2022 Inland Empire
Community Health Needs Assessment | Hospital Edition

Inland Empire Health Plan
Montclair Hospital Medical Center
Redlands Community Hospital
San Antonio Regional Hospital
San Gorgonio Memorial Hospital

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With technical assistance from:

HC² Strategies, Inc.
IP3 (Institute for People, Place, and Possibility)
SpeedTrack, Inc.

Version 1, August 2022

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Welcome

Dear Friends,

Stewardship is the foundation of this Inland Empire Community Health Needs Assessment (CHNA) – Hospital Edition. This document is not just a collection of data about our community. Rather, the CHNA and its transformational tools bring an opportunity for renewal — a time for new ways of thinking about how we invest together in our community's health, well-being and equity to support a vibrant Inland Empire region.

It's no secret that our world is more complicated than ever. The COVID-19 pandemic is just one of a bewildering array of threats to community health: public safety, environmental hazards, homelessness, under-resourced schools, illness and injury, poverty, unemployment and social exclusion.

Rather than focusing only on the urgent conditions and services related to these threats, we want to focus on the vital conditions our communities need to achieve vibrant health. The IP3 | Assess tool with the Vital Conditions for Well-Being framework is used in this CHNA. This framework quickly integrates data from multiple sources and transforms it into actionable information, allowing us to move straight to collaborative priority-setting that will foster collective action for well-being and equity.

In addition to the initial CHNA for the participating hospitals, we are launching the IP3 | Assess online platform as a support and engagement resource for collective investments by multiple community stakeholders. This is just the beginning of collaboration to support vibrant health in the Inland Empire. Our hospitals — in partnership with the Inland Empire Health Plan (IEHP) and other key stakeholders in nonprofit, public health and health care delivery spaces — are embarking on an even longer journey to develop collective priorities for our entire region.
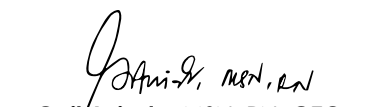
We are immensely proud of this work. Our fervent hope is that this Community Health Needs Assessment and the IP3 | Assess platform will inspire you — as they have us — to work together across our sectors to be better stewards of this Inland Empire region that has been entrusted to us.

Jarrod McNaughton, CEO
Inland Empire Health Plan

Megan Barajas, HASC
Inland Empire, Hospital Association
of Southern California

Gail Aviado, MSN, RN, CEO
Montclair Hospital Medical Center

James R. Holmes, President and CEO
Redlands Community Hospital

John Chapman, President and CEO
San Antonio Regional Hospital

Steven Barron, CEO
San Gorgonio Memorial Hospital

Executive Summary

This 2022 Inland Empire Community Health Needs Assessment (CHNA) is the work of a diverse group of stakeholders that set out to identify the top health and well-being needs of Inland Empire residents. Stakeholders will use the findings to build community interventions that generate collective investments addressing the identified priorities.

There are seven assessments within this document. The first three target the entire Inland Empire region, along with Riverside and San Bernardino counties. The remaining four assessments comprise drilled-down analyses for Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and San Gorgonio Memorial Hospital service areas. In addition to hospital CHNAs, an online platform will be launched as a support and engagement center for collective action.

This document includes burden of disease data, vital conditions data and hospital utilization data along with information gathered through key informant interviews and facilitated listening sessions with community residents.

The 2022 CHNA process followed these steps:

1. Key data were collected for the 2022 Inland Empire CHNA Stakeholder Committee's review. Quantitative data also were integrated into the IP3 | Assess platform, which has two frameworks that are used to identify specific levers that stakeholders can pull to improve community health through collective action.

   a. The **Burden of Disease framework** focuses on 12 health conditions, which were reduced to 10 for the purposes of this CHNA. (The domains of cardiovascular disease and diabetes were combined into one, and brain health was not included due to a dearth of indicators.)

   b. The **Vital Conditions for Well-Being framework** highlights seven conditions vital to the well-being of people and places (social and environmental drivers of health).

2. After reviewing the data, the 2022 Stakeholder Committee used a poll with five questions to rank disease and condition priorities for collective action in the Inland Empire. Additionally, the stakeholders selected four populations for special focus to address health disparities in their communities.

3. Based on the poll, the Stakeholder Committee selected the following priorities and populations for focus in the 2022 CHNA.

   a. Burden of disease framework
      - Cardiovascular disease and diabetes
      - Mental and behavioral health
      - Maternal and infant health

   b. Vital conditions
      - Basic needs for health and safety
      - Humane housing
      - Meaningful work and wealth

c. Populations of focus (addressing health disparities)
- Communities of color
- Individuals with low income and those living in poverty
- Seniors
- Communities in remote and rural areas

4. After this meeting, representatives of Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and the Hospital Association of Southern California met again to select priorities for their primary service areas (PSA). They validated that the above priorities and populations were also the most important for their service areas. San Gorgonio Memorial Hospital representatives selected the same priorities and populations at a subsequent meeting.

Vision for Collaboration

This document and all the corresponding data represent just one element in the stewardship required for health and well-being transformation in the Inland Empire. As the stakeholders continue to meet this year and beyond, they intend to leverage the COVID-19 disruption to develop and implement collaborative, measurable action plans that address the priorities identified in this regional CHNA and tracked through the IP3 | Assess platform.

Stakeholders recognize that this collaboration, which will enhance the vital condition of belonging and civic muscle, forms the foundation for all efforts leading to healthy, vital conditions and lives. Building a community engagement process that includes civic participation from diverse communities — in solving problems and taking collective responsibility for each other — is crucial to positive change. That work is the very definition of stewardship.

Background

A community health needs assessment (CHNA) uses systematic processes to evaluate a community's health and social needs as well as its assets. Information gathered through that evaluation is then used to identify priorities for action. The development of CHNAs and related plans was voluntary until the 1990s. In 1994, the California Legislature passed a statute that required not-for-profit hospitals to conduct comprehensive CHNAs every three years. Hospitals were asked to report annually on the progress of their implementation plans developed to meet the identified community needs. The passage of the federal Affordable Care Act in 2010 set forth a similar requirement for all not-for-profit hospitals in the United States. The CHNA process was to give special consideration to low-income, minority and underserved members of the community.

Health Equity as an Emerging Issue

In 2020, the COVID-19 pandemic increased public awareness of the health and socioeconomic inequities in health care and the rest of society. The pandemic turned the spotlight on the millions of people who live in poverty, do not make a livable wage, live in substandard housing and lack access to healthy food and affordable transportation, childcare, health care and other basic services.

The pandemic led to catastrophic job loss, unprecedented unemployment rates and severe economic hardship in renter households. In 2016, the percentage of home evictions in the United States hovered around 3.7 million. In 2020, more than 40 million people were at risk of eviction, and more than 75% of them were people of color. Eviction has been linked to increased hospitalizations in children, substance use, physical and sexual abuse and depression and anxiety *("Eviction and Health: A Vicious Cycle Exacerbated by a Pandemic," Health Affairs, April 1, 2021).*

Health inequities were widespread before they were highlighted by the COVID-19 pandemic. Policies and practices at every level of society have created deep-rooted barriers to good health. Many neighborhoods and communities have experienced generations of isolation from the opportunities that others experience. The inequities are reflected in differences in length of life, quality of life, rates of disease, disability and death, severity of disease and access to treatment. However, the political will to address these injustices is growing.

Health equity is achieved when every person has the opportunity to "attain his or her full health potential," notes the Centers for Disease Control and Prevention (CDC). To build vibrant communities, we must increase opportunities for everyone to live the healthiest life possible, no matter who we are, where we live or how much money we earn.

Public Health and Prevention

Public health is defined as the health of a population as a whole. The regional CHNA took this "population level" approach in identifying priorities to support vibrant health in the community.

This regional CHNA was strategically designed as a collaborative process that included county public health departments, a local Medi-Cal managed care organization (Inland Empire Health Plan), local hospitals, community clinics and other community-based organizations working towards health improvement in the Inland Empire region.

Many of the essential public health approaches have been intentionally adopted in this regional hospital CHNA process:

- Assess and monitor community needs and assets, population health status and factors that influence health.

- Investigate, diagnose and address health problems and hazards affecting the population.

- Communicate effectively to inform and educate people about health, factors that influence it and ways to
  improve it.

- Strengthen, support and mobilize communities and partnerships to improve health.

- Build and maintain a strong organizational infrastructure for public health.

As we work to address the health issues, social conditions and inequities identified in this CHNA, taking a public health approach will be critical.

2022 Inland Empire CHNA Stakeholder Committee

The 2022 Inland Empire CHNA Stakeholder Committee represented many key public health, health care delivery systems and community partners in the Inland Empire region of Southern California. Stakeholders were intentionally selected to represent organizations that work with vulnerable populations in the region.

To guide development of a hospital edition of the regional CHNA in partnership with the participating hospitals, the stakeholders held virtual meetings in February, March, April and May 2022. The stakeholders will continue to meet throughout 2022 and beyond to inform a broad regional assessment that supports the work of all non-hospital partners, as well.

2022 Inland Empire Stakeholder Committee members represented the following organizations:

Listed in Alphabetical Order by Organization

- Erin Managbanag, MBA
  Arrowhead Regional Medical Center

- Rolando Mantilla, MS
  Arrowhead Regional Medical Center

- Brian Cotter, MBA
  Barstow Community Hospital

- Christian Starks, MPA
  CommonSpirit Health

- Linda Pearson
  Corona Regional Medical Center

- Martin Kleinbart DPM,
  Corona Regional Medical Center

- Linda Evans, MHA, MS
  Desert Regional Medical Center

- Tammi Graham
  First 5 Riverside County

- Erica Williams, MPA
  First 5 Riverside County

- Scott McGrath, MS
  First 5 San Bernardino County

- Karen Scott
  First 5 San Bernardino County

- Jenna LeComte-Hinely, PhD
  HARC (Health Assessment and Research for Communities)

- Dora Barilla, DrPH, Facilitator
  HC² Strategies, Inc.

- Muder Alkrisat, MD
  Hemet Valley Medical Center

- Megan Barajas, MPA
  Hospital Association of Southern California

- Michelle Decker, MA
  Inland Empire Community Foundation

- Priya Batra, MD, MS, Chair
  Inland Empire Health Plan

- Marci Coffey, MPH
  Inland Empire Health Plan

- Sylvia Lozano, MHA, FACHE
  Inland Empire Health Plan

- Jessica Miller, DrPH
  Inland Empire Health Plan

- Natalie Miller, MS
  Inland Empire Health Plan

- Rosie Nava, MPH, MCHES
  Inland Empire Health Plan

- Nishtha Patel, MBA, MPH, PMP
  Inland Empire Health Plan

- Jane Wang, MPH, RDN
  Inland Empire Health Plan

- Cecelia Arias, MPH, MCHES
  Kaiser Permanente

- Martha Valencia, MPH
  Kaiser Permanente

- Marti Baum, MD
  Loma Linda University Health

- Juan Carlos Belliard, PhD, MPH
  Loma Linda University Health

- Jasmine Hutchinson, MSPH
  Loma Linda University Health

- Marti Baum, MD
  Loma Linda University Health

- Gail Aviado, MSN, RN
  Montclair Hospital Medical Center

- Karen Zirkle, MSHSA
  Redlands Community Hospital

- Erin Curlee
  Riverside University Health System, Public Health

- Wendy Hetherington, MPH
  Riverside University Health System, Public Health

- Kevin Meconis, MPH
  Riverside University Health System, Public Health

- John Chapman, MBA
  San Antonio Regional Hospital

- Aileen Dinkjian, EdD, MPH
  San Antonio Regional Hospital

- Cathy Rebman
  San Antonio Regional Hospital

- Anthony Arce, MPH
  San Bernardino County Department of Public Health, Community Vital Signs

- Dori Baeza
  San Bernardino County Department of Public Health, Community Vital Signs

- Steven Barron
  San Gorgonio Memorial Hospital

- Ariel Whitley, MHA
  San Gorgonio Memorial Hospital

- Kathleen McDonnell
  St. Bernardine Medical Center

- Michelle Burroughs, MPH
  University of California Riverside Medical School

- Maria Lemus
  Visión y Compromiso

Demographic Data for the Inland Empire, Riverside County and San Bernardino County

Understanding the community to be served is a crucial step in conducting a CHNA and setting priorities for action.

Demographics and population projections help tell the story. The demographic data for this CHNA, which were compiled by SpeedTrack, look at population projections by demographic cohort (gender, race, ethnicity and age).

The Inland Empire

The **Inland Empire** encompasses all of Riverside and San Bernardino counties. It covers more than 27,000 square miles and is larger than 10 U.S. states, according to the U.S. Census Bureau. Its 2022 population is 4.765 million.

Demographic data for the Inland Empire project an overall population growth of 3.7% by 2027. The fastest-growing ethnic group is Multiracial; the Hispanic/Latino and Black/African American populations will continue to grow at a slightly higher rate than the White population. The 65+ population will grow by 13%, while the number of children ages 1–17 is projected to decline by 0.7%.

Riverside County

Riverside County is home to 2.545 million people (2022) and covers 7,208 square miles. It is the fourth most-populous county in California and the ninth most-populous in the United States.

Riverside County is growing faster than the Inland Empire as a whole. The greatest ethnic growth by 2027 will be in the Multiracial population, followed by the Hispanic/Latino and Black/African American populations. There will also be significant growth in the Asian and White populations. Again, there is a large increase in the over-65 population and a decline in the 1–17-year-old population group.

San Bernardino County

San Bernardino County has 2.22 million residents in 2022. It is the fifth most-populous county in California and the 13th most-populous in the United States. It covers 20,105 square miles.

San Bernardino County is growing at a slightly slower rate than Riverside County and the Inland Empire as a whole. By far, the fastest-growing ethnic group is Multiracial, followed by Hispanic/Latino and Black/African American people. There will be a significant increase in people 65 and older and a decrease in children ages 1–17.

Appendix A provides additional demographic data on the Inland Empire, Riverside and San Bernardino counties and the primary service areas of Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and San Gorgonio Memorial Hospital.

Data Sources and Findings

This Community Health Needs Assessment synthesized primary and secondary data sources. Primary data are new data collected or observed directly from first-hand experience. Secondary data have already been collected and published by another party.

Primary Data

The stakeholders reviewed primary data that were collected for the Inland Empire regional CHNA from two sources: key informant interviews and community listening sessions.

In both the interviews and the listening sessions, participants were asked to describe — in their own words — what they saw to be the important health and social needs and the challenges that influence these needs. Participants were not shown any additional data (e.g., previously completed CHNAs, publicly available secondary data) in advance of the primary data collection sessions.

awareness
alcohol abuse
poverty substance abuse
access to health care diabetes
asthma childhood mental health
obesity psychiatry prevention
affordable housing
provider shortage stress depression meals
trauma mental health cancer
homelessness suicide
prevention childhood mental health COVID-19 education
mammograms food insecurity insurance access
colonoscopies access to primary care unemployment
medication cost nutrition
prediabetes anxiety childhood obesity addiction
child abuse racism medication cost
transportation exercise language
violence
income loss
affordability
health
ptsd

Key Informant Interviews

The CHNA stakeholders identified nine key informants who were interviewed individually in person or by telephone in March, April and May 2022 by HC² Strategies. The informants represented community, civic and government leaders in the Inland Empire. Questions focused on key health needs, social factors and community conditions that affect health as well as community assets that could be used to address these issues. Key themes (health priorities) that emerged from these interviews are listed below.

Most Common Themes

- Mental health — especially depression and anxiety
- Substance use disorder
- Education — learning loss among youth
- Financial strain — job and income loss
- Unemployment and lack of appropriate job skills training

Other Themes

- Delayed or deferred preventive care services
- Digital divide and technology gaps exposed by the pandemic and lockdown
- Housing instability and homelessness
- Safety and violence
- Convenient access to health care

Equity Themes

- Infant mortality — particularly in populations that identify as Black/African American
- Health equity among lower-income communities
- Health equity in communities of color
- Lack of prenatal care in rural and remote areas

Appendix B lists the key informants.

Listening Sessions

The Social Impact Artists, Inc. conducted eight listening sessions at multiple locations throughout the Inland Empire to gain insights from diverse communities on regional health priorities. Efforts were taken to include interviewees identifying with populations whose voices CHNA stakeholders wanted to elevate in the prioritization of regional health issues: immigrants, youth, working-class community members and individuals who identified as BIPOC (Black, indigenous and people of color).

In the sessions, which were conducted in English and Spanish, participants discussed community health problems as well as concerning environmental and community conditions.

About 90% of the 49 participants were female. They came from:

- Riverside County — Hemet, Perris, Menifee, Moreno Valley, Homeland (unincorporated area)
- San Bernardino County — Ontario, Rialto, Big Bear/Arrowhead, Victorville/Hesperia

Efforts to recruit participants included phone calls, emails, social media posts and direct outreach in community locations (health fairs, hospitals, pharmacies, laundromats, libraries). Recruitment for listening sessions was also pursued via door-to-door visits to homes and businesses.

Most Common Themes

The following health themes emerged in the listening sessions:

- Mental health/depression and anxiety/substance use
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Hypertension and heart disease
- Cancer
- Obesity

Environmental and community themes included:

- Air quality
- Affordable housing
- More green spaces
- Lack of entertainment, activities and a center for youth
- Role of faith communities in caring for community members
- Crime and violence
- More community celebrations

The themes uncovered in the listening sessions varied somewhat by geographical area.

Appendix Q contains the Listening Session Report.

Secondary Data

Hospital Data

Hospital secondary data in this needs assessment focus on hospital inpatient and emergency department (ED) utilization data, the top causes of death, morbidities (health conditions), chronic conditions and the social determinants affecting hospital use.

The 2016–2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

The hospital data were stratified by the Inland Empire as a whole and by San Bernardino and Riverside counties. In addition, SpeedTrack pulled utilization data specific to each hospital service area; these findings are noted in the hospital-specific CHNA reports found later in this document.

The California hospital data for inpatient admissions — flagged for Prevention Quality Indicators (PQIs) and "Z" type diagnosis codes (International Classification of Diseases, Tenth Revision – ICD 10) — are important because they highlight the most common chronic conditions and social drivers of health in the designated regions.

Hospital Prevention Quality Indicators (PQIs)

Prevention Quality Indicators (PQIs) help identify hospital inpatient admissions that might have been avoided if a patient had access to outpatient care, including follow-up after discharge.

All California hospitals report PQIs to the state's Department of Healthcare Access and Information (HCAI). Hospitals across the nation use the PQI algorithms, which are set by the federal Agency for Healthcare Research and Quality (AHRQ). PQIs measure hospital inpatient admission rates for:

- **PQI 01** - diabetes, short-term complications
- **PQI 03** - diabetes, long-term complications
- **PQI 05** - COPD or asthma in older adults
- **PQI 07** - hypertension
- **PQI 08** - heart failure
- **PQI 11** - bacterial pneumonia
- **PQI 12** - urinary tract infections

- **PQI 14** - uncontrolled diabetes
- **PQI 15** - asthma in younger adults
- **PQI 90** - overall composite
- **PQI 91** - acute composite
- **PQI 92** - chronic composite
- **PQI 93** - diabetes composite

Hospital Z Codes for Social Determinants of Health

Hospitals are now capturing data on the social needs of their patient's populations through what are commonly called "Z codes." These ICD 10 codes, which are documented in the patients' medical records, identify non-medical factors that may influence a patient's health status. These data are valuable not only for understanding a patient's health status but also for identifying unmet social needs in a community, which can inform and support community health investments.

Z code categories focus on social determinants of health that may impact patients' use of hospital services versus outpatient care. The social determinants are defined as the economic and social conditions that influence individual and group differences in health status. They include social drivers of health such as education level, employment, social and family supports, upbringing, housing, environmental stability and other psychosocial factors.

Unfortunately, Z codes are underused. While the data represented in this CHNA are limited by what have been collected, they provide some information on the greatest social needs being reported in the Inland Empire. With a collective approach to CHNAs and strategies, the hope is to encourage use of this standard approach for screening and tracking social needs, which will expand the community's collective knowledge for solutions.

Avoidable ED Visits

Avoidable emergency department (ED) visits are defined as conditions managed in the ED that likely could have been treated in a primary care setting. When community members visit the ED instead of a primary care doctor, they miss the opportunity for coordinated and comprehensive treatment for their ongoing medical needs.

Avoidable ED rates in the Inland Empire are largely associated with having Medi-Cal insurance and are more commonly seen in the infant and adolescent populations. The most common potentially avoidable conditions leading to ED use are abdominal pain, upper respiratory infections, musculoskeletal pain and urinary tract infections.

