

# 2018-2021 COMMUNITY HEALTH NEEDS IMPLEMENTATION STRATEGY



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## Executive Summary

The service area of City of Hope is richly diverse in language, culture, religion 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 or the language spoken at home—can increase or decrease the risk of preventing or contracting a life-threatening illness. Serving our community and providing programs and services to our local 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 2016 Community Health Needs Assessment (CHNA).

For this recent CHNA, City of Hope collected primary data from focus groups, interviews and surveys and secondary data on the leading causes of death, illness and social determinants of health and explored the health and socioeconomic issues that cause some of our area residents to experience health inequities. These were viewed in terms of the leading causes of death and illness affecting their communities. Our Community Benefit team took these data to community members and asked them, “What does this mean to you? How do you believe that these issues are impacting you and your community?” The community participants then prioritized the issues as follows:

- 1. Access to care – Need for culturally relevant partnerships that decrease barriers to care**
- 2. Chronic disease prevention – Need for information on healthy living, specifically related to how nutrition and physical activity impact cancer and diabetes**
- 3. Mental health – Need for supportive partnerships that increase access to mental health care/services**
- 4. Cancer prevention and early detection--Specifically related to lung, colorectal, prostate and women’s cancers**

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 as a means 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 [comm\\_benefits@coh.org](mailto:comm_benefits@coh.org).

## Who We Are and Whom We Serve

Founded in 1913, City of Hope is one of only 47 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 “Best Cancer Hospitals in America” issue, which recognizes the leading cancer centers in the country.

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 non-profit 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.

