Partners for Better Health

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

2022

11 YEAR ANNIVERSARY

Partners for Better Health

RANDALL LEWIS
HEALTH & POLICY
FELLOWSHIP

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Identification and Treatme…d Insecurity: Gaps in Screening and Management

Amanda Thurman, MSN, FNP-BC, DNPc
Azusa Pacific University, Center for Better Beginnings

Project Aim: To address food insecurity in the healthcare setting: Screening, treatment and policy recommendations

What is food insecurity and why does awareness matter?

- Living in a state without access to healthy, nutritious and affordable foods to live an active and healthy lifestyle is the definition of food insecurity (Feeding America, 2020)
- An astounding 1 in 3 people in the world in 2020 did not have access to adequate food (United Nations, 2022)
- In California, 1 in 5 Californians struggle with food insecurity (California Association of Food Banks, 2020)
  - **Effects of food insecurity:**

Adults:

Obesity, Depression, Anxiety

Pregnancy and Post-Partum:

Obesity, decreased breastfeeding and overfeeding of infants

Children:

Depression, Anxiety, Obesity, anemia, poor concentration

The Face of Hunger

- The mother who feeds her husband and children first, then herself
- The adult who purchases food over life saving medication
- The child who can't concentrate in school due to hunger
- The mother who won't report food insecurity to her doctor for fear the children will be taken away

What Can We Do?

ASK

We **MUST** start by asking: The Hunger Vital Sign: In the last 12 months have you ever worry whether your food would run out before you got money to buy more? Or in the last 12 months did the food you buy didn't last and there was no money to buy more?

Research shows that screening in the healthcare setting is minimal and left up to the providers discretion (Cannon, 2016)

ASSESS

Are all food resources accessed?

CalFresh is a monthly benefit for those that qualify.
CalFresh works! 20-30% of California households are food SECURE due to CalFresh benefits
Let them know they can call 211 for help

ADDRESS

Health Policy changes are imperative. Inequities exist! We urge policy makers to extend CalFresh to ALL working adults who qualify by income standards regardless of documentation status

ACT

Medical and nursing education must include training on identification and treatment of food insecurity.
We can make a difference by getting to the root of the problem and identifying the underlying causes of a person's health.

Conclusion: Food insecurity has tremendous effects on adults, children, pregnant women and their unborn child. Mandating screening for food insecurity in the clinical setting and providing food benefits for ALL low income persons in California are positive steps toward making a difference in the health of Californians.

Senate Bill (SB)1000

Tracking the Progression of SB 1000 in the SCAG Region

Antonia Izuogu
Southern California Association of Governments |UCLA Luskin School of Public Affairs

SB 1000

SB 1000 is a California legislative bill mandating the integration of environmental justice (EJ) in local jurisdiction general plans. EJ defined as "the fair treatment and meaningful involvement of people of all races, cultures, incomes, and national origins with respect to the development, adoption, implementation, and enforcement of environmental laws, regulations, and policies". SB 1000, approved on September 24, 2016, requires cities and counties with one or more disadvantaged communities (DACs) within its jurisdiction to adopt an EJ Element or incorporate EJ-related goals, policies, and objectives in other general plan elements when two or more general plan elements are updated and adopted on or after January 1, 2018.
(https://opr.ca.gov/docs/20200706-GPG_Chapater_4_EJ.pdf)

Background

DISADVANTAGED COMMUNITIES

Authorized by the California Global Warming Solutions Act of 2006 (AB 32) and guided by Senate Bill 535, which directs 25% of the proceeds from the Greenhouse Gas Reduction Fund to go to projects in disadvantaged communities, the California Office of Environmental Health Hazard Assessment (OEHHA) developed the CalEnviroScreen tool to determine disadvantaged communities. The CalEnviroScreen tool defines DACs as the top 25% highest scoring census tracts with indicators for health, economic and environmental burdens.

GENERAL PLAN

General Plans are long-range vision guidelines that cities and counties create to shape the future growth of their area through land use decisions. Required General Plans Elements include: land use, circulation, housing, conservation, open space, noise, safety and EJ (per SB 1000).
(https://oehha.ca.gov/calenviroscreen/sb535)
(https://opr.ca.gov/planning/general-plan/guidelines.html)

Methodology

We developed a tracking sheet to document progress of EJ Elements and noted various information like the type of document (EJ Element or EJ-related goals, policies and objectives), status, link to the document, notable goals and policies, and the last General Plan update. I identified DACs within the region, using SCAG's SB 535 Disadvantaged Areas Map, and reviewed general plans for the local jurisdictions that had DACs within the SCAG region to complete the tracking sheet. In total, I reviewed 198 general plans and related documents.

SCAG EJ Toolbox

In March 2021, SCAG created an EJ Toolbox with recommended practices and approaches to guide practitioners on integrating EJ in their general plans and related work. The toolbox is categorized into nine EJ topics, which are:

(1) Healthy, safe, and sanitary housing
(2) Access to essential services and facilities
(3) Active living, active transportation, and physical activity
(4) Climate vulnerability and resiliency
(5) Roadway and aviation noise impacts
(6) Air quality and pollution exposure impacts
(7) Impacts of road pricing mechanisms
(8) Community Outreach and engagement
(9) Other policy recommendations for EJ impacts

On the back side of this handout, I list few of the relevant and notable policies and goals in general plans during my research that align with these topics.

Currently

Within the six counties and ninety-three (93) cities that have DACs, four counties and thirty-four (34) cities have complied with SB 1000 requirements as of March 15, 2022. To track progress as well as provide a visual display of my research, I created an ArcGIS map that identifies which cities and counties have DACs and their status with compliance to SB 1000 requirements. This map will need to be updated periodically as general plans are updated.

Acronyms:
HE-Housing Element
EJ-Environmental Justice Element
LU-Land Use Element
HW-Health and Wellness Element
EP-Economic Prosperity Element
HEJ-Health and Environmental Justice Element

Notable Goals + Policies

I chose a few EJ goals and policies I found notable due to their uniqueness. Of the general plans I read, the following examples seem to address a distinct need within that one area that other jurisdictions may not find to be necessary or be appropriate for their communities.

Healthy, safe, and sanitary housing + Access to essential services and facilities
Santa Monica City, Los Angeles County HE Policy 1.5: Innovative and Sustainable Housing Design. Ensure that local regulations support: sustainable construction techniques and materials to the extent technically feasible, environmental justice that protects public health, open space, and expansion of the tree canopy.
Monterey Park City, Los Angeles County EJ Policy 7.1: Ensure that the City police and fire department equitably aid all communities in Monterey Park in a timely manner.
Active living, active transportation, and physical activity + Climate vulnerability and resiliency
San Juan Capistrano City, Orange County EJ Goal 10: Ensure an equitable distribution of and access to parks, trails, open space, and related programs.
Los Angeles City, Los Angeles County HW Policy 5.6: Resilience. In collaboration with public, private, and nonprofit partners, increase the city's resilience to risks (increasing temperatures and heat related effects, wildfires, reduced water supply, poor air quality, and sea level rise) resulting from climate change, and target resilience in the most vulnerable communities.
Roadway and aviation noise impacts + Air quality and pollution exposure impacts
El Centro City, Imperial County EJ Policy 4.4: Support cross-border efforts to address air pollution from sources in Mexico.
Santa Fe Springs City, Los Angeles County EJ Policy 1.2: Truck Idling Restrictions. Designate acceptable and unacceptable areas for freight trucking and diesel truck idling to limit impacts on disadvantaged communities already overburdened by air pollution.
Impacts of road pricing mechanisms + Community outreach and engagement
Beaumont City, Riverside County HEJ Policy 6.3.5: Work in partnership with the Beaumont Unified School District to develop a youth leadership group to provide input and guide youth-oriented planning and programmatic efforts in the City.
Jurupa Valley City, Riverside County EJ Policy 1.9: Tribal Consultation. Consult with Native American Tribes early in the process on issues that could affect culturally significant areas.
Other policy recommendations for EJ impacts
Riverside City, Riverside County EJ Policy 1.0: Arts and Culture: Promote Equitable Distribution of Arts and Cultural Facilities Across the City
Santa Ana City, Orange County EP Policy 2.4: Community-Led Economic Development. Support community-based economic development initiatives, such as buy-local campaign, marketing strategies, and worker cooperatives.

Recommendations

After my extensive research on general plans and SB 1000 compliance, I have developed a few actionable recommendations for practitioners to consider when integrating environmental justice in their work.

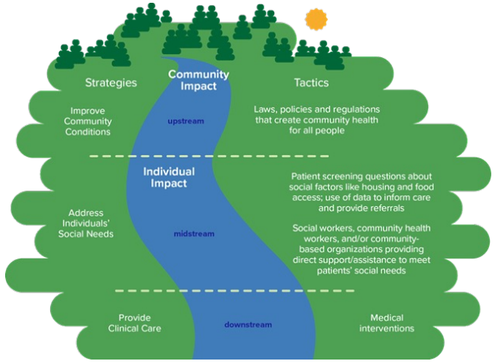
(1)Understand Community Demographics/Background. SCAG created the Racial Equity: Baseline Conditions Report for the SCAG region as a first step in advancing EJ and equity to get a better understanding of existing conditions and disparities. Typical general plans provide an overview of the demographics of the city or county but a more detailed assessment, such as baseline conditions, can aid in identifying disparities as a primary step to advancing equity efforts.
(2) Prioritize Community Input. Communities often know what they desire. Identify communities as primary stakeholders in plans and projects that impact them is key in successful implementation and change.
(3)Consider Road-Pricing Mechanisms. As a tool towards cleaner environments, successful road pricing programs can help manage air pollution and congestion. I did not come across any general plans that explicitly mentioned corridor/facility pricing, mileage -based user fees, or cordon pricing. Road-pricing programs can act as one of the s solutions to air pollution and traffic congestion.
(4) Consider Community Character. No community, city or county are alike therefore Environmental justice integration should be tailored to the impacted populations while taking into account the uniqueness of each community.
(5) Be Proactive. Some jurisdictions within the SCAG region do not have identified DACs but still integrated EJ policies into their general plans to address EJ. I urge practitioners to be proactive rather than reactive to plan for and foster healthy and equitable communities.

Multi-Sector Playbook for Rural Healthcare Investments

Ashauntee Jones
University of La Verne
Build Healthy Places Network

About BHPN: Founded in 2014, Build Healthy Places Network (BHPN) is a national nonprofit organization that is dedicated to health equity through non-traditional cross-sector collaboration. Through this mission, BHPN actively connects the dots between community development, finance, public health, and healthcare sectors nationwide in order to improve the health and well-being for marginalized communities. BHPN field building work creates resources, and tools, shares case studies and connects leaders across sectors with the intention to create momentum around cross sector partnerships that leverage community-centered investments.

Context: When it comes to resources that focus on rural economic development, there is a lack of consideration for involvement from healthcare. Rural communities are one of the most vulnerable populations that are in need for new innovations that will garner further support toward equity. The Healthcare sector in rural communities can use their assets or influence more efforts that can improve the conditions of the rural communities. Partnerships and "upstream" interventions from the healthcare sector call for addressing factors known as the social determinates of health. By shifting from downstream to upstream involvement, there will be a focus it on the real causes of health inequities and factors in the entire environment and community instead of the individual impact.



- Upstream: Investment interventions aimed at the root causes of a population health problem/benefit. Root causes are often identified by social determinants of health
- Healthcare Sector: hospital systems, public health departments, managed care organizations, private health insurance plans, health foundations, community clinics, Federally Qualified Health Centers (FQHCs), and social services organizations

Objective: Following their previously released playbooks, the purpose of the "Multi Sector Playbook for Rural Healthcare" is to create action-based content that will enable cross sector investments in rural areas, encouraging hospitals to invest "upstream" to address the lack of rural community resources, and serve as a resource for potential partnerships. This playbook will highlight a variety of strategies that can be adopted by the healthcare sector as it partners with community development and other sectors to target investments that impact community conditions in rural areas.

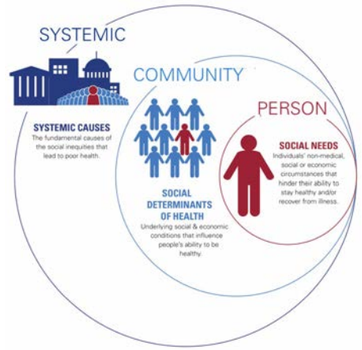
Methods: Resources used for the curation of this playbook were paired with insight from a diverse set of partners. Utilizing the rural development leaders and our national rural advisory committee members, the guidance received drove the team's approach. Published literature, articles, case studies, and interviews were all used to create the rural playbook.

Findings: The playbook takes cases, examples and stories of healthcare investments in rural communities. The following strategies showcase the playbook's direction of how multi-sector involvement with rural communities' advance healthcare:

- Economic opportunity and support of workforce
- Supporting local control
- Strengthening infrastructure in support of healthcare access
- Increasing resources (Capital, Funding, Government Resources)

Using these strategies as their basis, the playbook continues to speak to the healthcare industry through examples and case studies for each strategy.

My investment into this project was dedicated to writing, researching and applying examples to the strategies to showcase the power of healthcare upstream investment.



Conclusion: With the goal to complete and release the playbook within the Spring, BHPN has provided support and tools that create change in our communities. In relation to their mission, BHPN works diligently to create active change and push for inclusivity for cross sector investments and partnerships. Regarding rural involvement, BHPN is pushing the envelope and encouraging upstream methods from healthcare entities to ensure community development. Learning through this experience, there has been a huge insight to the way our communities can collaborate despite sector – in order to achieve a common mission for the betterment of our society.

Evaluation, and Implementation
By Brandon Law
MPH Student, Applied Biostatistics & Epidemiology

Background/Significance:

Reduction in greenhouse gases to mitigate the effects of climate change has been challenging over the years. Senate Bills (SB) were enacted in Southern California to address these issues, such as SB-743 and SB-1383.

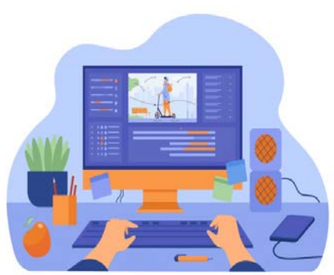
SB-743's goal is to reduce Vehicle Miles Traveled.

SB-1383's goal is to reduce the amount of organic and food waste in landfills.

To combat the public health problem of climate change, the City of Riverside utilized different projects to reduce the amount of greenhouse gases in the atmosphere long-term for the current population.

Methods:

Research was conducted on other transportation agencies to obtain the necessary documents and information for developing the VMT Mitigation Project Request for Proposal (RFP). A fiber map project was also conducted using GIS Viewer and Excel for traffic synchronization funding at the City of Riverside. Some outreach materials, such as an informational flyer and brochure, were created to promote the food waste pilot program at the City of Riverside. Food waste pilot program survey results were analyzed to determine the next steps before implementing the program city-wide at Riverside.

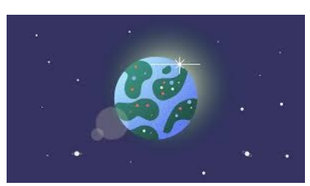


Results:

Through my research and outreach with other local transportation agencies, similar RFP's were successfully obtained to assist with the establishment and completion of the City of Riverside's VMT Mitigation Project RFP. The completed fiber map project will also determine the length of required fiber cables used for estimating future funding for the purpose of decreasing vehicular days between traffic signal intersections. With the completed outreach materials, the City of Riverside residents are now more aware of SB-1383 laws and more knowledgeable about the next steps to take. Evaluation of the food pilot program survey results will also be used to create suggestions and recommendations on how to improve the program before it is implemented city-wide.

