City of Hope

2021-2023
IMPLEMENTATION STRATEGY

Putting Words to Action

City of Hope's Plan to Address
Needs of the Community

Contents

Executive Summary

The service area of City of Hope is richly diverse in language, culture, religion, race and ethnicities. With this diversity comes a large variation in factors that put individuals at risk for health issues such as cancer and diabetes. Sociocultural factors — for example, the level of education achieved, language spoken at home, racism and cultural biases — can increase or decrease the risk of preventing and treating potentially life-threatening illness. Serving our community and providing programs and services to our residents designed to reduce risk and improve access to health care are paramount to our success as a nonprofit hospital. One way to ensure we do this is by developing a strategy to address the main opportunities identified in our 2019 Community Health Needs Assessment (CHNA).

For this recent CHNA, City of Hope collected primary data from focus groups, interviews and surveys. Secondary data was collected on the leading causes of death, illness, social determinants of health and deeper causes of health inequality. Our Community Benefit team took this data to community stakeholders and asked them, "What does this mean to you? How do you believe that these issues are impacting you and your community? What ideas for solutions do you have for addressing these concerns?" The stakeholders engaged in lively discussion and then prioritized the issues as follows:

1. **Access to Care – Specifically related to implicit bias, structural racism, policy, systems, environment, and cross-sectoral collaborations that address the social determinants of health**
2. **Mental Health - Prevention and upstream programming to address access, policy and quality services that serve both the adult and youth communities**
3. **Economic and Housing Insecurity – Create and support meaningful relationships with key players in the housing and economic arenas for the purpose of engaging community in the development of solutions to encourage more affordable housing and economic opportunities.**
4. **Chronic Disease – Support community-led efforts at addressing prevention strategies that promote healthy living.**
5. **Cancer – Create a safe and trusting bridge to cancer education, prevention, and treatment services/care from diagnosis to treatment.**

Although addressing these priorities is ambitious, we believe we have formulated a realistic implementation strategy that addresses these issues in a way that make the most sense for a comprehensive cancer center and research institution. We will continue to seek new pathways to meet the needs of our vulnerable residents and explore innovative strategies that maximize collaborations to building sustainable programs in our local communities. Ultimately, we will provide positive contributions to the collective impact of other hospitals, organizations, schools, churches, and government entities in our service area.

We encourage you to take your time reading this plan. Should you have any questions regarding how we plan to implement it, please feel free to contact our Community Benefit Department. We can be reached at CommunityBenefit@coh.org.

Who We Are and Whom We Serve

Founded in 1913, City of Hope is one of only 51 comprehensive cancer centers in the nation, as designated by the National Cancer Institute. City of Hope is also a founding member of the National Comprehensive Cancer Network, which uses research and treatment protocols to advance care nationwide. City of Hope is dedicated to making a difference in the lives of people with cancer, diabetes and other serious illnesses. Our mission is to transform the future of health care by turning science into practical benefit and hope into reality. We accomplish this by providing outstanding care, conducting innovative research and offering vital education programs focused on eliminating these diseases. For 13 years, *U.S. News & World Report* has listed City of Hope among the "Best Hospitals" for cancer.

City of Hope's main campus, located in Duarte, California, has 217 licensed beds and provides the latest treatments for cancer, HIV/AIDS and diabetes. City of Hope continues to be a pioneer of patient-centered care and remains committed to a tradition of exceptional care for patients, families and communities. Each day, we live out our credo: *"There is no profit in curing the body if, in the process, we destroy the soul."*

The Internal Revenue Service, through its 1969 Revenue Ruling 69-545, describes the Community Benefit Standard for charitable tax-exempt hospitals as helping the community in a way that relieved a governmental burden and promoted general welfare. In addition, the 1994 California Community Benefit Legislation (SB 697) required private nonprofit hospitals to assume a social obligation to provide community benefits in the public interest in exchange for their tax-exempt status. As part of this obligation, tax-exempt hospitals are directed to conduct a CHNA and develop an implementation strategy every three years. City of Hope has undertaken a CHNA as required. The CHNA is a primary tool used by City of Hope to determine our community benefit plan, which outlines how we will give back to the community in the form of health care and other services that address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the community benefit service area.

