RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

2020 | 2021

Partners for Better Health

10 YEAR ANNIVERS

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Promoting User-Friendly Language Equity and Opportunity in the Digital Era of COVID-19 in Los Angeles County

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Los Angeles County Department of Public Health

The overall goal of this project is to improve measures of community participation and engagement by increasing digital access to LEP Los Angeles County residents during COVID-19

OVERVIEW

The Center for Health Equity is an agency that promotes racial, social, environmental and economic justice for all community members, particularly underserved communities, under the Los Angeles Department of Public Health. Given that the population size of Los Angeles County is approximately 10.04 million, limited-English proficient speakers, LEP, account for almost one-third of individuals within the county. According to the US Census Bureau, 17% of households do not have an Internet broadband subscription. Although this number may seem low, many of those unaccounted for are LEP families. LEP are more likely to suffer from disparities as part of racial/ethic minority groups and greater stressors related to ethnicity, gender, education, citizenship and/or discrimination. Although LEP who identify with different communities might experience aforementioned stressors at various levels, these stressors are further exacerbated by lack of digital equity. COVID-19 unveiled the digital divide and intensified the reality of disconnect among LEP in a digitally connected world. This project aims to benefit traditionally underserved communities and would follow an "inclusive investment" model, working toward equity for all communities, particularly, strengthening the inclusion of LEP. The LEP community has been largely underserved and investment within these communities has been extractive, disproportionately affecting BIPOC communities. This proposal works toward a community-centered investment through facilitated access and the promotion of increased participation between community members and LA County liaisons. The increase of participation will increase cultural competency in outreach programs through county efforts.

OBJECTIVE

The objective of this project is to determine the preferred and most user-friendly video conference application by translation and interpretation services and other service organizations in LA County. The most preferred video conference application by these organizations will be recommended to LA County Department of Public Health leadership staff, proposing to remove the current video conference application, Microsoft Teams, and replace it with an improved application that will help facilitate increased community outreach and engagement from county departments. In turn, the Center for Health Equity, in coordination with all public health, mental health and health services staff, will implement future outreach programs and/or services with the preferred video conference application and measure attendance and engagement.

CRITERIA FOLLOWED

- The application should have an easy to use interface. The application should be straightforward in creating a meeting link or dial-in number, sharing with others and adding people to the call.
- The application should feature screen sharing, annotation and live chatting capabilities.
- The application should feature text chat capabilities, thus giving the opportunity to text an individual question in a way that does not interrupt the presenter.
- The application should have a video recording feature in order to involve those who were unable to make the original recorded meeting for any reason. This increases equity by giving those with time conflicts or constraints to access the information received when they are able.
- Though not as imperative as the others, file sharing is a useful tool when interacting with video communication applications.
- Cross-device capability allows for participants to change their media platform, whether it is their laptop computer, desktop or cell phone. Given the strain of busy and impacted work schedules, it is imperative to have the opportunity to change devices, even during the session, in case there are adjustments that need to be made.

RESULTS AND NEXT STEPS

Although it was initially believed that Zoom would be the preferred video conference application according to Business Insider Statista data, our data results also demonstrated that 73.7% of contacted translation and interpretation service organizations preferred Zoom over other video conference applications. Based on these results, Center for Health Equity staff proposed the adoption of Zoom Business to improve multiple measures of digital literacy and community involvement among LEP, contributing to greater advantages in community services and addressing LEP needs. The following were the specific aims proposed to county superiors:

1. **To incorporate Zoom Video Conference's Small and Medium Business package, including the language interpretation feature, as the normative video communication application accessible to Los Angeles County LEP for community outreach events during COVID-19**
2. **To evaluate whether Zoom has beneficial effects on increased presence and participation among Los Angeles County LEP.**

BENEFITS OF THE ZOOM LANGUAGE FEATURE

Zoom is already one of the most recognizable and popular of video communication applications. According to Business Insider Statista data, Zoom ranks third as the most popular video communication application (aside from Facetime and Facebook Messenger, which are not conferencing platforms). The Zoom language interpretation feature also enables original audio simultaneously at a lower volume to facilitate understanding inflections and tones or mute original audio. The interpretation feature is the key component that strengthens the argument of Zoom as the best video conference application in this setting. The ability for participants to adjust the sound of the original audio contributes phonology to morphology, syntax, semantics and pragmatics to linguistics and the ability for an individual to improve their understanding of language. Furthermore, the simultaneous screen feature also allows for ASL participants to participate as well.

MATERNAL MENTAL HEALTH DURING COVID-19: POLICIES & PROFESSIONAL PRACTICE GUIDELINES

BRIDGET A. MIRANDA, MSN, FNP-C, DOCTORAL STUDENT

Project Aim

- Examination of the relevant global, national, and local policies, as well as professional practice guidelines related to Maternal Mental Health.
- Focus on the impact during COVID-19 and identifying strategies to deter long term effects on mothers, infants, families and communities.

Screened **Prevalence**

Figure 1. Select Evidence in the Literature: Screening and Prevalence for Postpartum Depression as reported during 2020-2021.

64%

Sixty-four percent of mothers experience some type of psychological stress 10% more incidence in mothers with very preterm infants (Harris et al., 2018).

MOTHERS WITH PSYCHOLOGICAL STRESS

POSTPARTUM DEPRESSION

20%

The prevalence of Postpartum Depression is nearly 20% globally (WHO, 2021).

Households with low incomes report higher maternal depressive symptoms (Garfield et al, 2016).

In Collaboration with

Azusa Pacific University

Center for Better Beginnings

Partners for Better Health
Randall Lewis
Health & Policy Fellowship

POLICY AND PROFESSIONAL PRACTICE GUIDELINES

NATIONAL H.R. 3235 2015

Bringing Postpartum Depression Out of the Shadows Act of 2015:
- State grants for culturally competent programs for screening and treatment during pregnancy up to 12 months postpartum.

NATIONAL ACOG 2018

American College of Obstetricians & Gynecologists:
- Screen for postpartum depression and anxiety with validated instrument during parental visit and postpartum visit.

CALIFORNIA AB 3032 2018

Requires hospitals to educate/inform Hospital Employees, Women & Families about the signs & symptoms of maternal mental health disorders, treatments, & community resources by 2020.

NATIONAL AAP 2019

American Academy of Pediatrics:
- Screen for postpartum depression at the 1-, 2-, 4-, & 6-month well child visits.

GLOBAL FIGO 2020

International Federation of Gynecology and Obstetrics provides interim guidance for COVID-19.
- **Mother/baby separation may impede bonding & breastfeeding causing postpartum stress.**
- **Healthcare providers should screen for depression, anxiety & suicidal ideation.**

GLOBAL WHO 2008 & 2015

Improving Maternal Mental Health:
- Prioritize prevention & management during pregnancy & postpartum.
- Integrate mental health needs into existing policies.

NATIONAL AAFP 2016

American Academy of Family Physicians:
- Use a stepwise approach for mental health screening when peripartum depression is suspected.

CALIFORNIA AB 1893 2018

The Department of Public Health shall investigate & apply for federal funding to finance maternal mental health programs in whole by federal funds by 2020.

CALIFORNIA AB 2193 2018

Requires licensed health care practitioners who provide prenatal or postpartum care to screen mothers for maternal mental health conditions by 2020.

NATIONAL USPSTF 2019

The U.S. Preventative Services Task Force:
- Screen and treat pregnant and postpartum women for depression.

Figure 2. Policy and Professional Practice Timeline

Proposed Maternal Mental Health Screening Timeline

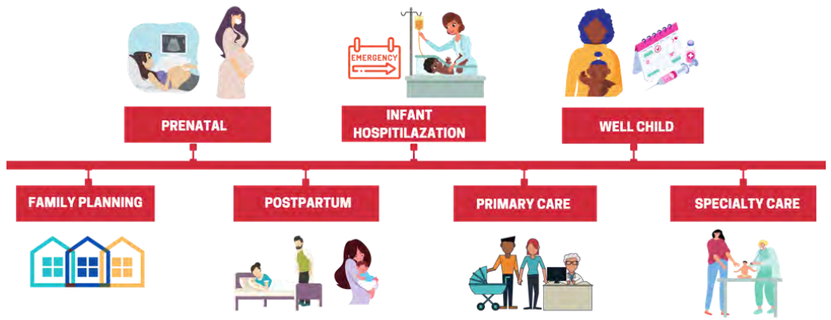


Figure 3. Proposed Timeline for Maternal Mental Health Screening

Public Health Implications

A Rapid Response to Maternal Mental Health during COVID-19.

- As a paramount public health issue, maternal mental health affects pregnancy, breastfeeding and the overall health and development of the mother/baby dyad.
- The Global Alliance for Maternal Mental Health emphasizes the importance of addressing maternal mental health by preventing what could lead to tragedy and suffering of women and families (2020). Identifying maternal mental health disorders deters the deleterious effects on the mother, child, family and communities (Slomian et al., 2019).
- To decrease the pre-existing disparities, equitable and culturally appropriate intervention is warranted.
- Expansion of consistent healthcare coverage to fund the cost of screening and treatment needs to be prioritized.
- COVID-19, a major public health event calls for a rapid response requiring systematic screening and treatment throughout the continuum of maternal and pediatric care.

AZUSA PACIFIC UNIVERSITY

CENTER for BETTER BEGINNINGS
Promoting Maternal Health And Child Development

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

Healthy RC Teen Summit
BUILD: Resilience, Your Best Self, Community, & Future

Chinyelu Odunze Ugwuanyi | Randall Lewis Health Policy Fellow
DrPH Student | Claremont Graduate University

Introduction and Background

City of Rancho Cucamonga
Healthy RC Division
Site: City Manager's Office
Preceptor: Hope Velarde, MPH

Mission: Healthy RC embraces the comprehensive, interrelated nature of health and works in partnership with all sectors to create a healthy and sustainable community.

Vision: Healthy Rancho Cucamonga – a community where all generations lead vibrant, healthy, happy lives.

Healthy RC is a comprehensive and integrated approach to **creating healthy bodies, minds, and a clean, sustainable earth**.

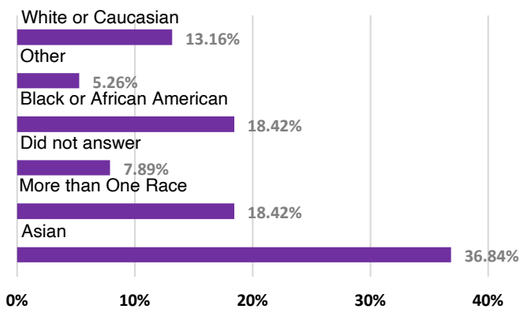
Healthy Body | Healthy Mind | Healthy Earth

Community Health Priorities
- Healthy Eating and Active Living
- Community Connections and Safety
- Education and Family Support
- Mental Health
- Economic Development
- Clean Environment
- Healthy Aging
- Disaster Resiliency

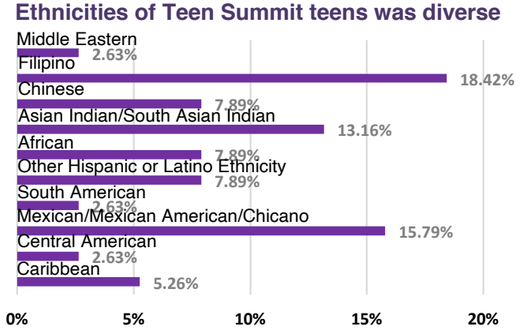
Rancho Cucamonga
- Large Population (est. 176K, 2019)
- Ethnically and Racially Diverse
- San Bernardino County (the largest county in the U.S.- land mass)

City Community Partnership
1. Internal City government
2. External across the community

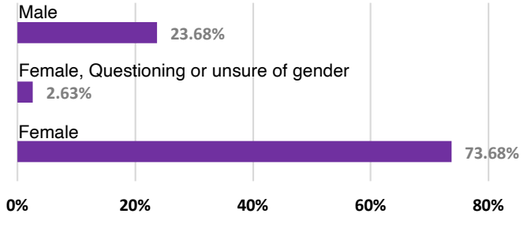
Race of Teen Summit teens was diverse



Ethnicities of Teen Summit teens was diverse



Gender of Teen Summit teens was diverse



Acknowledgements

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Hope Velarde, Preceptor
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Claremont Graduate University
Dr. Darleen Peterson, Academic Advisor

Sponsors

Healthy RC Teen Summit
BUILD: Resilience, Your Best Self, Community, & Future

Chinyelu Odunze Ugwuanyi | Randall Lewis Health Policy Fellow
DrPH Student | Claremont Graduate University

Program and Project Overview

Healthy RC Youth Leaders 3rd Annual Teen Summit (Virtual) I 3.24.21 I 9am-3:30pm I Free
Organizer: Healthy RC Youth Leaders
Invitee: Chaffey Joint Union High School District & City of Rancho Cucamonga Teens
Theme: "BUILD": Resilience, Your Best Self, Community, and Future
Goal: To provide a safe space for high school aged teens to come together to:
1. Harness the power of storytelling and address difficult topics:

Covid-19 | **Identity** | **Racial & Social Justice** | **Mental Health**
Social Media | **Failure** | **Diversity, Equity & Inclusion** | **LGTBQA**

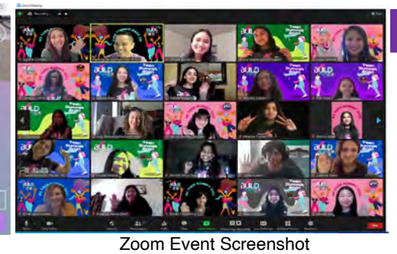
2. Participate in activities that provide tangible coping skills for teens to improve mental wellness.

Keynote Speaker & Panelists

Wellness Breakout Sessions

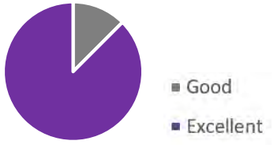
Community Leadership Activity

Website


Zoom Event Screenshot

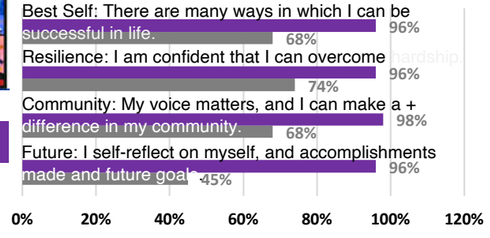
Results and Conclusion

100% of the teens rated the event well!



Results and Conclusion

The Teen Summit empowered teens to "BUILD resilience, [their] best [selves], community, and [futures]."



The Teen Summit was a success!
Empowered Teens!

Thriving Initiative I Meaningful Community Engagement I Healthier Community

Christine Lee | Azuza Pacific University

Maternal Attachment in the COVID-19 Pandemic: A Policy Analysis

Azusa Pacific University | Center for Better Beginnings
I. Christine Lee, PhD(c), MPH, RN

CENTER *for* BETTER BEGINNINGS
Promoting Maternal Health And Child Development

Problem

Immediate physical contact after birth is an essential facet in promoting maternal-infant engagement. Any suboptimal interactions during the time after birth can compromise an infant's development and attachment, creating serious long term cognitive, socio-emotional, and behavioral consequences. This engagement is foundational for future attachments along with the child's sense of self.

The COVID-19 pandemic has impacted the capacity of health services and delivery. Given the expectations of high transmission and risk to the dyad, hospitals enacted policies of maternal – infant separation. Health policy affecting the maternal-infant dyad intersects and influences nursing science, society, and potentially, the health of future generations.

Purpose

The purpose of this study is to examine policies enacted during COVID-19 in the State of California, nationally, and internationally which affect the maternal-infant dyad and attachment, including the following constructs:

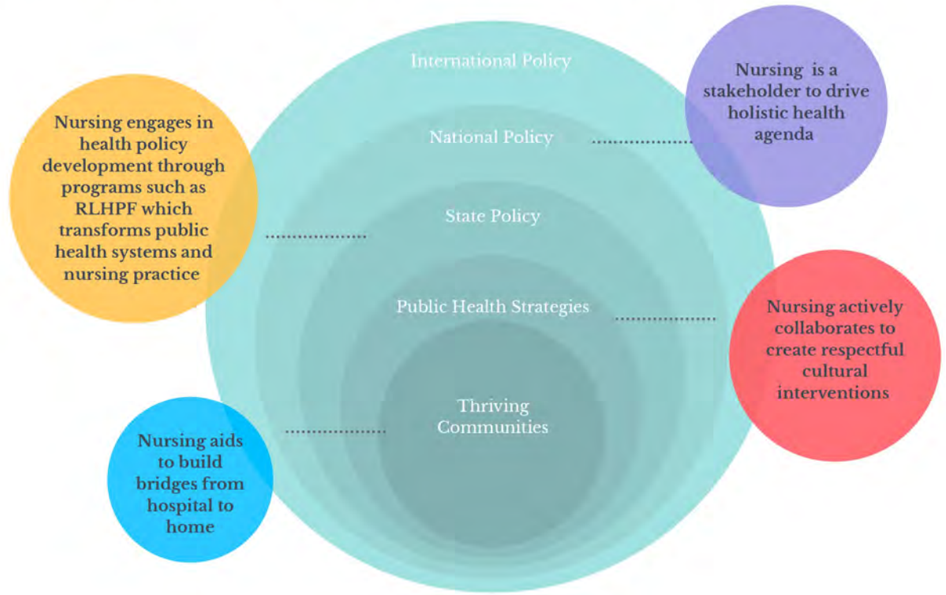
- Bonding: Skin-to-skin contact and breastfeeding
- Social support: Visitation policies during the COVID-19 pandemic

Findings

The inconsistent translation of guidelines has resulted in care considerations around hospitalized women who are both pregnant and/or breastfeeding and who are COVID-positive or persons under investigation; these considerations have created systematic policies that separate women from their infants. The World Health Organization had not changed its recommendation for breastfeeding initiation within the first hour of life despite a mother's COVID-positive status, skin to skin immediately after birth, or restrictions for a support partner at birth. Despite preliminary studies published early in the pandemic that confirmed minimal risk of of vertical transmission from mother to fetus, national organizations and state legislation were slow to align with policy standards established prior to the pandemic.

