Pomona Valley Hospital Medical Center

2024 Community Health Needs Assessment Study

In cooperation with California State University San Bernardino's Institute of Applied Research and Policy Analysis

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

2024-2026

ABOUT POMONA VALLEY HOSPITAL MEDICAL CENTER

Pomona Valley Hospital Medical Center (PVHMC) is a 427-bed, fully accredited, acute care hospital serving eastern Los Angeles and western San Bernardino counties. For over 100 years, 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 Hospital, PVHMC is home to four Centers of Excellence: The Robert and Beverly Lewis Family Cancer Care Center, Stead Heart and Vascular Center, Women's & Children's Center, and Trauma Center, and offers a full-service Emergency Department, Neonatal Intensive Care Unit and Perinatal Center. Specialized services include sleep disorder diagnosis and treatment, robotic surgery, and the Family Medicine Residency Program, in affiliation with the University of California, Los Angeles.

The Robert and Beverly Lewis Outpatient Pavilion houses an outpatient surgery center and rehabilitation services center. The outpatient surgery center has five outpatient surgical suites with state-of-the-art technology. The Charles M. Magistro Physical Therapy and Rehabilitation Center has the latest evaluation and exercise equipment, including telemetry treadmills and neurological suspension devices, as well as diagnostic programs and integrated technologies and software systems.

PVHMC also provides a wide range of other outpatient services such as urgent care, radiology, including 3D mammography, and occupational health to the surrounding cities of Pomona, Chino, Chino Hills, Claremont, Eastvale, Corona, Diamond Bar, Walnut, Ontario, Riverside, San Bernardino La Verne and eastern Los Angeles counties.

As a community hospital, we understand our responsibility to provide high-quality healthcare services, especially to our most vulnerable populations in need, and to find new ways to fulfill our charitable purpose. PVHMC works vigorously to meet our role in maintaining a healthy community by identifying health-related problems and developing ways to address them.

PVHMC is committed to the communities we serve and is pleased to share this Community Health Needs Assessment study. This information is used to support the development of our formal Community Benefit Plan.

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 at PVHMC
At Pomona Valley Hospital Medical Center, we are proud to be a trusted hospital in Pomona. Part of our vision is to be the region's most respected and recognized hospital, leading the community as a provider of world-class healthcare services.

Other aspects of our vision include:
- Remain the hospital of choice for local patients and their families due to our quality of care.
- Draw the top physicians in the area because they are valued and supported by expert healthcare teams, advanced systems, and cutting-edge technology.
- Be the hospital where professionals are excited to work due to the recognition of our excellence, as well as our commitment to reward initiative and encourage self-development.
- Be the medical center employers and payors request for their healthcare services because they are confident their beneficiaries will receive the highest value for the benefit dollar.
- Be the medical center that community leaders and volunteers are excited to support because they recognize our continued efforts to meet the health needs of our community.

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!

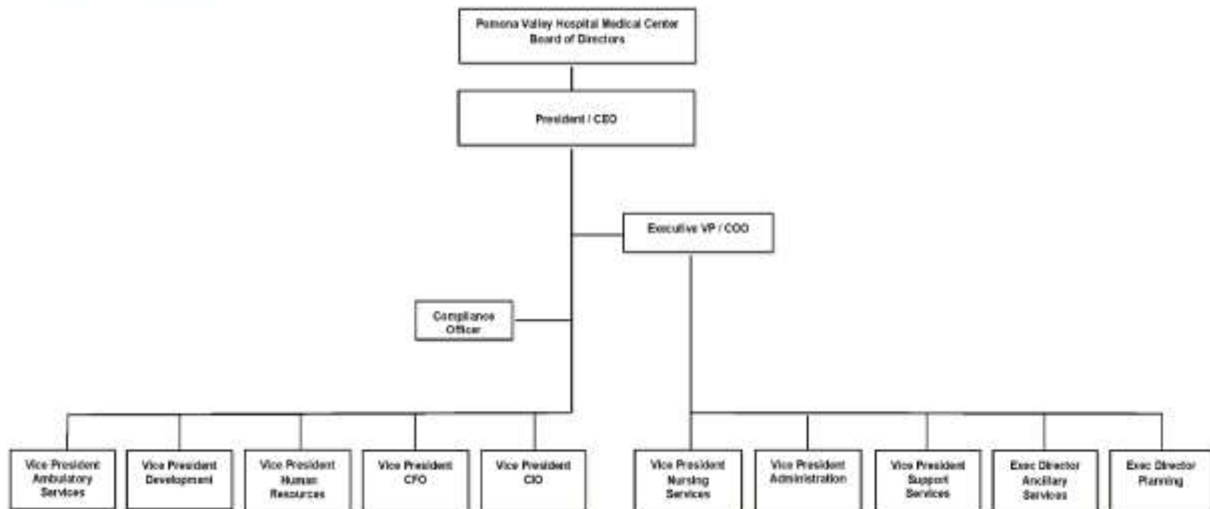
Our Location

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: William C. McCollum
Community Benefit Executive: Leigh C. Cornell, FACHE



As of 11/2024

PREFACE

California's Community Benefit Law

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

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

Federal Requirements

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

Approval from a Governing Body

PVHMC's 2021 Community Health Needs Assessment (CHNA) included in this report was adopted by the Board of Directors on November 11, 2024.

EXECUTIVE SUMMARY

The Institute of Applied Research and Policy Analysis (IAR) at California State University, San Bernardino (a full-service consulting and applied research organization), has contributed to Pomona Valley Hospital Medical Center's (PVHMC's) every-three-year community needs assessment since 2009. IAR was pleased to be asked to participate once again in PVHMC's 2024 needs assessment.

This year IAR was charged with collecting secondary data regarding Los Angeles County, San Bernardino County, and SPA3 (San Gabriel Valley); primary data from 1,215 residents in PVHMC's service area; information from 12 representatives of low-income, minority, and medically underserved populations in PVHMC's service area; and input regarding the health needs of the community from three public health executives (two from Los Angeles County and one from San Bernardino County).

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

HIGHLIGHTS OF FINDINGS

Biggest (most significant) health care needs:

- Care coordination and help navigating the complex health care system were mentioned as significant health care needs.
- Access to affordable primary care/prevention services is a high priority need, especially for low-income populations, communities of color, homeless, LGBTQ+, seniors, undocumented populations, and minority groups.
- Mental health services/resources were mentioned as a high priority need by interviewees (community residents; representatives low-income, minority, and medically underserved populations; and public health executives). This is especially important for marginalized communities (homeless and rural), BIPOC, Medicaid and uninsured populations, underrepresented minorities, youth and aging populations, people with special healthcare needs, and the severely mentally ill.
- More community-wide partnerships and collaborations would be of help to the entire population in PVHMC's service area, but in particular to seniors, minority populations, people with low income and education, special needs patients, LGBTQ+, homeless, undocumented, and marginalized communities (homeless and rural).
- There is a huge need for resources and support for homeless populations.
- There has been an increase in people diagnosed with cardiovascular diseases in Los Angeles and San Bernardino Counties.
- Food insecurity continues to be an issue for a large % of adults in the PVHMC region.

Other health needs include affordable medicine and more places to buy healthy foods at an affordable cost.

Major barriers to meeting receiving health care:

- Lack of communication between the patient and his/her health care provider, either because of a language barrier, providers who do not have an adequate understanding of culturally competent care, or fear/lack of trust in the healthcare system.
- Lack of patient health literacy, both general (e.g., the need for wellness appointments and screenings) and specific (relative to specific chronic disease conditions).
- Cost/financial issues, e.g., inability to pay due to lack of insurance or underinsurance, lost income from having to leave work to see the physician during usual office hours, lack of transportation to get to a health appointment, etc.
- Social determinants of health (SDOH), e.g., level of unemployment and increasing violence in the community.
- Increasing food insecurity.

Positive steps that could/should be taken to improve the health of the community:

- Provide education opportunities for the community regarding issues such as obesity/weight loss, healthy lifestyle, nutrition, smoking cessation, need for health screening, and importance of follow-up care.
- Increase the level of community outreach. This could be in the form of outreach events and health fairs, mobile clinics, and/or connecting with youth in schools regarding mental health issues, vaping, opioid use, etc.
- Provide education/outreach to help people make better lifestyle choices.
- Increase the number of primary care providers in the region to improve access and reduce the waiting time to get an appointment for routine or specialty care.
- Foster a stronger focus on care coordination and partnerships with community-based organizations and other community groups.
- Screen patients for food insecurity.
- Address the SDOH to build health equity.
- Increase availability of mental health resources, and work to communicate the availability of those (and other) resources to the community.

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I. INTRODUCTION

Pomona Valley Hospital Medical Center is located at 1798 N. Garey Avenue, Pomona, CA 91767. Its service area consists of eight cities in San Bernardino County and four in Los Angeles County.[1]

Table 1.1: PVHMC's Service Area

City	County	Zip Codes
Alta Loma	San Bernardino	91701, 91737
Chino	San Bernardino	91708, 91710
Chino Hills	San Bernardino	91709
Claremont	Los Angeles	91711
Fontana	San Bernardino	92331, 92334, 92335, 92336, 92337
La Verne	Los Angeles	91750
Montclair	San Bernardino	91763
Ontario	San Bernardino	91758, 91761, 91762, 91764
Pomona	Los Angeles	91766, 91767, 91768
Rancho Cucamonga	San Bernardino	91729, 91730
San Dimas	Los Angeles	91773
Upland	San Bernardino	91784, 91785, 91786

Source: https://censusreporter.org/

According to PVHMC's website, PVHMC is "a nationally recognized and accredited 427-bed, not-for-profit community medical center, proudly serving residents in eastern Los Angeles and western San Bernardino counties. With four Centers of Excellence – The Robert and Beverly Lewis Family Cancer Care Center, Stead Heart and Vascular Center, Women and Children's Center and Trauma Center – PVHMC offers residents specialized services close to home." In addition to the hospital, there are primary care, urgent care, and/or health center locations in Chino Hills, Claremont, La Verne, and Pomona, as well as a cancer care center in Pomona.

In order to maintain tax exempt status under section 501(c)(3) of the Internal Revenue Service Code, non-profit hospital organizations must conduct a community health needs assessment (CHNA) at least once every three years. As part of this process, hospitals must collect input from the community, ensuring that information regarding low-income, minority, and medically underserved populations is included in the study.

The Institute of Applied Research and Policy Analysis (IAR) at California State University, San Bernardino, a full-service consulting and applied research organization, has contributed to Pomona Valley Hospital Medical Center's (PVHMC's) every-three-year community needs assessment since 2009. IAR was pleased to be asked to participate once again in its 2024 needs assessment.

1. This is the first year Fontana has been included in PVHMC's Community Health Needs Assessment.

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

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

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

In addition, **primary data** were collected via an online survey of residents within PVHMC's service area to determine their perceptions and needs regarding various health issues, and to see if there have been any significant changes since the previous studies. Specific issues and questions included:

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

Some community members are unwilling or unable to respond to an online survey, so IAR supplemented the primary data with a **modified Delphi process** in which representatives of low-income, minority, and medically underserved people were surveyed using an online survey, and then given an opportunity to review the results and provide additional input via e-mail. The process addressed the health needs and health drivers in the community, specifically:

- Most significant **health needs** that have the greatest impact on overall health;

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

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

- Unmet needs in the community relative to **primary care and preventive care**;
- Unmet needs in the community relative to **support for patients and families** (e.g., support groups, classes, caregiver services);
- Unmet needs in the community relative to **chronic disease management**;
- **Health needs priorities** of the community;
- **Barriers** to receiving routine and urgent health care; and
- Ways in which PVHMC can help **improve the health and wellness** of the general community as well as the subgroups of low-income, minority, and medically underserved populations.

IAR is pleased to present this report including the results of its **2024 Community Needs Assessment** for Pomona Valley Hospital Medical Center (PVHMC), which summarizes the findings from the secondary data collection, primary data collection, Delphi process, and the executive interviews. The report concludes with overall observations and recommendations.

II. SECONDARY DATA

Introduction

As noted in the introduction to this report, PVHMC's triennial Community Health Needs Assessment has always included both secondary and primary data collection for PVHMC's service area. In that way, PVHMC can view secondary data (data collected by other organizations for other purposes and made available in government publications, reports, and websites) as well as "real time" data from interviews of community residents and stakeholders.

This section of the report presents secondary data regarding:

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

These data have been collected for Los Angeles County as a whole, San Bernardino County as a whole, and for SPA3 (Service Planning Area 3). Available city-specific secondary data for PVHMC's *primary* service area have also been collected. These figures are compared with Healthy People 2030 goals where appropriate. Where relevant, the data reported in the previous community health needs assessment are compared with the most current data collected. Together with the primary data from the online surveys, this information should help PVHMC create an action plan for improving the wellness of the community.

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

Table 2.1: Secondary Data Sources Used

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

Demographic Profile of PVHMC's Service Area

The following tables list the demographic profile of cities in PVHMC's service area, with California, Los Angeles County, and SPA3 figures provided for comparison purposes. The reader is cautioned that these data are from the ACS 2022 1-year estimates, and the margin of error is at least 10 percent of the total value.

The following table shows the city-specific (and regional) population, median age, and age distribution of residents.

Table 2.2: Population and Age (2022)

City/Region	Population	Median age	% Under 18 yrs. old	% 18 to 64 yrs. old	% 65+ yrs. old
Chino	93,149	36.5	26%	61%	12%
Chino Hills	77,923	40.1	21%	63%	16%
Claremont	36,891	41.5	16%	63%	20%
Fontana	212,448	33.6	26%	65%	9%
La Verne	31,239	45.8	19%	58%	23%
Montclair	37,842	32.9	25%	64%	11%
Ontario	179,062	33.6	25%	64%	11%
Pomona	146,015	35.9	24%	64%	12%
Rancho Cucamonga (includes Alta Loma)	176,359	39.8	22%	63%	15%
San Dimas	34,466	42.7	20%	62%	18%
Upland	78,851	37.1	24%	59%	16%
California	39,029,344	37.9	22%	62%	16%
Los Angeles County	9,721,138	38.2	20%	64%	15%
S.B. County	2,193,656	34.4	25%	62%	12%
SPA3	1,704,000	*	20.4%	65.2%	14.3%

*** Note:** The population for SPA3 for year 2022 reported varies by reporting agency or source.
Sources: Census Report, https://censusreporter.org/; County of Los Angeles Public Health, http://publichealth.lacounty.gov/, The 2022 California Health Interview Survey

Overall, the cities in PVHMC's service area covering L.A. County, San Bernardino County, and San Gabriel Valley account for about 11.95 million in population. Predominant age groups are between 18 and 64 in all cities within the service regions. The median age of the population in PVHMC's service areas is between 32.9 and 45.8 years, with a 48% to 52% male population.

The population in the cities of Chino, Fontana, Montclair, Ontario, and Pomona is predominantly Hispanic, whereas Claremont, La Verne, and San Dimas are predominantly White (non-Hispanic). Asian population is predominant in Chino Hills and San Gabriel Valley (SPA3).

Table 2.3: Gender and Ethnicity (2022)

City/Region	% Male	% White	% Black	% Asian	% Hispanic of any race
Chino	51%	16%	5%	21%	53%
Chino Hills	48%	15%	2%	42%	38%
Claremont	47%	48%	5%	15%	24%
Fontana	52%	12%	8%	7%	69%
La Verne	48%	45%	3%	10%	36%
Montclair	48%	11%	5%	10%	71%
Ontario	49%	12%	4%	10%	70%
Pomona	51%	6%	3%	11%	76%
Rancho Cucamonga (includes Alta Loma)	49%	34%	8%	15%	39%
San Dimas	48%	40%	3%	16%	36%
Upland	48%	33%	10%	9%	43%
California	50%	34%	5%	15%	40%
Los Angeles County	50%	24%	7%	15%	49%
San Bernardino County	50%	24%	7%	8%	56%
SPA3	50%	10%	1%	59%	27%

Sources: Census Report, https://censusreporter.org/; County of Los Angeles Public Health, http://publichealth.lacounty.gov/, The 2022 California Health Interview Survey

In 2022, the city-specific median household income figures (Table 2.4, next page) range between $72,789 for Montclair and $115,091 for Claremont. The percentage of persons below the poverty line exceeds 10 percent in five cities (Chino, Montclair, Ontario, Pomona, and Upland). The percentage of persons below the poverty line exceeded 10% in three cities in PVHMC's service area (Montclair, Ontario, and Pomona) in 2019. The cities of Upland and Chino have seen an increase in the percentage of people below the poverty line.

Table 2.4: Median Household Income, Poverty, Education, and Foreign Born (2022)

City/Region	Median Household Income	% Below Poverty Line	HS Grad or Higher	Bachelor's Degree or Higher	Foreign Born
Chino	$95,721	11.7%	84.1%	31.7%	26.4%
Chino Hills	$105,978	7.9%	90.5%	41.5%	35.8%
Claremont	$115,091	5.9%	94.5%	57.6%	17.2%
Fontana	$93,581	8.6%	79.0%	22.9%	29.1%
La Verne	$103,816	8.5%	93.5%	41.6%	17.0%
Montclair	$72,789	14.9%	73.7%	19.0%	32.2%
Ontario	$79,129	12.6%	80.0%	18.5%	26.6%
Pomona	$77,609	12.0%	71.9%	19.5%	33.3%
Rancho Cucamonga (includes Alta Loma)	$108,345	7.4%	91.2%	39.9%	18.5%
San Dimas	$102,241	9.3%	93.6%	38.0%	20.0%
Upland	$97,838	11.8%	91.2%	37.2%	17.3%
California	$91,551	12.2%	84.7%	37.0%	26.7%
Los Angeles County	$82,516	13.9%	80.6%	35.6%	33.1%
San Bernardino County	$79,091	13.4%	82.0%	23.0%	21.5%
SPA3	$84,056	12.9%	77.2%	34.3%	53.9%

Sources: Census Report, https://censusreporter.org/; County of Los Angeles Public Health, http://publichealth.lacounty.gov/, The 2022 California Health Interview Survey

The table below shows that there may be some language barriers when residents of the region seek health care. Based on these data (and the rate of foreign-born individuals in the table above), the need for culturally competent care is evident.

Table 2.5: Language Spoken at Home (2022)

	English ONLY spoken at home, Children 5-17	Spanish spoken at home, Children 5 -17	English ONLY spoken at home, Adults 18+	Spanish spoken at home, Adults 18+
United States	79%	15%	78%	13%
California	59%	31%	55%	28%
Los Angeles County	51%	39%	44%	37%
SB County	60%	35%	53%	38%
SPA3	35%	7%	35%	8%

Sources: Census Report, https://censusreporter.org/; The 2022 California Health Interview Survey

Health Status Indicators

Overall health self-assessment

Overall, the Health Assessment of the two-county areas of interest to PVHMC, which responded to the 2020 and 2022 California Health Interview Survey, characterized their health as "excellent" or "very good." In 2022, 54.3% of L.A. County residents (down from 56.9% in 2020), 52.7% of San Bernardino County residents (marginally down from 52.8% in 2020), and 58.3% of SPA3 respondents (up from 54.8% in 2020) rated their health as "excellent" or "very good" (see Table 2.6: bold with grey highlighting).

- **Decrease in Excellent Health Ratings:** There was a slight decrease in the percentage of individuals reporting their health as "Excellent" from 2020 to 2022 across most regions and genders. For example, L.A. County's percentage for all genders combined decreased from 25.70% in 2020 to 24.10% in 2022.
- **Gender Disparities:** Males generally report better health status than females, particularly in the "Excellent" and "Very good" categories. This trend is consistent across all regions and years examined.
- **San Bernardino County's Higher Poor Health Ratings:** In 2022, San Bernardino County has a higher percentage of individuals rating their health as "Poor" compared to the other regions, with 3.1% for the total of males and females (see Table 2.6, yellow highlighting).
- **Improvement in Very Good Health Ratings in San Gabriel Valley:** The San Gabriel Valley showed an improvement in the "Very good" health status in 2022, with an increase to 34.5% for all genders combined from 31.6% in 2020.
- **Increase in only "Fair" Health Ratings:** There is an observable increase in the percentage of individuals rating their health as only "Fair" across the years in all areas, suggesting a potential decline in overall health perception. For instance, L.A. County's rate increased from 11.8% in 2020 to 14.6% in 2022 for all genders combined (see Table 2.5, light blue highlighting).
- **Variation in Good Health Ratings:** The "Good" health status ratings show fluctuation over the years and among the regions but generally occupy a significant portion of responses. For instance, in the San Gabriel Valley in 2022, 25.4% of all individuals rated their health as "Good".

These observations indicate subtle yet meaningful changes in health perception over the years among different demographics and geographic areas, including a general trend towards lower ratings for excellent health and higher ratings for fair health, hinting at a slight decline in perceived health status over the examined period.

Table 2.6: General Health of Children, Teens, and Adults
2020 Data[2]

	Los Angeles County			San Bernardino County			San Gabriel Valley (SPA3)		
	MALE	FEMALE	ALL	MALE	FEMALE	ALL	MALE	FEMALE	ALL
Excellent	26.6%	24.8%	**25.7%**	26.9%	20.3%	**23.6%**	25.8%	20.6%	**23.2%**
Very good	32.9%	29.6%	**31.2%**	29.5%	29.0%	**29.2%**	32.5%	30.7%	**31.6%**
Good	27.4%	30.7%	29.1%	24.6%	34.4%	29.5%	28.6%	35.5%	32.0%
Fair	11.0%	12.7%	11.8%	16.7%	12.5%	14.6%	11.5%	11.6%	11.6%
Poor	2.2%	2.3%	2.3%	2.3%*	3.8%*	3.1%	1.6%*	1.6%*	1.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

2022 Data

	Los Angeles County			San Bernardino County			San Gabriel Valley (SPA3)		
	MALE	FEMALE	ALL	MALE	FEMALE	ALL	MALE	FEMALE	ALL
Excellent	24.9%	23.3%	**24.1%**	26.9%	20.3%	**23.6%**	25.3%	22.4%	**23.8%**
Very good	30.9%	29.5%	**30.2%**	29.5%	29.0%	**29.2%**	36.7%	32.5%	**34.5%**
Good	27.6%	29.0%	28.3%	24.6%	34.4%	29.5%	27.4%	23.4%	25.4%
Fair	14.2%	14.9%	14.6%	16.7%	12.5%	14.6%	9.5%	17.2%	13.4%
Poor	2.3%	3.3%	2.8%	2.3%*	3.8%*	3.1%	1.2%*	4.6%	2.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Sources: The 2020 California Health Interview Survey; The 2022 California Health Interview Survey

Table 2.7 (next page) shows that the cities with the highest percentages of adults rating their health as only "fair" or "poor" were Chino, Fontana, Montclair, Ontario, and Pomona (Bolded) in 2018 and 2020. Between 2018 and 2020, there has been a sizable decrease in negative health ratings among adults in all age groups in cities, which shows a high percentage of negative health ratings.

The results for the overall counties/regions show that fewer individuals rated their health as "fair" or "poor" in 2020 than in 2018 for the age group between the ages of 18 and 64 years old. At the same time, the same percentage **increased** for the group with 65 years and above. Perhaps that is the reason why the primary data in this report reflected calls for more services for seniors in the region.

2. 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.

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

City-Specific Figures

CITY	2018		2020	
	18 to 64 years old	**65+ years old**	**18 to 64 years old**	**65+ years old**
Chino	**20.5%**	**32.6%**	**15.7%**	**29.5%**
Chino Hills	14.1%	27.7%	11.7%	23.5%
Claremont	12.5%	21.2%	8.3%	15.4%
Fontana	**23.3%**	**36.9%**	**17.7%**	**33.8%**
La Verne	16.7%	23.2%	9.6%	17.1%
Montclair	**26.7%**	**38.7%**	**19.9%**	**36.3%**
Ontario	**24.1%**	**36.0%**	**17.8%**	**33.0%**
Pomona	**27.7%**	**40.6%**	**17.0%**	**31.7%**
Rancho Cucamonga	14.7%	26.3%	13.4%	25.0%
San Dimas	15.4%	24.5%	9.4%	17.4%
Upland	18.1%	24.2%	14.2%	23.0%

Sources: The 2018 California Health Interview Survey; The 2020 California Health Interview Survey

County/Region Figures

COUNTY/REGION	2019		2020	
	18 to 64 years old	**65+ years old**	**18 to 64 years old**	**65+ years old**
Los Angeles	13.5%	24.3%	13.3%	25.9%
San Bernardino	19.0%*	26.5%*	16.7%	28.5%
San Gabriel (SPA3)	15.6%*	24.3%*	14.6%	32.0%

Sources: The 2019 California Health Interview Survey; The 2020 California Health Interview Survey

Although the data show an increase in the number of individuals who rated their health as "fair" or "poor" in 2020 for age groups 65 and above, Table 2.8 (next page) holds some positive news. Specifically, the number of people getting their yearly physical exams had dropped between 2018 and 2021, but there was a significant increase in 2022 for Los Angeles County, San Bernardino County, and SPA3.

Table 2.8: % Physical Exam At Least In the Past 12 Months

COUNTY/REGION	2018	2019	2020	2020	2021
Los Angeles County	75.3%	70.1%	69.3%	61.5%	68.9%
San Bernardino County	70.2%	73.2%	64.5%	53.4%	63.7%
SPA3	77.1%	69.8%	70.6%	61.7%	72.7%

Sources: 2018, 2019, 2020, 2021, and 2022 California Health Interview Survey

Table 2.9: % Physical Exam At Least In the Past 12 Months (by Age Group)

	2021		2022	
COUNTY/REGION	18 to 64 years old	65+ years old	18 to 64 years old	65+ years old
Los Angeles	56.4%	81.2%	64.6%	85.5%
San Bernardino	49.2%	71.0%	58.9%	83.5%
San Gabriel (SPA3)	54.2%	87.6%	69.0%	89.2%

Sources: The 2021 California Health Interview Survey; The 2022 California Health Interview Survey

Prevalence of chronic diseases

Although the majority of individuals in each county/region rated their health as "excellent" or "very good," many people still battle conditions such as cardiovascular disease, diabetes, high blood pressure, cancer, and obesity. The following table (2.10) shows the prevalence of those diseases, broken down by geographical region and gender.