It is interesting to note that, overall, avoidable ED visits were down in 2020, possibly due to COVID-19 and the corresponding delays in health care utilization.

When designing interventions to reduce avoidable ED visits and health disparities, it is important to consider factors that affect the populations most represented in the data.

For example, individuals struggling with homelessness tend to visit the ED or urgent care for basic health services instead of a primary care provider, driving up the number of avoidable ED visits. They also tend to be difficult to reach or track for follow-up care. Establishing trust and relationships with this population and developing care pathways to simultaneously address housing and health needs must be a priority when incorporating interventions.

In addition, disparities exist in the diagnosis and management of cardiovascular diseases, diabetes, hypertension and cancer, among other diseases, which also can lead to avoidable ED visits. For example, populations who identify as Latinx and Black/African American in the Inland Empire do not achieve the same disease outcomes in these areas as compared to their counterparts who identify as White. These populations are also disproportionately more likely to seek care for these conditions in the ED — a site where care coordination and long-term condition management cannot be realistically prioritized. Partnering with these communities to address the structural barriers contributing to avoidable ED use will be key to improving health in historically excluded communities.

Appendix C contains data tables of avoidable ED rates for the Inland Empire and Riverside and San Bernardino counties.

Appendix P lists avoidable ED rates for the Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and San Gorgonio Memorial Hospital primary service areas.

IP3 | Assess

Additional secondary data for this assessment were derived from the IP3 | Assess platform developed by the Institute for People, Place, and Possibility (IP3). IP3 | Assess uses two frameworks: Burden of Disease and Vital Conditions for Well-Being. The domains in the Burden of Disease framework consist of common health conditions, and the domains in the Vital Conditions framework comprise seven community conditions that affect health and well-being. The IP3 | Assess data were reviewed systematically by regional CHNA stakeholders in prioritizing key health and environmental issues to support health in the Inland Empire.

Users can drill down into indicators in each domain to identify specific focus areas and prioritize efforts. They can toggle between different geographies to see how scores vary across service areas and explore driving factors for positive and negative composite domain scores.

Appendix D offers an in-depth description of the IP3 | Assess tool.

Other Community Needs Assessments

The Inland Empire CHNA stakeholders also considered primary and secondary data findings from other needs assessments conducted in Riverside and San Bernardino counties.

Riverside County

A COVID-19 Needs Assessment examined community attitudes and behaviors related to COVID-19 in Riverside County in 2021. The Riverside University Health System – Public Health conducted the assessment in cooperation with the Health Association and Research for Communities (HARC).

The assessment consisted of interviews with 9,200 county residents regarding fear of being sick, hospitalized or dying; COVID-19's impact on social life and work/school participation; travel avoidance; financial losses; delays in health and dental care; vaccination status and beliefs; and the burden of COVID-19 disease. Most participants "somewhat agreed" or "strongly agreed" that the pandemic had a disproportionate impact on people of color.

San Bernardino County

The San Bernardino County Department of Public Health published the Community Vital Signs survey in collaboration with the Community Vital Signs (CVS) initiative in 2020. This initiative is a collaboration of community leaders and decision-makers from different sectors across the county. The group identified and prioritized health equity issues in the county. The indicators incorporated demographics, health and wellness, education, economic factors and safety. The survey results have been used to create collaborative action plans in San Bernardino County.

Stakeholder Prioritization Process to Determine Key Issues

After a series of monthly preparatory discussion sessions, HC² Strategies facilitated a virtual strategy meeting

with the 2022 Inland Empire CHNA Stakeholder Committee on April 19, 2022. Their task was to review the results of the various data sets and to identify and prioritize critical health and community issues. They followed this process in their work.

Data Collection and Review	Virtual Polls	Priority & Population Selection	Hospital Selection
Reviewed data on avoidable ED visits, key informants, listening sessions, PQIs, Z codes, IP3 | Assess platform, needs assessments	Used five questions to rank 10 burden of disease areas and seven vital conditions	Selected top three burden of disease areas, top three vital conditions and key populations for equity focus	Hospitals and Hospital Association of Southern California selected same priorities and similar populations for service areas in second strategy session

In the April 19 strategy session, the stakeholders first considered the data they had received from the Montclair, Redlands and San Antonio regional hospitals, data in the IP3 | Assess Burden of Disease and Vital Conditions for Well-Being frameworks and qualitative findings from key informant interviews and listening sessions.

Stakeholders used virtual polling to rank the burden of disease and vital conditions data. The poll asked five key questions regarding these data. The stakeholders ranked their selections from one to five, with one being the highest and five being the lowest.

The five questions were:

1. How acute is this need?

2. Are there energy, capacity and resources for improving the need?

3. Does the issue disproportionately affect certain populations? (Consider race, ethnicity, income, geography and education.)

4. Are there investment opportunities for collaborative partners and/or practice — or evidence-based approaches to address these needs?

5. Has COVID-19 impacted the area of focus?

Burden of Disease Priorities

The Stakeholder Committee reviewed the most common diseases listed below, and asked Questions 1–5 regarding 10 health conditions in the IP3 | Assess Burden of Disease framework. While IP3 | Assess provides 12 categories in this framework, this CHNA includes 10. (The domains of cardiovascular disease and diabetes were combined into one, and brain health was not included due to a dearth of indicators.)

- Cardiovascular disease/diabetes
- Cancers
- Respiratory disease
- Kidney disease
- HIV/AIDs and sexually transmitted infections (STIs)

- Infectious disease
- Maternal and infant health
- Injury and violence
- Mental and behavioral health
- Oral health

The committee used the virtual polling process described above to determine the most critical health conditions in the Inland Empire. The number of responses in each question set the priorities for the below top three burden of disease areas in the Inland Empire.

Detailed data and information about these burden of disease categories and their indicators may be viewed using the links below. A drop-down menu on the top right corner of the page allows website visitors to review data for the Inland Empire and 13 other geographic areas within the region. Stakeholders will use these data to identify and collaborate on interventions focused on these priority conditions.

- Cardiovascular disease and diabetes
- Mental and behavioral health

- Maternal and infant health

The other conditions rank as secondary issues that may also be addressed if the need is large in a particular community.

Appendix E shows committee poll rankings for the burden of disease areas.

Appendices F, *G* and *H* list the selected IP3 | Assess Burden of Disease categories, the indicators that illuminate the causal factors, high-level results and links to the reports.

Appendix L details the IP3 | Assess Burden of Disease data sources for the indicators.

Vital Conditions Priorities

Next, the Stakeholder Committee members reviewed the seven IP3 | Assess Vital Conditions:

- Basic needs for health and safety
- Lifelong learning
- Meaningful work and wealth
- Humane housing

- Reliable transportation
- Thriving natural world
- Belonging and civic muscle

Again, using virtual polls, stakeholders were asked to rank the five vital conditions that they considered to be most important for the Inland Empire. Questions 1–5 (noted above) were again used in this virtual polling process. Raw vote counts identified the priorities for the top three vital conditions in the Inland Empire.

Detailed data and information about these vital conditions and their indicators may be viewed using the links below. A drop-down menu on the top right corner of the page allows website visitors to review data for the Inland Empire and 13 other geographic areas within the region. Stakeholders will use these data to identify and collaborate on interventions.

- Basic needs for health and safety
- Humane housing
- Meaningful work and wealth

The other conditions rank as secondary issues that may also be addressed if the need is large in a particular community.

Appendix E shows committee poll rankings for the vital conditions.

Appendices I, *J* and *K* list the selected IP3 | Assess Vital Conditions for Well-Being categories, the indicators that illuminate the causal factors, high-level results and links to the reports.

Appendix M details the data sources for the IP3 | Assess Vital Conditions for Well-Being indicators.

Appendix N provides information about the 2019 Inland Empire community health priorities, which are very similar to the 2022 priorities, and subsequent work on the issues.

Populations Disproportionately Impacted

The stakeholders then turned to identifying populations who — based on available data sources — might be experiencing a disproportionate share of the burden of disease conditions or obstacles to achieving the vital conditions for well-being. Through data review by the group, the following key populations were identified:

- Individuals with low incomes
- Individuals identifying as Black/African American, Latinx and/or Pacific Islander
- Remote and rural communities
- Senior citizens

Appendix O contains stakeholder comments from the strategy meeting.

Priority Selection Process
for Participating Hospitals

A second strategy session was facilitated by HC[2] Strategies on April 26, 2022, for the Hospital Association of Southern California (HASC) and three of the Inland Empire hospitals that participated in this Hospital Edition of the regional Community Health Needs Assessment:

- Montclair Hospital Medical Center
- Redlands Community Hospital
- San Antonio Regional Hospital

Findings in the Hospital Community Health Needs Assessments

The four participating hospitals will address the six priority areas identified for the larger Inland Empire region. The indicator tables (Appendices F–K) for the IP3 Burden of Disease and Vital Conditions for Well-Being frameworks show some variation in the contributing indicators for each hospital PSA (primary service area) and the rest of the Inland Empire region.

These hospital variations and the opportunities for improvement are noted below.

Appendix P provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.

Montclair Hospital Medical Center

Montclair Hospital Medical Center, established in 1973, is an award-winning, 106-bed facility located in the heart of Montclair. With a multidisciplinary team of experts and state-of-the-art technology, the hospital team is committed to serving the community with personalized, high-quality care. Montclair Hospital Medical Center offers a full range of comprehensive services, including 24-hour emergency care, advanced diagnostic services, cardiopulmonary services and rehabilitation care.

Located in southwestern San Bernardino County, the hospital's primary service area includes the cities of Montclair, Pomona, Ontario, Upland and Claremont. Its secondary service area comprises Rancho Cucamonga, La Verne, Diamond Bar and Chino.

Appendix A provides demographic information about the Montclair Hospital Medical Center PSA.

Hospital Disease Data

The following disease findings specific to Montclair Hospital Medical Center's PSA were compiled by SpeedTrack. The 2016–2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- Black/African American males and females 65+ have the highest number of chronic conditions.

- The top chronic conditions in males ages 18 – 34 are substance use disorders, mental illness and tobacco use.

- Males over 35 have high rates of hypertension, diabetes, kidney disease and hyperlipidemia. In addition, males over 65 have higher rates of heart disease and prostate conditions.

- The top chronic conditions in females 18 – 34 are obesity and anemia, following by depression and anxiety.

- Hypertension is the top condition for females ages 35 – 64, especially in the Black/African American population; anemia and diabetes are also high in this group. White females 65+ have the lowest rates of hypertension compared to the other ethnicities.

Appendix P provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in Montclair Hospital Medical Center's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High smoking rate
- Low rate of blood pressure management
- High death rates for diabetes

- High heart disease hospitalization rates for Medicare beneficiaries
- High diabetes rate

Mental and Behavioral Health

- Frequent mental distress

- Shortage of mental health providers

Infant and Maternal Health

- Low birthweight babies

- Pre-term births

Basic Needs for Health and Safety

- Shortage of dental providers
- HPSA (Health Professional Shortage Area) — Primary Care

- People with diagnosed hypertension who are not taking medication
- High rate of violent crime

Humane Housing

- High housing costs
- High rate of overcrowded housing
- High rate of residential segregation

Meaningful Work and Wealth

- Lack of high-paying jobs
- High unemployment rate
- Low median household income
- Low homeownership rate
- High child poverty rate

Redlands Community Hospital

Redlands Community Hospital (RCH) is a 229-bed facility that has cared for the community of Redlands

and its surrounding areas since 1904. It is founded on a mission to promote an environment where members of the hospital's community receive high-quality care and service by working in concert with the patients, physicians, staff and associates of RCH.

RCH is an independent, not-for-profit, full-service community hospital serving as a major health care provider in its primary service area of East San Bernardino Valley and a hospital of choice for medical staff.

Located in the most densely populated area of San Bernardino County, communities identified as being in the hospital's primary service area (from which 75% – 80% of patients come) are Banning, Beaumont, Cabazon, Colton, Calimesa, Forest Falls, Highland, Mentone, Redlands and Yucaipa. The hospital's secondary service area is described as including Bloomington, Bryn Mawr, Crestline, Fontana, Grand Terrace, Hemet, Loma Linda, Patton, Rialto, San Bernardino and several mountain communities.

Appendix A provides demographic information about the Redlands Community Hospital PSA. Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

Hospital Disease Data

The following disease findings specific to Redlands Community Hospital's PSA were compiled by SpeedTrack. The 2016–2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- For males, the number of chronic conditions ranges from 5.52 to 5.89 per individual. Black/African American males have the highest number followed by Hispanic/Latino males. Asian/Pacific Islander males have the lowest.

- For females, the number of chronic conditions ranges from 4.88 to 6.06 per individual. Black/African American females have the highest number, followed closely by White females and Hispanic/Latina. Again, females of Asian/Pacific Islander descent have the lowest.

- The top chronic condition for all four ethnicities is depression, followed by depressive disorders and asthma. White females report high levels of anxiety disorders.

- ED visits dropped in 2020 compared to prior years. The main social determinants for avoidable ED visits are primary support group and family, occupational risk, other psychosocial circumstances and social environment.

- Medicaid and Medi-Cal are, by far, the largest payers. Asian/Pacific Islanders and White people under age 65 have higher rates of private insurance than the other ethnic groups.

Appendix P provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in Redlands Community Hospital's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High obesity rate

- High smoking rates

- High rate of hypertension deaths

- High rate of heart failure deaths

- High diabetes rate

- High hospitalization rates for Medicare beneficiaries

- Low proportion of completed A1c tests for Medicare recipients

- High death rate for diabetes

Mental and Behavioral Health

- High rate of depression among Medicare beneficiaries

- Frequent mental distress

- Shortage of mental health providers

Infant and Maternal Health

- High infant death rate

- High rate of tobacco use during pregnancy

- High rate of pre-term births

- Below benchmark in early prenatal care

Basic Needs for Health and Safety

- HPSA (Health Professional Shortage Area) — Dental

- High rate of premature death

- High rate of people living with disabilities

- Lower life expectancy than the state average

Humane Housing

- High rate of homes with incomplete plumbing or kitchen facilities

- Low rate of multi-family housing

Meaningful Work and Wealth

- Lack of high-paying jobs

- Low median household income

San Antonio Regional Hospital

Founded in 1907, San Antonio Regional Hospital is a 363-bed, nonprofit, acute care hospital in Upland, California. In addition to its main campus, the hospital has satellite locations across the Inland Empire. Services include adult and neonatal intensive care; emergency and urgent care; robotic, open heart and other surgical procedures; dedicated obstetrics, oncology and orthopedic units; and imaging, lab, rehabilitation and other outpatient services.

San Antonio's primary service area comprises the cities of Chino, Claremont, Eastvale, Fontana, Montclair, Ontario, Rancho Cucamonga and Upland. The hospital's secondary service area extends to Pomona to the west, Chino Hills to the southwest, Norco to the southeast and Rialto at the eastern edge of the service area.

Appendix A *provides demographic information about the San Antonio Regional Hospital PSA.*

Hospital Disease Data

The following disease findings specific to San Antonio Regional Hospital's PSA were compiled by SpeedTrack. The 2016 – 2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- Black/African American males and females over age 65 have the highest number of chronic conditions.

- Hypertension is the primary chronic condition in males and females ages 35 – 64 and over 65, especially in Black/African American populations.

- Anemia, diabetes, kidney disease and obesity are major issues for all people over 35.

- Depression and depressive disorders are the primary chronic conditions in male and female youth ages 0 – 17.

- Medi-Cal is the primary payer for Black/African American and Hispanic/Latino adults under age 65.

- ED mental health use declined in 2020, likely due to COVID-19.

Appendix P provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in San Antonio Regional Hospital's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High obesity rate
- High cholesterol rate
- HPSA (Health Profession Shortage Area — Primary Care
- High rate of hypertension deaths
- High rate of smoking

- High stroke rate
- High rate of heart disease
- High diabetes rate
- Low diabetes management rate in Medicare beneficiaries
- High diabetes death rate

Mental and Behavioral Health

- Shortage of mental health providers
- HPSA (Health Professional Shortage Area) — Mental Health
- High rate of substance use disorder deaths
- High rate of depression in Medicare beneficiaries

Infant and Maternal Health

- High infant death rate
- High percentage of low birthweight babies
- High rate of tobacco use during pregnancy
- High rate of pre-term births

Basic Needs for Health and Safety

- HPSA (Health Professional Shortage Area) – mental health
- HPSA (Health Professional Shortage Area) – Dental
- High rate of premature death
- High population of people with disabilities
- Lower life expectancy

Humane Housing

- Low rate of multi-family housing

Meaningful Work and Wealth

- Lack of high-paying jobs
- Low median household income

San Gorgonio Memorial Hospital

San Gorgonio Memorial Hospital (SGMH) is a 79-bed general acute care hospital located in Banning, California, a rural area in the northwestern region of Riverside County.

The community-based hospital is dedicated to providing acute care services to the residents of the San Gorgonio Pass area. It is the only acute care hospital in the San Gorgonio Memorial Health Care District, which has approximately 90,000 year-round residents. The district includes the cities of Banning and Beaumont, a portion of Calimesa and the neighboring unincorporated areas of Cabazon, Cherry Valley and Whitewater.

SGMH offers many services, including 24-hour emergency care, robotic surgery, cardiology, teleneurology and advanced imaging.

The hospital's primary service area comprises zip codes 92220 and 92223; its secondary service area is the rest of the hospital district.

Appendix A provides demographic information about the San Gorgonio Memorial Hospital PSA.

Hospital Disease Data

The following disease findings specific to San Gorgonio Memorial Hospital's PSA were compiled by SpeedTrack. The 2016–2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- Black/African American males and females over age 65 have the highest number of chronic conditions.

- Hypertension is the primary chronic condition in males and females ages 35–64 and over 65, especially in Black/African American populations.

- Anemia, diabetes, kidney disease and obesity are major issues for all people over 35.

- Depression and depressive disorders are the primary chronic conditions in male and female youth ages 0–17.

- Medi-Cal is the primary payer for Black/African American and Hispanic/Latino adults under age 65.

- ED mental health use declined in 2020, likely due to COVID-19.

Appendix P provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in San Gorgonio Memorial Hospital's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High obesity rate

- High cholesterol rate

- High rate of hypertension

- High rate of smoking

- High stroke rate

- High diabetes rate

- High rate of heart attack, heart disease and heart failure

- Low rates of heart disease hospitalizations in Medicare beneficiaries

Mental and Behavioral Health

- Shortage of mental health providers

- HPSA (Health Professional Shortage Area) — Mental Health

- High rate of drug use disorder deaths

- High rate of depression in Medicare beneficiaries

Infant and Maternal Health

- High infant death rate

- High percentage of low birthweight babies

- High rate of tobacco use during pregnancy

- High rate of pre-term births

Basic Needs for Health and Safety

- High percentage of people without supermarket access

- HPSA (Health Professional Shortage Area) — Mental Health

- HPSA (Health Professional Shortage Area) — Dental

- High percentage of uninsured adults

- High rate of premature death

- High population of people with disabilities

Humane Housing

- Low rate of multi-family housing

Meaningful Work and Wealth

- Lack of high-paying jobs

- High rate of people on public assistance

- Low median household income

- High poverty rate

- High child poverty rate

Next Steps

Our communities are far better off when everyone has the opportunity to live their healthiest life. We must work collectively to support and improve the many systems that influence health — not only health care and social services, but also vital services such as education, housing, transportation and public safety.

As stewards of our communities — parents, educators, health providers, business leaders and other community members — we all have important roles in improving health and well-being, eliminating preventable health inequities and building communities with truly equal opportunities for all people.

To advance this work, all community members are encouraged to review the data and priorities in this report and identify where and how they might contribute to improvement. Along with that support, community stakeholders will continue to meet, study the community data, collaborate on implementation strategies and align regional investments to focus on the priorities identified.

Additional support and information are available and will be expanded. All community members have access to much of the IP3 | Assess data through links in Appendices F–K in this report as well as many other resources at ConnectIE.org. A comprehensive community needs assessment on the Inland Empire as well as Riverside and San Bernardino counties also will be released to the public later in 2022. In addition, an IP3 | Assess platform of data and information will be made available to stakeholders to support their collaboration.

Together, we can build a vibrant Inland Empire. It will take each of us seeing the possibilities and working together for good as stewards of our communities.

Appendix A: Additional Demographic Information

Population trends for the Inland Empire region as well as Riverside and San Bernardino counties are provided in the main body of this report.