These inconsistent recommendations regarding COVID-19 have molded hospital policies, separating mothers and infants whenever they are suspected to be covid positive. This blanket separation unravels one of the innate developmental processes that provides fundamental and critical influences on the biopsychosocial health and wellbeing of mother and child.

Integrating Health Policy with Public Health Practice: Alignment Opportunities with Nursing



Implications

COVID-19 has highlighted the critical need for health policy to facilitate allocation of high-quality, cost-effective health care services that protect and preserve the maternal-infant dyad. There is a need to further reframe the relationship between nursing, public health, and policymaking. Health policy in breadth and depth needs to expand in order to align implications of nursing practice and public health programs to address social determinants of health and making demands through effective nursing practice processes and efficient nursing practice delivery systems.

Conclusion

The future is uncertain with anticipated waves of the pandemic for years to come. The disruption of maternal attachment through the separation of mother and infant due to the pandemic may have generational repercussions. Examining the impact of separation that occurs early in this pandemic will likely shape and inform future policies on separation and the subsequent disruption of the maternal-infant dyad.

Healthy Cities Toolbox

Deedhiti Dola | MPH (c)
Department of Public Health
California State University, Los Angeles

ABOUT SCAG

Southern California Association of Governments (SCAG) is the nation's largest Metropolitan Planning Organization (MPO), representing 6 counties, 191 cities and more than 19 million residents. The SCAG region is home to a diverse population and a variety of built and natural environments. SCAG is responsible for developing Regional Transportation Plan and Sustainable Communities Strategy (RTP/SCS) or Connect SoCal. The multimodal transportation and land use strategies have many co–benefits for improving health outcomes and present opportunities to ensure investments result in equitable health outcomes and benefit all populations in the region.

DEFINING PUBLIC HEALTH

Public health promotes and protects the health of people and the communities where they live, learn, work and play. While a doctor treats people who are sick, those working in public health try to prevent people from getting sick or injured in the first place. Public health outcomes are understood to be the product of the Social Determinants of Health (**Figure 1**), or the circumstances in which people are born, live, work, play, and age. Economic opportunities, government policies, and the built environment all play a role in shaping these circumstances and influencing public health outcomes. Importantly, many public health outcomes are influenced by agencies that do not have public health as a core mission, such as transportation and land use planning agencies.

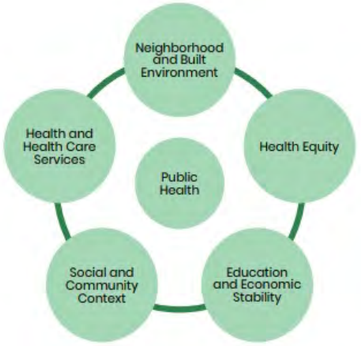
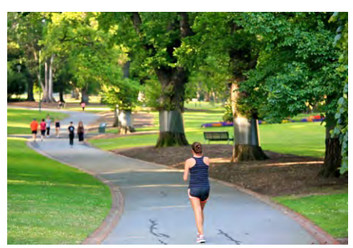


Figure 1: Social Determinants of Health

PURPOSE OF HEALTHY CITIES TOOLBOX

The **Healthy Cities Toolbox** supports local planning or policy processes that identify and implement opportunities to advance plans, projects, programs, and policies that improve community health. The Toolbox presents recommendations that may be effective in addressing public health impacts. These actions and strategies were identified through a review of literature and recent planning activities. Proposed actions and strategies could be effective for addressing public health impacts both across the region and within disadvantaged and vulnerable communities.



TOOLBOX USER GUIDE

The **Healthy Cities Toolbox** provides recommended actions and strategies and can be used as a checklist of possible considerations during plan, project, or program preparation. It is intended to help inspire planners to devise practices and approaches that are pertinent to local health conditions and needs. It examines seven different public health focus areas, which are shown on the next page.

PUBLIC HEALTH FOCUS AREAS

Accessibility to Essential Services

Affordable Housing

Air Quality

Climate Change

Economic Opportunity

Physical Activity

Transportation Safety

EXAMPLE: ACCESS TO ESSENTIAL SERVICES - EDUCATION

Education can lead to better jobs with improved compensation and benefits such health insurance, which can in turn lead to better access to quality health care. Higher earnings can also allow workers to afford better quality housing and help them maintain healthier diets. Students in high poverty schools are twice as likely to be chronically absent as students in low poverty schools. Chronic absenteeism has been shown to have significant negative impacts on student performance and graduation rates, which impact future job prospects.

Recommended Practices and Approaches for Improving Access to Education

Expand affordable, local e-bike, and scooter share program to increase the access to school.

In 2018, the City of Santa Monica launched a new Shared Mobility Pilot Program with four operators – Bird, Lime, Lyft, and Uber – managing the city's e-bike and scooter share.

Provide free bus access to youth.

Some local Examples: Riverside Transit Agency (RTA) free ride program, Metro's Fareless System Initiative.

Establish and maintain routes to schools by developing and sustaining Safe Routes to School (SRTS) programs supporting safe and convenient ways for children to walk, bike, or take public transit to school.

Some local examples: Regional SRTS program in San Bernardino County, City of Los Angeles SRTS program, Imperial County SRTS program.

Preserve and expand affordable housing in neighborhoods with high-performing schools through proactive policies (e.g., inclusionary zoning), enforcing fair housing laws, and dismantling exclusionary land-use policies.

Santa Monica passed an inclusionary zoning policy for its downtown area in 2017. Some other local examples include: City of Claremont Inclusionary Housing Program, City of Irvine Inclusionary Housing Ordinance.

For more information visit: https://scag.ca.gov/public-health

Diana Hong Hanh Tran | California Baptist University

COMMUNICATION

A FOUNDATIONAL COMPONENT FOR HEALTHY COMMUNITIES PLANNING

By Diana Tran, MPH Candidate

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

Partners for Better Health

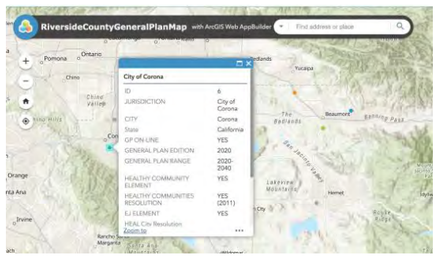
Riverside University HEALTH SYSTEM Public Health

CBU

INTRODUCTION & PURPOSE

The Riverside County Healthy Cities Resolution was adopted in 2011 because Riverside county ranked 35th out of 58 in California for adult obesity rates, and 52nd for its built environment conducive to health (Robert Wood Johnson Foundation, 2011). As a result of these resolutions, the county has introduced and established different initiatives to improve its residents' health and wellness. The following communication projects were renovated and implemented to provide residents with awareness and easier access to healthy community resources.

GIS MAPPING PROJECT



A new, interactive Riverside County Healthy Cities Network map was created on the ARCGIS platform, laying out the county's 28 cities and includes information regarding each cities' general plan, the cities' progress in the different elements, and will be available for public access. This will allow residents easy access to their cities' current built environment plans and allow residents to be informed on how these plans could personally affect them. Information used to make the GIS map was gathered from 28 Riverside County city websites, as well as through contacting each city's planning department for updated information. The data was then placed into an Excel spreadsheet and uploaded to the ARCGIS application.

PLANNERS4HEALTH

As a part of the APA CA Planners4Health (P4H) chapter, fellows are involved in advancing the P4H initiatives by organizing the annual P4H Summit, bringing together planners from all over California to discuss the need of inter-professional collaboration between urban planners and public health professionals to develop healthy communities and fight against health inequities.

APA CAP4H INITIATIVE

RIV CO HEALTHY CITIES NETWORK NEWSLETTER

Since 2016, the Riverside County Healthy Cities Network publishes a monthly newsletter targeted towards public health professionals and the community, featuring the most current news and trends in developing healthy communities. This year, the newsletter has been transferred from a standard PDF format to MailChimp, allowing for more accessibility and a user-friendly interface. Some topics covered in the newsletter include bringing awareness to CBO's, the Tobacco Control Project, COVID-19 updates, Active Transportation Network events, and other resources. The newsletter reaches on average 300 people each month.

DRACAEA AVENUE CAMPAIGNS

The Dracaea Avenue campaigns consisted of both virtual and in-person events that brought awareness, surveyed, and received feedback from hundreds of Moreno Valley residents regarding street changes over the 4-mile stretch of Dracaea Ave. The social media campaign was in both English and Spanish to ensure accessibility for the large Latino population in Riverside County.

These projects demonstrate the significance and necessity of communication and developing new, innovative ways to bring together professionals and community members. Communication is the first step to opening discussion, bringing forth awareness on the needs of the community, and what needs to be done by planners for the built environment to best accommodate disadvantaged populations. Communication is an essential and vital tool needed to influence behavior change and for the advancement of healthy communities and health equity.

Expanding Data Sources for SCAG's Active Transportation Database: Adding Permanent Bicycle & Pedestrian Counters

Emily Beglarian, Claremont Graduate University

Who is SCAG?

Southern California Association of Governments, or SCAG, is the country's largest council of governments. SCAG serves as the metropolitan planning organization (MPO) for over 18 million people in Southern California. The SCAG region contains 6 counties, including Los Angeles County, and covers almost 40,000 square miles. SCAG's work includes sectors such as transportation, sustainability, and housing.

What is Active Transportation?

Active transportation "refers to human powered transportation and low speed electronic assist devices" (SCAG). This includes transportation such as biking, walking, and scootering. Active transportation is a healthy alternative to car travel, and an effective way to reduce air pollution! According to the American Public Health Association, active transportation can have a significant impact on public health.

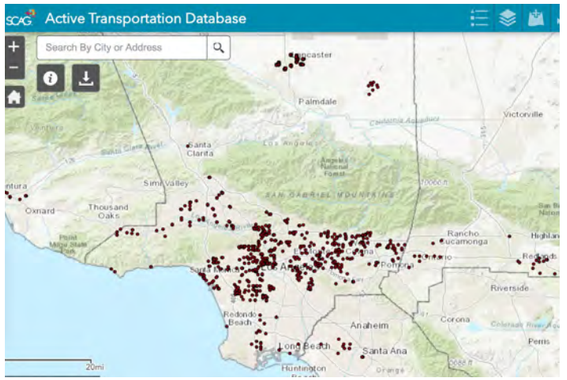
"Making active transportation a realistic, affordable and convenient option for all transportation users would help reduce health impacts and also promote physical activity, recreation and environmental preservation."

- American Public Health Association

California's Active Transportation Program

The majority of funding for SCAG's Active Transportation projects is provided by the California Active Transportation Program. This program was created in 2013 by Senate Bill 99 and Assembly Bill 101 to consolidate existing transportation programs. The Active Transportation Program has six main goals, two of which are significantly related to public health:

- The enhancement of public health, including (but not limited to) the reduction of childhood obesity
- Confirming that disadvantaged communities are able to share equally in the benefits of the program.



The Active Transportation Database was developed to collect and store active transportation data, such as bicycle and pedestrian counts, across the SCAG region. The Active Transportation Database (ATDB) was developed with the intention to support active transportation planning by cumulating historical and current active transportation data. This data can be used while considering future plans and policies within the SCAG region. The database was recently made to be compatible with automated permanent counter technology.

Fellow Tasks:

Incorporate new data sources into the Active Transportation Database by acquiring access to agencies' automated counter data and adding it into the ATDB. In total, 12 counters were added from San Luis Obispo Council of Governments and the cities of Long Beach, Santa Monica, and Ventura. The ATDB now has access to past and current data from these locations.

Impact and Considerations

- The Active Transportation Database now has multiple locations where longitudinal trends can be observed over multiple years. These trends can be used in program planning and policy development.
- Although automated permanent counter technology is useful, it is also expensive. Agencies with low Active Transportation budgets may not have the ability to purchase permanent counters.
- In the future, SCAG may consider developing a grant program to assist agencies with funding to purchase automated permanent counter technology.

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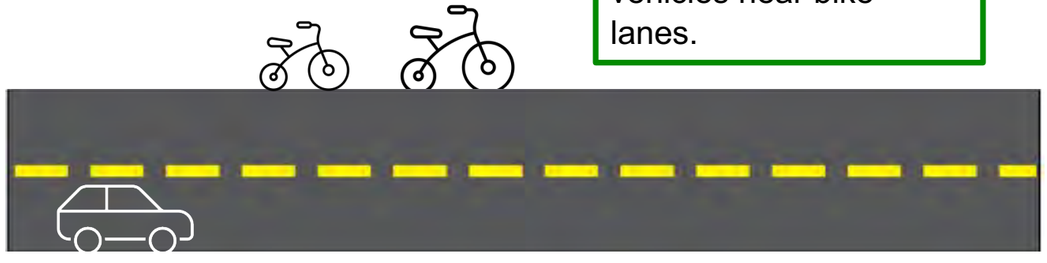
Getting Everyone to Actively Ride

Erica Park | Claremont Graduate University

Getting Everyone to Actively Ride (G.E.A.R.) began as a program to promote active transportation among city employees. Today, the program has expanded to include all Perris residents. The overall goal of G.E.A.R. is to reduce obesity and carbon emissions within the community and increase access to resources. These resources include grocery stores, parks, and schools.

G.E.A.R. involves expanding Perris's bike lanes and educating Perris residents regarding safe active transportation. This includes how to safely ride a bike as well as how to safely drive vehicles near bike lanes.



Within the last year, Perris has applied for two grants: a Southern California Association of Governments (SCAG) grant and a Community Development Block Grant (CDBG). The SCAG grant aims to expand Perris's bike lanes while the CDBG aims to connect Perris's existing bike lanes. The City decides where to propose new bike lanes based on demographic information such as income, access to vehicles, and access to available resources (grocery stores, etc.).

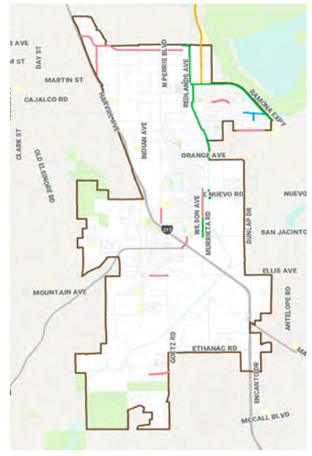


Figure 1: Perris's current bike lane system.

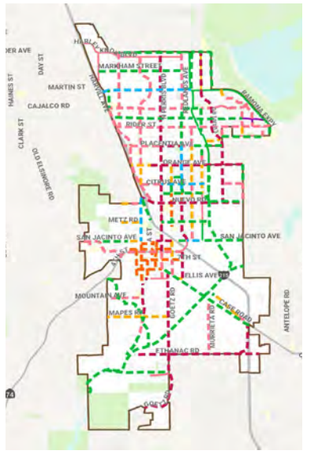
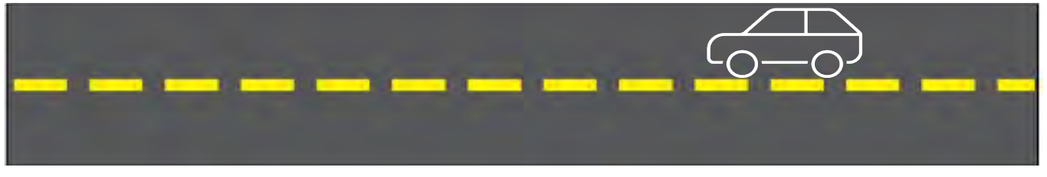


Figure 2: Perris's proposed bike lane system.

Social media will be heavily utilized to promote G.E.A.R. Educational posts will also be made to ensure that the bike lanes are being used properly. Surveys will be sent to Perris residents to gauge interest in G.E.A.R. and other forms of active transportation.