Service Area
As an internationally renowned Center of Excellence, City of Hope serves the global community. Located at 1500 East Duarte Road in the city of Duarte, City of Hope is situated in Los Angeles County Service Planning Area (SPA) 3. For purposes of community benefit planning, SPA 3 is included in City of Hope's primary service area (Figure 1). Cities in SPA 3 include Alhambra,

Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, Duarte, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut, West Covina and others. City of Hope's primary service area also includes portions of Los Angeles, Orange, Riverside, San Bernardino and Ventura counties.
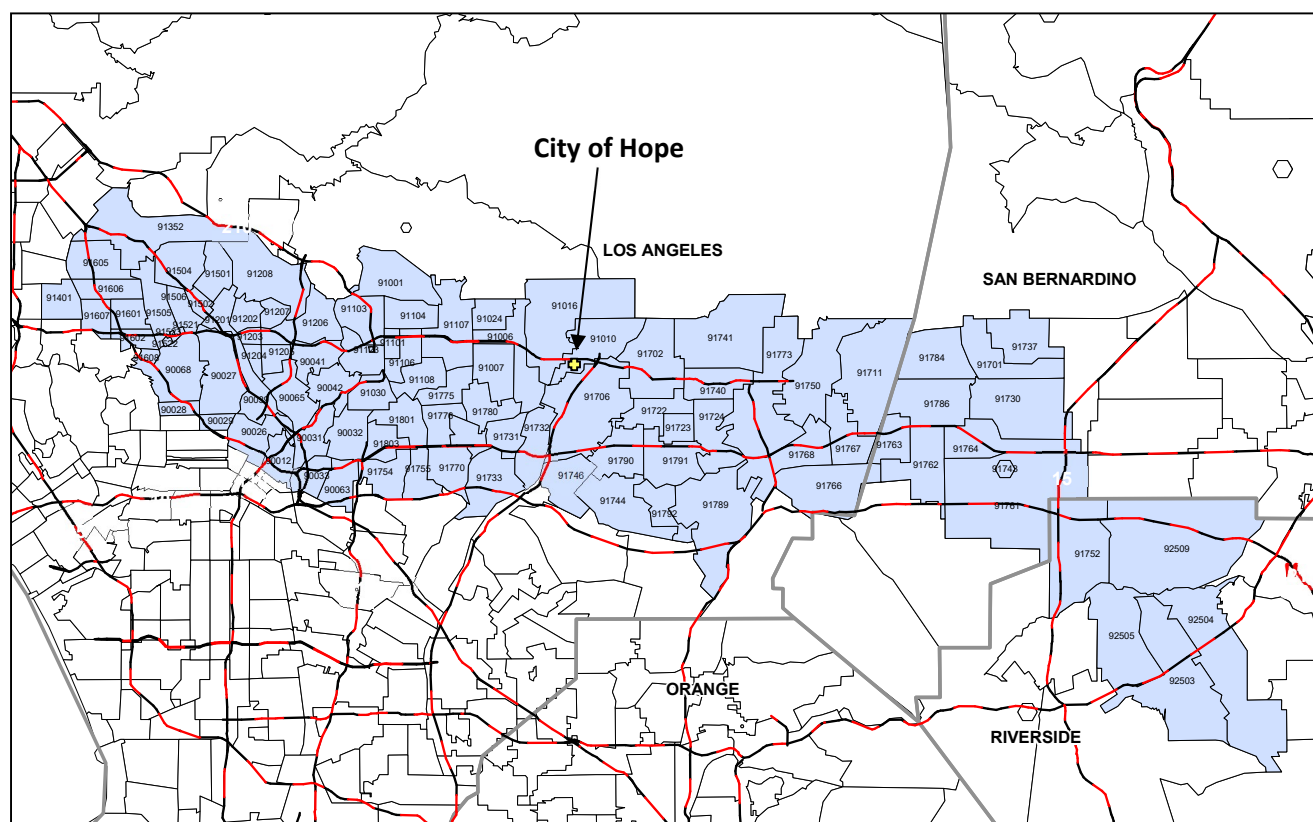

Figure 1. Service Area

Community Health Needs Assessment Findings

Secondary data analysis yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process helped validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations and ascertain community assets to address needs.

The following criteria were used to identify significant health needs:
1. Size of the problem (relative portion of population afflicted by the problem)
2. Seriousness of the problem (impact on individuals, families and communities)

To determine size and seriousness, health indicators identified in the secondary data collection were measured against benchmark data, specifically California rates and Healthy People 2020

objectives, whenever available. Health indicators that performed poorly against one or more of these benchmarks were considered to have met the size or seriousness criteria. Additionally, primary data sources (interview, focus group and survey participants) were asked to identify and validate community and health issues. Information gathered from these sources helped determine significant health needs.