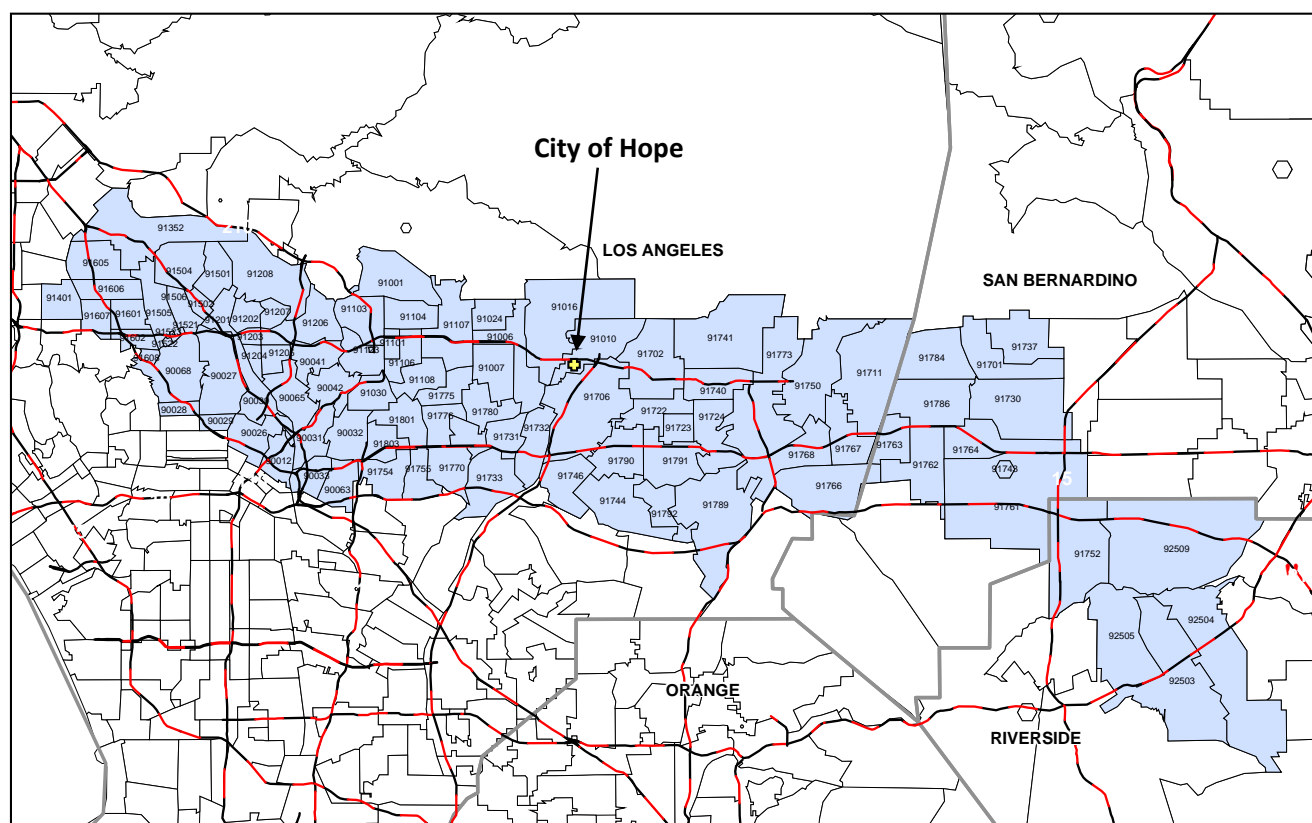


Figure 1. Service Area

## 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.

### Significant Health Needs

The following significant health needs were determined:

- Access to health care
- Cancer
- Heart disease
- Mental health
- Overweight and obesity
- Substance abuse (alcohol, drug, tobacco use)

Community input on these health needs is detailed throughout the community health needs assessment report.

### 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.

### 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

Each stakeholder interviewed was sent a link to an electronic survey on Survey Monkey in advance of the interview. They were asked to rank each identified health need in order of importance. The percentage of responses was noted for those health needs identified as having a severe or very severe impact on the community, having worsened over time and having a shortage or absence of local resources available for addressing the issue. Not all survey respondents answered every question; therefore, the percentages were calculated based on the number of responders rather than the sample size. Mental health and overweight/obesity scored the highest, indicating a severe impact on the community, a worsening over time and a shortage or absence of resources available to address these issues. Access to health care also rated high on insufficient resources available. Results are listed in Table 1:

Significant Health Need	Severe and Very Severe Impact on the Community	Worsened Over Time	Insufficient or Absence of Resources
Access to health care	63.7%	0%	72.7%
Cancer	63.7%	0%	36.4%
Heart disease	45.5%	0%	36.4%
Mental health	63.7%	36.4%	72.7%
Overweight and obesity	81.9%	45.5%	63.6%
Substance abuse	54.6%	9.1%	54.6%

Table 1. Community responses to significant health needs

The survey respondents, focus group attendees and interviewees were asked to rank the health needs according to highest level of importance in the community. The total score for each significant health need (possible score of 4) was divided by the total number of responses for which data was provided, producing an average score for each health need. How the significant health needs ranked in priority is found in Table 2:

Significant Health Needs	Rank Order Score (Total Possible Score of 4)
Access to health care	3.85
Mental health	3.72
Cancer	3.65
Heart disease	3.56
Overweight and obesity	3.54
Substance abuse	3.34

Table 2. Significant health needs ranked by priority

### Stakeholder Validation of Prioritized Needs

At a meeting of the City of Hope Community Benefit Advisory Council (CBAC), members were given the CHNA results. After listening to a report on the findings (both the health data and the community input), they were asked to prioritize the findings using the instructions in Figure 2.

### 2016 Community Health Needs Assessment Process

How the prioritization process will work:

1. Take topic/issues and ask: To what extent does this issue relate to each of the criteria below?

<b>Size:</b> # of persons affected	<b>Feasibility:</b> City of Hope's ability to reasonably impact issue given available resources/expertise
<b>Seriousness:</b> Degree to which the problem leads to death, disability and impairs one's quality of life	<b>Value:</b> The importance of the problem to the community
<b>Trends:</b> Whether or not the health problem is getting better or worse in the community over time	<b>Consequence of Inaction:</b> Risks associated with causing greater problems if not addressed at the earliest opportunity
<b>Equity:</b> Degree to which specific groups are affected by problem	<b>Social Determinants/Root Causes:</b> Whether or not a problem is a root cause or social determinants of health that impacts one or more health issues.
<b>Intervention:</b> Any existing strategies proven to be effective in addressing the problem	

2. Decide on the way you would like City of Hope to prioritize this issue.

- a. Red=#1
- b. Blue = #2
- c. Green = #3
- d. Yellow = #4

Access To Health Care	Heart Disease
Mental Health	Obesity/Overweight
Cancer	Substance Abuse

3. Then we come to an agreement on it all.

Figure 2. Community Benefit Advisory Council prioritization instructions

Each health issue was written on a large poster paper and attached to the wall of the meeting room in random order. Colored dot stickers were given to each participant. Different colors were used to represent different levels of importance, with red being highest and descending down through blue, green and yellow. Prior to placing their dots, the CBAC members chose to combine categories that had shared territory. For example, heart disease and obesity/overweight were added to a new category called Chronic Disease. Substance abuse was added to the mental health category.