Clearing the Air Initiative

By Haley Welch

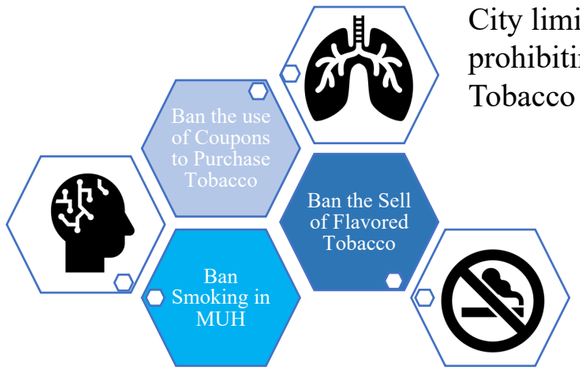
The City of Perris

Creating a Healthy Community

The Clearing the Air Initiative strives To improve the health of the Perris community by promoting individual, community, and City platforms that reduce and prevent tobacco use through multi-sectoral participation in tobacco control.

To increase awareness of the risks associated with tobacco usage through educational campaigns and introducing environmental policies that improve resident's access to clean air and protection from the risks of second-hand smoke exposure.

In order to prohibit the adverse heath effects of second-hand smoke, the Clearing the Air Initiative through the City of Perris' Public Health Department, aims to ban smoking within Multi-Unit Housing complexes within the City limits. Along with prohibiting the sell of Flavored Tobacco and coupon use.



The City of Perris

Creating a Healthy Community

Multi-Unit Housing

Multi-unit housing encompasses any form of public and private housing that encompasses multiple units which are close enough in proximity that second-hand smoke, produced in one apartment,
Can spread through:

- Doorways, cracks in walls etc.
- Ventilation such as windows and fans.

Flavored tobacco, such as vapes, have become popular amongst teens.

Currently:

10,000
new teens each year get hooked on tobacco in Riverside County.
Riverside County Tobacco Control Project, "Tobacco Retail Licensing: Riverside County. MMWR

1 in 5
high schoolers and 1 in 20 middle schoolers currently use e-cigarettes.
Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA

The Clearing the Air Initiative will help create a healthier Perris for all residents.

COVID-19 Vaccine Awareness Campaign

Witten by Ibrahim Kamel MD, MHA
Preceptors: Cathy Rebman, Roldan Aguilar

According to the San Bernardino County data, Spanish-speaking communities are disproportionately affected by the COVID-19 pandemic.
In 2018, the most common non-English language spoken in San Bernardino County was Spanish, with 36.4% of the overall population of the county being native Spanish speakers. We worked with local community partners to spread awareness regarding safety measures and vaccine availability.

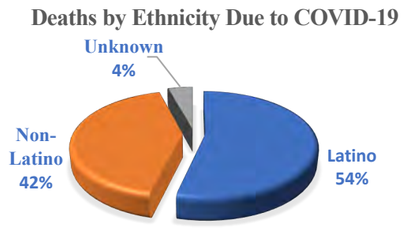


Figure 1. Death by ethnicity. 03/07/2021
Source: San Bernardino County COVID-19 Dashboard

San Antonio Regional Hospital recognized that traditional forms of media meant to increase awareness about emergencies do not simplify the information and are not shared directly with the local communities in Spanish language. In fact, they are often left in the dark and vulnerable to misinformation about life-saving measures and precautions, including information about the COVID-19 pandemic.

Community Partners

To bridge health and communication disparities, San Antonio Regional Hospital launched this awareness campaign focused on Spanish-speaking communities using radio segments, social media, digital flyers, and online video series with critical information about COIVD-19 and vaccines. The campaign materials are adapted to fit the Spanish community and work to debunk false information about the SARS-CoV-2 and vaccines. In addition to the information about COVID-19, the materials included links to the vaccine scheduling site.

Currently, the vaccination efforts are trending in the correct direction, covering the hardest his communities, as visible from the San Bernardino County vaccination data. Also, our success metrics indicate that a significant number of community members are receiving the message.

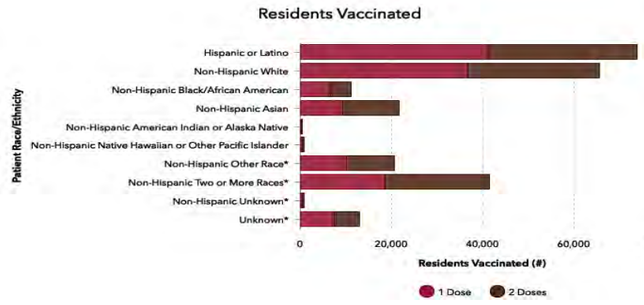


Figure 2. Residents Vaccinated.
Source: San Bernardino County COVID-19 Vaccination Dashboard

Recommendation

Community partners are an asset in eliminating health inequity and increasing population health. Local organizations are interested in improving the community they serve, but it is challenging to communicate with all the different organizations without a unified communication method.
A task force should be created to streamline the communication and dissemination of up-to-date information to benefit the entire community.

It's About US

...It's not just about me...it's not just about you

#StigmaFreeULV

Irena Krivenko
MHA Student

Randall Lewis Center for Well-Being and Research
University of La Verne

University of La Verne

#StigmaFreeULV Campaign

In collaboration with The Randall Lewis Center for Well-Being and Research, Office of Student Life, Student Outreach and Support, University of La Verne has launched #StigmaFreeULV campaign in order to break the negative perception of viewing mental health and mental health illness as a sign of weakness. The goal is to reduce the stigma associated with asking for help with common challenges like loneliness, anxiety, depression, or worry about the future. The campaign also wants to bring greater awareness to support options that already exist on campus to deal with these challenges.

Core: The campaign incorporates videos from students, faculty, and staff describing their own personal challenges and how they have coped with them. The videos are featured weekly on the social media with the message of encouragement and support of working together to decrease the stigma of depression, anxiety, loneliness by increasing the awareness and understanding/accepting challenging times.

Strategies: The campaign aims to incentivize any programming supporting mental health and/or social support. Every time a student participates in Stigma Free ULV, he/she enters into a raffle for a monthly prize such as tidbit watch. February 2021, 18 students entered for a raffle to win tidbit.

Goals: Utilizing Campus Labs to collaborate and track program participation, the early data indicates that although majority of students may have Zoom fatigue due to remote schooling, the campaign is on track to gain awareness among ULV students with events such as Mental Health Mondays presenting different theme every week and campus resources such as CAPs (Counseling and Psychological Services) directed towards assisting students who struggle during these challenging times.

Randall Lewis Center for Well-Being and Research
University of La Verne

“ Living God's love by inspiring health, wholeness and hope.”

Adventist Health Simi Valley (AHSV) is a hospital organization, one of seven health agencies that came together to become the Ventura County Community Health Needs Assessment Collaborative (VCCHNAC) that has a miraculous relationship with engagement and alliance with community-based organizations it increases engagement and alliance in the surrounding area of Ventura County. Events such as brushfires that affected the surrounding communities of Moorpark and Thousand Oaks, and the COVID-19 pandemic, which brought many households to seek various forms of aid such as food outlets from community-based organizations (CBOs). Schools were closed and public organizations were not open to serve the community, therefore, a number of children and parents lost resources and services. This pandemic brought the prevalence of food security as the main indicator of a household’s well-being and access to nourishing meals-- at least to meet dietary needs to lead a productive and healthy life. The combination of environmental disasters and a global health crisis have placed significant pressure on already strained food distribution organizations at both the community and state levels. AHSV stakeholders have surpassed in this past year's public health crisis. However, the hospital readmissions of underlying individuals, who have one of the diagnosis-related groups: sepsis, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease are discussed here. This staggering readmission rate is costly and overly burdensome for the patients that have gone through the emergency department. Unhealthy lifestyle behaviors and symptoms are the causes of high mortality rate, frequent readmission hospitalization, and low quality of life. As mentioned in Ventura County Community Health Needs Assessment 2019, the inception of the CHAMP® (Congestive Heart Active Management Program) demonstrated the decreased hospital readmissions for CHF, which are listed below:

FY19 Q-1, 75 enrolled with 0 Heart Failure readmissions

FY19 Q-2, 62 enrolled with 4 Heart Failure readmission

FY19 Q-3 100 enrolled with 4 Heart Failure readmissions

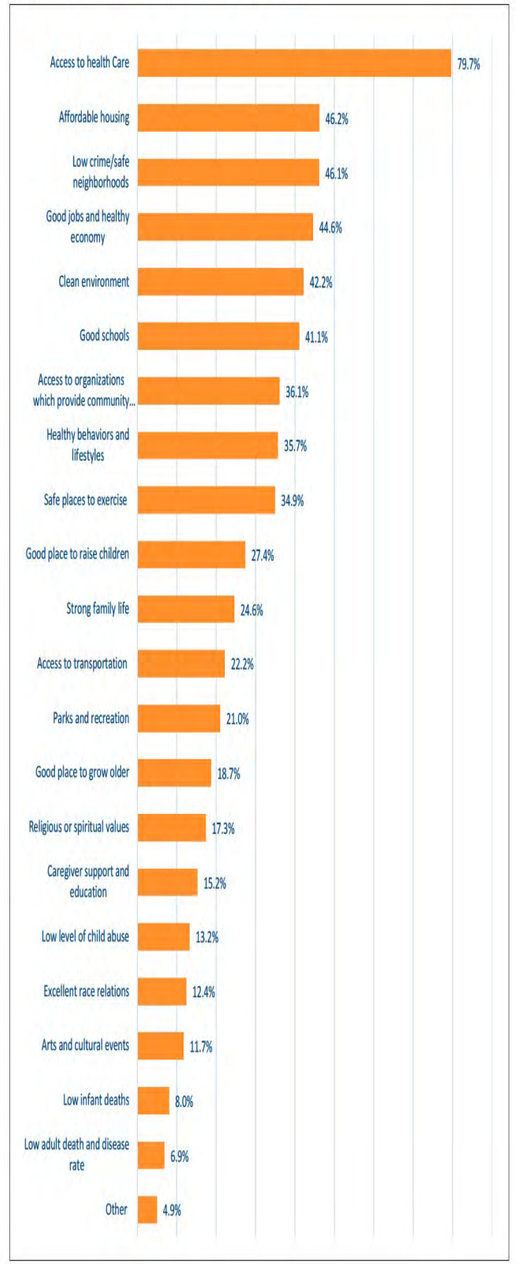
Written by: Jacqueline Nguyen, MHA | University of La Verne | Preceptor: Kathryn Stiles
Ventura County ‘s Community Health Needs Assessment
Randall Lewis Health Policy Fellowship 2020/2021

Ventura County’s Community Health Needs Assessment Collaborative (VCCHNAC)

One of VCCHNAC’s objectives is the Caregiver Patient Navigator education tools. The purpose of the educational tools implemented is to remove barriers to effectively coordinated clinical care and outpatient care. This is accomplished by engaging family members who will be serving as caregivers with coordinated care resources and by providing strategies after their loved one has been discharged from the hospital. The education for caregivers methods was as follows: a) I identified gaps in coverage and recommended resources to assist overburdened caregivers, and it ultimately improved care and coordination; b) The clinicians to work with caregivers to address any questions, challenges, or concerns the family of the caregivers might have; c) The caregivers’ were given tools to consider preparedness and response to various environmental factors.

A study has been conducted on the underlying condition of heart failure in ages above 65 years who are dependent on others for self-care and have lost their independence. Hence, caregivers become the physical, psychological, and socially responsible for patients: this is often referred to as the burden of care (Ghasemi et al., 2020). Studies have shown that there is a relationship between caregiver burden and family functioning in the family caregivers of older adults with heart failure. Family functioning is the social and emotional communication of family members and is the way people solve problems. It was recommended that programs that involve promoting adaptive skills and enhancing caregivers’ knowledge, attitudes, and beliefs have been shown to be effective in reducing the burden of care (Ghasemi et al., 2020). It is important to alleviate the burden of care on caregivers because pain and suffering can negatively impact the health outcomes of patients’ underlying illnesses.

FIGURE 51: FACTORS THAT IMPROVE LIFE IN THE COMMUNITY



References:

Ghasemi, M., Arab, M., & Shahrbabaki, P. M. (2020). Relationship Between Caregiver Burden and Family Functioning in Family Caregivers of Older Adults With Heart Failure. Journal of Gerontological Nursing, 46(6), 25-33.

https://doi.org/http://dx.doi.org/10.3928/00989134-20200511-04

https://www.cdc.gov/heartdisease/heart_failure.htm

Ventura County Community Health Needs Assessment 2019

ADVENTIST HEALTH WHITE MEMORIAL FOOD SECURITY PROGRAM SURVEY

BY: Jamila Cervantes
Randall Lewis Health & Policy Fellow
California State University, Los Angeles

BACKGROUND

Based in East Los Angeles, the Community Information Center (CIC) at Adventist Health (AH) White Memorial is not simply a resource hub: staff provide robust programming to meet the changing needs of the broader Los Angeles Community. Under the vision of Rosa Navas, Director of Community Well-Being, the CIC continues to transform to carry out AH's mission of, "living God's love by inspiring health, wholeness and hope," especially in the realm of food security.

Food insecurity and in-access posed an ongoing threat to the general well-being of the East Los Angeles and Boyle Heights community long before the COVID-19 pandemic. AHWM/CIC launched several initiatives in effort to alleviate hunger and malnutrition, such as establishing a community garden and sponsoring a weekly farmer's market. But in March of 2020 when the pandemic struck, community friends responded by bringing donated healthy produce and other food to the AHWM Community Garden to share with those in need.

In June 2020, this effort was formally recognized by AHWM/CIC's leadership and since has established partnerships with organizations that rescue surplus food to relieve hunger, such as Food Forward and Gleanings for Hunger, to create the Food Security Program at AHWM. While over 563,000 pounds of food were distributed between September 2020 and January 2021, little information was known of those who participate in the walk-up, drive-up food distribution.

METHODS

Using material originally developed by the Natural Resources Defense Council, I drafted a survey that would eventually be administered to AHWM Food Security program participants. I translated the document from English to Spanish; and gathered feedback from volunteers, staff, and colleagues about the language, format, and flow of the surveys. Heeding the recommendations from staff and mentors, I distributed the surveys in paper form, providing all participants with individual pens to prevent the spread of COVID-19. While 217 surveys were collected, only the data from 212 surveys was used, since the other five proved illegible. The data was prepared and coded in Microsoft Excel (see **FIGURE 1**) and analyzed using SPSS. In addition to organizing the results into an infographic/visual report-back, I also used ArcGIS to map the results.

#	Age	Transportation means	How did you find out?	How often do you come here?	How long have you been coming here?	Language
0	18-29	Car	Word of Mouth	Once a week	Since June 2020	Spanish
1	30-40	Walking	Online	Twice a week	Since July 2020	English
2	41-50	Bus	Flyer	Monthly	Since August 2020	
3	51-60	Train/Metro	Sign Outside	First time	Since September 2020	
4	61-70	Taxi/Uber	Other	Rarely	Since October 2020	
5	70+	Mixed Method: Bus + Walking	Vive Bien	Twice a month	Since November 2020	
6			Hospital		Since December 2020	
7					Since January 2021	

FIGURE 1. EXAMPLE OF CODING PROCESS

SURVEY RESULTS

ZIP CODES REPRESENTED

The follow three zip codes were the most represented among our respondents:

- 90033, Boyle Heights (42%)
- 90063, City Terrace (10%)
- 90031, Lincoln Heights (10%)

AGES REPRESENTED

- 77.8% of all survey respondents are 41 years of age or older
- 60.4% of all survey respondents are 51 years of age or older

HOUSEHOLDS REPRESENTED

- 28.8% (majority) of people who responded to the survey do not have children under the age of 18 at home

PARTICIPATION FREQUENCY

- 75% of survey respondents go the food distribution one or two times per week every week

REASONS FOR COMING

- 26.8% of responses mentioned that participants came because it was close to home
- 18% of responses cited financial struggle/unemployment as their reason for participating
- 14% mentioned they dropped by before/after their visit to AHWM for other services

COMMUNICATIONS

- 65% of respondents heard about the program through word of mouth
- 12% of respondents learned about the program from the sign outside

TRANSPORTATION REPRESENTED

- 52.8% of respondents travel to the site by car
- 38.2% of respondents walk to site

TOP 3 RESOURCES REQUESTS

1. Resources on food banks/pantries
2. Resources on rent/mortgage/utilities assistance
3. Resources on/for COVID

TOP 3 CHANGES TO IMPROVE ACCESS TO FOOD

1. More hours and/or days at AHWM
2. Additional programs near their homes
3. The ability to make an appointment/reserve food

RECOMMENDATIONS

- **Food security policy:** In the last few years, we have seen an attack on policy that supports food security, such as stringent ABAWD requirements for SNAP. Policy that intends to support food security should loosen work requirements/other barriers to food security.
- **Rent cancellation/renters' eviction moratorium extension:** An alarming amount of responses pointed to people needing resources around rent assistance. As such, policy that intents to adjacently improve food security should also focus on increasing housing security.