Obtain Community Input

Identify Heath Disparities

Collect & Analyze Secondary Data

Identify and Assess Trends
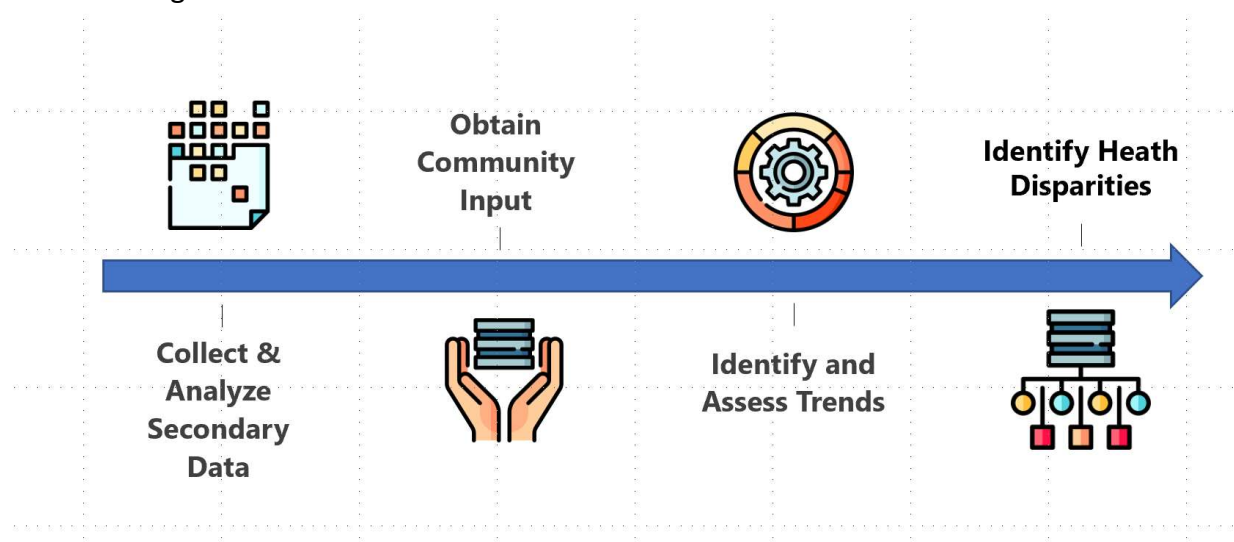
Significant Health Needs

The following significant health needs were determined:
- **Access to Care**
- **Cancer**
- **Chronic Disease**
- **Economic Insecurity**
- **Housing Insecurity and Homelessness**
- **Mental Health**
- **Overweight and Obesity**
- **Substance Use**

Community input on these health needs is detailed throughout the CHNA report (https://bit.ly/2W37jvq).

Resources to Address Significant Needs

Through the focus groups, surveys and interviews, community stakeholders and residents identified community resources that can help address the significant health needs. These resources are presented in the appendix.

Primary Data – Community Input

37 interviews and 18 focus groups with:

- Health experts

- Promotoras

- Local government representatives

- Local business owners

- Social and health service providers

- Residents, including monolingual Spanish speakers, monolingual Mandarin speakers, LGBTQ seniors, African American youth and adults
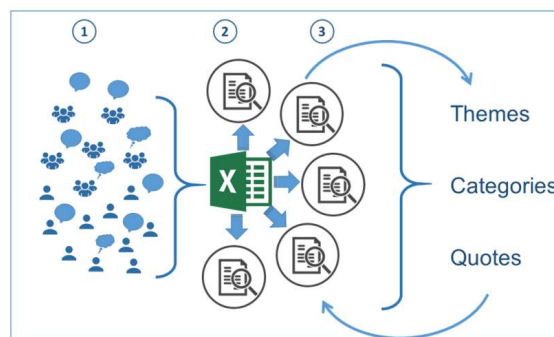
Focus groups were convened between January and October 2019. Individual interviews were conducted for this community health needs assessment, from February through July 2019.

Prioritization of Needs

The significant health needs identified in the process were prioritized with input from the community using the following criteria:

- Perceived severity of a health issue or health factor/driver as it affects the health and lives of community residents
- The level of importance City of Hope should place on addressing the issue

For this CHNA, we obtained primary data through focus groups, a community survey and interviews with key community stakeholders, public health and service providers, members of the medically underserved, low income, minority populations in the community, and individuals or organizations servicing or representing the interests of such populations.

Focus group representatives of select subpopulations were convened to advance understanding of the lived experience of residents in City of Hope's service area. Subpopulations represented in the focus groups included seniors, Spanish-speaking, Mandaring-speaking, African Americans, homeless and LGBTQ residents. In total, 18 focus groups were convened between January and October 2019. Interviews with key stakeholders provided opportunities to gather in-depth insights from experts' subfields of public health and social services targeted communities. A total of 32 individual interviews were conducted for this CHNA, from February through July 2019.

Stakeholder Validation of Prioritized Needs

CBAC member prioritizing health needs

Our Community Benefit Advisory Council (CBAC) met on December 19, 2019, to identify the top health needs to be prioritized over the next three years. Based on findings from the primary and secondary data collections, participants learned about the identified health needs within City of Hope's community service areas. After the data presentation, everyone was instructed to rate these leading indicators in relationship to seriousness, size of problem (number of people impacted), trends, equity, feasibility, value, consequence of Inaction, social determinants/root causes and effective strategies to address problem. Then they were instructed to represent their priorities by placing colored dots on the charts. Red #1, Blue #2, Green #3 and Yellow #4. People were also invited to elaborate on their prioritized issues with comments that can help us shape the overall strategies for the 2021 Implementation Strategy.