At the end of the exercise, the identified needs were organized in the following manner:

1. Access to care
2. Chronic disease
3. Mental health
4. Cancer

When asked why they placed cancer in the last category, the CBAC members responded that they believed that addressing access to care, chronic disease prevention and mental health would systematically reduce the overall risk of cancer. In addition, the CBAC members recognized the fact that these categories are broad reaching. In our focus groups, surveys and







## Mental Health

This year mental health rose to the top of our priority list. This may indicate that mental illness has finally reached a level where it impacts almost everyone in our community.



Figure 5. Community voices on mental health

Our community members and our CBAC have spoken: It is time to address the ways that mental health impacts our ability to fight chronic disease and cancer. They have indicated that mental health issues are oftentimes the underlying factor that prevents someone from achieving good health. We cannot expect to make sustainable behavior changes without addressing the mental health issues that prevent a person from changing his or her behavior. Many of the lifestyle risk factors that cause diabetes and cancer are modifiable. How can we provide the support necessary for someone to make behavior changes that will reduce their risk for cancer and other chronic conditions? Does City of Hope have the capacity to do this? Are there other ways to leverage our expertise to help the broader community increase access to mental health services that are culturally and linguistically appropriate?

## 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. That being said, our community members identified the issues that increased the risk of cancer and discussed how they impacted their lives. Prostate cancer was the most identified cancer. Community members felt that they need access to more cancer education on screenings and early detection. Within this, they expressed a desire for help in navigating the health system in order to get cancer care when they need it. Rather than voicing despair, our community members identified their fears and expressed an overarching wish to prevent cancer from impacting their loved ones, their jobs and their income. 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.



Figure 6. Community voices - cancer

## 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 7). 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 four identified categorical needs by designing program/services and building collaborations that will work to lessen the impact on local residents.



Figure 7. 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 work together to 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 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.



Patricia Duff-Tucker and Viki Goto  
Community Benefit Advisory Council 2015-2017 Co-Chairs

## Anticipated Impacts on Health Needs

When we look at the four priority areas identified by our community, we need to think about them through the framework already available to us as Healthy People 2020 Leading Health Indicators ([www.healthypeople.gov](http://www.healthypeople.gov)). Each priority has a measureable outcome indicator. While it may be unrealistic to believe that City of Hope can make a significant impact on the national goal, 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 recommended objectives below:



## 1. Access to Care – Culturally relevant partnerships that decrease barriers to care

- a. **AHS-5.1** Increase the proportion of persons of all ages who have a specific source of ongoing care.
- b. **AHS-2** Increase the proportion of insured persons with coverage for clinical preventive services.
- c. **COH –** Increase the number of collaborative efforts with organizations that provide programs/services to communities with disproportionate unmet health needs
- d. **COH –** Increase the percentage of health care force that is culturally and linguistically diverse.

### Key Code

- AHS = Access to Health Services
- COH = City of Hope
- PA = Physical Activity
- NWS = Nutrition Weight Status
- D = Diabetes
- MHMD = Mental Health and Mental Disorders
- C = Cancer

## 2. Chronic Disease Prevention – Healthy living, specifically related to how nutrition and physical activity impact cancer and diabetes

- a. **PA-1** Reduce the proportion of adults who engage in no leisure-time physical activity.
- b. **PA-3.3** Increase the proportion of adolescents who meet current federal physical activity guidelines for aerobic and muscle-strengthening activities.
- c. **PA-15** Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities.
- d. **NWS-8** Increase the proportion of adults who are at a healthy weight.
- e. **NWS-9** Reduce the proportion of adults who are obese.
- f. **NWS-10** Reduce the proportion of children and adolescents who are considered obese.
- g. **NWS-12** Eliminate very low food security among children.
- h. **NWS-14** Increase fruit consumption among residents aged 2 years and older.
- i. **NWS-15** Increase the consumption and variety of vegetables in the diets of residents aged 2 years and older.
- j. **D-1** Reduce the number of new cases of diabetes diagnosed annually.
- k. **D-14** Increase the proportion of persons with diabetes who receive formal diabetes education.

## 3. Mental Health – Supportive partnerships that increase access to mental health care/services

- a. **MHMD-6** Increase the proportion of children with mental health problems who receive treatment.
- b. **MHMD-9** Increase the proportion of adults with mental health disorders who receive treatment.
- c. **MHMD-11** Increase depression screenings by primary care providers.

