and
- An audit trail documenting the hospital's commitment to providing financial assistance

The Hospital may require waivers or releases from the patient or the patient's family authorizing the hospital to obtain account information from financial or commercial institutions or other entities including but not limited to credit reporting entities that hold or maintain the monetary assets, in an attempt to verify information the patient has provided on the charity care application. Information obtained pursuant to this paragraph regarding assets of the patient or the patient's family shall not be used for collection activities.

Reasons for Denial of Assistance
The PVHMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full assistance. Financial assistance may be denied for failure to submit applicable required documentation.

The hospital may deny financial assistance for reasons including, but not limited to, the following:

1) Patient is not eligible for full charity care based on amount of income plus monetary assets;
2) Patient is uncooperative or unresponsive, preventing the Hospital from determining financial assistance eligibility and qualification;
3) Service provided to a full charity care patient is not considered medically necessary;
4) Application is incomplete;
5) Patient's balance results from withholding from the Hospital an insurance payment;
6) Patient's balance after insurance pays does not meet the definition of high medical cost;
7) Assistance was requested on a service provided more than 180 days after the most recent request for assistance was approved.; and
8) Patient's liability is a Medicaid share of cost or out-of-pocket expense related to means tested and/or incomebased coverage such as a subsidized Covered CA qualified health plan.

The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

Approval Process
The patient or patient's representative shall submit the financial assistance application and required supplemental documents to the Patient Financial Services department at PVHMC. The Patient Financial Services department's contact information shall be clearly identified in the application instructions.

PVHMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response. Upon receipt of a completed financial assistance application, assigned staff in the business office will prepare a "Request for Consideration of Uncompensated Care (Charity)" attaching all supporting documentation as defined within this policy and submit to an applicable manager based upon the amount of the discount requested as defined below. For the circumstances defined below which do NOT require submission of a financial assistance application, the staff will

prepare a "Request for Consideration of Uncompensated Care (Charity)" clearly noting the reason an application was NOT prepared and attaching a credit report if a valid social security number is available.

A financial assistance determination will be made only by approved hospital management personnel according to the eligibility criteria specific to the patient and the amount of financial assistance requested. Financial assistance shall not be provided on a discriminatory or arbitrary basis. The hospital retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

The Hospital's designee authorized to approve financial assistance applications is based on the amount of the financial assistance requested; larger discounts require a higher level of approval as indicated below:

- Discounts less than $25,000: Director of Patient Financial Services or the Director of Patient Access
- Discounts greater than $25,000: Chief Financial Officer

Application Exceptions
A completed financial assistance application may not be required in certain circumstances. These circumstances are limited to situations when PVHMC determines it has sufficient patient financial information from which to make a financial assistance eligibility and qualification decision. Examples of circumstances not requiring a financial assistance application include, but are not necessarily limited to:
1) Patient is homeless;
2) Patient is a resident at a shelter including but not limited to Prototypes and The American Recovery Center;
3) Patient's address is the address for the Department of Public Social Services (DPSS) 2040 Holt Ave Pomona;
4) Patient is unknown;
5) Patient is receiving General Relief, Cal WORKS or Cal Fresh (documentation required);
6) Patient qualified for Medi-Cal without a share of cost (SOC) during a portion of the confinement or subsequent to their discharge/visit (proof of eligibility required); or
7) Non-covered and/or denied services provided to Medi-Cal eligible patients;
8) A patient's balance after VOVC pays;
9) Patient's qualifying for Susan G. Komen funding; the grant from Susan G. Komen will be recorded as Nonoperating revenue (904050)

Appeal Process
In the event that a patient disagrees with the hospital's determination regarding qualification, the patient may file a written appeal for reconsideration with the hospital as follows:

The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.

Any or all appeals will be reviewed by the hospital Director of Patient Financial Services. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the director shall provide the patient with a written explanation of findings and determination.

In the event that the patient believes a dispute remains after consideration of the appeal by the Director of Patient Accounting, the patient may request in writing, a review by theChief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and documentation, as well as the findings of the Director of Patient Financial Services. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

REPORTING AND BILLING:

Billing Statements

Consistent with Health and Safety Code Section 127420, the Hospital will include the following clear and conspicuous information on a patient's bill:

(1) A statement of charges for services rendered by the hospital.

(2) A request that the patient inform the hospital if the patient has health insurance coverage, Medicare, Medi-Cal, or other coverage.

(3) A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for coverage offered through the California Health Benefit Exchange (Covered CA), Medicare, Medi-Cal, California Children's Services Program, or charity care.

(4) A statement indicating how patients may obtain an application for the Medi-Cal program, coverage offered through the California Health Benefit Exchange, or other state- or county-funded health coverage programs and that the hospital will provide these applications. If the patient does not indicate coverage by a third-party payer or requests a discounted price or charity care, then the hospital shall provide an application for the Medi-Cal program, or other state- or county-funded programs to the patient. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care. The hospital shall also provide patients with a referral to a local consumer assistance center housed at legal services offices.

(5) Information regarding the financially qualified patient and charity care application, including the following:

(A) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain lowand moderate-income requirements, the patient may qualify for discounted payment or charity care.

(B) The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.

(C) If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

Public Notice

PVHMC shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, areas and in outpatient service areas of the hospital, including but not limited to the emergency department, inpatient admission and outpatient registration areas, or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

These notices shall be posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. The notice states the following:

Pomona Valley Hospital Medical Center provides financial assistance to our patients who qualify.
Contact our Eligibility Services Department at (909) 630-7720 to speak with a representative to obtain more information.

Access to the Financial Assistance Policy

A copy of this Financial Assistance Policy and a plain language summary is available on the Hospital's website. A hard copy of the policy will be made available to the public upon request at the Hospital's main campus or by mail.

OSHPD Reporting

PVHMC will report actual Charity Care provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with the applicable requirement, the hospital will maintain written documentation regarding its Charity Care criteria, and for individual patients, the hospital will maintain written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

In compliance with OSHPD adopted regulations approved by the Office of Administrative Law on August 8, 2007 (Title 22, Sections 96040-96050), the Director of Patient Financial Services will submit an electronic copy of its discount payment and charity care policies, eligibility procedures and review process (as defined and documented in one, comprehensive Financial Assistance Program Policy) and its Financial Assistance application form to OSHPD at least every other year by January 1 beginning January 1, 2008, or whenever a significant change to the policy is made.

GENERAL PROVISIONS:

Equal Opportunity

The Hospital is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service, or any other classification protected by federal, state or local laws.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values. The Charity Care documentation will not be reviewed or accessed by staff involved in collection activities.

Good Faith

PVHMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, PVHMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for the PVHMC Financial Assistance Program.

Additional Resources

For more information, please visit the following websites:

Pomona Valley Hospital Medical Center
www.pvhmc.org

Office of Statewide Health Planning and Development Health care Information Division – Hospital Community Benefit Plan
http://www.oshpd.ca.gov/HID/hospital/hcpb/faqshcbp.htm

Hospital Annual Financial Data
http://www.oshpd.state.ca.us/HQAD/Hospital/financial/hospAF.htm

Internal Revenue Service on Section 501(c) (3) Organizations
http://www.irs.gov/publications/p557/ch03.html

Institute of Applied Research
http://iar.csusb.edu/index.htm

POMONA VALLEY HOSPITAL
MEDICAL CENTER

Expert care with a personal touch