Results were as follows:

2019 Stakeholder Prioritized Health Needs

Rank	Health Needs
1	Access to Care
2	Mental Health and Substance Use
3	Economic and Housing Insecurity
4	Chronic Disease
5	Cancer Prevention

It is important to know that while there were eight identified areas of need, those schooled in public health language will see that the CBAC combined topics because they felt that the root causes and shared risk factors were similar, and by addressing them collectively rather than individually we could have a greater impact. Thus, you will see that mental health was combined with substance abuse. In recent years, mental health researchers have found that creating an integrative approach for mental health and substance use disorders made more

sense and provided greater support for the patients[1],[2]. The chronic disease was combined with obesity/overweight because the shared risk factors and methods for addressing those risks are similar. While some might say City of Hope is not addressing the eight originally identified needs, we are in fact addressing them all.

No. 1: Access to Care
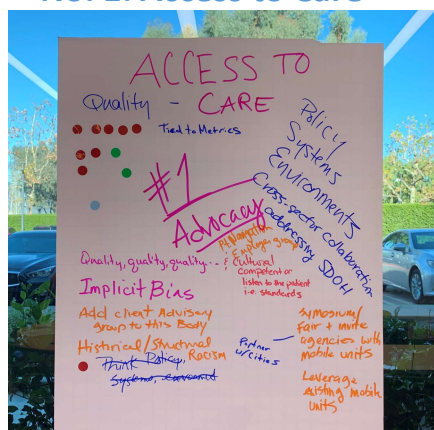
Access to Care stakeholder comments

Over the last few years, we have seen the impact that the Affordable Care Act has had on our most vulnerable communities. In SPA3 (Service Planning Area) our CHNA revealed that 100% of children have health insurance coverage. Yet, while listening to our community members, we found that base issues of implicit bias and structural racism in policies and service delivery keep people from seeking care. Our stakeholders suggest that we need to address issues through cross-sectoral collaborations that address the social determinants of health.

No. 2: Mental Health

In the last CHNA, our community members prioritized mental health third. This year, it has moved up to second. The reason for this can be possibly be attributed to the fact that homelessness has hit a critical mark, and mental health and substance abuse have been major drivers for homelessness, especially in communities of color[3]. Stakeholders suggest that we focus future efforts on prevention and upstream programming to address access, policy and quality of services that serve both the adult and youth communities.
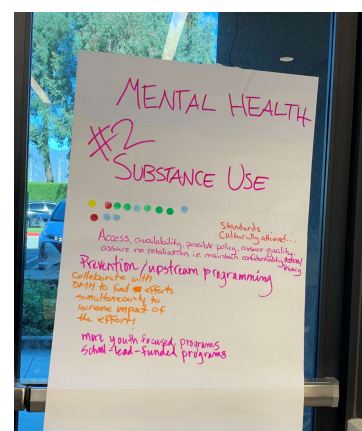
Mental Health stakeholder comments

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[1] Ungar, M., Liebenberg, L., Ikeda, J. (2014). Young people with complex needs: Designing coordinated interventions to promote resilience across child welfare, juvenile corrections, mental health and education services. *The British Journal of Social Work*, **44**, 675–693.

[2] Clark, H. W., Power, A. K., Le Fauve, C. E., Lopez, E. I. (2008). Policy and practice implications of epidemiological surveys on co-occurring mental and substance use disorders. *Journal of Substance Abuse Treatment*, **34**(1), 3–13.

[3] Olivet J., Dones M., Richard M. (2019) The Intersection of Homelessness, Racism, and Mental Illness. In: Medlock M., Shtasel D., Trinh NH., Williams D. (eds) Racism and Psychiatry. *Current Clinical Psychiatry*. Humana Press, Cham

No. 3: Economic and Housing Insecurity

In SPA 3, eight cities have poverty levels greater than the state's rate of 15.1%. They include Pasadena (15.5%), Monterey Park (15.8%), Azusa (16.4%), La Puente (18%), Rosemead (185), South El Monte (18.7%), Pomona (20.7%), and the highest level in El Monte, where almost one out of four (22.6%) of the population lives below the poverty level.
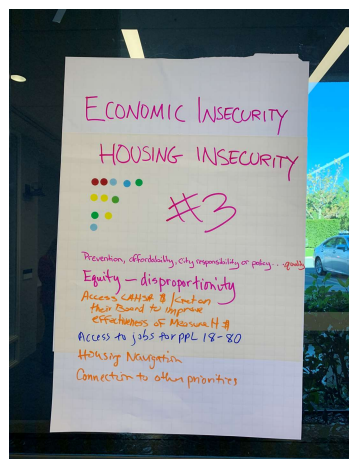
Economic and Housing Insecurity community comments

