Desert Highland Gateway Community Health Assessment 2013-2014

El Sol Neighborhood Educational Center
"Transforming Hearts, Minds and Actions"

Desert Healthcare District
Doing Healthy Deeds

Loma Linda University Health

Prepared by

The Institute for Community Partnerships
Loma Linda University Health, Loma Linda, CA
Katie Dambrun, Research Associate
Molly Krancari, Research Assistant
Kristen Arthur, Research Analyst

For

The Desert Healthcare District
Palm Springs, CA

And

The Desert Highland Gateway Community
Palm Springs, CA

Assessment Team Members

Loma Linda University Health

Katie Dambrun
Nellie Leon
Juan Carlos Belliard
Kristen Arthur
Crystal Jackson
Jason Lee
Richmond Pajela
Molly Krancari

El Sol Neighborhood Educational Center

Susie del Toro
Alex Fajardo

Desert Highland Gateway Community Health Workers

Natalie Edwards
Phillip Frazier
LaVonne Hill
Marjorie Holland

Abbreviations

CHA:	Community Health Assessment
CHW:	Community Health Worker
CHWA:	Community Health Worker Academy
DHG:	Desert Highland Gateway
JOJ:	James O. Jessie Desert Highland Unity Center
KI:	Key Informant
KII:	Key Informant Interview
LLUH:	Loma Linda University Health

Acknowledgements

The community health assessment would not have been possible without the generous funding and support provided by the Desert Healthcare District.

We would like to express our sincere appreciation to our stakeholder group, who provided invaluable insight and guidance throughout the assessment.

A special thanks goes out to the staff of the James O. Jessie Desert Highland Unity Center for their support and hospitality by allowing us to use the center as our home base and center of operations during the length of this project.

Lastly, and most importantly, we would like to thank the community health workers for contributing their knowledge, passion, and dedication to the development of their community. They were the soul, hands, and feet of the project.

Table of Contents

Executive Summary

The Desert Highland Gateway (DHG) community, Loma Linda University, and El Sol Neighborhood Educational Center collaborated to conduct a community health assessment (CHA) in northern Palm Springs. The purpose of the CHA was to look at both needs and assets of the Desert Highland Gateway Community in order to recommend strategies in which the community can draw upon its own resources to address identified needs.

Demographics

The gender distribution among community respondents was even (51%/ 49%). The majority of respondents were African-American/ Black (81%) followed by Hispanic/ Latino (9%). A large number of respondents were unemployed (32%) and the average education level was a high school diploma (43%).

Methods & Results

The CHA consisted of a two-phase quantitative and qualitative assessment that was conducted February-June 2014 and involved the participation of more than 330 community members. The first phase was a quantitative assessment using a survey, which consisted of questions on demographics, disease measures, health behaviors, and healthcare access. The results of the survey revealed the most common health-related issues in the community, which were then narrowed down to four priority areas for a more in-depth assessment. These four priority areas are:

1. Healthcare affordability
2. Healthcare access and emergency room use
3. Hypertension, high cholesterol, and obesity
4. Health impacts of arrest/ incarceration

The second phase of the CHA engaged the community in discussions focused on these four priorities. These conversations provided further insight into underlying issues behind the statistics in the survey data and identified community assets. Data was collected through three activities — a community asset mapping activity, key informant interviews and focus group discussions.

Quantitative and qualitative data revealed that few were untouched by the four priority areas. Issues of healthcare affordability affect almost 40% of community members and 1 in 3 are affected by healthcare access. About 1 in 3 community members are affected by high blood pressure, high cholesterol or obesity and 2 in 5 community member's health is impacted by arrest or incarceration.

Recommendations

Data from all assessment activities was summarized and systematically reviewed to identify the underlying causes and effects for each of the four priority areas. These causes and effects were then analyzed to identify potential solutions to improve health outcomes for the community. The majority of recommendations dealt with social determinants of health, such as job placement programs, programs for at risk youth, improvements in public safety and improved transportation. These outcomes show the necessity of building internal capacity and partnering with a variety of organizations to address indirect and direct determinants of health in this community. Moving forward, the community has decided to create a Community Wellness Committee to lead the charge in planning health and community development programs and advocating for the Desert Highland Gateway community.

Introduction

Purpose

The Desert Highland Gateway Community Health Assessment (DHG-CHA) strived to answer the following questions:

1. *What health conditions are common in the community?*
2. *How does the community access healthcare?*
3. *What community resources are available or needed?*

Background

The Desert Highland Gateway (DHG) community is located on the north side of Palm Springs and is bordered by the following roadways: 1) Tramview Road to the north, 2) Highway 111 to the west, 3) San Rafael Road to the south, and 4) Indian Canyon Road to the east. The community is comprised of approximately 480 households, made up of single-family homes and two federally-subsidized apartment complexes. The majority of community members are low to middle income and are predominantly African-American with a Latino and Caucasian minority.

Map of Desert Highland Gateway

Project Overview

Community Health Workers

The approach of this community health assessment (CHA) was to build community capacity by training community members, equipping them with necessary skills to assess their own community. This approach was accomplished with the guidance of Loma Linda University researchers, who made sure the community was involved in every stage of the process, and the El Sol Neighborhood Educational Center, who provided logistical and administrative support to the project. Four community members completed the certification process through the Community Health Worker Academy (CHWA), a certified training program developed and administered by El Sol Neighborhood Educational Center and Loma Linda University. This training included 96 hours of general training (October-December 2013), with an additional 100 hours of specialized field training (January-June 2014) to conduct community health assessments.

Study Design and Data Collection

A CHA was chosen because it looks at both needs and assets of a community in order to recommend ways a community can draw upon its own resources to address existing needs. The CHA was conducted February-June 2014 and involved the participation of more than 330 community members. It was designed as a community-based participatory research project with an explanatory sequential mixed-methods design. Following community-based participatory research protocol, the community health workers (CHWs) participated in all aspects of the CHA. Following a sequential explanatory mixed-methods study design, the CHA consisted of two data collection phases – quantitative followed by qualitative. All study participants provided informed written consent.