Conclusions & Recommendations:

Some recommendations would be essential for moving the projects forward, such as building a stakeholder committee for the VMT Mitigation project and having more incentives & resources to increase food waste pilot program success. The projects implemented by the City of Riverside will ultimately have a significant impact on greenhouse gas emissions in the future.



Project Handout

- The health issue being addressed is the health inequity of in-access to The Program for All-inclusive Care for the Elderly (PACE) services as it impacts the aging Latinx population in Washington. This project was undertaken to find ways to better meet the needs of Latinx individuals as they relate to aging in place successfully. The purpose of this project is to identify ways in which PACE could increase access to their health services by evaluating best practices for serving Latinx individuals and providing data-driven recommendations to improve the intra-organizational patient experience.

- My methods consist of a literature review of health equity in hospice and palliative care for elderly Latinx individuals, a correlations analysis for social factors driven by poverty that influence access to healthcare, a thematic analysis of disenrollment and grievance data, and an overview of best practices for serving Latinx populations across the National PACE Association.

- Major results of the project include identified gaps in publicly available research for Latinx individuals in hospice and palliative care settings; “Very High” Pearson Correlation test statistic between older Latinx individuals “With a broadband Internet subscription” and who “Speak English less than very well”; prevalent themes of inequitable transportation coordination, language barriers, and cultural underrepresentation.

- My interpretation of the project connects to larger issues that make serving Latinx communities less feasible. The outcomes of my research reveal opportunities for PACE to pursue improvements in marketing tactics for diverse communities, culturally competent care coordination, evidence-based outreach strategies, and data management.

- The implications of this project are to help PACE understand how to better serve its elderly Latin constituents. Comprehensive research from both organizational, and population-level perspectives can serve as a benchmark for PACE to continue their work in health equity with more clarity of issues that need to be addressed about understanding their target markets, maximizing resources to promote equitable experiences within the organization, and novel means to serve the poorest and most vulnerable individuals in need of culturally competent intervention.

- My recommendations include marketing tactics that frame messages for the family unit to identify trusted support systems; an increased presence of Spanish-speaking staff at PACE (healthcare providers, clerical staff, transportation staff, etc.); data integration for information collected by the intake team regarding grievances, disenrollment’s from the program, and referrals to make finding potential problem areas more accessible; enhanced mechanisms to help older individuals connect with each other through as a means to promote “word-of-mouth” referrals; a higher emphasis on community-based participatory research to further integrate the role of underrepresented communities in efforts to improve healthcare access; finally, novel ways to serve undocumented individuals who often don’t qualify for PACE programs, but that could benefit from our efforts to set them up for official residency status.

USC University of Southern California

Partners for Better Health

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

Thriving Together Across the Vital Conditions:
Resource Curation, Multi Solving, and Shared Stewardship

Colleen Corrigan
MPH STUDENT | GLOBAL HEALTH |
UNIVERSITY OF SOUTHERN CALIFORNIA

IP3 INSTITUTE FOR PEOPLE, PLACE, & POSSIBILITY

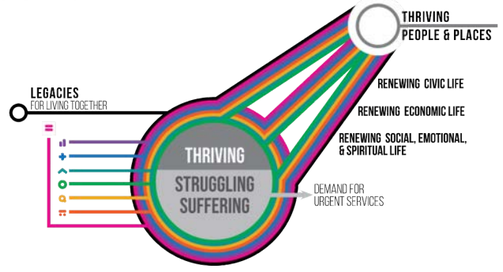
CI Community Initiatives network

Introduction/Background

For over two decades, Community Initiatives Network has been helping hundreds of community coalitions and partnerships strengthen their local capacity and build trusting relationships. It is led by a set of Vital Conditions that all humans rely on to reach their full potential. (Figure 1)

In partnership with Rethink Health and the Well Being Trust, Community Initiatives Network published Thriving Together: A Springboard for Equitable Recovery and Resilience in Communities Across America. Written in the early days of the COVID-19 pandemic and during increased calls for racial justice, Thriving Together drew on the contributions of more than 100 leaders and nonprofits. The document presents a unifying framework for action to allow all people and places to thrive, no exceptions.

(Figure 1). Seven Vital Conditions for Well-Being and Justice



(Figure 2). Thriving Together Framework

The Institute of People, Place, and Possibility (IP3) is a nonprofit that works to build capacity for change through strategic thought partnership, curated resources, and IP3 Assess—a web-based data tool with a robust list of indicators, maps, and shareable reporting. For over a decade, CI and IP3 have worked together to connect leaders to the best tools, resources, data, and stories to support this work. A product of this partnership, Community Commons is a robust online platform that supports change-makers working to advance equitable community health and well-being.

Fellow Strategies

(Figure 4). PHERN helps navigate resources for ending the pandemic, advancing equity, & building a resilient, robust, sustainable public health system.

As a Fellow, I:

- Expanded steward and change-maker understanding of the Thriving Together ethos and Vital Conditions framework through use case and multi-solving content.
- Developed Community Commons collections and original blogs to support learning.
- Supported further development of the Thriving Together Learning and Action Infrastructure, including resource library curation for partners like the North Sound Accountable Community of Health (ACH).
- Co-authored a health system toolkit for advancing Thriving Together ethos (Figure 3).
- Created a library of Vital Conditions multi-solving tables for learning materials and future publications.
- Supported data capacity (metadata curation, quality assurance) needs on PHERN, the Public Health Equity and Resource Navigator, in partnership with the American Public Health Association (APHA). (Figure 4).

(Figure 3). Executive Summary of Shared Stewardship Guide

Results

Deliverables included contributions to the Shared Stewardship in Health Care: Transformational Practices for Thriving Together Guide (Figure 3) and the following original Community Commons pieces:

- *American Rescue Plan 101: A Call for Equitable Recovery and Systems Renewal*
- *American Rescue Plan in Action: Leveraging Flexible Funding and Community Engagement for Equitable Recovery*
- *Multi-Solving 101: Co-Creating Vital Conditions*
- *Leaving Legacies: Transforming College Campus Histories of Exclusion into Futures of Equity, Diversity, and Inclusion*
- *Confronting Environmental Racism: Justice at the Intersections of Environment and Race*

Conclusions/Implcations

As the Thriving Together and Vital Conditions framework demonstrate, it is crucial to understand what allows people and places to thrive to utilize data to support community stewards of health. Organizations in this space must collaborate, rather than compete, to build a movement for change. IP3 Assess and Community Commons are two valuable tools for utilizing health data and resources to advance equity across the U.S.

The Development of Community Well-Being Programs

Daniela Flores

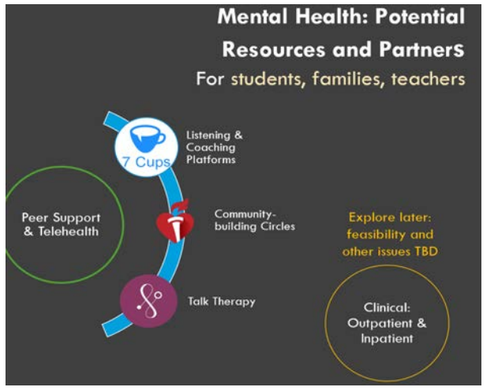
April 2022

Background

Adventist Health Glendale (AHGL) hopes to renovate the health experience of Glendale and its surrounding communities by enhancing spiritual, mental, and physical health, improving interactions, and making care considerably ***affordable and accessible***. As a Randall Lewis Health & Policy fellow, under the guidance of Justin Henderson, I helped support AHGL by building out the Community Well-Being programs including the **Glendale Healthier Community Coalition (GHCC) project, Community Health Needs Assessment (CHNA),** and the **Schools Mental Health Program** more extensively.

Schools Mental Health Program

The main goal is to provide a variety of mental health resources to offer support to the teachers, students, and families at the Glendale Unified School District. I helped research literature reviews, evidence-based practices, social-emotional learning (SEL) models, a range of applications, and free listening platforms. I helped produce recommended resources for the staff, therapists, and students based on their prioritized needs.



The Development of Community Well-Being Programs

Glendale Healthier Community Coalition (GHCC)

The GHCC is an ongoing project to update and revamp the former website, which was initially created to fill the gaps and needs of Glendale and its surrounding communities.
As a team effort, I helped brainstorm ideas to organize the website and make it streamline and presentable to the public.

Community Health Needs Assessment (CHNA)

The CHNA is a multi-layered effort in which I assisted by taking the content from the key informant interviews and connecting them to key categories and phrases in a software program.
This process is to help drive measurable and sustainable development in social determinants of health and well-being.

Community Needs Assessment: Maneuvering the opioid and substance abuse data terrain using interrelated frameworks

Daniela Gilet, M.S.

Loma Linda University
The Institute for People, Place, and Possibility(IP3)

Who is The Institute for People, Place, and Possibility(IP3)?

IP3 is a non-profit organization that amplifies community change by building strategic thought partnerships through use of data, technology, and storytelling. IP3 services change makers, community organizations, health systems, local public health, philanthropic funders, and national initiatives.

IP3 Assess

A web-based solution to community need assessments that features data analysis capabilities, community insights, shareable reports, data frameworks, and public health indicators that support data alignment the lead to concerned action.

What is a Community Needs Assessment?

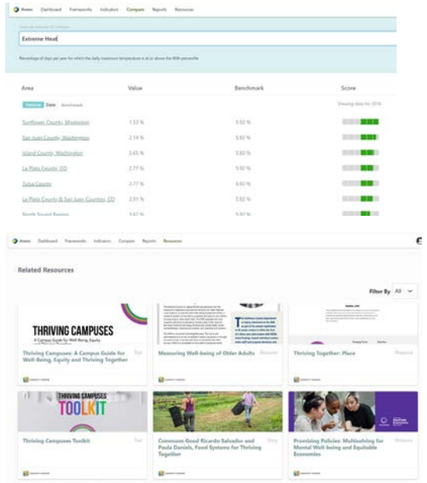
A community needs assessment is an invaluable process that aids in identifying the factors that influence a populations health and available resources. Data for community needs can be sourced from individual surveys, focus groups, town hall meetings, interviews, or secondary data. A community needs assessment provides leaders with the insight they need to create innovative strategies for effective change and sustainability.

Community Needs Assessment steps

1. Define the scope
2. Plan for a Community Needs Assessment
3. Review and categorize the data
4. Record and summarize the data
5. Create a community action plan
6. Share the findings

Fellows tasks:

Incorporate new data sources into IP3 Assess, perform quality assurance testing on the website interface, geographic information system(GIS) data population verification, score gauge testing, metadata validation, source link verification. In total, over 15 health indicators were uploaded to IP3 including data sourced from CMS Medicare Mapping Disparities, CDC Atlas plus, CDC wonder and more..



Recommendations

Community partners, health systems, and organizations are essential in contributing to the health and wellness of communities. More organizations are becoming interested in ameliorating substance use as well as other public health issues. At times it is challenging to communicate across sectors and create meaningful plans without understanding the insights that datasets provide.

Designated task forces should be developed to spearhead initiatives around substance abuse particularly as it pertains to policy, resources, and statistics. Data knowledge sharing sessions should be held throughout organizations so that stakeholders and members are informed of project objectives, data trends, internal/external benefits, and the overall contribution to the wellness of our communities.

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City of Rialto Healthy Communities Initiative

Diana Cervantes, MPP Candidate, University of California, Riverside
Site: City of Rialto
Preceptors: Barbara McGee, City Clerk & Cristian Gutierrez, Senior office Specialist/Healthy Rialto

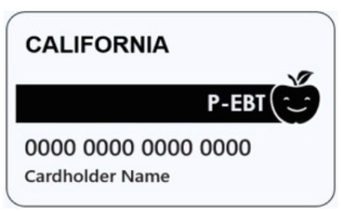
Healthy Rialto Healthy Communities

In order to combat malnutrition and food insecurity in the City of Rialto, the City Clerk Barbara McGee launched the Healthy Rialto initiative in 2008. The Initiative provides healthy programs and services to enrich and empower the lives of residents of Rialto. Their mission is "to promote community wellness and wholeness through education, resources, and activities."

Rialto Certified Farmers Market

The Rialto's Certified Farmers Market, established in 2012, provides the community with accessible and affordable locally sourced healthy food options, including produce (fruits and vegetables), nuts/seeds, pure raw honey, free-range cage-free eggs, hummus, bread, and more. The Rialto Certified Farmers Market is one of the only farmers market that stayed opened throughout the COVID-19 pandemic.

The Certified Farmers Market accepts:



What is EBT also known as CalFresh?

SNAP/ EBT is also known as CalFresh. Supplemental Nutrition Assistance Program. The CalFresh program helps people have healthy and nutritious food on the table. The program issues monthly electronic benefits through a card similar to a bank debit card that can be used to buy most foods such as bread, cereal, fruits, vegetables, meat and fish at many markets, grocery stores and farmers' markets.

What is P-EBT?

P-EBT also known as Pandemic EBT in which it is a federal program. In response to the COVID-19 pandemic the California Department of social services (CDSS), in partnership with the California Department of Education (CDE) received approval to implement P-EBT. P-EBT provides food benefits to help families with young children (under age 6) who got CalFresh Food benefits between October 2020 and August 2021 and school age children who were eligible for free or reduced-price school meals through the federal School Breakfast or National School Lunch Program for School Year 2020-21).

How does Market Match work at Rialtos Certified Farmers Market?

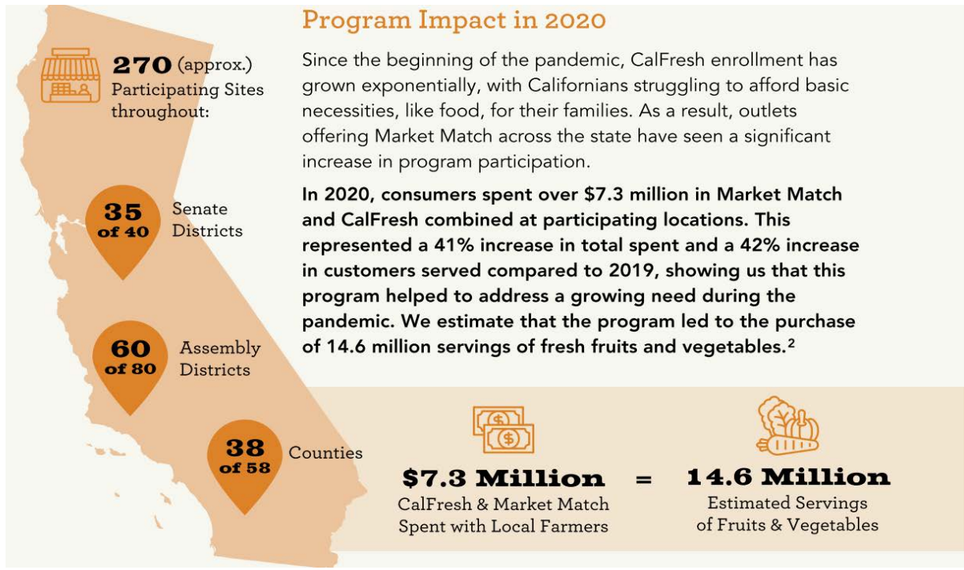
1. A recipient of CalFresh or P-EBT must find the booth that exchanges funds.

2. Swipe your Card

3. Receive Market Match tokens (each is a value of $1)

When you spend $15 of your own CalFresh or P-EBT funds, you receive additional $15 of market match funds that can be used for fruits and vegetables only.