Regarding homelessness, in just under four years, the number of homeless individuals in Los Angeles County has risen 43% to 58,936. In SPA 3, the rate of homelessness has increased by 45%. The majority among them are single adult individuals (81.1%) and unsheltered (75%). In contrast, the homeless in SPA 3 has a better shelter rate (63.3%), though the rate of unsheltered has increased drastically by a 7.2% margin. Despite the increase in the homeless population, the percentage of chronically homeless has decreased between 2014 and 2019. In SPA 3, 28% of the homeless population is now chronically homeless in both SPA 3 and Los Angeles County. Both areas have seen improvements in the rates of homeless who are mentally ill, veterans or suffering from substance abuse. For instance, the rate of homeless with substance abuse has decreased significantly in SPA 3 and Los Angeles County, by 10.8% and 11.9%, respectively. Perhaps most disturbing though is the outsized increase of homeless with a domestic violence history, particularly in SPA 3 were the rate has jumped from 18.6% to 35%.

Focus group participants explained that for many with unmanaged chronic conditions, lack of economic resources is a primary underlying factor.

> *"They don't have money to purchase good food. They don't have money to purchase medications that are recommended."* — focus group participant

> *"They are using so much of their funds to sustain housing that they don't comply with what the doctors are asking them to do. The conditions don't get better or they reach a crisis and ended up in emergency room, which is more expensive. This contributes to a cycle of not being able to sustain themselves and their health."* — focus group participant

> *"Our clients — when they are sick with cancer, they have to quit their jobs to receive treatment. They lose the source of income. That's another thing that we have to do for them — help find resources. There are very few resources available for financial assistance during their treatment. As soon as they recover, they immediately go back to work because they have to survive."* — focus group participant

Our community stakeholders recommend the creation and support of meaningful relationships, with key players in the housing and economic arenas, for the purpose engaging community in the development of solutions to encourage more affordable housing and economic opportunities.

No. 4: Chronic Disease

Some health conditions, as well as lifestyle and genetic factors, can put a person at a higher risk for developing a chronic disease like cancer, diabetes and heart disease. Our community members understand that proper nutrition and physical activity are key to preventing chronic illness or supporting the maintenance of chronic illness. They recognize, however, that good nutrition and physical activity are difficult to attain in the context of economic stress. For example:

Chronic Disease community comments

> *"It's hard to manage sugar and eating healthy even when you have access and means to afford it. Disproportionally lower income populations are more impacted as they have less money and are managing multiple jobs. They have less time to make healthy meals and less income to afford health options. For the same reasons, homeless people have a huge difficulty staying healthy."* — focus group participant

> *"It's hard to eat well even when you know the health consequences of not doing so. It's also difficult to have the discipline to say no. It also takes time for healthy meals. Many lack access to food on a regular basis that's healthy and affordable."* — focus group participant

> *"With my particular population, we have children who are in group homes for examples — all these services and resources we have are available to them, and we reach out to these group homes regularly with very little participation from them. I would say that no, I don't think that nutrition is something they are properly exposed to. We have families who are new to a homeless situation, and now we have to eat frozen meals, etc.; we can't cook anymore."* — focus group participant

Our community and CBAC members understand that to address risk for, or management of chronic conditions, there needs to be a culturally appropriate approach that reduces access to health care, health education and supportive environments that lead to sustainable change. They want us to continue our support of community-led efforts at addressing prevention strategies that promote healthy living.

No. 5: Cancer

After the CBAC prioritized the community issues, they placed cancer at the bottom of the list, rather than the top. The CBAC members said that they believed if the other issues were addressed, the risk for cancer would drop. This year, the stakeholders began to see the disparities among African Americans when compared to other races, for cancer deaths. They voiced concern that institutional racism fuels lack of trust in the health systems prevents people from accessing care. In addition to the usual cancer education and treatment avenues, they wanted City of Hope to look at creating a safe and trusting bridge to cancer education, prevention and treatment services/care with a focus on the seamless continuum of care from diagnosis to treatment. If we can successfully build the trust with our most vulnerable
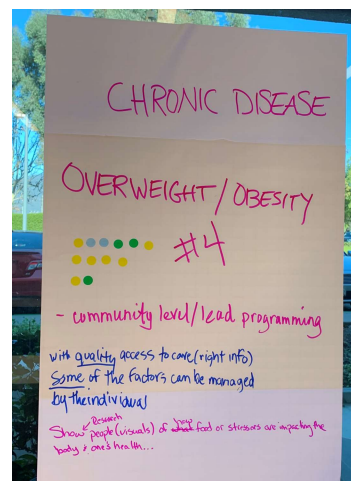
communities, through culturally appropriate means, we can effectively bring our most vulnerable, like the African American, communities into care earlier and perhaps level out the disparities related to cancer deaths.