Inland Empire Population Projections by Demographic Cohort

Gender	2023	2024	2025	2026	2027	% Change
Female	2,373,485	2,395,289	2,416,737	2,440,123	2,462,993	3.8%
Male	2,359,370	2,382,216	2,405,735	2,426,260	2,445,601	3.7%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	21,633	1,760	22,014	22,150	22,206	2.6%
Asian / Pacific Islander	291,036	293,368	295,738	297,660	299,231	2.8%
Black / African American	334,977	338,671	341,630	344,981	347,789	3.8%
Hispanic or Latino	2,250,730	2,272,451	2,295,437	2,316,419	2,337,963	3.9%
Multiracial	106,257	107,703	108,987	110,865	112,667	6.0%
Native Hawaiian / Other Pacific Islander	12,561	12,577	12,746	12,801	12,756	1.6%
Other Race	7,737	7,737	7,737	7,737	7,737	0.0%
White	1,707,924	1,723,238	1,738,183	1,753,770	1,768,245	3.5%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	2,250,730	350,933	353,100	355,501	357,908	2.5%
Non-Hispanic or Non-Latino	2,482,125	277,552	278,966	280,112	281,212	1.7%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	60,424	61,134	61,844	62,399	62,899	4.1%
1–17 Years	1,105,211	1,101,949	1,099,304	1,097,307	1,097,482	-0.7%
18–34 Years	1,205,453	1,215,750	1,223,150	1,229,053	1,228,899	1.9%
35–64 Years	1,642,415	1,655,593	1,670,291	1,685,505	1,706,690	3.9%
65 Years or Greater	719,352	743,079	767,883	792,119	812,624	13.0%
Total Population Trend	**4,732,855**	**4,777,505**	**4,822,472**	**4,866,383**	**4,908,594**	**3.7%**

Riverside County Population Projections by Demographic Cohort

Gender	2023	2024	2025	2026	2027	% Change
Female	1,259,921	1,274,589	1,287,868	1,300,862	1,314,108	4.3%
Male	1,254,752	1,269,117	1,283,501	1,295,323	1,306,311	4.1%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	12,226	12,301	12,518	12,588	12,627	3.3%
Asian / Pacific Islander	151,820	153,662	155,336	156,764	158,106	4.1%
Black / African American	149,366	151,629	153,129	154,850	156,077	4.5%
Hispanic or Latino	1,139,918	1,152,607	1,165,830	1,174,882	1,185,636	4.0%
Multiracial	56,282	56,905	57,645	58,464	59,224	5.2%
Native Hawaiian / Other Pacific Islander	6,363	6,365	6,494	6,545	6,521	2.5%
Other Race	3,682	3,682	3,682	3,682	3,682	0.0%
White	995,016	1,006,555	1,016,735	1,028,410	1,038,546	4.4%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	1,139,918	1,152,607	1,165,830	1,174,882	1,185,636	4.0%
Non-Hispanic or Non-Latino	1,374,755	1,391,099	1,405,539	1,421,303	1,434,783	4.4%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	30,356	30,642	31,027	31,282	31,346	3.3%
1–17 Years	563,756	562,895	561,203	559,991	559,789	-0.7%
18–34 Years	630,188	638,382	644,228	648,823	650,879	3.3%
35–64 Years	872,610	880,225	888,795	896,641	908,014	4.1%
65 Years or Greater	417,763	431,562	446,116	459,448	470,391	12.6%
Total Population Trend	**2,514,673**	**2,543,706**	**2,571,369**	**2,596,185**	**2,620,419**	**4.2%**

San Bernardino County Population Projections by Demographic Cohort

Gender	2023	2024	2025	2026	2027	% Change
Female	1,113,564	1,120,700	1,128,869	1,139,261	1,148,885	4.3%
Male	1,104,618	1,113,099	1,122,234	1,130,937	1,139,290	4.1%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	9,407	9,459	9,496	9,562	9,579	1.8%
Asian / Pacific Islander	139,216	139,706	140,402	140,896	141,125	1.4%
Black / African American	185,611	187,042	188,501	190,131	191,712	3.3%
Hispanic or Latino	1,110,812	1,119,844	1,129,607	1,141,537	1,152,327	3.7%
Multiracial	49,975	50,798	51,342	52,401	53,443	6.9%
Native Hawaiian / Other Pacific Islander	6,198	6,212	6,252	6,256	6,235	0.6%
Other Race	4,055	4,055	4,055	4,055	4,055	0.0%
White	712,908	716,683	721,448	725,360	729,699	2.4%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	1,110,812	1,119,844	1,129,607	1,141,537	1,185,636	4.0%
Non-Hispanic or Non-Latino	1,107,370	1,113,955	1,121,496	1,128,661	1,434,783	4.4%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	30,068	30,492	30,817	31,117	31,553	4.9%
1–17 Years	541,455	539,054	538,101	537,316	537,693	-0.7%
18–34 Years	575,265	577,368	578,922	580,230	578,020	0.5%
35–64 Years	769,805	775,368	781,496	788,864	798,676	3.8%
65 Years or Greater	301,589	311,517	321,767	332,671	342,233	13.5%
Total Population Trend	**2,218,182**	**2,233,799**	**2,251,103**	**2,270,198**	**2,288,175**	**3.2%**

Montclair Hospital Medical Center PSA
Population Projections by Demographic Cohort

The Montclair service area is projected to grow by 2.1% by 2027. The primary growth will be in the Multiracial population, followed by Hispanic/Latinos and Black/African Americans. The ages 1–34 group shows a decline while the 65+ group shows an increase of 12.5%.

Gender	2023	2024	2025	2026	2027	% Change
Female	315,236	316,516	318,182	320,227	322,172	2.2%
Male	310,481	311,969	313,884	315,386	316,948	2.1%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	1,431	1,442	1,444	1,447	1,454	1.6%
Asian / Pacific Islander	68,812	68,842	68,908	68,883	68,770	-0.1%
Black / African American	40,278	40,468	40,722	40,975	41,234	2.4%
Hispanic or Latino	349,281	350,933	353,100	355,501	357,908	2.5%
Multiracial	11,601	11,716	11,803	11,992	12,202	5.2%
Native Hawaiian / Other Pacific Islander	1,261	1,263	1,274	1,276	1,273	1.0%
Other Race	1,249	1,249	1,249	1,249	1,249	0.0%
White	151,804	152,572	153,566	154,290	155,030	2.1%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	349,281	350,933	353,100	355,501	357,908	2.5%
Non-Hispanic or Non-Latino	276,436	277,552	278,966	280,112	281,212	1.7%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	7,738	7,821	7,882	7,936	8,046	4.0%
1–17 Years	145,436	144,411	143,577	142,830	142,217	-2.2%
18–34 Years	165,316	165,191	165,397	165,355	164,809	-0.3%
35–64 Years	222,399	223,536	224,864	226,386	228,632	2.8%
65 Years or Greater	84,828	87,526	90,346	93,106	95,416	12.5%
Total Population Trend	**625,717**	**628,485**	**632,066**	**635,613**	**639,120**	**2.1%**

Redlands Community Hospital PSA Population Projections by Demographic Cohort

The fastest-growing population group in race is Multiracial, followed by Black/African American and White populations. The number of people 65+ is expected to increase significantly, while the 1–17 group will decline.

Gender	2023	2024	2025	2026	2027	% Change
Female	169,435	170,907	172,436	174,156	175,724	3.7%
Male	159,409	160,991	162,393	163,823	165,165	3.6%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	2,420	2,441	2,463	2,483	2,500	3.3%
Asian / Pacific Islander	25,823	25,992	26,135	26,312	26,434	2.4%
Black / African American	19,218	19,459	19,636	19,828	20,000	4.1%
Hispanic or Latino	109,970	111,002	112,064	113,175	114,259	3.9%
Multiracial	8,542	8,687	8,774	8,977	9,141	7.0%
Native Hawaiian / Other Pacific Islander	774	775	786	784	785	1.4%
Other Race	498	498	498	498	498	0.0%
White	161,599	163,044	164,473	165,922	167,272	3.5%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	109,970	111,002	112,064	113,175	114,259	3.9%
Non-Hispanic or Non-Latino	218,874	220,896	222,765	224,804	226,630	3.5%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	3,747	3,782	3,826	3,861	3,914	4.5%
1–17 Years	66,395	66,084	65,881	65,771	65,656	-1.1%
18–34 Years	76,936	77,400	77,584	77,760	77,527	0.8%
35–64 Years	114,484	115,093	115,802	116,530	117,692	2.8%
65 Years or Greater	67,282	69,539	71,736	74,057	76,100	13.1%
Total Population Trend	**328,844**	**331,898**	**334,829**	**337,979**	**340,889**	**3.7%**

San Antonio Regional Hospital PSA Population Projections by Demographic Cohort

The greatest population growth in the region will be in the Multiracial ethnic group and seniors.

Gender	2023	2024	2025	2026	2027	% Change
Female	480,557	483,690	487,304	491,931	496,091	3.2%
Male	475,832	479,682	483,663	487,425	491,026	3.2%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	2,344	2,359	2,369	2,380	2,381	1.6%
Asian / Pacific Islander	84,289	84,698	85,255	85,650	85,886	1.9%
Black / African American	67,697	68,226	68,691	69,306	69,920	3.3%
Hispanic or Latino	526,275	530,779	535,550	541,315	546,385	3.8%
Multiracial	18,798	19,087	19,288	19,624	20,003	6.4%
Native Hawaiian / Other Pacific Islander	2,092	2,097	2,122	2,126	2,120	1.3%
Other Race	1,833	1,833	1,833	1,833	1,833	0.0%
White	253,061	254,293	255,859	257,122	258,589	2.2%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	526,275	530,779	535,550	541,315	546,385	3.8%
Non-Hispanic or Non-Latino	430,114	432,593	435,417	438,041	440,732	2.5%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	12,393	12,553	12,686	12,813	12,987	4.8%
1–17 Years	230,736	229,832	229,327	228,954	229,016	-0.7%
18–34 Years	258,604	259,874	260,879	261,671	260,916	0.9%
35–64 Years	342,455	345,332	348,484	352,262	357,167	4.3%
65 Years or Greater	112,201	115,781	119,591	123,656	127,031	13.2%
Total Population Trend	**956,389**	**963,372**	**970,967**	**979,356**	**987,117**	**3.2%**

San Gorgonio Memorial Hospital PSA Population Projections by Demographic Cohort

The fastest-growing population group in race in the San Gorgonio PSA is White, followed by Black/African American and Multiracial. The number of people 65+ is expected to increase significantly, while the 1–17 group will decline (although the number of births is expected to increase.

Gender	2023	2024	2025	2026	2027	% Change
Female	45,925	46,553	47,155	47,715	48,225	5.0%
Male	43,417	44,062	44,623	45,090	45,570	5.0%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	1,370	1,386	1,396	1,407	1,423	3.9%
Asian / Pacific Islander	5,482	5,559	5,625	5,671	5,729	4.5%
Black / African American	5,075	5,182	5,245	5,300	5,343	5.3%
Hispanic or Latino	33,732	34,127	34,562	34,877	35,204	4.4%
Multiracial	2,036	2,055	2,082	2,118	2,139	5.1%
Native Hawaiian / Other Pacific Islander	127	127	130	131	130	2.4%
Other Race	107	107	107	107	107	0.0%
White	41,413	42,072	42,631	43,194	43,720	5.6%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	33,732	34,127	34,562	34,877	35,204	4.4%
Non-Hispanic or Non-Latino	55,610	56,488	57,216	57,928	58,591	5.4%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	1,084	1,097	1,110	1,117	1,118	3.1%
1–17 Years	17,632	17,612	17,561	17,576	17,574	-0.3%
18–34 Years	20,196	20,438	20,629	20,781	20,858	3.3%
35–64 Years	28,504	28,757	29,023	29,193	29,494	3.5%
65 Years or Greater	21,926	22,711	23,455	24,138	24,751	12.9%
Total Population Trend	**89,342**	**90,615**	**91,778**	**92,805**	**93,795**	**5.0%**

Appendix B: Key Informants

The key informants interviewed for this CHNA are:

Dori Baeza, project manager, Community Vital Signs, San Bernardino County Department of Public Health

Kyoni Cummings, education coordinator, National Alliance on Mental Illness, Pomona Valley, San Bernardino County

Matt Holden, superintendent, Chaffey Joint Union High School District, San Bernardino County

Sarah Kahn, **MD**, director of medical affairs, San Antonio Regional Hospital, Upland, San Bernardino County

Geoffrey Leung, **MD**, public health officer, Riverside University Health System, Public Health

Scott McGrath, deputy director, systems and impact, First Five Riverside County

Kevin Meconis, **MPH**, epidemiologist, Riverside University Health System

Bill Ruh, mayor pro tem, City of Montclair, San Bernardino County

Karen Scott, executive director, First Five Riverside County

Dennis Trigueros, **MD**, medical director, emergency department, and San Antonio Regional Hospital, Upland, San Bernardino County

The interviews were conducted by HC² Strategies.

Appendix C: Emergency Department (ED) Avoidable Visits and Volumes by Social Determinants

For the Inland Empire as a whole, and for Riverside and San Bernardino counties and the four hospitals, avoidable ED rates were driven in large part by a combination of visits associated with the Medi-Cal, infant and adolescent populations. The charts below show avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services.

The left side of the charts shows the number of avoidable hospitalizations, and the right side shows the percentage of total ED visits that were considered avoidable. As noted earlier in this report, social determinant Z codes are severely under-reported.

Inland Empire

Category	Visits by Volume					Avoidable Visits				
	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Inland Empire Total	1,468,326	1,441,897	1,487,418	1,179,052	-308,366	53%	53%	53%	49%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	762,077	732,603	736,132	540,831	-195,301	56%	56%	57%	52%	-5
Health Maintenance Organization (HMO)	213,757	209,967	222,708	193,186	-29,522	51%	51%	51%	47%	-3
Health Maintenance Organization (HMO) Medicare Risk	158,794	165,679	182,988	156,627	-26,361	49%	49%	50%	46%	-3
Self-Pay	99,847	100,038	104,011	86,737	-17,274	50%	50%	51%	48%	-3
Medicare Part B	91,927	91,015	89,531	68,920	-20,611	50%	51%	52%	47%	-3

Age Groups	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	44,327	40,702	41,704	23,812	-17,892	65%	65%	64%	58%	-7
1–17 Years	306,320	290,443	302,614	171,829	-130,785	57%	57%	58%	51%	-5
18–34 Years	404,405	396,068	403,582	347,254	-56,328	51%	51%	51%	47%	-4
35–64 Years	507,341	504,234	514,545	450,562	-63,983	53%	53%	53%	49%	-3
65 Years or Greater	205,933	210,450	224,973	185,595	-39,378	49%	49%	50%	46%	-3

Social Determinants	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	3,588	2,275	1,219	1,563	344	39%	39%	42%	36%	-3
Other Psychosocial Circumstances	193	278	854	687	-167	32%	27%	29%	30%	-2
Primary Support Group and Family	331	471	507	661	154	31%	29%	35%	30%	-1
Employment	85	98	122	425	303	34%	26%	30%	44%	10
Upbringing	275	299	286	256	-30	40%	32%	34%	23%	-17
Social Environment	154	223	267	222	-45	26%	32%	29%	31%	5
Occupational Risk	223	194	150	127	-23	16%	14%	14%	15%	-1
Psychosocial Circumstances	9	9	33	40	7	56%	44%	33%	40%	-16
Education and Literacy	11	41	35	28	-7	73%	24%	14%	11%	-62

Race/Ethnicity	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	35,337	36,574	37,356	30,121	-7,235	53%	53%	53%	49%	-4
Black / African American	170,378	168,556	173,264	132,139	-41,125	56%	56%	55%	52%	-4
Hispanic or Latino	675,502	677,820	715,771	564,598	-151,173	55%	55%	56%	50%	-5
White	495,703	470,152	479,869	382,649	-97,220	49%	49%	50%	46%	-3

Riverside County

Category	Visits by Volume					Avoidable Visits				
	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Riverside County Total	722,692	707,863	731,694	566,008	-165,686	53%	53%	54%	48%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	369,094	354,445	360,025	258,450	-101,575	56%	56%	56%	51%	-5
Health Maintenance Organization (HMO)	99,761	95,453	102,074	86,728	-15,346	50%	50%	51%	47%	-3
Health Maintenance Organization (HMO) Medicare Risk	79,783	84,796	93,722	80,684	-13,038	50%	50%	51%	46%	-3
Self-Pay	51,632	51,932	52,501	41,950	-10,551	50%	50%	51%	47%	-2
Medicare Part B	51,415	50,393	49,472	37,594	-11,878	50%	50%	53%	47%	-3

Age Groups	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	20,304	18,727	19,633	10,687	-8,946	65%	65%	64%	57%	-8
1–17 Years	147,905	140,679	147,542	81,081	-66,461	56%	56%	57%	51%	-5
18–34 Years	192,052	187,464	190,596	159,992	-30,604	51%	51%	51%	47%	-4
35–64 Years	248,295	244,679	250,933	213,910	-37,023	53%	53%	54%	49%	-4
65 Years or Greater	114,136	116,314	122,990	100,338	-22,652	49%	49%	51%	46%	-3

Social Determinants	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	1,611	955	789	918	129	41%	41%	45%	40%	-2
Employment	38	32	41	305	264	29%	19%	32%	47%	18
Primary Support Group and Family	129	172	190	278	88	36%	30%	43%	34%	-1
Social Environment	80	97	103	105	2	25%	36%	37%	35%	10
Upbringing	88	125	115	94	-21	36%	33%	37%	19%	-17
Other Psychosocial Circumstances	107	70	57	94	37	36%	24%	30%	27%	-9
Occupational Risk	109	101	86	66	-20	17%	17%	13%	14%	-3
Education and Literacy	1	10	6	9	3	100%	20%	33%	11%	-89
Psychosocial Circumstances	1	1	1	5	4	100%	100%	0%	100%	0

Race/Ethnicity	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	% Change
Asian / Pacific Islander	16,231	16,788	18,073	13,910	-4,163	54%	54%	54%	49%	-5
Black / African American	73,337	72,729	73,012	55,053	-17,959	56%	55%	56%	52%	-4
Hispanic or Latino	322,456	323,957	344,199	262,771	-81,428	55%	55%	56%	50%	-6
White	274,728	260,039	259,377	204,788	-54,589	49%	49%	50%	46%	-4

San Bernardino County

Category	Visits by Volume					Avoidable Visits				
	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
San Bernardino County Total	676,939	664,846	683,844	550,739	-133,105	53%	53%	54%	49%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	361,307	347,197	344,961	257,199	-87,762	57%	57%	57%	53%	-4
Health Maintenance Organization (HMO)	102,691	102,832	107,626	94,372	-13,254	51%	52%	52%	48%	-4
Health Maintenance Organization (HMO) Medicare Risk	71,096	72,678	80,421	67,675	-12,746	49%	49%	49%	47%	-2
Self-Pay	42,910	42,582	45,792	39,899	-5,893	51%	51%	52%	48%	-3
Medicare Part B	37,178	37,259	36,678	28,674	-8,004	50%	51%	51%	48%	-3

Age Groups	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	21,468	19,537	19,496	11,314	-8,182	66%	65%	65%	60%	-6
1–17 Years	143,863	135,957	140,721	81,323	-59,398	58%	57%	59%	52%	-6
18–34 Years	192,838	188,739	192,914	168,410	-24,504	52%	52%	51%	48%	-4
35–64 Years	235,274	235,348	238,311	212,727	-25,584	53%	53%	53%	50%	-3
65 Years or Greater	83,496	85,265	92,402	76,965	-15,437	49%	49%	49%	46%	-3

Social Determinants	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Other Psychosocial Circumstances	78	203	771	577	-194	24%	27%	30%	30%	6
Housing and Economic	1,808	1,220	363	540	177	38%	38%	35%	31%	-7
Primary Support Group and Family	189	269	294	331	37	29%	28%	29%	27%	-1
Upbringing	171	158	150	137	-13	44%	31%	30%	26%	-18
Employment	43	59	76	112	36	37%	31%	30%	38%	1
Social Environment	60	112	151	98	-53	28%	28%	25%	26%	-3
Occupational Risk	79	66	45	34	-11	18%	17%	22%	24%	6
Psychosocial Circumstances	7	8	31	30	-1	43%	38%	35%	33%	-10
Education and Literacy	9	26	23	16	-7	67%	27%	9%	13%	-54

Race/Ethnicity	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	16,893	17,465	16,856	14,103	-2,753	53%	52%	52%	49%	-5
Black / African American	89,084	87,823	92,064	70,081	-21,983	56%	56%	56%	53%	-4
Hispanic or Latino	323,197	323,383	338,915	273,318	-65,597	55%	56%	56%	50%	-6
White	195,656	185,139	195,642	156,839	-38,803	49%	49%	49%	46%	-4

Appendix P provides hospital-level data on avoidable ED visits.