Starting March 2022 Market match has dropped from $15 to $10



The Role of School Gardens and Cafeteria Design in Nutrition Education for Elementary Schools

Elizabeth F. Allen, M.A.

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

Claremont Graduate University

UPLAND UNIFIED SCHOOL DISTRICT

Upland Unified Farm to School Program

Nutrition education is paramount for building a foundation of healthy eating habits and positive attitudes toward nutritious food. Schools play an important role in establishing nutrition literacy by providing students with the necessary tools and knowledge to make healthy choices. Upland Unified School District fosters nutrition education through organizations such as Food Corps, school garden clubs, and a dedicated Farm to School Manager. On site nutrition lessons and opportunities to participate in garden clubs enables students to establish healthy habits that will last a lifetime.

Garden bed building at Upland Jr. High

Garden Clubs

Upland Unified strives to empower students to increase nutrition literacy by allowing experiential learning opportunities in the Farm to School Program. By participating in after school garden clubs, students gain experience in gardening through seed planting, garden maintenance, crop harvesting, and garden design.

Mobile Dairy – Abagail the cow

Farm to School Field Days

Farm to school field days are opportunities for local farmers to teach kids about where the food they eat comes from. Five elementary schools at Upland Unified held Farm to school field days with lessons from a local farmer on food production and a "mobile dairy" (a cow on a trailer!) to teach kids where milk comes from.

Taste tests are a good way to try foods harvested from school gardens

Poverty and Obesity in Upland, CA

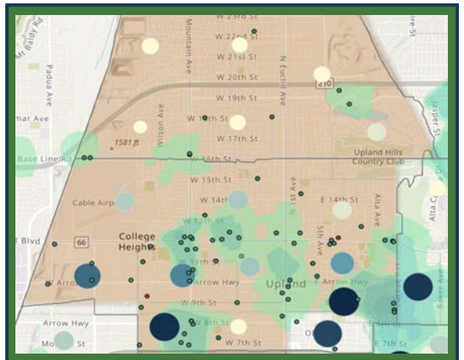
37% Obesity

12% Poverty

5% Food Insecurity

Upland By The Numbers

Food insecurity and poverty are linked to obesity. Oftentimes, families must choose between nutritious or budget friendly food. A bean-and-cheese burrito at Del Taco is $1 while a salad with chicken is $8 at Chipotle.



South Upland, which is home to many Upland Unified School District's elementary schools, has higher rates of poverty according to Census tract data.

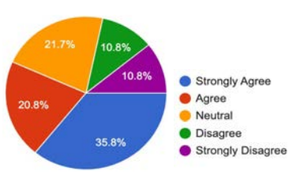
Policy Recommendation

School gardens can provide access to fresh fruit and vegetables for students in low-income areas. School garden clubs can increase food production in school gardens and invite families to a monthly farmer's market offering food from the gardens.

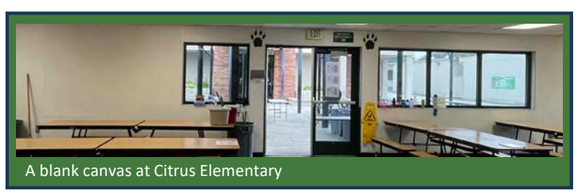
Cafeteria Aesthetics

Messages about how nutrition is portrayed can affect food and snack choices. Positive images of nutrition and healthy foods on cafeteria walls can favorably affect students' attitudes toward nutrition and healthy eating and can further affect social behavior such as making healthy food choices when among their peers.

Surveys from elementary schools revealed that students did not like the look of their cafeteria walls – an opportunity for positive change!



I wish the cafeteria walls looked different



A blank canvas at Citrus Elementary

Policy Recommendation

Cafeterias should consider that food and nutrition choices are influenced by the physical environment of the cafeteria. When designing decor, walls should display positive images of fruits and vegetables to increase consumption.

HEALTHY AGING AND NUTRITION EDUCATION: ASSISTING THE BLUE ZONE PROJECT TO IMPROVE HEALTH OUTCOMES FOR OLDER ADULTS IN BOYLE HEIGHTS.

Emmanuel Sanchez-Ramos | MPH Student | California State University, Los Angeles

BLUE ZONES - Adventist Health acquired Blue Zones Project in 2020 to improve and transform the health of communities by optimizing public policy, social connections, and places. Blue Zones Project aims to help communities implement evidence-informed programs that lead to greater stability and improve health equity, where people live long healthy lives. Blue Zones Project focuses on influencing the life radius, the area close to home in which people spend most of their time by strengthening social ties, reshaping places, and sharpening policies to support healthy choices. The community of Boyle Heights is in the beginning stages to receive Blue Zone Project certification.

LIFE RADIUS MODEL - Certified Blue Zones Communities have populations with greater well-being, improved health outcomes, and cost-effective programs that help reduce chronic diseases like obesity and diabetes.

The Blue Zone Project leans on the nine specific lifestyle traits that were identified as keys in longevity and healthy living in the five-core blue zone. The goal is to see which elements could lead to healthier outcomes at the local level and Boyle Heights could be the next LA neighborhood to join the group of communities whose lifestyle habits have improved.

PEOPLE
Blue Zones Project engages people in activities that change mindsets and habits in lasting ways.

PLACES
Blue Zones Project is designed to influence places across the community, optimizing each environment to support healthy choices.

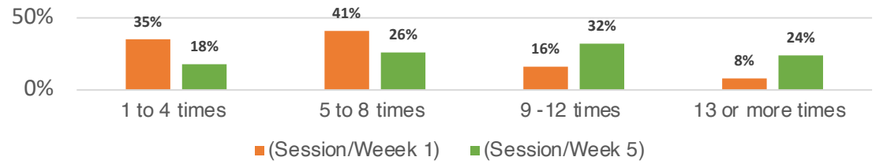
POLICY
Policy change is a driving force behind blue zones project transformation.

PROJECT GOAL: The goal is to show how healthy eating and knowledge of fruits and vegetables can impact people's health, and behaviors.

PROJECT OVERVIEW

- My project with a focus on Healthy Aging consists of hosting nutrition education classes to enhance knowledge among older adults and promote intake of fruit and vegetables.
- Develop a 5-session nutrition education curriculum to encourage healthy behaviors.
- Host a 60-minute nutrition education session once a week at the local health center.
- Collect pre- and post- evaluation data at each session to develop educational material.

IN THE PAST 7 DAYS, HOW MANY TIMES DID YOU EAT A SERVING OF FRUIT OR VEGETABLE?



KEY FINDINGS

- A total of 37 participants attended 5 weekly nutrition classes. All participants were 55 years of age and older and Hispanic/Latino.
- Recommended fruit/vegetable intake is 3-5 servings a day, or 21-35 servings a week. Pre-evaluation test showed that most participants reported low intake of Fruit and Vegetables (F/V) in the lapse of 7 days. About 76% (n=28) of participants reported less than 10 servings of fruit/vegetables per week. See graph above.
- After completion of all 5 sessions, results from post-evaluation indicated a positive shift in fruit and vegetable consumption. About 55% (n=20) of participants learned ways to incorporate F/V in their diet and by the end of all 5-session data showed an increase of F/V intake among participant, going from 24% (n=9) session 1 to 60% (n=22) in session 5. Meaning that more than half of the participants were consuming more than 2 servings of F/V a day. See graph above.

CONCLUSION & POLICY RECOMMENDATION

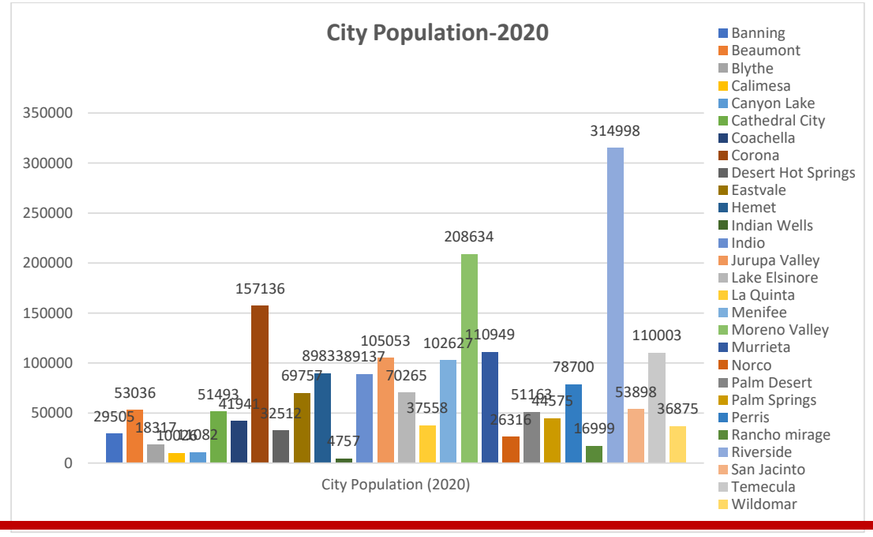
The eating habits of people living in Blue Zones communities play a key role in their lifelong good health. Fueling the body with nutritious fruits and vegetables will benefit people's health now and in the future. A policy recommendation I would propose involves a collaboration between local community organizations, local stakeholders and Blue Zones Project teams. The collaboration would focus on enhancing current programs or creating new programs that integrate increasing access to fresh F/V and healthy foods, particularly for those living in low-income neighborhoods and older adults. At the same time, these programs would provide food and nutritional knowledge to community members about ways to improve their habits. The collaboration can help the community develop a plan to keep people healthy by integrating local strategies and deepening community reach and trust.

An Assessment of Mental Health Needs in the Pediatric Population in the Riverside County

Eva-Vera Kouassi Clollet
MHA Student | Healthcare Administration | Loma Linda University
Riverside University Health System | *Site Supervisor*: Dr. Gabrielle Pina

OVERVIEW

The national suicide rate amongst children has significantly increased over the past few years, showing the need for resources for kids with depression or suicidal ideation. The research conducted is a community needs assessment of pediatric patients in the Inland Empire cities. It focuses on the mental health resources available to children under 18 years old based on their geographical location. In order to attain our goal, we used three general methods of assessment, notably key informant interviews, geographic indicator analysis, and data review. The data derived from the research shows a weak patient to provider ratio and the need for more mental health resources in the Riverside County. We will also use these results to better serve suicidal patients who check in the Emergency Room (ER) at the Riverside University Health Systems. By taking preventative measures and educating staff members, we hope to help reduce the youth suicide rate.



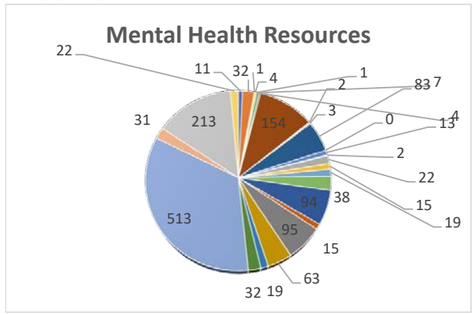
STEPS

1. Assess for mental health bed allocation for pediatric patients in riverside county.

2. Survey school districts in riverside county for on campus or affiliated campus resources for pediatric patients.

3. Create a map of school districts at risk for mental health issues based on hospital ER visits and admissions for suicide attempts.

RESULTS



The data revealed a significant difference between schools and the resources they have at their disposal to assist students in need. Some districts have a plethora of resources, while others lack the necessary tools and staff to conduct mental health screenings which puts them at risk for psychiatric issues. It is often due to the amount of funding that school districts receive and the partnerships they can develop. Out of the 28 cities assessed in the Inland Empire, none registered a Patient per Provider Ratio (PPR) equal to 1:1000, which is the ratio recommended by the World Health Organization (WHO).

RECOMMENDATIONS

- Allocate a mental health budget to every school district in the Riverside County.
- Create and Encourage Partnerships between school campuses and local mental health providers and Emergency Rooms.
- Perform mental health screenings on the pediatric population to prevent suicidal ideation and reduce the child suicide rate.

Acknowledgements

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- *Riverside University Health System*
  Dr. Gabrielle Pina, Pediatrician
- *Loma Linda School of Public Health*
  Sharilyn Andersen, Practicum Professor
  Dr. Huma Shah, Program Director

Not Available

Not Available

Not Available

Not Available

Southern California Association of Government's Tree Planting Suitability Webtool

George Karam
MURP Candidate
University of California, Los Angeles

The SCAG Region

SCAG, the Southern California Association of Governments, encompasses a six-county region—Ventura, Los Angeles, Orange, Riverside, San Bernardino, and Imperial Counties—that spans over 38,000 square miles and is home to over 19 million people in over 190 cities.

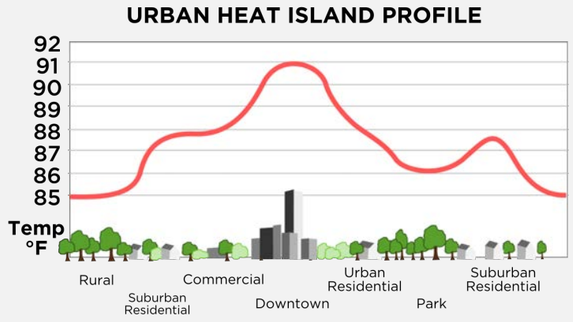
Source: *SCAG*

Social Determinants of Health and the Built Environment

According to the US Department of Health and Human Services' Office of Disease Prevention and Health Promotion (ODPHP), there are five social determinants of health—economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context–which refer to the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (ODPHP 2022). Due to exclusionary planning practices in the 20th century, lower income communities of color are more likely to be in neighborhoods with less access to jobs and healthcare, unsafe drinking water, poor air quality, and **higher temperatures**.

Urban Heat Island Effect

Urban heat island (UHI) effect occurs when cities replace native vegetation and other land cover with pavement, buildings, and other surfaces that inadvertently trap heat and increase surface and air temperatures to levels high enough to impact community health.



Source: *U.S. National Oceanic and Atmospheric Administration*

Methods

To strengthen data accuracy, I conducted an in-depth literature review on the effect of urban heat on public health, heat mitigation through the built environment, tree planting best practices, and the nexus of urban tree canopy cover and equity. After acquiring the data, our team developed a system to score communities on a variety of factors. The suitability score considers sociodemographic makeup—population density, age, sex, income, and poverty—land cover, and urban heat severity data to produce a score for each community at the block group level.

Planning and Development Process

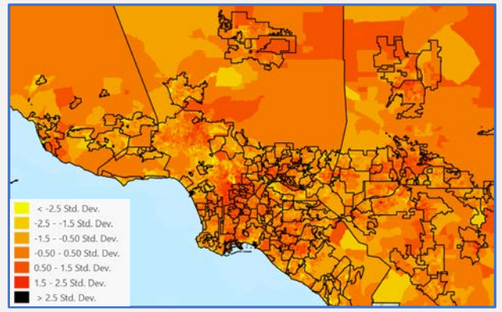
Data Collection
- Review literature on UHI to identify communities most vulnerable to urban heat
- Create a tree-planting suitability scoring system

Tool Development
- Integrate interactive maps into GIS Experience Builder
- Include information on effects of UHI on public health, list of existing programs, and tree-planting best practices

Local Application
- Partner with cities, counties, and nonprofits and share the webtool
- Aid jurisdictions in crafting tree-planting and urban greening programs

Conclusion

This webtool, once complete, is one way to allow jurisdictions to prioritize these communities by offering the co-benefits of urban trees for mental health, carbon capture, and UHI effect mitigation. Urban trees require strategic placement that depends on climate, maintenance, and public rights of way. By adding this to the toolbox forestry departments regionwide, jurisdictions can avoid the guesswork and focus on providing more shade for its communities in need.