No one wants to get cancer. As a world-renowned cancer research institution, we can help deliver the cancer education, screening and treatment programs that ultimately save lives.

Community Benefit Advisory Council members who prioritized the 2019 CHNA results.

Plan to Address Needs

It would be unreasonable to think that City of Hope can solve all the issues identified in the needs assessment. Given our expertise and resources as a cancer institution, we need to find pragmatic ways to work with our community to address the identified needs. First, we need to acknowledge that the prioritized categories are even more complex than presented above. Next, we need to view the issues through the lens of the Public Health Institute's "Five Core Principles" (Figure 2). As we plan programs, we must ask ourselves, "How will our work impact the lives of vulnerable people in a way that supports prevention, builds a seamless continuum of care and enables the community to take ownership of their health issues? How can we be a leader in creating a healing environment?" From here, we can tackle the five identified categorical needs by designing program/services and building collaborations that will work to lessen the impact on local residents.

Figure 2. Five Core Principles

Collaborations

City of Hope is an institution that is overflowing with compassionate individuals. In order to address the needs of our community, we will leverage these rich resources to design interventions that specifically target the identified issues within our service areas. Internal teams are already trained to change the way they see their work, from looking through a marketing lens to using a community benefit lens that focuses how the program will impact the health of a targeted group.

Externally, City of Hope will call on the diverse relationships it has nurtured with local organizations, schools/universities, governments, other nonprofit hospitals and the multitude of passionate souls that serve the vulnerable. By collaborating with our local communities, we can create systems level approaches that meet the needs of our most vulnerable populations in culturally appropriate ways. Additionally, by including our community stakeholders in planning our community benefit programs and services, we ensure these programs are built on trust and shared vision. This provides a strong foundation for programs that will survive and thrive within the community we serve.

Oversight

To guarantee City of Hope's reportable community benefit programs and services are targeting identified needs and are being seen through the lens of the Five Core Principles, our CBAC will meet at least four times a year.

To ensure council members represent local vulnerable populations or are experts in issues important to vulnerable communities, we sought individuals with the following areas of expertise:

- Residence in a local community with a disproportionate percentage of unmet health-related needs
- Knowledge and expertise in primary disease prevention
- Experience working with local nonprofit community-based organizations
- Knowledge and expertise in epidemiology
- Expertise in the analysis of service utilization and population health data

The Community Benefit Department also established an internal hub comprised of City of Hope staff members who are responsible for contributing to community benefit programs and services. They meet on a quarterly basis to discuss federal reporting requirements, receive technical assistance, develop new data collection tools and learn about City of Hope's processes for ensuring programs address priorities outlined in the Implementation Strategy. Additionally, this group has an internal website that provides links to resources, community benefit best practices, and internal tools for sharing and building collaborations that strengthen the quality of staff contributions.

Anticipated Impacts on Health Needs

Christian Port and Tashera Taylor, co-chairs of the Community Benefit Advisory Council. 2017-2019

When we look at the five priority areas identified by our community, we need to think about them through a realistic framework that allows us to address issues with strategies that make the most sense given City of Hope's capacity to do so. Each priority has a broad measurable outcome indicator. While it may be unrealistic to believe that City of Hope can make a significant impact regarding these priorities, mindful programming and collective impact will enable us to make changes to the communities we serve. As an institution, we will aim our programs and services at our residents, focusing on the following recommended strategies:

1. **Access to Care – Specifically related to implicit bias, structural racism, policy, systems, environment and cross-sectoral collaborations that address the social determinants of health**

   1.1 Increase cultural competency and anti-bias training among service providers.
   1.2 Increase the number of service providers that share the cultural backgrounds and languages of clients.
   1.3 Increase patient retention in health care treatment programs by building more services that are rooted in cultural values and traditions.
   1.4 Increase patient understanding of how to best communicate with health care providers.

     1.5   Improve messaging indicating that providers are safe spaces for immigrants, LGBTQ individuals and other sensitive populations/communities.

2. **Mental Health - Upstream programming to address access, policy, and quality services that serve both the adult and youth communities.**
   2.1 Increase access to integrated care.
   2.2 Increase cultural competency training and anti-bias training among mental and behavioral health care providers.
   2.3 Form parent/client advisory councils for mental/behavioral health care providers.
   2.4 Provide trauma-informed care, and particularly care informed by an understanding of racial trauma.
   2.5 Provide training for youth/adults around how to prevent and respond to violence (including relationship violence).
   2.6 Incorporate social emotional literacy into youth development programs.
   2.7 Work through schools to destigmatize mental health issues and mental health care services.
   2.8 Train mental health and behavioral health care providers to recognize the signs of homelessness and provide resources to respond.
   2.9 Bring services to workplaces and schools and make them available in the evenings and on weekends.