Appendix D: In-Depth Description of the IP3 | Assess Tool

IP3 | Assess is a web-based data platform that allows users to combine and compare data from different sources, surface community insights, align data across organizations and sectors and use information to guide community action. IP3 | Assess was originally designed by IP3 (Institute for People, Place, and Possibility) in partnership with Kaiser Permanente to support the community health needs assessment (CHNA) process. The platform is now being used to support broader assessment needs among statewide and local community coalitions throughout the nation.

The platform's three main features help users identify and prioritize community needs: data frameworks, z-score analyses, integration of qualitative data and stakeholder engagement through IP3 | Assess Reports.

Data Frameworks

IP3 | Assess automatically applies data frameworks to help analyze and present indicators that are organized in an actionable way. Data frameworks are a series of "domains" or categories; each domain is populated by multiple data indicators from a variety of sources that are updated as new information is released. Data frameworks can translate data into solutions by sorting indicators into categories that both are more easily connected to real-life programming and can inform planning efforts.

Long lists of indicators alone fail to shed light on levers that organizations can actually pull to improve their community. Instead, computing scores for both individual indicators and composite scores for each domain in a framework allows users to compare data not traditionally comparable.

For example, a community may have an above-average commute time, with a disproportionate effect on low-income residents, and the community's rate of unemployment may also be higher than average. But what does that mean for that community's implementation plan? IP3 | Assess can compare the relative score for transportation to the relative score for meaningful work and wealth, which can in turn help guide decision-making around the best area in which to invest.

Users can also drill down indicators in each domain (see Appendix D) to identify specific focus areas and prioritize efforts. They can toggle between different geographies to see how scores vary across service areas and explore any different driving factors for good and bad composite domain scores.

Z-Score Analysis

IP3 | Assess uses a z-score approach to score individual indicators and data across domains in frameworks. Z-scores show where the score lies on a normal distribution curve. "Fuel gauge" visualizations depict z-scores relative to the selected benchmark (such as the corresponding state or national value). In this way, users can see how a given community or geographic area performs relative to the state or nation. This allows an apples-to-apples comparison of data from a variety of sources and with a variety of units and collection methods. It also builds in prioritization for improvement efforts (similar to the County Health Rankings methodology).

The fuel gauge provides users with a clear view of how an area performs for specific indicators or domains compared to a benchmark. The gauge shows up bright red if an indicator or domain scores significantly worse than the benchmark, light red or light green if the data are not significantly different (within one standard deviation) from the benchmark and bright green if the data are significantly better than the benchmark.

The Fuel Gauge Key

- 0 +
Benchmark

Light Green
Performing **better** than the benchmark

- 0 +
Benchmark

Bright Green
Performing **significantly better** than the benchmark

- 0 +
Benchmark

Light Red
Performing **worse** than the benchmark

- 0 +
Benchmark

Bright Red
Performing **significantly worse** than the benchmark
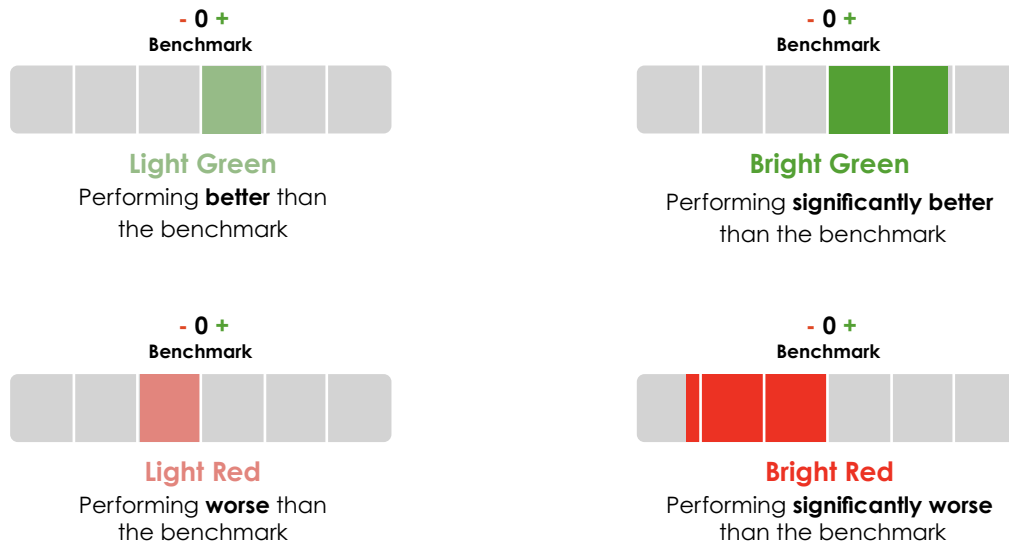
IP3 | Assess Reports

Quantitative data do not tell the whole story of what is happening in a community or service area.

Therefore, qualitative data can be collected through key informant interviews and/or community conversations, alongside stories from people with lived experience in a community. These data give a fuller picture of what life is really like in a given community and prompt decision-makers to consider more than just quantitative data when setting priorities.

IP3 | Assess reports include additional data information to provide a more complete picture of the community and the domains.

Appendix E: Stakeholder Committee Ranking of Priorities

During the April 19, 2022, strategy session, the 2022 Inland Empire CHNA Stakeholder Committee members ranked burden of disease areas and vital conditions, using five questions as ranking guides. The responses were used to identify priorities for the Inland Empire regional CHNA. Below are the top-voted responses under each question.

Burden of Disease

Q1. How acute is each need?

Cardiovascular disease and diabetes

Mental and behavioral health

Respiratory diseases

Maternal and infant health

Cancer

Q2. Are there energy, capacity and resources for improving the need?

Cardiovascular disease and diabetes

Mental and behavioral health

Respiratory disease

Maternal and infant health

Infectious disease

Q3. Does the issue disproportionally affect certain populations?
(Consider race, ethnicity, income, geography and education.)

Cardiovascular disease and diabetes

Mental and behavioral health

Maternal and infant health

Infectious disease

Q4. Are there investment opportunities for collaborative partners and/or practice — or evidence-based approaches to address these needs?

Mental and behavioral health

Cardiovascular disease and diabetes

Maternal and infant health

Infectious disease

Injury and violence

Q5. Has COVID-19 impacted the area of focus?

Mental and behavioral health

Cardiovascular disease and diabetes

Maternal and infant health

Oral health

Respiratory disease

Seven Vital Conditions

Q1. How acute is each need?

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Lifelong learning

Thriving natural world

Q2. Are there energy, capacity and resources for improving the need?

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Lifelong learning

Reliable transportation

Q3. Does the issue disproportionally affect certain populations?
(Consider race, ethnicity, income, geography and education)

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Lifelong learning

Reliable transportation

Q4. Are there investment opportunities for collaborative partners and/or practice — or evidence-based approaches to address these needs?

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Reliable transportation

Civic muscle and belonging

Q5. Has COVID-19 impacted the area of focus?

Basic needs for health and safety

Meaningful work and wealth

Humane housing

Civic muscle and belonging

Reliable transportation

Appendix F: Cardiovascular Disease and Diabetes Indicator Report

To access the full data report, which includes population breakouts where available, click to view Cardiovascular Disease & Diabetes. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Obesity - *percentage of adults 18+ with BMI of 30 or above*							
27.5	32.6	31.2	32.6	28.5	31.2	31.8	31.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High cholesterol - *percentage of adults 18+ reporting high cholesterol*							
30.2	36.2	36.2	30.1	29.6	31.8	34.2	36.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Current smoking - *percentage of adults 18+ who report smoking 100+ cigarettes in their lifetime, and currently smoke daily or some days*							
13.4	14.8	12.8	15.5	13.8	14.7	14.3	12.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Hypertension deaths - *Number of deaths due to hypertensive heart disease per 100,000 people*							
14.0	22.7	20.8	24.5	12.3	21.7	22.7	20.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart attack deaths - *number of deaths due to acute myocardial infarction per 100,000 people*							
25.8	25.8	27.0	24.8	25.9	26.5	25.9	27.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart failure deaths - *number of deaths due to heart failure per 100,000 people*							
19.4	21.8	22.8	20.8	21.4	22.3	21.4	22.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diagnosed stroke - *percentage of adults 18+ who have ever been diagnosed with a stroke*							
3.2	3.1	4.0	3.0	3.4	3.3	3.7	4.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure - *percentage of adults 18+ who have been told they have hypertension*							
28.7	29.9	36.3	28.0	29.1	30.8	33.8	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure management - *percentage of adults 18+ with diagnosed hypertension who report taking hypertension medication*							
67.1	67.4	72.6	66.6	66.9	69.4	70.8	72.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease among Medicare beneficiaries - *percentage of Medicare beneficiaries with ischemic heart disease*							
22.2	24.5	25.0	24.0	No data	24.8	25.4	25.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease - *percentage of adults 18+ who have been told they have angina or coronary heart disease*							
5.5	5.2	5.2	7.4	5.7	5.7	6.6	7.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease hospitalizations among Medicare beneficiaries - *number of hospitalizations for heart disease per 1,000 Medicare beneficiaries*							
55.7	61.5	56.9	67.1	66.6	63.5	62.0	56.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diagnosed diabetes - *percentage of adults 20+ who have been told they have diabetes (including gestational)*							
9.4	10.4	10.4	10.4	9.5	10.2	10.2	10.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diabetes management - *percentage of diagnosed Medicare beneficiaries having an annual A1c test*							
81.9	78.6	80.4	76.0	81.2	75.9	78.6	80.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diabetes death - *number of deaths due to type 2 diabetes per 100,000 people*							
17.7	22.8	15.7	29.8	21.1	19.2	22.8	15.7

Appendix G: Mental and Behavioral Health Indicator Report

To access the full data report, which includes population breakouts where available, click to view Mental & Behavioral Health. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in* red. *The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Poor mental health days - *age-adjusted number of reported mentally unhealthy days per month*							
4.2	4.5	4.5	4.5	4.3	4.4	4.5	4.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Frequent mental distress - *percentage of adults 18+ who report 14+ days of poor mental health per month*							
13.6	14.9	13.0	15.1	14.0	14.5	14.0	13.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Self-harm deaths - *age-adjusted number of self-harm deaths per 100,000 people*							
14.7	10.7	10.5	11.0	8.0	10.8	10.7	10.5

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Mental health care providers — *number of mental health care providers per 100,000 people*							
373.3	229.9	217.1	242.7	362.6	223.5	229.9	217.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Mental Health - *percentage of population that is underserved by mental health providers*							
23.9	30.4	30.4	30.4	22.1	21.7	33.4	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Drug use disorder deaths - *age-adjusted number of drug use disorder deaths per 100,000*							
8.8	10.1	10.9	9.1	5.8	9.7	10.0	10.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Depression among Medicare beneficiaries - *percentage of Medicare beneficiaries with diagnosed depression*							
14.7	15.0	15.0	15.0	No data	15.8	15.5	16.0

Appendix H: Infant and Maternal Health Indicator Report

To access the full report, which includes population breakouts where available, click to view Maternal & Infant Health. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in* red. *The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Infant death - *number of deaths in infants younger than one year per 1,000 live births*							
4.2	5.1	4.2	5.9	3.9	4.7	5.1	4.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Low birthweight - *percentage of births with low birthweight*							
6.9	7.1	6.8	7.4	7.2	7.0	7.1	6.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Tobacco use during pregnancy - *percentage of births for which tobacco use is a maternal risk factor*							
1.3	2.0	1.7	2.2	0.6	1.8	2.0	1.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Pre-term births - *percentage of births occurring before the 37th week of pregnancy*							
9.1	9.5	9.1	10.0	9.5	9.7	9.6	9.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Early prenatal care - *percentage of births for which prenatal care began in the first trimester*							
85.5	**84.5**	**84.7**	**84.2**	86.0	**84.4**	**84.5**	**84.7**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Teen births - *number of infants per 1,000 to females aged 15–19*							
26.2	23.5	20.7	**26.3**	19.2	22.1	23.5	20.7

Appendix I: Basic Needs for Health and Safety Indicator Report

To access the full report, which includes population breakouts where available, click to view Basic Needs for Health and Safety. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in* red. *The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Grocery stores - *number of grocery stores per 1,000 population*							
0.2	**0.1**	**0.1**	**0.1**	0.2	**0.1**	**0.1**	**0.1**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Low food access - *percentage of the population living beyond one mile (urban) or 10 miles (rural) from a supermarket*							
29.4	**36.3**	**34.7**	**38.5**	25.6	**35.4**	25.8	**34.3**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Food insecurity - *percentage of the population that is food insecure*							
10.0	9.3	9.0	9.6	**10.7**	9.2	9.3	9.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Mental Health - *percentage of the population that is underserved by mental health providers*							
23.9	**33.5**	**36.3**	**30.4**	22.1	21.7	**33.4**	**36.3**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Primary Care – *percentage of the population that is underserved by primary care providers*							
26.4	**38.2**	**39.6**	**38.1**	**36.0**	11.1	**39.1**	**39.6**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Dental – *percentage of the population that is underserved by dental health providers*							
76.0	**79.3**	**80.1**	**79.1**	**86.9**	**100.0**	**78.0**	**80.1**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Insured adults - *percentage of uninsured adults 18–65*							
88.0	**85.7**	**85.6**	**86.2**	**84.9**	88.7	**86.2**	**85.6**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Recent primary care visit - *percentage of adults 18+ who have had a routine checkup in the past year*							
70.7	69.1	74.2	68.4	71.7	70.3	71.8	74.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure management - *percentage of adults 65+ who have high blood pressure and are taking medicine for it*							
67.1	67.4	72.8	66.6	66.9	69.4	70.8	72.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Exercise opportunities - *percentage of population with access to areas for physical activity*							
86.1	86.6	88.9	84.4	97.7	87.8	86.6	88.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Breast cancer screening - *percentage of females 50–74 who have had a mammogram within the past two years*							
77.9	76.4	76.4	76.5	78.5	76.3	76.5	76.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Premature death - *Age-adjusted number of years of potential life lost (YPLL) (under age 75) per 100,000 population*							
5,292.9	6,344.0	5,842.4	6,845.6	5,005.0	6,093.2	6,344.0	5,842.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Population with any disability – *percentage of the population with a disability*							
10.6	12.2	11.6	11.8	10.0	13.5	11.3	11.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Life expectancy at birth – *estimated life expectancy at birth*							
81.7	79.9	80.9	78.8	82.4	80.4	79.9	80.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Violent crimes – *number of reported violent crimes per 100,000 people*							
418	358.8	291.0	442.0	488.0	389.3	366.5	291.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Binge drinking - *percentage of adults 18+ who report an occasion of binge drinking in the past month*							
17.8	17.3	15.0	17.2	17.4	16.9	15.9	15.0

Appendix J: Humane Housing Indicator Report

To access the full report, which includes population breakouts where available, click to view Humane Housing. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in* red. *The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High housing costs - *percentage of occupied housing units for which housing costs are greater than 30% of household income*							
42.1	40.6	39.7	40.7	**47.4**	36.3	39.2	39.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Multi-family housing - *percentage of housing structures with two or more units per structure*							
23.5	**18.2**	**11.9**	**19.8**	29.5	**18.9**	**19.8**	**11.9**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Incomplete plumbing or kitchen facilities - *percentage of occupied housing units that lack plumbing or kitchen facilities*							
1.3	1.0	0.9	1.1	1.2	**1.4**	1.0	0.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Overcrowded housing - *percentage of housing units with more than one occupant per room*							
12.0	8.4	10.7	9.4	**16.6**	5.4	9.3	10.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Residential segregation (Black/White) — *Index of dissimilarity – between 0 (complete integration) and 100 (complete segregation) representing residential segregation between Black and White residents*							
49.1	38.0	39.4	36.7	56.3	38.7	38.0	39.4

Appendix K: Meaningful Work and Wealth Indicator Report

To access the full report, which includes population breakouts where available, click to view Meaningful Work and Wealth. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Absolute upward mobility - *expected income by percentile rank for children whose parents are at the 25th percentile of the national income distribution*							
46.2	45.2	45.4	44.9	44.4	45.0	45.1	45.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Public assistance - *percentage of families with cash public assistance or Supplemental Nutrition Assistance Program (SNAP) benefits in the past 12 months*							
13.3	15.4	14.6	18.6	14.0	13.6	17.6	14.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Income inequality — Gini coefficient - *statical dispersion of income distribution; the higher the Gini coefficient, the greater the gap between the incomes of an area's richest and poorest people.*							
0.4	0.0	0.0	0.0	0.4	0.4	0.4	0.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High-paying jobs - *percentage of jobs within five miles with earnings greater than $3,333 per month (2015 numbers are most recent available)*							
50.4	37.3	39.8	38.9	47.5	35.9	40.5	39.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Unemployment - *annual percentage of the labor force that is unemployed*							
10.0	9.7	9.9	9.4	12.3	9.8	9.7	9.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Median household income - *median household income for the population*							
$83,398	$67,326	$69,261	$64,943	$74,027	$67,337	$79,461	$71,277

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Homeownership - *percentage of occupied housing units with owner occupants*							
54.8	62.9	66.3	59.6	45.8	63.5	63.1	66.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Poverty - percentage of adults over 18 whose incomes are below the federal poverty level							
13.4	15.5	14.5	16.7	13.4	15.3	11.7	13.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Child poverty - percentage of children under 18 who live below the federal poverty level							
16.9	18.3	18.3	18.3	18.3	15.1	13.8	17.0

Appendix L: IP3 | Assess Burden of Disease Categories and Indicators with Source List

Indicators in the Burden of Disease Framework

Learn more at www.i-p3.org. *Updated February 2021.*

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
Brain health	Alzheimer's Disease	Number of deaths due to Alzheimer's disease per 100,000 population	CDC WONDER	County	2020
	Parkinson's Disease	Number of deaths due to Parkinson's disease per 100,000 population	CDC WONDER	County	2020
	Hemorrhagic Stroke Deaths	Age-adjusted number of deaths due to hemorrhagic strokes per 100,000 population	Institute for Health Metrics and Evaluation	County	2020
	Ischemic Stroke Deaths	Age-adjusted number of deaths due to hemorrhagic strokes per 100,000 population	Institute for Health Metrics and Evaluation	County	2020
Brain health; Cardiovascular diseases	Stroke Deaths	Number of deaths due to strokes (includes transient cerebral ischaemic attacks and related syndromes, central retinal artery occlusion, subarachnoid haemorrhage, intracerebral haemorrhage, other nontraumatic intracranial haemorrhage, cerebral infarction and stroke not specified as haemorrhage or infarction) per 100,000 population	CDC WONDER	County	2020
Cancers	Diagnosed Cancer	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have cancer (excludes skin cancer)	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Cancer Deaths	Number of deaths due to cancer (all sites) per 100,000 population	CDC WONDER	County	2020
	Breast Cancer Deaths	Number of deaths due to breast cancer per 100,000 females	CDC WONDER	County	2020
	Cervical Cancer Deaths	Number of deaths due to cervical cancer per 100,000 females	CDC WONDER	County	2020
	Colorectal Cancer Deaths	Number of deaths due to cancers of the colon, rectosigmoid junction and rectum per 100,000 population	CDC WONDER	County	2020
	Lung Cancer Deaths	Number of deaths due to cancers of the bronchus and lung per 100,000 population	CDC WONDER	County	2020
	Prostate Cancer Deaths	Number of deaths due to prostate cancer per 100,000 males	CDC WONDER	County	2020
	Breast Cancer Incidence	5-year age-adjusted average number of new breast cancer cases (all stages) among women per 100,000 population	NIH State Cancer Profiles	County	2018
	Cancer Incidence	5-year age-adjusted average number of new cancer cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
	Cervical Cancer Incidence	5-year age-adjusted average number of new cervical cancer cases (all stages) among women per 100,000 population	NIH State Cancer Profiles	County	2018
	Colon and Rectum Cancer Incidence	5-year age-adjusted average number of new colon and rectum cancer cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
	Lung Cancer Incidence	5-year age-adjusted average number of new lung cancer cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
	Prostate Cancer Incidence	5-year age-adjusted average number of new prostate cancer cases (all stages) among men per 100,000 population	NIH State Cancer Profiles	County	2018