CHWs conducted the first phase of the assessment between February 2014 and April 2014 by conducting interview-administered surveys of 307 adults (18 years and older). After analyzing the data from the survey (April 2014), the assessment team identified key problem areas and prioritized them from eight to four priority areas. The qualitative phase followed the quantitative phase with the purpose to help explain key findings from the survey. The purpose of the qualitative phase was to engage the community in discussions focused on the four priorities. This phase of the assessment provided further insight into deeper issues and causes behind the statistics in the survey. Qualitative data was collected between April 2014 and June 2014 through three activities – a community asset mapping activity, ten key informant interviews, and four focus group discussions.

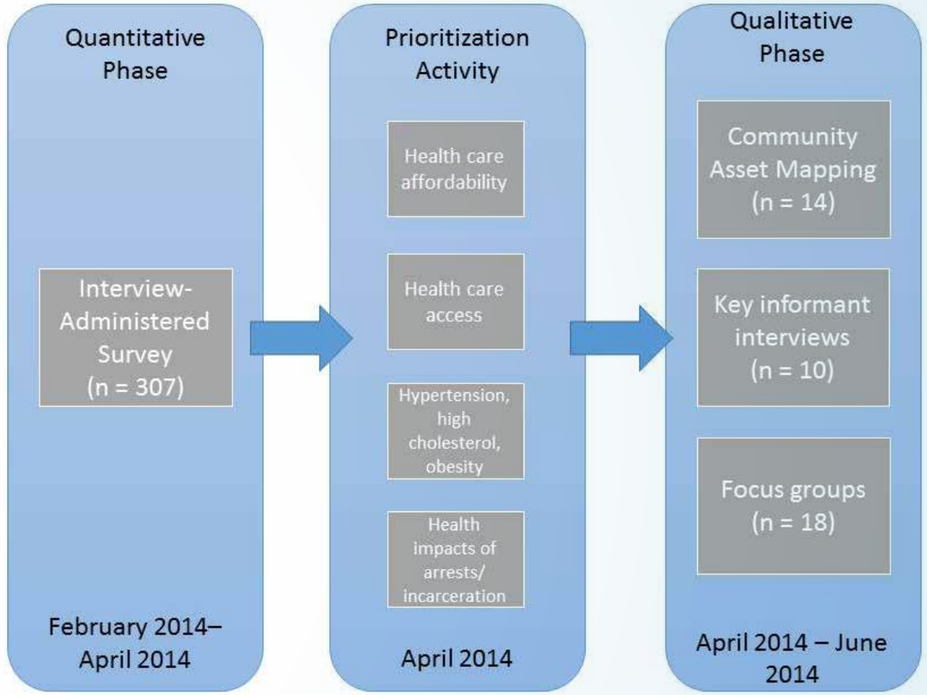


Figure 1. Overview of the Desert-Highland Gateway Community Health Assessment.

Recommendations and Dissemination of Results

After assessment activities were completed, all data was compiled and analyzed in order to make recommendations for next steps to address the health needs identified by the community. The CHWs developed a presentation to summarize the CHA results and recommendations, which was presented to the DHG community in August 2014.

Quantitative Assessment

Overview

The first phase of the assessment included a survey based on the National Health Interview Survey developed by the Centers for Disease Control (National Center for Health Statistics, 2013). Survey items included questions on demographics (e.g. What is your age?), medical conditions (e.g. Has a medical professional diagnosed you with hypertension in the last five years?), healthcare access (e.g. Is there a place you usually go to when you are sick and need medical treatment?), healthcare affordability (e.g. Do you currently have health coverage/ insurance?), and health behaviors (e.g. Do you currently smoke cigarettes?).

Quantitative and qualitative data revealed that few were untouched by the four priority areas. Issues of healthcare affordability affect almost 40.0% of community members and 1 in 3 are affected by health care access. About 1 in 3 community members are affected by high blood pressure, high cholesterol, or obesity, and 2 in 5 community member's health is impacted by arrest/ incarceration.

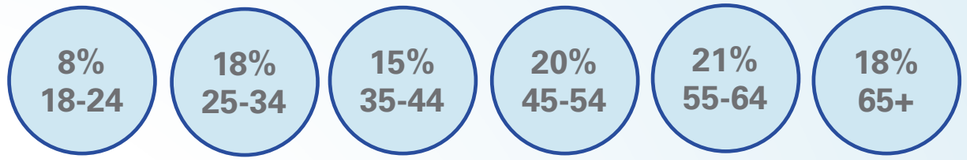
The 2013 National Health Interview Survey was modified based on issues that were important to the community. For example, the community health workers identified the importance of gathering data on 1) alcohol and tobacco as prevalent health behaviors in the community, 2) medical conditions that impact African-American citizens (e.g. high blood pressure) and 3) the arrested/ incarcerated subpopulation. Thus, questions were adapted and added to the survey to appropriately gather relevant data.

Survey data was collected by two different mediums – 1) digital tablet and 2) paper-based survey. Initially, all CHWs collected survey data with digital tablets. There were multiple technical difficulties, which led the CHWs to change how data was collected. They decided to use paper-based surveys and manually enter all data into a database. The majority of the data was collected through paper-based surveys.