Jane Lam | USC

Environmental Justice Toolbox

The Environmental Justice (EJ) Toolbox supports local planning or policy processes intended to identify and implement opportunities to advance equitable plans, projects, programs, and policies that improve outcomes for EJ communities. It provides recommended practices and approaches for nine different EJ topics for the six counties in the SCAG region: Imperial, Los Angeles, Orange, Riverside, San Bernardino, and Ventura.

- **Healthy, Safe, and Sanitary Housing**
- **Climate Vulnerability and Resiliency**
- **Impacts of Road Pricing Mechanisms**
- **Access to Essential Services and Facilities**
- **Roadway and Aviation Noise Impacts**
- **Community Outreach and Engagement**
- **Active Living, Active Transportation, and Physical Activity**
- **Air Quality and Pollution Exposure Impacts**
- **Other Policy Recommendations for EJ Impacts**

What is environmental justice?

The fair treatment of people of all races, cultures, and incomes with respect to the development, adoption, implementation, and enforcement of environmental laws, regulations, and policies.

Source: State of California Department of Justice

What are environmental justice communities?

Low-income communities of color experiencing disproportionate negative environmental impacts that affect their access to more mobile, sustainable, and prosperous futures.

SCAG INNOVATING FOR A BETTER TOMORROW

CONNECT SoCal

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

Keck School of Medicine of USC

E X A M P L E

Climate Vulnerability and Resiliency

Climate change already impacts all communities in California, but EJ communities can potentially suffer disproportionately higher adverse impacts when EJ is not considered during the planning process. Extreme heat, flooding, wildfire, drought, and sea-level rise are hazards that can harm people and present risk to the built and natural environment.

Below are examples of existing projects, programs and policies that local jurisdictions and community members can reference during their planning process to address climate vulnerability and resiliency.

Example Practices & Approaches

Project Examples

- California Department of Public Health (CDPH), California Building Against Resilience Against Climate Effects (CalBRACE) Initiative

Program Examples

- City of Los Angeles Cooling Center Program
- City of Riverside Heat Response Plan

Policy Examples

- California Air Pollution Control Officers Association, Model Policies for Greenhouse Gases in General Plan (2009)
- Ventura County Tree Protection Ordinance

About SCAG

The Southern California Association of Governments (SCAG) is the nation's largest Metropolitan Planning Organization (MPO), representing 6 counties, 191 cities and more than 19 million residents. The SCAG region is home to a diverse population and a variety of built and natural environments. With this diversity comes a wide range of health outcomes and challenges, but also opportunities to plan for healthy communities and to prioritize policies that support healthy outcomes for people of all ages and socioeconomic backgrounds. SCAG is responsible for developing the Regional Transportation Plan and Sustainable Communities Strategy (RTP/SCS), or "Connect SoCal". The multimodal transportation and land use strategies of Connect SoCal include many co–benefits for improving health outcomes and present opportunities to ensure investments result in equitable health outcomes and benefit all populations in the region.

For more information visit: https://scag.ca.gov/environmental-justice

A Sustainable Approach to Keeping Families Housed

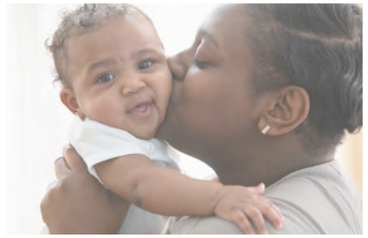
Joyce Paraico
MPH Urban Community Health Candidate
California State University Los Angeles Public Health Department

Introduction

Jamboree Housing Corporations seeks to deliver high quality affordable housing and services that transform lives and strengthen communities throughout California. As Orange County's largest developer of supportive housing, Jamboree fosters strong , health sustainable communities of every individual and family who experience homelessness. For over 30 years, Jamboree prides itself in providing more than a shelter, by providing more affordable housing through integrity, accountability and respect for the community. Jamboree Housing has partnered with housing developers, cities, lenders and contractors in an equitable manner. This ripple effect of equity has improved individual's overall quality of life. A new wave of opportunity has given every resident at Jamboree the opportunity to live in a strong, healthy and sustainable community.

What is Permanent Supportive Housing?

"Permanent Supportive Housing (PSH) combines affordable housing with voluntary supportive services (i.e. case management, physical, and mental health services, substance abuse treatment services) to address the needs of chronically homeless individuals" (Raven et al., 2020). Housing plays as an essential platform for human and community development. Stable housing is the foundation on which stable lives are built. Jamboree Housing Corporation has created more than just housing as a shelter but also safe, nurturing, and cohesive community with responsive on-site residential services. Their Permanent Supportive Housing program seeks to foster strong , health sustainable communities of every individual of all ages. Jamboree seeks to provide measurable outcomes based on Social Determinants of Health (SDOH).



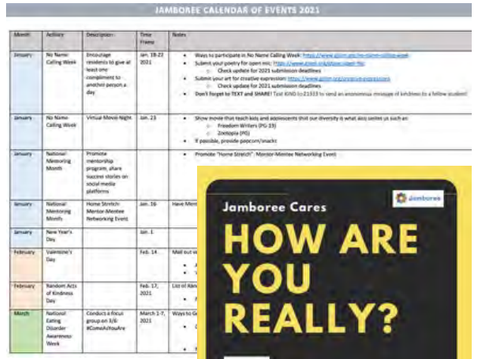
Summary of the Need

Research shows the severity of homelessness nationwide as the U.S. Department of Housing and Urban Development (HUD) estimated that 610,042 people were homeless on a single night in January 2013 (Benson, 2015). Similarly, there are barriers face are incessant. Chronic homelessness is tied to an increase of morbidity, mortality, and victimization. Studies have shown that homeless individuals with a diagnosis of concurrent mental and substance use disorders have more frequent use of emergency department and inpatient hospital services. "The rate of mental health illness in the homeless population is higher than that in the general population" (Benson, 2015). PSH is targeted to those who face the most complex challenges of homelessness, low-income, or diverse disabilities. Considering this, part of the cost of supportive housing may be offset by relieving the cost burden of homeless adults with disability on public health systems of care.

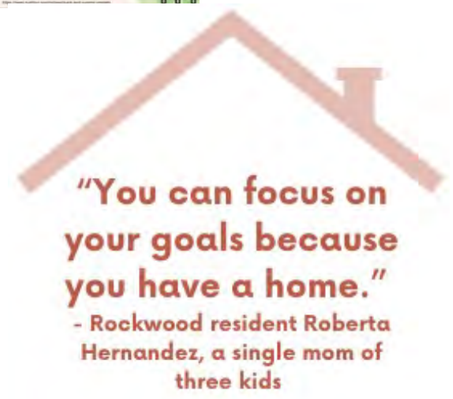
Benston, E. A. (2015). Housing programs for homeless individuals with mental illness: Effects on housing and mental health outcomes. Psychiatric Services, 66(8), 806-816. https://doi.org/10.1176/appi.ps.201400294
Raven, M. C., Niedzwiecki, M. J., & Kushel, M. (2020). A randomized trial of permanent supportive housing for chronically homeless persons with high use ofpublicly funded services. HealthServices Research, 55(S2), 797-806. https://doi.org/10.1111/1475-6773.13553

Project Overview

- Acquire an understanding of urban health planning assist with PSH program implementation and evaluation
- Review and update PSH program model and theory of change
  - Literature review on various state and nationwide policies and procedures for PSH methods
  - Assist in drafting models for PSH and services
  - Assist with drafting a yearly calendar of events
- Assess effectiveness of program model by review data outcomes
  - Quality of Life Survey
  - Update performance metrics
- Present data outcomes for program
  - Run data outcomes for quantitative and qualitative data
  - Provide a one page handout of recommended delivery of outcomes



Recommended Practices and Approaches



Conclusions

Recommended Practices and Approaches to effectively evaluating Jamboree's Permanent Supportive Housing program will be implemented in setting the foundation for future assessments. This includes an annual review of performance metrics as well as standardizing the question format to better address improvement of residents Social Determinants of Health.

Upland Unified School District Nutritional Services Health Campaign

Karisma Melwani, MSHS
Western University of Health Sciences
Upland Unified School District: City of Upland
Preceptor: Ksenia Glenn

UUSD Nutrition Services is a dept. made up of a team of food and nutrition professionals that are dedicated to students' health, well being and their ability to learn. With COVID-19, UUSD was faced with challenges on how to ensure and provide students were receiving healthy and nutritional meals.

My goal as a fellow and intern was to create visuals and videos for the Nutrition team. I captured various employees working, dedicating time during the peak of the pandemic to make sure students received meals weekly.

During my time at UUSD, I helped with the Food Corps. Initiative, together we planted seeds to harvest future vegetables for the Farm to Plate program

The Nutrition Services team developed a farm to house program. The program serves 11 schools with a population of: Not only does Nutrition Services provide for students on a daily basis, but provides for the fundamentals for healthy eating. Baldy View Elementary & Upland High School have on site citrus trees and vegetable gardens where authorized faculty harvest various vegetables such as lemons, oranges, cabbage and eggplant.

Upland Unified School District Nutritional Services Health Campaign

Karisma Melwani, MSHS
Western University of Health Sciences
Upland Unified School District: City of Upland
Preceptor: Ksenia Glenn

Over the course of 2 months, two videos were created. The first: capturing the faces behind the community. The second: promoting UUSD's Farm to Plate program, encouraging the community to take full interest in this extremely beneficial program.

The second phase of my fellowship consisted of creating visuals to market the what UUSD's goals are.

Months of planning, directing and editing went into creating 2 video infomercials for UUSD's current site. The goal here was to recognize and acknowledge how hard UUSD employees work to create a healthy meal plan for the community.

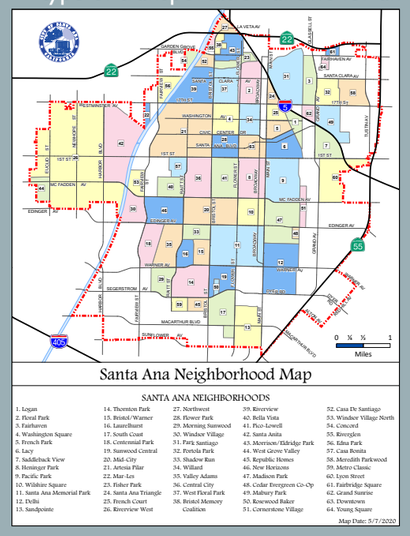
MICRO-MOBILITY IMPLEMENTATION PLAN

CITY OF SANTA ANA

KAYLA ARMIJO

Background

Micro-Mobility is a concept that is defined as lightweight transportation designed for individual use. The most popular devices used by cities e-bikes and e-scooters. This type of transportation allows for an alternative way to get around the community while having a positive impact on the environment. This allows for an increase in to public transportation use by giving convenient ways to travel while reducing the number of cars on the road.



Santa Ana Neighborhood Map

SANTA ANA NEIGHBORHOODS

1. Logan	14. Thornton Park	27. Northwest	39. Riverview	52. Casa De Santiago
2. Floral Park	15. Bristol/Warner	28. Flower Park	40. Bella Vista	53. Windsor Village North
3. Fairhaven	16. Laurelhurst	29. Morning Sunwood	41. Pico-Lowell	54. Concord
4. Washington Square	17. South Coast	30. Windsor Village	42. Santa Anita	55. Riverglen
5. French Park	18. Centennial Park	31. Park Santiago	43. Morrison/Eldridge Park	56. Edna Park
6. Lacy	19. Sunwood Central	32. Portola Park	44. West Grove Valley	57. Casa Bonita
7. Saddleback View	20. Mid-City	33. Shadow Run	45. Republic Homes	58. Meredith Parkwood
8. Heninger Park	21. Artesia Pilar	34. Willard	46. New Horizons	59. Metro Classic
9. Pacific Park	22. Mar-Les	35. Valley Adams	47. Madison Park	60. Lyon Street
10. Wilshire Square	23. Fisher Park	36. Central City	48. Cedar Evergreen Co-Op	61. Fairbridge Square
11. Santa Ana Memorial Park	24. Santa Ana Triangle	37. West Floral Park	49. Mabury Park	62. Grand Sunrise
12. Delhi	25. French Court	38. Bristol Memory Coalition	50. Rosewood Baker	63. Downtown
13. Sandpointe	26. Riverview West		51. Cornerstone Village	64. Young Square

Map Date: 5/7/2020

With this I began to research the current City's ordinances and what needed to be changed or added to comply with micro-mobility needs. In order to do this, I constructed an Implementation Plan that would help the City of Santa Ana deploy an effective permit program, starting from the planning and designing of new ordinances to actively deploying vendors throughout the city.

THE IMPLEMENTATION PLAN

Summary

Step 1 Plan: This is the very first step, finding out what our objective is and the possibilities of achieving it. During this phase I looked over current City of Santa Ana ordinances to see what needed to be changed along with reviewing past research and drafts that were generated during the pilot program. From there I compiled questions that I needed to further research.

Step 2 Analyze: Once I had a list of questions, I began to find answers to them. By researching surrounding cities' ordinances on micro-mobility I was able to see what methods were used. Understanding how different cities were working with vendors, the type of restrictions that were placed. Figuring out if Santa Ana could utilize their methods.

Step 3 Design: After researching various cities and compiling resources then I began to create a draft of ordinances. Along with this I also drafted an Administrative Regulations which is a more detailed description for micro-mobility vendors to follow. This took about a month to complete. Once completed I turned it over to be reviewed in order to make changes to finalize the draft.

Step 4 Validate: This step confirms that when the ordinances and administrative regulations are finalized, they go through the proper channels of approval. The result would be to officially be approved by the City Council. Implementation of the actual program cannot be started until this step is complete. It is extremely important for all paperwork, such as ordinances, be updated and instilled before any action takes place.

Step 5 Deploy: Beginning the implementation process of the permit program. Allowing micro-mobility vendors to apply for permits and allow for devices to be placed throughout approved areas. Making a team in charge of guaranteeing implementation, checking in on vendors and keeping an eye to ensure compliance. Creating an action plan that would include step by step instructions on the role of different team members.

Step 6 Repeat Process: Every six months review current conditions of the program and see if there are any changes that need to be made. It is extremely important to constantly review and make changes when needed, allowing for success.

Conclusion

This Implementation Plan allows the City of Santa Ana to deploy an efficient micro-mobility permit program. By doing so they can create alternative transportation for their community that allows access for all residents along with having a better impact on the environment.

Kevin Alvillar | California Baptist University

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

Community Vital Signs Fellow: Evaluating COVID-19 Impact in San Bernardino County

Kevin Alvillar | **MPH Candidate in Health Policy and Administration**

Introduction

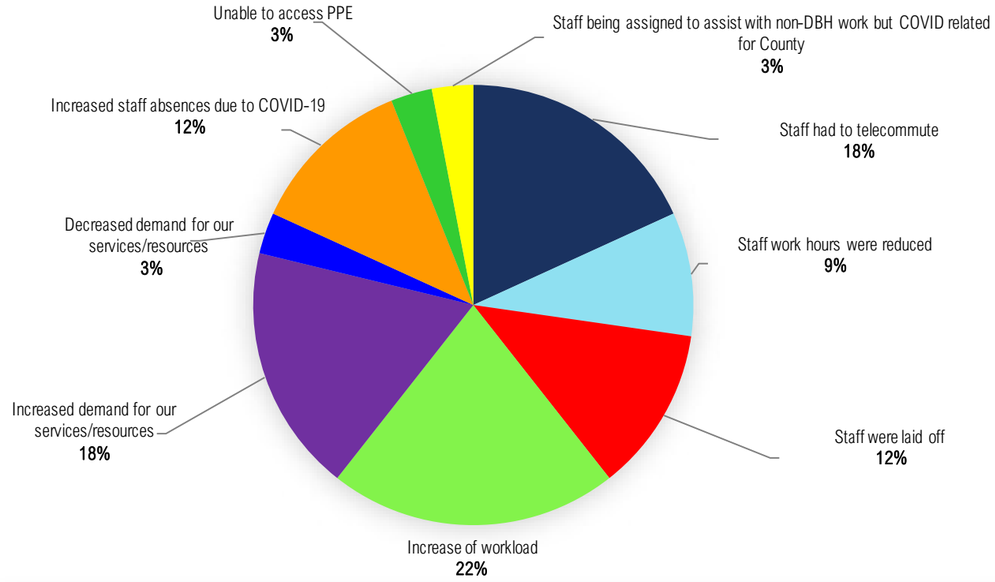
Community Vital Signs Initiative (Vital Signs) is a community-wide initiative driven by San Bernardino County's community. This community health improvement framework aims to support the wellness element under the County-Wide Vision. Vital Signs is led by a Steering Committee, which is made up of key stakeholders who are the movers and shakers who can make upstream changes to address the Social Determinants of Health (SDOH). Vital signs applies the Mobilizing for Action Through Planning and Partnerships (MAPP) Framework to address the four priority indicators: Education, Economic, Health and Wellness, and Safety.