It should be noted that in 2022, there is a marked increase in individuals being diagnosed with **cardiovascular diseases** in both L.A. County and San Bernardino County (grey highlighting), with a decrease reported in San Gabriel Valley (green highlighting). While the percentage of individuals diagnosed with cardiovascular diseases has increased among male members of these three regions, a decreasing trend can be noted among females.

Compared to 2020, the percentage of individuals diagnosed with obesity decreased in L.A. County, and an increase in San Bernardino County and San Gabriel Valley has been reported. These increases in obesity diagnosis rates have shown the same trend among male and female members. Diabetes has decreased among the three regions from 2020 to 2022; the same cannot be said for hypertension, which has increased in L.A. County and San Bernardino County for the same period. Cancer diagnosis data has not been available in recent years.

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

2020 Data

	L.A. County			S.B. County			San Gabriel Valley		
	MALE	FEM.	TOT.	MALE	FEM.	TOT.	MALE	FEM.	TOT.
Cardio-vascular	5.8%	6.0%	5.9%	8.6%	5.5%	7.0%	7.6%	5.7%	6.6%
Obesity*	43.7%	44.1%	43.9%	50.0%	47.3%	48.6%	34.4%	39.7%	37.2%
Diabetes	13.9%	11.8%	12.9%	16.4%	15.1%	15.7%	17.3%	9.7%	13.3%
Hypertension	26.5%	25.9%	26.2%	27.9%	29.0%	28.5%	27.4%	27.4%	27.4%
Cancer	3.53%	3.42%	3.42%	3.46%	3.84%	3.6%	-	-	-

2022 Data

	L.A. County			S.B. County			San Gabriel Valley		
	MALE	FEM.	TOT.	MALE	FEM.	TOT.	MALE	FEM.	TOT.
Cardio-vascular	7.8%	4.8%	6.3%	11.9%	4.8%	8.3%	5.0%	4.9%	5.0%
Obesity*	43.5%	42.3%	42.9%	50.7%	51.1%	50.9%	40.0%	47.0%	43.7%
Diabetes	12.2%	12.1%	12.2%	13.8%	11.4%	12.6%	6.8%	10.7%	8.9%
Hypertension	27.5%	27.2%	27.3%	31.9%	25.8%	28.8%	25.0%	27.1%	26.1%
Cancer	-	-	-	-	-	-	-	-	-

*Obesity: BMI WHO Definition Level 4 with BMI> 27.5 classifies as a higher high-risk

Sources: The 2020 California Health Interview Survey; The 2022 California Health Interview Survey; California Cancer Registry, https://explorer.ccrcal.org/

City-specific data are not available for most major chronic diseases, but they are available for diagnoses of heart disease, diabetes, and obesity (BMI $\geq$ 30). Table 2.11 presents those data for 2018 and 2020. Overall, there is an increase in the percentage of adults being diagnosed with heart disease, diabetes, and obesity. This pattern of increase is seen among all the reporting cities with the exception of Diabetes prevalence in La Verne and San Dimas.

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

	2018			2020		
CITY	**% Heart Disease**	**% Diabetes**	**% Obese (BMI ≥ 30)**	**% Heart Disease**	**% Diabetes**	**% Obese (BMI ≥ 30)**
Chino	5.5	12.5	28.8	6.1	14.2	32.2
Chino Hills	5.8	10.7	21.6	6.7	11.6	24.5
Claremont	6.7	6.8	16.9	7.3	6.7	19.6
Fontana	5.2	13.7	33.1	5.9	16.4	35.2
La Verne	7.2	8.8	20.1	7.7	8.2	23.7
Montclair	5.7	14.6	33.8	6.4	17.8	36.0
Ontario	5.4	13.8	33.3	6.1	16.3	35.4
Pomona	4.8	11.1	29.0	5.3	12.0	32.6
Rancho Cucamonga	6.2	11.7	26.9	6.9	12.1	29.2
San Dimas	6.9	8.7	20.2	7.5	8.6	24.5
Upland	6.8	11.9	26.8	7.6	12.1	29.2

Sources: The 2018 California Health Interview Survey; The 2020 California Health Interview Survey

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 healthcare organizations. According to the Center for Disease Control (National Center for Health Statistics 2023 Release), **heart disease** is the leading cause of death in the **United States**.[3] Other leading causes of death are cancer, COVID-19, stroke, Alzheimer's, accidents, chronic lower respiratory disease, diabetes, chronic liver disease or cirrhosis, and hypertension. Table 2.12 presents data on the rates of leading causes of death in California, L.A. County, and San Bernardino County. Data related to suicide and drug overdose-related deaths are provided in the table as they have been presenting an increasing trend.

Consistent with the state statistics, **cancer** and **heart disease** are the leading causes of death in **L.A. County and San Bernardino County**. Age-adjusted rates for deaths related to cancer are lower in L.A. County in comparison to the State and H.P. 2030 target, while it is higher in San Bernardino County. However, the age-adjusted death rates are higher in both L.A. County and San Bernardino County when compared to State and H.P. 2030 targets for deaths caused by heart disease.

In general, age-adjusted death rates from the leading causes of death are lower in L.A. County in comparison with the death rates from these causes in the state of California, with the exceptions of heart disease, Alzheimer's, Diabetes, Influenza, and Chronic liver disease. San

3. https://www.cdc.gov/heartdisease/facts.htm

Bernardino County reports much higher death rates in comparison to the State of California as causes of death.

In L.A. County and San Bernardino County, the death rates caused by drug overdose are lower than the State and H.P. 2030 targets, indicating a positive status relative to the rest of the state of California. However, the suicide rates are higher in San Bernardino County measured against the rates of deaths for the State of California.

The rates are bolded when they exceed State death rates.

Table 2.12: Leading Causes of Death (2019 – 2021 average)

Cause of Death	L.A. County		S.B. County		California		HP 2030
	Crude Rate	Age-Adjusted	Crude Rate	Age-Adjusted	Crude Rate	Age-Adjusted	Age-Adjusted Target
All Cancers	142.0	119.7	139.6	**141.7**	149.9	124.9	122.7
Heart Disease	113.8	**94.1**	93.7	**100.8**	95.8	79.0	71.1
Stroke	38.7	32.6	40.4	**43.6**	44.6	37.2	33.4
Drug Overdose	18.3	17.9	20.5	20.6	21.8	21.4	20.7
Suicide	8.3	7.9	10.9	**11.0**	10.7	10.3	12.8
Chronic Lower Respiratory Disease (COPD)	27.7	23.3	40.5	**43.5**	31.5	26.2	N/A
Alzheimer's Disease	46.0	**38.0**	35.3	**41.6**	44.1	36.6	N/A
Unintentional injuries (accidents)	36.5	34.9	49.5	**50.2**	45.6	43.4	43.2
Diabetes Mellitus	32.8	**27.7**	36.8	**37.3**	27.6	23.1	N/A
Influenza and Pneumonia	18.7	**15.7**	13.9	**14.6**	13.7	11.5	N/A
Chronic Liver Disease & Cirrhosis	16.2	**14.0**	19.9	**19.4**	15.8	13.8	10.9

Sources: California Department of Public Health, https://www.cdph.ca.gov/Programs/CHSI/Pages/County-Health-Status-Profiles.aspx

Major Health Influencers

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

commonly considered factors such as access and use of health care services often have less of an impact."[4]

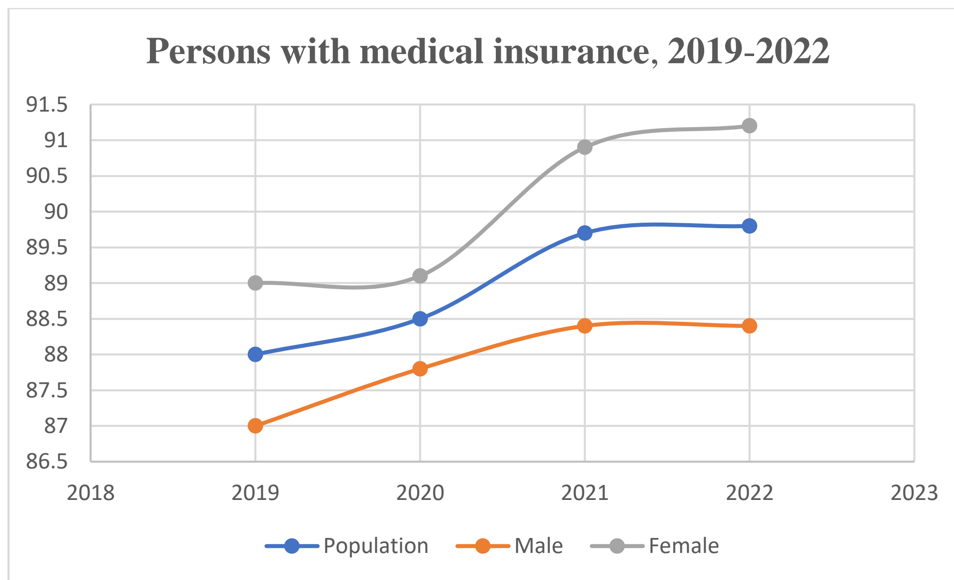
Consistent with this concept, Healthy People 2020 and Healthy People 2030 have indicated that a person's health is influenced/determined by the interrelationships between multiple factors, including individual behaviors, policymaking, social factors, availability of health services, and biology and genetics.

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

Insurance Coverage

Before 2013, the proportion of people with medical insurance was between 80 and 85 in the United States as a whole. Rates increase to a high of 89.7% in 2016, and then declined in 2017 and 2018. But an increasing trend has returned.

According to Healthy People 2030, the target for the proportion of people aged 65 and under with health insurance (AHS-01) is now 92.4 percent (compared to the baseline of 88.0 percent having medical insurance in 2019).

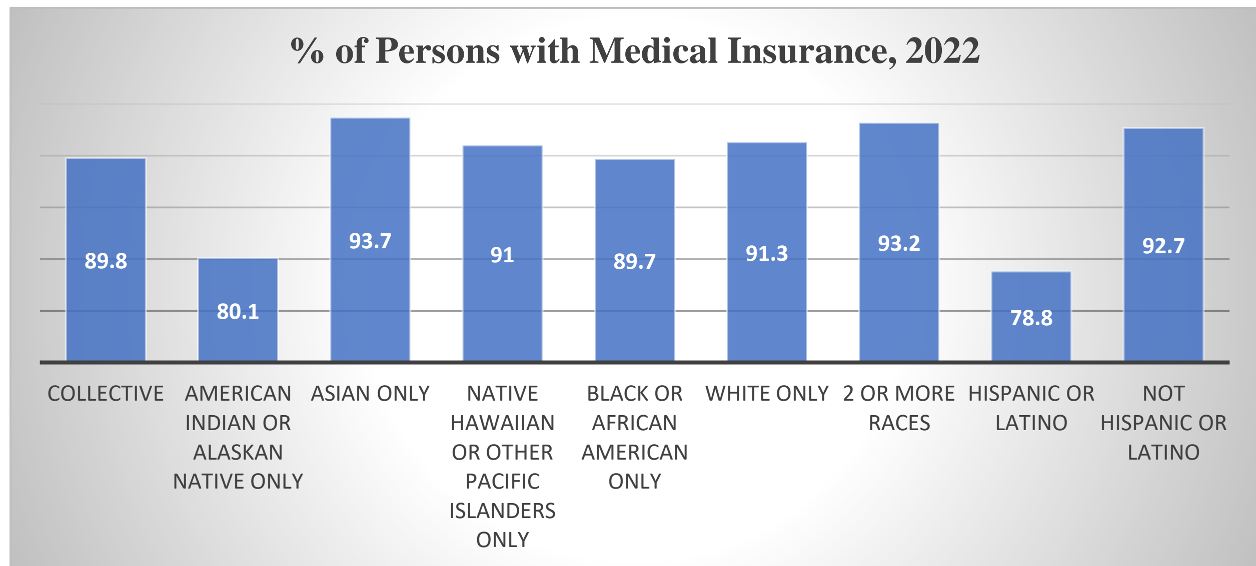


Sources: Healthy People 2030, https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-health-insurance-ahs-01

The increasing trend in the above graph could be partly attributed to the requirements of the Affordable Care Act. Percentages increased from 88% in 2019, 88.5% in 2020, 89.7% in 2021, to 89.8 % in 2022, and are on track to the target of 92.4 % set by AHS-01.

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

Yet there is clearly a disparity by ethnicity. To understand the disparities among the population groups, the data related to the proportion of the population belonging to different races and ethnic groups is presented below. Hispanics or Latinos have the lowest proportion (78.8%) of the population to hold health insurance in 2022; American Indian and Alaskan natives have the second lowest proportion to hold health insurance. The Asian (93%) and members identifying as two or more races (93.2 %) are the two groups with the most significant proportion of the population holding medical insurance in 2022.



Source: Healthy People 2030, https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-health-insurance-ahs-01/data?group=Race/Ethnicity&from=2022&to=2022&state=United%20States&populations=#data-chart

Below (Table 2.13) are the health insurance coverage data specific to L.A. County, San Bernardino County, and SPA3 region. The data shows that adults between the ages of 18 and 64 have the lowest insurance coverage across the three regions. Overall, there has been an increasing percentage of coverage over time (from 2020 to 2022) in LA County and San Bernardino County, and a marginal decline in health insurance coverage in SPA3.

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

		L.A. County	S.B. County	SPA3
2020 data	Children and teens (0 – 17)	98.9%	98.0%	99.2%
	Adults (18 – 64)	87.8%	92.6%	92.0%
	Seniors (65+)*	99.7%	100%	99.1%
	All ages	**92.1%**	**94.9%**	**94.9%**
2021 data	Children and teens (0 – 17)	99.0%	97.1%	96.2%
	Adults (18 – 64)	88.3%	81.3%	89.4%
	Seniors (65+)*	99.8%	100%	100%
	All ages	**92.4%**	**88.1%**	**92.7%**
2022 data	Children and teens (0 – 17)	96.5%	100%	97.3%
	Adults (18 – 64)	89.7%	91.8%	90.8%
	Seniors (65+)	99.3%	98.9%	99.4%
	All ages*	**92.8%**	**94.9%**	**93.4%**

Sources: The 2020, 2021, and 2022 California Health Interview Survey

Following are the available city-specific data on health insurance coverage. The positive news is that the rate of adults with health insurance increased from 2018 to 2020 in all cities in the PVHMC service area. However, the cities of Fontana, Montclair, Ontario, and Pomona had insurance coverage lower than the national average.

Table 2.14: % Insured (City-Specific)

	2018		2020	
CITY	**% children & teens**	**% adults (18 - 64)**	**% children & teens**	**% adults (18 - 64)**
Chino	14.8%	85.2%	Current Data Unavailable	91.7%
Chino Hills	11.1%	88.9%		93.8%
Claremont	7.9%	92.1%		93.1%
Fontana	15.5%	84.5%		**89.8%**
La Verne	8.3%	91.7%		91.8%
Montclair	17.4 %	82.6%		**88.9%**
Ontario	16.2%	83.8%		**89.5%**
Pomona	14.8 %	85.2%		**86.5%**
Rancho Cucamonga	11.5%	88.5%		93.0%
San Dimas	9.2%	90.8%		92.1%
Upland	11.8%	88.2%		91.7%

Sources: The 2018 California Health Interview Survey; The 2020 California Health Interview Survey

Tobacco and E-Cigarette Use

One of the Healthy People 2030 goals is to "reduce US current adult cigarette smoking prevalence to 5% by 2030." The HP 2020 website indicates that tobacco use (and secondhand smoke) causes cancer, heart disease, lung diseases, a variety of health issues for pregnant women, and health problems in infants and children. It is cited as the "single most preventable cause of death and disease in the United States."[5]

In addition, the Healthy People 2030 objectives include reducing current tobacco use in adolescents and adults, reducing the use of flavored tobacco products in adolescents who use tobacco, reducing the proportion of adolescents exposed to tobacco marketing, and reducing the current use of smokeless tobacco products among adolescents.

The following table shows the percentage of adults who are current smokers, former smokers, or who never smoked tobacco. In addition, data on e-cigarettes is presented for 2021 and 2022. Over time, there has been a decrease in the percentage of current adult smokers and an increase in the percentage of adults who have never smoked. However, there is an increase in the percentage of people who smoke e-cigarettes in L.A. County and the SPA3 region, while there is a decrease reported for the same in San Bernardino County.

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

		L.A. County	S.B. County	SPA3
2021 data	Current smoker	5.1%	11.1%	5.1%
	Former smokers	17.5%	15.9%	14.5%
	Never smoked	77.4%	73.0%	80.4%
	Current E-cig user	3.3%	6.8%	2.8%
	Former E-cig user	11.9%	11.0%	9.6%
	Never smoked E-cigarettes	84.8%	82.2%	87.5%
2022 data	Current smoker	5.6%	6.1%	5.4%
	Former smokers	18.7%	18.1%	16.3%
	Never smoked	75.8%	75.7%	78.5%
	Current E-cig user	4.8%	5.6%	5.5%
	Former E-cig user	12.5%	16.3%	9.6%
	Never smoked E-cigarettes	82.7%	78.2%	85.0%

Sources: 2021 and 2022 California Health Interview Survey

City-specific data for tobacco and e-cigarette use among adults is reported in Table 2.16 below. The cities of Chino, Montclair, and Ontario reported the highest percentage of smokers in 2018, which dramatically decreased as reported in 2020. Chino, Montclair, and Ontario continue to be the cities with the highest percentage of smokers in the region, even in the year 2020, as

5. https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-us

reported. The usage of tobacco in general and e-cigarettes decreased dramatically in all cities in the region between 2018 and 2020.

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

CITY	2018		2020	
	% Current Smokers	% Current E-cigarette User	% Current Smokers	% Current E-cigarette User
Chino	**13.2**	**6.2**	**7.6**	3.4
Chino Hills	10.4	**6.3**	5.9	2.9
Claremont	7.9	5.1	3.3	**4.6**
Fontana	12.2	**6.3**	7.1	3.1
La Verne	9.3	4.7	4.2	2.6
Montclair	**13.6**	5.5	**7.8**	3.0
Ontario	**13.0**	6.0	**7.3**	3.1
Pomona	11.1	4.3	5.6	3.0
Rancho Cucamonga	12.9	**6.4**	7.0	3.6
San Dimas	8.4	4.5	3.9	2.6
Upland	12.5	6.0	7.1	3.1

Sources: The 2018 California Health Interview Survey 2018; The 2020 California Health Interview Survey

Alcohol Use

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

How does the CDC define "excessive" alcohol use? The definition includes **binge drinking** (for women, four or more drinks in about 2 hours; for men, five or more drinks during a 2-hour period), or **Heavy Drinking** (for women, eight or more drinks per week; for men, fifteen or more drinks per week), or **any drinking by pregnant women or people younger than age 21**. The National Institute on Alcohol Abuse and Alcoholism adds that binge drinking is a pattern of drinking alcohol that brings blood alcohol concentration to .08 or higher.[7] According to the 2022 National Survey on Drug Use and Health (NSDUH), 221.3 million people ages 12 and older (78.5% in this age group) reported that they drank alcohol at some point in their lifetime. Also, 135.7 million adults ages 18 and older (52.9% in this age group) reported that they drank in the past month.[8] This data can be used to compare PVHMC's service area rates.

6. Centers for Disease Control and Prevention, https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm
7. https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics
8. https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics/alcohol-use-united-states-age-groups-and-demographic-characteristics

The following table addresses binge drinking by adults and teens in Los Angeles County, San Bernardino County, and SPA3 between 2011 and 2022. Some of the data is unavailable.

Table 2.17: Alcohol Use

		L.A. County	S.B. County	SPA3
2011 – 2012 Data (pooling)	% ***adults*** binge drinking in the past *year*	29.9%	28.7%	28.5%
	% ***teens*** (12 – 17) binge drinking in the past *month*	5.1%	a	3.0% *
2015 data	% ***adults*** binge drinking in the past *year*	33.8%	33.6%	27.0%
2016 data*	% ***teens*** (12 – 17) binge drinking in the past *month*	3.0% *	a	b
2019 data*	% ***adults*** binge drinking in the past *year*	b	b	b
	% ***teens*** (12 – 17) binge drinking in the past *month*	2.8%*	16.3%*	b
2022 data*	% ***adults*** binge drinking in the past *year*	19.2%	21.3%	15.6%
	% teens (12 – 17) binge drinking in the past *month*	4.1%	a	a

Sources: 2011 – 2012, 2016, 2019, and 2022 California Health Interview Survey (CHIS); healthypeople.gov
* Statistically unstable
a. Suppressed due to small sample size.
b. Data are unavailable

Food and Nutrition

According to the CDC, poor nutrition is one of the main risk factors for preventable chronic diseases (along with tobacco use, lack of physical activity, and excessive alcohol use).[9] CDC's website indicates that only 1 in 10 adults and adolescents in the United States eat enough fruit and vegetables, and most adults and young people consume sugary drinks. In general, a diet high in added sugars, sodium, and fat tends to contribute to several disease states, including heart disease, obesity, diabetes, some cancers, high cholesterol, and high blood pressure.[10] But a recent study shows that "around 50% of Americans say they are actively trying to eat more healthily."[11] That is good news, considering that healthy eating can significantly prevent such diseases.

9. https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm
10. 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.
11. https://www.weforum.org/agenda/2023/03/health-food-us/

The California Health Survey (published by the UCLA Center for Health Policy Research) includes various measurements to determine residents' health behaviors relative to food and nutrition. The following table is a snapshot of healthy (and not-so-healthy) eating patterns reported by respondents in Los Angeles County, San Bernardino County, and SPA3 in 2017 and 2022. Data for some measured areas is unavailable for some of the years.

Some of the highlights to observe in the data presented in Table 2.18 are that the percentage of children consuming soda increased from 2019 to 2020. The change is marginal in Los Angeles County, while there is notably high consumption in San Bernardino County and the SPA3 region. However, it can be noted that there is a decrease in the consumption of non-soda sugary drinks in Los Angeles County, San Bernardino County and SPA3 regions between 2021 and 2022. Similarly, a notable positive health trend is an increase (from 2019 to 2020) in the percentage of teens from all three regions that have increased consumption of moderate to high amounts of vegetables and fruits. Also, a more considerable proportion of the population was able to afford fresh fruits and vegetables in all three regions in 2018 compared to 2017.

However, it can be noted from the last section of Table 2.18 that although there was a decrease in the percentage of Los Angeles County and San Bernardino County adults without the consistent ability to be able to afford enough food between 2021 and 2022, there was an increase in that percentage in Los Angeles County. Also, there was an increase in percentage of the population receiving food stamps in Los Angeles County and San Bernardino County, with a significant increase in San Bernardino County in 2022.

Table 2.18: Food and Nutrition

Category	Measure	2019 L.A. Co.	2019 S.B. Co.	2019 SPA3	2020 L.A. Co.	2020 S.B. Co.	2020 SPA3
Soda consumption	% ***children & teens*** ≥ 2 glasses of soda yesterday	9.1%	4.7%	11.0%	9.3%	17.5%	12.4 %
		2021			**2022**		
		L.A. Co.	**S.B. Co.**	**SPA3**	**L.A. Co.**	**S.B. Co.**	**SPA3**
Sugary drinks consumption	% ***children & teens*** ≥ 2 glasses of sugary drinks (other than soda) yesterday	25.6%	22.2%	30.4%	20.3%	22.0%	19.6%
		2019			**2020**		
		L.A. Co.	**S.B. Co.**	**SPA3**	**L.A. Co.**	**S.B. Co.**	**SPA3**
Consumption fruits/vegs	% ***teens*** ate ≥ 5 servings of fruits and vegetables daily	27.1%	19.1%	23.4%	36.3%	26.7%	51.1%
Consumption fruits/vegs	% ***teens*** ate ≥ 2 servings of fruits and vegetables yesterday	66.0%	58.3%	54.3%	77.9%	61.9%	85.3%
		2017			2018		
		L.A. Co.	**S.B. Co.**	**SPA3**	**L.A. Co.**	**S.B. Co.**	**SPA3**
Avail & cost of fruits/vegs	% ***adults*** who can *always* or *usually* find fresh fruits and vegs in neighborhood	76.0%	77.8%	76.6%	76.5%	76.9%	76.9%
Avail & cost of fruits/vegs	% ***adults*** with fresh fruits/vegs *always* or *usually* **affordable** in neighborhood	79.2 %	81.4%	77%	80.8 %	81.9%	81.3%
		2021			2022		
		L.A. Co.	**S.B. Co.**	**SPA3**	**L.A. Co.**	**S.B. Co.**	**SPA3**
Issues among the poverty population	% of adults without the consistent ability to be able to afford enough food	40.9%	45.8%	41.5%	42.7%	45.1%	36.9%
Issues among the poverty population	% ***of children/teens/ adults with income < 200%*** of FPL currently receiving food stamps	31.2%	26.9%	32.4%	32.4%	40.8%	30.4%

Sources: The 2017, 2019, 2020, 2021, and 2022 California Health Interview Survey

City-specific food insecurity data is shown below in Table 2.19. Fontana, Montclair, Ontario and Pomona had high percentages of low-income adults who are unable to consistently buy food. Between 2016 and 2020, Pomona has shown a drastic improvement.

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

CITY	2016 data	2018 data	2020 data
Chino	8.2	7.1	8.0
Chino Hills	4.1	3.6	3.6
Claremont	2.4	2.2	0.6
Fontana	**10.3**	**10.2**	**12.5**
La Verne	3.7	3.4	0.9
Montclair	**12.0**	**11.7**	**14.1**
Ontario	**11.0**	**10.2**	**11.8**
Pomona	**11.2**	**10.1**	5.3
Rancho Cucamonga	4.9	5.0	5.1
San Dimas	3.9	3.1	0.9
Upland	5.4	5.3	5.6

Sources: The 2016, 2018 and 2020 California Health Interview Survey

City-specific food insecurity data is shown above in Table 2.19. Fontana, Montclair, Ontario and Pomona had high percentages of low-income adults who are unable to consistently buy food. Between 2016 and 2020, Pomona has shown a drastic improvement.