- d. **MHMD-12** Increase the proportion of homeless adults with mental health problems who receive mental health services.
- 4. **Cancer prevention and early detection, specifically as they relate to lung, colorectal, prostate and women's cancers**
  - a. **C-15** Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines.
  - b. **C-16** Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines.
  - c. **C-17** Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines.
  - d. **C-19** Increase the proportion of men who have discussed the advantages and disadvantages of the PSA (prostate-specific antigen) test to screen for prostate cancer with their health care provider.
  - e. **COH** Increase the proportion of men who receive a prostate cancer screening based on the most recent guidelines.
  - f. **C-14** (Developmental) Increase the mental and physical health-related quality of life for cancer survivors.

Moving forward, City of Hope will align its efforts at addressing the indicators above. 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 local residents from experiencing a good quality of life.

## Needs Not Addressed

Unlike many non-specialty hospitals, City of Hope will not dive deeply into the root causes of health inequities and social determinants of health, such as poverty and homelessness. Because the social determinants of health and root causes of health disparities are intertwined with risk factors for cancer and diabetes, however, 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 our community partners. We will continue to seek out ways to meet the needs of our vulnerable residents and explore innovative strategies that maximize collaborations as a means to building 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 2018-2021 Implementation Strategy. Should you have any questions, please feel free to call our Community Benefit Department at [comm\\_benefits@coh.org](mailto:comm_benefits@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/](http://www.211la.org/) and Think Health LA at [www.thinkhealthla.org](http://www.thinkhealthla.org).

Significant Health Needs	Community Resources
Access to care	<ul style="list-style-type: none"> <li>• Clinica Ramona in El Monte provides one year of health coverage for free.</li> <li>• Community Health Alliance of Pasadena (ChapCare)</li> <li>• Set for Life hosts health expos with health screenings.</li> <li>• Senior Advocacy Program, a county program for seniors primarily in nursing homes</li> <li>• CVS and Rite Aid offer flu shots and screenings.</li> <li>• Foothill Transit offers bus service from Duarte to Pasadena.</li> <li>• Duarte Senior Center publishes a newsletter that identifies resources</li> <li>• City of Hope Health Fair.</li> <li>• Herald Christian Health Center</li> <li>• Tzu Chi Foundation</li> <li>• Cleaver Family Wellness Clinic and food pantry</li> <li>• Good Samaritan Hospital</li> <li>• Parish nurses offer screenings with referrals for more services.</li> <li>• El Monte School District developed a Family Center in El Monte, which includes a number of services and community organizations.</li> <li>• AltaMed</li> <li>• Western University provides dental services at two dental clinics at schools.</li> <li>• Duarte School District's Health Services Center focuses on getting kids access to health insurance.</li> <li>• Foothill Unity Center food bank</li> <li>• Department of Health Services clinic in El Monte</li> <li>• C-Care</li> <li>• Latinos for Hope (City of Hope group) goes out into the community and inform/educate about what's available.</li> <li>• Certified Enrollment Counselors at El Proyecto del Barrio help patients understand eligibility and enrollment and keep them on their programs to maintain their benefits.</li> <li>• East Valley Community Health Center</li> <li>• Antelope Valley Community Clinic</li> <li>• Antelope Valley Children's Center</li> <li>• Antelope Valley Partners for Health</li> <li>• Palmdale Regional Medical Center</li> <li>• Antelope Valley Hospital</li> <li>• Garfield Health Center</li> </ul>