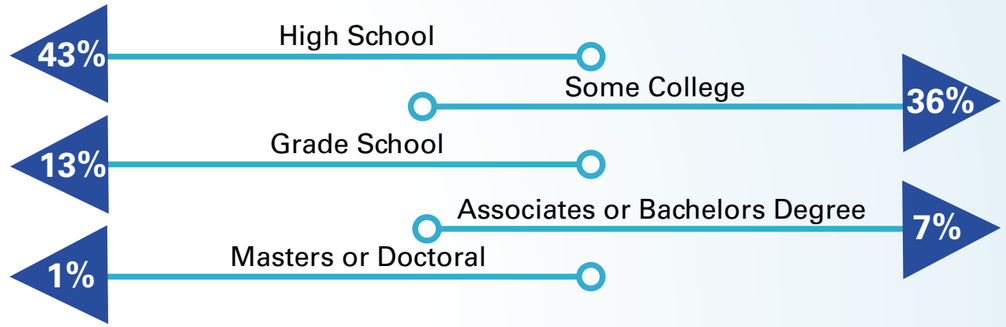
Demographics

Desert Highland Gateway Survey Population

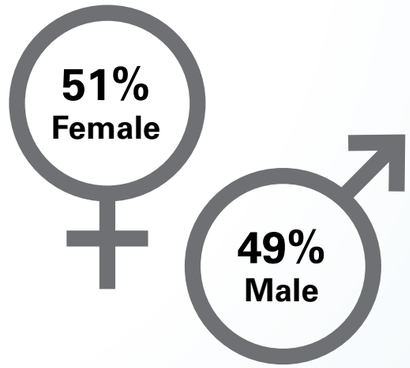
Ages



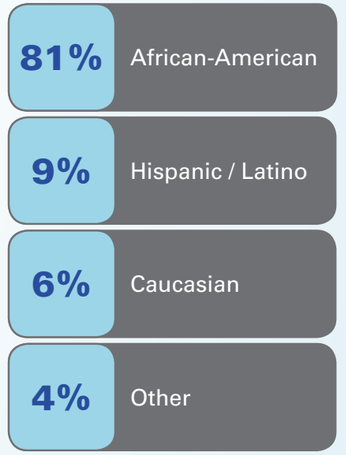
Educational Level



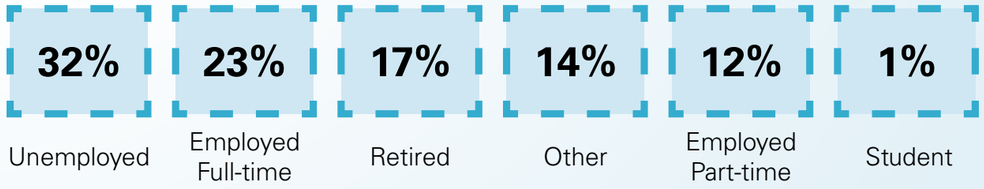
Gender



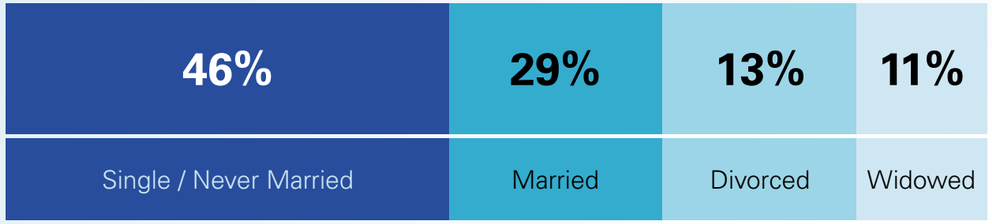
Race



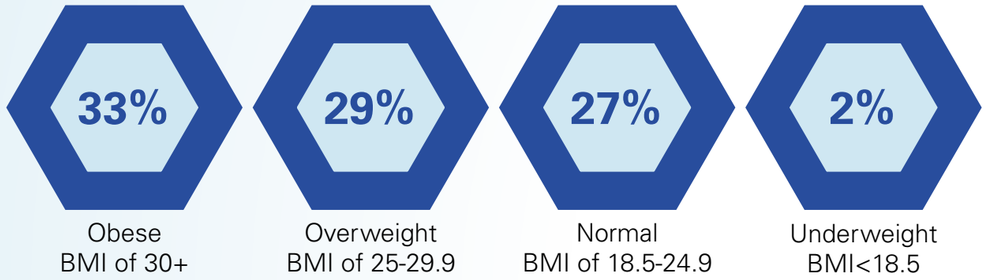
Employment



Marital Status

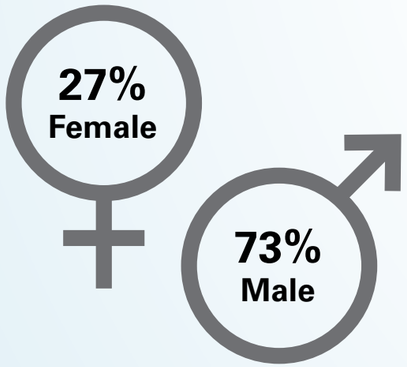


Weight Category

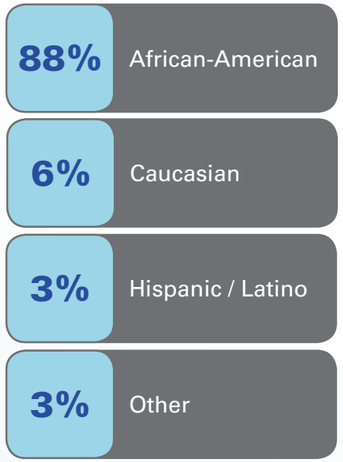


Arrested/ Incarcerated Subpopulation Demographics

Gender



Race



Desert Highland Gateway Population

There was an even distribution among community respondents in the areas of gender- 50.5% were female and 48.5% were male. The majority of respondents identified themselves as African-American/ Black (80.8%), followed by Hispanic/ Latino (8.8%), Caucasian (5.9%), and other (3.9%).