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 L.A. County and SPA3.[12] Although not "perfect," the figures for adults are higher than the H.P. 2030 figures. HP 2030 figures for children are not available, however we note that the regional figures for children's exercise are relatively low and have declined over time.

Unfortunately, there is no data on physical activity more current than the 2018 data presented in the 2021 CHNA report. Hence, we present the data through 2018.

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

Table 2.20: Measures of Physical Activity

	2015 data		2018 data		
	L.A. County	SPA 3	L.A. County	SPA 3	HP 2030
Percent of ***adults*** who obtain recommended amount of aerobic exercise per week (≥150 minutes/week of moderate exercise or ≥75 min of vigorous exercise)	65.1%	64.2%	64.4%	63.4%	52.9%
Percent of ***adults*** who obtain recommended amount of muscle-strengthening (≥2 days/week)	41.3%	37.3%	43.1%	40.9%	36.6%
Percent of ***adults*** who obtain recommended amount of aerobic and muscle strengthening exercise per week	34.1%	31.3%	35.1%	33.4%	29.7%
Percent of ***children*** ages 6-17 who obtain recommended amount of aerobic exercise each week (≥60 min daily)	28.5%	28.4%	23.7%	22.4%	N/A
Percent of ***children*** ages 6-17 who obtain recommended amount of aerobic and muscle strengthening exercise per week	17.7%	15.7%	15.1%	12.2%	N/A

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

The California Health Interview Survey also includes questions regarding the amount of daily physical activity for children, teens, and adults; visits to parks/open spaces by teens; hours spent by children and teens on sedentary activities during weekdays and weekends; and walking for transportation and leisure for adults. The data were available for 2018; however the only data we could find for 2020 was hours spent by children and teens on sedentary activities on a typical weekend which increased significantly in all three regions, i.e., Los Angeles County, San Bernardino County, and the SPA3 region.

Table 2.21: Other Measures of Physical Activity

	2018 data			2020 data		
	L.A. County	S.B. County	SPA3	L.A. County	S.B. County	SPA3
Percent ***children*** physically active ≥ 1 hour during at least 5 days in the past week	49.9%*	31.1%*	30.5%*	-	-	-
Percent ***teens*** (12 – 17) who visited a park, playground, or open space in the last month	50.5%	61.5%*	42.5%*	-	-	-
≥ 5 hours spent by ***children and teens*** on sedentary activities on typical weekdays after school	15.8%*	21.9%*	16.5%*	-	-	-
≥ 5 hours spent by ***children and teens*** on sedentary activities on a typical weekend days	17.6%*	24.2%*	20.0%*	39.7%	32.1%	33.8 %
Percent ***adults*** who are physically active at least 20 minutes at a time, ≥ 5 days a week	48.6%	51.9%*	51.2%*	-	-	-

Sources: The 2018, 2019, and 2020 California Health Interview Survey (CHIS)

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

Unfortunately, the California Health Interview Survey did not include up-to-date city-specific physical activity data. The following is the city-specific data for physical activity available for 2016 (the most current data available). The table shows that the physical activity level of children and teens is far lower than that of adults in all reported cities.

Table 2.22: City-Specific Physical Activity Measures

CITY	*2016 Data*	
	***% 5 – 17 yr olds* > 1 hr of daily physical activity (excluding P.E.)**	***% adults* who walked ≥ 150 minutes**
Chino	18.2%	32.8%
Chino Hills	20.5%	33.9%
Claremont	20.2%	36.8%
Fontana	16.6%	33.8%
La Verne	20.4%	33.9%
Montclair	13.7%	35.8%
Ontario	15.9%	33.5%
Pomona	15.2%	34.9%
Rancho Cucamonga	20.9%	34.7%
San Dimas	21.4%	33.8%
Upland	18.6%	35.5%

Sources: The 2016 California Health Interview Survey

Mental Health

The COVID-19 pandemic in the year 2020 had a significant effect on the mental health of adults and children in the United States. Table 2.23 below presents data on mental health issues among teens and adults in 2021 and 2022. Post-pandemic, the percentage of teens experiencing serious psychological distress in the past year declined in L.A. County and SPA3 regions, with an increase reported in San Bernardino County. Similarly, adults experiencing serious psychological distress declined in L.A. County, while increasing marginally in San Bernardino County and the SPA 3 region.

Adults reporting severe work impairment due to moderate or severe psychological distress decreased from 2021 to 2022 in L.A. County while a significant increase was reported in San Bernardino County. The rate of moderate work impairment increased in SPA3. Only marginal changes between 2021 and 2022 were seen in rates of impairment in family life and in percent of adults needing help for emotional/mental health problems or use of alcohol/drugs.

On the other hand, in the same years (2021-2022) there was a drastic increase in the percentage of teens needing emotional or medical help in Los Angeles County, San Bernardino County, and the SPA 3 region. On a similar note, there was an increase in the percentage of adults with serious thoughts of committing suicide increase in San Bernardino County and SPA3 regions, with only a slight decrease in Los Angeles County.

Table 2.23: Mental Health

	2021 data			2022 data		
	L.A. County	S.B. County	SPA3	L.A. County	S.B. County	SPA3
Percent ***teens and adults*** who likely have had serious psychological distress during the past year	18.5%	18.7%	15.7%	16.6%	20.2%	14.4%
% teens only	39.8%	25.8%	43.5%	30.4%	28.3%	29.9%
% adults only	16.2%	17.6%	11.9%	15.0%	19.2%	12.5%
Work impairment past 12 months – ***Adults*** with moderate/severe psychological distress						
Moderate	54.1%	47.6%	49.1%	54.1%	45.2%	54.2%
Severe	32.3%	29.1%	29.3%	31.0%	40.8%	25.4%
Percent *adults* with moderate to severe family life impairment over the past 12 months						
Moderate	16.2%	16.0%	12.2%	15.3%	13.4%	14.3%
Severe	9.3%	10.4%	8.5%	9.5%	13.0%	7.4%
Percent ***adults*** needed help for emotional/mental health problems or use of Alcohol/drugs	25.0%	22.0%	20.6%	25.4%	22.7%	20.3%
Percent ***teens*** needed help for emotional/mental health problems	26.7%	32.2%	15.4%	34.1%	41.9%	37.1%
Percent ***adults*** ever seriously thought about committing suicide	17.2%	18.8%	13.0%	16.9%	20.9%	17.0%

Sources: The 2021 California Health Interview Survey; The 2022 California Health Interview Survey

City-specific data related to mental health issues is reported in Table 2.24 for the year 2020. It can be noted that in the year 2020, Chino, Rancho Cucamonga, and Upland (grey highlighting) had the highest percentage of adults experiencing serious psychological distress. At the same time, the cities of Chino, Claremont, and Ontario reported the highest percentage of adults whose emotions interfered with work performance (blue highlighting). The cities of Chino, Claremont, Ontario, Rancho Cucamonga, and Upland reported (orange highlighting) the

highest percentage of adults with family life impairment. Finally, the cities of Claremont, Rancho Cucamonga, and Upland cities reported (green highlighting) the highest percentage of adults who needed help with emotional, mental, alcohol, or drug-related problems.

Table 2.24: 2020 City-Specific Mental Health Issues Over Past 12 Months

CITY	% adults experiencing serious psychological distress	% adults whose emotions interfered with work performance	% adults with family life impairment	% adults who needed help for emotional/mental or alcohol/drug problems
Chino	**13.0%**	**16.5%**	**20.6%**	17.4%
Chino Hills	11.7%	15.1%	19.1%	16.9%
Claremont	12.3%	**18.0%**	**20.9%**	**21.9%**
La Verne	9.9%	15.5%	18.8%	16.3%
Fontana	11.6%	13.2%	16.7%	17.7%
Montclair	12.6%	15.9%	19.7%	16.5%
Ontario	12.6%	**16.3%**	**20.0%**	17.4%
Pomona	11.3%	15.9%	18.8%	17.9%
Rancho Cucamonga	**12.9%**	16.0%	**20.2%**	**18.7%**
San Dimas	9.9%	13.4%	16.9%	17.9%
Upland	**13.4%**	16.2%	**20.3%**	**19.6%**

Source: The 2020 California Health Interview Survey

Domestic Violence

Domestic violence is defined as a "pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, psychological, or technological actions or threats of actions or other patterns of coercive behavior that influence another person within an intimate partner relationship. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone."[13] Such abuse is clearly a "health influencer" for the 162,422 people in California who made domestic violence-related calls for assistance in 2022. Victims of domestic violence suffer immediate trauma. In addition, violence can contribute to various chronic health problems (e.g., depression, substance abuse, and hypertension).

As the table and graph below demonstrate, domestic violence-related calls for assistance had been decreasing over time in Los Angeles County until 2021 when calls increased. San Bernardino County saw a decrease until 2019 and then the trend reversed. That same pattern exists over time in the PVHMC primary service area.

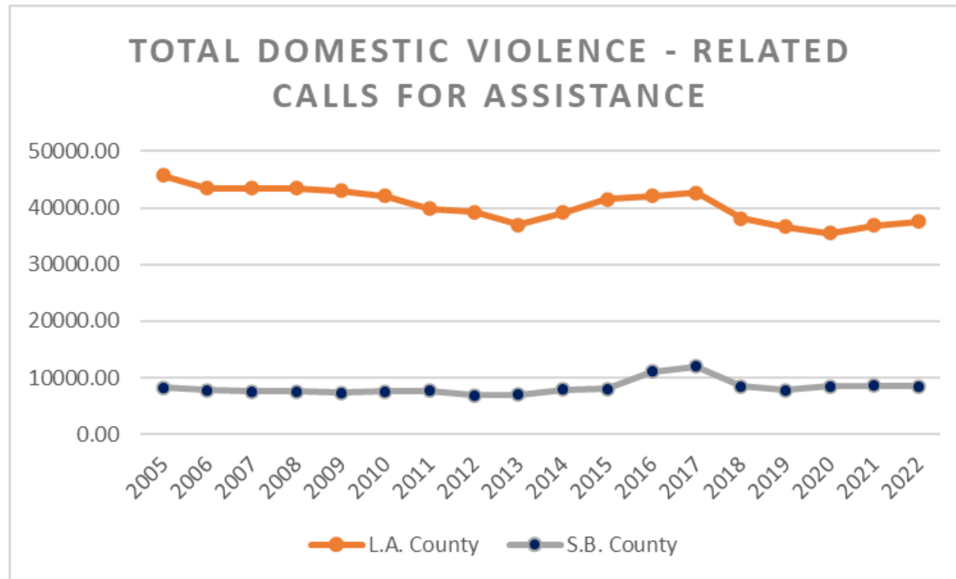
13. https://www.justice.gov/ovw/domestic-violence

Table 2.25: Total Domestic Violence-Related Calls for Assistance

Year	Los Angeles County	San Bernardino County	PVHMC primary service area *without* Fontana*	PVHMC primary service area *including* Fontana*
2004	48,041	9,146	3,558	4,392
2005	45,684	8,235	3,538	4,282
2006	43,508	7,831	3,167	3,877
2007	43,416	7,650	3,484	4,311
2008	43,458	7,579	3,246	3,975
2009	43,014	7,327	3,015	3,768
2010	42,052	7,563	3,269	3,982
2011	39,817	7,681	3,317	4,564
2012	39,253	6,882	3,131	3,919
2013	37,038	7,002	2,815	3,569
2014	39,145	7,919	2,958	3,684
2015	41,534	8,052	3,175	3,942
2016	42,148	11,109	2,998	3,708
2017	42,702	12,012	3,097	3,822
2018	38,190	8,525	2,959	3,679
2019	36,707	7,781	2,960	3,618
2020	35,498	8,456	3,017	3,686
2021	36,947	8,612	3,071	3,809
2022	37,614	8,522	2,844	3,552

*NOTE: until this year, Fontana was not included in Community Health Needs Assessment.
The trend data are shown both with and without Fontana included.

Source: Open Justice, https://openjustice.doj.ca.gov/data



Homelessness

According to the United States Interagency Council on Homelessness's 2023 annual report, homelessness continues to be an urgent public health crisis across the United States. Homelessness increased by 12% nationally between January 2022 and January 2023. According to this report, approximately 653,100 people experienced homelessness in the 2022-2023 fiscal year. According to California State Auditor's report, California is home to 12% of the total U.S. population, but 28% of its homeless population and 51% of its unsheltered homeless.[14]

Homelessness-related data for three regions are reported for the years 2020 and 2022 in Table 2.26. Homelessness increased in L.A. County and San Bernardino County in the two years; SPA3 reported a decrease in point-in-time homeless count in 2022 compared to 2020.

Table 2.26: Point-in-Time Homeless Counts

	2020 data			2022 data		
	L.A. Co.	**S.B. Co. (2020)**	**SPA3**	**L.A. Co.**	**S.B.Co. (2022)**	**SPA3**
# People who are homeless	66,436	3,125	5,082	69,144	3,333	4,661
% Sheltered	27.69%	23.52%	34.65%	29.87%	28.32%	64.04%
% Unsheltered	72.31%	76.48%	65.35%	70.21%	71.68%	35.96%

Sources: San Bernardino County, https://www.sbcounty.gov/uploads/sbchp/SBC-2022-Homeless-Count-Report.pdf ; San Bernardino County, https://www.sbcounty.gov/uploads/sbchp/community-projects/pitc/2020-SBC-Homeless-Count-Report.pdf; Los Angeles Homeless Service Authority, https://www.lahsa.org/news?article=895-lahsa-releases-2022-great-los-angeles-homeless-count-results-released ; Los Angeles Homeless Service Authority,

14 https://www.auditor.ca.gov/issues/briefs/housing-and-homelessness

https://www.lahsa.org/documents?id=4692-2020-greater-los-angeles-homeless-count-total-point-in-time-homeless-population-by-geographic-areas

Final Comments Relative to Secondary Data

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

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

- United States Census Bureau
- California Health Interview Survey 2011-2012, 2014, 2016, 2018, 2019, 2020, 2022
- California Health Interview Survey (CHIS), Neighborhood Edition
- California Cancer Registry
- Department of Public Health County of Los Angeles
- Centers for Disease Control and Prevention Leading Causes of Death in California
- Center for Disease Control and Prevention Chronic Disease
- Center for Disease Control and Prevention Alcohol
- California Department of Public Health, County Health Status Profiles https://www.cdph.ca.gov/Programs/CHSI/CDPH Document Library/CHSP-County Profiles 2018.pdf
- Healthy People 2020 and Healthy People 2030
- KidsData.org
- State of California Dept. of Justice, Office of the Attorney General
- U.S. Census Bureau (2019) American Community Survey 5-year estimates. Retrieved from Census Reporter Profile (then using zip codes)
- Employment Development Department CA Latest News Releases
- Homelessness Data Exchange
- Los Angeles Homeless Services Authority
- National Institute on Alcohol Abuse and Alcoholism
- 2020 Greater Los Angeles Homeless Count Results
- 2019 and 2020 San Bernardino County Homeless Count and Subpopulation Survey Final Report
- World Economic Forum
- World Health Organization
- US Department of Agriculture and US Department of Health

Other links that PVHMC may find helpful:

- California Department of Public Health
- American Community Survey Five Year Estimates
- Healthy People
- Center for Disease Control and Prevention, Division of Nutrition, Physical Activity, and

Obesity

- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System
- Centers for Disease Control and Prevention, Leading Causes of Death
- California Health Interview Survey
- National Center for Health Statistics
- San Bernardino County Department of Behavioral Health
- California Department of Health Care Services
- National Institute of Mental Health. Suicide in the U.S.: Statistics and Prevention.
- The State of Obesity in California Data, Rates and Trends
- National Cancer Institute
- National Institute of Diabetes and Digestive and Kidney Diseases
- American Diabetes Association
- EDD Employment Development Department Newsroom
- EDD Labor Market Information
- American Cancer Society
- Bureau of Justice Statistics
- Domestic Violence Statistics
- U.S. Breast Cancer Statistics
- U.S. Health Resources and Services Administration Data Warehouse
- http://www.dartmouthatlas.org/data/topic/
- http://www.dartmouthatlas.org/publications/
- Los Angeles County Department of Public Health (Key Health Indicators, Epidemiology, Data and Reports)
- California Office of Statewide Health Planning and Development (OSHPD)
- U.S. Department of Health & Human Services Preventions Surgeon General.gov Reports and Publications
- California Department of Education Physical Fitness Test, State, County, District Breakdowns
- CDC Youth Risk Behavior Surveillance System (YRBSS) 2021
- California Dream Index Los Angeles Region
- Opportunity Insights Economic Tracker impacts of COVID-19
- US Census Bureau Household Pulse Survey Data Tables
- US EPA
- United Way of California
- Careeronestop
- Employment Development Department CA Interactive Maps and Data Tools

III. PRIMARY DATA COLLECTION (PHONE AND ONLINE SURVEYS)

Process and Methodology Used

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

This is the sixth time IAR has conducted the every-three-year Community Health Needs Assessment. In 2009, 2012, 2015, and 2018, a telephone survey methodology was used to survey residents within PVHMC's service area. Due to budget constraints, PVHMC chose to request only an online survey in 2021, but this year *both* survey methodologies – telephone and online – were used. Telephone surveys have a "personal touch" and have a higher response rate (as well as a higher accuracy rate) than online surveys. But over the past decade there has been a tremendous increase in the use of the internet and social media to communicate, gather information, provide an opportunity for community engagement, and enhance relationships. Not surprisingly, the use of online surveys has skyrocketed, offering the advantages of speed, efficiency, community engagement, and lower costs of data collection. Thus this year's approach of using a combination of a telephone survey approach and an online survey approach enables IAR to offer the best of both worlds.

To begin, IAR (in consultation with PVHMC) spent a great deal of time reviewing previously used questionnaires regarding residents' healthcare behaviors and needs. Most of the questions had been used in the 2009, 2012, 2015, 2018, and 2021 community needs assessment surveys in order to reveal trends over time.

Surveys (especially telephone surveys) need to remain within a 12-minute running time to ensure optimal respondent participation and data quality. Since the previously used surveys were much longer than that, IAR designed this year's survey to be a "split-questionnaire" instrument in which respondents were asked to answer a series of "core questions" and then HALF of the remaining non-core questions. This design reduced the length of the final survey to 13.5 minutes – a bit longer than desired, but not *significantly* longer. The initial questionnaire, after its approval by PVHMC staff, was then translated into Spanish and pretested in both languages. The questionnaire is attached as Appendix A.

Three distribution methods were prepared in order to target three slightly different target populations. First, IAR worked with MDC Research to implement the telephone survey of residents in PVHMC's service area using a **registered voter** list as the sampling frame for the study. The advantage of such a list is that one can establish quotas by gender, geography, and age to better represent the population of voters. And it is much more efficient and cost-effective than random digit dialing. Of course, the downside of using registered voter lists is that not everyone is registered! But given the increase in registrations in advance of the 2020 presidential election, this is not as serious a downside as it has been in the past. The phone

survey was conducted between January 22 and February 5, 2024, and yielded 305 completed surveys (resulting in a 95% level of confidence and an accuracy of +/- 6% when generalizing to the population of adult registered voters in PVHMC's service area). A total of 14.8% of the surveys were completed in Spanish.

Next, IAR worked with MDC research to launch an online survey using **an established panel** of individuals who have already agreed to take part in research of this type. That survey was "live" between February 8, 2024, and February 13, 2024. The total sample size was 248 completed surveys, resulting in a 95% level of confidence and an accuracy of +/- 6.2% when generalizing to the population of adults in PVHMC's service area. All surveys were completed in English.

Finally, IAR prepared a link to **an online Qualtrics survey which was distributed by PVHMC's outreach team** on dedicated websites, social media (Facebook, Instagram, Twitter), ads, patient outreach, community leader outreach, flyers, and internal communication outreach. *Statistical validity is not optimal with this mode of outreach*, however it served to maximize community input and engagement. That survey was launched on February 1, 2024 and left active until February 29, 2024 to maximize community response. This approach yielded a total of 662 residents from the twelve cities within PVHMC's service area. No estimates of confidence and accuracy can be provided given the non-random nature of the distribution method. Very few of the surveys (2.7%) were taken in Spanish.

The above methods yielded input from a total of 1,215 people. When used together, the three distribution methods provided the broadest opportunity for people to provide input via landline phone, cell phone, or online -- either in English or Spanish. But we must emphasize that of the three methods, **the results from the telephone survey are the most accurate** and reflective of the adult population in PVHMC's service area.

Sampling and Response Issues

Before presenting the highlights of the major findings from the 2024 PVHMC online surveys, IAR needs to list several "caveats":

- Research shows that females tend to answer online surveys in much greater numbers than males, whereas telephone surveys have close to a 50/50 split between females and males. Hispanic participation tends to be higher in telephone surveys than in online surveys. Young people are more likely to respond to web surveys than telephone surveys (if they agree to participate at all), whereas older people are more likely to participate in phone surveys.[15] The surveys for the 2024 Community Health Needs Assessment were reflective of these patterns.
- For some questions, results differed based on mode of delivery due to the fact that *hearing* a phone survey question (and answering off the "top of the head") is different than *reading/seeing* an online survey question (and selecting among the choices

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

provided). In addition, the target populations for the three survey modes differed, thus some differences in results are to be expected.

- In order to correct for under-sampling of young people and people of Hispanic origin who are traditionally less likely than older people and non-Hispanics to respond to surveys, a weighting factor was applied to the phone survey data. The weighted results cited in this report are a more accurate representation of the opinions of the full population of residents in PVHMC's service area.
- As the reader compares results from the 2021 survey and the current 2024 survey, we must place the 2021 results in context. During the COVID pandemic which began in early 2020, the lives of virtually everyone worldwide were affected in some way, either through employment changes, sickness and death of loved ones, the need to balance work and home-schooling children, or fear and depression due to isolation during the lock-down. Systemic racism, violence arising from political disagreements, anti-Asian hate crimes linked to the pandemic, etc., were highlighted in social and mainstream media. Indeed, the responses to the 2021 survey may have reflected situational health issues and opinions as opposed to more general and long-lasting ones. Thus comparisons between the 2021 and 2024 survey results must be made with caution.
- The tables for questions given to only ½ of the respondents are denoted by either "Split A" or "Split B" in the table heading. Tables without those designations are considered to be the core questions given to all respondents.

Survey Findings

The findings from the 2024 PVHMC online surveys are presented in sections, divided into conceptual categories (e.g., demographic profile of respondents, health status indicators, health influencers, and "other" issues). We begin with a brief profile of survey respondents.

Demographic profile of respondents

The following table shows the number of people from each city who responded to each version of the survey. The reader will note that the telephone survey represented the City distribution most accurately. The IAR online survey over-represented Claremont and Pomona, and under-represented Fontana, Ontario, and Rancho Cucamonga/Alta Loma, perhaps due to the outreach method used for the survey. The MDC Online survey significantly under-sampled Fontana and Upland residents.

Table 3.1: Adult Population in Respondent City of Residence

Cities	Total Adult Pop.	Percent	Telephone		MDC Online		IAR Online	
			# in Sample	Percent	# in Sample	Percent	# in Sample	Percent
Chino	69,906	8.4%	18	5.9%	27	10.9%	60	9.1%
Chino Hills	60,877	7.3%	25	8.2%	21	8.5%	57	8.6%
Claremont	30,822	3.7%	17	5.6%	17	6.9%	116	17.5%
Fontana	150,799	18.0%	66	21.6%	1	0.4%	28	4.2%
La Verne	25,284	3.0%	13	4.3%	9	3.6%	67	10.1%
Montclair	28,248	3.4%	10	3.3%	16	6.5%	15	2.3%
Ontario	132,436	15.8%	50	16.4%	46	18.5%	57	8.6%
Pomona	113,447	13.6%	46	15.1%	48	19.4%	135	20.4%
Rancho Cucamonga/ Alta Loma	135,082	16.1%	33	10.8%	49	19.7%	51	7.7%
San Dimas	27,506	3.3%	12	3.9%	14	5.6%	28	4.2%
Upland	61,918	7.4%	15	4.9%	0	0.0%	48	7.3%
TOTAL	**836,325**	**100.0%**	**305**	**100.0%**	**248**	**100.0%**	**662**	**100.0%**

The following table shows the demographic profile of the survey respondents. In general, the respondents can be described as predominantly highly educated (i.e., some college or college degree), middle-income, Caucasian, middle-aged/seniors, and long-time residents. Phone survey respondents were predominantly male, without children in the household. The MDC online survey was majority female with one or two children in the household.

Table 3.2: Demographic Profile of Respondents

	Telephone	MDC online	IAR online
Gender			
Male	52.7%	41.3%	26.7%
Female	47.0%	58.3%	72.6%
Married	43.3%	35.4%	60.9%
Education			
High School Degree or Less	27.2%	21.6%	10.3%
Some College or College Degree	72.8%	78.4%	89.7%
Median Household Income	$65,000 - $80,000	$50,000 - $65,000	$80,000-$100,000
Less than $35,000	25.0%	27.5%	16.0%
$35,000 to < $80,000	27.8%	42.9%	27.4%
$80,000 or more	47.2%	29.6%	56.6%
Employment			
Working full-time for pay	36.8%	41.2%	37.2%
Working < 30 hours/wk for pay	6.9%	10.7%	8.2%
Unemployed, looking for work	3.2%	12.8%	2.5%
Retired/Disabled	40.5%	16.9%	45.3%
Ethnicity (multi response question)			
Caucasian	47.4%	47.5%	58.5%
Hispanic	44.1%	35.8%	29.1%
Asian/Pacific Islander	5.6%	15.8%	10.8%
Black/African American	5.6%	11.3%	7.2%
Hispanic, Spanish, or Latino Origin	46.3%	39.4%	30.5%
Average (Mean) Age	54	44	62
18 to 34 years old	21.9%	34.7%	5.9%
35 to 54 years old	25.6%	35.9%	25.4%
55 or older	52.4%	29.4%	66.9%
Average (Mean) # of Years Living in Community	19	18	30
Average (Mean) # of People Living in the Household	3	3	3
Those with No Children Living in the Household	70.2%	40.7%	75.1%
(Of those with Children): # of Children Living in the Household			
One	46.2%	58.4%	50.9%
Two	33.0%	30.7%	31.5%

Regarding the demographic profile of respondents: the table shows that Hispanics are slightly underrepresented in the surveys when compared with prevalence in the adult population. As noted in a report by the Pew Research Center, this is a nationwide trend. Overall response rates among Hispanics have been in decline since the late 1997s and have finally

begun to stabilize, but concerns about confidentiality continue to lead to underrepresentation of Hispanics. Further, sampling accuracy can suffer based on the Latino tendency to live in households with many family members. The phone survey contains included approximately 46.3% people of Hispanic, Spanish, or Latino origin, the MDC survey included 39.4%, and the IAR online survey included only 30.5% Hispanics. Yet those figures are all well below the population estimates of 49% Hispanics in LA County, 56% in San Bernardino County, and 27% in SPA3 (which is predominantly Asian).