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
Cancers; Cardiovascular diseases; Diabetes	Obesity	Percentage of adults aged 18 years and older with obesity (BMI of 30 or above)	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
Cancers; Cardiovascular diseases; Respiratory diseases	Current Smoking	Percentage of adults aged 18 years and older who report having smoked 100 or more cigarettes in their lifetime, and currently smoke every day or some days	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
Cardiovascular diseases	High Blood Pressure Management	Percentage of adults aged 18 years and older with high blood pressure who report taking medicine for high blood pressure	Places	Tract	2013, 2015, 2017, 2019
	Heart Disease	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have angina or coronary heart disease	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Diagnosed Stroke	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they had a stroke	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
	High Blood Pressure	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have high blood pressure (excludes high blood pressure occurring only during pregnancy and borderline hypertension)	Places	Tract	2013, 2015, 2017, 2019
	High Cholesterol	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have high cholesterol	Places	Tract	2013, 2015, 2017, 2019
	Heart Disease Deaths	Number of deaths due to ischaemic heart diseases (e.g., angina pectoris, acute and subsequent myocardial infarction, certain current complications following acute myocardial infarction and other acute and ischaemic heart diseases) per 100,000 population	CDC WONDER	County	2020
	Heart Attack Deaths	Number of deaths due to acute myocardial infarction per 100,000 population	CDC WONDER	County	2020
	Heart Failure Deaths	Number of deaths due to heart failure per 100,000 population	CDC WONDER	County	2020
	Hypertension Deaths	Number of deaths due to hypertensive heart disease per 100,000 population	CDC WONDER	County	2020
	Heart Disease	Percentage of Medicare beneficiaries with ischemic heart disease	Mapping Medicare Disparities Tool	County	2018, 2019, 2008
	Heart Attack Hospitalization	Number of hospitalizations among adults aged 35 years and older for acute myocardial infarction (heart attack) per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	Heart Disease Hospitalizations	Number of hospitalizations for coronary heart disease per 1,000 Medicare beneficiaries aged 65 years and older	Interactive Atlas of Heart Disease and Stroke	County	2016
Diabetes	Diabetes Deaths	Number of deaths due to type 2 diabetes per 100,000 population	CDC WONDER	County	2020
	Diabetes Management	Percentage of diabetic Medicare enrollees aged 65–75 years having an annual hemoglobin A1c test	Dartmouth Atlas of Health Care	County	2015
	Diagnosed Diabetes	Percentage of adults aged 20 years and older who report ever being told by a health-care provider that they have diabetes (excludes gestational diabetes)	US Diabetes Surveillance System	County	2016, 2017, 2018, 2019
	Newly Diagnosed Diabetes	Age-adjusted number of new diabetes diagnoses among adults aged 20 years and older per 1,000 population	US Diabetes Surveillance System	County	2016, 2017, 2018

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
HIV/AIDS and STIs	HIV/AIDS Deaths	Number of deaths due to human immunodeficiency virus (HIV) disease per 100,000 population	CDC WONDER	County	2020
	Active Syphilis	Number of new active syphilis cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Chlamydia	Number of new chlamydia cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Congenital Syphilis	Number of new congenital syphilis cases per 100,000 population	CDC AtlasPlus	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017
	Gonorrhea	Number of new gonorrhea cases per 100,000 population	CDC AtlasPlus	County	2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	HIV Diagnoses	Number of HIV diagnoses per 100,000 population	CDC AtlasPlus	County	2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	HIV Prevalence	Number of HIV cases per 100,000 population	CDC AtlasPlus	County	2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Latent Syphilis	Number of new latent syphilis cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	HIV/AIDS Deaths	Age-adjusted number of HIV/AIDS deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
IEHP: Cardiovascular diseases	Hypertension Admissions	Admissions with a principal diagnosis of hypertension per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Heart Failure Admissions	Admissions with a principal diagnosis of heart failure per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
IEHP: Diabetes	Short-Term Diabetes Complications	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity or coma) per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Long-Term Diabetes Complications	Admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory or complications not otherwise specified) per 100,000 population	SpeedTrack	County	2018, 2019, 2020
	Uncontrolled Diabetes Admissions	Admissions with a principal diagnosis of diabetes without mention of short-term or long-term complications per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Lower-Extremity Amputation	Lower-extremity amputations (excludes toe amputations) with diabetes diagnosis per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Chronic Admissions	Admissions with one or more of the following chronic conditions per 100,000 adults aged 18 years and older: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension or heart failure without a cardiac procedure	SpeedTrack	County	2018, 2019, 2020
IEHP: Infectious diseases	Community-Acquired Pneumonia Admissions	Admissions with a principal diagnosis of community-acquired bacterial pneumonia per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
IEHP: Respiratory diseases	COPD or Asthma Admissions	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 adults aged 40 years and older	SpeedTrack	County	2018, 2019, 2020
	Asthma Admissions	Admissions with a principal diagnosis of asthma per 100,000 aged 18 to 39 years	SpeedTrack	County	2018, 2019, 2020
IEHP: TRUE	Urinary Tract Infection Admissions	Admissions with a principal diagnosis of urinary tract infection per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Acute Admissions	Admissions with one or more of the following acute conditions per 100,000 adults aged 18 years and older: bacterial pneumonia or urinary tract infection	SpeedTrack	County	2018, 2019, 2020
	Diabetes Admissions	Admissions with one or more of the following diabetic conditions per 100,000 adults aged 18 years and older: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation	SpeedTrack	County	2018, 2019, 2020
	Overall Admissions	Admissions with one or more of the following conditions per 100,000 adults aged 18 years and older: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia or urinary tract infection	SpeedTrack	County	2018, 2019, 2020
Infectious diseases	Pneumonia and Influenza Deaths	Number of deaths due to pneumonia and influenza per 100,000 population	CDC WONDER	County	2020
	Tuberculosis	Number of new tuberculosis cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Flu Vaccination	Percentage of Medicare enrollees who had an annual flu vaccination	County Health Rankings	County	2016, 2017

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
	Pneumonia Vaccination	Percentage of Medicare beneficiaries who had pneumonia vaccination	Mapping Medicare Disparities Tool	County	2018, 2019, 2010
	Tuberculosis Deaths	Age-adjusted number of tuberculosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Meningitis Deaths	Age-adjusted number of meningitis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Hepatitis Deaths	Age-adjusted number of hepatitis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Diarrheal Disease Deaths	Age-adjusted number of diarrheal disease deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Injury and violence	Opioid Overdose Deaths	Number of deaths for which opioids, including opium, heroin, methadone and other opioids and synthetic narcotics, were a contributing cause	CDC WONDER	County	2019
	Intentional Self-Harm Deaths	Number of deaths due to intentional self-harm, including intentional poisonings due to drugs and alcohol, per 100,000 population	CDC WONDER	County	2020
	Violent Crimes	Number of reported violent crime offenses per 100,000 population	County Health Rankings	County	2014, 2016
	Motor Vehicle Crash Deaths	Number of deaths due to traffic collisions involving a motor vehicle per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Alcohol-Impaired Driving Deaths	Percentage of driving deaths with alcohol involvement	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Injury Deaths	Number of deaths due to injury per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Drug Overdose Deaths	Number of deaths due to drug poisoning per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Gun Deaths	Number of deaths due to firearms per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Interpersonal Violence Deaths	Number of deaths due to homicide per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Interpersonal Violence Deaths	Age-adjusted number of interpersonal violence deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Kidney diseases	Chronic Kidney Disease	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have kidney disease	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Renal Failure Deaths	Number of deaths due to renal failure per 100,000 population	CDC WONDER	county	2020
Maternal and infant health	Pre-Term Births	Percent of births occurring before the 37th week of pregnancy	CDC WONDER	county	2019
	Early Prenatal Care	Percent of births for which prenatal care began in the first trimester	CDC WONDER	county	2019
	Tobacco Use During Pregnancy	Percent of births for which tobacco use is a maternal risk factor	CDC WONDER	county	2019

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
	Low Birthweight	Percentage of live births with low birthweight (less than 2,500 grams)	County Health Rankings	County	2016, 2017, 2018, 2019
	Teen Births	Number of births per 1,000 females aged 15–19 years	County Health Rankings	County	2014, 2016, 2017, 2018
	Infant Deaths	Number of deaths among infants (less than one year of age) per 1,000 live births	County Health Rankings	County	2013, 2016, 2017, 2018, 2019
Mental + behavioral health	Frequent Mental Distress	Percentage of adults aged 18 years and older who report 14 or more days of poor mental health per month	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Mental Health Care Providers	Number of mental health care providers per 100,000 population	County Health Rankings	County	2016, 2017, 2018, 2019, 2020
	Poor Mental Health Days	Age-adjusted average number of reported mentally unhealthy days per month	County Health Rankings	County	2015, 2016, 2017, 2018
	Health Professional Shortage Area	Federally designated area that indicates health provider shortages in mental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019
	Depression — Medicare	Percentage of Medicare beneficiaries with diagnosed depression	Mapping Medicare Disparities Tool	County	2015, 2016, 2017, 2018
	Alcohol Use Disorder Deaths	Age-adjusted number of alcohol use disorder deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Drug Use Disorder Deaths	Age-adjusted number of drug use disorder deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Self-Harm Deaths	Age-adjusted number of self-harm deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Oral health	Recent Dental Visit	Percentage of adults aged 18 years and older who report having been to the dentist or dental clinic in the past year	PLACES	Tract	2014, 2016, 2018
	Teeth Loss	Percentage of adults aged 65 years and older who report having lost all of their natural teeth because of tooth decay or gum disease	PLACES	Tract	2014, 2016, 2018
	Oral Cancer Deaths	Number of deaths due to cancers of the lip, oral cavity and pharynx per 100,000 population	CDC WONDER	County	2020
	Health Professional Shortage Area	Federally designated area that indicates health provider shortages in dental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019
	Oral Cavity and Pharynx Cancer	5-year age-adjusted average number of new oral cavity and pharynx cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
Respiratory diseases	Current Asthma	Percentage of adults aged 18 years and older who report having asthma	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Chronic obstructive pulmonary disease (COPD)	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Particulate Matter (PM) 2.5 Level	Average annual ambient concentrations of PM 2.5 in micrograms per cubic meter	National Environmental Public Health Tracking Network	County	2018

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
	Asthma ER Visits	Number of emergency department visits for asthma per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	Asthma Hospitalizations	Number of hospitalizations for asthma per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	COPD ER Visits	Number of emergency department visits among adults aged 25 years and older for chronic obstructive pulmonary disease (COPD) per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	COPD Hospitalizations	Number of hospitalizations among adults aged 25 years and older for chronic obstructive pulmonary disease (COPD) per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	Chronic Respiratory Disease Death	Age-adjusted number of chronic respiratory disease deaths per 100,000 population	National Environmental Public Health Tracking Network	County	2014
	COPD Deaths	Age-adjusted number of chronic obstructive pulmonary deaths per 100,000 population	National Environmental Public Health Tracking Network	County	2014
	Asbestosis Deaths	Age-adjusted number of asbestosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Asthma Deaths	Age-adjusted number of asthma deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Coal Workers Pneumoconiosis Deaths	Age-adjusted number of coal workers pneumoconiosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Interstitial Lung Disease Death	Age-adjusted number of interstitial lung disease deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Other Chronic Respiratory Disease	Age-adjusted number of other chronic respiratory disease deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Other Pneumoconiosis Deaths	Age-adjusted number of other pneumoconiosis deaths	Institute for Health Metrics and Evaluation	County	2014
	Pneumoconiosis Deaths	Age-adjusted number of pneumoconiosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Silicosis Deaths	Age-adjusted number of silicosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Respiratory diseases; Infectious diseases	Lower Respiratory Infection Deaths	Age-adjusted number of lower respiratory infection deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014

Appendix M: IP3 | Assess Vital Conditions of Well-Being and Indicators with Source List

Indicators in the Vital Conditions Framework

Learn more at www.i-p3.org. Updated February 2021.

Vital Condition	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
Basic Needs for Health and Safety	Exercise Opportunities	Percentage of population with access to locations for physical activity	County Health Rankings	County	2016, 2018, 2019	No
	Food Environment Index	Food Environment Index number — between 0 (worst) and 10 (best) — representing factors that contribute to a healthy food environment	County Health Rankings	County	2016, 2017	No
	Food Insecurity	Percentage of population who are food insecure	Map the Meal Gap	County	2017	No
	Grocery Stores	Number of grocery stores per 1,000 population	County Business Patterns	County	2017	No
	Health Professional Shortage Area — Dental	Federally designated area that indicates health provider shortages in dental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019	No
	Health Professional Shortage Area — Mental	Federally designated area that indicates health provider shortages in mental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019	No
	Health Professional Shortage Area — Primary	Federally designated area that indicates health provider shortages in primary care; indicator displays the percent of population that is underserved	HRSA	Tract	2019	No
	High Blood Pressure Management	Percentage of adults aged 18 years and older with high blood pressure who report taking medicine for high blood pressure	PLACES	Tract	2013, 2015, 2017	No
	Insured Adults	Percentage of the civilian noninstitutionalized population aged 19 to 64 years who are insured	American Community Survey	Tract	2018, 2019	No
	Life Expectancy at Birth	Estimated life expectancy at birth	Institute for Health Metrics and Evaluation	County	2014	No
	Low Food Access	Percentage of population with low food access, defined as living beyond 1 mile (urban) or 10 miles (rural) of supermarket	USDA Food Access Research Atlas	Tract	2015	No
	Property Crimes		FBI Uniform Crime Reports			No
	Recent Primary Care Visit	Percentage of adults aged 18 years and older who report having been to a doctor for a routine checkup in the past year	PLACES	Tract	2014, 2015, 2016, 2017, 2018	No
	Violent Crimes	Number of reported violent crime offenses per 100,000 population	County Health Rankings	County	2014, 2016	No
	Breast Cancer Screening	Percentage of women aged 50–74 years who report having had a mammogram within the previous 2 years	PLACES	Tract	2014, 2016, 2018	No
	Population with any Disability	Percentage of the civilian noninstitutionalized population with a disability	American Community Survey	Tract	2018, 2019	No
	Premature Death	Age-adjusted number years of potential life lost (YPLL) (under age 75) per 100,000 population	County Health Rankings	County	2014, 2016, 2017, 2018	No

Vital Condition	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
	Binge Drinking	Percentage of adults aged 18 years and older who report binge drinking (five or more drinks for men, or four or more drinks for women) on a single occasion at least once in the past month	PLACES	Tract	2014, 2015, 2016, 2017, 2018	No
Belonging and Civic Muscle	Cultural, Arts and Entertainment Institutions	Number of cultural, arts and entertainment institutions per 10,000 population	County Business Patterns	County	2018	No
	Libraries	Number of libraries per 10,000 population	Institute of Museum and Library Services	Tract	2018	No
	Population Change	Percentage change in population over a 5-year period	American Community Survey	Tract	2018, 2019	No
	Inadequate Social and Emotional Support	Percentage of adults 18 years and over who report not receiving adequate social-emotional support	County Health Rankings	County	2010	No
	Social Associations	Number of membership associations per 10,000 population	County Business Patterns	County	2017	No
	Voting Participation	Percentage of total voting age population who cast votes in the most recent presidential election	New York Times	County	2020	No
	Youth Not In School, Not Working	Percentage of the population aged 16–19 years who are not enrolled in school and not working	American Community Survey	Tract	2018, 2019	No
	Limited English Proficiency	Percentage of the population aged 5 years and older who speak English less than "very well"	American Community Survey	Tract	2018, 2019	No
	Social Capital Index	Standardized index combining measures of voter turnout rates, the fraction of people who return their census forms and measures of participation in community organizations	Opportunity Insights	County	2016	No
	Computer and Internet Access	Percentage of the population in households with a computer and a broadband internet subscription	American Community Survey	Tract	2019	Yes
	Incarcerated Population	Proportion of the population residing in federal detention centers, federal prisons, state prisons, local jails, residential correctional facilities, military jails or juvenile correctional facilities on the day of the 2010 Census (April 1, 2010)	Opportunity Insights			No
	Census Engagement	Percent of 2010 Census mail forms that were completed and returned	Opportunity Insights	Tract	2010	No
Humane Housing	Accessible Housing	Zero-step entrances	American Housing Survey			No
	High Housing Costs	Percentage of occupied housing units for which housing costs amount to 30% or more of household income	American Community Survey	Tract	2018, 2019	No
	Incomplete Plumbing or Kitchen Facilities	Percentage of occupied housing units that lack complete plumbing or kitchen facilities	CHAS Consolidated Planning/CHAS Data	Tract	2016	No
	Multi-family Housing	Percentage of housing structures with two or more housing units per structure	American Community Survey	County	2018, 2019	No
	Residential Mobility	Percentage of renter-occupied housing units for which the householder moved in within the past year	American Community Survey	Tract	2018, 2019	No

Vital Condition	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
	Overcrowded Households	Percentage of occupied housing units with more than one occupant per room	American Community Survey	Tract	2018, 2019	No
	Residential Segregation — Black/White	Index of dissimilarity — between 0 (complete integration) and 100 (complete segregation) — representing residential segregation between Black and White county residents	County Health Rankings	County	2015, 2016, 2017, 2018	No
	Subsidized Housing		Public and Affordable Housing Research Corporation; National Low Income Housing Coalition's 2015 National Housing Preservation Database; HUD Public Housing Buildings Database		2018	No
	Vacant Housing	Percentage of residential addresses that are vacant	HUD, U.S. Postal Service	Tract	2020	No
Lifelong Learning	Access to Child Care Facilities		County Business Patterns	County		No
	Adult Literacy	Percentage of adults who are illiterate	US Skills Map	County		No
	Adults with at Least Some College	Percentage of the population aged 25 years and older with at least some college	American Community Survey	Tract	2018, 2019	No
	On-Time High School Graduation	Percentage of students who graduate high school within 4 years of entering 9th grade	County Health Rankings	County	2020	No
	Per-Pupil Spending	Amount spent per student in public K–12 schools	Opportunity Insights	County	2016	No
	Preschool Enrollment	Percentage of the population aged 3–4 years who are enrolled in school	American Community Survey	Tract	2018, 2019	No
	Reading Proficiency	Average Reading Language Arts test scores for students in grades 3–8 relative to the national average	Stanford Education Data Archive	County	2016	Yes
	Adults with a High School Diploma	Percentage of the population aged 25 years and older who are high school graduates or higher	American Community Survey	Tract	2019	No
	Math Proficiency	Average math test scores for students in grades 3–8 relative to the national average	Stanford Education Data Archive	County	2018	No
Meaningful Work and Wealth	Absolute Upward Mobility	Expected income by percentile rank for children whose parents are at the 25th percentile of the national income distribution	Opportunity Insights	County	2016	No
	Banking Institutions	Number of banking institutions per 10,000 population	County Business Patterns	County	2017	No
	Child Poverty — Below 100% FPL	Percentage of the population under 18 years of age for whom poverty is determined who are below the federal poverty level (FPL)	American Community Survey	Tract	2018, 2019	No

Vital Condition	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
	Homeownership	Percentage of occupied housing units with owner-occupants	American Community Survey	Tract	2018, 2019	Yes
	Income Inequality — Gini Coefficient	Gini Index of income inequality, a measure of statistical dispersion representing income distribution	American Community Survey	Tract	2018, 2019	No
	Median Household Income	Median household income (in U.S. dollars) for the population	American Community Survey	Tract	2018, 2019	Yes
	Poverty — Below 100% FPL	Percentage of the population for whom poverty is determined who are below the federal poverty level (FPL)	HUD, U.S. Postal Service	Tract	2018, 2019	Yes
	Proximity to Jobs		Opportunity Insights	Tract	2018	No
	Public Assistance	Percentage of families with cash public assistance income or households that received food stamps/ Supplemental Nutrition Assistance Program (SNAP) benefits in the past 12 months	American Community Survey	Tract	2018, 2019	No
	Unemployment	Average annual percentage of the labor force that is unemployed	Bureau of Labor Statistics	Tract	2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019	No
	High-Paying Jobs	Percent of jobs within 5 miles with earnings greater than $3,333 (2015 dollars)	Opportunity Insights	Tract	2015	No
	Income Segregation	Rank-order income segregation index	Opportunity Insights	County	2018	No
	Segregation of Affluence	Rank-order segregation index of highest quartile incomes	Opportunity Insights	County	2016	No
	Segregation of Poverty	Rank-order segregation index of lowest quartile incomes	Opportunity Insights	County	2016	Yes
	Wage Growth	Difference in logarithms between high school graduate wages over a five-year period	Opportunity Insights	Tract	2018	No
	Annualized Job Growth	Average annual percent job growth over a 10-year period	Opportunity Insights	Tract	2013	No
Meaningful Work and Wealth	Active Transportation	Percentage of workers aged 16 years and older who commute to work via public transportation, bicycle or walking	American Community Survey	Tract	2018, 2019	No
	ADA-accessible stations and vehicles		National Transit Database			No
	Commute Time	Mean travel time to work (in minutes) for workers aged 16 years and older who do not work from home	American Community Survey	Tract	2018, 2019	No
	Driving Alone to Work	Percentage of workers aged 16 years and older who drive alone to work	American Community Survey	Tract	2018, 2019	No
	Household Transportation Costs		HUD Location Affordability Index	Tract		No
	Motor Vehicle Crash Deaths	Number of deaths due to traffic collisions involving a motor vehicle per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018	Yes
	National Walkability Index	Walkability Score	EPA Smart Location Database	Tract		No