	<ul style="list-style-type: none"> <li>• Asian Community Center</li> <li>• Kaiser Permanente</li> <li>• Huntington Hospital</li> <li>• City of Pasadena Public Health Department</li> <li>• Chinatown Service Center</li> <li>• Planned Parenthood – Pasadena and San Gabriel Valley</li> </ul>
Cancer	<ul style="list-style-type: none"> <li>• Clínica Médica Familiar (Family Medical Clinic) holds clinics twice a year.</li> <li>• Brotherhood Labor League Annual Men's Conference</li> <li>• City of Hope offers cancer screenings at health fairs.</li> <li>• Set for Life offers mammograms.</li> <li>• Children's Hospital Los Angeles</li> <li>• Southern California Health Conference at Pasadena Civic Center</li> <li>• Cleaver Clinic</li> <li>• American Cancer Society has resources that can help with transportation and navigation assistance.</li> <li>• Susan B. Komen</li> <li>• My Health LA patients provides emergency Medi-Cal for women 40+ with breast cancer, and for women of any age with cervical cancer through the Every Woman Counts program..</li> <li>• Prostate Cancer Research Institute annual conference</li> <li>• MEMAH (Men Educating Men About Health) annual conference partners with City of Hope to provide digital rectal exams.</li> <li>• Garfield Health Center provides mammograms and colorectal cancer screenings.</li> <li>• Herald Cancer Association offers support, consultation, answers questions, written information and links to websites.</li> </ul>
Heart disease	<ul style="list-style-type: none"> <li>• American Heart Association</li> <li>• Set for Life</li> <li>• Labor Union Conference</li> <li>• Curbside CPR classes offered by the fire department</li> <li>• Tzu Chi Foundation</li> <li>• Children's Hospital Los Angeles</li> <li>• Los Angeles County Department of Public Health Service</li> <li>• City of Azusa has a Wellness Center.</li> <li>• El Proyecto del Barrio does medication management and assistance.</li> <li>• Clinic pharmacy dispensary provides some additional medications.</li> <li>• 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.</li> <li>• Foothill Unity Center offers a walking program and checks blood pressure.</li> </ul>



	<ul style="list-style-type: none"> <li>• Health plans provide educational materials about foods to eat and foods to avoid. Some have been translated by health plans.</li> </ul>
Mental health	<ul style="list-style-type: none"> <li>• Alma Services</li> <li>• Spirit Family Services</li> <li>• Enki Mental Health Center</li> <li>• Foothill Unity Center provides referrals and services for families and homeless.</li> <li>• National Association for the Mentally Ill</li> <li>• Tri-Cities Mental Health serves Pomona, La Verne and Claremont.</li> <li>• Los Angeles County Department of Mental Health</li> <li>• Foothill Family Service offers some group services.</li> <li>• Libraries provide information on where to access services.</li> <li>• Whittier Hospital offers a lot of free classes.</li> <li>• El Monte School District added a district social worker and school counselor.</li> <li>• Pacific Clinics/Asian Pacific Family Center</li> <li>• Foothill Family Services</li> <li>• D'Veal Family &amp; Youth Services</li> <li>• District Homeless Coordinator has information about referrals for kids.</li> <li>• Duarte School District has partnerships with providers (Foothill Family Services and D'Veal) to come into the schools and provide services.</li> <li>• Asian Coalition helps people find resources.</li> <li>• Each Mind Matters, the California Mental Health movement</li> <li>• Mental Health Services Act</li> <li>• Asian Youth Center hosts a mental health day.</li> <li>• Health Consortium of Greater San Gabriel Valley is looking to build more connections between physical and behavioral health providers.</li> <li>• 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.</li> <li>• Santa Anita Family Services</li> <li>• Foothill Family Services</li> <li>• Arcadia Mental Heath</li> <li>• Aurora Clinic</li> <li>• Pacific Clinics</li> <li>• Asian Pacific Health Care Venture has Chinese language mental health services.</li> </ul>
Overweight and obesity	<ul style="list-style-type: none"> <li>• San Gabriel Valley Service Center has free Zumba, yoga, line dancing and aerobics classes.</li> <li>• Women, Infants and Children offers nutrition classes.</li> <li>• Our Saviour Center has nutrition and cooking classes.</li> <li>• Community centers offer exercise programs, such as Zumba and walking.</li> <li>• Senior centers</li> </ul>

	<ul style="list-style-type: none"><li>• Each city has some exercise programs.</li><li>• Swim programs for school-age children</li><li>• Some nonprofits organize physical education and/or nutrition education/healthy snacks, such as Boys &amp; Girls Clubs.</li><li>• City of Duarte hosts a Biggest Loser contest and sponsors city walks.</li><li>• Duarte Senior Center offers referrals and some free services, including a hiking club.</li></ul>
Drugs, alcohol, tobacco	<ul style="list-style-type: none"><li>• Alcoholics Anonymous</li><li>• Azteca</li><li>• California's anti-tobacco campaign</li><li>• Policies that prevent tobacco use in public settings and more enforcement of laws that prevent tobacco sales to minors</li><li>• American Cancer Society</li><li>• Unity One</li><li>• Los Angeles County Sherriff's drug and alcohol prevention programs</li><li>• Parent University</li><li>• Narcotics Anonymous</li><li>• Asian Youth Center program helping cities create smoke-free parks,</li></ul>



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