Source: *SCAG, Sustainability Department*

SAN ANTONIO HEALTH
Community Health Improvement Program

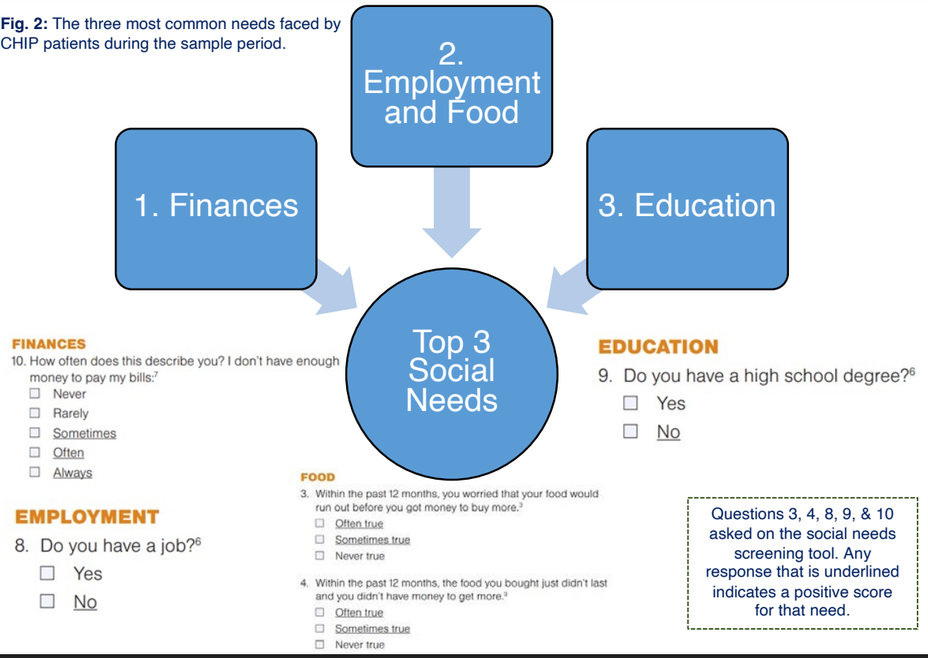
What is the Community Health Improvement Program (CHIP)?

CHIP's purpose is to provide a system of care coordination and coaching for patients with difficulty navigating and managing their chronic illnesses. Emergency room visits could be prevented if someone were to help: 1. Manage the patient's chronic conditions; 2. Coordinate the patient's care; 3. Address the patient's social, economic, and environmental issues; 4. Follow-up with the patient. CHIP intends to fill these gaps to prevent unnecessary acute care utilization and cost.

Fig. 1: Social-ecological model

What results did we find?

Fig. 2: The three most common needs faced by CHIP patients during the sample period.



Questions 3, 4, 8, 9, & 10 asked on the social needs screening tool. Any response that is underlined indicates a positive score for that need.

To address social determinants of health related to financial needs, CHIP piloted a partnership program with a local thrift store. The partnership enables CHIP to distribute vouchers to patients for their personal use, and at their own discretion. As of March 25, 2022, the following has been found about the use of vouchers:

- (4) vouchers have been used.
- The vouches were used on 11/2021, 12/2021, 01/2022, and 02/2022.
- Items purchased with vouchers were:
  - Clothing (shirt, jacket, & sweater)
  - Children's cleats
  - Kitchen items (cups & dishes)
  - Home decoration items
  - Books & DVDs

What lessons did we learn?

CHIP learned that the following is required to improve the program's ability to address the social determinants of health of patients who participate in the program:

- Conduct follow-up to determine if patients utilized their vouchers, and what motivated them or discouraged them from using the vouchers.
- Conduct follow-up on patients' experiences shopping at the thrift store to identify areas for growth.
- Re-assess patients' financial needs prior to their exit from the program.
- Address any remaining needs that arise during the re-assessment.
- Continue to assess for social needs to upstream the responsibility of addressing needs to the appropriate entities in due time.

"Health improvement requires action on multiple fronts– medical care, healthy behaviors, the social and physical environment."

SOCIAL DETERMINANTS OF HEALTH
Iris Vanegas
Randall Lewis Health and Policy Fellow

SOCIAL DETERMINANTS OF HEALTH
Iris Vanegas
Randall Lewis Health and Policy Fellow

Best Practices in Tracking Transportation Network Company (TNC) & Transit Partnerships in Southern California

By James Morimoto, MPH Candidate

RANDALL LEWIS HEALTH & POLICY FELLOWSHIP

SCHOOL OF COMMUNITY & GLOBAL HEALTH
Claremont Graduate University

Who is SCAG?

The Southern California Association of Governments (SCAG) is the largest council of governments in California and serves as the Metropolitan Planning Organization (MPO) for over 18 million people in Southern California. SCAG tracks and evaluates various sustainable community Strategies (SCS) developed for Connect SoCal, the regional transportation plan (RTP). The tracking and evaluation of these strategies and the associated Greenhouse Gas (GhG) reductions need to be reported to the California Air Resources Board (CARB) to comply with environmental regulations.

What are Transit/ TNC Partnerships?

Transit/ TNC partnerships are collaborations between public transit agencies and private rideshare companies to supplement existing transit systems by providing on-demand services to improve the accessibility, reliability, and sustainability of the existing transit system. These partnerships can be implemented in a myriad of forms including first-last mile trips. paratransit supplementation, and microtransit supplementation.

Fellow's Tasks

- Research prevalence of transit/ TNC partnerships and other on-demand service and solutions for transit agencies within the SCAG region.
- Create best practices recommendations for the development of 2024 Connect Socal SCS/ RTP on various mobility strategies.

Methods

- Conducted a short survey for transit agencies about TNC partnerships and other on-demand services within SCAG region using Survey123.
- Interviewed with TNC companies operating in the SCAG region about their transit partnerships.
- Incorporated follow-up questions for survey and interview responses and analyze survey results using Microsoft Excel.
- Created best practices recommendations to track partnerships and other on-demand solutions implemented within the SCAG region.

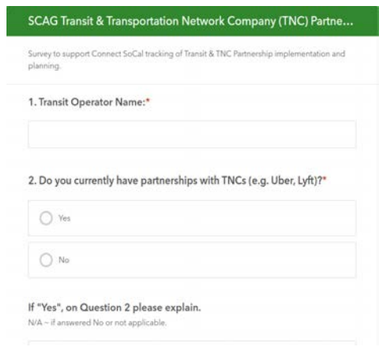
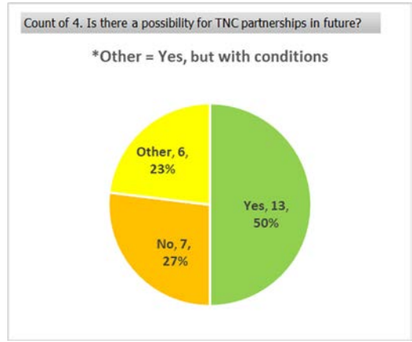


Figure 1. Transit Survey on Survey123

Results

- The survey results show 12% of the 26 participating transit agencies have a TNC partnership, 12% of the transit agencies surveyed had past TNC partnerships, and at least 50% would consider a future TNC partnership.
- The interview results showed TNCs have transit partnerships within the SCAG region, at various capacities, that help address challenges (ridership, changes in transit demand, and sustainability), and support equity.
- The data revealed how the process to establish a partnership is difficult for some transit agencies.
- Transit agencies with TNC partnerships from this project include Santa Monica Big Blue Bus, City of West Hollywood, and City of San Clemente (Orange County Transportation Authority).



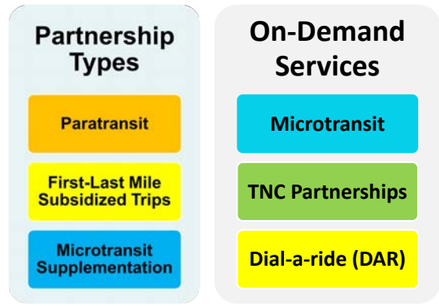


Figure 2. Survey results for future TNC partnerships
Figure 3. Most common TNC/ Transit Partnership variations.
Figure 4. Most common on-demand services from survey.

Discussion & Future Considerations

Some best practice recommendations for SCAG to consider for future projects and tracking of Transit/ TNC Partnerships:

- Conduct a short annual survey for transit agencies and an annual interview with TNC partners in the SCAG region to track progress. Use ESRI compatible software to allow for GIS data and follow-up questions for qualitative data to supplement descriptive analyses.
- Facilitate TNC/ Transit Partnerships discussions between stakeholders and private partners in meetings with 6 or fewer people to discuss potential partnerships.
- Off-model assumptions to track microtransit should be considered for Connect SoCal as microtransit is the most common alternative on-demand transit solution from our survey for transit agencies.
- These mobility programs should be tracked and evaluated with criteria for equity as these solutions are originally designed to address accessibility, reliability, and sustainability issues for transit.

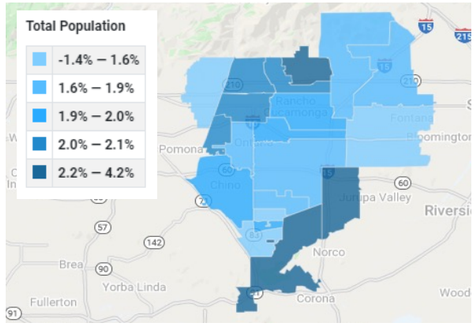
References

- American Public Transportation Association. (2020, November 12). *Transit and TNC partnerships*. American Public Transportation Association. Retrieved April 5, 2022, from https://www.apta.com/research-technical-resources/mobility-innovation-hub/transit-and-tnc-partnerships/
- *Read "partnerships between Transit Agencies and Transportation Network Companies (tncs)" at nap.edu*. National Academies Press: OpenBook. (2019). Retrieved April 5, 2022, from https://www.nap.edu/read/25576/chapter/10

SAN ANTONIO REGIONAL HOSPITAL | pbh Partners for Better Health | RANDALL LEWIS HEALTH & POLICY FELLOWSHIP | La Sierra UNIVERSITY

Hospital Strategic Initiatives Related to Service Line Development and Operational Efficiencies

2020 – 2025 Population Projections

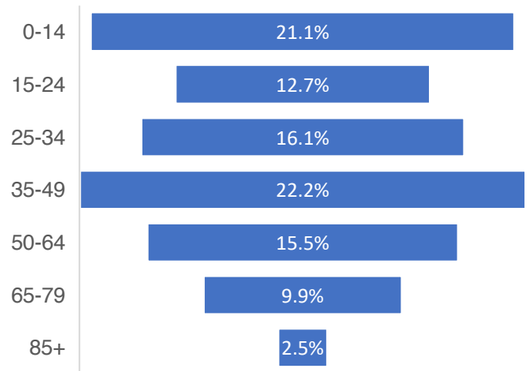


Source: Advisory Board, Demographic Profiler

San Antonio Regional Hospital's (SARH) mission is to improve the health and well-being of the people it serves. These people make up a large portion of the population in the Inland Empire and it is vital to align SARH's strategy and operations with the community's current and projected demographics and their health needs.

Modelling population shifts in tools like ARCGIS, Advisory Board, and Optum Market Advantage gives SARH insight into where and when new health needs in its service areas might arise. Combining this understanding with market share analysis based on claims data from the California Department of Health Care Access and Information, SARH can evaluate the impact of population shifts on its service offerings and how to adapt to adequately meet health needs.

Population Age, Primary Service Area (2021)



Source: ESRI, ARCGIS

Fellow: Max Proebstle I MBA Health Care Management, Finance
Preceptor: Roldan Aguilar I Executive Director of Strategic Operations

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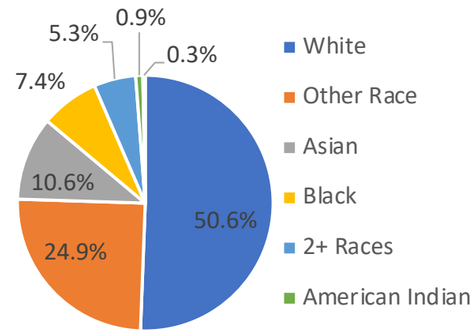
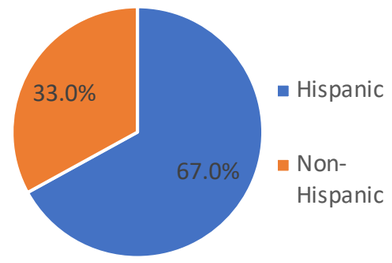
Race in Primary Service Area



Source: Advisory Board, Demographic Profiler

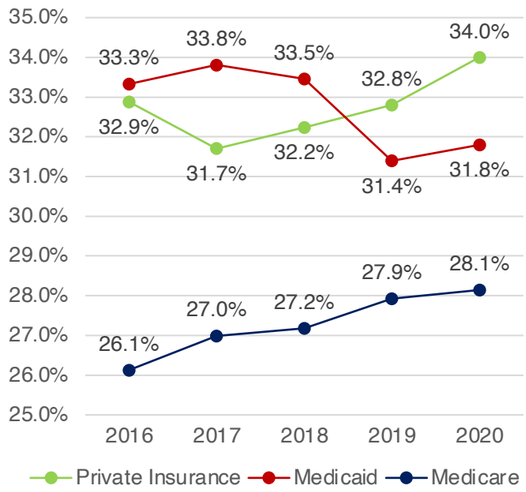
Ethnicity in Primary Service Area



Source: Advisory Board, Demographic Profiler

One area of impact that these analyses affect is in contributing to the formation of a new five-year strategic plan for SARH. Taking into consideration internal variables as well as patient factors such as age, gender, race, ethnicity, insurance coverage, income, and employment rate, multiple actionable steps were formulated at a strategic planning retreat. These efforts all enhance SARH's goal to best serve the community in which the hospital is located.

Primary Service Area: Inpatient Payer Shares



Source: Advisory Board, Market Scenario Planner Premium

Fellow: Max Proebstle I MBA Health Care Management, Finance
Preceptor: Roldan Aguilar I Executive Director of Strategic Operations

Bicyclist & Pedestrian Diversion Education Program

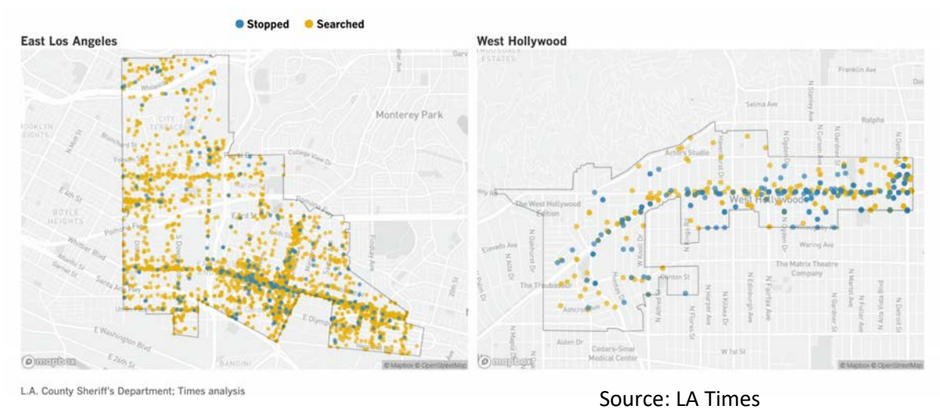
Policies for Livable Active Communities & Environments (PLACE)

Jorge A. Barahona | Randall Lewis Health Policy Fellow
MPH Student | University of Southern California

County of Los Angeles Public Health | Partners for Better Health | Randall Lewis Health & Policy Fellowship | Keck School of Medicine of USC

Introduction & Background

Fatalities and serious injuries as a result of a collision have been steadily increasing across the US. California passed AB-902 in 2015 allowing for the implementation of cyclist/pedestrian diversion programs. Diversion programs are local efforts involving municipal or county governments and local law enforcement. The focus of these programs is to increase safety through education and reduce financial impact caused by citations. In August 2020 the Los Angeles county Board of Supervisors adopted the County's Vision Zero Action Plan, including action B-2: "Identify process and partners for establishing a diversion program for persons cited for infractions related to walking and bicycling." On November 4th 2021, the LA Times published an investigation, "*L.A. sheriff's deputies use minor stops to search bicyclists, with Latinos hit hardest,"* highlighting this inequity. On November 16th 2021, the LA County Board of Supervisors passes a motion directing Public Health to act on Vision Zero Action B-2. Communities of color in poorer areas of LA County have the highest rates of citation including: East LA, Lancaster, Compton. We are currently working with County agencies on a report for the Board of Supervisors to begin a pilot.