Further, the table shows that the sample is somewhat skewed toward older individuals (particularly in the phone survey and IAR online survey). This is, again, typical in nationwide surveys. Young adults are used to multi-tasking and responding via short text messages or tweets, so they tend to be unwilling to take 10 – 15 minutes of their time for a survey unless it is of extreme relevance to them (which is not necessarily the case for a health needs survey). Young people were more heavily represented in the MDC online survey than the phone survey.

So what are the solutions to these under-representations? First, IAR has applied a **weighting scheme** to the telephone survey results to correct for potential bias based on demographics. The figures in this report are based on that weighting scheme. In addition, we have analyzed the databases on **demographic subgroups** to point out significant differences by subgroup (where they exist).

Health Status Indicators

Self-reported health evaluation

When respondents were asked "*would you say that in general your health is excellent, good, fair or poor,*" the answer from the majority of the respondents was "excellent" or "good" (74.1% in the phone survey, 65.6% in the MDC online survey, and 69.8% in the IAR online survey), with the rest evaluating their health as "fair" or "poor." Based on the phone survey results, the percent rating their health as "excellent" is the highest it has ever been. That is the good news. On the other hand, Gallup survey results from November 2023[16] show that approximately 24% of U.S. residents rated their health as "fair" or "poor." Table 3.3 shows a higher percentage of those negative ratings from residents in PVHMC's service area. There were no significant differences in health evaluation based on gender or ethnicity.

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

Table 3.3: Respondents' Rating of their Health

	Excellent	Very Good/Good	Fair	Poor
2009 phone	15.1%	54.9%	23.7%	6.2%
2012 phone	16.4%	51.4%	25.1%	4.3%
2015 phone	15.2%	53.6%	27.9%	3.3%
2018 phone	15.4%	51.4%	29.3%	3.9%
2021 IAR online	17.0%	53.1%	25.7%	4.3%
2021 MDC online	14.5%	49.7%	30.3%	4.5%
2024 phone	**19.4%**	**54.6%**	**22.2%**	**3.8%**
2024 MDC online	13.8%	51.8%	31.6%	2.8%
2024 IAR online	9.9%	60.0%	26.7%	3.4%

In 2021 and again this year, a question was included about the impact of the pandemic on overall health: *"How did the pandemic impact your overall health? Would you say that it had a negative impact, or a positive impact, or not much impact?"* In response, approximately 4 in 10 respondents indicated that the pandemic had ***negatively*** affected their overall health, whereas about half indicated that the pandemic had not had much impact on their health. One might have thought that the percentage of people recalling negative impacts might have diminished over time, but seemingly that wasn't the case: the results in Table 3.4 are not too different from those in the 2021 survey when people were in the midst of dealing with the pandemic.

Table 3.4: How did the pandemic impact your overall health and well-being? (Split B only)

	Phone		MDC Online		IAR Online	
	Counts	**Percent**	**Counts**	**Percent**	**Count**	**Percent**
Negative impact	59	40.6%	48	39.3%	133	42.6%
Positive impact	12	8.0%	9	7.4%	20	6.4%
Not much impact	75	51.4%	65	53.3%	169	51.0%
Total	146	100.0%	122	100.0%	322	100.0%

As a follow-up question, those who had indicated that the pandemic had negatively impacted their health were asked to indicate the way(s) in which their health was impacted. The following table shows the results of that multiple response question. The main negative impact for respondents, regardless of survey delivery mode, was the stress, anxiety, and depression that most likely came from isolation, job loss (and resulting loss of health insurance), financial difficulties, illness/death of family and friends, etc. Further, 43.8% of MDC online and 42.5% of IAR online respondents reported gaining weight, and a quarter of MDC online respondents reported "long COVID."

Table 3.5: Ways the pandemic negatively impacted overall health and well-being (Split B only)

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% of who answered
More stressed, anxious, and/or depressed	**29**	**52.6%**	**36**	**75.0%**	**90**	**75.0%**
Lost job, financial hardships	**13**	**24.2%**	**16**	**33.3%**	10	8.3%
Frequent sickness	9	17.0%	0	0.0%	9	7.5%
Got "long COVID" --still feeling fatigue, fogginess, pain, cough, difficulty breathing	6	10.1%	**12**	**25.0%**	23	19.2%
Missed recommended Dr visits and preventative care	3	5.7%	6	12.5%	40	33.3%
Loss of loved one	2	3.0%	9	18.8%	**29**	**24.2%**
Kids lost time in school	2	3.0%	0	0.0%	0	0.0%
Gained weight	2	3.0%	**21**	**43.8%**	**51**	**42.5%**
Drinking alcohol more	0	0.0%	5	10.4%	12	10.0%
Smoking more	0	0.0%	6	12.5%	4	3.3%
Others	10	17.9%	1	2.1%	12	10.0%
Total # responding to the question	54	136.5%	48	233.3%	120	233.3%

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

Chronic Illnesses

As noted in the secondary data analysis, obesity, high blood pressure, and diabetes are the most prevalent chronic diseases for residents of Los Angeles County, San Bernardino County, and SPA3. This is the same pattern we have seen in previous reports.

Over a third of phone survey respondents (39%) as well as 28% of respondents in the MDC online survey and 11% in the IAR online survey indicated that they have NO chronic or ongoing health problems. Table 3.6 reflects the chronic health problems of those residents who DO have those issues. Residents of PVHMC's service area show a high prevalence of high blood pressure and diabetes as well as issues of high cholesterol, arthritis, and asthma. We also note that mentions of obesity, although still high, have declined somewhat from the 2021 community health needs assessment.

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

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
High blood pressure	**87**	**49.0%**	**64**	**38.6%**	**355**	**64.1%**
Diabetes	**58**	**32.3%**	**59**	**35.5%**	**181**	**32.7%**
High cholesterol or arteriosclerosis	**54**	**30.2%**	**36**	**21.7%**	**231**	**41.7%**
Arthritis	**31**	**17.2%**	**46**	**27.7%**	**220**	**39.7%**
Asthma	**34**	**19.2%**	**42**	**25.3%**	**111**	**20.0%**
Obesity	**35**	**19.4%**	**41**	**24.7%**	**178**	**32.1%**
Cancer	23	12.9%	23	13.9%	94	17.0%
Mental health disorder	30	16.7%	36	21.7%	91	16.4%
Osteoporosis	15	8.7%	12	7.2%	95	17.1%
Chronic heart failure	11	5.9%	2	1.2%	36	6.5%
Alcoholism	5	3.0%	18	10.8%	22	4.0%
Drug use	4	2.5%	13	7.8%	8	1.4%
Chronic Pain	0	0.0%	0	0.0%	22	4.0%
Autoimmune Disorders	0	0.0%	0	0.0%	13	2.3%
Chronic Breathing (COPD, Sleep Apnea, etc.)	0	0.0%	0	0.0%	14	2.5%
Chronic Heart Conditions (AFib, Arrhythmia, etc.)	0	0.0%	0	0.0%	12	2.2%
Thyroid Issues	0	0.0%	0	0.0%	6	1.1%
Gastroenterology Issues	0	0.0%	0	0.0%	9	1.6%
Neurological Issues	0	0.0%	0	0.0%	12	2.2%
Dementia	0	0.0%	0	0.0%	3	0.5%
Kidney Stones, CKD, Rhabdomyolysis	0	0.0%	0	0.0%	6	1.1%
Others	10	5.6%	12	7.2%	28	4.7%
Total # responding to the question	178	222.7%	166	243.4%	554	315.7%

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

A few respondents mentioned chronic illnesses other than the ones in the above table, including eating disorders, fibromyalgia, or back issues.

It is not enough for physicians to simply diagnose a chronic disease, tell patients what to do, and hope the patients will make the lifestyle choices necessary to live a healthy life. The literature would indicate that active participation of patients, caregivers, and families in health care design/decisions brings positive results in terms of increased self-esteem and

empowerment. Further, the literature indicates that many people have trouble staying involved and “on track.” Yet it notes that some patients studied “felt that their involvement was important but tokenistic, especially when their requests were denied or decisions had already been made.”[17]

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

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

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Yes	140	79.6%	114	72.6%	397	78.1%
No	31	17.6%	38	24.2%	74	14.6%
Only for some of the illnesses	5	2.8%	5	3.2%	37	7.3%
Total	176	100.0%	157	100.0%	508	100.0%

Those who indicated that they had not received adequate help for their illness were asked to specify their illness and what type of help they had not received. A great variety of diseases were mentioned, including cancer, diabetes, high blood pressure, obesity/weight loss, mental illness, and asthma. There were also comments revolving around the general need for more advice, information, support, and education regarding their disease without specifying exactly what type of information they were seeking. For example, one asked for “*accurate, reliable information regarding test results*” and another said: “*doctors need to give education/teaching regarding the patient’s diagnoses*.” One said: “*I’m not always sure what I’m supposed to be doing for myself.*”

Another group of respondents talked about not getting appointments in a timely manner, and some complained about the difficulty finding doctors or concerns about “difficult” doctors. Further, some mentioned financial issues (their treatment wasn’t covered by insurance or they had no insurance).

Social determinants of health for adults

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

17. https://implementationscience.biomedcentral.com/articles/10.1186/s13012-018-0784-z

In an attempt to address those social determinants of health, respondents were presented with a list of various issues that can affect health and well-being, and asked if they (or a member of their household) have experienced the health issues. The vast majority of respondents (73.0% of phone survey respondents as well as 54.2% of MDC online and 70.2% of IAR online respondents) said that they had not experienced ANY of the health issues listed.

In the 2021 report, the top response given by those *with* experience was **mental health disease**. That is still the case in this year's report. Fortunately, most respondents (75.3% of phone survey, 63.6% of MDC online survey, and 78.3% of IAR online survey respondents) indicated that they are aware that there are community resources to help if someone they know is experiencing a mental health crisis.

Experience with substance use has risen from being an issue for approximately 20% of respondents to 33.6% in this year's phone survey. Homelessness was listed as #9 out of the 10 issues listed in the 2021 report, whereas this year's data it has risen to #5. Given that this is an increasing issue nationwide, we note an interesting approach to the problem being taken in Los Angeles County. Specifically, an experimental program is using AI technology to predict who in the county is most likely to become homeless, and then reaching out to provide financial support for rent, car payments, etc. UCLA researchers are involved, and other counties are working on the same approach.[18]

18. Press Enterprise, 3/14/24

Table 3.8: Following is a list of issues that can affect health and well-being. Have you or a member of the household experienced any of these health issues? Please check all that apply.

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Mental health disease	**33**	**40.9%**	**63**	**57.3%**	**116**	**67.4%**
Substance use	**27**	**33.6%**	**42**	**38.2%**	**36**	**20.9%**
Intellectual or physical disabilities	**22**	**28.0%**	14	12.7%	49	**28.5%**
Poverty/joblessness	**21**	**26.6%**	**34**	**30.9%**	32	18.6%
Homelessness	**18**	**22.7%**	**27**	**24.5%**	10	5.8%
Children falling behind in school	17	20.8%	13	11.8%	21	12.2%
Living in an unsafe neighborhood with gangs, gun violence, and crime	12	15.0%	20	18.2%	21	12.2%
Domestic violence	11	13.5%	20	18.2%	16	9.3%
Malnutrition/hunger	6	7.0%	10	9.1%	7	4.1%
Incarceration	6	8.0%	12	10.9%	6	3.5%
Total # responding to the question	80	216%	110	231.8%	172	182.6%

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

Children's Health Conditions

This year's survey asked some new questions about specific health conditions experienced by the children in the household. The sample size is small, since only 29.8% of phone survey respondents, 59.3% of MDC online respondents, and 24.9% of IAR online respondents have children in the household. Further, only half of those individuals received the questions about their children (due to the split-questionnaire methodology).

Respondents were asked: *"Have you been told by any of your children's doctors that they have any of the following conditions?"* The vast majority of respondents indicated that their children had NONE of the conditions noted. Asthma/breathing problems and attention-deficit disorder were the main conditions reported by those respondents whose children DO have medical issues.

Table 3.9: (Split A only) Children's medical conditions

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Asthma or breathing problems	**7**	**50.4%**	**14**	**63.6%**	**17**	**58.6%**
Attention-deficit disorder	**6**	**42.9%**	**7**	**31.8%**	5	17.2%
Diabetes	2	18.5%	3	13.6%	3	10.3%
Disability *	1 D	8.7%	1 P	4.5%	4 (1 D & 3 P)	13.8%
Overweight/Obese	0	0.0%	**7**	**31.8%**	5	17.2%
Others	1	8.7%	1	4.5%	2	6.9%
Total # responding	13	129.1%	22	150.0%	29	124.1%

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

"Other" conditions listed include Bronchitis, Polycystic ovary syndrome, Sensory issues, and Foot/Ankle issues.

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

Table 3.10: (Split A only) How many times during the past 12 months did you visit the emergency department because of your child's…

	Asthma/Breathing			Diabetes		
	Phone	MDC Online	IAR Online	Phone	MDC Online	IAR Online
Zero Visits	**4 (79.0%)**	**5 (35.7%)**	**12 (70.6)**	**2 (100.0%)**	**2 (66.7%)**	**1 (33.3%)**
1 visit	0 (0.0%)	5 (35.7%)	3 (17.6%)	0 (0.0%)	0 (0.0%)	2 (66.7%)
2 visits	0 (0.0%)	1 (7.1%)	2 (11.8)	0 (0.0%)	0 (0.0%)	0 (0.0%)
3 visits	0 (0.0%)	2 (14.3%)	0 (0.0%)	0 (0.0%)	1 (33.3%)	0 (0.0%)
>3 visits	1 (21.0%)	1 (7.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total # responses	5	14	17	2	3	3
Average # visits	0.84 visits	1.21 visits	0.41 visits	0.00 visits	1.00 visits	0.67 visits

Relatively few respondents reported having trouble finding pediatric specialists for their children (2 phone survey respondents, 11 MDC online respondents, and 15 IAR online respondents). Those individuals were then given a follow-up question asking: "*What specialists couldn't you find for your child(ren)*?" Table 3.11 includes responses from 24 of those individuals.

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

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Bone or joint specialist	0	0.0%	1	9.1%	2	16.7%
Cancer specialist	0	0.0%	0	0.0%	0	0.0%
Diabetes specialist	0	0.0%	0	0.0%	1	8.3%
Heart specialist	0	0.0%	2	18.2%	0	0.0%
Lung or breathing specialist	1	50.0%	2	18.2%	0	0.0%
Autism or developmental disorder specialist	0	0.0%	1	9.1%	4	33.3%
Mental health psychiatrist, psychologist, or therapist	0	0.0%	3	27.3%	7	58.3%
Others	1	50.0%	4	36.4%	3	25.0%
Total # responding to the question	2	100.0%	11	118.2%	12	141.7%

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

"Other" specialists that parents couldn't find included: Dermatologist, OT, PT, Speech, Nutrition, and Pediatric Ophthalmologist.

Table 3.12 shows reasons offered for not being able to see a specialist. For the most part, it appears that parents either couldn't find the appropriate type of specialist locally, or else they were unable to get a timely appointment for their children's issue. Transportation was also mentioned as an issue.

Table 3.12: What difficulties have you had getting in to see a specialist for your child? (Split B only)

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Couldn't get a timely appointment	0	0.0%	**5**	**45.5%**	**6**	**40.0%**
Couldn't find this type of specialist locally	**2**	**100.0%**	**4**	**36.4%**	**9**	**60.0%**
No transportation to get to the office (e.g., no car)	1	50.0%	1	9.1%	0	0.0%
Couldn't get to the office during their hours of operation	0	0.0%	0	0.0%	1	6.7%
Don't know how to find this type of specialist	0	0.0%	3	27.3%	2	13.3%
Specialist is not in my health network	0	0.0%	2	18.2%	**5**	**33.3%**
No health insurance/couldn't afford it	0	0.0%	2	18.2%	1	6.7%
Specialist I wanted for my child was not seeing new patients	0	0.0%	2	18.2%	2	13.3%
Others	0	0.0%	2	18.2%	1	6.7%
Total # responding to the question	2	154.3%	11	190.9%	15	180.0%

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

The "other" responses were predominantly statements about insurance not covering the cost of the visit and/or procedure.

Safety (Accidents, injuries, and other concerns)

According to the Center for Disease Control and Prevention (CDC), injury is the leading cause of death for people between the ages of 1 to 44 years old.[19] And the Healthy People 2030 website shows that many of the objectives related to the topic (including reduction of fatal

19. https://www.cdc.gov/injury/wisqars/animated-leading-causes.html#:~:text=Injuries%20and%20violence%20affect%20everyone,%2C%20HIV%2C%20or%20the%20flu.

injuries, reduction in unintentional injury deaths, reduction of fatal traumatic brain injuries, reduction of fall-related deaths among older adults, etc.) are getting worse over time.[20]

Respondents were asked: "*In the past 2 years, have you or has anyone in your household experienced a traumatic injury like a work accident, car accident, or sports injury*?" In the 2021 report, we found that approximately 1 in 6 families answered in the affirmative. That number has decreased significantly in all three 2024 surveys. Very few people reported that the injury was from an act of violence.

Table 3.13: In the past 2 years, have you or has anyone in your household experienced a traumatic injury resulting from an accident or act of violence?

	Phone		MDC Online		IAR Online	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Yes	24	7.9%	25	10.4%	70	11.6%
No	280	92.1%	215	89.6%	536	88.4%
Total	304	100.0%	240	100.0%	606	100.0%

Table 3.14: Was the injury from an accident or some sort of violence?

	Phone		MDC Online		IAR Online	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Accident	19	77.8%	17	68.0%	60	85.7%
Act of violence	4	16.2%	4	16.0%	2	2.9%
Both	0	0.0%	1	4.0%	4	5.7%
Other	1	6.0%	3	12.0%	4	5.7%
Total	24	100.0%	25	100.0%	70	100.0%

Major Health Influencers

Healthy eating

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

20. https://health.gov/healthypeople/objectives-and-data/browse-objectives/injury-prevention
21. https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

Most health need surveys such as this one include a question such as: "*Do you typically find it difficult to eat healthy or maintain a healthy body weight*?" Most respondents to the phone survey denied having difficulty. In contrast, online survey respondents were relatively evenly split between responses of "yes," "no," and "sometimes." Perhaps phone survey respondents felt awkward admitting to an interviewer that they have trouble with their weight, whereas clicking that option on an online survey may have been "easier."

Table 3.15: Do you typically find it difficult to eat healthy or maintain a healthy body weight?
(Split A only)

	Phone	MDC online	IAR online
Yes	42 (26.9%)	**37 (30.8%)**	**80 (24.4%)**
No	**99 (64.0%)**	**33 (27.5%)**	**129 (39.3%)**
Sometimes	12 (7.7%)	45 (37.5%)	103 (31.4%)
Not usually, but eating and exercise habits changed as a result of the pandemic	2 (1.3%)	5 (4.2%)	16 (4.9%)
Total	100.0%	100.0%	100.0%

Table 3.16: Trend: Do you typically find it difficult to eat healthy or maintain a healthy body weight?
(Split A only)

	Yes	No	Sometimes	Not usually, but eating and exercise habits changed as a result of the pandemic
2018 phone	28.3%	62.9%	8.8%	---
2021 IAR online	25.8%	33.0%	26.1%	15.0%
2021 MDC online	27.0%	26.1%	31.5%	15.5%
2024 phone	**26.9%**	**64.0%**	**7.7%**	**1.3%**
2024 MDC online	30.8%	27.5%	37.5%	4.2%
2024 IAR online	24.4%	39.3%	31.4%	4.9%

Those who reported that they **typically** find it difficult (or sometimes difficult) to eat healthy or maintain a healthy body weight were then asked a follow-up question: *"What would you say is the NUMBER ONE reason it is difficult?"* In 2021 the predominant response was: "*it's hard to change my eating and exercise habits*." That was still the most-often provided response

among IAR online respondents this year. Phone and MDC survey respondents provided a financial reason as well: the cost of healthy food (fruits and vegetables).

Table 3.17:
Number "ONE" reason it is difficult to eat healthy and maintain a healthy body weight (Split A only)

	Phone		MDC Online		IAR Online	
	Count	Percent	Count	Percent	Count	Percent
Cost of healthy food (fruits and vegetables)	**16**	**31.7%**	**25**	**31.6%**	30	17.8%
Too busy to exercise or prepare healthy meals	10	19.3%	10	12.7%	28	16.6%
It's hard to change my eating and exercise habits	7	13.6%	**20**	**25.3%**	**49**	**29.0%**
I like food too much	5	10.0%	14	17.7%	27	16.0%
The pandemic changed my eating habits	3	6.2%	0	0.0%	3	1.8%
Not sure how to cook/prepare healthy foods	2	3.5%	2	2.5%	5	3.0%
Not sure what is considered "unhealthy"	1	2.0%	3	3.8%	6	3.6%
I don't care about my weight	0	0.0%	1	1.3%	2	1.2%
Other	7	13.6%	4	5.1%	19	11.2%
Total	50	100.0%	79	100.0%	169	100.0%

"Other" responses included dental work, stress, cooking is boring, and "don't want to cook separate meals for me and the rest of the family."

Use of tobacco or vaping

Smoking (or being in the same house as someone who smokes) is another factor which can negatively affect a person's health status. In fact, "cigarette smoking is the number one risk factor for lung cancer. In the United States, cigarette smoking is linked to about 80% to 90% of lung cancer deaths."[22]

Some people are tempted to turn to electronic cigarettes to help them stop smoking. Vaping is perceived as a "safer alternative" which exposes people to fewer toxic chemicals than tobacco. In 2021, 4.5% of American adults used e-cigarettes. In 2019, 27.5% of high school students reported using e-cigarettes, and 40% of college students either had used or were

22. https://www.cdc.gov/cancer/lung/basic_info/risk_factors.htm

currently using of e-cigarettes.[23] Yet there have been lung injuries and deaths associated with vaping, and although little is known about the long-term effects of vaping, the most current data suggests that there are links to chronic lung disease and asthma.[24]

Respondents were asked whether anyone living in the house smokes tobacco or vapes. One would have hoped that there would have been a significant increase over time in the proportion of households where no one smokes or vapes. That was not the case. The 2021 survey showed that 85.8% of respondents to the IAR online survey lived in a smoke-free house – that number improved to 88.4% in the 2024 survey. But whereas 66.0% of those in the 2021 MDC online survey lived in smoke-free houses, this year that figure dropped to 61.0%.

Table 3.18: Does anyone living in the house vape or smoke cigarettes, cigars, pipes, or marijuana? (Split A only)

	Phone		MDC Online		IAR Online	
	Count	Percent	Count	Percent	Count	Percent
Yes, smoke	22	14.2%	25	21.2%	21	6.6%
Yes, vape	2	1.2%	11	9.3%	7	2.2%
Yes, both smoke and vape	5	3.3%	10	8.5%	9	2.8%
No one in the house smokes or vapes	123	81.3%	72	61.0%	281	88.4%
Total	152	100.0%	118	100.0%	318	100.0%

Respondents living with someone who smokes and/or vapes were then asked whether that household member who smokes or vapes has ever had a lung cancer screening." Only 9.3% of phone survey respondents, 19.6% of MDC online respondents, and 29.0% of IAR online respondents answered in the affirmative. This may be something that PVHMC would like to include in its educational outreach.

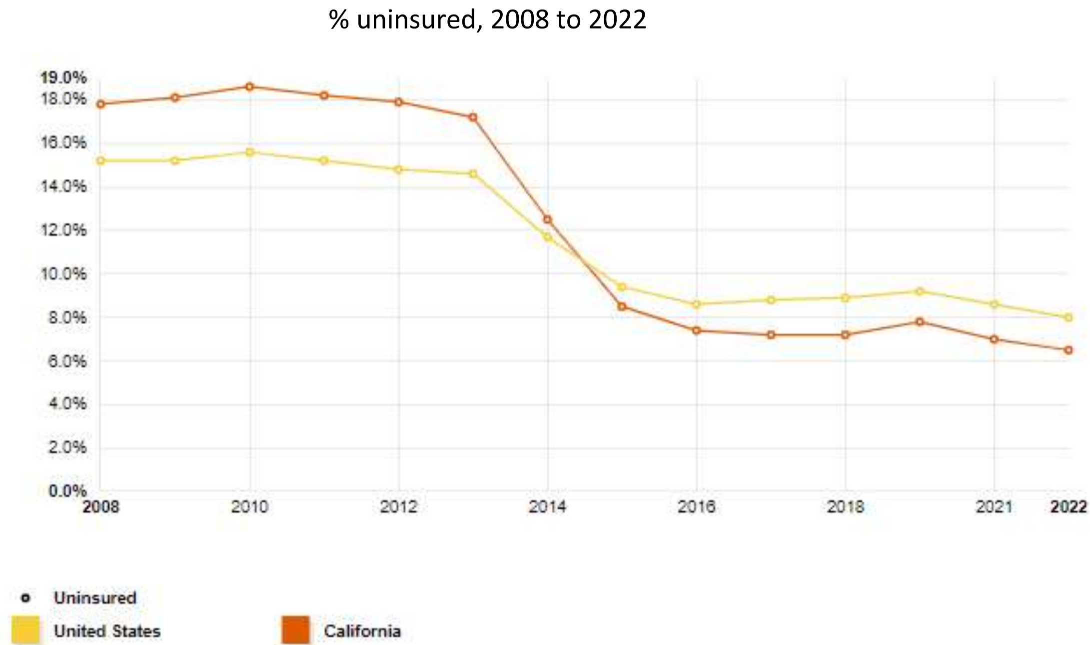
Health insurance coverage

The Affordable Care Act (ACA) signed into law in 2010 was designed to provide an opportunity for all Americans access to affordable, quality health insurance. The 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 number of uninsured decreased by 3.3 million nationwide in 2022. Most of the uninsured nonelderly individuals are in low-income families with at least one worker in the family, and most of those people cite the cost of coverage as the reason for their lack of insurance. There continues to be a disparity in

23. https://www.singlecare.com/blog/news/vaping-statistics/
24. https://www.hopkinsmedicine.org/health/wellness-and-prevention/5-truths-you-need-to-know-about-vaping

uninsured rates by ethnicity: the data for the US shows that the 2022 rate was 18.0% uninsured for Latinx/Hispanics, 10.0% Blacks, 6.6% Whites, and 6% Asians.[25]

% uninsured, 2008 to 2022



Four questions on the 2024 Community Health Needs Assessment survey dealt with health insurance coverage among respondents and their family members in PVHMC's service area: number of adults in the household covered by medical insurance, number of children in the household covered by medical insurance, type(s) of health insurance covering household members, and reasons why the uninsured members of the household (if any) do not have insurance.