The unprecedented COVID-19 Pandemic challenged the San Bernardino community's resilience. As a result, this pandemic affected the four priority indicators that are vital to mitigate the SDOH. Therefore, Mr. Kevin Alvillar, Randall Lewis Health and Policy Fellow, created a Health Equity Assessment to understand the COVID-19 Pandemic impacts in San Bernardino County. On January 2021, Mr. Alvillar referenced the Collaborating Partnership Survey's critical features under the Bay Area Regional Health Inequity Initiative (BARHII) Toolkit and partner's surveys to understand the COVID-19 impact on the four priority indicators. The Vital Signs team send out this assessment to the Steering Committee on February 4, 2021. The results are vital to support the Steering Committee in strategically developing the actions needed to increase resiliency and support the County-Wide Vision's wellness element and help identify the new phase for the Transformation Plan.

Health Equity Assessment Summary

9 Steering Committee Members completed the survey.

COVID-19 Impact on Organizations



Three Inequities Identified by Community Partners During COVID-19

- Employment and Financial Insecurity
- Food and Shelter Insecurity
- Internet Connectivity issues

Three solutions to address the inequities

- Implement educational programs and support that is appropriate for the community
- Business financial funds to open safely
- Increase rate of COVID-19 vaccine to schools and most impacted communities

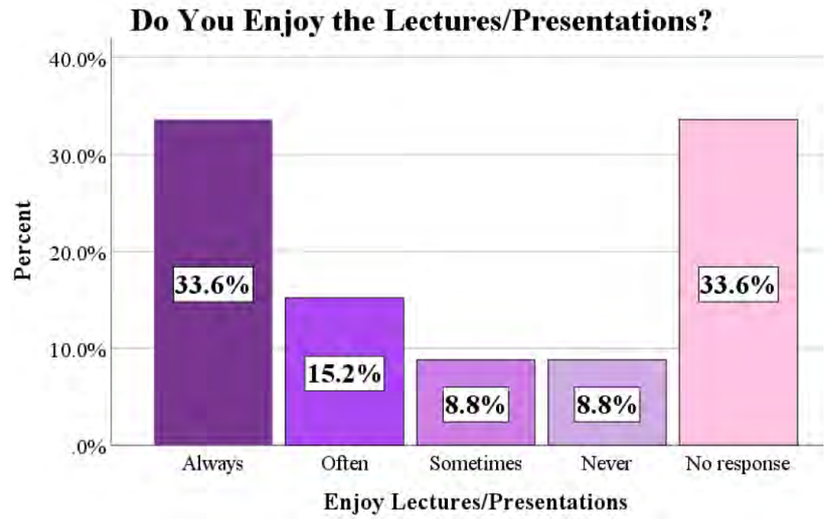
Senior Nutrition

Mackenzie Orr, MPH-C, Randall Lewis Health Policy Fellow, California Baptist University
Site: City of Montclair
Preceptor: Alyssa Colunga, DrPH, CHES

Problem: Approximately 50% of Senior Citizens are not getting the appropriate nutrition they need, according to the National Institutes of Health. The City of Montclair attempts to bridge this nutrition gap through the Healthy Montclair Senior Nutrition Program. Seniors can visit the Montclair Senior Center in order to enjoy one meal each day. With the restrictions surrounding the COVID-19 Pandemic, staff at the Montclair Senior Center have made it possible for Senior Citizens to collect their meals curbside in order to maintain social distancing and ensure the health and safety of this vulnerable population.

Demographics:

- 55% Female
- 45% Male
- 90% English Speaker
- 10% Spanish Speaker
- 32% Live Alone
- 68% Do Not
- 19% Veteran
- 81% Not Veteran
- 46% Married
- 18% Single
- 18% Widowed
- 6% Divorced
- 12% Other



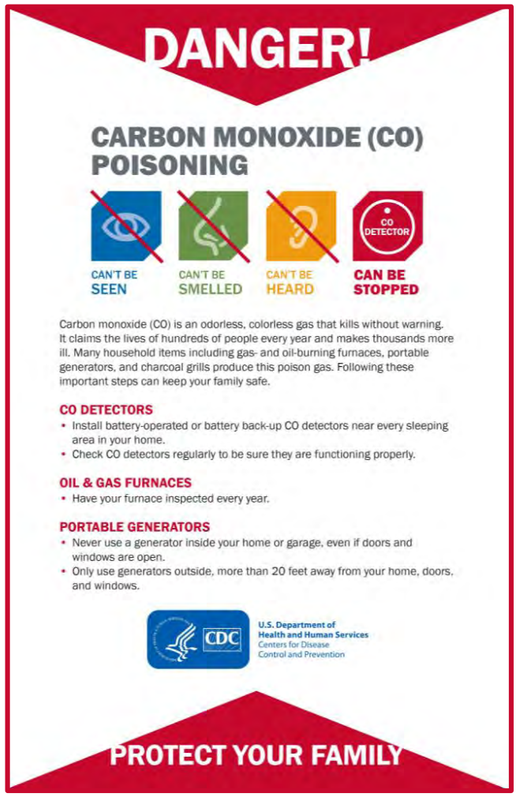
In addition to nutrition meals once daily, the Montclair Senior Center also offers educational presentations to the Senior Citizens.

What Are You Most Interested in Learning About? (Top 10 Items)	
Topic	Percentage of Senior Participants
Cooking for One or Two	**7.7%**
High Blood Pressure Prevention and Control	**7.7%**
Nutrition & Aging	**7.4%**
Vitamins & Supplements	**7.4%**
Physical Fitness & Exercise	**6.6%**
Nutrition & Arthritis Control	**6.3%**
Healthy Eating on a Low Budget	**6.1%**
Diet & Cancer Prevention	**5.7%**
Shopping & Eating Out Tips	**5.1%**
None of the Above	**5.1%**
Other	**34.9%**

Other Lectures/Presentations You'd Like to See:

- COVID-19 Vaccine
- Exercise Safety
- Mental Health
- Flu Shots
- Diabetes
- Cooking
- Shingles
- Shots All Seniors Should Have
- Depression Management
- Importance of Diets
- Sleep
- Causes of dementia
- Blood Pressure
- V.A. Benefits
- Meditation
- Pneumonia
- Eye Health
- COVID-19
- Arthritis
- Exercise
- Vertigo

Dangers of Carbon Monoxide



Both Images: CDC, 2021

Protect yourself & your loved ones. Prevent CO poisoning.

Mary DerMovsesian, MA, MPH
(expected May 2021)
Azusa Pacific University

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

AZUSA PACIFIC UNIVERSITY

WHEN THE POWER GOES OUT, KEEP YOUR GENERATOR OUTSIDE

Portable back-up generators produce the poison gas carbon monoxide (CO). CO is an odorless, colorless gas that kills without warning. It claims the lives of hundreds of people every year and makes thousands more ill. Follow these steps to keep your family safe.

PORTABLE GENERATORS
- ✔ Never use a generator inside your home or garage, even if doors and windows are open.
- ✔ Only use generators outside, more than 20 feet away from your home, doors, and windows.

CO DETECTORS
- ✔ Install battery-operated or battery back-up CO detectors near every sleeping area in your home.
- ✔ Check CO detectors regularly to be sure they are functioning properly.

CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention

Intersection of Prevention, Policy & Change

Policy, education, and surveillance can significantly reduce CO related poisonings.

Propper use, maintenance, & placement → **reduces 50% of deaths** (Graber et al., 2007)

Programs aimed at teaching awareness of risks, symptoms, & preventative methods.

Most useful during natural disasters & completely preventable.
- Texas Winter Storm, 2021:
- 700+ CO calls to PCC
- 300 CO poisonings
- 2 fatalities

Examples:
CO danger sign and free CO detectors at:
- Fire stations, police departments, and emergency departments
  WIC clinics

Community outreach programs aimed at:
- Education and proper CO detector inspection, & installation

National:
- Clean Air Act, 1967 (amendment): air quality guidelines
- H.R. 1796 CO Poisoning Prevention Act (2010)
  - Publish CO detector national standards
    Prevention: purchase & installation of CO detectors
  - Educational programs: CO risk & prevention methods

33 U.S. states have passed CO detector requirements, laws, & regulations
- California:
  - Health & Safety Code §13260-13263 CO Prevention Act of 2010;
  - Edu. Code §32081 (2013);
  - HSC §1569.311 (1985); and HSC §17926-17926.2 (2015)
    → **CO detectors in ALL dwellings** (care facilities, schools, housing, hotels, etc.)

CITY *of* EASTVALE

Michael Seley | University of California, Riverside

What's going on in Eastvale?
The City of Eastvale received a grant from CalFIRE plant 350 new trees around the city.

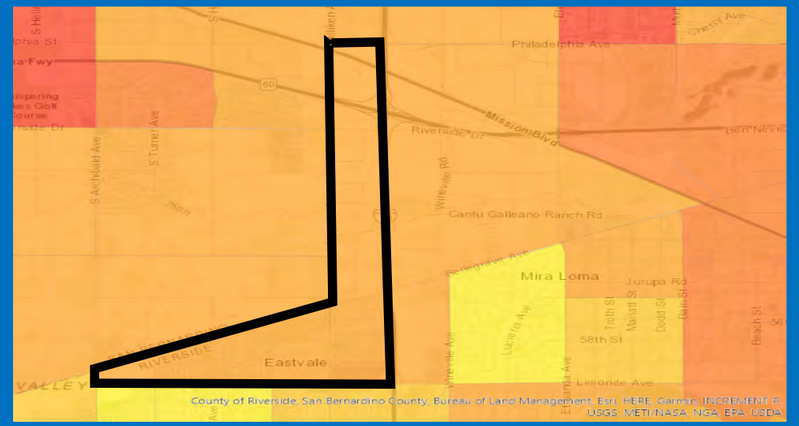
Wait, why does Eastvale need more trees?
Eastvale is a very young city; it was incorporated in 2010. Eastvale does not have an extensive urban forest to mitigate the effects of increased pollution from passing commuters. As the Inland Empire grows, trees are Eastvale's best defense to combat the health issues caused by pollution.

How much CO2 could 350 new trees really absorb?
These trees are estimated to eliminate 1,683,900 metric tons of CO2. To put that into perspective, that is equivalent to the CO2 produced by 366,056 cars.

What other benefits will this grant bring to Eastvale?
This project will capture more stormwater, create permanent tree maintenance jobs, improve public health, improve water quality, and create shade to keep the city cooler.

Why do trees matter to a city?
Trees are often a defining characteristic for a city. For example, Sacramento is called the "City of Trees". In the Inland Empire, older cities like Riverside have historic trees with deep roots in its upbringing. Eastvale has the opportunity build its city identity using trees. These trees will grow with the city and become part of its history. In short, these trees will grow to define Eastvale.

Where will these trees go?
These trees will be planted in census tracts that are highly polluted and have low-income residents. Some will be visible from the I-15 and SR-60 freeways.



RIVERSIDE COUNTY RODA OVERDOSE DATA TO ACTION

What do we do?

The purpose of Riverside County Overdose Data to Action program is to enhance surveillance of overdose morbidity and mortality in Riverside County and use data to guide overdose prevention efforts. Data is used to create responsive and collaborative prevention efforts for the community of Riverside. RODA works within the Riverside University Health Systems-Public Health, Epidemiology and Program Evaluation Department and uses several strategies to reach these goals.

Michelle Sheen
B.S. Public Health, MPP

UC Riverside School of Public Policy
PBH Randall Lewis Health Policy Fellowship
Riverside University Health System

Projects

Strategic Plan

The purpose of Strategic Plan is to draft RODA's purpose and future plans for addressing and preventing overdoses in Riverside County. It includes overdose statistics, future goals and Community Asset Survey Results.

Several activities within each strategy help further the organizations goals.

Flyer

The flyer is a 2-page handout for partner organizations that details RODA's strategies and activities

Twitter Account

RUHS-PH has plans to create a Twitter account including Tweets from RODA, Riverside Resilience and Injury Prevention Services. The purpose is to reach the community through social media. The account will launch in the future once all Tweets have been drafted and approved.

Newsletter

The RODA Newsletter will be released quarterly and the first issue is to be released in April. Program updates such as the Overdose Data Dashboard (pictured above) and announcements from other departments will be featured on this document. This will help other departments see progress and encourage those to share success stories.

Policy Recommendations

Support educational efforts pertaining to drug misuse and establish access to care facilities

Nasaura Miles | University of LaVerne

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

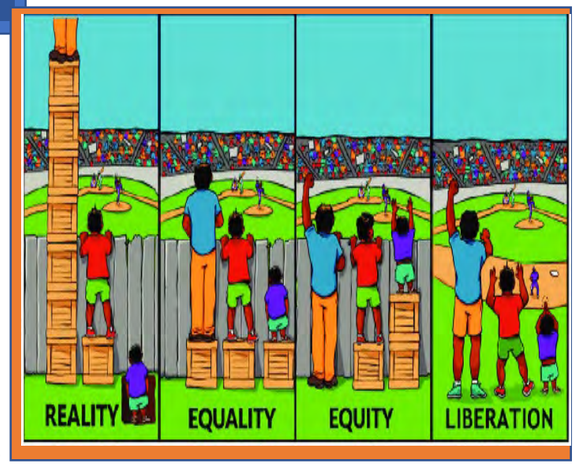
UNIVERSITY OF LA VERNE

By: Nasaura Miles

Racism as a Public Health Crisis

Striving Toward Equity

Every human deserves the divine right to life and should not be systematically removed from quality healthcare, housing, or access to healthy food due to the color of their skin or ethnic origins. The initiative Racism as a Public Health Crisis took way in 2019 when one of the most segregated cities in the United States declared Racism a Public Health Crisis. Belware (2020) writes, "Milwaukee among the worst places for Black residents because of disparities in income, housing, and incarceration rates. In 2018, Milwaukee also had among the highest mortality rates for Black residents in the United States and the highest-in-the-nation infant mortality rate for Black babies." Milwaukee was a catalyst for other states and cities to declare racism a Public Health crisis. With the current social, racial, and political climate and the mass slayings of black bodies in daylight, this initiative is at the forefront of the world and needs to be addressed.



The A-Z of Social Justice Physical Education: Part 1

Why Equity?

We tend to say we want to strive toward equality, yet equality doesn't mean everyone can see. Equity is seen as giving everyone a level playing field. Some people may need a box to stand on while others may not. Striving toward equity means meeting people where they are and giving them the tools, or in this case, the boxes to stand on so everyone gets a good view.

Health equity should be addressed in the same way. While we know the healthcare system is flawed, we cannot change the past; we must meet healthcare entities where they are and give them the tools to make the system more just and overall equitable.

What Does the Data Say?

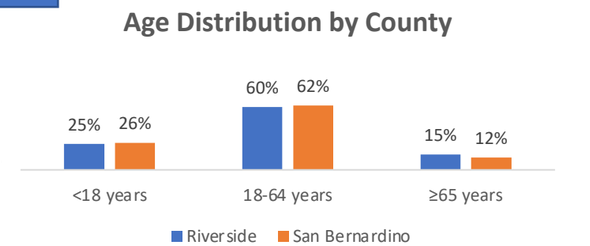
Socioeconomic and demographic data were collected in SanBernardino and Riverside county; the data conveyed that:

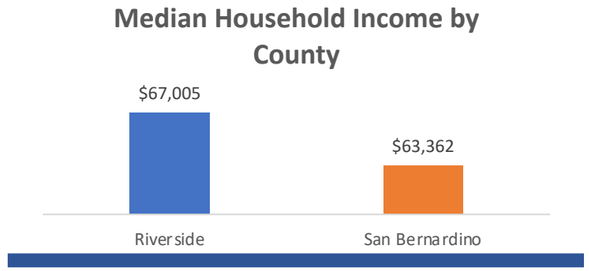
- A vast majority of the population in both counties are in-between the ages of 18 and 64.
- The median household income is about $60,000.
- Educational attainment in both counties shows that the highest degree that the. population has is a high school degree.
- In both SanBernardino and Riverside county it is predominantly populated by White people and Hispanic people.

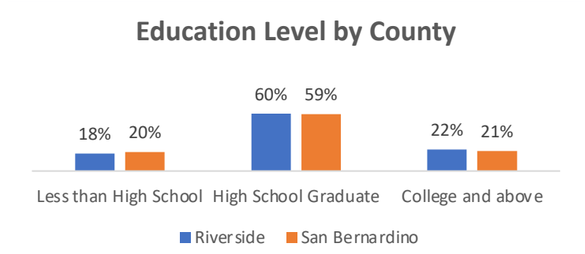
What Can You Do?