Source: LA Times

Program & Project Overview

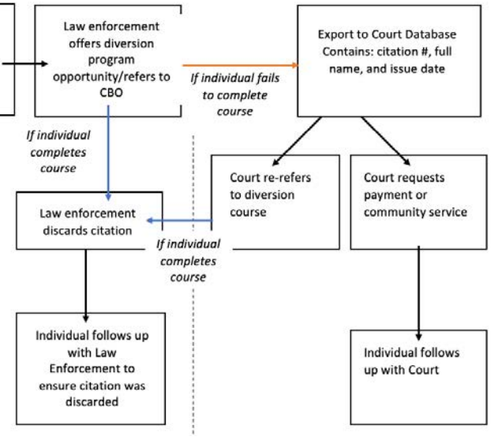
To begin implementation, DPH began meeting with stakeholders including Community Based Organizations (CBOs), Law Enforcement (CHP & LASD), Criminal Justice Advocates, LA Superior Courts and Public Works. Beyond these conversations, we investigated other similar diversion programs in Gilroy, Sacramento, and Huntington Beach. There are two fundamental models for these diversion programs: pre-filing and post-filing models. Through our various meetings, we believe pursuing a pre-filing model would help reduce inequities from citations. In addition to researching an ideal model, we gathered data from LASD to identify the area that would benefit the most from a diversion program. Using citation data from LASD we identified which areas have the highest prevalence of citations. This data helped identify which area would be most suitable for the pilot diversion program.

STATIONS WITH HIGHEST BICYCLE CITATIONS	STATIONS WITH HIGHEST PEDESTRIAN CITATIONS
East LA Station (286)	Lancaster Station (360)
Lakewood Station (233)	West Hollywood Station (272)
Carson Station (165)	Palmdale Station (269)
Lancaster Station (141)	Lakewood Station (123)
Temple Station (100)	Santa Clarita Station (114)

STATIONS WITH HIGHEST BICYCLE CITATIONS PER 100,000	STATIONS WITH HIGHEST PEDESTRIAN CITATIONS PER 100,000
Compton Station (258.8)	West Hollywood Station (747.6)
East LA Station (155.2)	Compton Station (204.6)
Marina Del Rey Station (151.2)	Lancaster Station (198.6)
Carson Station (143.4)	Palmdale Station (141.1)
Lakewood Station (95.4)	Cerritos Station (65.8)

Source: Pascual 2020; LASD Citations (2016-2018)

Concept for a Pre-Filing model



Source: LA County Vision Zero

Recommendations & Conclusion

The County of Los Angeles can improve health by reducing collisions and fatalities by:

- Increasing investment in cyclist and pedestrian infrastructure.
- Providing free cyclist and pedestrian safety education.
- Providing free safety equipment: bicycle lights & helmets.
- In lieu of monetary fines, allow cited individuals to participate in a diversion education program.
- Evaluate the effectiveness of program and continue to monitor disparities.

VISION ZERO LOS ANGELES COUNTY

Building a Healthier Glendale Community

Lauren D'Souza, MSHS Community Health Education, Western University of Health Sciences

Introduction

Glendale Healthier Community Coalition (GHCC) is a community of 52 different program partners and organizations on networking, information sharing, and collaborating on projects to create healthier communities for Glendale and the surrounding service planning areas (SPAs). I mainly focused on Glendale Healthier Community Coalition (GHCC). Other projects I worked on were Go Heart Program, Adventist Health School Wellness Programs (AHSWP) and Community Health Needs Assessment (CHNA). The Glendale Healthier Community Coalition plans and implements projects that promote disease prevention, health education, clean and safe environments, adequate housing, affordable and quality education, and community revitalization. GHCC was led through a community partnerships committee with Adventist Health Glendale (AHGL), YMCA Glendale and Foothills, USC Verdugo Hills Hospital Foundation to address social determinants of health in Glendale and the surrounding communities it serves. Recommendations for health policy are to build health equity in Glendale to improve the community well being. Individual behavior change interventions included offering membership to the GHCC to provide a calendar of activities and events to improve health.

Objective: (What should this program accomplish?)

- Improving healthy lifestyles and health outcomes for members and community.
- Building awareness of program, along with member enrollment, retention, and relationship expansion.
- Referring members to resources and services available through our partners.
- Building and expanding community partner relationships.

Project Examples

- Glendale Healthier Community Coalition (GHCC)
- Go Heart Program
- Adventist Health School Wellness Programs (AHSWP)
- Community Health Needs Assessment (CHNA)

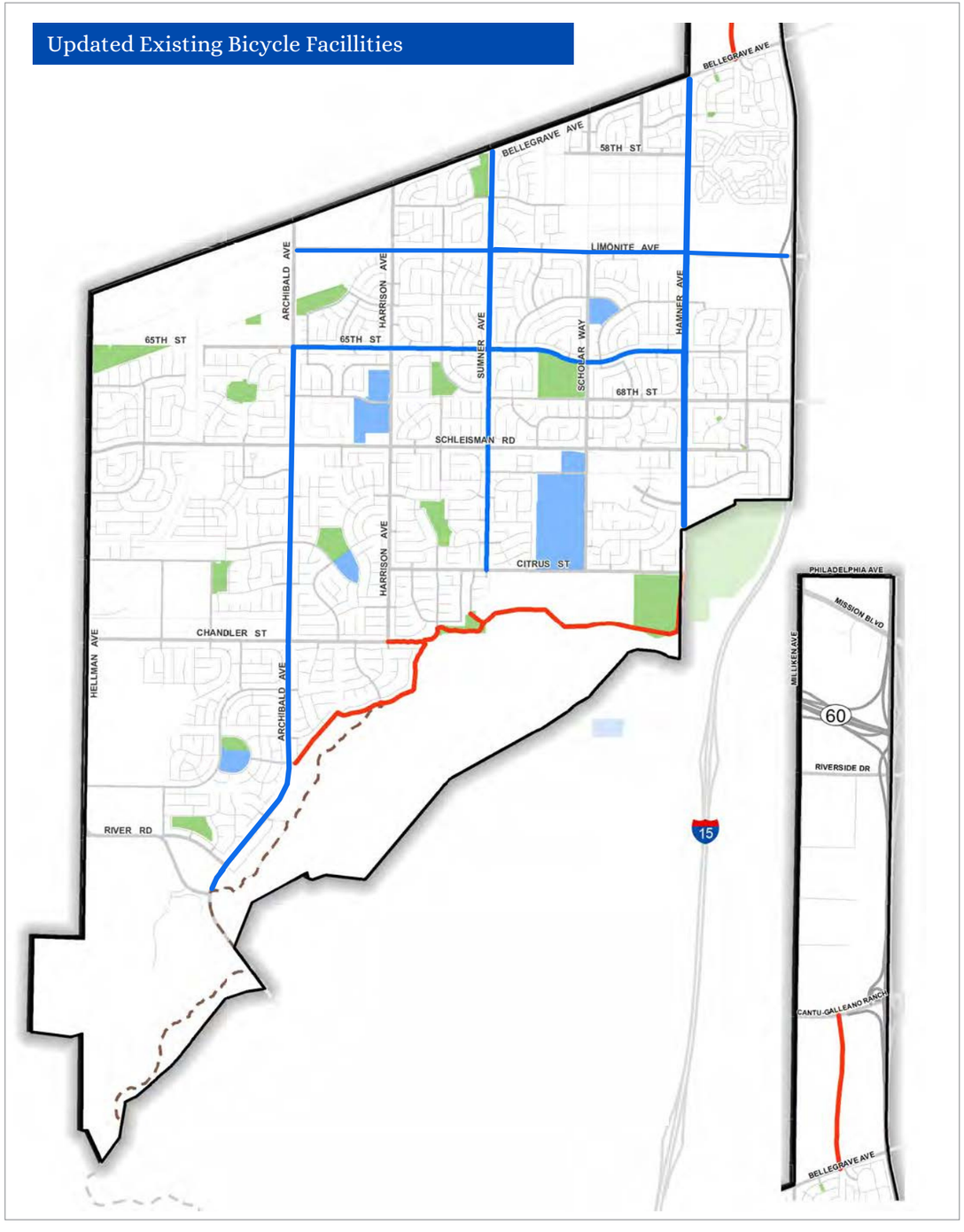
GHCC Health Outcomes

- New Community Outreach Plan
- New website design which included:
- Operations Plan
- Calendar of 3 quarterly events to reconnect partners, identify current health priorities and drive action

Lessons Learned

- Collective impact model – driven by needs, voice, and contributions of partners
- This approach takes time
- Based on relationships – this is the key determinant of success
- Requires a range of communication styles
- Benefits of this approach:
  - Efficiency – can be done with little resources, since all partners contribute what they have available
  - Make initiatives more relevant, successful, and sustainable

Community Partners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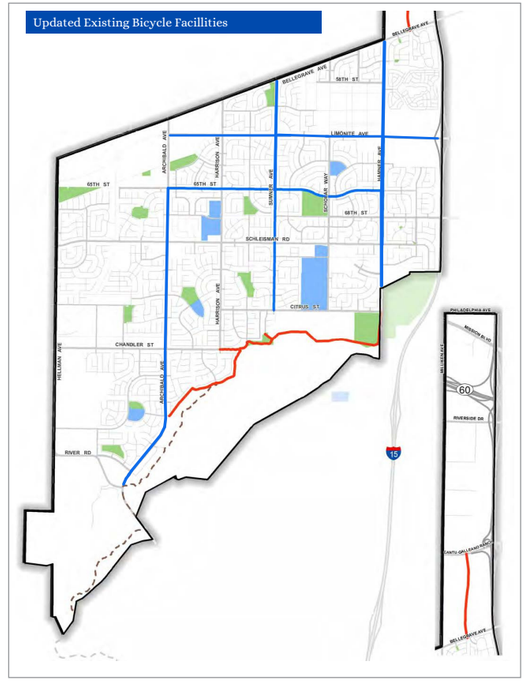
BELLEGRAVE AVE
58TH ST
LIMONITE AVE
ARCHIBALD AVE
HARRISON AVE
SUMMER AVE
SCHOLAR WAY
HAMNER AVE
65TH ST
68TH ST
SCHLEISMAN RD
CITRUS ST
CHANDLER ST
HELLMAN AVE
RIVER RD
PHILADELPHIA AVE
MISSION BLVD
MILLIKEN AVE
60
RIVERSIDE DR
15
CANTU-GALLEANO RANCH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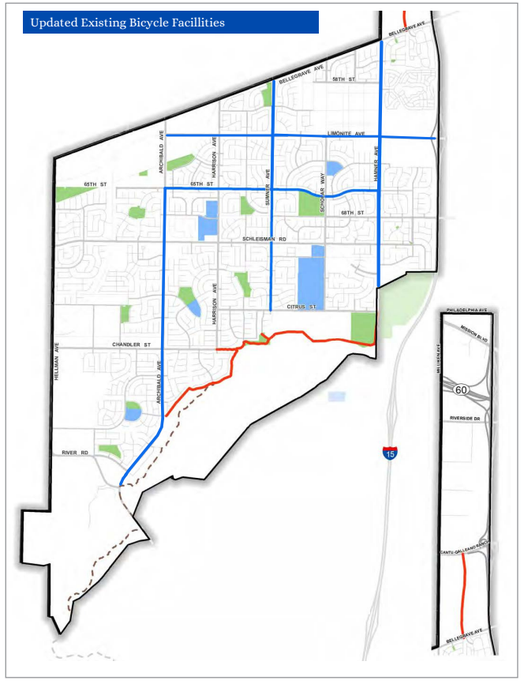
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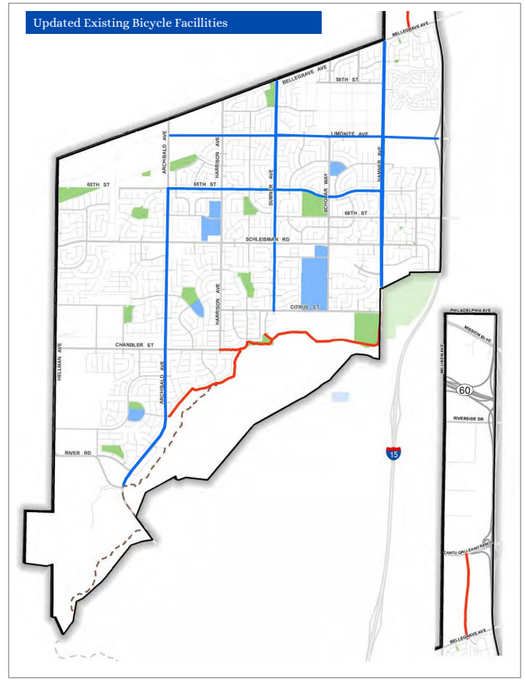
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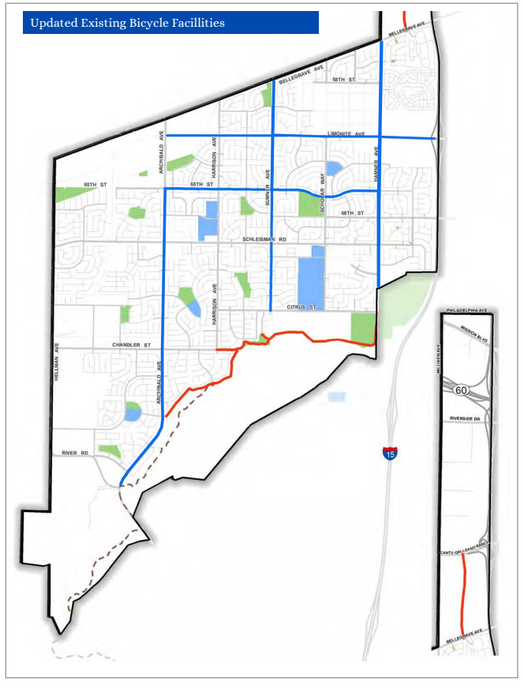

Updated Existing Bicycle Facillities

Achieving Health Equity in the City of Montclair
Mental Health Crisis Response Program

MONTCLAIR

City of Montclair Demographics

The City of Montclair is located in San Bernardino County with a population of 37,865. According to the 2021 U.S. Census Bureau data, racial and ethnic demographics of the city consist of:

- 69.8% Latinx
- 11.6% White
- 11.3% Asian
- 4.3% Black
- 0.8% American Indian/Alaska Native
- 0.3% Native Hawaiian

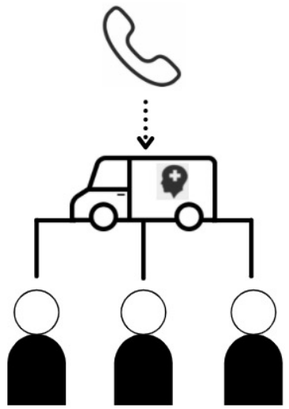
Background

The COVID-19 pandemic has not only exacerbated existing mental health issues among the population, it has also shed light on the consequences of having officers respond to situations they are ill-equipped to handle. Therefore, a program report was created in order to outline a program model that will effectively address those experiencing mental health crises.