The vast majority of households show full insurance coverage of the adults in the household (80.3% in the phone survey, 79.2% in the MDC online survey, and 89.6% in the IAR online survey). This is a slight decline from 2021 figures, but still a significant improvement from 2012 when only 76.6% of respondents said that all of the adults in the household were covered by insurance. Most importantly, however it is still far from the desired 100%. For the most part, it appears that households with more adults tend to have a reduced likelihood that all will be covered by insurance.

25. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

Table 3.19: Adults Covered by Health Insurance

	# Adults in Household	1	2	3	4	5	6 or more	Total
Phone Number & Percent of households in which…	All are covered	69 90.8%	88 81.5%	55 84.6%	16 57.1%	12 57.1%	5 60.0%	**245 80.3%**
	Some are covered	0 0.0%	8 7.4%	6 9.2%	11 39.3%	6 28.6%	2 40.0%	33 10.8%
	None are covered	7 9.2%	12 11.1%	4 6.2%	1 3.6%	3 14.3%	0 0.0%	27 8.9%
	Total	**76 100.0%**	**108 100.0%**	**65 100.0%**	**28 100.0%**	**21 100.0%**	**7 100.0%**	**305 100.0%**
MDC Online Number & Percent of households in which…	All are covered	14 100.0%	76 80.9%	30 85.7%	17 60.7%	7 70.0%	1 100.0%	**145 79.2%**
	Some are covered	0 0.0%	13 13.8%	5 14.3%	11 39.3%	3 30.0%	1 100.0%	33 18.0%
	None are covered	0 0.0%	5 5.3%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	5 2.7%
	Total	**14 100.0%**	**94 100.0%**	**35 100.0%**	**28 100.0%**	**10 100.0%**	**2 100.0%**	**183 100.0%**
IAR Online Number & Percent of households in which…	All are covered	118 92.9%	277 89.9%	104 87.4%	68 89.5%	18 78.3%	8 100.0%	**593 89.6%**
	Some are covered	0 0.0%	19 6.2%	14 11.8%	8 10.5%	4 17.4%	1 100.0%	46 6.9%
	None are covered	9 7.1%	12 3.9%	1 0.8%	0 0.0%	1 4.3%	0 0.0%	23 3.5%
	Total	**127 100.0%**	**308 100.0%**	**119 100.0%**	**76 100.0%**	**23 100.0%**	**9 100.0%**	**662 100.0%**

Table 3.20: Trends in Adult Insurance Coverage, Community Health Needs Assessment

	% of households in which all are covered	% of households in which some are covered	% of households in which none are covered
2012	76.6%	15.0%	8.4%
2015	80.5%	14.0%	5.5%
2018	87.9%	10.2%	1.9%
2021 IAR	88.3%	8.5%	3.2%
2021 MDC	83.7%	8.0%	8.3%
2024 Phone	**80.3%**	**10.8%**	**8.9%**
2024 MDC Online	79.2%	18.0%	2.7%
2024 IAR Online	89.6%	6.9%	3.5%

We looked for significant differences in health insurance coverage for adults based on demographics such as age, ethnicity, income, and education. The data show that there are statistically significant differences in coverage based on all of those variables. Specifically, younger people, people with higher incomes and education are the most likely to have households where all adults are covered. Further, non-Hispanics were more likely than Hispanics to have coverage for all adults in the household.

Table 3.21: Number of Adults Covered by Health Insurance
Selected Subgroup results
(**NOTE:** Phone data is in **bold**, MDC data is underlined, IAR data is in *italics*)

	Phone Black, **bold** MDC Blue, underlined, IAR Green, ***Italic***	None Covered	Some Covered	All Covered	Pattern
Age	18 to 34	**1.6%** 6.8% ***0.0%***	**19.7%** 21.9% ***24.2%***	**78.7%** 71.2% ***75.8%***	Younger people are somewhat *less* likely to have all adults covered than older people
	35 to 54	**9.9%** 6.8% ***1.4%***	**4.2%** 13.7% ***6.3%***	**85.9%** 79.5% ***92.3%***	
	55 or older	**11.0%** 14.3% ***3.1%***	**8.9%** 14.3% ***5.2%***	**80.1%** 71.4% ***91.7%***	
Ethnicity	Hispanic Origin	**11.9%** 10.6% ***1.8%***	**14.3%** 17.6% ***10.9%***	**73.8%** 71.8% ***87.3%***	Hispanics are *less* likely to have all

	Non-Hispanic	**6.2%** 6.5% ***3.0%***	**6.2%** 16.7% ***4.2%***	**87.7%** 76.9% ***92.8%***	adults covered than non-Hispanics
Income	Less than $35,000	**9.4%** 17.4% ***1.5%***	**11.3%** 30.4% ***13.4%***	**79.2%** 52.2% ***85.1%***	People with higher incomes are *more* likely to have all adults covered than those with lower incomes
	$35,000 to < $80,000	**8.5%** 4.1% ***3.5%***	**15.3%** 15.1% ***11.3%***	**76.3%** 80.8% ***85.2%***	
	$80,000 or more	**2.0%** 4.8% ***2,9%***	**7.0%** 7.9% ***3,8%***	**91.0%** 87.3% ***93.3%***	
Education	High school degree or less	**16.0%** 17.8% ***6.9%***	**12.0%** 22.2% ***17.2%***	**72.0%** 60.0% ***75.9%***	People with more education are *most* likely to report that all adults are covered
	Some college	**6.1%** 8.5% ***1.7%***	**10.6%** 16.9% ***8.4%***	**83.3%** 74.6% ***89.9%***	
	College degree +	**5.2%** 2.6% ***2.5%***	**8.9%** 13.0% ***3.7%***	**85.9%** 84.4% ***93.9%***	

Turning to an analysis of **children** covered by insurance: According to an analysis by the Georgetown University Center for Children and Families, the uninsured rate for children under 19 dropped significantly until 2016, when the rate increased. Fortunately, the uninsured rate has been dropping since 2019. In 2022, 3.2% of California children did not have health insurance (3.4% of children 6 – 18 years old, and 2.6% of children under the age of 6). But unfortunately, "the continuous coverage protection has now been lifted and children are losing coverage as California redetermines eligibility for everyone enrolled."[26]

Table 3.22 below shows the data from the PVHMC region based on the 2024 Community Health Needs Assessment, and Table 3.23 shows the trend over time (and the fact that full coverage for children has decreased since the 2018 community needs assessment).

26. https://kidshealthcarereport.ccf.georgetown.edu/states/california/

Table 3.22: Children Covered by Health Insurance

	# Adults in Household	1	2	3	4	5	6 or more	Total
Phone Number & Percent of households in which…	All are covered	38 95.0%	28 96.6%	13 100.0%	1 33.3%	0 0.0%	1 100.0%	**81 93.1%**
	Some are covered	0 0.0%	1 3.4%	0 0.0%	1 33.3%	0 0.0%	0 0.0%	2 2.3%
	None are covered	2 5.0%	0 0.0%	0 0.0%	1 33.3%	1 100.0%	0 0.0%	4 4.6%
	Total	**40 100.0%**	**29 100.0%**	**13 100.0%**	**3 100.0%**	**1 100.0%**	**1 100.0%**	**87 100.0%**
MDC Online Number & Percent of households in which…	All are covered	59 100.0%	27 96.4%	7 100.0%	3 100.0%	1 100.0%	0 0.0%	**98 99.0%**
	Some are covered	0 0.0%	1 3.6%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 1.0%
	None are covered	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%
	Total	**59 100.0%**	**28 100.0%**	**7 100.0%**	**3 100.0%**	**1 100.0%**	**0 0.0%**	**99 100.0%**
IAR Online Number & Percent of households in which…	All are covered	79 94.0%	45 86.5%	20 95.2%	6 100.0%	1 100.0%	1 100.0%	**152 92.1%**
	Some are covered	0 0.0%	3 5.8%	1 4.8%	0 0.0%	0 0.0%	0 0.0%	4 2.4%
	None are covered	5 6.0%	4 7.7%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	9 5.5%
	Total	**84 100.0%**	**52 100.0%**	**21 100.0%**	**6 100.0%**	**1 100.0%**	**1 100.0%**	**165 100.0%**

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

	% of households in which all are covered	% of households in which some are covered	% of households in which none are covered
2012	69.5%	0.0%	3.5%
2015	95.2%	2.4%	2.4%
2018	98.1%	0.9%	0.9%
2021 IAR	95.6%	0.9%	3.4%
2021 MDC	95.8%	1.7%	2.5%
2024 Phone	**93.1%**	**2.3%**	**4.6%**
2024 MDC Online	99.0%	1.0%	0.0%
2024 IAR Online	92.1%	2.4%	5.5%

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

Table 3.24: What type(s) of health insurance cover(s) people in your household? (Split A only)

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Private insurance (HMO or PPO)	**85**	**60.2%**	**46**	**41.4%**	**236**	**71.5%**
I have insurance but don't know the type	23	16.1%	7	6.3%	10	3.0%
Medi-Cal	20	13.9%	**42**	**37.8%**	53	16.1%
Medicare	18	13.1%	**35**	**31.5%**	**141**	**42.7%**
Obamacare, Covered CA, ACA	8	5.8%	5	4.5%	14	4.2%
Veterans (VA)	0	0.0%	3	2.7%	8	2.4%
Others	0	0.0%	0	0.0%	0	0.0%
NOT COVERED	2	1.8%	1	0.9%	3	0.9%
Total # responding	141	111.1%	111	125.2%	330	140.9%

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

As noted earlier, very few respondents said that at least some of the people in their household are uninsured. Those respondents were asked to indicate the main reason(s) that

they and/or their family members don't have health insurance. Reasons given were a change of job (2), lack of understanding of available plans (1), he/she became ineligible because of age or leaving school (1), or the employer doesn't offer insurance or stopped offering coverage (1).

Barriers to receiving needed health services

Another series of survey questions dealt with the barriers to receiving needed health services. Respondents were first asked if they or anyone in their family had needed any health services within the past year that they could not get. A total of 8.5% of phone survey respondents, 20.4% of MDC online respondents, and 18.2% of IAR online respondents answered in the affirmative. The problem was especially acute among young people. For example, based on responses to the MDC online survey, 34.7% of 18- to 34-year-olds vs 21.2% of 35- to 54-year-olds and 4.3% of seniors 55 and older said that there were services they were not able to get. Similarly, respondents who indicated that they are of Hispanic/ Spanish/ Latino origin were significantly more likely than non-Hispanics to report that they were not able to get services (27.2% of Hispanics vs 15.3% of non-Hispanics in the MDC online survey). And as might be expected, income was strongly related to this question's responses: 27.1% of those making less than $25,000 reported that they had needed services that they couldn't get vs 17.4% of those making $80,000 to $110,000.

Findings from the 2020 Commonwealth Fund Biennial Health Insurance Survey indicate that access to care in the U.S. is significantly hampered by being uninsured, underinsured, or having coverage with significant cost sharing. In fact, that was considered to be the most important barrier to accessing care. The study said: "Sixty-one percent of working-age adults who were underinsured and 71 percent of those who lacked continuous coverage said they had avoided getting needed health care because of the cost of that care. This included not going to the doctor when sick, skipping a recommended follow-up visit or test, not seeing a specialist when recommended, or not filling a prescription."[27]

Yet the reasons expressed by our respondents for the lack of services were more broadly based than that (although linked somewhat to insurance status). People expressed concerns about the cost of services and co-payments, or said that their provider wouldn't accept their insurance. Others focused on the cost of prescriptions and the difficulty of getting appointments.

27. https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey

Table 3.25. What kept you or your family members from getting the health services you needed?

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Worried about cost of service/co-payments	**5**	**20.5%**	**21**	**46.7%**	**28**	**25.7%**
Provider wouldn't accept my insurance	**6**	**26.6%**	8	17.8%	22	20.2%
No health insurance	**5**	**20.5%**	5	11.1%	8	7.3%
The medical service wasn't available in the area	3	12.1%	3	6.7%	8	7.3%
Needed services weren't available	2	9.1%	**11**	**24.4%**	**29**	**26.6%**
Worried about cost of prescription(s)	1	4.4%	**16**	**35.6%**	19	17.4%
Didn't know where to find the services	1	4.4%	7	15.6%	18	16.5%
Lacked transportation	0	0.0%	8	17.8%	10	9.2%
Lacked childcare/ babysitter	0	0.0%	5	11.1%	5	4.6%
Hours not convenient	0	0.0%	**10**	**22.2%**	15	13.8%
Difficulty scheduling	0	0.0%	**17**	**37.8%**	**54**	**49.5%**
PVHMC didn't have the services needed	0	0.0%	3	6.7%	15	13.8%
Language or cultural barriers	0	0.0%	2	4.4%	4	3.7%
Didn't like the programs or services	0	0.0%	3	6.7%	4	3.7%
Other	7	31.4%	1	2.2%	18	16.5 %
Total # responding to the question	23	134.4%	45	266.7%	109	235.8%

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

Following are a few of the illustrative "other" comments made regarding reasons for not getting the needed health services: *"Available services were not able to help me," "Doctor left the area," "the location I was referred to did not have mobility aids for me."*

Respondents were also asked to indicate what services they were unable to get. The answers from the people who responded were quite varied, but focused mainly on the inability to get the prescriptions or medication they needed and/or the need for dental care. This finding is consistent with 2021 results.

Table 3.26: What services couldn't you get? Please check all that apply. (Asked only if there were services they couldn't get)

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Prescription or medication needed	**5**	**20.2%**	**17**	**37.8%**	**21**	**22.6%**
Dental care	**6**	**25.7%**	**15**	**33.3%**	**19**	**20.4%**
Mental Health	2	7.6%	**15**	**33.3%**	**22**	**23.7%**
Vision care	3	15.2%	7	15.6%	11	11.8%
Medical equipment (walker, etc.)	2	7.6%	8	17.8%	9	9.7%
Surgery	1	5.5%	8	17.8%	10	10.8%
Timely Appointments	0	0.0%	0	0.0%	12	12.9%
Dermatology	0	0.0%	0	0.0%	4	4.3%
Others	11	48.0%	6	13.3%	19	20.7%
Total # responding to the question	23	129.1%	45	168.9%	93	146.2%

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

"Other" comments on services the respondents were unable to get included: Annual physical, Disability, Primary Care, Sleep Study, TMJ Rehabilitation, Neurology, MRI, Ultrasound, and X-rays.

Utilization of Health Care Services for Routine Primary /Preventative Care

Surveys conducted for the 2012, 2015, and 2018 Community Needs Assessment reports revealed that approximately 80% of respondents had visited a doctor for a general physical exam (as opposed to an exam for a specific injury, illness, or condition) in the previous year. That changed in 2021. The 2021 surveys showed a significant drop in respondents being able to get the general physical exams they needed to look for issues that could cause medical concerns in the future and build a relationship with the primary care physician. At that time we

hypothesized that the reasons for the drop were predominantly COVID-based, including physician's offices being closed during the "stay-at-home orders," patients' fears of contracting COVID during their visit to a medical office, and hearing advice indicating that patients should **only** come to doctor offices, urgent care, and ER for emergencies.

This year's surveys show an increase in the percentage of people getting yearly general physical exams; however statistics have not yet rebounded to pre-pandemic levels.

Table 3.27: Length of Time since Respondent's Last General Physical Exam (Split A only)

	Phone		MDC Online		IAR Online	
	Counts	**Percent**	**Counts**	**Percent**	**Count**	**Percent**
Within the past year	110	71.0%	81	68.6%	264	79.0%
Within the past 2 years	23	14.6%	20	16.9%	36	10.8%
Within the past 5 years	12	7.9%	8	6.8%	20	6.0%
More than 5 years ago	9	5.8%	5	4.2%	12	3.6%
Never	1	0.7%	4	3.4%	2	0.6%
Total	155	100.0%	118	100.0%	334	100.0%

Use of telehealth services by California adults grew exponentially during the pandemic, growing from 12.4% in 2018 to 49.0% in 2021, and dropping to 46.7% in 2022.[28] That study also showed that telehealth usage in the Greater Bay area and Sacramento area was higher than usage in Southern California (and presumably the PVHMC region).

To assess the feelings of PVHMC region residents regarding telehealth services, respondents were asked: "*In the past year, have you used telehealth services where you do a video chat with a healthcare provider using a mobile device or computer?"* The data show that less than half of all survey respondents had used telehealth services in the past year. The figures for all three survey modalities were significantly LESS than those reported in 2021.

Table 3.28: In the Past Year Have You Used Telehealth Services?

	Phone		MDC Online		IAR Online	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Yes	135	44.2%	109	46.0%	310	48.2%
No	170	55.8%	128	54.0%	333	51.8%
Total	305	100.0%	237	100.0%	643	100.0%

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28. UCLA Center for Health Policy Research, https://healthpolicy.ucla.edu/sites/default/files/2023-09/telehealth-fact-sheet-october-2023.pdf

A follow-up question was included asking respondents' preferences for in-office physician visits or telehealth treatment, and probed the reasons for their preference. Approximately half of this year's respondents indicated a preference for in-office physician visits, and those figures are significantly HIGHER than those reported in 2021. It appears that people used telehealth services during the pandemic, yet now that things are returning to "normal," they wish to go back to the non-technology-based types of visits with their doctor.

Table 3.29
Overall, do you prefer having in-office physician visits or telehealth treatment?
(Asked only of those who have used telehealth services)

	Phone		MDC Online		IAR Online	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Prefer in-office	67	51.0%	55	51.4%	184	59.9%
Prefer Telehealth	34	25.8%	25	23.4%	39	12.7%
No preference	31	23.3%	27	25.2%	84	27.4%
Total	132	100.0%	107	100.0%	307	100.0%

When asked for the reasons they prefer in-office visits, about three-quarters of respondents simply said that they prefer seeing a "human-being" in-person. Some also noted that a doctor can't do a physical exam using telehealth. Relatively few people complained about the technology used for the telehealth appointments…they simply want to be seen and examined in-person.

Table 3.30: What makes you prefer in-office visits?
(Asked only of those expressing a preference for in-office visits)

	Phone		MDC Online		IAR Online	
	# of mentions	**% who answered**	**# of mentions**	**% who answered**	**# of mentions**	**% who answered**
Prefer seeing a "human" in-person	**49**	**73.5%**	**39**	**70.9%**	**138**	**76.2%**
Doctor can't do a physical exam	22	32.4%	**23**	**41.8%**	**127**	**70.2%**
Easier to schedule than telehealth appts.	7	11.1%	**19**	**34.5%**	17	9.4%
Hard to hear or see on the computer	5	7.2%	9	16.4%	21	11.6%
Don't use a computer	4	5.5%	1	1.8%	6	3.3%
Concerns about privacy and security	3	4.0%	16	29.1%	24	13.3%

Technology-it's hard to set up the audio/video connections	3	3.9%	10	18.2%	20	11.0%
Other	7	10.4%	0	0.0%	8	4.4%
Total # responding to the question	67	148.0%	55	212.7%	181	199.4%

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

Some of the "other" responses were statements that telehealth and in-person services are ***both*** good and needed. For example, telehealth may be preferred for minor issues or a follow-up visit, but for major issues the in-person approach seems to be preferred.

The next series of questions were designed to determine whether or not the respondent or any member of his/her household has had recommended health screenings recently. The reader will note that the recommended frequency of pap smears changed since the 2012 report from every year to every ***three*** years, and the recommended frequency of colon cancer screening changed from every five years to every ***ten*** years. Thus direct comparisons of survey results over time must be made with caution. Further, the Healthy People 2020 and 2030 targets don't necessarily coincide with the time frames in the questions asked, thus comparisons must be made with caution.

The National Cancer Opinion Survey conducted in 2020[29] showed that 24% of adults delayed or cancelled routine screening tests because of the pandemic, and 63% of those who delayed/cancelled their tests were *concerned* about being behind on the screenings. Those who cancelled or delayed the tests may have believed that concerns about the pandemic were more important than concerns about missing the cancer screenings, or they may have simply been unable to get to the screenings due to lack of transportation or unwillingness to miss work in order to have the tests.

A study by Elevance Health (Public Policy Institute) indicates that screening rates nationwide are beginning to return to pre-pandemic levels for breast, cervical, and colorectal cancers.[30] However based on the 2024 Community Needs Assessment phone survey of PVHMC region residents, it appears that rates of completed screening tests for various types of cancer are still below the desired levels.

29. https://www.asco.org/research-data/reports-studies/national-cancer-opinion-survey
30. https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/reports/EHPPI_CancerScreen_Final.pdf

Table 3.31: Trend: Percent of Respondents Who Said They or a Family Member Has Had a Health Screening (% Yes) (Split B only)

Health Screen Test	Pap smear in the past year (2009 & 2012) or three years (2015, 2018, and 2021)	Mammogram in the past year (or "typically" every year)	Screened for colon cancer in the past five years (2009 & 2012) or ten years (2015 - 2024)
2009 phone	51.2%	52.9%	46.6%
2012 phone	49.8%	53.9%	49.8%
2015 phone	63.1%	50.8%	52.9%
2018 phone	61.0%	58.8%	61.2%
2021 IAR online	62.2%	61.6%	62.0%
2021 MDC online	47.8%	35.6%	40.3%
2024 phone	**50.7%**	**49.9%**	**48.1%**
2024 MDC online	50.5%	32.4%	53.0%
2024 IAR online	54.4%	68.5%	76.3%
HP 2030 Targets	79.2%[a]	80.3%[b]	68.3%[c]

a. The HP 2030 target for cervical cancer screening (C-09) is age adjusted, 21 – 65 years, and refers to receiving a Pap test within the past ***3 years.***

b. The HP 2030 target for mammograms (C-05) refers to the past ***2 years***, not the past year, and is age adjusted for ages 50 – 74.

c. The HP 2030 target for the screening (C-07) is age adjusted for ages 45 to 75 years. No time element is given for the colon cancer screenings in HP 2030.

Typically, respondents justify the fact that they haven't received the screenings by listing reasons such as "I don't need the test", or the "ick factor" (fear or dislike of the test), or the perception that "healthy people don't need it," or the feeling that the tests are not important or necessary (especially for people who say they are healthy). Those reasons are listed in large numbers in the table below.

Table 3.32: Reasons for not getting the cancer screenings (Pap, Mammogram, Colon Cancer) (Split B only)

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Don't need it (due to age or gender)	**48**	**75.4%**	**30**	**39.5%**	**51**	**45.1%**
Didn't think it is important or necessary	11	17.6%	**18**	**23.7%**	20	17.7%
Fear/dislike of the test	3	4.6%	**11**	**14.5%**	**24**	**21.2%**
No insurance	3	4.2%	9	11.8%	5	4.4%
No transportation to get to a test	2	2.8%	7	9.2%	1	0.9%
Financial issues-the out of pocket cost	1	1.6%	7	9.2%	7	6.2%
Lack of child care	0	0.0%	1	1.3%	3	2.7%
Fear of the results	0	0.0%	5	6.6%	5	4.4%
No regular doctor	0	0.0%	10	13.2%	9	8.0%
Others	5	7.2%	4	5.3%	9	8.0%
Total # responding to the question	64	113.4%	76	134.2%	113	118.6%

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

There were also "other" reasons offered for not getting the recommended cancer screening. For example: "I was focusing on other health issues," "Can't get through to the department to schedule, "I work 6+ days a week, no time," and simple procrastination.

COVID-19 Pandemic

In Fall of 2023, the FDA and CDC approved updated COVID-19 vaccines, and in February 2024 they recommended an additional dose for senior adults (65 and older). Early uptake of the shot was slow, and as of March 2024 just 42% of Americans 65 or older had received the monovalent shot.[31] And the CDC indicates that only 22.6% of ***all*** U.S. adults (age 19 or older) reported that they had received the updated vaccine as of early March 2024.[32]

31. https://www.washingtonpost.com/opinions/2024/03/07/covid-vaccine-spring-booster-cdc-seniors/
32. https://www.cdc.gov/vaccines/imz-managers/coverage/covidvaxview/interactive/vaccination-dashboard.html

The vaccine isn't truly a "booster" in that it provides protection against the current COVID variants (as opposed to "boosting" immunity from the previous vaccination). But the American public tends to think of it as a "booster," thus IAR used that verbiage in the question: "*Have you received the latest dose of the COVID-19 booster*?" The predominant answer was "no," however the rate of people saying "yes" is clearly much higher than the figures provided above for the U.S. population.

Table 3.33: Have you received the latest dose of the COVID-19 vaccine booster? (Split B only)

	Phone		MDC Online		IAR Online	
	Count	Percent	Count	Percent	Count	Percent
Yes	62	44.6%	55	47.0%	181	60.5%
No	77	55.4%	62	53.0%	118	39.5%
Total	138	100.0%	117	100.0%	299	100.0%

There were clear and statistically significant differences in vaccination rates based on age, Hispanic origin, income, and education in the IAR online data. Specifically, older people, non-Hispanics, higher income respondents, and more educated respondents had a higher vaccination rate than other subgroups. Those trends were muted somewhat in the phone and MDC online data.