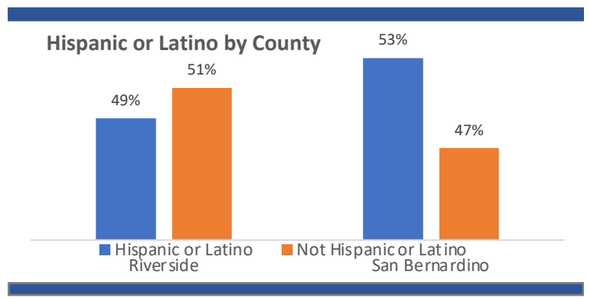
Striving toward equity is not something that can just be done overnight. Striving toward racial and health equity is no feat either. Learning the historical aspect of racism, disparities, and how to strive toward equity can help. Mitigate this problem of inequitable treatment to black people and people of color. Mary Bassett (2019) exclaims the initiative Racism as a public health crisis focuses on systems and structures rather than dismiss inequalities as the fault of individuals. Understanding that this oppressive and broken system needs to be dismantled and rebuilt is the starting point.

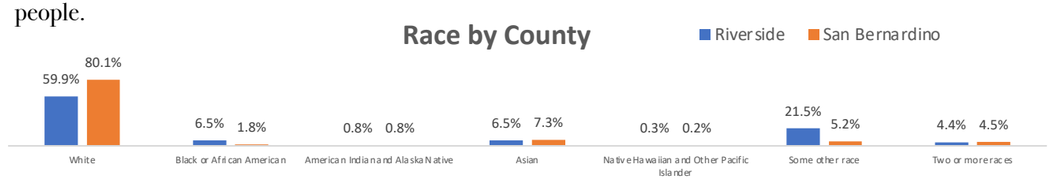
Getting out, engaging with your communities, and creating power can get this movement far. The more people that understand that everyone deserves the divine right to life, we can strive toward equity. Start by changing mindsets, not people.











Social Determinants of Health & Community Involvement with Healthy Fontana

Nataly Giselle Morales Sandoval

Introduction

Healthy Fontana (HF) is a program in the City of Fontana that seeks to create greater awareness of health in the community to inspire people to make impactful changes to their lifestyle to live a long and healthy life. With the guidance of my preceptor, Jasmine Sarsadias, 5 social determinants of health: education, economic stability, social & community, health & health care, and neighborhood/built environment was analyzed to determine effect on involvement in community health programming.

Methods

Survey Types

Respondent Type	Surveys	Interviews
Active HF	10	3
Nonactive HF	8	7
Community	59	0
Stakeholder	12	4
Total	**103**	

Defined Survey/Interview Type:

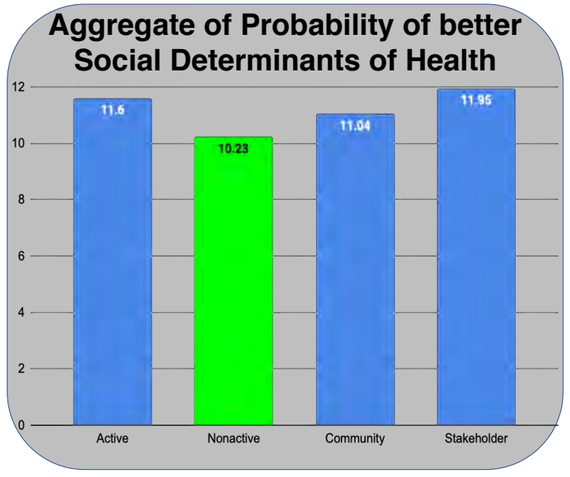
Active HF: registered participants of the ***Fontana Walks!*** program who have submitted pictures/steps to the program in the last year.

Nonactive HF: registered participants of the ***Fontana Walks!*** program who have not submitted pictures/steps to the program in the last year.

Community: individuals who have not registered/ participating in HF programming but live in Fontana; reached out by the local afterschool program, churches, and other connections.

Stakeholder: individual from an organization that have collaborated/partnered with the HF program.

Results

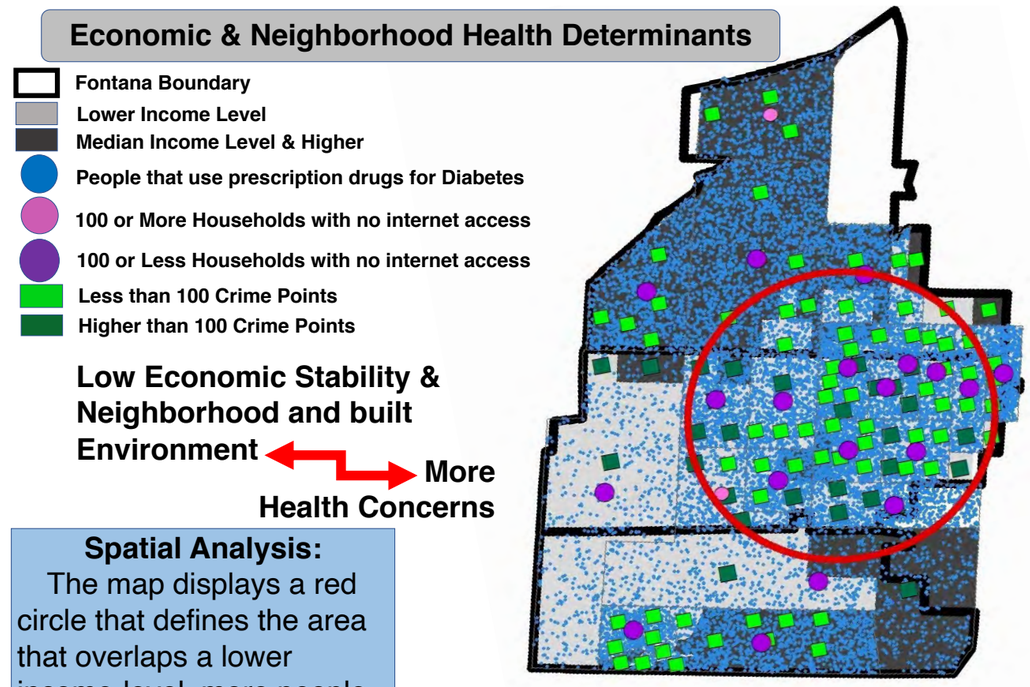


Low Social Determinants of Health ⟷ **Low Community Involvement**

Statistical Analysis:

The bar graph to the left shows that the Nonactive HF members had the lowest level in all social determinants of health.

Economic & Neighborhood Health Determinants



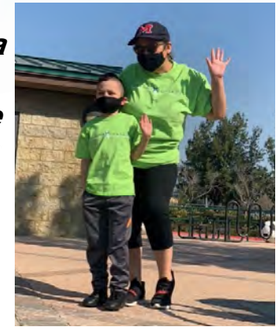
Low Economic Stability & Neighborhood and built Environment ⟷ **More Health Concerns**

Spatial Analysis:

The map displays a red circle that defines the area that overlaps a lower income-level, more people with health concerns like diabetes, more people without internet access, and more crime points. This signifies that both economic stability and neighborhood and built environment are significant social determinants of health for Fontana residents.

"make small groups or a fellowship even if it is just 2 people... from the same neighborhood or nearby"

- Nonactive HF participant recommendation regarding ***Fontana Walks!***



- Active HF participants

Conclusion

Social determinants of health do affect residents' health and community involvement. As a healthy community program, the City of Fontana could benefit from increasing socialization efforts to strengthen community involvement in the HF program. A method the program has connected through COVID-19 is distributing monthly e-Newsletters, and hopes to continue even after the pandemic, and encourage virtual walk events for participants like the picture above.

Nataly Giselle Morales Sandoval

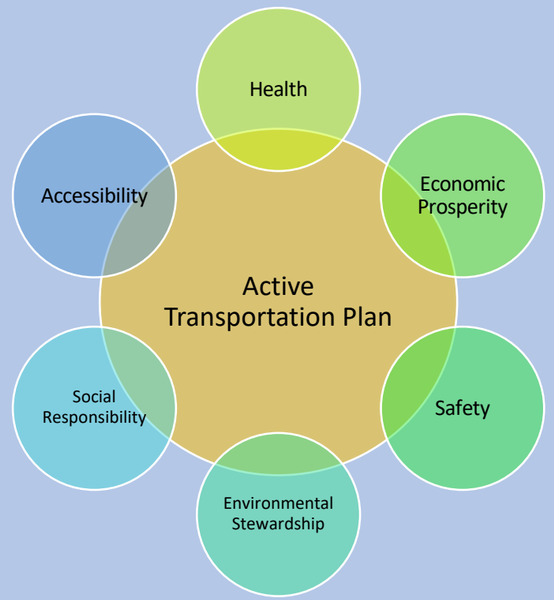
Empowering Healthy Communities By Expanding Active Transportation Network

Pouya Metanat
Fellow at Randall Lewis health and Policy Fellowship
City of Riverside, Public Works Department

Active Transportation – Center for Disease Control defines Active Transportation as any self-propelled, human-powered mode of transportation, such as walking or bicycling. Physical inactivity is a major contributor to the steady rise in rates of obesity, diabetes, heart disease, stroke, and other chronic health conditions in the United States. Many Americans view walking and bicycling within their communities as unsafe due to heavy traffic and a scarcity of sidewalks, crosswalks, and bicycle facilities.

Extension of Active Transportation network can increase physical activity by providing an inviting environment for the population to walk and bike to school, workplace, shopping and recreational facilities and other destinations. Active transportation can also increase access to services specially for those who do not have car or can not afford one.

Active Transportation Goals:



Health and Physical Activity:

The role of regular physical activity is well established in impacting health and preventing early death and morbidity. Active transportation by promoting the physical activity is an effective health promoting tool.

Economic Prosperity:

Caltrans supported studies shown that by generating new jobs and market revenue the Active Transportation project generate economic revenue where they are implemented. Some studies suggested that $1 dollar spent in ATP in support of more walkable and bikeable communities is expected to increase sales out put by $8.41.

Safety:

AT projects by increasing safety of Bikeway and Walkway network specially in collision prone areas can prevent injury and death due to vehicle involved accidents. The increased sense of safety will increase adaptation rate of active transportation in the communities.

Environmental Stewardship:

ATP projects in addition to improve the safety and livability of the communities, can impact the air quality by providing sustainable alternative to vehicular transport.

Social Responsibility:

In addition to expanding facilities and providing education and encouragement, one aspect of AT plans include removing the socio-economic barriers in utilizing AT for disadvantaged communities. Including providing equipment's through community and school events.

Accessibility:

AT plans by providing safe routes within the communities expand the reach and access of the communities to the community facilities and life necessities.

Results:
ATP Recommendations:
Recommendation included in the PACT plan includes:

- 51 Intersection Enhancements
- 21 miles of enhanced bikeways
- 50 walkway enhancing projects

Grant Options Available in the California for Active Transportation Projects:

- Sustainable Communities Planning Grants
- 2020-2021 Sustainable Communities Program (SCP)
- Affordable Housing and Sustainable Communities Program (AHSC)
- Urban Greening
- Transformative Climate Communities (TCC)
- Office of Traffic Safety Grant Program
- Clean Mobility Options
- Transit and Intercity Rail Capital Program (TIRCP)
- Local Partnership Program (LPP)
- And more…

Resources:
Following data and analysis sources play a significant role in assessment of AT projects:

- California Healthy Places Index
- CalEnviroScreen 3.0 and 4.0
- SB 353 Disadvantaged Community map
- UC Berkley, TIMS collision data tool
- Municipal annual and Semi-annual Surveys
- Project specific Surveys
- Esri products:
  - ArcGIG online, Map, Pro
  - Survey123

Reyna Peña - Calvillo | UC Riverside

Children's Behavioral Health Peer Navigation Collaboration

Jamboree Housing Corporation is the largest nonprofit affordable housing development organization in California.

Mission: To deliver high quality affordable housing and services that transform lives and strengthen communities.

Vision: To improve communities throughout California by developing a full range of quality housing affordable to everyone in a community, and provide supportive, life-enhancing services.

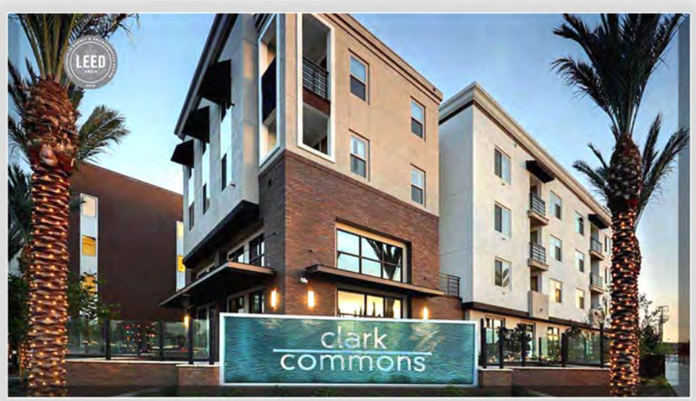
Program Objective

To provide accessible behavioral health for children and their families living at Jamboree's Clark Commons affordable housing property and the surrounding community in Buena Park, who are CalOptima members.

Methods and Goals

Surveys were used to collect data on the participants and programs offered. Goals to improve on and measure:

1. The effectiveness the programming is having on the community.
2. The need for such programming in the community.
3. The overall satisfaction of the services offered through the CalOptima grant.



Services Surveyed

Mental Health Workshops

- Conflict Resolution
- Community Chats

Leadership Empowerment Workshops

- Resident Leadership Academy Modules

Programs

- Teen Program
- Resident Leadership Academy

The Children's Behavioral Health Peer Navigation Collaboration Program
Is overall well received by the residents of Clark Common's and the surrounding community and have has created a safe space for the community to be educated in mental health and its practices.

Resident Leadership Academy
Has given the residents the education and tools necessary to be leaders and advocates for the community.

Teen program
Is a positive contribution to the community, it is engaging teens, making them aware of how to deal with stress, and it is giving them a safe place to talk and share amongst one another.

Conclusion: The community has a strong desire to be educated, to lead, and to be empowered by the services offered by Jamboree and its community partners. The services offered are well received and are making a difference at an individual and community level.

CAREGIVER RESOURCES AND HEALTH COMMUNICATION TOOLS

Sheila Seño
Master of Public Health Urban Community Health
California State University, Los Angeles

Introduction

Adventist Health Simi Valley, a faith-based, integrated, and dedicated healthcare hospital, is part of a 20-hospital network of the Adventist Health group in the US [1]. The organization aims to provide positive healing experiences for people from diverse faiths, communities, and cultures. Simi Valley is located in Ventura County, which ranks in the lowest category of health outcomes (according to the 2021 County Health Rankings and Roadmaps initiative). As per state and federal law, the hospital undertakes a Community Health Needs Assessment every three years to determine community benefit plans and how to address community healthcare needs, including the Caregiver Support & Care Navigator Program (CSCNP), which assists caregivers with the overall care planning, treatment, and implementation of interventions for patients.

Caregiver Support and Care Navigation Program (CSCNP)

The CSCNP primarily helps caregivers and patients make effective clinical decisions, which creates informed, quality health care. It targets caregivers, especially those who support elderly patients who are seriously ill, disabled, or injured.

Figure 1: Service Map of Adventist Health Simi Valley

This program also supports at-risk patients, including sepsis, COPD, CHF, and pneumonia patients. Moreover, the CSCNP program is oriented towards empowering, equipping, and strengthening caregivers to meet the challenges of informal care, which include stress, depression, financial duress, and emotional exhaustion. The program also promotes assessment; staff services; community partner identification; care planning; referrals; education; integration into health systems; and program monitoring, learning, and evaluation.

Role of Caregiver Literacy and Resources in the Caregiver Program for DRGs (Sepsis, COPD, CHF, and Pneumonia)

Health communication informs and influences decisions and actions to improve health. Healthcare professionals can use effective communication strategies to educate the public about the importance of getting flu vaccines, encourage women to get mammograms, raise awareness about stigmatized topics like mental health, and properly care for patients at home. Disseminating health information requires a critical understanding of the elements of care for a patient. For example, caregivers caring for a sepsis patient at home can achieve health literacy through hospital's websites, infographics, brochures, YouTube videos, and educational materials. Using straightforward vocabulary is crucial to communicating effectively with the general public. For this project, I developed clear, comprehensible resource materials for sepsis caregivers. My end goal is to make these resources reproducible for other DRG use that AHSV uses for their caregivers' resources.

Figure 2: Caregiver Support and Care Navigation Program Components

Project Overview

1.Gathered and assessed existing reports of AHSV's Caregiver Support and Care Navigation Program (CSCNP).

2. Attended CSCNP collaborative meetings to learn the program's organizational structure, care team services, and care planning.