The distribution was relatively even across the different age groups, excluding 18-24 year olds which may have been due to selection bias as CHWs stated that young people were less compliant to participate. The mean age was 49 years old and the age range was between 18-91 years old. Results showed that 7.8% of respondents were between the ages of 18-24, 17.9% of respondents were between the ages of 25-34, 14.7% of respondents were between the ages of 35-44, 19.2% of respondents were between the ages of 45-54, 19.9% of respondents were between the ages of 55-64, and 17.3% of respondents were 65 years or older.

Data analysis revealed that 42.7% of respondents stated the highest level of education they had attained was a high school diploma , followed by completed some college, vocational, business, or trade school (35.2%), grade school or less (13.0%), an associate or bachelor's degree (7.2%), or master's or doctoral degree (1.0%).

The highest number of respondents were unemployed (31.9%), followed by employed full-time (23.1%), retired and not working (16.9%), other (14%), employed part-time (11.4%), retired and working (1.0%), or student (0.7%). The majority of those who selected "other" regarding their employment status were disabled followed by self-employed.

Data analysis revealed that 45.6% of respondents were single or never married, 28.7% were married, 13.0% were divorced/ separated, and 10.7% were widowed.

Body Mass Index (BMI) scores were calculated based on height and weight measurements provided by respondents. Based on these calculations, the majority of respondents were obese (33.2%) (BMI > 30 kg/ m2), 29.0% were overweight (BMI 25-29.9 kg/ m2), 26.4% of respondents fell into a normal weight category (BMI 18.5-24.9 kg/ m2), and 2.0% of respondents were underweight (BMI < 18.5 kg/ m2).

Arrested/ Incarcerated Subpopulation

The majority of arrested/ incarcerated respondents were male (72.8%) and 27.2% were female. Data analysis revealed that 88.1% of arrested/ incarcerated respondents were African-American/ Black, 6.3% were Caucasian, 3.2% were Hispanic/ Latino, and 2.4% were other. A total of 51.3% of arrested/ incarcerated respondents were between the ages of 45-64 years old.

The highest average level of education achieved in this subpopulation was a high school diploma (49.6%). Forty-six percent of those respondents were unemployed and 56.0% responded they were single or had never been married.

Results by Priority Area

The results of the survey data analysis were used to determine key areas of concern to be further explored through several qualitative assessment activities. The assessment team carefully reviewed the survey results and then chose eight topics of significance. These eight topics were compared by using a priority matrix to narrow them down to four priority areas. These four priority areas were: 1) healthcare affordability; 2) healthcare access and emergency room use; 3) hypertension, high cholesterol, and obesity; and 4) health impacts of arrest/ incarceration.

Healthcare Access

Table 1. Usual place to access healthcare

	Desert Highland Gateway Community n = 307 (%)	National Average: All Adults (%)	National Average: African-American or Black Adults (%)
Emergency Room	37.5	3.0	6.9
Doctor's office/ HMO	29.3	74.3	71.1
Clinic or health center	20.5	21.7	21.0
Some other place	3.6	1.1	1.1
No usual place of care	7.8	16.9	16.0
Missing data	3.3	--	--

Analysis revealed that 37.5% of respondents reported to use the Emergency Room as their usual place of care when they are sick or need medical treatment. Blackwell, Lucas, and Clarke (2014) report the national average to be much lower, where only 3% (6.9% of African-American or Black adults) report to use the Emergency Room as their usual place of care. In addition, 9.5% of respondents stated they had attended the Emergency Room two or more times in the last 12 months.

Only 29.3% reported to use a doctor's office/ HMO as their usual place of care when they are sick or need medical treatment. Blackwell, Lucas, and Clarke note the national average is much higher as 74.3% (71.1% African-American or Black adults) use a doctor's office/ HMO as their usual place of care.

Approximately 20.5% reported to use a clinic or health center as their usual place of care when they are sick or need medical treatment. This compares to the national average where 21.7% (21% African-American or Black adults) use a clinic or health center as their usual place of care (Blackwell, Lucas & Clarke, 2014).

In addition, 3.6% reported to use "some other place" as their usual place of care when they are sick or need medical treatment. Blackwell, Lucas, and Clarke (2014) report the national average is even smaller, where only 1.1% (1.1% African-American or Black adults) use "some other place" as their usual place of care when they are sick or need medical treatment (Blackwell, Lucas & Clarke, 2014).

Only 7.8% of respondents stated they did not have a usual place of care when they are sick or need medical treatment. The national average is about double at 16.9% for all adults and 16% for all African-American or Black adults (Blackwell, Lucas & Clarke, 2014).

Healthcare Affordability

Table 2. Healthcare affordability in past 12 months

	Desert Highland Gateway Community n = 307 (%)
Couldn't afford:	
Dental care	49.8
Eye exam	41.4
Prescriptions	34.9
Mental healthcare or counseling	27.7
Specialist care	25.4
To save money:	
Delayed prescription	14.3
Took less medication	13.7
Asked for lower cost medication	13.4
Skipped medication	10.7

About 1 in 2 (49.8%) reported they could not afford dental care in the past year. About 41.4% of respondents reported they could not afford an eye exam and 34.9% reported they were unable to afford prescriptions in the past year. Respondents also stated they delayed a prescription (14.3%), took less medication (13.7%), asked for a lower cost medication (13.4%), or skipped medication (10.7%) to save money in the past 12 months.

Comparing these numbers to national averages, 6.1% of surveyed adults (7.8% of African-American or Black adults) did not receive medical care due to cost and 8.2% (8.8% of African-American or Black adults) delayed medical care due to cost (Adams, Kirzinger & Martinez, 2013).