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

Some 41.4% of phone survey respondents, 50.8% of MDC online respondents, and 91.3% of IAR online respondents reported having gone to PVHMC *at some point in time* for health care.[33]

As in the past, the main reason(s) cited for choosing PVHMC for health care were convenience/location (i.e. "close to home"), insurance, and referral by a physician. Further, 44.2% of IAR online respondents mentioned that they chose PVHMC because of its quality and reputation. The reader will note that 4.2% of the IAR online respondents mentioned that they are current or past employees of PVHMC, whereas that was not the case for the phone or MDC online surveys.

33. Since the IAR online survey was promoted by PVHMC through their social media, it is not surprising that such a high percentage of respondents to that survey would have reported going to PVHMC for their health care.

Table 3.34. Why did you choose PVHMC?

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Close to home	**52**	**42.6%**	**64**	**53.3%**	**356**	**65.6%**
Insurance	**20**	**16.1%**	**48**	**40.0%**	**316**	**58.2%**
Referred by my physician	**28**	**23.0%**	**30**	**25.0%**	**246**	**45.3%**
Types of services	10	8.2%	16	13.3%	**178**	**32.8%**
Quality/reputation	9	7.5%	15	12.5%	**240**	**44.2%**
Word of mouth	9	7.2%	16	13.3%	54	9.9%
Internet	0	0.0%	4	3.3%	6	1.1%
Newspaper/radio/TV	0	0.0%	0	0.0%	3	0.6%
Community Presentation	0	0.0%	5	4.2%	11	2.0%
Taken by ambulance	11	8.9%	17	14.2%	50	9.2%
Respondents works at PVHMC	1	1.2%	0	0.0%	23	4.2%
Others	4	3.3%	1	0.8%	6	1.1%
Total # responding	121	118.0%	120	180.0%	543	274.2%

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

"Other" reasons for seeking health care at PVHMC included a good variety of doctors, clean facilities, great service, and good emergency services.

Table 3.35. Trends in Top 5 Reasons to choose PVHMC?

	Close to home	Insurance	Referred by my Physician	Types of services offered	Quality / reputation
2009 phone	49.3%	25.3%	20.0%	14.0%	10.7%
2012 phone	42.9%	17.9%	18.5%	7.1%	14.9%
2015 phone	44.9%	20.4%	19.8%	14.4%	19.2%
2018 phone	43.6%	27.9%	18.4%	7.3%	12.8%
2021 IAR online	65.7%	55.7%	39.4%	23.5%	31.1%
2021 MDC online	57.2%	37.3%	31.3%	8.4%	14.5%
2024 phone	**42.6%**	**16.1%**	**23.0%**	**8.2%**	**7.5%**
2024 MDC online	53.3%	40.0%	25.0%	13.3%	12.5%
2024 IAR online	65.6%	58.2%	45.3%	32.8%	44.2%

The needs assessment questionnaire also queried respondents about whether they have attended any classes offered by PVHMC. This is an important question since according to a study *Frontiers in Medicine*, therapeutic patient education for people with chronic diseases were effective in "improving biologic outcomes, adherence to the treatment regimen, knowledge, self-efficacy, and psychological health."[34] Over time, approximately 10% of survey respondents have expressed such interest. The 2024 data follow that pattern.

Table 3.36: Have you or any member of your family attended any health-related classes or support groups at PVHMC *in the past year*?

	Phone		MDC Online		IAR Online	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Yes	9	2.9%	27	11.2%	64	10.8%
No	292	97.1%	214	88.8%	530	89.2%
Total	301	100.0%	241	100.0%	594	100.0%

Respondents were also asked to specify the type of classes they (or someone else in their family) might be interested in. As one might anticipate, a sizable group of people indicated that they are simply not interested in classes (52.3% of phone survey respondents, 22.7% of MDC online respondents, and 26.7% of IAR online respondents). Among those who expressed any interest at all, by far, the classes/support groups most desired were those dealing with nutrition, exercise/fitness, and weight management. Also of interest were classes or support groups addressing mental health or substance use in addition to heart disease, high blood pressure, and stroke. The IAR online survey also revealed interest in classes/support groups on diabetes, sleep disturbances, and CPR. These classes should be promoted on the same social media sites that were used to promote this survey itself.

34. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9905441/#:~:text=Evidence%20has%20shown%20that%20therapeutic,controlled%20and%20evidence%2Dsynthesis%20studies.

Table 3.37: What type of classes or support groups might you or someone else in your family be interested in?

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Nutrition, exercise/fitness, weight management	**40**	**41.6%**	**64**	**37.6%**	**183**	**48.8%**
Mental health or substance use	**28**	**29.1%**	**49**	**28.8%**	**59**	**15.7%**
Diabetes	11	11.6%	35	20.6%	**104**	**27.7%**
Cancer	8	8.4%	22	12.9%	50	13.3%
Sleep apnea/ sleep disorders	8	8.4%	33	19.4%	**111**	**29.6%**
Alzheimer's	8	8.4%	17	10.0%	41	10.9%
CPR classes	8	8.4%	**46**	**27.1%**	**103**	**27.5%**
Heart disease, high blood pressure, stroke	5	5.3%	**38**	**22.4%**	**130**	**34.7%**
Grief and bereavement	5	5.3%	30	17.6%	57	15.2%
Geriatric care management	3	3.2%	11	6.5%	59	15.7%
Female health classes (prenatal, miscarriage, lactation, etc.)	3	3.2%	22	12.9%	35	9.3%
Smoking cessation	2	2.2%	37	21.8%	16	4.3%
Others	11	11.7%	1	0.6%	24	6.4%
Total # responding to the question	95	146.1%	170	238.2%	375	259.2%

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

Next on the survey were questions dealing specifically with the emergency department at PVHMC. About a third (32.8%) of phone survey respondents, 38.4% of MDC online respondents, and 78.2% of IAR online respondents indicated that they or a member of their household had received services at PVHMC's emergency department.[35]

35. Since the IAR online survey was promoted by PVHMC through their social media, it is not surprising that such a high percentage of respondents to that survey would have received services at PVHMC's ED.

As in the past, the predominant reason for visits to the emergency room was injury or accident, following by chest pain/heart attack, and COVID or other breathing difficulties.

Table 3.38. What was the reason emergency services were needed?

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Injury or accident	**30**	**32.5%**	**39**	**47.6%**	**163**	**38.2%**
Chest pain/heart attack	**16**	**16.9%**	**13**	**15.9%**	**89**	**20.8%**
Breathing difficulties	**8**	**8.9%**	**15**	**18.3%**	**40**	**9.4%**
Covid-19	**3**	**3.3%**	**10**	**12.2%**	**43**	**10.1%**
Pain (back, leg, etc.)	5	5.4%	3	3.7%	14	3.3%
Vomiting / stomach issues	5	5.4%	3	3.7%	23	5.4%
Asthma	5	5.4%	0	0.0%	0	0.0%
Stroke	4	4.1%	7	8.5%	20	4.7%
Lightheaded/ dizzy/ dehydration	3	3.3%	1	1.2%	15	3.5%
Gallbladder/ appendix attacks	3	3.3%	2	2.4%	11	2.6%
Child-birth, Pregnancy check-up	0	0.0%	4	4.9%	0	0.0%
Blood pressure issues	0	0.0%	0	0.0%	13	3.0%
Infections, UTI, etc.	0	0.0%	0	0.0%	14	3.3%
Kidney stones	0	0.0%	0	0.0%	11	2.6%
Mental health issues	0	0.0%	0	0.0%	6	1.4%
Others	32	34.7%	12	14.6%	81	19.0%
Total # responding to the question	92	122.3%	82	132.9%	427	127.2%

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

The reader will note that there were a large number of “other” issues mentioned, with no real commonality of response. People mentioned RSV, seizures, blood clots, allergies, and a variety of other issues. PVHMC has been provided with an excel file of open-ended responses.

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

Table 3.39: Did you or the household member try to see your doctor before going to the emergency room?

	Phone		MDC Online		IAR Online	
	Counts	Percent	Counts	Percent	Count	Percent
Yes	23	23.9%	22	26.2%	166	37.3%
No	72	76.1%	62	73.8%	279	62.7%
Total	95	100.0%	84	100.0%	445	100.0%

The predominant reason for not trying to see a doctor before going to the emergency department was that "it was a true emergency," after office hours, or the patient was "brought by ambulance." For all of these reasons, there was no opportunity to visit a doctor before going to the emergency department.

Table 3.40: What was the reason you didn't try to see your doctor before going to the emergency room?

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
It was a true emergency	**39**	**56.6%**	**18**	**30.5%**	**134**	**48.6%**
It was after office hours	**20**	**28.9%**	**25**	**42.4%**	**119**	**43.1%**
Brought by ambulance	**7**	**10.9%**	**21**	**35.6%**	**79**	**28.6%**
Doctor was too busy to fit me in or told me to go to the ED	4	5.9%	2	3.4%	16	5.8%
Don't have a regular doctor	2	2.6%	10	16.9%	4	1.4%
Others	5	7.1%	1	1.7%	15	5.4%
Total # responding to the question	68	112.2%	59	130.5%	276	133.0%

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

“Other” Issues

Diversity, Equity, and Inclusion (DEI)

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

In healthcare, DEI means hiring and retaining a diverse workforce that understands and can offer culturally competent care. It means creating an environment in which all community residents have equal access to high quality healthcare. It means eliciting the views of patients, employees, and the broader community to help guide policy and engage in continuous improvement of services. DEI is not only a business imperative, it is an ethical imperative.

Three “Likert” questions were included on the survey to provide a measure of current successes and challenges in DEI. First: respondents with experience at PVHMC were asked if they perceived that PVHMC staff reflects the diversity of the community. The vast majority of respondents said that they strongly agree or agree with the statement, meaning that they believe PVHMC staff are aware of the social, cultural, and linguistic needs of their patients which often leads to better treatment and increased patient satisfaction.

Table 3.41: "Based on my experience at Pomona Valley Hospital Medical Center, the staff reflect the diversity of the community."
ASKED ONLY OF PEOPLE WHO HAVE GONE TO PVHMC OR ATTENDED CLASSES AT PVHMC

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Strongly agree	**22**	**18.3%**	**20**	**15.7%**	**176**	**35.0%**
Agree	**88**	**72.6%**	**67**	**52.8%**	**230**	**45.7%**
Neither agree nor disagree	7	6.2%	30	23.6%	71	14.1%
Disagree	1	1.2%	6	4.7%	17	3.4%
Strongly disagree	2	1.7%	4	3.1%	9	1.8%
Total	120	100.0%	127	100%	503	100.0%

Respondents were split in terms of agreement with the statement: “*All community residents have equal access to community resources*.” Respondents were more likely to agree than disagree, but we still see a larger than desirable percentage of people believing that there

is disparity in access to resources. PVHMC may wish to investigate this perception of a lack of equity in terms of access to community resources. Future surveys can track changes over time.

Table 3.42: "All community residents have equal access to community resources"

	Phone		MDC Online		IAR Online	
	# of mentions	**% who answered**	**# of mentions**	**% who answered**	**# of mentions**	**% who answered**
Strongly agree	30	10.8%	39	16.7%	79	15.4%
Agree	**138**	**48.8%**	**65**	**27.9%**	**131**	**25.6%**
Neither agree nor disagree	14	4.9%	57	24.5%	105	20.5%
Disagree	**72**	**25.7%**	**50**	**21.5%**	**131**	**25.6%**
Strongly disagree	28	9.8%	22	9.4%	66	12.9%
Total	282	100.0%	233	100.0%	512	100.0%

Fortunately, respondents disagreed or strongly disagreed with the statement that a lack of equity has negatively impacted their ability to receive the best care.

Table 3.43: "Lack of equity (equality) or inclusion in healthcare has negatively impacted my ability to receive the best care."

	Phone		MDC Online		IAR Online	
	# of mentions	**% who answered**	**# of mentions**	**% who answered**	**# of mentions**	**% who answered**
Strongly agree	19	7.2%	15	6.5%	39	7.3%
Agree	52	19.3%	29	12.6%	49	9.2%
Neither agree nor disagree	15	5.4%	77	33.3%	105	19.7%
Disagree	**127**	**47.2%**	**63**	**27.3%**	**178**	**33.3%**
Strongly disagree	**56**	**20.9%**	**47**	**20.3%**	**163**	**30.5%**
Total	269	100.0%	231	100.0%	534	100.0%

As a final DEI item, respondents were asked an open-ended question regarding the most important thing PVHMC could do to enhance diversity and inclusion in the community. Some people made comments reflecting their view that **diversity is not a huge issue**. For example:

- *"Hire people based on their abilities and nothing else!"*
- *"I just want the best, most qualified doctors and nurses, regardless of color or ethnicity."*

But most respondents felt differently. Following are some of the major conceptual categories of comments, with a few illustrative direct quotes in each category.

Category: Hire more diverse staff

- *“Continue diversifying associates, doctors, and volunteers.”*
- *“Hire a diverse group of people at each level of care.”*
- *“My health care is not impacted by lack of diversity, but for many residents this may be an important issue, especially for mental health, addiction, and other issues.”*
- *“Representation matters! Hire black doctors and nurses. Extensive cultural awareness and sensitivity training are important. Many staff have biases that affect patient outcomes. There must be continual education. Do better in 2024.”*
- *“Send out more information with available doctors of all races and ethnicities.” Let us see those people help us.”*
- *“Offer free programs for diverse high school students that helps them enter and pay for schooling in the medical field. If you have more diverse people entering the medical field, it’s easier to hire more.”*

Category: Diverse leadership

- *“Need more diversity in hospital leadership that reflects the community.”*
- *“Have more African Americans and Latinos in managerial positions.”*
- *“Include more diverse populations in the higher management staff and administration.”*

Category: Training and education

- *“Actively promote and support diversity initiatives within the organization. This includes implementing programs that encourage diversity in hiring practices, providing cultural competency training for staff members, fostering a welcoming and inclusive environment for patients from diverse backgrounds, and actively engaging with community groups to address healthcare disparities. By prioritizing diversity and inclusion at all levels of the organization, PVHMC can create a more equitable and culturally sensitive healthcare environment that meets the diverse needs of the community it serves.”*
- *“Require annual anti-racism training for all Pomona Valley Hospital Medical Center members (including, but not limited to medical assistants, clinical coordinators, residents, associate physicians, and board members/leadership).”*
- *“Have physicians who are trained in dealing with a variety of people, i.e.; the elderly.”*

Category: More community outreach needed to educate the community and help you understand the community better

- *"Encourage more programs for our Mexican American students to get involved in the medical field, starting with our local schools and adult education programs."*
- *"Have a billboard with Pomona faculty of diverse ethnic backgrounds."*
- *"Have a jumbotron on hospital site that displays education classes (diabetic, mental illness for Latinos/Black, care of seniors with Alzheimers, etc.)"*
- *"Health career fair."*
- *"Events on healthy eating, bring back the farmers market."*
- *"Collaborate with our local public schools to provide education about nutrition and health as well as other services available."*
- *"Promote on local newspaper and news websites."*
- *"Send hospital care teams into the community, especially in parts of cities that are severely impacted by all the negatives (poverty, drugs, homelessness, etc.) without endangering team members."*
- *"Poll more to know the community."*
- *"Have city websites provide information and distribute information at City events and functions."*
- *"Encourage more youth volunteers to outreach to diverse communities."*

Category: Access to healthcare

- *"Outreach to minority communities via clinics to provide better access to health care."*
- *"Have a clinic to see the non-emergency type issues for those not insured."*
- *"Pop up clinics in underserved neighborhoods and low-income areas for preventive services."*
- *"Help the poor and homeless who can't afford insurance but need it.*
- *"A free clinic with basic health services and a residential drug rehabilitation program would be great."*
- *"Offer more resources for the homeless."*

Category: Care about people and treat them as we all wish to be treated

- *"Just show more care. Remember everyone is different in the hurting of what's going on with them."*
- *"Be more mindful of persons that take themselves to ER that are on Medicare. They deserve a full evaluation, workup and treatment as those who come in with expensive insurance."*
- *"Treat everyone with kindness, dignity, and respect."*
- *"Show that you care and be respectful to everyone."*
- *"The homeless people are not always treated fairly. I know they may not have insurance but they need help too."*

Category: Develop better communication with patients

- *"Provide interpretation service when requested by the patient."*
- *"Employ doctors and nurses who speak the various languages needed by residents in the area."*
- *"Have in-person Spanish translators (not cyracom)."*
- *"Have materials in as many languages as possible based on the languages spoken in the community."*
- *"There is a language barrier."*

Category: Mental health outreach

- *"Pediatric mental health care."*
- *"Consider the LGBTQ+ community. A lot of members of the community deal with mental health issues and generally the same obesity and substance abuse that other Pomona community members deal with. However due to other people and maybe even staff, queer people may feel uncomfortable with seeking help."*
- *"Send mailing materials showing where services could be provided in the event of a mental health crisis."*
- *"Develop an inpatient psych ward since the area is saturated with homeless who are at increased risk for mental health issues. These people saturate the ER and the ER cannot deal with other medical emergencies when mental health patients are tying up resources while waiting for placement in a mental health ward."*

Biggest health-related issue or service needed

The bottom-line question of this needs assessment is: "*What is the biggest health related issue or service that people in the community need*?" The question was asked as a multiple response item on which people were able to check all needs that apply. Priority 1 among phone survey respondents appears to be **mental health services** – specifically availability, cost, and letting community know about the services. A very close second (Priority 2) was increasing **access to affordable health care**. Those same priorities were mentioned by online survey respondents (although the priority "rankings" switched). We note that these same two priorities were mentioned as "biggest needs" in the 2021 report.

Rankings of the other possible priorities differed based on survey mode of delivery. As noted earlier in this report, *hearing* a phone survey question (and answering off the "top of the head") is different than *reading/seeing* an online survey question (and selecting among the choices provided). That was quite evident in this question, where online survey respondents were much more likely than phone survey respondents to mention homeless services, services for seniors, affordable medicine/prescriptions, places to buy healthy foods affordably, and preventive care.

Table 3.44: What is the biggest health-related issue or service that people in your community need? Please check all that apply. (Split B only)

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
Mental health services	**27**	**26.4%**	**58**	**51.8%**	**144**	**54.3%**
Affordable health care	**25**	**24.8%**	**70**	**62.5%**	**183**	**69.1%**
Preventive care	20	20.0%	22	19.6%	**113**	**42.6%**
Services for diabetes	11	10.9%	13	11.6%	46	17.4%
Substance use or addiction treatment	8	7.8%	18	16.1%	63	23.8%
Housing and services for the homeless	8	7.8%	**57**	**50.9%**	**121**	**45.7%**
Services for seniors	8	7.8%	**33**	**29.5%**	**117**	**44.2%**
Obesity	8	7.8%	24	21.4%	63	23.8%
Affordable medicine/ prescriptions	6	5.9%	**41**	**36.6%**	**128**	**48.3%**
Place to buy healthy foods affordably	4	3.9%	**45**	**40.2%**	**90**	**34.0%**
Education	5	4.9%	1	0.9%	1	0.4%
COVID-19 testing and treatment	3	2.9%	10	8.9%	36	13.6%
Cancer cure/treatment	2	2.0%	**21**	**18.8%**	**54**	**20.4%**
Others	6	5.9%	1	0.9%	12	4.5%
Total # responding to the question	102	140.7%	112	368.8%	265	441.9%

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

Information Sources

Throughout this report the data have shown that respondents are looking to PVHMC for more community outreach, collaboration, and health education. The vast majority of respondents indicated that they ARE interested in receiving information. Indeed, only 4.6% of phone survey respondents, 5.2% of MDC online respondents, and 3.3% of IAR online respondents indicated that they are "not interested in the information."

But what are the best ways to let the community know about the health fairs, classes, events, disease prevention education, etc.? In previous health needs assessments, “mail sent home” and “doctor’s visits” were the information channels preferred by most respondents. In this year’s survey, “TV or social media” has surpassed mail and doctor visits as the information choice selected by phone survey respondents. It was the second choice among MDC online respondents, and the third choice of IAR online respondents as an important information source.

There is clearly a role for TV or social media in transmitting health information, however we note that it is important that the information include scientific references or statements from “health influencers” (e.g., known physicians) to convince people of the reliability of the information. Otherwise, people could rely on sites with “questionable” accuracy and content, and they might see TV information as nothing more than “marketing” or “advertising.”

Table 3.45: What are the best ways of providing you with information about community health and safety education (that is, disease or injury prevention)? Please check all that apply. (Split B)

	Phone		MDC Online		IAR Online	
	# of mentions	% who answered	# of mentions	% who answered	# of mentions	% who answered
TV or social media	**58**	**43.3%**	**56**	**50.9%**	**117**	**44.2%**
Mail sent home	**44**	**32.8%**	**49**	**44.5%**	**137**	**51.7%**
Doctor’s visits	**35**	**25.6%**	**72**	**65.5%**	**174**	**65.7%**
Community events	23	17.0%	32	29.1%	**114**	**43.0%**
Workplace	21	15.8%	20	18.2%	51	19.2%
Public schools	17	13.0%	18	16.4%	59	22.3%
Email, text, internet	7	5.2%	1	0.9%	11	4.2%
Other	5	3.7%	0	0.0%	6	2.3%
Total # responding to the question	135	156.3%	110	225.5%	265	252.5%

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

IV. DELPHI GROUP FINDINGS

Representatives of Low Income/Minority/Medically Underserved

INTRODUCTION

Data sources for hospital Community Needs Assessments often include focus groups consisting of representatives of low-income, minority, and medically underserved populations – people on the “front lines” providing needed health care services. Although IAR has conducted such focus groups in the past, it was determined that this would not be the best option for PVHMC’s 2024 needs assessment due to the difficulty in getting representatives to such a meeting. As an alternative, IAR used a modified Delphi process with participants selected from various regional community groups.

Potential participants were first identified by PVHMC staff as individuals who could provide needed input to the study. On February 28, 2024, IAR sent each participating individual a link to an online survey. The survey introduction described the study process and obtained the participant’s consent to participate (per IRB protocol).

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

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

The survey was active until March 14, 2024, in order to maximize participation. In total, eleven of the 35 potential respondents agreed to participate in the study. IAR summarized their input, sent it back to the participants to ensure that we had properly captured their opinions, and updated the results based on the input from the original eleven participants plus one additional respondent. In this section of the report, we present their input.

The following table shows the participating organizations and the populations they serve:

Table 4.1: Participating Organizations and Populations They Serve

Organization	Low Income	Home-less	Minorities	Children	Seniors	Women	Victims of Domestic Violence	Language Barriers	Other
AgingNext	X				X			X	
Alzheimer's Association					X				
Hillcrest	X		X		X	X			
House of Ruth	X	X	X	X	X	X	X	X	
Latino and Latina Roundtable	X		X		X	X		X	Immigrant communities
Pilgrim Place					X	X			
Pomona Community Health Center (dba ParkTree Community Health Center)	X	X	X	X	X	X		X	
Project Sister Family Services	X		X	X		X	X		
San Gabriel/Pomona Regional Center									Individuals with Developmental Disabilities (all ages)
SGV Consortium on Homelessness		X	X						Organizations that serve the homeless
Tri-City Mental Health	X	X	X	X	X	X	X	X	LGBTQ
We-Reachout.org	X	X	X	X		X			

Following is a brief summary of responses to the survey questions (shown in **bold print**). Where possible, responses are summarized under general themes. All direct quotes from participants are shown in *italics*.

Question: What types of services does your organization offer?

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

- **AgingNext**: Volunteers, Senior Companions, Volunteer Transportation, Case Management, Information and Referral, Village Model Membership, Respite Care.
- **Alzheimer's Association**: We offer services to the community and those who are facing Alzheimer's and Dementia. We also offer services to the Health System that needs support to improve dementia care.
- **Hillcrest:** Housing, Health, Wellness, Fitness, Social Services, Programs, Activities, Chaplains Services, Dining Services, Education, Service, etc. in a Life Plan Community that offers multiple levels of care and living.
- **House of Ruth**: Our organization is a comprehensive domestic violence agency offering emergency and transitional shelter, housing assistance, case management, trauma counseling for adults and children, legal advocacy, DV and teen violence prevention education, outreach services, food, clothing, essentials for living, 24-hr crisis hotline.
- **Latino and Latina Roundtable**: Immigration, education, economic development, advocacy and community engagement.
- **Pilgrim Place**: Retirement Community offering Independent Living, Assisted Living, Memory Care, Skilled Nursing.
- **Pomona Community Health Center** (dba ParkTree Community Health Center): Medical, Dental, Mental Health, Optometry, Podiatry, Chiropractic health services. Enabling services such as patient navigation, chronic disease management, health education, case management, care coordination, enrollment services.
- **Project Sister Family Services**: We offer sexual assault and child abuse crisis and education services.
- **San Gabriel/Pomona Regional Center**: Service Coordinators assist clients and their families with advocacy, connection with generic resources, and integration into community life.
- **SGV Consortium on Homelessness:** Education, collaboration, and advocacy, as part of capacity building and community organizing to prevent and end homelessness in SPA 3.
- **TriCity Mental Health:** Specialty Mental Health outpatient services.
- **We-Reachout.org:** Bringing people together to solve our region's toughest issues: Quality healthcare, education, housing, safe homes/neighborhoods/schools, equitable economic opportunity, dignity in justice, healthy foods & environments, voice and leadership.

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

The most significant health needs were judged to be: (1) care coordination, (2) mental health services/resources, and (3) more community-wide partnerships/ collaboration. This has changed since the 2021 report, when the priorities were (in order of significance) primary care and prevention services, mental health services/resources, and more community-wide partnerships/ collaboration (with care coordination coming in as a close 4th place).

Table 4.2: Most Significant Health Needs

	Percent of respondents
Care coordination	**54.5%**
Mental Health services/resources	**54.5%**
More community-wide partnerships/ collaboration	**36.4%**
Chronic disease management	
Heart disease/heart failure	9.1%
Diabetes	9.1%
Alzheimer's & other dementia	9.1%
Hypertension	9.1%
Primary care & prevention services	18.2%
Dementia/Alzheimer's services and resources	18.2%
Transportation	18.2%
Resources/support for homeless populations	18.2%
Recuperative Care for homeless	9.1%
Home health services	9.1%
Health education/support groups	9.1%

Question: Why do you believe the selected health needs are the most significant? What factors and conditions contribute to those health needs?