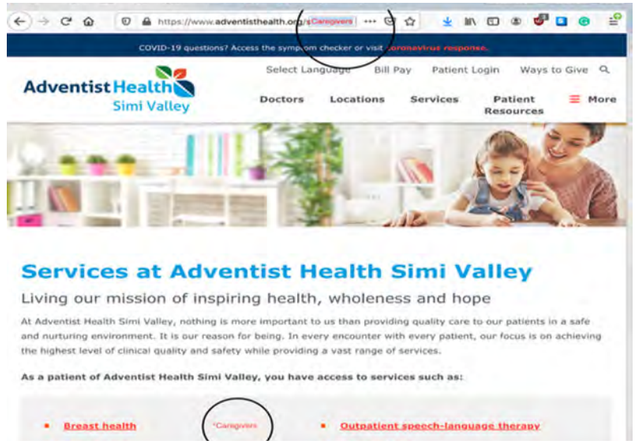
3. Researched diagnosis-related groups (DRGs) with the highest rates of admission for AHSV. This includes vulnerable patients re-admitted for sepsis care (which is the most common condition), followed by patients with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and pneumonia.

4. Developed health communication tools that will allow AHSV to strengthen their CSCNP program intervention and support, boost their online presence, and build on their public health messaging systems.

Policy Recommendation

I would recommend that federal and state governments enact legislation that will upgrade the training requirements of caregivers, especially those working in the formal healthcare setting. Currently, caregivers or nursing assistants only require a high school diploma and 75 hours of training for them to start working. This training is inadequate to prepare them for the responsibilities they are supposed to perform in the healthcare system. New policies propose that new caregivers take between 18 to 24 months of formal training. This proposed training will be tailored to caregivers' educational levels. My fellowship assessment targeted its educational tools towards a 5th-grade level of literacy. Hence, trainers must train caregivers in accordance with their educational level to enable them to acquire the required skills. The proposed law can require healthcare colleges to develop appropriate course content that will meet the skill needs of the caregivers. The proposal for advanced training for caregivers may also require the federal government to increase caregivers' annual remuneration in order to match their work and education levels.

Figures 3&4: : Website Prototype and Infographic



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Conclusion

Through the Randall Lewis Health Policy fellowship, my work enabled me to research the role of caregivers who served patients with sepsis, COPD, CHF, and pneumonia. Caregivers act as links between patients and healthcare systems, especially after hospital discharge [2]. It is not easy for them to cope with the emotional, physical, social, and financial challenges associated with caring for chronically ill patients [6]. Thus, they require a broad range of resources to enable them to perform their duties effectively. These resources include communication tools, knowledge, technical support, and encouragement, among others [3]. By equipping them with the necessary tools and skills, caregivers can successfully face the numerous challenges in their work [4,5]. Additionally, given the acute crisis facing healthcare organizations in present times, integrating health communication tools into their program allows AHSV to bolster the support they provide to caregivers.

By and large, we are discharging patients into the care of family members...if they are not trained, aware, and educated, patients are likely to end up back in the hospital."

-University of Pittsburgh Medical Center Researchers

Contributing Randall Lewis Health Policy Fellow, Sheila Seño, MPH(c). Contributing AHSV Director of Community Well-Being, Kathryn Stiles.

Evaluating Social Determinants of Health in Affordable Housing

Shivani Kakade

Introduction

Jamboree Housing is a non-profit, affordable housing company based in California that delivers high-quality affordable housing and services that transform lives and strengthen communities. This project aims to create a data-based guide to visualize levels of **social determinants of health (SDOH)** at each property to tailor future decisions.

Figure 2: SDOH are the non-medical factors that influence health, including aspects of a person's social and physical environment.

The impact of housing on health is considered a major component in SDOH, as healthy homes promote positive physical and mental health outcomes.

SDOH Objectives

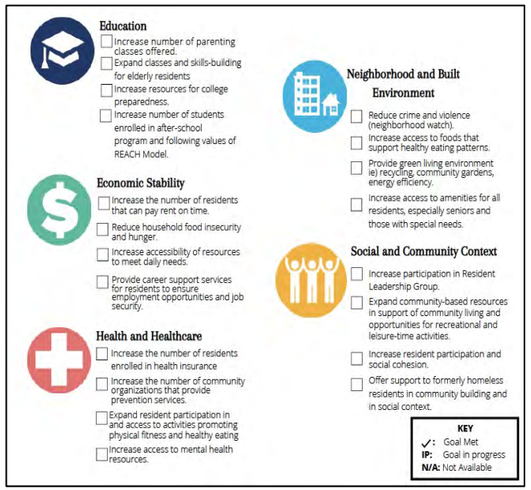


Figure 1: All 5 SDOH listed with 4 unique objectives for each one.

Materials and Methods

Information collected included 36 compliance binders for 2019 from each property's manager. These contained materials tracking utilization of support programs at each property within the 5 SDOH: Education, Economic Stability, Health and Healthcare, Neighborhood and Built Environment, and Social and Community Context. We created 4 objectives or criteria to support each SDOH, depicted in Figure 1. Using the objectives, we quantified the events and resources relating to a specific SDOH for each property. From there, we were able to calculate percentages for each SDOH at each property. For example, Laurel Crest had 35% in 2019 allocated to Education and about 20% towards Health and Healthcare (Figure 3).

PBH Partners for Better Health | Jamboree | Claremont Graduate University

Results

The final product was a digital handout unique to each property visualizing resident-specific data such as: demographic, average income level, city median income, gender, age group, and average time lived in property. These measures are depicted using bar graphs comparing levels of SDOH measured at each property. The checklist of 4 objectives under each of the 5 SDOH in Figure 1 is included in the property guides.

Conclusion

We evaluated all resources and events across 36 Jamboree Housing properties in 2019 to create a visual guide tracking levels of SDOH that currently exist at each property and any gaps that need to be addressed. This will serve as a guide for property managers, residents, and other community stakeholders to ensure that Jamboree continues to evolve and improve upon its quality housing services to low-income communities across California.

Sample Property Guide

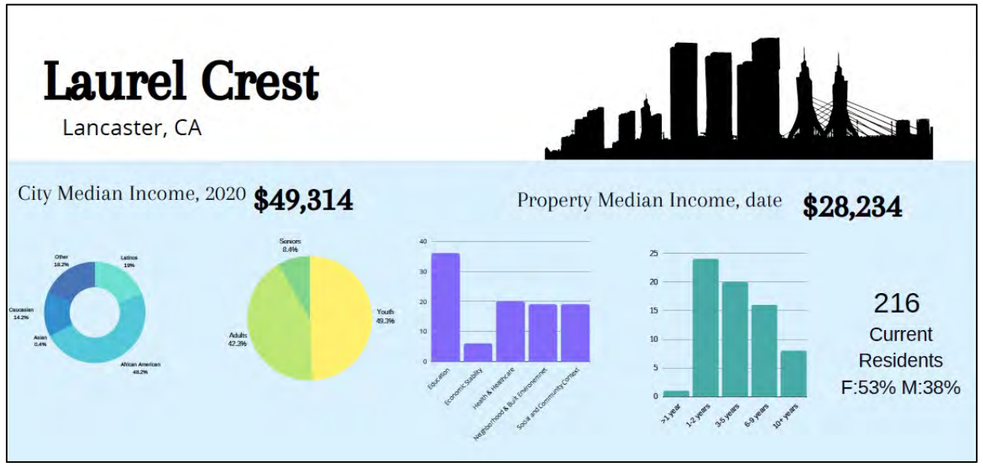


Figure 3: Example of one property guide with resident-specific data and SDOH bar graph.

Future Directions

Jamboree has implemented the property guides and has plans to create a Community Impact model based on the data. This model will be expanded upon in the future to also focus on training surrounding SDOH in housing.

PBH Partners for Better Health | Jamboree | Claremont Graduate University

COVID-19 Inland Empire Employer Toolbox

Sreejitha Munda, MPH

COVID-19, has affected millions of people in the United States. Studies show Hispanic and African American communities are disproportionately impacted by this disease. Inland Empire (IE) area is a region in Southern California located across San Bernardino and Riverside counties with a large Hispanic population. Many residents are working in production, transportation, and sales, hence do not have an option of working from home. COVID-19 has impacted these communities and various small businesses in IE area. Inland Empire Economic Partnership (IEEP) is an economic development organization in this area which has been helping these communities by providing knowledge about COVID-19 prevention and to alleviate its impact on various industries. The toolbox contains information on vaccine distribution, eligibility, locations, and business safety guidelines. The employers in this area can use this toolbox for improving their business environment and keeping their employees safe.

COVID-19 Vaccines

Moderna

mRNA vaccine
Two shots (28 days interval)

Pfizer-BioNTech

mRNA vaccine
Two shots (21 days interval)

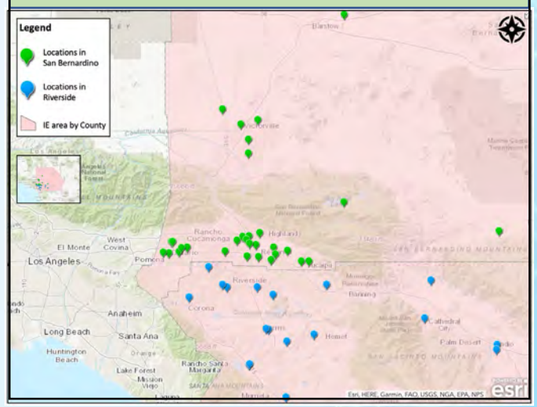
Johnson & Johnson's Janssen

Viral vector vaccine
Single shot

Vaccine Safety and side effects

- COVID-19 vaccines are safe and effective.
- More than 56 million people are fully vaccinated by March 31, 2021
- Individuals will be monitored on site for 30 minutes after giving a shot
- Side effects include pain, swelling, redness in the arm, fever, chills, tiredness.

Vaccine Locations in the IE area



Guidance for Employers and Businesses Responding to COVID-19

Provide face masks and hand sanitizers to the workers or provide reimbursements to them for safety measures

Train the employees to keep the workplace clean and sanitize regularly

Set up proper ventilation, air filtration systems to ensure the air quality for indoor operations

Build temporary structures such as tents, canopies or outdoor operations

Provide paid leave and other benefits if the employees are or their family members are sick

Assistance Programs and Other Helps for Business and Employers Impacted by COVID-19

- Small Business Relief Grant Program
- Paycheck Protection Program (PPP) Loans
- Economic Injury Disaster Loan (EIDL)
- Small Business Disaster Relief Loan Guarantee Program
- California Capital Access Program (CalCAP) (1-500 employees)
- CalOSBA - Small Business Assistance and Resources
- California Entrepreneurship Task Force
- CA Network of Small Business Technical Assistance Centers

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Industry guidance for 40 different industries in 14 languages. https://covid19.ca.gov/industry-guidance/#statewide-guidance

Assistance for Small Business and Employers https://covid19.ca.gov/business-and-employers/#managing-covid
CA Network of Small Business Technical Assistance Centers
https://business.ca.gov/advantages/small-business-innovation-and-entrepreneurship/how-we-can-help/covid-19-resources-map/

Stephanie Lao | Loma Linda University

RESIDENT DASHBOARD AND DATA PROCESSES

The Hope Through Housing Foundation

HOPE through HOUSING FOUNDATION

PROJECT TIMELINE

Analysis of YARDI Database reports and resident data points	
Affordable Demographics Table	September 2020-November 2020
Construction of Resident Dashboard on Excel and presentation	
Resident Dashboard Excel File	December 2020-January 2021
Collaboration with Data Integration and Business Analytics teams for improving HTHF data processes and reports	
Executive Summary	February 2021-May 2021

BACKGROUND

The goal of this project is to assist both Hope Through Housing and National CORE in utilizing a data-driven process to better understand their current resident population. Most of the primary data on residents is housed in the YARDI Property Management application which is used to keep track of resident certification and financial information, with occasional report generation to assess and aggregate qualitative information on residents. The result is an Excel dashboard that visualizes socioeconomic resident data by property/region.

KEY OBJECTIVES

- Review the YARDI application and understand its reporting capabilities.
- Utilize YARDI reports to extract primary socioeconomic data on residents and aggregate them by property and region.
- Summarize findings in a brief report/meeting with preceptor and on final fellowship presentation.

HOUSING AND HEALTH

According to a policy brief authored by the Kaiser Family Foundation in 2018, the social determinants categorized are the primary drivers of health outcomes, while socioeconomic factors shape individuals' health behaviors. Of these determinants, Hope Through Housing provides four programs that specifically address each determinant of health:

SOCIAL DETERMINANTS OF HEALTH

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

RESULTS

This project has identified the socioeconomic data points of interests that Hope Through Housing can explore further, precisely identifying their target populations and specifically address their needs, especially within the context of the flagship programs mentioned above.

CONCLUSION

Housing is one of the most important social determinants of health because it provides the stability people need in order to live. In addition, Hope Through Housing's services and programs are designed towards empowering residents to elevate themselves from generations of cyclical poverty. The Residential Dashboard provides a foundation for the organization to leverage data analysis towards higher quality programming and services while accurately meeting objective outcomes, overall strengthening the success of their anti-poverty mission. With their basic needs secured, residents are free to develop their physical and mental health for a happier and healthier life.

CITY OF EASTVALE
COMMUNITY WELLNESS IN EASTVALE

Veronica Onochie | **Randall Lewis Fellow, PhD student**
Miguel Ramirez-Cornejo | **Site Preceptor**

Ethnic Inequity in Wellness

The City of Eastvale is a newly developed community located in the northwestern part of Riverside county in Southern California. With a population of 61,337 and a majority of Asian and White ethnic groups (Hispanic and non-Hispanic) suffering from obesity, mental distress, suicide, asthma and other chronic diseases related to unhealthy living choices. The City of Eastvale is committed to serving and providing healthier living alternatives for all its residents.

Action Plan

The data indicates high rates of suicide (c. 10.9), obesity (21.7%), mental distress (8.7%) and other chronic diseases amongst White and Latino residents of Eastvale. Additionally, the evidence indicates that there are no resources available to engage Eastvale resident in wellness activities. The purpose of this community action plan initiative is to help encourage and enlighten Eastvale residents on healthier alternatives.

Regression Analysis on Ethnic Inequity in Mental Health

Source	SS	df	MS	Number of obs	=	1,404
				F(6, 1397)	=	511.01
Model	394.949746	6	65.8249576	Prob > F	=	0.0000
Residual	179.950894	1,397	.128812379	R-squared	=	0.6870
				Adj R-squared	=	0.6856
Total	574.90064	1,403	.409765246	Root MSE	=	.3589

lSuiciderate	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Asian	-.6567383	.0425666	-15.43	0.000	-.7402397	-.5732369
Black	-.5931058	.0495966	-11.96	0.000	-.6903976	-.495814
Female	-.8145509	.0303003	-26.88	0.000	-.8739899	-.755112
Male	-.9347969	.0344971	-27.10	0.000	-1.002469	-.8671251
Hispanic	.3984792	.0301768	13.20	0.000	.3392824	.457676
White	.4172433	.0285161	14.63	0.000	.3613043	.4731823
_cons	2.497573	.0186586	133.86	0.000	2.460971	2.534175

Data Source:
California Department of Public Health

Interviews & Surveys

Stakeholders and partners indicated the effectiveness of action teams would be dependent on the level of active participation and management by Eastvale residents. Action teams should address the inequity of access to health and wellness resources of Eastvale residents with active participation.

Recommendations

Action teams should maintain higher and healthier living standards and residents actively participating in either of the following :

- Physical fitness team
- Emotional support team
- Nutrition/Grocery team
- Gardening
- Local/Small businesses coalition
- Youth coalition
- Drug enforcement
- Service providers

In collaboration with pbh Partners for Better Health | RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

HOMELESSNESS

Victorville: *2nd highest concentration of homeless persons in the County for a third year; 2019 experienced a 35.4% increase in Homelessness.*

California Advancing & Improving Medi-Cal (Cal AIM)

1. Identify risk(s) and manage care addressing SDOH
2. Move Medi-Cal to a more seamless system
3. Improve quality outcomes, reduce health disparities, drive system transformation through value-based initiatives and payment reform.

Providence St. Mary Medical Center strives to create awareness of current and needed services to high-need neighborhoods through advocacy. Healthy Communities' efficacy exuberates the hospital's vision of "Health for a Better World" by creating awareness. Providing mental health and substance-use education brings resources that address our poor and vulnerable populations' needs in a dignified manner. Investing in housing and services to those experiencing homelessness can improve the population's chronic needs experiencing homelessness. The hospital's Community Health Needs Assessment (CHNA) identified three (3) prime health priorities amongst our served communities:

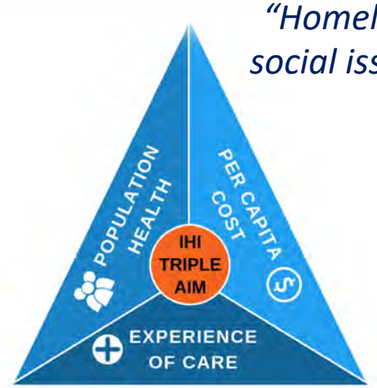
1.) Access to Care **2.) Mental Health** **3.) Homelessness & Housing Instability**

HOMELESSNESS SOLUTIONS TASK FORCE:

Victor Valley Rescue Mission — An Outreach Ministry of Rescue Mission Alliance
Town of Apple Valley California
City of Victorville California
San Bernardino County Behavioral Health
Hesperia
High Desert Community Foundation
IEHP Inland Empire Health Plan

HOMELESSNESS

"Homelessness was ranked highest of all the social issues by both community residents and partners."