Hypertension, High Cholesterol, and Obesity

Disease Prevalence

Table 3. Disease prevalence

	Desert Highland Gateway Community n = 307 %	National Average: All Adults (%)	National Average: African-American or Black Adults (%)
Hypertension*	46.3	23.9	32.9
High Cholesterol*	27.4	13.4	10.3
Obesity**	33.2	27.4	37.0

**Self-reported diagnosis by a healthcare provider.*
***Self-reported height and weight.*

Data analysis showed that 46.3% of respondents reported to have been diagnosed with hypertension by a health professional in the past five years. This compares to the national average of 23.9% from all surveyed adults and 32.9% of surveyed African-American or Black adults (Blackwell, Lucas & Clarke, 2014).

About 1 in 4 (27.4%) respondents reported to have been diagnosed with high cholesterol by a health professional in the past five years. Comparing this data to a 2009-2010 report from the National Health and Nutrition Examination Survey, 13.4% of all adults have high cholesterol, while only 10.3% of African-American or Black adults have high cholesterol (Carroll, Kit & Lacher, 2012). The DHG community has approximately triple the number of high cholesterol cases when compared to the national average of African-American or Black adults.

About 1 in 3 (33.2%) respondents were obese (BMI > 30). This can be compared to the national average of all adults (27.4%) and the national average for African-American or Black adults (37%) (Schoenborn, Adams & Peregoy, 2013).

Hypertension and Age

Table 4. Hypertension and age

Age (years)	Desert Highland Gateway Community n = 307 (%)	National Average: All Adults (%)
18-44	19.8	8.3
45-64	57.5	33.7
65-74	80.0	52.3
75+	87.9	59.2

After examining the percentage of respondents who have hypertension, the DHG community held a greater number of hypertension cases in all age categories compared to national averages (Blackwell, Lucas & Clarke, 2014). About 1 in 5 respondents ages 18-44 years old have hypertension (national average, 8.3%), followed by 57.5% of 45-64 year olds (national average, 33.7%), 80.0% of 65-74 year olds (national average, 52.3%), and 87.9% of respondents 75 years or older (national average, 59.2%).

Health Impacts of Arrest/ Incarceration

Health Status

Table 5. Health status

	Arrested/ Incarcerated Subpopulation n = 128 (%)	Desert Highland Gateway Community n = 307 (%)	National Average: All Adults (%)	National Average: African-American or Black Adults (%)
Excellent or Very Good	21.6	25.0	66.0	57.0
Good	24.0	30.9	24.0	28.0
Fair or Poor	54.4	42.7	10.0	15.0
Missing Data	--	1.3	--	--

The arrested/ incarcerated subpopulation's health fared worse when compared to the surveyed DHG population and far worse when compared to current national averages. When asked to rate their general health status, 54.4% of the subpopulation respondents stated their health to be either "fair" or "poor." When asked the same question to the surveyed DHG population, 42.7% stated their health to be either "fair" or "poor." When these percentages are compared to national averages, the differences are much greater. The national average of adults who state their general health to be "fair" or "poor" is 10.0% and the national average for African-American or Black adults is 15.0% (Adams, Krizinger & Martinez, 2012).

Health Behaviors

Table 6. Current substance use

Arrested/ Incarcerated Subpopulation n = 128 (%)	Desert Highland Gateway Community n = 307 (%)	National Average: All Adults (%)	National Average: African-American or Black Adults (%)
Currently drink alcohol*			
66.4	48.2	64.9	52.5
Currently smoke cigarettes*			
57.0	36.5	20.2	20.2
Currently use illegal substances*			
23.4	12.4	--	--

**Self-reported*

The incarcerated/ arrested subpopulation had higher percentages of respondents that currently drink alcohol (66.4%) and smoke cigarettes (57.0%) when compared to the surveyed DHG population and to current national averages. Of those that consume alcohol, 53.6% drink three or more times a week. In addition, of those who smoke cigarettes, 87.7% smoke everyday (Quantity was not measured on the survey.)

When compared to the surveyed DHG population, 48.2% currently drink alcohol and 36.5% currently smoke cigarettes. Of those that consume alcohol, 19.9% of respondents drink three or more times a week. In addition, of those who smoke cigarettes, about 1/3 (30.6%) smoke every day. (Quantity was not measured on the survey.)

The national average of adults that currently drink alcohol is 64.9% (52.5% of African-American or Black adults) and the national average of adults that currently smoke is 20.2% (20.2% of African-American or Black adults) (Schoenborn, Adams & Peregoy, 2013). Cigarette smoking among the incarcerated/ arrested subpopulation is almost three times the amount of the national average.

Qualitative Assessment

Overview

Following a sequential explanatory mixed-methods study design, the qualitative phase of the CHA followed the quantitative phase with the purpose of explaining key findings from the survey. The CHWs participated in all aspects of the qualitative phase — establishing purpose statements and research questions, designing data collection tools, gathering data in the field, and analyzing and summarizing data.

To establish a detailed understanding of the community's perceptions and to speak to a representative sample of the community, the qualitative phase had three activities — a community asset mapping activity, ten key informant interviews and four focus groups. Fourteen community members attended the community asset mapping activity and identified strengths and resources within the Desert Highland Gateway community. Key informant interviews were completed with 10 community leaders of various backgrounds and occupations. One focus group discussion was conducted for each of the four priority areas and included a total number of 18 community members.

Community Asset Mapping Activity

Purpose

The purpose of this activity was to help identify resources and assets in the Desert Highland Gateway community.

Approach

A heterogeneous convenience sample was selected from the DHG community to achieve generalizability (also called external validity). DHG community members were invited by announcements at local church events and flyers placed in public venues.

The activity took place between 5:30-7:00 pm on a weekday (April 8, 2014) to accommodate most working schedules. The activity took place at the James O. Jessie Desert Highland Unity Center (JOJDHUC) during hours that provided child care, so that parents with young children could also attend. Dinner was offered as an incentive to participate.