Some representative responses are shown below, categorized under the health need selected (one answer may have addressed multiple health needs, thus some "overlaps" in categories exist):

Care Coordination

- *"Care Coordination and Transportation are critical elements for older adults aging in place. Our service area is similar to the service area of Pomona Valley Hospital; there is a growing population of older adults, and one of the significant needs is information about Dementia and Alzheimer's."*

- *“We encounter a disproportionate number of individuals who experience chronic disease conditions, including hypertension and diabetes. Our clients also experience challenges in navigating the health system, especially with transitions of care between hospitals, specialists and the primary care system.”*
- *“Our communities need support to bridge the barriers that exist. Usually there is mistrust and also lack of information on navigating the healthcare system. Also, transportation to and from appointments or treatments. I see a lot of sick people waiting for the bus that are too weak to be doing that.”*
- *“Many of the clients we serve have multiple chronic issues, including mental health, substance abuse, homelessness, low income etc. Working together in collaboration is the best way to address these multi-layered crises. Having well-developed resources is key to supporting the populations we serve.”*
- *“Individuals and families that are unhoused have difficulty caring for their health including their mental health. We, as a health system, lack true care coordination across physical, SUD and mental health for our clients that results in poor outcomes for all health domains. Finally, we know that individuals with a mental health diagnosis on average die 20 to 30 years sooner than the general population. We have a moral imperative to serve that population better as a healthcare system.”*
- *“Having a resource list that allows for care coordination among the different health professions would be ideal in order to refer appropriately or have warm hand-off to partners.”*
- *“The current Health Care System is more complex than ever before. It’s a mixed system of Medi-Cal, Medicare, and private health insurance. A combination of coverage may be difficult to navigate, especially for the aging population and people with disabilities.”*
- *“With a low Socioeconomic status come barriers to accessing and coordinating care.”*

Mental health services/resources

- *“Mental Health Services through TriCity are important but not sufficient to the need. Home Health services need to be more affordable for the elderly, the sick and the shut in, perhaps subsidized. The health system needs to produce more PCP's and other clinical professionals to improve accessibility and promote population health on broader scale.”*
- *“Our waitlist for therapy grows longer and longer - having more mental health resources is a priority.”*
- *“Mental health issues have been observed growing especially in the youth, increasing in anxiety, depression, and other mental illnesses.”*
- *“Mental health has been an issue since prior to the COVID-19 Pandemic, but the situation was exacerbated by it. There are children and young adults exhibiting symptoms of mental health conditions and there are waiting lists to access mental health services throughout our community. This is inclusive of talk therapy and psychiatric services for the treatment of a mental health condition.”*

More community-wide partnerships/collaboration

- *"Each community partner provides a needed service. By working together these partners can address unmet needs. Funding collaborations may be an important way for the hospital to facilitate such partnerships. Hillcrest is desirous to help convene partner agencies with similar community-focused nonprofit interests and together serve those "outside" existing systems. This would be a long-term strategy to not only identify unmet needs, but also use a systemic approach to filling in the gaps. I recognize that this is an approach to addressing needs that this survey seeks to unveil; but the establishment of such an approach can work in a complimentary way with the PVHMC to identify, serve, and report on efforts to meet the underserved. The results of this survey will identify health needs and drivers that could be the focus of an effort to establish community-wide partnerships."*
- *"There is a disconnect between the different systems that provide services to the community. Although there's progress being made, there is room for improvement. Partnerships in action show transparency. By inviting community partners and members to take part in stakeholder meetings they will be part of the solution and know that their opinion matters."*
- *"Hospital partnerships with community organizations are important social determinants of health because they bring in expertise not otherwise available within."*

Resources/support for homeless populations

- *"I think that upstream issues addressing homelessness are the most important, due to the death and quality of life issues for clients."*
- *"Our clients are always looking for peer groups to help them connect with individuals that have shared experiences. They are often faced with high risk of homelessness due to loss of wages as a result of their victimization and need assistance with programs that can help them keep their housing or find new housing."*

Other

- *"Alzheimer's is the 3rd leading cause of death in CA. Patients are not being screened for dementia. We have a shortage of specialists like Neurologists and Geriatricians. We are not equipped for the aging population we have in California. It is important for Primary Care systems to start screening for dementia those are 65 and older."*

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

Table 4.3 lists the unmet health needs, along with the populations most affected.

Table 4.3:
Populations most affected by various unmet health needs

Health Need	Populations most affected
Care coordination	Homeless/unhoused; low income; low health literacy; those with language barriers; those who lack transportation; seniors; people with mobility issues; people with mental health issues; developmentally disabled Individuals, especially those that are disabled minorities
Mental health services/resources	Low income; minority women; homeless; adult and youth victims of trauma/violence; undocumented; those with mental health issues; developmentally disabled Individuals, especially those that are disabled minorities; youth
More community-wide partnerships/ collaboration	Low income; immigrant; undocumented who feel alienated by the health system; seniors; people with mobility issues; homeless/unhoused; adult and youth victims of trauma/violence; Developmentally Disabled Individuals, especially those that are disabled minorities
Chronic disease management: Heart disease/heart failure	Low income; immigrant; undocumented who feel alienated by the health system
Chronic disease management: Diabetes	Low income; individuals with low health literacy; those with language barriers; those who lack transportation
Chronic disease management: Alzheimer's and other dementia	Latino and African Americans (who have higher risk of developing Alzheimer's and other dementia)
Chronic disease management: Hypertension	Low income; individuals with low health literacy; those with language barriers; those who lack transportation
Primary care & prevention services (i.e. Primary physicians, community clinics, wellness visits, screenings, prenatal care)	Latino and African Americans; Low income; minority women
Dementia/Alzheimer's services and resources	Latino and African Americans; older adults and their families
Transportation	Low income; immigrant; undocumented individuals who feel alienated by the health system
Resources/support for homeless	Homeless/unhoused; victims of trauma; undocumented
Recuperative care for homeless	Homeless/unhoused
Home health services	Low income; minority women
Health education/support Groups	Undocumented; Spanish speaking population

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

Respondents were asked in an open-ended question to indicate what service(s) or resource(s) are needed in the community. Classes/support groups, nutritional services, mental health services, community outreach, and specialty care were the most-often mentioned services needed. More specifically:

Classes/support groups

- Health education; nutritional education, access to information
- Community education

Nutritional services

- Assistance with obtaining food
- Nutritional services

Mental health services

- Long term behavioral health
- Supportive living situations
- Wellness and early mental health services on school campuses

Community outreach

- Active and aggressive community outreach
- Must reach out instead of waiting for people to seek help

Specialty care

- Affordable dental care
- Alzheimer's and other dementia
- Dental/vision care, as most insurances do not include this coverage or have high out of pocket costs
- Specialty access in key areas (i.e. endocrinology, psychiatry)

Primary care/Prenatal care

- Community clinics
- Competent Prenatal care (especially difficult for minority women)
- Transportation to a medical facility for preventative care (or need for mobile clinics)

Other

- Better communication to remove barriers to help patients feel at ease in a stressful situation
- Case management

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

Lack of communication was mentioned by several Individuals as a barrier to receiving health care. The literature has shown that communication between a patient and his/her health care provider is key to delivering high quality health care resulting in improved patient outcomes. Therefore, it is not surprising that the lack of communication would be mentioned as a significant barrier. When the health care provider speaks a different language than the patient and his/her family, it is virtually impossible for there to be optimal quality of care and understanding of the necessary follow-up care. Language barriers, in addition to a perception that health care providers lack the understanding of cultural norms, reduce the likelihood of creating the necessary linkages between hospital care and primary care. Respondents said:

- *"There are challenges in navigating the health system for individuals with limited English proficiency."*
- *"Lack of minority clinical professionals who would likely hear patients' concerns from a less dismissive perspective."*
- *"Poor communication due to language issues and cultural barriers."*
- *"Patients are not given explanations in terms that they understand and can comprehend."*

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

Lack of health literacy and the resulting need for education was also mentioned. Respondents talked about low health literacy and limited knowledge/understanding about available resources and how to access needed care.

Several respondents mentioned **cost/financial issues** as a barrier to receiving health care for minority and medically underserved populations. Respondents indicated that some patients simply do not have the money to seek health care, or there is a fear of large medical bills. Another cited the lack of portability of insurance coverage. And the **lack of transportation** was also mentioned.

Finally, several people cited other challenges such as the **lack of convenient hours** for appointments, the need for **medical advocacy** (especially for older adults), and the need for primary care clinics to conduct a **cognitive health assessment** for seniors.

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

Suggested ways to *improve* the health of people:

There are many models of good community health care that focus on positive actions that can improve people's health. Most of them focus on healthy eating, physical activity, regular sleep, and having a positive outlook on life. Our respondents echoed these actions in their suggestions, as well as education/outreach, improving access, and more.

Education/outreach was mentioned by several people as a way of improving community health. They mentioned that education is needed about the importance of preventative health services, and they noted that practitioners should have resources (flyers, brochures, etc.) easily available for their patients. They also stressed the need for patient education about various health conditions and nutrition. And a suggestion was made that trust in the information (and possible acceptance of advice) can be increased if the information is provided by people from within their own community. As one respondent said: "Engage and employ individuals that understand the need to speak to the residents and community in a language they understand, but also are a representation of them." These individuals should be mobilized to provide information at outreach events and health fairs. Outreach to youth in schools to help with mental health issues was specifically mentioned.

Related to the need for education/outreach is the need to help people make **better lifestyle choices**. For example, one person suggested more city-wide programs encouraging physical activity (tai chi, yoga, walking clubs, and community centers with activities) which can improve physical health while promoting a positive outlook on life. Farmer's markets with foods that promote healthy nutrition can help.

Of course, **improving access** is a vital component of improving community health. Respondents noted the need to improve access to (1) primary care through conveniently located clinics, and (2) healthy foods. One person suggested having health promoters in the community that are paid staff, navigators, and people that can accompany people to appointments (and perhaps remove the "transportation barrier"). Another suggested enlisting hospitals, schools, churches, nonprofits, and other service agencies to help people access health services and support.

Negative influences (impacts) on health in our community:

Most of the negative influences mentioned are the "flip side" of the positive factors listed above: lack of education, lack of healthy food options, lack of transportation, lack of trust, and language barriers. Following are a few direct quotes about negative influences on health:

- *"Lack of education."*
- *"Lack of healthy food options, and the inability to obtain healthy food due to cost."*

- *“Lack of specialty care: eye, dermatology, and others sometimes do not take HMO coverage.”*
- *“Lack of transportation.”*
- *“Lack of trust in the health care system by patients.”*
- *“Language barriers.”*
- *“Low health literacy, including lack of understanding of importance of preventative health services.”*
  - *“Social determinants of health: Drugs, guns, crime, violence.”*
  - *“The healthcare system has become siloed by and because of payor source divisions, instead of uniting around community needs.”*
- *“There are local doctors with open panels who are willing to take new patients, but care concern is spotty.”*
- *“There is NYMBYism in SPA 3 – show the cost benefit from a health perspective.”*
- *“When information is not provided or is provided in a language that is not spoken by the patient or at a high academic level, it is not understood.”*

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

In previous PVHMC needs assessments, IAR’s data gathering process has revealed that PVHMC is already taking steps to improve the health and wellness of the community. The data show that PVHMC is active in the community, partnering with area CBOs, and reaching out with education and services. Yet more can be done by PVHMC and the other health care facilities in the region. The suggestions above in response to the question “*what are some ways to improve the health of people in our community*” are equally valid here. Those include increasing education/outreach, giving people the tools to make better lifestyle choices, improving access to health care and healthy food, and focusing on care coordination and partnerships with other organizations in the region.

Service availability was also mentioned by multiple people in answer to this question. For example:

- “*Extend/expand ER services for those who do not have access to primary care physicians on a regular basis*.”
- “*Health and wellness may be improved by going directly into the community and offering the services that they need, including mobile screening services*.”

People responded with a perspective that healthcare is a community-wide effort. **Care coordination** and **partnerships** were common themes.

- *“Foster a stronger focus on care coordination and navigation between primary care sites and hospitals in order to reduce the barriers to access that many in our community experience, as well as to ensure patients have a primary care health home.”*

- *“Partnerships with other community-based organizations.”*
- *“Whether it is fair to hospitals or not, they are seen by the community as the hub for healthcare. Hospitals should embrace that perception and build a system around it.”*
- *“Work more with community agencies and cities to help with discharge issues for those who are unhoused. Use recuperative care, board and care, beds, etc..., instead of referring to rescue missions and having clients sign off.”*
- *“Hospitals and other health care institutions are currently under financial stress to hire, train, and maintain sufficient staff; pay competitive wages, and meet the growing needs of an expanding (and aging) population. Collaborate with other agencies that have various forms of underutilized assets that could be used and contributed to a community-wide effort to address unmet needs. These contributions could include:*
    - *donation of meeting space for periodic gatherings*
    - *leadership talent to find and expose creative pathways to desired goals*
    - *equipment, supplies, communication systems, and/or educational resources to help improve community health.”*

Other suggestions included:

- *“Have MSW level social workers on staff to triage multi-layered cases with physical, mental, social, housing, children and many other life challenges.”*
- *“Provide transportation and create health summits.”*
- *“Provide care and more frequency follow-up for the region’s aging population.”*
- *“Use health metrics to assess minority patient outcomes and the performance of the clinical system.”*
- *“Have on-site translation services either in person or virtually.”*

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

In response to this question, suggestions were made that matched the themes they have already touched upon in previous questions: care coordination, partnerships, mental health services, education/outreach, communication, and service availability and access. Following are some direct quotes which focus on their specific suggestions:

- *“Due to the high need for mental health services, it is important to address wellness and early mental health situations on school campuses. That could include working through community-based organizations to bring more mental health and wellness programming to school sites and having wellness centers which are open every day for students to easily access support.”*
- *“Engage with organizations such as COACH (Center for Older Adult Community Health) to expand the outreach to benefit older adults in our broader community.”*

- *“Engaging ambassadors volunteers that can provide resources and presentations in various languages to different communities.”*
- *“Focus on adapting to current clinical realities/needs and change as needed.”*
- *“Partnerships, mobile screening services, Promotora type services, educational campaigns in various languages (videos w/ scenarios), etc.”*
- *“PVHMC has a strong history of community partnerships to meet the needs of the community, for example providing access for certain laboratory and radiology services for the uninsured of the community. These offerings ensure key access that would be missing without PVHMC's efforts, and it is recommended that they continue providing these key services.”*
- *“Reach out to the Alzheimer’s Association which can help PVHMC become an Age-Friendly Health system.”*
- *“Re-establish meeting groups/partnerships to strategize ways to reduce hospital readmissions and unnecessary ER utilization. That could happen by linking patients to a health home for primary care health services.”*

V. EXECUTIVE INTERVIEWS WITH PUBLIC HEALTH OFFICIALS

INTRODUCTION

The final component of PVHMC's Community Health Needs Assessment consisted of eliciting the views of public health officials in both Los Angeles and San Bernardino Counties. The Los Angeles County Department of Public Health officials who agreed to be interviewed were Ms. Jasmine Ting, Area Administrator, Community and Field Services, SPA 3 (SGV); and Mr. Jose Escobar, Regional Health Officer for SPA 3. Ms. Monique Amis (San Bernardino County Chief of Community and Family Health) provided information regarding San Bernardino County.

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

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

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

Overall, comments from the executive interviews focused heavily on the need for knowledge and access. 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.

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

One of the interviewees focused on the following populations: low-income, homeless, people with chronic diseases, and people with language barriers. Interviewees gave their perspective that the biggest unmet need was **education**. Specifically, there is a lack of knowledge among those populations regarding navigating the health care system on their own. There is also a lack of (1) awareness of support services, (2) services in various languages targeted at different cultures, and (3) system navigation staff who could help people confirm eligibility. Further, these populations tend to have a lack of financial literacy.

A secondary concern is **access t**o the available support. *"If people work from 6 AM to 7 PM, there is no way of accessing services."*

<u>Suggestions</u>: There needs to be more priority placed on education and outreach to inform people about the availability of services and explain to people that they CAN access the services without fear of consequences. Some educational programs should be held on evenings and weekends to maximize access to the services.

The other interviewee focused on health equity and the need to address social determinants of health (SDOH) under a population health focus. That respondent focused on unmet needs related to transportation, food insecurity, housing, and behavioral health access (particularly maternal mental health. These needs especially affect at-risk youth, low-income households, people of color, immigrants, and LGBTQ.

<u>Suggestions</u>: Screen patients for food insecurity, and connect patients who are in need to food and nutrition services. Offer lactation services and allow doulas to fully support people giving birth, especially Black women and families. Connect Black women and families to other local supportive services (e.g., Prototypes Outpatient Adult and Children Outpatient Services). Connect patients (youth and families) to mental health services. Increase collaboration with community-based organizations: "*While there are collaborative efforts within the County, the ability to share information and close the loop with referrals made with partners remains a challenge."*

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

Identified needs in the area of primary care and preventative health services include knowledge about services, increased access to services, assistance navigating the health care system, and providing linkages to care for newly arrived refugees.

Knowledge about services: There is a huge lack of knowledge about services. For example, beginning January 1, 2024, a new law in California enabled adults 26 through 49 years of age to access the full scope of Medi-Cal services. Immigration status does not matter, but people don't know that. Undocumented people fear that they will have to pay later, or it might affect their chances of becoming a citizen.

Access: "*Access to receive primary care and preventive health services remains a huge challenge. There are many outlying communities in our vast county (San Bernardino) that have limited access to services. In addition, health care is not prioritized by some employers, and they provide very few (if any) sick days."*

Assistance navigating the health care system: There is a need for assistance to navigate the Medi-Cal and other government supported services for those with literacy challenges, and those with limited or no digital access.

Linkage to care for newly arrived refugees: Newly arrived refugees are unaware of available health care resources in the area of primary care and preventative health services. They require linkage to care (as do other at-risk populations).

<u>**Suggestions**</u>**:**

- Deploy more mobile units, CHW/P/Rs (Community Health Workers, Promotores, and Representatives), and health navigators embedded in entry points into the health system (such as the Emergency Department).
- Provide more support for school-based service sites as a one-stop shop for children and adolescents.
- Provide cultural training for dealing with the diverse population (including new refugees) to assist in their transition into our healthcare system.
- Work in partnership with a collaborative of various hospitals and health care agencies, local resettlement agencies and community-based organizations.
- Increase outreach efforts, which could include teams going door to door as well as outreach events where the population comes to THEM.
- Provide funding to non-profits ("empowering the grass roots"). For example, ActiveSGV provides nutrition information. They work with school principals to provide access to health education for students and their parents.

3. Unmet needs in the area of chronic disease management

Low-income individuals often have no **"medical home"** and **insufficient education** about their condition. They often need to change providers and they don't always keep appointments, so their chronic issues are hard to treat. This issue is especially important relative to diabetes, obesity, and hypertension. "*This is all linked to food insecurity (lack of access to nutritious food, lack of education on preparing the food, etc.). This all ties into the medical literacy pieces.*"

<u>**Suggestions:**</u>

- Provide more education about people's conditions. Any education dealing with chronic disease management must be linguistically and culturally appropriate. For example, recipes must be for foods people actually eat in their culture and are available to them.
- Education is needed for high-priority populations regarding chronic disease prevention and management; this can be done by implementing group visits and/or through deploying more CHWs out in the community and establishing care navigation for those who have chronic conditions at high-risk of being hospitalized due to exacerbation of their chronic diseases. This is particularly important for those on Medi-Cal/Medicare, low socioeconomic status, Black and Hispanic race/ethnicity, which often show disparities in chronic disease burden, such as obesity, hypertension, type 2 diabetes, etc.

This even applies for aspects of maternal/child/adolescent health (MCAH) work as chronic disease often impacts pregnancy and can often lead to worse perinatal outcomes.

- Partnerships among health care providers and community-based organizations are vital.

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

As noted above, Food insecurity is seen as a huge challenge, particularly in terms of access to low cost or free fresh fruit and vegetables. Further, there needs to be more education regarding **vaping** (especially among youth). *"Technology allows kids to communicate easily with groups telling them where to meet to vape. Principals say vaping is a big issue with teens. They don't recognize the addictiveness of it."*

Suggestions:

- Educate and empower physicians of patients with chronic conditions to refer to farmer's markets and produce distributions.
- Work with schools to educate youth on the dangers of vaping.

5. "Other" unmet needs

Mental health is a huge issue, in part as an outcome of the pandemic. The PVHMC region has above-average suicide rates. Especially among youth, there is a great deal of anxiety and depression. Yet there are barriers to accessing care including access, cost, and shame/stigma. There is also an important **violence prevention** piece (dealing with gang activity). And this area has a high incidence of **homelessness**.

Disparities persist in healthcare services among communities of color, particularly in the Black/African-American community in San Bernardino County. "*Black women are dying and Black babies are dying as compared to their white counterparts. These disparities are just exacerbated by the lack of mental health resources which is a function of lack of providers and lack of funding for these services. Additionally, moms who need higher levels of support for breastfeeding find themselves without resources*."

One further health-related need is dealing with the opioid epidemic "*which continues to take the lives of our youth*."

Suggestions:

- Work with schools to develop programs dealing with mental health issues.
- Develop programs on road rage and traffic incidents as well as injury prevention.
- Conduct more programs on anger management for adults and youth.
- For kids, homelessness leads to chronic absenteeism which leads to a continuous cycle of poverty. Collaborate with community partners to provide resources for the homeless.
- Although Narcan resources and training are prevalent, increase efforts to create effective ways of getting the message out to youth about the dangers of opioids.

6. Barriers to meeting the health needs of the community

Representatives of both counties mentioned **lack of access** to healthcare and other resources as a major barrier and top priority for meeting the health needs of the community. **Lack of knowledge** was also mentioned as a barrier. As one person said**: "***There is a lack of knowledge of what exists, and even the staff don't know who is doing what among the partners. There is a resource "map" but it isn't updated. Maybe try to implement something like "One Degree" in New Mexico (a system navigation tool/resource guide)."*

Interviewees stressed that the resources accessed must be prepared to deal with the region's "very diverse population" – in other words, it must be able to deal with **language and cultural barriers**. **"I***f providers don't understand "culturally competent services," it is hard to convince patients to live healthy lives*."

Consistent with the above answers, interviewees also mentioned education as a high priority to reduce barriers to meeting the health needs of the community. They also mentioned SODH. Following are the top barriers to meeting the health needs of the community, in rank order:

Table 5.1
Identified Health Need Priorities and Barriers

Respondent #1	Respondent #2
1. Access to resources and knowledge of what exists	1. Timely, affordable access to culturally sensitive healthcare
2. Language and cultural barriers	2. Difficulties with navigating the healthcare system
3. Poverty, food insecurity and nutrition	3. Challenges attaining adequate, evidence-based health literacy/education
4. Homelessness	4. Adverse social determinants of health that make the healthy choices harder choices to make
	5. Inequities in access to costly prescription medications

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

Empower the community! Partner with community-based organizations and organizations such as the SGV health consortium. Funding is an issue…can hospitals provide funding, or perhaps the experts for programming? Partner with schools.

Appendix A

Phone And Online Survey Instrument

2024 PVHMC Questionnaires – FINAL VERSION 1/21/24

Anonymous link in English:
https://csusb.az1.qualtrics.com/jfe/form/SV_6J4dhzFByGM1xNY

https://bit.ly/PVHMC2024CommunityNeedsSurveyEnglish

Anonymous link in Spanish:
https://csusb.az1.qualtrics.com/jfe/form/SV_6J4dhzFByGM1xNY?Q_Language=ES

https://bit.ly/PVHMC2024CommunityNeedsSurveySpanish

NOTE: question "numbers"/labels are in bold. They will not show up to the respondent. NOTE: IAR wishes to be clear that this survey is VERY long, and completion rate may suffer somewhat. PVHMC has agreed to a split questionnaire approach. Questions highlighted in green with names starting with a "C" (FOR "CORE QUESTION") must be given to everyone. Other questions can be assigned based on random numbers.

CATEGORIES IN CAPS SHOULD NOT BE READ.

ONLINE INTRO

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

This survey takes about 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 after the initial screening questions. We hope you can respond by **February 29, 2024**.

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

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

☐ Agree to participate. Continue with the survey.

☐ Disagree (end survey)

PHONE INTRO

Hi, my name is ___________ and I'm calling on behalf of MDC Research. We're conducting a study regarding the health needs of the community so that we can help improve the quality of health services available in the region.