3. **Economic and Housing Insecurity – Create and support of meaningful relationships, with key players in the housing and economic arenas, for the purpose engaging community in the development of solutions to encourage more affordable housing and economic opportunities.**
   3.1   Educate the public about the different types of people who fall into housing insecurity and homelessness, to help ameliorate the stigma around "homelessness."
   3.2   Increase availability of short-term, emergency and Section 8 housing.
   3.3   Provide job opportunities and training.
   3.4   Increase the number of food pantries in communities.

4. **Chronic Disease Prevention – Support community-led efforts at addressing prevention strategies that promote healthy living.**
   4.1   Advocate for policies to increase the number of affordable healthy food vendors in low-income communities
   4.2   Reduce the proportion of adults who are obese.
   4.3   Reduce the proportion of children and adolescents who are considered obese.
   4.4   Increase the consumption and variety of vegetables in the diets of residents aged 2 years and older.
   4.5   Reduce the number of new cases of diabetes diagnosed annually.
   4.6   Increase the proportion of persons with diabetes who receive formal diabetes prevention education

5. **Cancer – Create a safe and trusting bridge to cancer education, prevention, and treatment services/care from diagnosis to treatment.**

5.1 Increase access to cancer prevention and screening services in communities disproportionately impacted by cancer morbidity and mortality

5.2 Development of awareness strategy to promote the knowledge of ongoing community cancer screening and prevention programs/services

5.3 Identify all potential community outreach services within City of Hope

5.4 Develop and implement a widespread Community of Cancer Network to facilitate cancer education and screening

5.5 Support efforts for cancer treatment equity and access to cancer care at City of Hope

Moving forward, City of Hope will align its efforts at addressing the indicators above. Yearly, the CBAC will assist in prioritizing strategies with the same lens they used to prioritize the health needs in the CHNA (e.g., feasibility, size of issue). We will develop more specific outcome measures as program are planned and delivered. A yearly report will be published describing the efforts we have made to address these issues. Comments from our local community will be accepted throughout the year and used to strengthen City of Hope's resolve to decrease the disparities that prevent our residents from experiencing a good quality of life.

Needs Not Addressed

As a specialty hospital, City of Hope is not mandated to address issues that may not align with its specialty. However, because the social determinants of health and root causes of health disparities are intertwined with risk factors for cancer and diabetes, we will make every effort to include language and programming that will ensure we focus our community benefit investments on the most vulnerable. The Five Core Principles will be used to set the tone for all programs and services, and guarantee focus remains on those communities with disproportionate unmet health needs.

Conclusion

There are many opportunities for City of Hope to be a good steward to the community we serve. Much like the spoke-and-hub approach to investments, the City of Hope community benefit process allows each department that provides community benefit programs and services to manage their own planning and delivery. The Community Benefit Department will be the central collection point for all reportable work. Throughout the year, the Community Benefit Department will provide structure and guidance in the planning and delivery of programs and services. At the end of the fiscal year, the Community Benefit Department will compile the yearly report to the community.

As an institution, City of Hope is looking forward to strengthening our relationships with community partners. We will continue to seek out ways to meet the needs of our vulnerable residents and explore innovative strategies that maximize collaborations that build sustainable

change. We believe this will provide the most positive contributions to the collective impact of the other hospitals, organizations, schools, churches and government entities in our service area.

We hope that you have enjoyed reading our 2021-2023 Implementation Strategy. Should you have any questions, please feel free to contact our Community Benefit Department at CommunityBenefit@coh.org.

Appendix

Community Resources

City of Hope solicited community input through key stakeholder interviews, a community survey and focus groups to identify programs, organizations and facilities potentially available to address significant health needs. This is not a comprehensive list of all available resources. For additional resources, refer to 211 LA County at www.211la.org/ and Think Health LA at www.thinkhealthla.org.

Significant Health Needs	Community Resources
Access to Care	- Clinica Ramona in El Monte provides one year of health coverage for free. - Community Health Alliance of Pasadena (ChapCare) - Set for Life hosts health expos with health screenings. - Senior Advocacy Program, a county program for seniors primarily in nursing homes - CVS and Rite Aid offer flu shots and screenings. - Foothill Transit offers bus service from Duarte to Pasadena. - Duarte Senior Center publishes a newsletter that identifies resources. - City of Hope Health Fair - Herald Christian Health Center - Tzu Chi Foundation - Cleaver Family Wellness Clinic and food pantry - Good Samaritan Hospital - Parish Nurses offer screenings with referrals for more services - El Monte School District developed a Family Center in El Monte, which includes a number of services and community organizations. - AltaMed - Western University provides dental services at two dental clinics at schools. - Duarte School District's Health Services Center focuses on getting kids access to health insurance. - Foothill Unity Center food bank - Department of Health Services clinic in El Monte - CCARE - Latinos for Hope (City of Hope group) goes out into the community to inform/educate about what's available. - Certified Enrollment Counselors at El Proyecto del Barrio help patients understand eligibility and enrollment, and to keep them on their programs to maintain their benefits. - East Valley Community Health Center - Antelope Valley Community Clinic - Antelope Valley Children's Center - Antelope Valley Partners for Health - Palmdale Regional Medical Center