Program Recommendation

An alternative first responder model was proposed in the program report. By having a team of individuals trained in responding to those experiencing mental health crises, there will be less adverse outcomes and ultimately ensure that the individuals receive the needed resources.

Mental Health Crisis Response Program Model



- Calls are triaged and the alternative first responder team is dispatched if calls fit the criteria
- Teams consist of an EMT, licensed mental health clinician, and case worker

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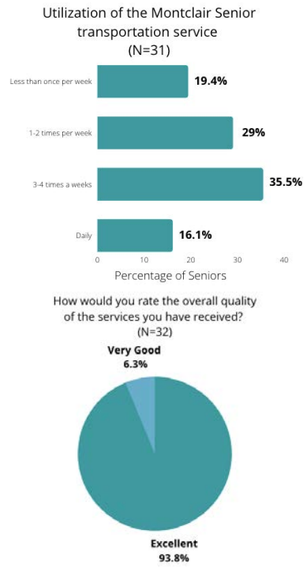
Achieving Health Equity in the City of Montclair
Program Evaluation of the Senior Nutrition & Senior Transportation Programs

MONTCLAIR

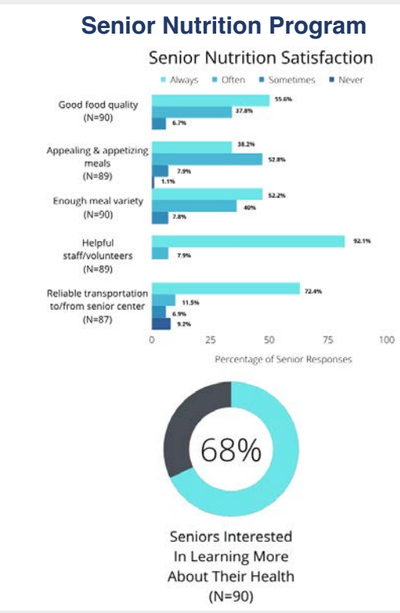
Program Evaluation

The Senior Nutrition and Senior Transportation Programs were evaluated in order to ensure that the programs were adequately serving their intended population. Nutrition and transportation satisfaction surveys were distributed in February 2022, to seniors utilizing the programs. The survey data was then analyzed via Excel and SPSS and is partially summarized:

Senior Transportation Program



Senior Nutrition Program



Program Recommendation

The data indicated that seniors utilize the programs at least 3-4 times a week, and were very satisfied with the Nutrition and Transportation Programs overall.
Some program recommendations include creating lectures and presentations based on health topics seniors are interested in learning more about and adding questions regarding demographic information in order to gather a more in-depth understanding of the senior population being served by the City of Montclair's health programs.

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VENTURA COUNTY COMMUNITY HEALTH IMPROVEMENT COLLABORATIVE

About

VCCHIC is a multi-sectoral collaborative of hospitals, health agencies and community organizations. The primary objective is to break down "siloes between health systems and identify issues that impact the most vulnerable populations."

Population Served

Ventura County

- 10 Cities
- Population 843,843
- Age Groups: 22.9% of the population is under the age of 18 with 15.6% over the age of 65.
- Primary Language and Linguistic Isolation – English and Spanish are the primary languages.
- Insurance status – 9.3% of the population under 65 years are uninsured.

Community Engagement Toolkit

About

Community engagement is essential for sustainability long term. The Minnesota Department of Health believes "that the public has a right to participate, the public has valuable knowledge about what will work in their communities to improve health, and the public makes good decisions."

Benefits

- Health Promotion
- Policy Change
- Thriving Communities
- Community Resource and Power Building

VCCHIC Showcase Piece & Community Engagement Toolkit

Communities Lifting Communities
Lindsay Valenzuela
Loma Linda University

VCCHIC Showcase Piece

Overview

The showcase piece details VCCHIC's background, partnerships, charter information, service area, major outcomes and ingredients for success. It is a comprehensive reference to learn about VCCHIC and inspire others to get involved.

Projects

- 2022 Community Health Needs Assessment
- Community Information Exchange
- California Advancing and Innovating Medi-Cal (CalAIM)
- Nurse-Family Partnership

Why is it important to address the social determinants of health in patient care?

These social determinates are the biggest drivers of healthcare costs in any community. More importantly, they reflect how well we function as a society in the county, city, or neighborhood. Understanding the social determinants will help us to root out the inequities and other factors that block individuals and families from thriving.-Will Grand

Community Engagement Toolkit

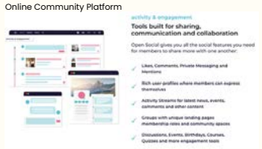
Overview

This toolkit explores the benefits of community engagement. Stakeholder buy-in is vital in establishing/sustaining thriving and healthy communities. There are several tools and resources to help health care leaders engage their community. Below are examples that can easily be referenced and replicated.

Building Better Communities Power Building Framework

Public Health Education Training Modules

Online Community Platform



Addressing Food Insecurity at ULV: Best Practices and Future Planning

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

Mandeep Bhinder, MHA Candidate
University of La Verne
Preceptors: Sarah Rodman-Alvarez
& Adrianne Montero-Camacho

University of La Verne

pbh Partners for Better Health | RANDALL LEWIS HEALTH & POLIC FELLOWSHIP

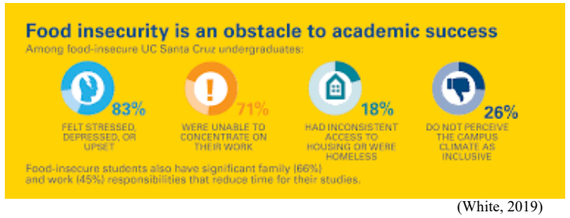
Introduction

Leo Food Pantry was established in 2016 at the University of La Verne to address food insecurity and alleviate student hunger on campus. Currently, the pantry hosts one distribution a month serving around 60-70 students. The pantry uses a distribution model, in which students can choose from either a standard bag or vegetarian bag. Leo Food Pantry's goal this academic year is to research the best practices that can help improve the pantry and expand resources to better serve students facing food insecurity in the future.

What is food insecurity and why is it a concern?

Food insecurity is the lack of availability or access to a sufficient quantity of food or adequate quality food.[1,2] This is due to socio-economic or geographical barriers, such as lack of affordable housing, systemic racism, or unemployment. Studies have found that the rates of food insecurity prevalence on campus is 20% to over 50%.[4] This rate is higher than the 12% rate found in the entire population of United States.[4] Therefore, food insecurity is a growing issue, not only in the United States but on campus community as well. Food insecurity is associated with adverse effects on students' physical wellbeing, such as obesity and malnourishment.[2] Other consequences of food insecurity on students are poorer cognitive function, poorer academic performance, and elevated levels of depression, anxiety, and stress.[2]

(Rada, 2018)



(White, 2019)

Methods

1. Conducted interviews with other universities to learn about their food pantry's best practices. This consisted of two rounds of interviews. Colleges and smaller private universities in Southern California were interviewed in the first round of interviews, followed by the second round of interviews with larger universities across California.
2. Outreached to other companies, agencies, and community food pantries to increase resources for the food pantry.
3. Researched grants to increase the food pantry's funding.

1. *Household food insecurity in Canada: Overview.* (2020, February 18). Government of Canada. https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/household-food-insecurity-canada-overview.html
2. Coffino, J.A., Spoor, S.P., Drach, R.D., Hormes, J.M. (2020). Food insecurity among graduate students: prevalence and association with depression, anxiety, and stress. *Public Health Nutrition*, 24(7), 1889-1894. doi:10.1017/S1368980020002001
3. *Hunger and food insecurity.* (n.d.). Feeding America. https://www.feedingamerica.org/hunger-in-america/food-insecurity
4. Freudenberg, N.,Goldrick-Rab, S., Poppendieck, J. (2019). College students and SNAP: The new face of food insecurity in the United States. *American Journal of Public Health*, 109(12), 1652-1658. DOI: 10.2105/AJPH.2019.305332
5. Rada, R. (2018, February). CalFresh: The most vital anti-hunger intervention in San Diego County. *Congressional Hunger Center*. https://www.hungercenter.org/wp-content/uploads/2018/03/Rada_CalFresh_The_Most_Vital_Anti-Hunger_Intervention-1.pdf
6. White, D. (2019, October). Food for all. *UC Santa Cruz Magazine*. https://magazine.ucsc.edu/2019/10/food-for-all/

Results

The research conducted resulted in creating a Best Practices Manual for campus stakeholders to evaluate, which concludes the following components:

- Literature review
- Eligible grants that can be explored
- Community partnerships that can be established
- Short-term and long-term recommendations on improving the food pantry

Examples of Recommendations

Short-term recommendations (next academic year)

- Tabling events to increase visibility (e.g., club fairs)
- Partner with local food banks to increase distribution frequency to twice a month
- Create campus partnerships (e.g., dorms or campus clubs)
- Apply to grants to increase funding
- Update inventory to be more culturally exclusive (e.g., halal, kosher)

Long-term recommendations (2 – 3 years)

- Grocery model to increase autonomy, remove stigma, and reduce food waste
- Create partnerships with regional food banks to increase distribution to every week (e.g., LA Regional Food Bank
- Provide perishable food items (e.g., fruits and vegetables)
- Offer nutrition classes
- Create a partnership with CalFresh

Conclusion

The Leo Food Pantry will utilize the Best Practices Manual to improve pantry operations and advocate for systemic change on campus. Several barriers were identified during the research (such as financial limitations, staffing constraints, and space availability). Universities, lawmakers, and stakeholders should evaluate these barriers so students experiencing food insecurity do not go hungry.

City of Ontario Mental Health Initiative

Mario Alberto Mendoza, Master of Public Policy Candidate, University of California, Riverside
Site: City of Ontario, Community Life & Culture Agency
Preceptor: Lacey Rightmer, Senior Management Analyst

Community Life & Culture

Mental Health is an area that has slowly gained the attention of the City from incidents that have occurred globally and locally. As the City focuses its attention on serving the community it finds ways to seek assistance on making sure the community has the resources needed for the community to strive. As the City values being committed to the community and doing the right thing.

Community Life & Culture strengthens our diverse community through art, learning, leisure. Heritage and health. They create memorable experiences by connecting people to places, resources, and each other.

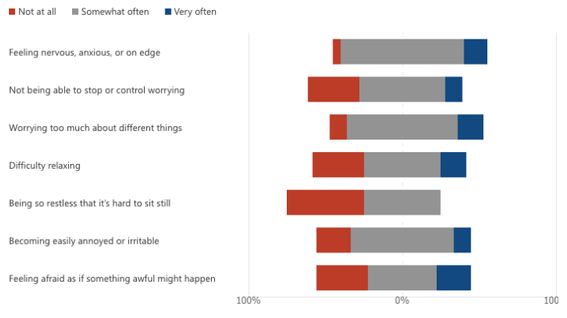
Healthy Ontario

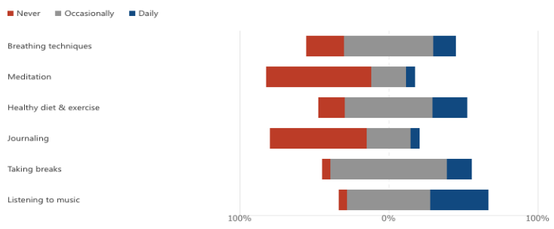
The Healthy Ontario Initiative is a long-term umbrella initiative that aims to improve community health through collective impact. Its mission is to empower the community of Ontario to take ownership of its health and to make Ontario a model for healthy communities by improving physical, social, environmental, and economic health and well-being. It represents a community-based approach to wellness that seeks to make changes at multiple levels in order to bring about improved health outcomes. It focuses our efforts on four main areas:

Mental Health Initiative

The Mental Health Initiative focuses on three components - partnerships, assessments, and workshops - to see the community's needs. Partnerships focus on outside internal and external agencies on building relationships to see how they can collaborate to provide resources to the community. Assessments create a survey that analyzes the community's needs and needs to serve specific populations. Finally, workshops evaluate the assessment results and create programming events to the needs of the residents. Simultaneously, the initiative works with the Mental Health Task Force on breaking down the stigma of mental health in the community.

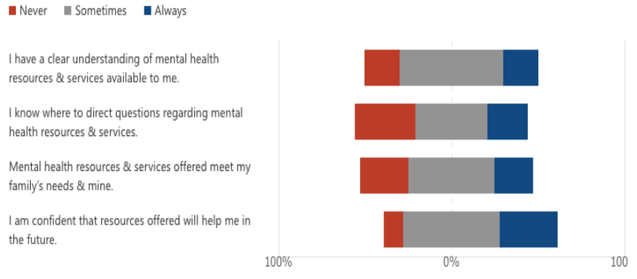
Based on the survey, out of total respondents, about 50% of individuals somewhat experience some level of discomfort/downness daily. This information allowed us to understand the community's level and the best initial workshops for coping mechanisms.





Based on the survey, out of total respondents, most individuals find ways to manage their mental health issues out of the total respondents based on the survey. This information allows us to focus our workshops on various other techniques that may be useful for individuals.

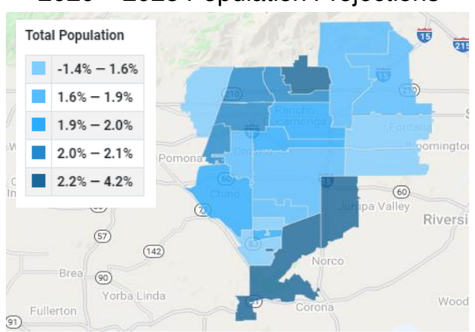
Based on the survey, out of total respondents, about 50% of individuals cannot confidently state that they are aware of services and resources. This information is beneficial to know as it allows us to know that there need to be efforts on promoting resources around the community and how individuals can better their wellbeing.



SAN ANTONIO REGIONAL HOSPITAL | pbh Partners for Better Health | RANDALL LEWIS HEALTH & POLICY FELLOWSHIP | La Sierra UNIVERSITY

Hospital Strategic Initiatives Related to Service Line Development and Operational Efficiencies

2020 – 2025 Population Projections

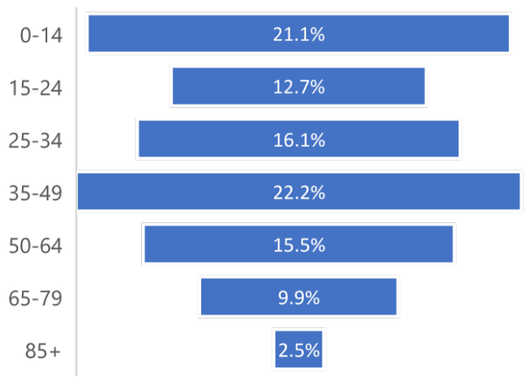


Source: Advisory Board, Demographic Profiler

San Antonio Regional Hospital's (SARH) mission is to improve the health and well-being of the people it serves. These people make up a large portion of the population in the Inland Empire and it is vital to align SARH's strategy and operations with the community's current and projected demographics and their health needs.