If you have content-related or technical questions related to this survey, please contact Dr. Barbara Sirotnik at bsirotni@csusb.edu, or call 909.537.5729. (*Programmer - please also copy this on the INT99 screen as well)*

CQ1CityZip

This survey is designed for residents of Pomona Valley Hospital Medical Center's service area. To make sure you are in the area, what is the city and zip code where you live? **DO NOT READ LIST**. **OPEN ENDED.**

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. 92331 FONTANA
23. 92334 FONTANA
24. 92335 FONTANA
25. 92336 FONTANA
26. 92337 FONTANA
27. NOT ON LIST – **TERMINATE - THANK YOU, BUT WE ARE ONLY SURVEYING PEOPLE WHO LIVE IN POMONA VALLEY HOSPITAL MEDICAL CENTER'S SERVICE AREA**

CQ2NumPeople

Including YOURSELF, how many people live in your household? _________ (numeric only 1-98)

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

CQ3NumKids

How many children ages 0 - 17 live in your household? ______ (numeric only 0-98)

CQ4NumInsured

How many persons in your household AGES 18 AND ABOVE are covered by medical insurance? ________ (numeric only 0-98)

Display This Question if # of children > 0

CQ5NumKidsInsured

How many children in your household AGE 0 - 17 are covered by medical insurance? _________ (numeric only 0-98)

SPLIT A

Q6InsuranceType

What type of health insurance covers people in your household? **DO NOT READ LIST**. **MULTIPLE RESPONSE. NOTE: IF THEY SAY BLUE CROSS, BLUE SHIELD, IEHP, UNITED HEALTHCARE, AETNA, ETC. PUT "I HAVE PRIVATE INSURANCE"**

1. I HAVE INSURANCE BUT DON'T KNOW THE TYPE
2. I HAVE PRIVATE INSURANCE (EITHER HMO OR PPO)
3. MEDI-CAL
4. MEDICARE
5. VETERANS (VA)
6. OBAMACARE, COVERED CALIFORNIA, AFFORDABLE CARE ACT INSURANCE

7. OTHER (PLEASE SPECIFY) ___________

8. NOT COVERED, NO INSURANCE AT ALL

99. PREFER NOT TO ANSWER

Display This Question if have no insurance (Q6InsuranceType=No Insurance at all) OR if CQ4 and CQ5 are = 0

SPLIT A

Q7WhyNoIns

What are the main reasons you and/or your family members don't have health insurance? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. I AM (WE ARE) HEALTHY
2. DON'T NEED INSURANCE
3. DID NOT UNDERSTAND PLANS WELL ENOUGH TO BUY INSURANCE
4. PERSON WITH COVERAGE (SELF, SPOUSE OR PARENT) LOST OR CHANGED JOB
5. BECAME INELIGIBLE BECAUSE OF AGE OR LEFT SCHOOL
6. EMPLOYER DOESN'T OFFER OR STOPPED OFFERING COVERAGE
7. COULDN'T AFFORD PREMIUMS
8. LOST MEDICAID OR MEDI-CAL ASSISTANCE ELIGIBILITY
9. OTHER (PLEASE SPECIFY) _____________
10. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT B

Q8-Q10 asked together.

Q8Covid1

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

1. YES
2. NO
98. NOT SURE
99. PREFER NOT TO ANSWER

SPLIT B

Q9Covid2

How did the pandemic impact your overall health and well-being? Would you say that it has had a negative impact, or a positive impact, or not much impact?

1. NEGATIVE IMPACT
2. POSITIVE IMPACT
3. NOT MUCH IMPACT
98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT B

Display This Question if negative impact for Q9Covid2 (Q9Covid2=1)

Q10Covid3

In what ways did the pandemic negatively impact your overall health and well-being? **DO NOT READ LIST. MULTIPLE RESPONSE.**

1. MORE STRESSED, ANXIOUS, AND/OR DEPRESSED
2. GAINED WEIGHT
3. GOT "LONG COVID" AND STILL FEELING FATIGUE, FOGGINESS, PAIN, COUGH, DIFFICULTY BREATHING.
4. SMOKING MORE
5. DRINKING ALCOHOL MORE
6. LOST JOB
7. LOSS OF LOVED ONE
8. MISSED RECOMMENDED DOCTOR VISITS AND PREVENTATIVE SERVICES
9. OTHER (PLEASE SPECIFY) ___________

99. PREFER NOT TO ANSWER

CQ11Telehealth1

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

1. YES
2. NO

98. DON'T RECALL
99. PREFER NOT TO ANSWER

Display This Question if have used telehealth services (CQ11Telehealth1=1)

CQ12Telehealth2

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

1. PREFER IN-OFFICE PHYSICIAN VISITS
2. PREFER TELEHEALTH SERVICES
3. NO PREFERENCE FOR IN-OFFICE VS TELEHEALTH -- IT DOESN'T MATTER EITHER WAY

98. DON'T KNOW
99. PREFER NOT TO ANSWER

Display This Question if prefer in-office visits (CQ12Telehealth2=1)

CQ13Telehealth3

What makes you prefer in-office visits? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. EASIER TO SCHEDULE THAN TELEHEALTH APPOINTMENTS
2. TECHNOLOGY – IT'S HARD TO SET UP THE AUDIO/VIDEO CONNECTION
3. DON'T USE A COMPUTER
4. DOCTOR CAN'T DO A PHYSICAL EXAM
5. PREFER SEEING A "HUMAN" IN-PERSON

6. CONCERNS ABOUT PRIVACY AND SECURITY
7. HARD TO HEAR OR SEE ON THE COMPUTER
8. OTHER (PLEASE SPECIFY)

CQ14NoServices

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
98. DON'T RECALL
99. PREFER NOT TO ANSWER

Display This Question if someone needed health services they couldn't get (CQ14NoServices=1)

CQ15WhyNoServices

What kept you or your family members from getting the health services you needed? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. WORRIED ABOUT COST OF SERVICE/CO-PAYMENTS
2. WORRIED ABOUT COST OF PRESCRIPTION(S)
3. LACKED TRANSPORTATION
4. LACKED CHILDCARE/BABYSITTER
5. HOURS WERE NOT CONVENIENT
6. DIFFICULTY SCHEDULING
7. NEEDED SERVICES WEREN'T AVAILABLE
8. DIDN'T KNOW WHERE TO FIND THE SERVICES
9. POMONA VALLEY HOSPITAL MEDICAL CENTER DIDN'T HAVE THE SERVICES NEEDED
10. LANGUAGE OR CULTURAL BARRIERS
11. DIDN'T LIKE THE PROGRAMS OR SERVICES
12. PROVIDER WOULDN'T ACCEPT MY INSURANCE
13. THE MEDICAL SERVICE WASN'T AVAILABLE IN THE AREA
14. NO HEALTH INSURANCE
15. OTHER (PLEASE SPECIFY) ____________
16. DON'T KNOW

99. PREFER NOT TO ANSWER

Display This Question if someone needed health services they couldn't get (CQ14NoServices=1)

CQ16WhatServices

What services couldn't you get? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. DENTAL CARE

2. VISION CARE
3. PRESCRIPTIONS OR MEDICATION NEEDED
4. SURGERY
5. MEDICAL EQUIPMENT (WALKERS, WHEELCHAIRS, SPECIAL MEDICAL EQUIPMENT)
6. MENTAL HEALTH
7. OTHER (PLEASE SPECIFY)

99. PREFER NOT TO ANSWER

SPLIT A

Q17GeneralPhys

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? Was it within the past year, or past 2 years, or past 5 years, or has it been more than 5 years ago?

1. WITHIN THE PAST YEAR (1-12 MONTHS AGO)
2. WITHIN THE PAST 2 YEARS (13 MONTHS TO 2 YEARS)
3. WITHIN THE PAST 5 YEARS (25 MONTHS TO 5 YEARS AGO)
4. MORE THAN 5 YEARS AGO
5. NEVER HAD A GENERAL PHYSICAL EXAM

98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT A

Q18-Q21 All asked together.

Display This Question if respondent has at least one child (CQ3NumKids>=1)

Q18Kidcondition

Have you been told by any of your children's doctors that they have any of the following conditions? **READ CATEGORIES AND CHECK ALL THAT APPLY**

1. Asthma or breathing problems
2. Diabetes
3. Overweight/obese
4. Disability
5. Attention-deficit disorder
6. Other (please specify) ______________

7. NONE

99. Prefer not to answer

SPLIT A

Display This Question if child has a disability (Q18KidCondition=4)

Q19Kidconditionb

Is your child's disability physical or developmental?

1. PHYSICAL
2. DEVELOPMENTAL
3. OTHER

98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT A

Display This Question if child has asthma or breathing problems (Q18KidCondition=1)

Q20Asthma

How many times during the past 12 months did you visit the emergency room because of your child's **asthma or breathing problems**? ____________ (numeric only 0-98)

99. Prefer not to answer

SPLIT A

Display This Question if child has diabetes (Q18KidCondition=2)

Q21Diabetes

How many times during the past 12 months did you visit the emergency room because of your child's **diabetes**? _____________

99. Prefer not to answer

SPLIT B

Q22-Q24 All asked together.

Display This Question if respondent has at least one child (CQ3NumKids>=1)

Q22Specialist1

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

1. YES
2. NO

98. DON'T RECALL
99. PREFER NOT TO ANSWER

SPLIT B

Display This Question if had trouble finding pediatric specialists for any of your children (Q22Specialist1=1)

Q23Specialist2

What specialists couldn't you find for your child(ren)? **DO NOT READ LIST**. **OPEN-ENDED MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. Bone or joint specialist
2. Cancer specialist
3. Diabetes specialist
4. Heart specialist
5. Lung or breathing specialist
6. Autism or developmental disorder specialist
7. Mental health psychiatrist, psychologist, or therapist
8. Other (Please specify) _____________
98. Don't know/don't recall
99. Prefer not to answer

SPLIT B

Display This Question if had trouble finding pediatric specialists for any of your children (Q22Specialist1=1)

Q24Specialist3

What difficulties have you had getting in to see a specialist for your child? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. Couldn't get a timely appointment
2. Couldn't find this type of specialist locally
3. No transportation to get to the office (e.g., no car)
4. Couldn't get to the office during their hours of operation
5. Don't know how to find this type of specialist
6. Specialist is not in my health network
7. No health insurance/couldn't afford it
8. Specialist I wanted for my child was not seeing new patients
9. Other (please specify) ___________
98. Don't know
99. Prefer not to answer

SPLIT A

Q25-Q26 Asked together.

Q25Weight

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

1. YES
2. NO
3. SOMETIMES
4. NOT USUALLY, BUT MY EATING AND EXERCISE HABITS CHANGED AS A RESULT OF THE COVID-19 PANDEMIC/QUARANTINE
98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT A

Display This Question if said "yes" or "sometimes" they typically find it difficult to eat healthy or maintain a healthy body weight (Q25Weight=1 or 3)

Q26HardWeight

What would you say is the NUMBER ONE reason it is difficult to eat healthy or maintain a healthy body weight? **INTERVIEWER: DON'T READ LIST. USE THESE CODING CATEGORIES**

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. THE PANDEMIC CHANGED MY EATING HABITS
9. OTHER (PLEASE SPECIFY) ____________

98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT B

Q27-Q30 Asked together.

Q27Pap

Now moving on to health prevention tests. Has any female member of your household had a cervical cancer screening (also called a Pap and /or HPV test) within the past three years?

1. YES
2. NO
3. DOES NOT APPLY

98. DON'T KNOW
99. Prefer not to answer

SPLIT B

Skip To: Q29Colon If does not apply since No female in household (SKIP IF Q27Pap=3)

Q28Mammogram

Typically, how often do you or members of your household get a breast cancer SCREENING, also called a mammogram? Is it every year, or every 2 years, or every 3 years or less often?

1. EVERY YEAR
2. EVERY TWO YEARS
3. EVERY THREE YEARS OR LESS OFTEN
4. DOES NOT APPLY

98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT B

Q29Colon

Has anyone in your household had a SCREENING test for colon cancer in the past TEN years?
1. YES
2. NO
3. DOES NOT APPLY – NOT BETWEEN THE AGES OF 45-75.
98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT B

Display This Question if "no" to pap smear or colonoscopy or every three years or less often for mammogram (IF Q27Pap=2 OR IF Q29Colon=2 OR IF Q28Mammogram=3)

Q30WhyNoScreening

May I ask why people in your household haven't had all of the cancer screenings for Cervical, Breast, or Colon cancer? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

01. No insurance
02. Financial issues -- the out of pocket cost is high, even with insurance
03. Fear of the test/dislike of the test
04. Didn't think it is important or necessary
05. Lack of child care
06. Fear of the results
07. No transportation to get to a test
08. No regular doctor
09. Don't need it
10. Other (Please specify) ___________
98. Don't know
99. Prefer not to answer

CQ31Chronic

Do you or any member of your family have any of the following chronic or ongoing health problems? **READ LIST**. **MULTIPLE RESPONSE.**

01. Cancer
02. Diabetes
03. Asthma
04. High blood pressure
05. Obesity
06. Osteoporosis
07. Chronic heart failure
08. High cholesterol or arteriosclerosis

09. Arthritis
10. Alcoholism
11. Drug use
12. Mental health disorder
13. Are there any other chronic conditions? If so, please specify. _________
14. NO CHRONIC OR ONGOING HEALTH PROBLEMS **(DO NOT READ)**
98. Don't know **(DO NOT READ)**
99. Prefer not to answer **(DO NOT READ)**

Skip To: Q34Smoke If NO CHRONIC OR ONGOING HEALTH PROBLEMS (CQ31Chronic=14 or 98 or 99)

CQ32Help

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

1. YES
2. NO
3. ONLY FOR SOME OF THE ILLNESSES (PLEASE SPECIFY WHICH ONES) ____________

98. DON'T KNOW

99. PREFER NOT TO ANSWER

Display This Question if didn't get adequate help, or only for some of the illnesses (CQ32Help=2 or 3)

CQ33Help

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

____

SPLIT A

Q34-Q35 Asked together.

Q34Smoke

Does anyone living in the house vape or smoke cigarettes, cigars, pipes, or marijuana? INTERVIEWER: YOU MAY NEED TO PROMPT WITH "DO THEY SMOKE OR VAPE?" IF THEY JUST SAY "YES"

1. YES, SMOKE
2. YES, VAPE
3. YES, BOTH SMOKE AND VAPE
4. NO ONE IN THE HOUSE SMOKES OR VAPES

98. DON'T KNOW

99. PREFER NOT TO ANSWER

SPLIT A

Display This Question if smoke or vape. It should be displayed if any of the top 3 options are mentioned – either cigarettl ges/cigars/pipe, or vape, or both smoke AND vape (Q34Smoke=1 or 2 or 3)

Q35LungScreen

HAS THE HOUSEHOLD MEMBER WHO SMOKES OR VAPES EVER HAD A LUNG CANCER SCREENING?

1. YES
2. NO
3. SOME HAVE, SOME HAVEN'T
4. DON'T KNOW
5. PREFER NOT TO ANSWER

CQ36Injury

In the past 2 years, have you or has anyone in your household experienced a **traumatic injury** resulting from an accident or act of violence?

1. YES
2. NO

98. DON'T KNOW
99. PREFER NOT TO ANSWER

Display This Question if someone had an injury (CQ36Injury = 1)

CQ37InjuryFollowup

Was the injury from an accident or some sort of violence?

1. ACCIDENT
2. ACT OF VIOLENCE
3. BOTH
4. OTHER

99 PREFER NOT TO ANSWER

CQ38GoToPVHMC

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

1. YES
2. NO

98. DON'T KNOW
99. PREFER NOT TO ANSWER

Display This Question if have gone to PVHMC (CQ38GoToPVHMC=1)

CQ39WhyChoose

Why did you choose Pomona Valley Hospital Medical Center? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

01. CLOSE TO HOME (CONVENIENCE/LOCATION)
02. INSURANCE

03. REFERRED BY MY PHYSICIAN
04. TYPES OF SERVICES OFFERED
05. QUALITY/REPUTATION
06. WORD OF MOUTH (FROM A FRIEND, NEIGHBOR, FAMILY MEMBER, CO-WORKER)
07. INTERNET
08. NEWSPAPER, RADIO, OR TELEVISION
09. COMMUNITY PRESENTATION
10. OTHER (PLEASE SPECIFY) ________________
11. TAKEN THERE BY AMBULANCE IN AN EMERGENCY, SO THERE WAS NO CHOICE
98. DON'T KNOW
99. PREFER NOT TO ANSWER

CQ40Support
Have you or any member of your family attended any health-related classes or support groups at Pomona Valley Hospital Medical Center in the past year?
1. YES
2. NO
98. DON'T KNOW/ DON'T REMEMBER
99. PREFER NOT TO ANSWER

CQ41TypeSupport
What topics for classes or support groups might you or someone else in your family be interested in? **READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**
01. NOT INTERESTED AT ALL **(DO NOT READ)**
02. SMOKING CESSATION / STOP SMOKING
03. DIABETES
04. CANCER
05. HEART DISEASE, HIGH BLOOD PRESSURE, STROKE
06. GRIEF AND BEREAVEMENT
07. SLEEP APNEA/SLEEP DISORDERS
08. GERIATRIC CARE MANAGEMENT
09. MENTAL HEALTH OR SUBSTANCE USE
10. ALZHEIMER'S
11. NUTRITION, EXERCISE/FITNESS, WEIGHT MANAGEMENT
12. CPR CLASSES
13. FEMALE HEALTH CLASSES (PRENATAL, MISCARRIAGE, LACTATION, ETC.)
14. OTHER (PLEASE SPECIFY) ____________
98. DON'T KNOW
99. PREFER NOT TO ANSWER

CQ42EmergencyRoom

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

1. YES
2. NO

98. DON'T REMEMBER/DON'T KNOW
99. PREFER NOT TO ANSWER

Display This Question if have received services at PVHMC emergency room (CQ42EmergencyRoom=1)

CQ43WhyER

What was the reason emergency services were needed? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. INJURY OR ACCIDENT
2. CHEST PAIN/HEART ATTACK
3. STROKE
4. BREATHING DIFFICULTIES FROM THE "REGULAR" FLU OR A SINUS INFECTION
5. COVID-19
6. OTHER (PLEASE SPECIFY) _____________

98. DON'T REMEMBER
99. PREFER NOT TO ANSWER

Display This Question if have received services at PVHMC emergency room (CQ42EmergencyRoom=1)

CQ44SeeDRfirst

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

1. YES
2. NO

98. DON'T KNOW/DON'T REMEMBER
99. PREFER NOT TO ANSWER

Display This Question if have received services at PVHMC emergency room (CQ44SeeDRfirst=2)

CQ45ReasonWhyNoDr

What was the reason you didn't try to see your doctor before going to the emergency department? **DO NOT READ LIST. MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**

1. DON'T HAVE A REGULAR DOCTOR
2. IT WAS AFTER OFFICE HOURS
3. BROUGHT BY AMBULANCE

4. DOCTOR WAS TOO BUSY TO FIT ME IN OR TOLD ME TO GO TO THE EMERGENCY ROOM
5. IT WAS A TRUE EMERGENCY
6. OTHER (PLEASE SPECIFY) __________
98. DON'T REMEMBER
99. PREFER NOT TO ANSWER

CQ46HealthStatus
Would you say that in general your health is excellent, good, fair, or poor?
1. EXCELLENT
2. GOOD
3. FAIR
4. POOR
98. DON'T KNOW
99. PREFER NOT TO ANSWER

SPLIT A
Q47MentalHealth
Are you aware that there are community resources to help if someone you know is experiencing a mental health crisis?
1. YES
2. NO
98. NOT SURE
99. PREFER NOT TO ANSWER

SPLIT B
Q48BigNeed
The survey is almost done. What is the biggest health-related issue or service that people in your community need? **DO NOT READ LIST**. **MULTIPLE RESPONSE. CODING CATEGORIES ARE BELOW.**
01. AFFORDABLE HEALTH CARE
02. HOUSING AND SERVICES FOR THE HOMELESS
03. MENTAL HEALTH SERVICES
04. OBESITY
05. PREVENTIVE CARE
06. PLACE TO BUY HEALTHY FOODS AT AFFORDABLE COST
07. SERVICES FOR DIABETES
08. SERVICES FOR SENIORS
09. AFFORDABLE MEDICINE/PRESCRIPTIONS
10. SUBSTANCE USE OR ADDICTION TREATMENT

11. CANCER CURE/TREATMENT
12. COVID-19 TESTING AND TREATMENT
13. OTHER (PLEASE SPECIFY) ___________
98. DON'T KNOW
99. PREFER NOT TO ANSWER

CQ49HealthIssues

The following is a list of issues that can affect health and well-being. Have you or a member of the household experienced any of these issues? **INTERVIEWER: READ CATEGORIES AND CHECK ALL THAT APPLY. IF NONE APPLY MOVE TO NEXT QUESTION.** *(Programmer please make this so that an answer is not required)*

- ☐ Substance use
- ☐ Mental health condition
- ☐ Intellectual or physical disabilities
- ☐ Homelessness
- ☐ Domestic violence
- ☐ Living in an unsafe neighborhood with gangs, gun violence, and crime
- ☐ Malnutrition/hunger
- ☐ Incarceration
- ☐ Poverty/joblessness
- ☐ Children falling behind in school
- ☐ NONE
- ☐ Prefer not to answer

SPLIT B

Q50info

What are the best ways of providing you with information about important topics that affect overall health and well-being? Would you say community events, or at a doctor's office, or social media, or mail, or at your workplace, or at school?

1. COMMUNITY EVENTS
2. DOCTOR'S VISITS
3. TV OR SOCIAL MEDIA
4. MAIL SENT HOME
5. WORKPLACE

6. PUBLIC SCHOOLS
7. OTHER (PLEASE SPECIFY) _____________
8. NOT INTERESTED IN THE INFORMATION
98. DON'T KNOW
99. PREFER NOT TO ANSWER

CQ51DEI2

Please indicate your level of agreement with the following statements: "All community residents have equal access to community resources." **INTEVIEWER:** Do you strongly agree, agree, disagree or strongly disagree?

1. Strongly agree
2. Agree
3. Neither agree nor disagree
4. Disagree
5. Strongly disagree
98. Don't know
99. Prefer not to answer

Display This Question if have either gone to PVHMC or attended classes or went to the ER (CQ42EmergencyRoom=1 OR CQ38GoToPVHMC=1)

CQ52DEI3

"Based on my experience at Pomona Valley Hospital Medical Center, the staff reflect the diversity of the community." **INTEVIEWER:** Do you strongly agree, agree, disagree or strongly disagree?

1. Strongly agree
2. Agree
3. Neither agree nor disagree
4. Disagree
5. Strongly disagree
98. Don't know
99. Prefer not to answer

CQ53DEI5

"Lack of diversity, equity or inclusion in healthcare has negatively impacted my ability to receive the best care." **INTEVIEWER:** Do you strongly agree, agree, disagree or strongly disagree?

1. Strongly agree
2. Agree
3. Neither agree nor disagree
4. Disagree

5. Strongly disagree
98. Don’t know
99. Prefer not to answer

CQ54DEIsuggest
Next, what is the most important thing Pomona Valley Hospital Medical Center could do to enhance diversity and inclusion in your community?

____
____

CQ55educ
FINALLY, please answer a few questions about you and your background.
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 (Master's, Ph.D., MD, JD, etc.)
98. Don't know
99. Prefer not to answer

CQ56Marital
Which of the following best describes your marital status?

1. Single, never married
2. Married
3. Divorced
4. Widowed
5. Separated
6. Single, living with partner
7. Other (Please specify) ______________
99 Prefer not to answer

CQ57Hisp

Are you of Hispanic, Spanish, or Latino origin?
1. Yes
2. No
98. Don't know
99. Prefer not to answer

CQ58Race
How would you describe your race or ethnicity? Please check all that apply.
1. Asian or Pacific Islander
2. Black or African American
3. Caucasian or White
4. Hispanic
5. Other (Please specify) ______________
98. Don't know
99. Prefer not to answer

CQ59Age
What was your age at YOUR LAST birthday? ______________ (numeric 18-105)

CQ60Employ
Which of the following best describes your current employment status? Are you...
1. Working full-time for pay
2. Self employed
3. Working less than 30 hours a week for pay
4. Full-time student
5. Full-time homemaker, parent or caregiver
6. Unemployed and looking for work
7. Retired
8. Disabled and not able to work
9. OTHER (PLEASE SPECIFY) __________________
99 Prefer not to answer

CQ61longevity

How long (in years) have you lived in your community? _______

CQ62Income

Which of the following categories best describes your total household or family income before taxes, from all sources, for 2023? Is it….

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
98. Don't know
99. Prefer not to answer

CQ63Gender

What is your gender identity?

1. Female
2. Male
3. Non-binary
4. Prefer to self-describe: ____________

99 Prefer not to answer

That's all the questions I have for you. On behalf of Pomona Valley Hospital Medical Center, I want to thank you for completing the survey. Have a great day!

Appendix B

Delphi Instrument

Delphi Survey – 1/25/24 FINAL

Each person will have his/her own unique link when it is sent out.

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

Q1Intro

CSUSB's Institute of Applied Research is conducting the data gathering effort for Pomona Valley Hospital Medical Center's (PVHMC's) 2024 Community Health Needs Assessment. As part of that effort, we need to elicit the input of people who work with minority and medically underserved populations in PVHMC's service area. We need your help! You are receiving this short survey because you have first-hand in-depth knowledge of the health care needs of these populations.

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

The survey should only take about 10 minutes to complete. If you are interrupted while responding you can use the same link to get you back into the survey. We would appreciate it if you could complete it by **March 14, 2024**. If you have any questions or would like additional information about the survey, feel free to contact Dr. Barbara Sirotnik, bsirotni@csusb.edu. Thank you, in advance, for your help!

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

○ Agree to participate

○ Disagree (end survey)

Q2RespInfo

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

○ Name: ____

○ Organization you work for: _____________________________

○ What is your position? _________________________________

Q3Populations

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

☐ Children

☐ Senior citizens

☐ Homeless

☐ Victims of violence

☐ Women

☐ Low income

☐ Minorities

☐ People with language barriers

☐ Other (please specify) ______________________

Q4services

What types of services does your organization offer?

____

____

Q5healthPriorities

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

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

- ☐ More community-wide partnerships/collaboration
- ☐ Palliative care
- ☐ Home health services
- ☐ Reduced cost medications or medical supplies
- ☐ Dementia/Alzheimer's services and resources
- ☐ Day treatment/adult day care services
- ☐ Physical therapy/rehabilitation services
- ☐ Dental services
- ☐ Other (please specify)

Q6WhyPriorities

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

____
____

Q7Populations

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

____
____

Q8Services

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

____
____

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

____
____

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

____
____

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

____
____

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

____
____

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

○ Yes

○ No

Display This Question if willing to attend

Q14timeOfDay

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

- ☐ 8 AM
- ☐ Noon
- ☐ 4 PM
- ☐ 5 PM
- ☐ 6 PM
- ☐ Other (please specify) ________________

Display This Question if willing to attend

Q15day

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

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Doesn't matter

Thanks

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

Appendix C

Executive Interview Instrument

Community Health Needs Assessment 2024
Executive Interview

Part I. About your Agency

Date of Interview:

Agency:

Part II. Health Needs of Our Community.

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

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

Identified Need in the Community

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

Identified Need in the Community

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

Identified Need in the Community

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

Identified Need in the Community

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

Identified Need in the Community

Part III. Barriers to Health

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

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

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

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

Part V. Suggestions and Additional Comments

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