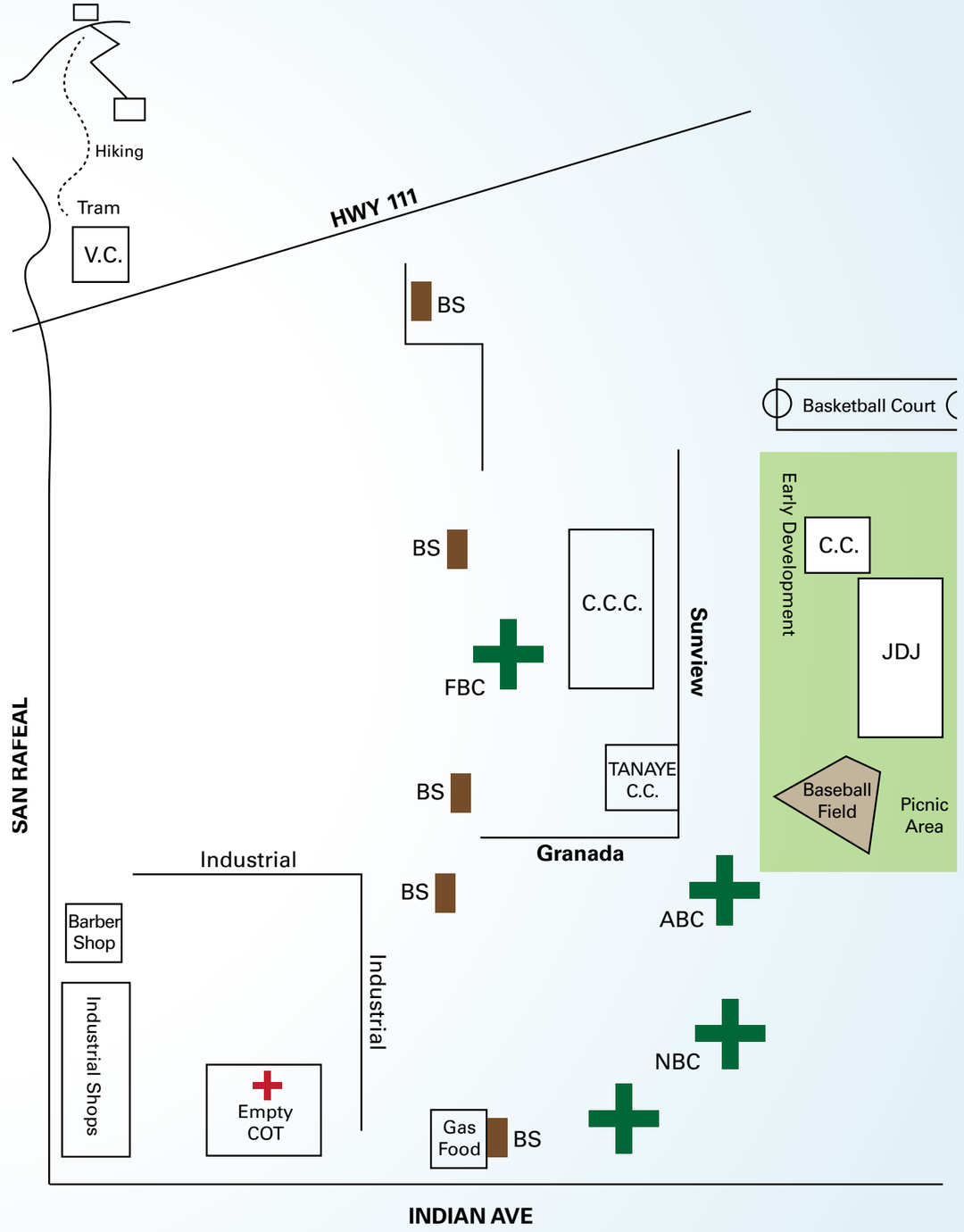
The community members worked in groups, and each group was given a poster-sized paper to draw a map of their community. On the map, they were to include community assets and resources. The boundaries of the community mapping were designated by four main roads: West Tramview Road to the north, Highway 111 to the west, West San Rafael Drive to the south and North Indian Canyon Drive to the east.

Participant Characteristics

A total of 14 community members participated in the community mapping activity. Community members were divided into three groups: (1) three men ages 58-82 years, (2) seven women ages 50-75 years, and (3) two men and two women ages 31 to 42 years.

Findings

Within the boundaries defined by the community mapping activity, there were two areas that were perceived as "outside" of the community: (1) the gated neighborhood in the northwest and (2) the industrial area in the southeast.



The following were identified as DHG community resources:

- JOJDHUC and park*
- Churches*, including Bible studies and Sunday services
- Gas Station*
- Four bus stops
- Hiking trails
- CPR class
- Cement finisher
- A teacher with a Master's degree

**Mentioned by all three groups*

The following were identified as DHG community areas and items for improvement:

- Public safety, need for more police presence and need for more street lights
- Day-care center
- Clean the empty lots and then sell them
- Community store
- Community pool
- Pharmacy
- Wheelchair accessibility at bus stops
- Medical resources within the community borders*
- Bicycle promoting infrastructure
- Promotion of health and wellness for all age groups
- Fitness classes at JOJDHUC

**Agreed upon by more than one group*

There were a few inconsistencies among the results of each group. The younger group identified multiple locations for childcare and several bus stops, mainly along Rosa Parks, as community assets. The older two groups did not mention childcare or bus stops, although, more than one group requested a designated day-care center to improve the community. The older two groups agreed upon the necessity for more wheelchair accessibility.

"I see people trying to help people on wheelchairs."

With regards to improved public safety within the community, the three older males agreed,

"We want police presence in the neighborhood."

Groups also commented on how the empty lots could be used:

"That empty lot could be used as a prenatal health facility, or an ROP [Regional Occupational Program] facility, or a food store. A lot of people have to travel all the way to Stater Brothers."