	• Antelope Valley Hospital • Garfield Health Center • Asian Community Center • Kaiser Permanente • Huntington Hospital • Arcadia Methodist • Emanate Health • City of Pasadena Public Health Department • Chinatown Service Center • Asian Community Center • Kaiser Permanente • Huntington Hospital • City of Pasadena Public Health Department • Planned Parenthood – Pasadena and San Gabriel Valley
Cancer	• Clínica Médica Familiár (Family Medical Clinic) has clinics twice a year. • Brotherhood Labor League Annual Men's Conference • City of Hope offers cancer screenings at health fairs. • Children's Hospital Los Angeles • Southern California Health Conference at Pasadena Civic Center • Cleaver Clinic • American Cancer Society has resources that can help with • transportation and navigation assistance. • Susan B. Komen • My Health LA patients provides emergency Medi-Cal for women 40+ with breast cancer, and for women of any age with cervical cancer through Every Woman Counts program. • Prostate Cancer Research Institute annual conference • MEMAH (Men Educating Men About Health) annual conference partners with City of Hope to do digital rectal exams. • Garfield Health Center provides mammograms and colorectal cancer screening • Herald Cancer Association offers support, consultation, answers questions, written information and links to websites.
Heart Disease	• American Heart Association • Set for Life • Labor Union Conference • Curbside CPR classes are offered by the fire department. • Tzu Chi Foundation • Children's Hospital Los Angeles • Los Angeles County Department of Public Health Service • City of Azusa has a Wellness Center. • El Proyecto del Barrio does medication management and assistance. • Clinic pharmacy dispensary provides some additional medications.

	• Los Angeles County Department of Health Services, Healthy Choice the Easy Choice works to make healthier options more accessible, such as holding exercise breaks in meetings. • Foothill Unity Center offers a walking program and checks blood pressure. • Health plans provide educational materials about foods to eat and foods to avoid. Some have been translated by health plans.
Mental Health	• Alma Services • Spirit Family Services • Enki Mental Health Center • Foothill Unity Center provides referrals and services for families and homeless. • National Association for the Mentally Ill • Tri-Cities Mental Health serves Pomona, La Verne and Claremont. • Los Angeles County Department of Mental Health • Foothill Family Service offers some group services. • Libraries provide information on where to access services. • Whittier Hospital offers a lot of free classes. • El Monte School District added a district social worker and school counselor. • Pacific Clinics/Asian Pacific Family Center • Foothill Family Services • D'Veal Family & Youth Services • District Homeless Coordinator has information about referrals for kids. • Duarte School District has partnerships with providers (Foothill Family Services and D'Veal) to come into the schools and provide services. • Asian Coalition helps people find resources. • Each Mind Matters, the California Mental Health movement • Mental Health Services Act • Asian Youth Center hosts a mental health day. • Health Consortium of Greater San Gabriel Valley is looking to build more connections between physical and behavioral health providers. • Healthy Neighborhoods initiative from Department of Mental Health pilot site in El Monte. Department of Mental Health Service Area Advisory Committee includes consumers and deals access issues. • Santa Anita Family Services • Foothill Family Services • Arcadia Mental Heath • Aurora Clinic • Pacific Clinics • Asian Pacific Health Care Venture has Chinese language mental health services.
Overweight and Obesity	• San Gabriel Valley Service Center has free Zumba, yoga, line dancing and aerobics classes.

	• Women, Infants and Children offers nutrition classes. • Our Savior Center has nutrition and cooking classes. • Community centers offer exercise programs such as Zumba and walking. • Senior centers • Each city has some exercise programs. • Swim programs for school-age children • Some nonprofits organize physical education and/or nutrition education/healthy snacks such as Boys & Girls Clubs. • City of Duarte hosts a Biggest Loser contest and sponsors city walks. • Duarte Senior Center offers referrals and some free services, including a hiking club.
Drugs, Alcohol, Tobacco	• Alcoholics Anonymous • Azteca • California's anti-tobacco campaign • Policies that prevent tobacco use in public settings and more enforcement of laws that prevent tobacco sales to minors • American Cancer Society • Unity One • Los Angeles County Sherriff's drug and alcohol prevention programs • Parent University • Narcotics Anonymous • Asian Youth Center program helping cities create smoke-free parks,