Vital Condition	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
Thriving Natural World	Climate-Related Mortality Impacts	Number of deaths due to climate impacts per 100,000 population	Climate Impact Lab	County	2017	No
	Drinking Water Violations	Presence or absence of water systems violations	County Health Rankings	County	2016, 2017	No
	Flood Vulnerability	Percentage of housing units that are within FEMA-designated flood hazard areas	National Environmental Public Health Tracking Network	County	2011	No
	Developed Land	Percentage of land cover that is developed imperviousness	National Environmental Public Health Tracking Network	Tract	2011, 2016	No
	Extreme Heat	Percentage of days per year for which the daily maximum temperature is at or above the 90th percentile	National Environmental Public Health Tracking Network	Tract	2010, 2011, 2012, 2013, 2014, 2015, 2016	No
	Proximity to Highways	Percentage of the population living within 150 meters, or less than one-tenth mile, of a highway	National Environmental Public Health Tracking Network	County	2010	No
	Ozone Above Regulatory Standard	Number of person-days per year for which ozone levels were above the regulatory standard	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014	No
	Particulate Matter 2.5 Level	Average annual ambient concentrations of PM 2.5 in micrograms per cubic meter	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014	No
	Particulate Matter 2.5 Level		City Health Dashboard	Tract		No
	Respiratory Hazards	Respiratory Hazard Index number summarizing total noncancer respiratory hazard risk	EPA National Air Toxics Assessment	Tract	2014	No
	Tree Canopy Cover		National Environmental Public Health Tracking Network	Tract	2001, 2006, 2011, 2016	Yes
	Particulate Matter 2.5 Above Regulatory Standard	Percentage of days per year for which PM 2.5 levels were above the regulatory standard	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014	No

Appendix N: 2022 Inland Empire Priorities as Compared to 2019 Priorities

Hospital community health needs assessments (CHNAs) are conducted every three years in the Inland Empire. Many of the 2019 priorities outlined below are the same as those identified in the 2022 assessment.

Following the 2019 assessment, the CHNA stakeholder group was working to build collaborative interventions when their work was dramatically interrupted and superseded by the COVID-19 pandemic that hit in March 2020. The pandemic generated multiple crises; in fact, most of the identified community priorities were likely magnified by the pandemic.

With the easing of the pandemic, the 2022 CHNA stakeholders will move forward with collaborative efforts to address the ongoing community conditions as well as those spawned or worsened by COVID-19.

2019 Hospital CHNA Disease Priorities

- Mental and behavioral health
- Alcohol/Substance use
- Chronic disease
- Asthma
- Diabetes — higher in the Latino population

- Heart disease and stroke
- COPD
- Cancer — colorectal, lung
- Obesity

2019 Hospital CHNA Clinical Care Priorities

- Access to care
- Provider shortage
- Poor provider access to primary care and behavioral health

- Insurance
- Lack of preventive cancer screenings
- Inadequate prenatal care

2019 Hospital CHNA Built Environment Priorities

- Housing shortages
- Lack of access to healthy food

Appendix O: Stakeholder Committee Member Comments in Priority Session

Following the ranking and priority area efforts, members of the Stakeholder Committee provided verbal feedback during the virtual meeting and in the Zoom Chat Room. Following are committee members' verbatim comments.

Equity

- Everything we do should be run through a broad Equity lens.

- This is a big Equity reveal.

- Great job getting the Listening Sessions out to the more isolated areas and in Spanish.

Access to Care

- People delayed preventive medical care due to fears about COVID. Will this have an impact in this year's data and beyond, especially in cancers?

- Many people do not have access to Telehealth due to a lack of internet and computers.

COVID-19

- Fewer people commuting may have improved air quality.

- Virtual learning may have led to poorer education outcomes.

- A fear of COVID likely sparked a fear of public transit.

- The lockdown in 2020 result in layoffs.

- Is the 2020 homeless count complete? There may be a data delay in the count.

- How do we regroup after COVID to get diseases managed?

Education

- Preschool enrollment was down in 2020-21 because of COVID.

- This and other Education issues provide important opportunities.

- It would be helpful to see the data specific to ages 1-17.

CHNA Action Plans

- I have seen some of these plans organized by "health issues across the life span."

Appendix P: Hospital PSA Chronic Conditions, Avoidable ED Visits, Mental Health Visits

The hospital data noted below are derived from the California Department of Health Care Access and Information (HCAI).

Montclair Hospital Medical Center

Montclair Hospital Medical Center PSA
Chronic Conditions — Males

The primary chronic conditions in males in the Montclair Hospital Medical Center PSA vary by age. Young males of all ethnicities have substance use disorders, followed by mental health and tobacco use. Hypertension is the primary chronic condition for males 35–64, followed by diabetes, kidney disease and hyperlipidemia. This is the same for males 65+; many of them also have heart disease and prostate issues.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Drug Use Disorders	24.7%	Drug Use Disorders	42.8%	Drug Use Disorders	34.9%	Drug Use Disorders	41.2%
Depression	21.9%	Schizophrenia and Other Psychotic Disorders	32.3%	Tobacco Use	21.8%	Tobacco Use	31.2%
Tobacco Use	20.9%	Tobacco Use	26.8%	Schizophrenia and Other Psychotic Disorders	20.2%	Depression	24.0%
Depressive Disorders	20.7%	Schizophrenia	22.6%	Obesity	17.7%	Alcohol Use Disorders	20.3%
Schizophrenia and Other Psychotic Disorders	20.2%	Anemia	20.6%	Alcohol Use Disorders	17.6%	Schizophrenia and Other Psychotic Disorders	20.3%
Hypertension	17.2%	Hypertension	18.1%	Chronic Kidney Disease	17.0%	Depressive Disorders	20.0%
Anemia	17.2%	Chronic Kidney Disease	17.8%	Hypertension	15.7%	Anxiety Disorders	14.5%
Chronic Kidney Disease	16.5%	Depression	16.2%	Depression	15.7%	Schizophrenia	14.0%
Schizophrenia	14.5%	Asthma	14.3%	Depressive Disorders	13.9%	Hypertension	12.9%
Anxiety Disorders	14.2%	Alcohol Use Disorders	13.6%	Anemia	13.6%	Bipolar Disorder	12.7%

35–64 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	63.2%	Hypertension	67.9%	Hypertension	57.4%	Hypertension	56.5%
Hyperlipidemia	41.4%	Chronic Kidney Disease	41.7%	Diabetes	45.4%	Chronic Kidney Disease	31.0%
Diabetes	40.0%	Diabetes	34.1%	Chronic Kidney Disease	42.3%	Diabetes	30.5%

35 – 64 Males (continued)

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Chronic Kidney Disease	37.0%	Anemia	30.9%	Hyperlipidemia	30.5%	Hyperlipidemia	29.6%
Anemia	33.8%	Hyperlipidemia	26.3%	Anemia	29.5%	Tobacco Use	23.9%
Ischemic Heart Disease	25.0%	Tobacco Use	25.5%	Obesity	22.9%	Anemia	22.6%
Tobacco Use	17.7%	Drug Use Disorders	21.7%	Alcohol Use Disorders	16.8%	Obesity	22.4%
Heart Failure	14.5%	Heart Failure	21.4%	Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	16.5%	Ischemic Heart Disease	18.4%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	13.0%	Obesity	20.4%	Tobacco Use	15.8%	Drug Use Disorders	16.3%
Obesity	10.8%	Ischemic Heart Disease	18.0%	Ischemic Heart Disease	15.5%	Heart Failure	16.1%

65+ Males

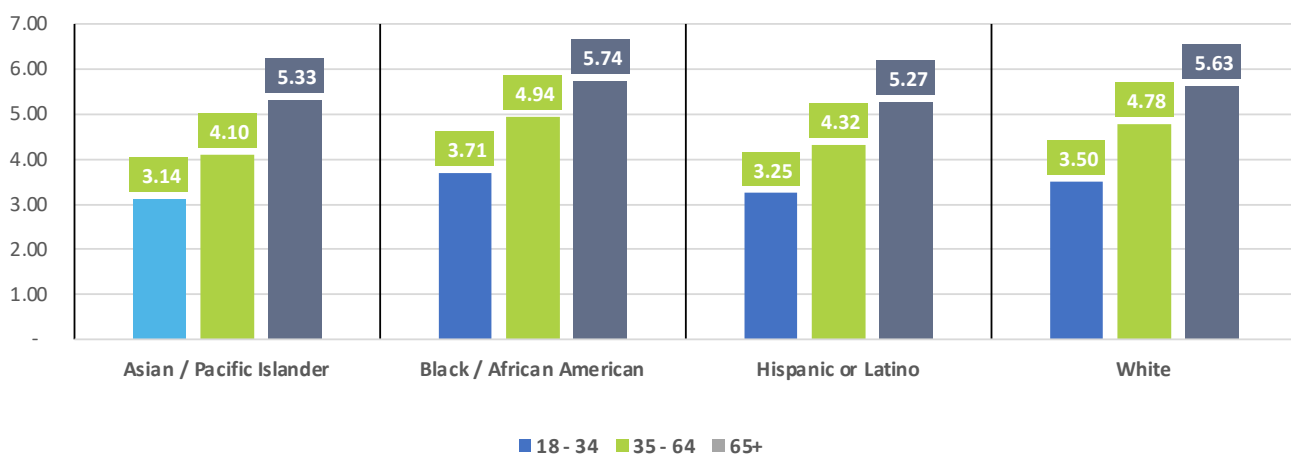| Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	83.6%	Hypertension	87.4%	Hypertension	80.6%	Hypertension	77.6%
Hyperlipidemia	52.9%	Chronic Kidney Disease	60.5%	Diabetes	56.5%	Hyperlipidemia	49.4%
Chronic Kidney Disease	52.1%	Anemia	52.4%	Chronic Kidney Disease	53.8%	Chronic Kidney Disease	46.6%
Diabetes	50.9%	Hyperlipidemia	51.4%	Anemia	47.6%	Anemia	44.5%
Anemia	48.8%	Diabetes	49.7%	Hyperlipidemia	46.7%	Ischemic Heart Disease	39.8%
Ischemic Heart Disease	39.2%	Ischemic Heart Disease	35.4%	Ischemic Heart Disease	34.4%	Diabetes	36.6%
Benign Prostatic Hyperplasia	27.6%	Heart Failure	32.9%	Heart Failure	29.2%	Heart Failure	30.0%
Heart Failure	24.1%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	23.5%	Benign Prostatic Hyperplasia	25.5%	Benign Prostatic Hyperplasia	26.4%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	18.2%	Benign Prostatic Hyperplasia	23.3%	Peripheral Vascular Disease (PVD)	17.6%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	25.0%
Peripheral Vascular Disease (PVD)	13.9%	Peripheral Vascular Disease (PVD)	21.3%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.5%	Rheumatoid Arthritis / Osteoarthritis	16.8%

Black/African American males 65+ in the Montclair Hospital Medical Center PSA had an average of 6.3 chronic conditions from 2016 to 2019. They also had the most — 4.89 — in the 35–64 age group, followed by White males. Males 65+ averaged the highest number of chronic conditions across all ethnic groups.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges

Bar chart legend: ■ 18 - 34 ■ 35 - 64 ■ 65+

Asian / Pacific Islander: 3.13, 4.35, 5.39
Black / African American: 3.59, 4.89, 6.30
Hispanic or Latino: 3.17, 4.60, 5.68
White: 3.61, 4.84, 5.81
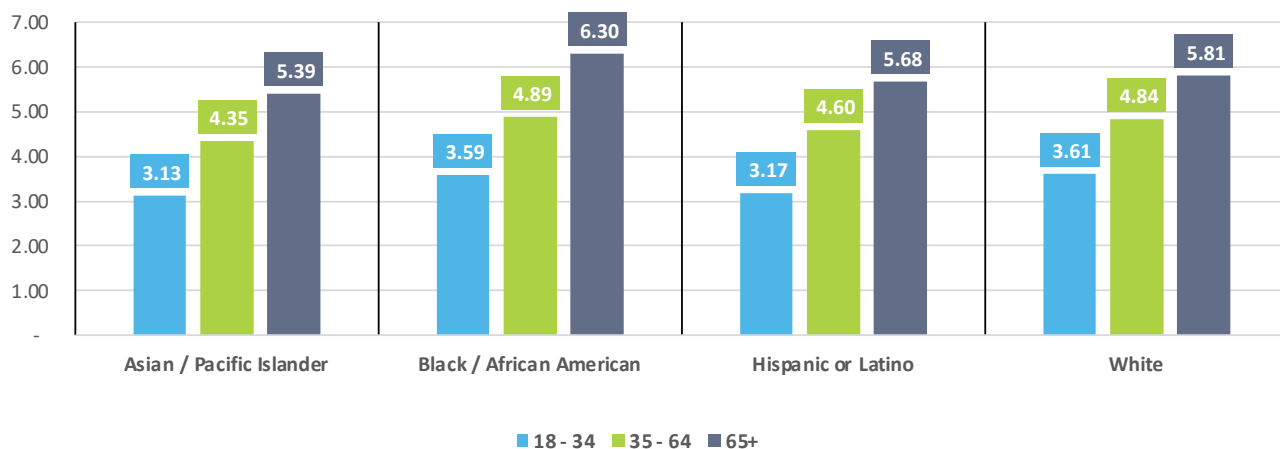
In 2020, the distribution among race/ethnicity groups was similar to 2016–2019, but the average number of chronic conditions decreased among 65+ groups and all White age groups.

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges

Bar chart legend: ■ 18 - 34 ■ 35 - 64 ■ 65+

Asian / Pacific Islander: 3.14, 4.10, 5.33
Black / African American: 3.71, 4.94, 5.74
Hispanic or Latino: 3.25, 4.32, 5.27
White: 3.50, 4.78, 5.63

Montclair Hospital Medical Center PSA
Chronic Conditions — Females

From 2016 to 2019, the top chronic conditions for all ethnic groups in the 18–34 female group in the Montclair Hospital Medical Center PSA were obesity and anemia, followed by depression and anxiety. For ages 35–64, hypertension was the top diagnosis, especially among Black/African American females; anemia and diabetes are also high in the group. For older females, hypertension is the highest in Black/African American females followed by Hispanic/Latina and Asian/Pacific Islander females.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	23.1%	Anemia	35.7%	Obesity	34.7%	Obesity	22.5%
Obesity	13.8%	Obesity	25.8%	Anemia	24.5%	Depression	21.8%
Depression	12.2%	Asthma	20.7%	Depression	11.5%	Anxiety Disorders	19.4%
Depressive Disorders	11.5%	Drug Use Disorders	19.6%	Drug Use Disorders	10.2%	Depressive Disorders	18.6%
Acquired Hypothyroidism	10.2%	Depression	18.7%	Depressive Disorders	10.1%	Anemia	17.7%
Asthma	7.3%	Depressive Disorders	16.2%	Asthma	9.9%	Drug Use Disorders	17.4%
Anxiety Disorders	6.9%	Anxiety Disorders	14.2%	Anxiety Disorders	9.9%	Asthma	13.2%
Drug Use Disorders	4.7%	Tobacco Use	11.3%	Chronic Kidney Disease	8.8%	Tobacco Use	12.7%
Chronic Kidney Disease	4.5%	Schizophrenia and Other Psychotic Disorders	10.4%	Diabetes	7.4%	Diabetes	8.9%
Diabetes	4.2%	Sickle Cell Disease	9.5%	Tobacco Use	6.0%	Hypertension	7.7%

35–64 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	38.4%	Hypertension	62.6%	Hypertension	45.7%	Hypertension	45.8%
Anemia	32.2%	Anemia	35.5%	Diabetes	38.6%	Obesity	27.8%
Hyperlipidemia	23.2%	Diabetes	33.0%	Obesity	33.8%	Anemia	25.7%
Diabetes	23.1%	Obesity	32.2%	Chronic Kidney Disease	32.6%	Hyperlipidemia	24.1%
Chronic Kidney Disease	22.0%	Chronic Kidney Disease	32.0%	Anemia	31.6%	Diabetes	23.7%
Obesity	10.5%	Hyperlipidemia	27.4%	Hyperlipidemia	27.3%	Chronic Kidney Disease	22.8%
Acquired Hypothyroidism	10.3%	Tobacco Use	17.8%	Depression	13.0%	Anxiety Disorders	21.2%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	7.3%	Heart Failure	17.8%	Anxiety Disorders	13.0%	Depression	20.5%
Depression	7.3%	Depression	15.4%	Acquired Hypothyroidism	12.6%	Depressive Disorders	18.4%
Anxiety Disorders	7.0%	Anxiety Disorders	15.2%	Depressive Disorders	12.1%	Tobacco Use	18.3%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	80.4%	Hypertension	87.2%	Hypertension	81.9%	Hypertension	75.9%
Anemia	50.1%	Anemia	55.3%	Diabetes	55.2%	Anemia	45.7%
Hyperlipidemia	48.3%	Chronic Kidney Disease	53.8%	Anemia	49.4%	Hyperlipidemia	43.6%
Diabetes	45.9%	Diabetes	51.7%	Chronic Kidney Disease	48.5%	Chronic Kidney Disease	38.8%
Chronic Kidney Disease	42.3%	Hyperlipidemia	49.5%	Hyperlipidemia	46.2%	Diabetes	30.2%
Ischemic Heart Disease	24.9%	Heart Failure	32.8%	Heart Failure	25.9%	Acquired Hypothyroidism	29.3%
Heart Failure	22.1%	Ischemic Heart Disease	29.7%	Ischemic Heart Disease	25.4%	Heart Failure	26.0%
Rheumatoid Arthritis / Osteoarthritis	17.2%	Rheumatoid Arthritis / Osteoarthritis	23.0%	Acquired Hypothyroidism	22.0%	Rheumatoid Arthritis / Osteoarthritis	25.2%
Acquired Hypothyroidism	15.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	22.8%	Rheumatoid Arthritis / Osteoarthritis	21.3%	Ischemic Heart Disease	24.7%
Osteoporosis	11.6%	Obesity	20.7%	Obesity	20.2%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	24.0%

Older Black/African American females in the Montclair Hospital Medical Center PSA had an average of 6.19 chronic conditions from 2016 to 2019; their numbers were also the highest for ages 18–34 and 35–64. White and Hispanic/Latina females had the next highest number of conditions across all age groups.