Modelling population shifts in tools like ARCGIS, Advisory Board, and Optum Market Advantage gives SARH insight into where and when new health needs in its service areas might arise. Combining this understanding with market share analysis based on claims data from the California Department of Health Care Access and Information, SARH can evaluate the impact of population shifts on its service offerings and how to adapt to adequately meet health needs.

Population Age, Primary Service Area (2021)



Source: ESRI, ARCGIS

Fellow: Max Proebstle I MBA Health Care Management, Finance
Preceptor: Roldan Aguilar I Executive Director of Strategic Operations

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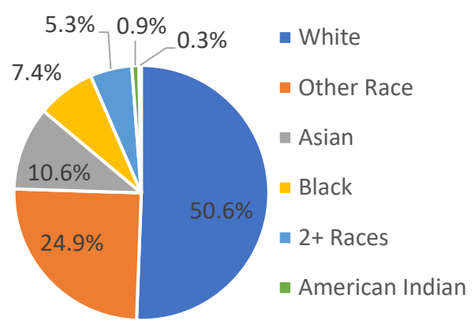
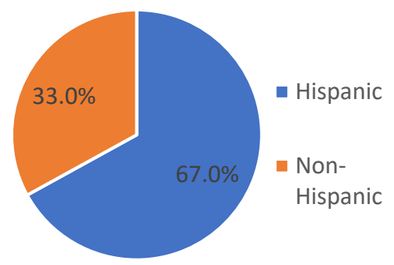
Race in Primary Service Area



Source: Advisory Board, Demographic Profiler

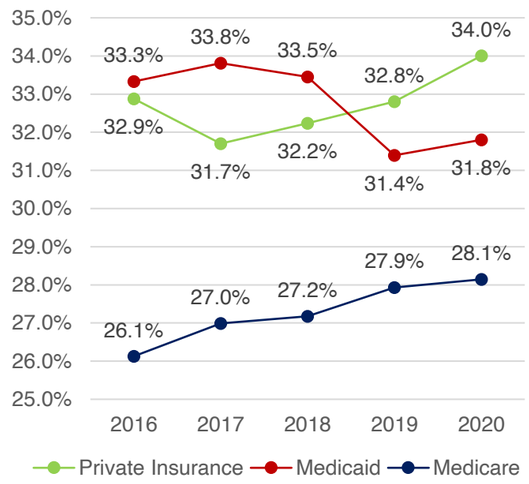
Ethnicity in Primary Service Area



Source: Advisory Board, Demographic Profiler

One area of impact that these analyses affect is in contributing to the formation of a new five-year strategic plan for SARH. Taking into consideration internal variables as well as patient factors such as age, gender, race, ethnicity, insurance coverage, income, and employment rate, multiple actionable steps were formulated at a strategic planning retreat. These efforts all enhance SARH's goal to best serve the community in which the hospital is located.

Primary Service Area: Inpatient Payer Shares



Source: Advisory Board, Market Scenario Planner Premium

Fellow: Max Proebstle I MBA Health Care Management, Finance
Preceptor: Roldan Aguilar I Executive Director of Strategic Operations

Healthy RC Teen Summit

Connect with yourselves, your friends, your community.

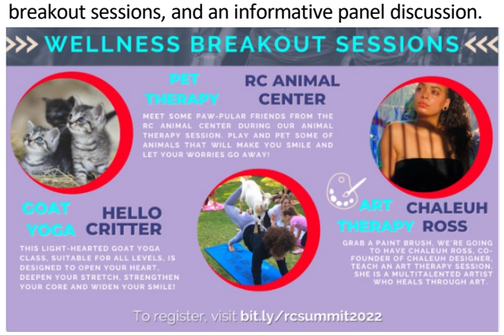
Nadia Ziglari, MPA
Healthy RC Fellow
City Manager's Office
City of Rancho Cucamonga
Preceptor: Hope Velarde, MPH

Introduction & Background

Since 2008, Healthy RC has successfully cultivated city-community partnerships and improved health across the community.

These partnerships include dedicated residents, community organizations, and public and private entities working together to make Rancho Cucamonga the healthiest it can be!

Healthy RC and their Youth Leaders address teen health in the community through the annual Teen Summit. This is a free wellness event for local high school teens that includes an inspiring keynote speaker, activities, wellness breakout sessions, and an informative panel discussion.



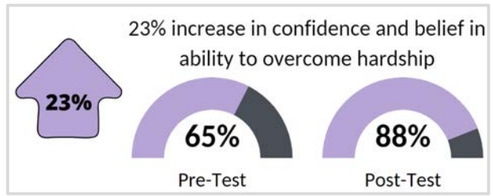
#RepresentationMatters Guest Panel

The focus groups conducted prior to the event indicated that most teens were struggling with their mental health; especially due to the social isolation that has resulted from COVID-19. Due to this, we really wanted to reconnect teens in the community through fun activities that inspire self-expression and vulnerability. It was inspiring to see the teens openly share their struggles and it showed that we successfully created a safe space where they felt comfortable to be vulnerable.

In addition to all the activities, we arranged a resource fair that included many wonderful local organizations. This was an important component that showed teens where they can turn for support in moments of need.

Results

From the pre and post tests conducted, we noticed an overall increase in the teen's confidence and belief in themselves.



In addition, we asked the teens what one thing is that they can take back with them to their daily lives and here are some quotes:

> "That I always have someone to talk to and I can always look forward to the future."

> "I will take all the information I learned today and use it to be a better version of myself."

The feedback from the teens indicated that the 2022 Teen Summit was successful in uplifting and inspiring these students. Many indicated that they learned new and useful coping skills to assist with their mental health struggles.

Acknowledgments

City of Rancho Cucamonga
Hope Velarde – Preceptor & Joanna Marrufo

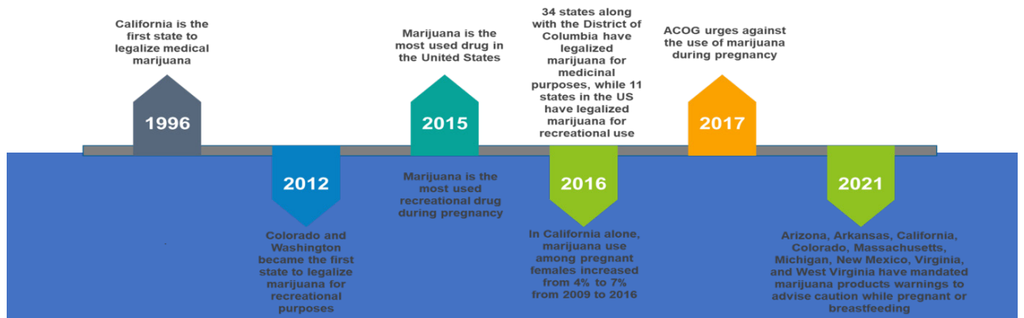
University of La Verne
Dr. Keith Schildt
Academic Advisor

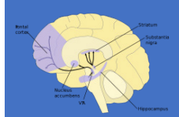
Partners for Better Health
Jaynie Boren
Executive Director

Adverse Effects of Marijuana During Pregnancy, Breastfeeding, and Postpartum Periods

Rachel Oliver, MPH
Preceptor: Teresa Dodd-Butera, PhD; RN/DABAT
Azusa Pacific University, Center for Better Beginnings

Timeline of Marijuana Legalization and its Impact on Maternal Health





- Marijuana use in pregnancy may have adverse effects on neurodevelopment, resulting in hyperactivity, attention-deficits, and/or damage to fundamental brain receptors.
- Marijuana use during pregnancy is associated with impaired fetal growth and development, stillbirth, and preterm birth.
- Marijuana exposure of offspring during lactation may adversely impact infant growth and development (Bérard, 2020)
- In a review of literature, a study found that 70% of Colorado cannabis dispensaries recommended cannabis products to treat nausea in the first trimester (Dickson et al, 2018).
- Pregnant women are less likely to report using marijuana to their healthcare providers due to fear and stigma.

Public Health Implications:

- A discussion about health concerns surrounding cannabis use may influence women's perceptions of risk and help them to make informed choices (Bayrampour, 2019)
- Universal verbal screening for substance use is recommended by the US Centers for Disease Control and Prevention (CDC), the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.
- 48% of providers did not provide counseling to patients who disclosed marijuana use (Holland et al, 2018)
- Verbal screening during pregnancy is recommended for substance use, due to the opportunity for health education during a time of a trusted relationship with a healthcare provider.

Policy Implications:

- Explore the use of mandatory warning labels for pregnant women on legalized marijuana packaging.
- Examine healthcare professional educational curriculums for opportunities in training related to cannabis dispensaries and adverse effects of marijuana use during the perinatal period.
- Mandate marijuana and maternal health education in cannabis dispensary owners.

Not Available

Not Available

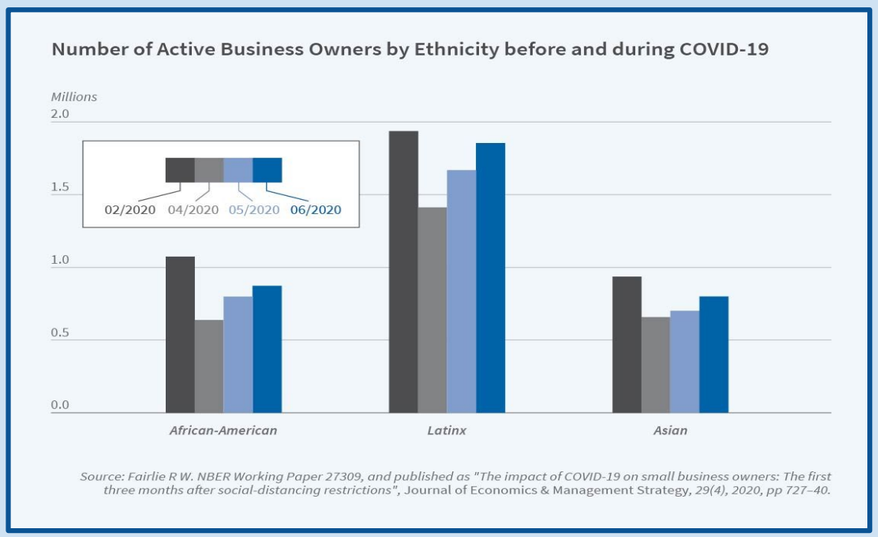
Not Available

Not Available

Business Resiliency Through Employee Ownership

Kaiser Permanente's Impact Spending team is responsible for utilizing economic resources and assets to help improve the socio-economic and environmental social determinants of the communities that they serve. They ensure that their spending decisions are environmentally sound, economically viable, and socially equitable.
This includes working with their diverse supplier companies, to which some were severely impacted by the COVID-19 factors, such as Courier Corporation of Hawaii (CCH). Statistics have shown that minority small businesses faced significant hardships and closures due to the pandemic.

41% of Black-owned businesses have been shuttered by COVID-19, compared to just 17% of white-owned businesses (UC Santa Cruz & The National Bureau of Economic Research, 2020).



Source: Fairlie R W. NBER Working Paper 27309, and published as "The impact of COVID-19 on small business owners: The first three months after social-distancing restrictions", Journal of Economics & Management Strategy, 29(4), 2020, pp 727–40.

Partnership

Information Education

Transitional Support

The Impact Spending team developed the Business Resiliency Through Employee Ownership initiative. By partnering with Project Equity and Obran, we were able to support CCH's employees to become owners of the company. Employee ownership for CCH not only prevents a small business from being sold or closed down, it also leads to:

- Continued support for local jobs
- Local economy support
- Increase in living wages
- Retirement sharing
- Job tenure
- Local and individual wealth building

In addition to the initiative, we created a communication strategy to share the story and efforts of the Impact Spending team, to which the Business Resiliency Through Employee Ownership project will be featured. The strategy will focus on Impact Spending's business model which layers the social and economic lenses into operations that can continue to support inclusive equitable community development.

Permanent Supportive Housing at Various Jamboree Housing Sites: A Needs Assessment Analysis

By Sarah Wynglarz

About

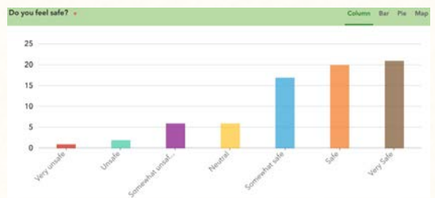
Jamboree Housing is a non-profit organization established in Irvine, CA. Their mission is to deliver high-quality and permanent supportive housing to formerly homeless and at-risk individuals and families.

Importance

It is of high importance to not only provide shelter, but also appropriate physical and mental resources allowing residents to develop the skills and knowledge to self-sustain a healthy and thriving life.

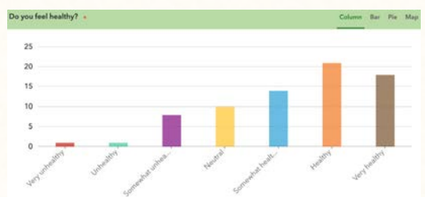
Method

Through ArcGIS Survey123 analysis, a need assessment was conducted to determine important physical and mental health resources required to help residents thrive.



Analysis

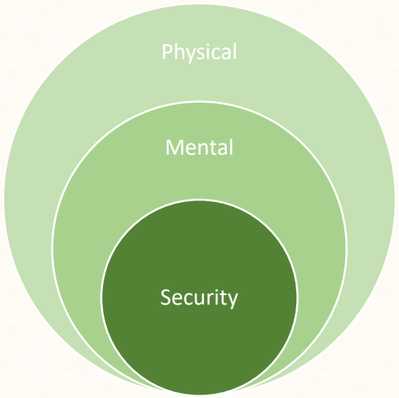
Analyses derived from 73 resident participants suggest that safety measures and health factors could be improved. 12.33% of residents claimed to have felt unsafe at their current housing site, while 13.7% did not feel healthy.



Jamboree

Success

The combination of physical, mental, and security aspects of Jamboree Housing will contribute to growing communities with the potential to succeed and thrive in life.



Future Implications

Implementation of health assessments as part of the onboarding process could also be of use in directing residents to appropriate resources or recommendations, aiding in the overall health journey.

Opportunity

Organization of a Resource/Wellness Fair provides opportunity for future partnerships in public health as well as direct exposure of on-site resources for residents.

Adverse Childhood Experiences (ACEs) Awareness

Seda Khalulyan, University
of Southern California

ACEs are traumatic life events that occur during childhood, including abuse, neglect, and different household challenges. The more ACEs a child is exposed to, the more likely they are to experience life challenges and health issues in adulthood. In Ventura County specifically, 1-3 ACEs was the prevalent number of hardships faced in households. We worked with local community organizations and members to raise awareness on ACEs and potentially break the cycle of generational trauma.

Ventura County	Percent		
Number of ACEs	Households with Children	Households without Children	All Households
0 ACEs	S	S	S
1-3 ACEs	47%	46%	46%
4 or More ACEs	18%	15%	17%

Adventist Health Simi Valley recognizes the importance of raising awareness among ACEs by providing accurate information, connecting with local partners, identifying target populations, and simplifying essential material to create positive change. Adventist Health Simi Valley understands the significance of creating supportive and healthy relationships, building resilience, providing local resources, and enhancing trauma informed care in a non-clinical settings for those who are facing any hardships because of ACEs.