Key Informant Interviews

Purpose

The purpose of conducting key informant interviews was to explore key informants' perceptions of resources in the DHG community, to determine opinions of health priorities identified by the community health worker and LLUH team, and to confirm if the quantitative data (i.e. survey results) is perceived as an accurate representation of the DHG community.

Approach

A purposeful sample of ten key informants (KIs) were chosen by the CHWs. KIs were selected on the basis of their leadership role in the community and/ or experience with community members. Of 18 KIs invited to participate, 10 were interviewed between April and May 2014 by trained CHWs.

A semi-structured interview guide was created by the community health worker training team. Two CHWs led each interview and asked if selected survey results in each priority area were an accurate representation of the community.

All interviews were audio-recorded and written informed consent was received by each KI prior to participation.

Summaries were written using an ethnographic writing style by CHWs, and no identifiers were included, so that interviewees could remain anonymous. Audio-tapes and summaries were reviewed by training team for quality assurance.

Participant Characteristics

Five males (ages 38-70 years) and six females (ages 30-80 years) were interviewed; note, one key informant interview included a married couple. The key informants were predominantly African-American (n=7), but other race/ ethnicities were also represented (Caucasian, Hispanic, Native American, and multi-ethinic/ racial). All were chosen, as a purposeful sample, because of their leadership role and/ or experience within the DHG community. Occupations included: staff at the community center, retired contractor, volunteer educator, retired educator, pastor, property manager, retired nurse, retired real estate agent, care taker, community member for 18 years, and community member for more than 30 years.

Focus Groups

Purpose

The purpose of the focus groups was to explore the community members' perceptions of the four priority areas.

Approach

A convenience sample was selected for each focus group by placing flyers in public places in the neighborhood. For the health care access focus group, however, flyers were also handed to survey participants who responded they utilized the emergency room as their usual place of care. The preferred size for each focus group was eight participants and each focus group was held at the JOJDHUC, as community members perceive this location as a neutral environment. All focus groups were held on weekday evenings to accommodate most working schedules, and dinner was offered as an incentive for participation.

Each CHW led one focus group. The focus group guide was semi-structured and was designed by the CHWs with the assistance of the training team.

Qualitative Findings by Priority Area

Healthcare Affordability

Most participants felt the statistics presented by CHWs were reflective of community health access patterns. Due to lack of sufficient income and too high of health care costs, DHG community members expressed going to the Emergency Room because they perceive it to be cheaper. Other participants felt that many residents have difficulty accessing medical care because many doctors in the Coachella Valley do not accept "Obama Care" or Medi-Cal and medical transportation is severely limited or inadequate.

"Many residents must go to Riverside, there are problems getting there, lack of transportation or money to pay for it."

One key informant interviewed discussed the difficulty to afford health care by saying,

"Health care is a hustle."

Healthcare Access

About 75% of participants expressed surprise at the survey results which indicated the high number of residents who use the emergency room as a usual place to get health care. Though surprised, they agreed this number was a realistic representation of what goes on in the DHG community. Key informants, in particular, mostly agreed that the Desert Regional Medical Center is being improperly utilized by residents and residents need to take more responsibility for their health by modifying lifestyle habits. One key informant summarized this by saying,

"The ER is a quick fix and we are a part of the problem when we don't take care of ourselves."

The general consensus was that quality and affordable health care was not easily accessible. Lack of (affordable) health insurance, chronic diseases to manage, or the physical distance of providers were common reasons listed by DHG community members. One participant explained that managing chronic diseases has been a problem,

"People wait until their health situations are extremely bad before seeking medical attention, telling themselves, it'll get better on its own."

An unexpected result emerged from these discussions, there is a feeling that some health care providers stereotype patients from the DHG community and this is one reason some reported to have not received quality care. One participant described this as a stereotype of being "unacceptable" (i.e. providers will not accept them as patients because they are presumed to be welfare recipients).

Hypertension, High cholesterol, and Obesity

When asked what they felt to be the main cause of high blood pressure, high cholesterol, and obesity in this community, DHG community members responded with one clear answer – stress! Identified causes of stress were criminal activity, unemployment, inadequate income, incarceration, poor access to health care, racism and perceptions of an unsafe neighborhood.

"Hypertension is a medical term for stress" and that it is a "general American condition."

"Disease means dis-easement in life." She continued to explain she does not allow anger, strife and aggravation in her house. Her motto is "de-stress!"

Other lifestyle choices were also identified: eating habits, substance use (smoking, drinking, or illegal substances), and lack of or little exercise.

"Hypertension is controllable if we reduce our salt, fat, and chemical intake."

An unexpected result emerged from these discussions; some community members deny their health conditions, which delays them from being diagnosed, receiving care or managing these conditions. A "suck it up" attitude and lack of awareness/ education were possible reasons stated for this denial.

Among all priorities, but in particular with regards to personal health, a theme of hope was present among participants. Expressing hope, participants made replies like,

"I am not moving out of my community. I'm living good now!"

"Our neighborhood has a sense of community"

Because hope was so prevalent among community members, some key informants suggested empowering individuals as a way to overcome health hardships and improve the community. One participant stated the need for awareness and education of these health issues,

"We must take responsibility for ourselves."

Another male key informant built on the sense of community by saying he likes the fact the DHG is,

"A close knit community and there's a lot of resources amongst the community members."

Another woman key informant shared her motto of,

"Kick the 'T' off CAN'T and go with CAN!"

She suggested there be a once-a-month class where men and women can have the opportunity to come and talk about what they are doing and to be made aware of resources available to the community.

Health Impact of Arrest/ Incarceration

Due to a lack of other opportunities, an already existing high crime rate, lack of awareness of addiction, minimal social support beginning at an early age, lack of support service programs in the area, and an already existing high prevalence of risky behavior (i.e. substance abuse), arrest/ incarceration remains a problem for youth.