Female Average Number of Chronic Conditions by Race and Age Range 2016 - 2019 Discharges
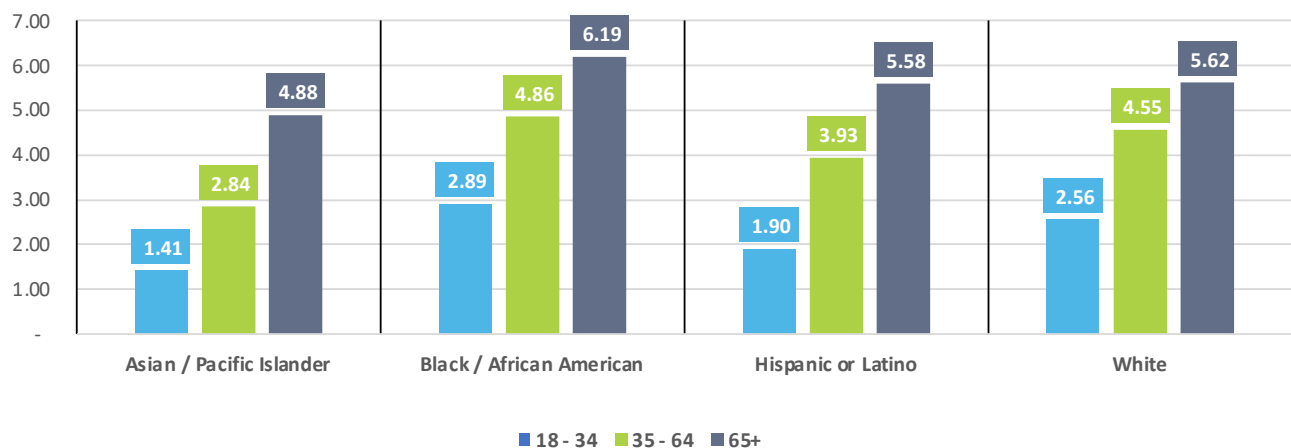
Older Black/African American females had the highest number — an average of 5.75 per individual — of chronic conditions in 2020; this number is lower than in 2016–2019. This is also true of other ethnic groups except Asian/Pacific Islander females; their average number increased from 4.88 to 5.01.

Montclair Hospital Medical Center PSA
Chronic Conditions — Youth

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges
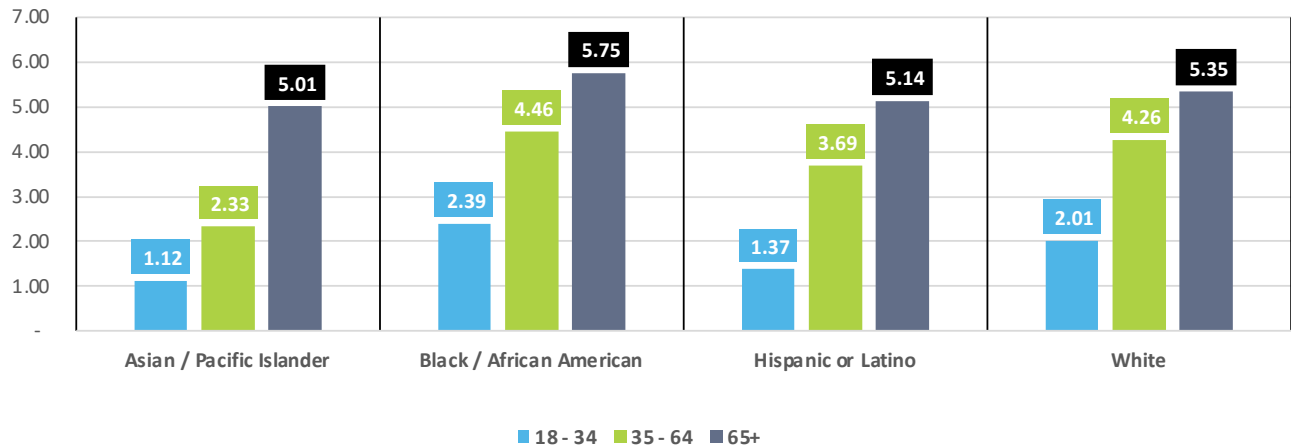
Depression and depressive disorders were the primary chronic conditions for females ages 0–17 in the Montclair Hospital Medical Center PSA; the rate is especially high in the White group. Depression, depressive disorders and asthma rates were highest in males 0–17; Asian/Pacific Islander youth had higher rates of epilepsy than other ethnic groups.

1–17 Females

| Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Depression	47.0%	Depression	35.1%	Depression	36.2%	Depression	44.0%
Depressive Disorders	47.0%	Depressive Disorders	31.3%	Depressive Disorders	34.1%	Depressive Disorders	41.0%
Anxiety Disorders	45.8%	Asthma	20.8%	Asthma	14.4%	Anxiety Disorders	17.8%
Epilepsy	13.3%	Anemia	18.5%	Anxiety Disorders	11.9%	Asthma	14.1%
Anemia	11.4%	Diabetes	10.9%	Obesity	11.5%	Epilepsy	12.9%
Asthma	11.4%	Obesity	9.4%	Anemia	11.1%	Drug Use Disorders	9.6%
Chronic Kidney Disease	8.4%	ADHD Conduct Disorders and Hyperkinetic Syndrome	9.4%	Epilepsy	9.2%	Anemia	8.8%
Obesity	7.8%	Anxiety Disorders	8.7%	Drug Use Disorders	8.5%	Obesity	7.9%
Leukemias and Lymphomas	6.0%	Epilepsy	8.3%	Intellectual Disabilities and Related Conditions	8.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.7%
Drug Use Disorders	6.0%	Sickle Cell Disease	7.2%	Schizophrenia and Other Psychotic Disorders	6.2%	Schizophrenia and Other Psychotic Disorders	6.2%

1–17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Depression	14.9%	Asthma	29.2%	Depression	20.0%	Depression	32.6%
Epilepsy	13.7%	Depression	27.1%	Depressive Disorders	18.8%	Depressive Disorders	29.7%
Asthma	13.7%	Depressive Disorders	21.9%	Asthma	18.3%	Asthma	20.8%
Depressive Disorders	12.9%	Anemia	19.8%	Epilepsy	12.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	13.2%
Anemia	11.4%	ADHD Conduct Disorders and Hyperkinetic Syndrome	17.0%	Anemia	10.9%	Drug Use Disorders	12.3%
Other Developmental Delays	6.7%	Sickle Cell Disease	11.1%	Obesity	10.1%	Anxiety Disorders	10.2%
ADHD Conduct Disorders and Hyperkinetic Syndrome	6.7%	Epilepsy	10.4%	Intellectual Disabilities and Related Conditions	9.1%	Epilepsy	10.1%
Leukemias and Lymphomas	5.9%	Drug Use Disorders	10.4%	Drug Use Disorders	8.9%	Anemia	7.1%
Intellectual Disabilities and Related Conditions	4.7%	Obesity	7.6%	Chronic Kidney Disease	7.4%	Bipolar Disorder	6.4%
Chronic Kidney Disease	4.7%	Bipolar Disorder	7.3%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.4%	Autism Spectrum Disorders	6.2%

Montclair Hospital Medical Center PSA Payers and ED Visits

Medi-Cal is the primary payer for Black/African American and Hispanic/Latino patients ages 18–34 and 35–64 in the Montclair Hospital Medical Center PSA. Asian/Pacific Islander and White females under age 65 have the highest rates of private insurance. All ethnic groups have very small percentages of Medi-Cal payers in people 65+.

## Percent Primary Payer by Race/Ethnicity and Age Range
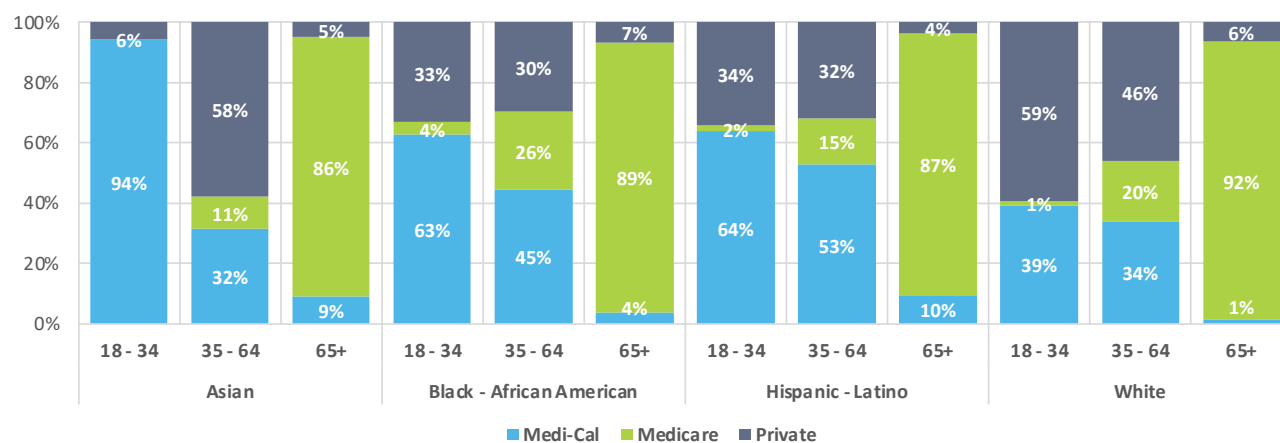
Avoidable ED Visits

The charts below show avoidable ED visits associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. The primary determinants for avoidable ED visits in the Montclair Hospital Medical Center PSA in 2020 were occupational risk and other psychosocial conditions (crime, incarceration, release from prison, legal issues, etc.) followed by employment and social conditions. Z codes, which are used to identify social determinants, are severely underreported.

Category	Visits by Volume					Avoidable Visits				
	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total ED Visits	196,975	196,846	206,618	158,328	-48,290	54%	53%	54%	50%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	77,176	78,522	80,651	57,649	-23,002	59%	57%	58%	53%	-5
Health Maintenance Organization (HMO)	26,092	26,101	29,379	24,778	-4,601	54%	54%	55%	50%	-4
Health Maintenance Organization (HMO) Medicare Risk	21,948	21,505	23,416	18,424	-4,992	49%	49%	50%	48%	-1
Self-Pay	11,115	10,815	11,719	8,586	-3,133	51%	50%	52%	47%	-4
Medicare Part B	9,215	9,168	9,093	6,719	-2,374	51%	50%	50%	49%	-2

Age Groups	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	5,032	4,514	4,781	2,426	-2,355	69%	66%	67%	62%	-7
1–17 Years	37,029	35,143	36,648	19,373	-17,275	60%	59%	60%	54%	-5
18–34 Years	43,736	44,194	45,559	38,316	-7,243	53%	52%	52%	49%	-4
35–64 Years	54,653	55,884	58,836	50,272	-8,564	54%	54%	54%	51%	-3
65 Years or Greater	22,958	23,796	25,685	20,026	-5,659	50%	49%	50%	48%	-2

Social Determinants	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	47	61	89	76	-13	28%	31%	31%	29%	1
Other Psychosocial Circumstances	912	334	95	76	-19	38%	44%	45%	37%	-1
Primary Support Group and Family	15	15	25	66	41	33%	27%	28%	39%	6
Employment	17	19	48	53	5	29%	37%	17%	42%	12
Upbringing	26	29	56	26	-30	23%	38%	41%	27%	4
Social Environment	12	19	27	23	-4	25%	16%	30%	4%	-21
Occupational Risk	22	25	15	8	-7	23%	12%	13%	38%	15
Psychosocial Circumstances	1	3	8	7	-1	100%	33%	13%	29%	-71
Education and Literacy	1	-	2	2	-	0%	0%	50%	0%	0

Race/Ethnicity	Visits by Volume					Avoidable Visits				
	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	35,337	36,574	37,356	30,121	(7,235)	53%	53%	53%	49%	-4
Black / African American	170,378	168,556	173,264	132,139	(41,125)	56%	56%	55%	52%	-4
Hispanic or Latino	675,502	677,820	715,771	564,598	(151,173)	55%	55%	56%	50%	-5
White	495,703	470,152	479,869	382,649	(97,220)	49%	49%	50%	46%	-3

Mental health ED primary diagnoses in the Montclair Hospital Medical Center PSA took a large jump between 2018 and 2019 but dropped significantly in 2020.
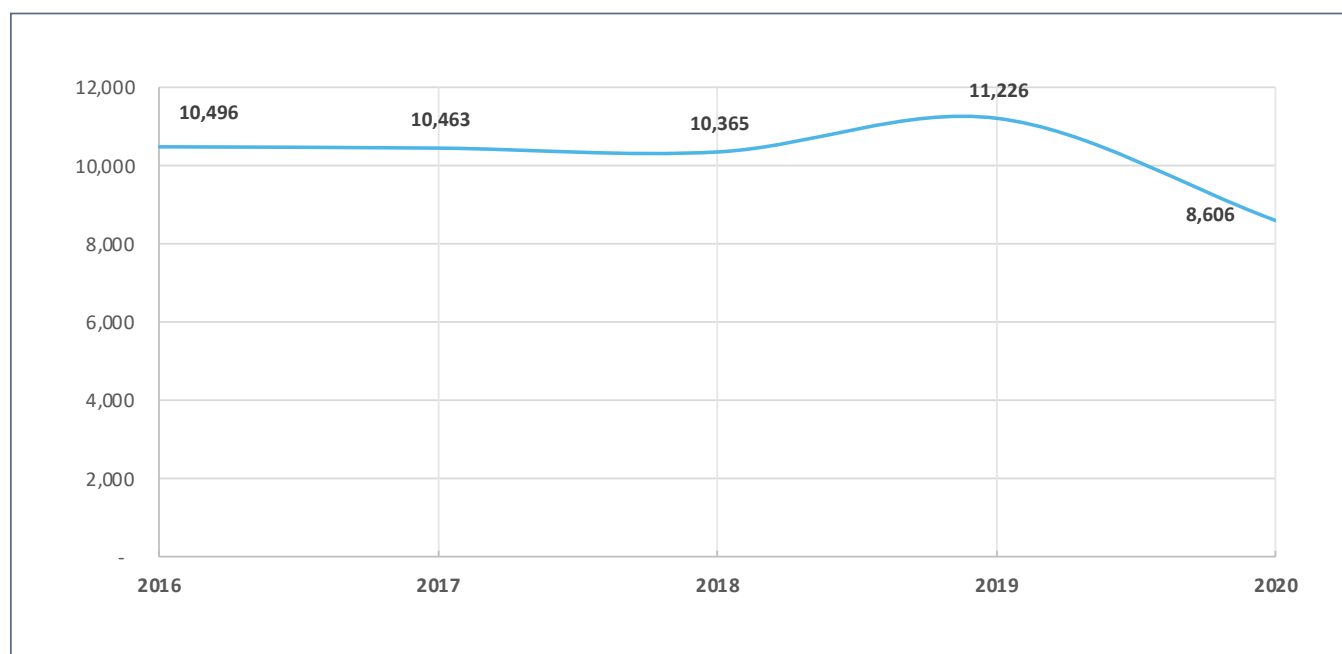
ED Visits for Mental Health Conditions

Redlands Community Hospital

Redlands Community Hospital PSA
Chronic Conditions — Males

For younger males in the Redlands Community Hospital PSA, substance and tobacco use were the most common chronic conditions. There are high rates of annual and kidney disease in the Asian/Pacific Islander group. For males over age 35, hypertension was the most common condition in all race/ethnic groups, followed by diabetes, chronic kidney disease and anemia.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	23.8%	Tobacco Use	36.0%	Drug Use Disorders	38.3%	Drug Use Disorders	42.8%
Drug Use Disorders	21.9%	Schizophrenia and Other Psychotic Disorders	35.3%	Tobacco Use	26.6%	Tobacco Use	34.4%
Chronic Kidney Disease	21.9%	Drug Use Disorders	35.0%	Alcohol Use Disorders	19.6%	Depression	24.3%
Hypertension	20.5%	Schizophrenia	26.3%	Schizophrenia and Other Psychotic Disorders	18.4%	Depressive Disorders	20.9%
Obesity	19.2%	Anemia	19.3%	Depression	18.4%	Alcohol Use Disorders	18.9%
Tobacco Use	17.9%	Diabetes	18.0%	Hypertension	17.3%	Anxiety Disorders	16.9%
Asthma	15.9%	Hypertension	17.3%	Depressive Disorders	16.8%	Schizophrenia and Other Psychotic Disorders	15.7%
Depression	13.9%	Chronic Kidney Disease	16.8%	Chronic Kidney Disease	15.0%	Hypertension	15.5%
Depressive Disorders	12.6%	Asthma	15.0%	Anemia	13.9%	Opioid Use Disorder (OUD) #3 - Opioid-Related Hospitalizations/Ed Visits	14.4%
Anxiety Disorders	11.3%	Alcohol Use Disorders	13.0%	Anxiety Disorders	13.7%	Opioid Use Disorder (OUD) #1	14.4%

35–64 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	73.7%	Hypertension	67.7%	Hypertension	61.4%	Hypertension	58.2%
Diabetes	44.0%	Chronic Kidney Disease	42.7%	Diabetes	44.0%	Diabetes	29.6%
Chronic Kidney Disease	41.7%	Diabetes	37.0%	Chronic Kidney Disease	38.4%	Hyperlipidemia	28.0%
Hyperlipidemia	40.5%	Anemia	28.5%	Anemia	29.9%	Chronic Kidney Disease	27.4%
Anemia	29.7%	Hyperlipidemia	25.8%	Hyperlipidemia	28.5%	Tobacco Use	27.1%
Ischemic Heart Disease	29.3%	Tobacco Use	24.6%	Obesity	19.8%	Anemia	21.9%
Heart Failure	21.4%	Heart Failure	24.2%	Tobacco Use	19.0%	Obesity	20.7%

35 – 64 Males (continued)

Asian / Pacific Islander	%	Black / African American	%	Hispanic or Latino	%	White	%
Tobacco Use	13.7%	Drug Use Disorders	21.2%	Drug Use Disorders	17.7%	Ischemic Heart Disease	19.4%
Obesity	11.4%	Schizophrenia and Other Psychotic Disorders	17.7%	Ischemic Heart Disease	17.1%	Heart Failure	17.7%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	10.4%	Obesity	16.6%	Heart Failure	16.8%	Drug Use Disorders	17.5%

65+ Males

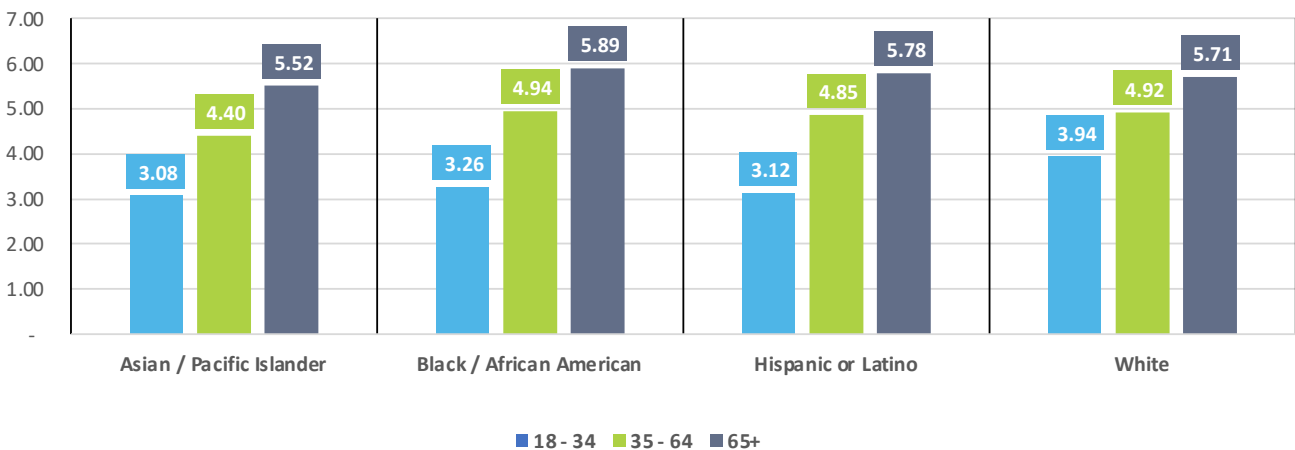| Asian / Pacific Islander	%	Black / African American	%	Hispanic or Latino	%	White	%
Hypertension	82.2%	Hypertension	85.9%	Hypertension	79.8%	Hypertension	75.9%
Chronic Kidney Disease	57.2%	Chronic Kidney Disease	58.1%	Diabetes	53.3%	Chronic Kidney Disease	46.5%
Diabetes	50.7%	Anemia	50.6%	Chronic Kidney Disease	51.8%	Hyperlipidemia	43.9%
Hyperlipidemia	47.7%	Diabetes	48.9%	Anemia	44.2%	Ischemic Heart Disease	38.7%
Anemia	47.7%	Hyperlipidemia	41.3%	Hyperlipidemia	42.0%	Anemia	38.0%
Ischemic Heart Disease	39.7%	Heart Failure	32.3%	Ischemic Heart Disease	33.4%	Diabetes	35.3%
Heart Failure	33.8%	Ischemic Heart Disease	30.7%	Heart Failure	29.0%	Heart Failure	31.0%
Benign Prostatic Hyperplasia	27.2%	Benign Prostatic Hyperplasia	26.9%	Benign Prostatic Hyperplasia	26.1%	Benign Prostatic Hyperplasia	28.1%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.4%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	20.8%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	17.8%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	27.5%
Rheumatoid Arthritis / Osteoarthritis	12.3%	Rheumatoid Arthritis / Osteoarthritis	14.2%	Peripheral Vascular Disease (PVD)	14.4%	Rheumatoid Arthritis / Osteoarthritis	17.0%