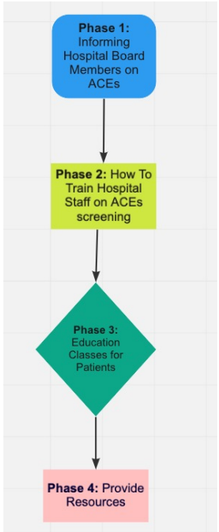
Living God's love by inspiring health, wholeness and hope.

aces aware
SCREEN. TREAT. HEAL.

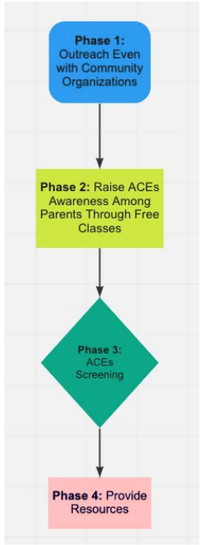
To combat the issue of ACEs among community members, community involvement, internal, and external frameworks were developed. Also, partnering with For the Need Foundation enabled for the creation and implementation of training volunteers on ACEs, how to help those experiencing ACEs, and how to practice trauma informed care in a non-clinical setting.

Community Involvement

Internal Framework



External Framework



For the need foundation

Recommendations

Partnering with local community organizations is key when trying to create real social change. They aid in resources and help with extending a mission's reach and impact. Trauma informed care methods in non-clinical settings should continuously be trained and practiced.

COMMUNITY GARDENS TO COMBATE HEALTH INEQUITY IN THE CITY OF FONTANA

Tanialee Sanchez
University of La Verne-MPA
Healthy Fontana

Background:

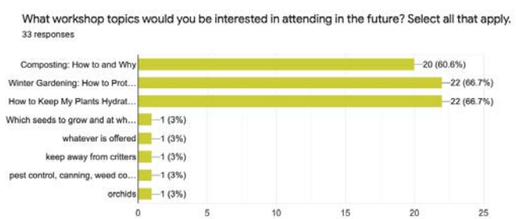
The City of Fontana has a population of over 210,000 people, many of them actively participate in the walking program by Healthy Fontana. Healthy Fontana aims on combating health inequity by tackling mental health while making their services more available to those that need it most thanks to funding in part by Kaiser Permanente. We wanted to focus on gardening and its potential food cost saving benefits as well as its potential mental decompressing properties that being more physical can bring. Fontana alone has 15 percent of its population on some form of food assistance program such as food stamps or WIC based on Census data. Gardening is proven to be therapeutic and growing fresh food has been shown to cut cost for those with limited access. Using ArcGIS, we can also highlight areas that have the greatest need by showing those living under the poverty line within the city limits. Showcasing the garden is a tangible as well as measurable way to get the community more involved and aware of how they can grow their own garden at home.

Goal:

My overall goals as an intern was to showcase that community gardens are a way to combat inequality in the areas of, mental health and food access. This information is vital for community funding initiatives for the future. While the city already has a great walking program the next element to healthy Fontana should be a focus on nutrition and mental health because these are both part of our overall health as community members. We also know that based on San Bernardino's vital signs data, that mental health services needs are on the rise along with the rising cost in food.

Survey Findings:

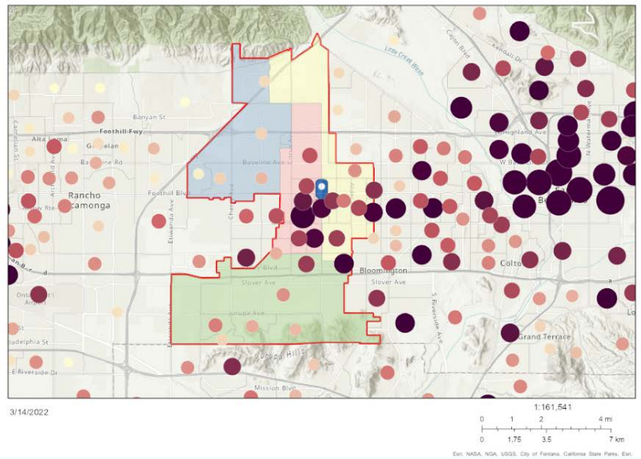
These events showed us overall positive feedback, with people telling us what they want to see from their garden. We were able to gather information on how best to serve the community and gather data on how we are reaching them. The community garden showcase was in partnership with the San Bernardino Master gardeners with multiply inquiries for rental plot applications.Our survey findings showed that community members are genuinely interested in learning about gardening for both recreational reasons to food preservation reasons. They also gave positive feedback at the first garden showcase event. Prior to the event, I was able to gather surveys on community member's needs with their food habits. Fontana residences were vocal on the rising cost in food. The average answer to how much they spent per month was between 300 dollars to 600 dollars on food. Residents were also vocal on their need to save money but also time since many families are more likely to eat out due to its time saving ability. The City has an immensely active participation rate at their community events, which shows promise in the ability to reach at risk populations.



Policy Recommendation:

Direct resources to areas with highest poverty rates and food stamps recipients. Advertising at WIC centers and targeting areas of the darkest circles on the map showcase the higher rates of poverty. If we can divert attention to these "red zones" where we can combat health associated ailments using things such as the community garden to combat unhealthy diets. The city can also adopt a co-op model on unused plots where volunteer-based work equates to 1 pound of produce that can be taken home to offset community food cost. Funding from large private donors such as the Kaiser Foundation means the funds can be used to pay for startup cost on a co-op garden model with surveys on health to be administered to active volunteers to prove overall health improvements for future funding measurability. And this can be expanded into the Key Club program that is a youth-based volunteer program in Fontana, since they are already required to volunteer for set number of hours and create a behavioral survey around gardening for stress reduction thus hitting the cities expansions into mental health aids. And the exposure with expanding on programs within the community garden would mean access to vital resource's centered around mental, physical, and dietary health. Based on our ArcGIS map we can also see the darker bubbles of areas with higher poverty within the city limits. We can deduce that central Fontana is most at risk with spaced out outliners within the city experiencing poverty.

FONTANA CITY W/DISTRICTS



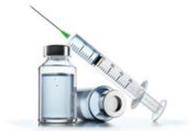
ACS Poverty Status Variables - Boundaries - Tract

Percent of Population whose income in the past 12 months is below poverty level
Darkest Dots Rate of > 25%
13% - national average

Darker Dots Indicate larger concentration of poverty.
Central Fontana Holds highest groupings of poverty.

Making Adolescents Health our Priority

Victoria Montiel Perez
Fellow at Kaiser Permanente Fontana Pediatric Clinic
MHA student
University of La Verne



Introduction

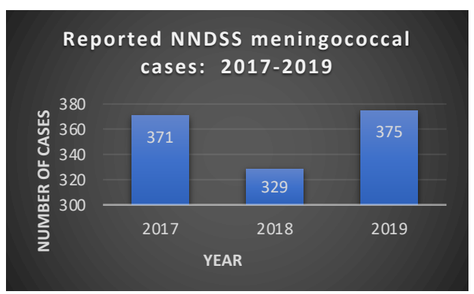
Kaiser Permanente's mission is to provide high-quality, affordable healthcare services and to improve the health of its members and the communities it serves. Currently the Kaiser Permanente Fontana Pediatric Clinic is not reaching their Combo 1 (Meningococcal, Tetanus, Diphtheria, and Pertussis vaccines) adolescents Clinical strategic goal (CSG) month over month.

Objective

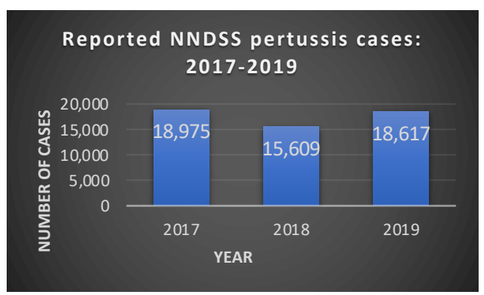
The goal of this project is to improve the adolescent immunization Combo 1 (Meningococcal, Tetanus, Diphtheria, and Pertussis vaccines) rate at the Fontana Pediatric Clinic from 88.3% in November, 2021 to 91% by May 15, 2022 by identifying and closing care gaps at the time of visit.

Why are vaccines important?

Vaccines are important because they can prevent infectious diseases that once killed or harmed many infants, children, and adults. When children are not vaccinated, they run the risk of suffering pain, disability, and even death.



This graph illustrates the number of meningococcal cases reported to CDC from 2017 to 2019.



This graph illustrates the number of pertussis cases reported to CDC from 2017 to 2019.

Globally **38,000** people died from tetanus in 2017 (Hannah et al., 2020)

Even with treatment, about 1 in 10 people with respiratory diphtheria will die (CDC, 2020).

Recommendations

-**Usage of the Proactive Care Tab:** When the staff checks the Proactive Care Tab it allows the staff to see if patients are due for vaccines.
-CAIR website usage: The California Immunization Registry website is a secure, confidential, statewide computerized immunization information system for California residents.
-Usage of Reconcile button: Some outside immunization records can be found under the reconcile button. The reconcile button is found under the patient's electronic health record.

The graph to the left shows how many Licensed Vocational Nurses and Medical Assistants had access to CAIR at the beginning of the study and how many had access at the end of the study.

Conclusion

By having staff click on the Proactive Care Tab and having them address care gaps we hope to improve the quality performance. An outreach team will also be created to outreach those adolescent patients that are due for the Combo 1 vaccines.

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CDC. (May 26, 2020). *Diphtheria*. 'https://www.cdc.gov/diphtheria/about/diagnosis-treatment.html'
CDC. (Feb 7, 2022). *Meningococcal Disease*. 'https://www.cdc.gov/meningococcal/surveillance/index.html'
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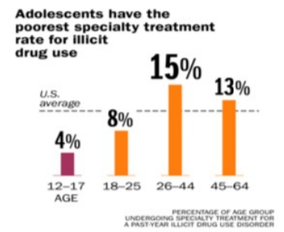
Hannah Behrens, Sophie Ochmann, Bernadeta Dadonaite and Max Roser. (2019). *Tetanus*. 'https://ourworldindata.org/tetanus'

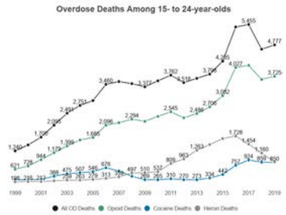
Yvonne Nebechi MPH| California State University, Northridge
Adventist Health Simi Valley

Substance Use Disorders-Related Stigma Reduction Program

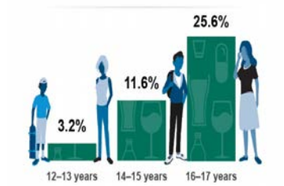
Substance use disorders (SUDs) are severe conditions in which a person uses a substance without thinking about the repercussions. Millions of Americans' health and well-being are affected by SUDs. Evidence shows that 19.3 million persons aged 18 and up had a SUDs health issues in 2021. According to Substance Abuse and Addiction Statistics [2022], 53 million or 19.4% of people 12 years and over have used illegal drugs or misused prescription drugs within the last year. If alcohol and tobacco are included, 165 million or 60.2% of Americans aged 12 years or older currently deal with SUDs. Also, 139.8 million Americans 12 and over drink alcohol, and 14.8 million or 10.6% have an alcohol use disorder. 58.8 million people use tobacco. 31.9 million use illegal drugs. 8.1 million of 25.4% of illicit drug users have a SUD. Two million people, or 24.7% of those with drug disorders, have an opioid disorder; this includes prescription pain relievers and heroin.

It is essential to recognize and address potential psychological issues of SUDs before they become critical. SUDs have negative consequences at both the individual and community levels. SUDs is a serious problem on their own without the burden of stigma. However, it becomes a deadly issue when it is associated with stigmatization. Hundreds, if not thousands, of projects and programs are ongoing across the United States at any given period to reduce negative attitudes, beliefs, and behaviors related to substance use disorder, but stigma continues.





Rates of alcohol or illicit drug use in the past 30 days among adolescents aged 12–17 years increased with age. The rate for adolescents aged 16–17 years was **more than 7.5 times** the rate for adolescents aged 12–13 years.



Impacts of SUDs and Related Stigma

SUDs kills tens of thousands of people each year, including college students, and significantly influences many more lives, negatively. Deaths resulting from SUDs can be prevented if individuals with SUDs commonly use effective tools such as medications for opiate and alcohol use disorders. However, these tools are not commonly used because many people who could benefit do not seek them out. One of the most crucial reasons is the stigma that follows those who suffer from substance use disorder. Health-related stigma describes a socio-cultural process in which social groups are undervalued, ostracized, and marginalized based on a socially criticized health issue. Establishing an appropriate conceptual framework to guide intervention creation, measurement, research, and policy is vital to stop the stigmatization process and reduce the detrimental impacts of health-related stigma.

Yvonne Nebechi MPH| California State University, Northridge
Adventist Health Simi Valley

Substance Use Disorders-Related Stigma Reduction Program

- **The Rationale for Program Development, Goal, and Objectives**

According to a comprehensive evaluation of 13 research, stigma-related to drug use disorders is typically addressed through education and contact-based interventions. Educational approaches have been demonstrated to help lower self-stigma, increase stress management, and raise self-esteem when administered as cognitive and behavioral therapy.

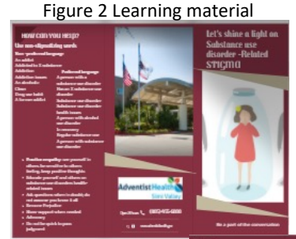
Anti-stigma educational intervention gives accurate information about the stigmatized condition to correct misconceptions or refute negative attitudes and beliefs. They debunk false preconceptions or assumptions by providing facts in their place. The goal and objectives of this program align with the evidence from the review.

The "Shining Light" program aims to reduce substance use-related stigma among teenagers and young adults. Combined with program objectives, such as helping the target group to understand stigma and its consequences and identify ways to reduce it (see figure 1). Delivering educational strategies with supporting activities (see figure 2) may help reduce SUDs related stigma among our immediate target audience.

Figure 1. Goal and Objectives

Goal: Reduce substance use disorders (SUDs) -related stigma among teenagers and young adults in Simi Valley and surrounding communities		
Objectives-Session 1	**Objectives-Session 2**	**Objectives-Session 3**
By the end of the session, participants will demonstrate an understanding of SUD related stigma	By the end of the session, participants will demonstrate an understanding of social stigma	By the end of the session, participants will demonstrate an understanding of SUDs self-stigma
By the end of the session, participants will list three factors that contribute to SUDs related stigma	By the end of the session, participants will list three impacts of social stigma on SUDs individuals, families, and friends	By the end of the session, participants will list three impacts of SUDs self-stigma
By the end of the session, participants will identify three ways to address SUDs stigma	By the end of the session, participants will identify three ways to reduce SUDs social- stigma	By the end of the session, participants will identify three ways to reduce SUDs self-stigma

Figure 2 Learning material



Recommendations

Implementing programs such as "Shinning Light" across the nation will help disseminate helpful information to educate the public on the facts about SUD-related stigma. Doing so may contribute to the reduction of this deadly health issue. Stigma can negatively affect stigmatized groups' emotional, mental, and physical health and their communities (Centers for Disease Control and Prevention [CDC], 2022). Stigmatized individuals may experience isolation, depression, anxiety, or public embarrassment. Reducing SUDs related- stigma is essential to making *all* communities and community members safer and healthier.

p4bhealth.org

Jaynie Boren, MBA Executive Director