Problem: The High Desert lacks support services and housing to meet the needs of people who experience homelessness. As a result, data-supported an influx of emergency department (ED) visits that were avoidable amongst this vulnerable population.

Vision: Promote community support to expands services and shelters to people experiencing homelessness, scale-up the availability of housing, and improve the quality of health services provided.

Rationale: Our nation intersected two major paradigm shifts; presidential election and a global pandemic. This hurdle granted opportunities to analyze data from the hospital's emergency department (ED), service-area demographics, quality improvement metrics, and care delivery tactics to our vulnerable populations in rural areas.

Senate Bill (SB) No. 1152:
Hospital patient discharge process: Homeless Patients

Assembly Bill (AB) No. 240:
Local Health Department Workforce Assessment

- Primary Care
- Dental Care
- Preventative Care
- Acute Care
- Continuum of Care
- Referrals Social Services
- Psychotherapy
- Community Health Education
- Transportation

Action Plan: To reduce ED admissions, delivering care to communities in need is advantageous for the population's health, cost, and overall quality. We are bringing solutions to the problems for opportunities for improvements – *Health for a Better World.*

Delivering Equitable Care

- ☑ **Evidence-Based Practice (EBP)**
- ☑ **Reduce Health Disparities & Social Inequalities**
- ☑ **Values: Justice & Dignity**
- ☑ **Community Engagement**

EVALUATION PROPOSAL ON THE EFFECTIVENESS OF REGISTERED DIETITIANS IN PUBLIC HEALTH PROGRAMS

Written by: Yaellie Mae Deroca, MHA / University of La Verne / Preceptor: Sandy Knox, BSN, PHN

Comorbidities of chronic conditions have become more widespread and most patients have difficulties in managing their conditions. Barriers to chronic care management include a limited education to disease monitoring and overall medical condition, inadequate social support, low self-efficacy, physical limitations, presence of comorbid diseases and inadequate knowledge of proper nutrition. Nutrition is a vital component in managing chronic conditions because diet is an adjustable risk factor for most chronic conditions that can either be one or in comorbid states. Registered Dietitians play a vital role in healthcare teams by helping patients safely change their eating plans to help manage their chronic conditions. An RD''s training and qualifications allow them to produce effective care management especially for patients with complex health issues.

Issue:

Due to COVID-19 RDs of CHIP were temporarily suspended from the program.

What Is Currently Being Done?

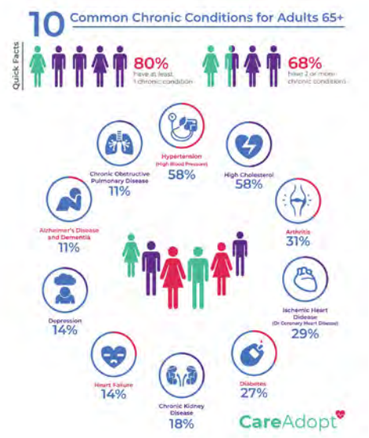
Due to the RDs being temporarily suspended, CHIP needed to make adjustments in the nutrition assessments by revising the nutrition questionnaire that Health Coaches do with their patients. Based on the answers, the Registered Nurse on the CHIP team, Sandy Knox, evaluates what the patient needs. Handouts that have been approved by the RDs, are then gathered and sent to patients. These handouts will then be discussed by the patient and their Health Coach.

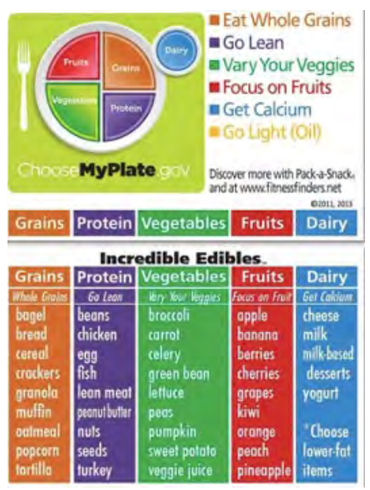
Objective:

The purpose of this evaluation is to demonstrate the effectiveness of Registered Dietitians in Community Health Improvement Programs in helping improve and manage patient care dealing with chronic conditions. The results of this evaluation will be used to reestablish the role of the RD's in CHIP and to implement the importance of RD's in similar programs.

Evaluation Questions:

- *How well has the program achieved its primary objective of helping patients have a better understanding and management of their chronic conditions, with the changes of not having Registered Dietitians on board?*
- *Were the patients of CHIP who received RD consultations more likely to have better understanding and management of their chronic conditions, than the patients that did not?*
- *Did the implementation of RD consultations in CHIP result in changes in knowledge, attitudes, and self-patient care skills among the members of the target population?*



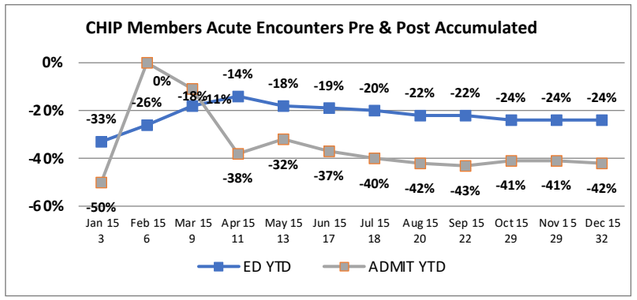


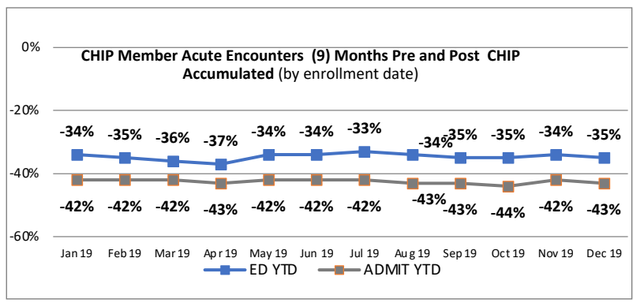
Evaluation Measures:

Target population: CHIP patients enrolled with RD consults and patients enrolled after program changes

Evaluation Method

1. Data will be collected pre- and post-enrollment into the program through a series of reports and surveys. A report card will be generated by the hospital's program to check how many ED and hospital admission visits each participating patient has six months prior to their enrollment, and then 9 months post enrollment. This data will consist of patients who have received an RD evaluation prior to the new changes of the program due to the pandemic and will then be compared to the patients who do not receive RD evaluations
2. After the initial intake and enrollment with the RN and social worker, the health coaches assigned to the patients will be doing a pre-RD assessment nutrition questionnaire.
3. A post follow-up assessment survey will then be conducted 9 months after their 12-month enrollment in the program. Data gathered from pre- and post-assessment surveys and ED visit and admission reports will be tallied and compared from pre-enrollment to post enrollment to the program.
4. This data will also then be compared to the assessment surveys of patients who did receive RD consultation prior to the changes of the program.





The data retrieved from the assessments will determine the effectiveness and how important nutrition and RDs are to public health programs when dealing with management of chronic conditions. This evaluation will base the data of patients one year before the change was implemented and after the first year of RDs being taken off the CHIP team. Based on previous studies of the Member Acute Encounter (Pre and Post CHIP Accumulated, Admit and ED visits have overall significantly decreased from when CHIP started in 2015 to 2019.

eat well • live healthy

Recommendations:

1. Due to budget cuts and the current state of the pandemic, it is difficult to find the funds to employ an RD; however, applying for government grants is one way to find funding through a third-party source. The hospital would not have to allocate their own funds to hire an RD.
2. Hiring an RD per diem would also reduce the full cost of hiring a full time RD.
3. As most of the health coaches are students at universities, partnering up with their professors and their Dietetics and Nutrition department to get nutrition plans for CHIP patients, while following HIPAA rules.

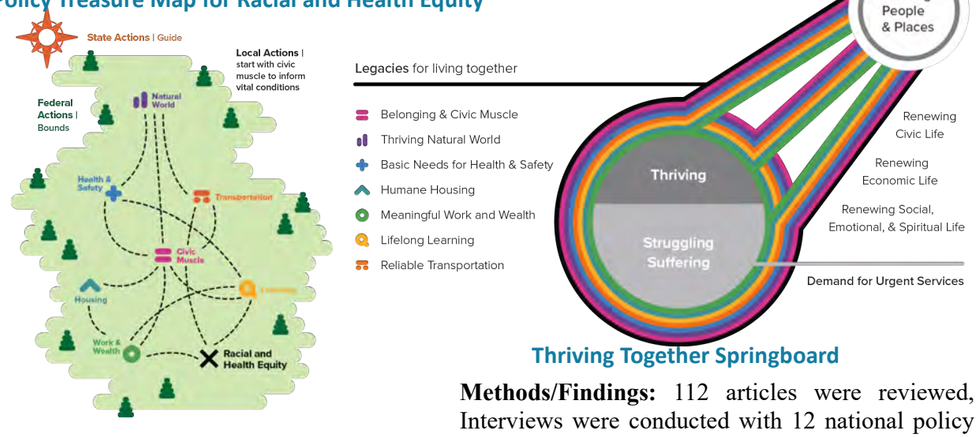
Zachary Travis | California Baptist University

Healthy Neighborhood Investments: A Policy Scan & Strategy Map

Zachary D. Travis PhD, MPH candidate

Introduction: With the COVID-19 pandemic and massive social unrest (due in large part to the growing tension that had been brewing due to 400 years of policies propagated by systemic racism) causing a true public health crisis, Build Healthy Places Network and Shift Health Accelerator partnered to identify policy strategies for advancing racial and health equity through cross-sector investments and to serve as a tool for community-owned priority setting that reduces inequities and strengthens neighborhood revitalization. Through this work strategies were identified that communities could take up and work in partnership with other sectors (see chart on pg.2).

A Policy Treasure Map for Racial and Health Equity



Thriving Together Springboard

Multi-sector partnerships for policy action

Methods/Findings: 112 articles were reviewed, Interviews were conducted with 12 national policy experts, and a 38-member Policy Council was convened. with the overall goal to identify policies with the potential to impact health and racial equity across seven vital conditions of the Thriving Together: A Springboard for Equitable Recovery and Resilience (see above). This Policy Scan sets the stage for potential policies that can advance health and racial equity by utilizing the Policy Treasure map, which as identified by the Policy Council, centers *leaning into belonging and civic muscle* (The capacity for communities to engage and the structures for engagement are foundational. The incorporation of racial and health equity into citywide plans, budgeting, and voting processes can help link policies to the community's needs and wants. The power to access flexible, coordinated funding also enables cross-sector work) as the number one cross-cutting policy theme for every potential policy action.

Healthy Neighborhood Investments: A Policy Scan & Strategy Map

Zachary D. Travis PhD, MPH candidate

Vital Conditions	Policy Strategies for Healthy Neighborhoods
Belonging and Civic Muscle	Equitable decision-making must include the voices of those most impacted by decisions and provide structures and spaces for people to have the power to make the collective and civic decisions that shape their future. Decision-making power is far too often held by a few people, and belonging and civic muscle efforts should grow to engage people as equals, collectively, to make change. **Specific strategies:** Make sure every person and their vote counts; Reform campaign finance; Fund community capacity and require community engagement; Collect and use disaggregated data; Commit to leadership development; Use comprehensive master plans (parks, housing, transport); Enact anti-displacement measures; Establish city and state racial equity umbrella policies; Improve intergovernment and interagency coordination; Promote equitable tax and revenue policy; Create flexible sources of funding.
Thriving Natural World	Natural and built environments significantly affect health, and climate change affects communities. Policy can prevent, reduce, or remediate people's exposure to toxins in the environment and bring lifestyles into harmony with the natural processes that keep people healthy and resilient. **Specific strategies:** Mitigate climate change; Improve climate resilience; Ensure universal access to clean, affordable water; Reduce exposure to extreme heat and air pollution; Ensure that everyone has a good park within a 10-minute walk; and Invest for multiple benefits.
Basic Needs for Health and Safety	Promoting physical health, mental health, and emotional resilience involves removing sources of harm, supporting recovery, and integrating all the aspects of care to meet the different needs of different communities and people. Safety creates freedom from harm or danger and prevents further trauma from occurring. **Specific strategies:** Avoid harm and facilitate recovery; Promote maternal health and reduce infant mortality; Reduce domestic violence; Provide incentives for healthcare to invest in addressing social determinants of health; Co-locate services; Develop community approaches to public safety; End violence in the policing and criminal justice system; Improve healthcare access; Promote integrated approaches to care; Transform the healthcare workforce; Get and use data; Provide access to the good food individuals and communities want.
Humane Housing	Housing is a cornerstone of community development and a human right. Having access to a safe, affordable, stable, quality place to live is essential to health and economic wellbeing. Housing policies can help ensure that housing builds wealth, health, and community ownership. **Specific strategies:** Build and renovate quality housing in places that need it; Help people afford and own good homes; Enable people to choose and stay in the homes they want; Provide housing for those experiencing homelessness; Promote responsible local ownership.
Meaningful Work and Wealth	Unless incomes grow for low-income families, the United States will never shrink the wealth gap associated with health inequities. With basic income security, families and communities can grow their wealth, save money, and invest to give the next generation a head start. Closing the wealth gap will require nondiscriminatory and equitable access to credit and lending, entrepreneurship, rewarding jobs, and business growth. **Specific strategies:** Ensure equitable procurement; Cultivate job pathways; Advocate for universal basic income; Provide opportunities to save and invest; Improve access to capital; Provide good working conditions and protections; Support small businesses and entrepreneurs; Promote digital inclusion.
Lifelong Learning	Lifelong learning creates leadership pathways, career choices, and opportunities to cultivate collective visions to advance racial and health equity. The power to dream and choose leads to health. There are opportunities to create universal access to early childhood education, shift how elementary and high school education is delivered, identify ways for education to be equitably funded, and prepare youth not just for jobs but for a choice of career pathways. **Specific strategies:** Provide access to early childhood development and childcare; Support outside-of-school programs; Encourage joint use of facilities; Provide student loan forgiveness/tuition support; Reduce the incidence of adverse childhood experiences; Coordinate cradle-to-career partnerships; Meet students' basic needs.
Reliable Transportation	Having access to affordable, accessible transportation options that encourage physical activity and do not cause stress is important for health. It is also important that transportation not cause harm to people or the planet (e.g., increase pollution exposure, sever communities, or increase displacement). **Specific strategies:** Commit to equitable transit-oriented development and anti-displacement; Provide transportation alternatives; Promote safe and accessible street design/planning; Provide flexible funding and infrastructure; Reduce commute times.

Build Healthy Places Network worked with SHIFT Health Accelerator and this project was supported by the Blue Shield of California Foundation.

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City of Rialto Healthy Communities Initiative

Healthy Rialto was established in 2008 as an initiative to enrich and empower the lives of Rialto residents. By providing innovative and proactive solutions so that everyone who desires to get fit, stay healthy, and support safe environments.

Rialto Certified Farmer's Market

Established in 2012, the Rialto Certified Farmers' Market provides the community with accessible and affordable locally sourced healthy food options including produce (fruits and vegetables), nut/seeds, pure raw honey, free range cage free eggs, and more. The vendors are comprised of local farmers and businesses encouraging:

- Sustained economic growth in the city of Rialto
- Nourishing communities with affordable healthy food options
- Slowing the increasing prevalence of obesity and chronic diseases
- Serving all income levels, bringing the community together

Market Match Program

Market Match is California's healthy food initiative program which matches customers' federal nutrition assistance benefits such as CalFresh and WIC at farmers' markets and other farm – direct sites. Market Match empowers low-income patrons to make healthier food choices by overcoming financial barriers. The program supports local economic development and civic engagement.

Market Match provides matching funds so that patrons are able to purchase even more fruits and vegetables. For example, a shopper who spends $10 of CalFresh benefits at the farmer's market gets an additional $10 to spend on fresh produce.

Goals and Objectives

- Promote Market Match Program
- Evaluate access to food sources and identify areas of need
- Create social media marketing campaign highlighting healthy habits
- Develop virtual Walk-a-Thon to increase resident's physical activity

Intervention Impacts

- Total CalFresh Distributed: $8,888
- Total Market Match Distributed: $3,482
- New Market Match Customers: 142
- Market Match Repeat Customers - 240
- Social Media Increase - 99%

Recommendations

Health inequities are defined as the differences in health status between different population groups which stem from the social conditions in which people are born into, grow, live, and work over time. Healthy Rialto is taking the steps to increase the health of the population. Partnering with the school district, health/fitness center, and senior center will further enhance their efforts as they make Rialto healthier.

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