These risk factors create a vicious lifestyle cycle of not obtaining rightful employment, stress, poor mental health, higher likelihood to obtain an infectious disease and repeat criminal offenses. This cycle negatively affects the community by creating a burden on the family, a negative economic impact and decreases the perception of community safety.

When asked how incarceration impacts their community, one participant explained,

"Incarceration impacts the community because they put a burden on the families. They don't have or cannot get jobs; the families must take care of them. Many of the young people with arrest records and have been incarcerated don't care about what they are doing and don't want to work. They don't care about how what they are doing affects other people."

Many participants agreed that while drugs are the number one cause of criminal activity in the neighborhood, the youth have a particularly difficult time after being incarcerated because "they do not have jobs and cannot get jobs." Many participants also agreed there is a lack of programs for teenagers and young adults, such as jobs for teenagers or after-school programs. The lack of these programs is viewed as a lack of prevention against crimes. This was expressed in many ways,

"What else can they do?"

"Many of the youth in community don't know anything about life other than standing on [the] street corner."

Research Limitations

The scope of this assessment process was planned according to the agreed upon timeline and resources. The one year project, with a six-month assessment period, created some limitations in the scope of the assessment. The quantitative and qualitative components were limited to adults (ages 18 and over), but a recommendation for further assessment is to do a similar study on children and youth in the community (up to 18 years of age). Four priority areas for further exploration were agreed upon by the research team, but other areas of concern for future exploration include, but are not limited to, mental health, dental health, hearing and vision and substance abuse.

Recommendations

Data from all assessment activities was summarized and systematically reviewed to identify the underlying causes and effects for each of the four priority areas. These causes and effects were then analyzed to identify potential solutions to improve health outcomes for the community. The following are recommended programs, interventions and strategies to address these priority areas:

1. **Community Wellness Committee:** A committee of community members interested in improving the health of the community by planning health programs, building partnerships and advocating for the community.
2. **Health Navigator Program:** Community Health Workers are trained as health navigators to assist community members in a variety of areas — accessing healthcare, answering questions about insurance and advocating for patients.
3. **Community workshops on the Affordable Care Act (ACA):** Community discussions revealed much confusion and misperceptions regarding the ACA. Many community members may be eligible to receive coverage under the ACA but are currently unaware of ACA regulations and obtaining this type of insurance.
4. **Chronic disease management classes:** Health education classes that teach people how to better manage their conditions and keep them from overusing healthcare services. Activities could include healthy cooking classes, fitness classes, support groups, etc.
5. **Access to free or low-cost dental and vision care:** Even those with insurance often do not have coverage for dental and vision care.
6. **Free or low-cost health clinic:** A local clinic would address the need for access to affordable health services.
7. **Community garden:** A community garden could provide access to fresh produce, beautify the neighborhood, and foster community involvement.

8 **Improve public safety in the community:** The community stated "stress" as the most common cause of chronic disease. Further discussion revealed that community members don't feel safe in their own neighborhoods due to lack of safe streets for exercising and lack of police presence.

9 **Improved transportation:** Access to public transit in the community is limited. Additional bus stops/ routes to connect to Palm Springs and the greater Coachella Valley are needed to access healthcare and job opportunities.

10 **Vocational training program:** Unemployment is very high in the community, especially amongst certain groups (i.e. those with felonies).

11 **Job placement programs:** Vocational training needs to be followed by job placement with local employers, through a partnership between the vocational training program and local businesses.

12 **Programs for at-risk youth:** After-school programs to keep kids engaged and off the streets. These could include sports teams, tutoring, mentoring, art programs, college prep workshops, etc.

13 **Substance abuse programs:** Awareness campaigns, support groups, and counseling were all mentioned as needed programs.

Community intervention recommendations by priority area

	Healthcare Affordability	Healthcare Access	Hypertension, High Cholesterol, Obesity	Health Impacts of Arrest/ Incarceration
Community Wellness Committee	✓		✓	✓
Health Navigator Program	✓		✓	✓
Community workshops on the Affordable Care Act	✓		✓	✓
Chronic disease management classes	✓		✓	✓
Access to free or low-cost dental and vision care	✓			✓
Free or low-cost health	✓		✓	✓
Community garden			✓	✓
Improve public safety in the community			✓	✓
Improved transportation	✓			✓
Vocational training program	✓			✓
Job placement programs	✓		✓	✓
Programs for at-risk youth			✓	✓
Substance abuse programs	✓		✓	✓

References

Adams, P.F., Kirzinger, W.K., & Martinez, M.E. (2012). Summary health statistics for the U.S. population: National Health Interview Survey, 2011. National Center for Health Statistics, Vital Health Statistics, 10(255).

Adams, P.F., Kirzinger, W.K., & Martinez, M.E. (2013). Summary health statistics for the U.S. population: National Health Interview Survey, 2012. National Center for Health Statistics, Vital Health Statistics, 10(259).

Blackwell, D.L., Lucas, J.W., & Clarke, T.C. (2014). Summary health statistics for U.S. adults: National Health Interview Survey, 2012. National Center for Health Statistics, Vital Health Statistics, 10(260).

Carroll, M.D., Kit, B.K., & Lacher, D.A. (2012). Total and high-density lipoprotein cholesterol in adults: National Health and Nutrition Examination Survey, 2009-2010. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

National Center for Health Statistics. (2013). 2013 National Health Interview Survey. Hyattsville, Maryland.

Schoenborn, C.A., Adams, P.F., & Peregoy, J.A. (2013). Health behaviors of adults: United States, 2008–2010. National Center for Health Statistics, Vital Health Statistics, 10(257).

LOMA LINDA UNIVERSITY
HEALTH

LLUMCMKTG#CP-233-14/09/14/TBD

MANY STRENGTHS. ONE MISSION.

A Seventh-day Adventist Organization