From 2016 to 2019, Black/African American males over 65 in the Redlands Community Hospital PSA had an average of 6.01 chronic conditions per person; they and White males had the most in the 35 – 64 age group. Among males 18 – 34, White males had an average of 3.46 conditions per person, the highest of this age group.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges

Chart legend: ■ 18 - 34 ■ 35 - 64 ■ 65+

Race	18 - 34	35 - 64	65+
Asian / Pacific Islander	2.70	4.38	5.45
Black / African American	3.31	4.84	6.01
Hispanic or Latino	3.12	4.78	5.60
White	3.46	4.83	5.64
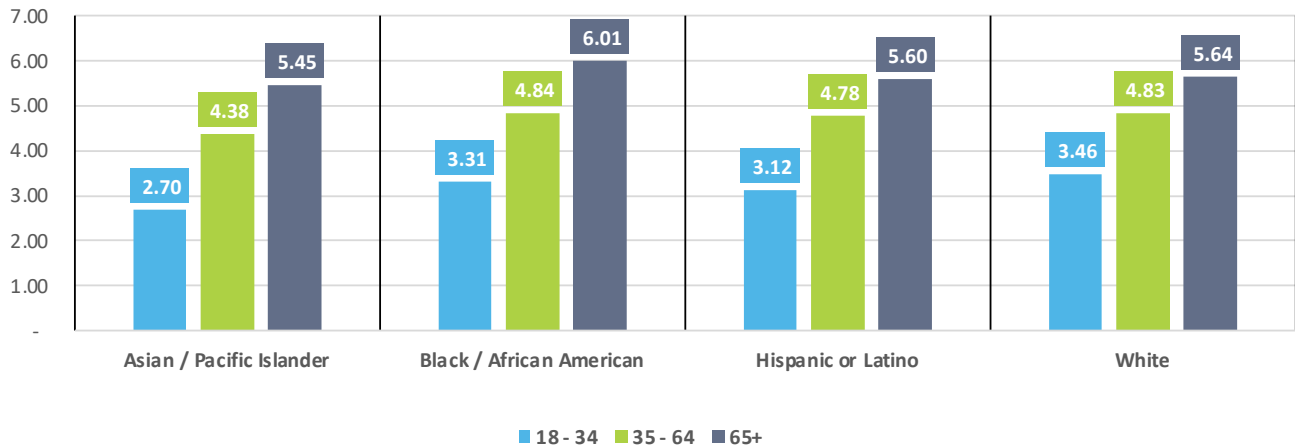
The chronic condition numbers for 2020 continue to reflect ethnic disparities

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges

Chart legend: ■ 18 - 34 ■ 35 - 64 ■ 65+

Race	18 - 34	35 - 64	65+
Asian / Pacific Islander	3.08	4.40	5.52
Black / African American	3.26	4.94	5.89
Hispanic or Latino	3.12	4.85	5.78
White	3.94	4.92	5.71

Redlands Community Hospital PSA
Chronic Conditions — Females

The most common chronic condition in females ages 18–34 in the Redlands Community Hospital PSA was anemia, followed by obesity. Hypertension is the most common condition in the two older groups; anemia is also high in these groups. Diabetes is highest in the Black/African American and Hispanic/Latina populations.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	37.3%	Anemia	37.4%	Anemia	34.6%	Anemia	29.8%
Obesity	11.6%	Obesity	23.2%	Obesity	26.3%	Obesity	17.8%
Asthma	11.5%	Asthma	22.0%	Drug Use Disorders	10.7%	Depression	17.7%
Depression	10.8%	Drug Use Disorders	17.9%	Anxiety Disorders	10.5%	Anxiety Disorders	16.2%
Depressive Disorders	9.9%	Anxiety Disorders	14.2%	Depression	10.4%	Depressive Disorders	15.9%
Chronic Kidney Disease	8.3%	Depression	13.0%	Asthma	10.1%	Drug Use Disorders	14.5%
Acquired Hypothyroidism	8.3%	Tobacco Use	12.0%	Depressive Disorders	9.5%	Asthma	14.0%
Hypertension	7.6%	Depressive Disorders	11.6%	Diabetes	6.9%	Tobacco Use	12.1%
Diabetes	5.9%	Schizophrenia and Other Psychotic Disorders	8.7%	Chronic Kidney Disease	5.3%	Acquired Hypothyroidism	6.4%
Anxiety Disorders	4.9%	Hypertension	8.5%	Tobacco Use	5.0%	Alcohol Use Disorders	5.4%

35–64 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	39.1%	Hypertension	63.9%	Hypertension	43.6%	Hypertension	45.8%
Anemia	31.3%	Anemia	37.8%	Diabetes	33.6%	Obesity	27.0%
Diabetes	23.8%	Chronic Kidney Disease	36.0%	Anemia	31.3%	Anemia	24.9%
Hyperlipidemia	22.0%	Diabetes	34.5%	Obesity	30.8%	Depression	23.9%
Chronic Kidney Disease	20.8%	Obesity	33.3%	Chronic Kidney Disease	25.2%	Diabetes	23.2%
Obesity	11.6%	Hyperlipidemia	25.8%	Hyperlipidemia	21.8%	Depressive Disorders	22.2%
Asthma	10.4%	Heart Failure	22.4%	Depression	17.1%	Anxiety Disorders	22.1%
Acquired Hypothyroidism	10.2%	Tobacco Use	19.2%	Depressive Disorders	15.7%	Hyperlipidemia	21.0%
Ischemic Heart Disease	8.5%	Anxiety Disorders	14.7%	Anxiety Disorders	15.7%	Tobacco Use	19.6%
Depression	8.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	14.6%	Asthma	11.6%	Chronic Kidney Disease	19.1%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	87.4%	Hypertension	88.6%	Hypertension	81.6%	Hypertension	76.0%
Chronic Kidney Disease	45.1%	Chronic Kidney Disease	50.9%	Diabetes	50.9%	Chronic Kidney Disease	40.1%
Diabetes	44.8%	Anemia	47.0%	Anemia	44.9%	Hyperlipidemia	39.8%
Anemia	44.6%	Diabetes	43.2%	Chronic Kidney Disease	44.9%	Anemia	38.9%
Hyperlipidemia	44.4%	Hyperlipidemia	40.6%	Hyperlipidemia	41.8%	Acquired Hypothyroidism	28.6%
Heart Failure	32.3%	Heart Failure	38.9%	Heart Failure	28.7%	Diabetes	28.5%
Ischemic Heart Disease	25.8%	Ischemic Heart Disease	31.4%	Acquired Hypothyroidism	24.8%	Heart Failure	28.3%
Rheumatoid Arthritis / Osteoarthritis	17.1%	Rheumatoid Arthritis / Osteoarthritis	23.1%	Ischemic Heart Disease	23.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	26.4%
Acquired Hypothyroidism	16.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	22.9%	Rheumatoid Arthritis / Osteoarthritis	20.6%	Rheumatoid Arthritis / Osteoarthritis	23.3%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.2%	Obesity	22.1%	Obesity	17.8%	Ischemic Heart Disease	23.2%

Black/African American, Hispanic/Latina and White females over age 65 in the Redlands Community Hospital PSA had the highest numbers of chronic conditions — on average, per individual — from 2016 to 2019. Black/African American had the highest number in the 35–64 age group.

Female Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges
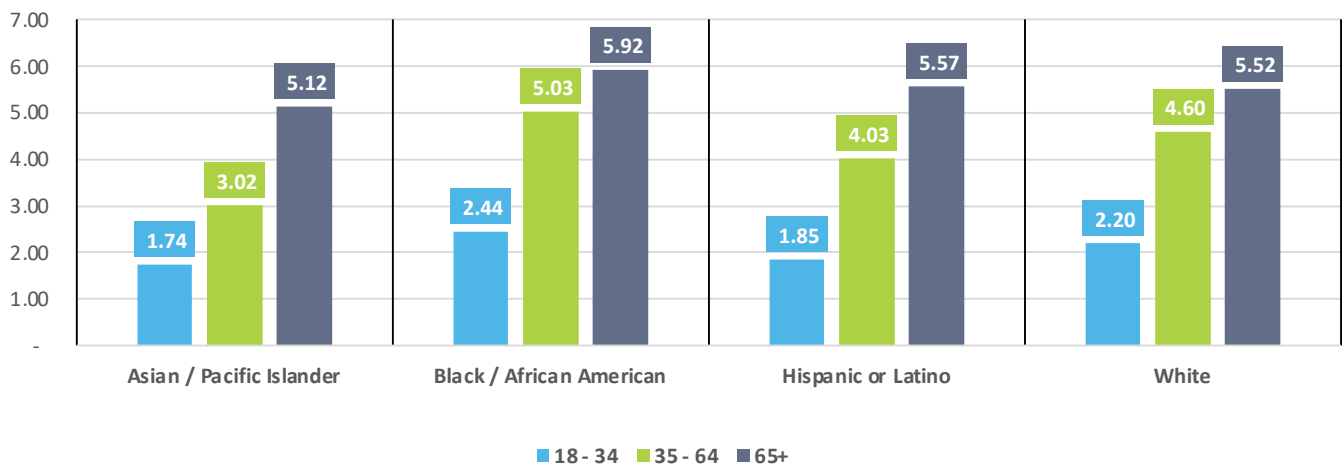
The rate of chronic conditions in Black/African American females age 65+ increased to 6.06 on average, per individual, in 2020. Black/African American females ages 35–64 have the highest number of conditions among the ethnic groups in that age group. The numbers for Hispanic/Latina females decreased slightly in 2020, but the numbers in the 18–34 White population grew.

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges

Legend: ■ 18 - 34 ■ 35 - 64 ■ 65+
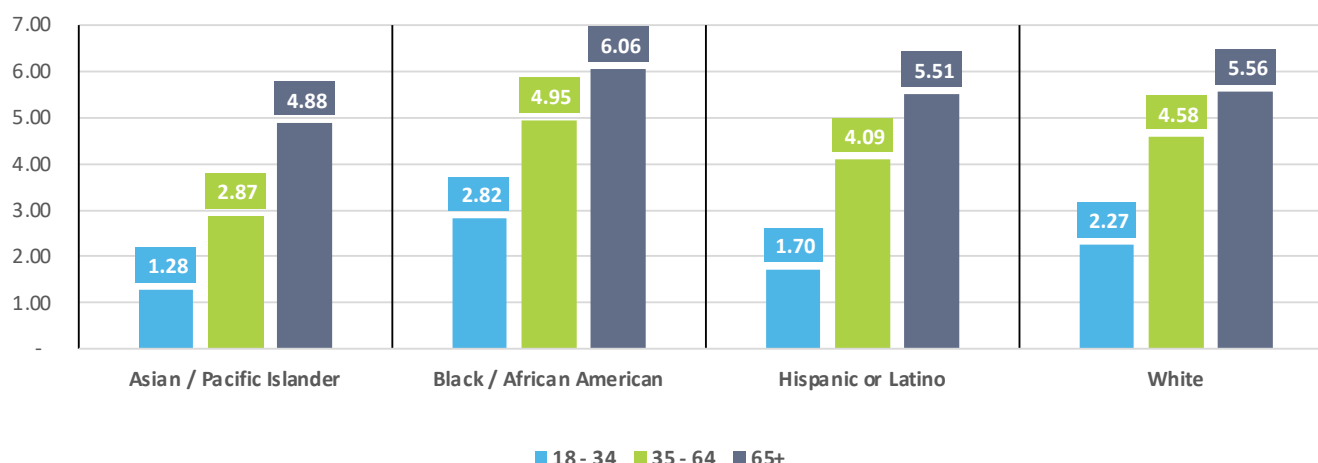
Redlands Community Hospital PSA
Chronic Conditions — Youth

For females 0–17 in the Redlands Community Hospital PSA, the most common chronic conditions in all ethnicities are depression, depressive disorders, asthma and anxiety; the depression rate in White females was especially high compared to the other ethnic groups. For all male youth, asthma, anemia and depression are the most common conditions.

1–17 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Depression	26.9%	Depression	29.9%	Depression	31.6%	Depression	46.5%
Depressive Disorders	24.6%	Depressive Disorders	28.4%	Depressive Disorders	30.6%	Depressive Disorders	44.2%
Asthma	20.8%	Asthma	27.5%	Asthma	20.8%	Anxiety Disorders	21.0%
Intellectual Disabilities and Related Conditions	15.4%	Anemia	24.5%	Epilepsy	14.2%	Asthma	13.4%
Epilepsy	10.8%	Epilepsy	15.5%	Anemia	13.9%	Drug Use Disorders	10.2%
Anemia	10.0%	Sickle Cell Disease	13.1%	Anxiety Disorders	13.2%	Epilepsy	9.4%
Autism Spectrum Disorders	8.5%	Intellectual Disabilities and Related Conditions	11.6%	Intellectual Disabilities and Related Conditions	12.8%	ADHD Conduct Disorders and Hyperkinetic Syndrome	8.9%

1–17 Females (continue)

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anxiety Disorders	8.5%	ADHD Conduct Disorders and Hyperkinetic Syndrome	11.0%	Obesity	12.7%	Obesity	7.5%
Cerebral Palsy	7.7%	Cerebral Palsy	10.4%	Cerebral Palsy	10.2%	Anemia	6.8%
Learning Disabilities	6.2%	Anxiety Disorders	10.1%	Chronic Kidney Disease	9.1%	Intellectual Disabilities and Related Conditions	6.7%

1–17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Asthma	20.9%	Anemia	28.0%	Asthma	24.9%	Depression	27.9%
Depression	16.3%	Asthma	27.1%	Depression	20.9%	Depressive Disorders	26.6%
Intellectual Disabilities and Related Conditions	15.5%	Depressive Disorders	18.2%	Depressive Disorders	20.2%	ADHD Conduct Disorders and Hyperkinetic Syndrome	20.2%
Depressive Disorders	15.5%	Depression	18.2%	Epilepsy	14.0%	Asthma	18.9%
Leukemias and Lymphomas	14.7%	Sickle Cell Disease	17.3%	Intellectual Disabilities and Related Conditions	12.8%	Drug Use Disorders	11.3%
Epilepsy	14.7%	ADHD Conduct Disorders and Hyperkinetic Syndrome	17.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	12.5%	Anxiety Disorders	10.4%
Anemia	10.9%	Epilepsy	16.4%	Obesity	11.7%	Epilepsy	10.2%
Hypertension	9.3%	Other Developmental Delays	10.3%	Cerebral Palsy	10.6%	Anemia	8.7%
Chronic Kidney Disease	9.3%	Intellectual Disabilities and Related Conditions	10.3%	Anemia	9.7%	Intellectual Disabilities and Related Conditions	8.4%
ADHD Conduct Disorders and Hyperkinetic Syndrome	8.5%	Drug Use Disorders	10.3%	Other Developmental Delays	8.3%	Autism Spectrum Disorders	6.9%

Redlands Community Hospital PSA —
Payers and ED visits

Medi-Cal is the primary payer for adults 18–34 and 35–44 for more Black/African American and Hispanic/Latino patients in the Redlands Community Hospital PSA. Asian/Pacific Islander and White populations in these age groups have the highest rates of private insurance.

Percent Primary Payer by Race/Ethnicity and Age Range
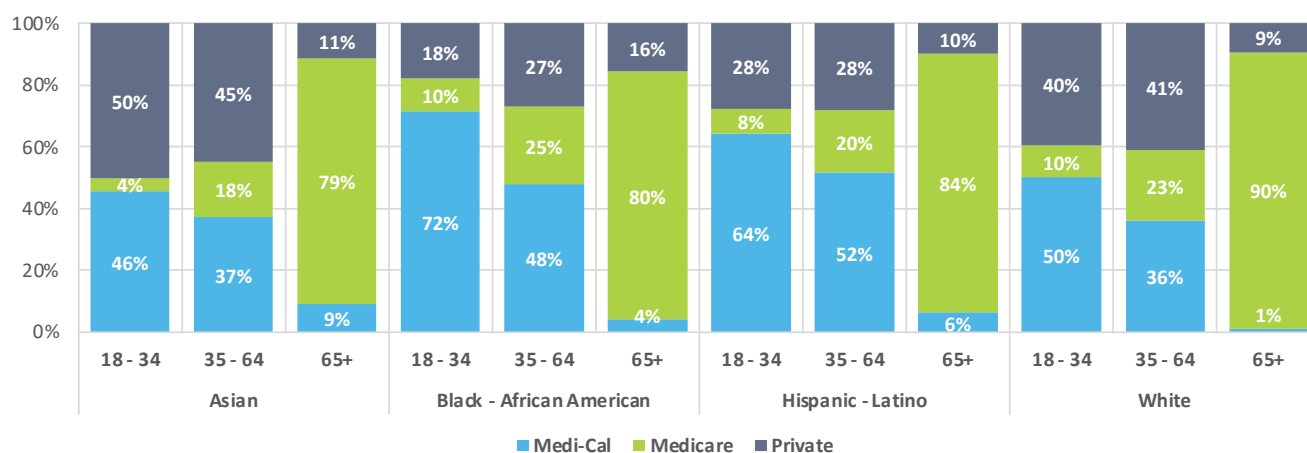
Avoidable ED Visits

The charts below show avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. Medi-Cal is the highest volume payer for avoidable ED visits in the Redlands Community Hospital PSA. The highest users are people 18–34 and 35–64. The primary determinants driving these visits are primary support group and family, and other psychosocial circumstances (crime, incarceration, release from prison, legal issues, etc.). The left side of the below charts shows the number of avoidable hospitalizations, and the right side shows the percentage of total ED visits that were considered avoidable. Social determinant Z codes are severely under-reported.

Category	Visits by Volume					Avoidable Visits				
	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total	105,163	664,846	683,844	550,739	-14,901	52%	52%	52%	52%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	52,337	48,488	48,885	37,655	-11,230	57%	56%	56%	51%	-5
Health Maintenance Organization (HMO) Medicare Risk	18,347	18,250	18,844	16,476	-2,368	48%	48%	47%	45%	-3
Health Maintenance Organization (HMO)	10,711	11,277	11,962	12,602	640	48%	49%	49%	46%	-2
Preferred Provider Organization (PPO)	7,638	7,445	7,880	7,088	-792	48%	47%	49%	46%	-2
Self-Pay	6,836	6,842	7,314	6,978	-336	47%	48%	50%	46%	-1

Age Groups	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	2,795	347,197	344,961	257,199	-858	64%	63%	64%	57%	-7
1–17 Years	19,625	102,832	107,626	94,372	-7,288	57%	56%	57%	50%	-6
18–34 Years	27,696	72,678	80,421	67,675	-2,292	51%	50%	51%	47%	-4

Age Groups (continued)	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
35–64 Years	36,289	42,582	45,792	39,899	(2,251)	51%	52%	52%	48%	-3
65 Years or Greater	18,758	37,259	36,678	28,674	(2,212)	48%	48%	47%	44%	-3

Social Determinants	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	437	199	81	77	-4	41%	41%	36%	25%	-17
Primary Support Group and Family	21	39	35	54	19	33%	26%	29%	30%	-4
Upbringing	42	38	36	31	-5	29%	34%	25%	29%	0
Occupational Risk	45	30	23	25	2	11%	10%	4%	8%	-3
Other Psychosocial Circumstances	8	9	12	22	10	25%	11%	25%	18%	-7
Social Environment	7	15	14	19	5	29%	27%	7%	26%	-2
Employment	6	7	11	9	-2	33%	29%	55%	33%	0
Education and Literacy	1	5	3	2	-1	100%	20%	0%	0%	-100%
Psychosocial Circumstances	-	1	3	-	-3	0%	100%	67%	0%	0

Social Determinants	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	3,501	3,551	3,579	3,100	-479	51%	53%	52%	48%	-4
Black / African American	10,529	10,443	10,703	8,322	-2,381	55%	55%	56%	53%	-3
Hispanic or Latino	39,060	38,392	40,096	34,449	-5,647	55%	55%	55%	50%	-6
White	48,316	46,031	45,476	39,100	-6,376	49%	48%	48%	45%	-4

Mental health ED primary diagnoses in the Redlands Community Hospital PSA dropped in 2018, rose in 2019 and dropped to 2018 levels in 2020.

ED Visits for Mental Health Conditions
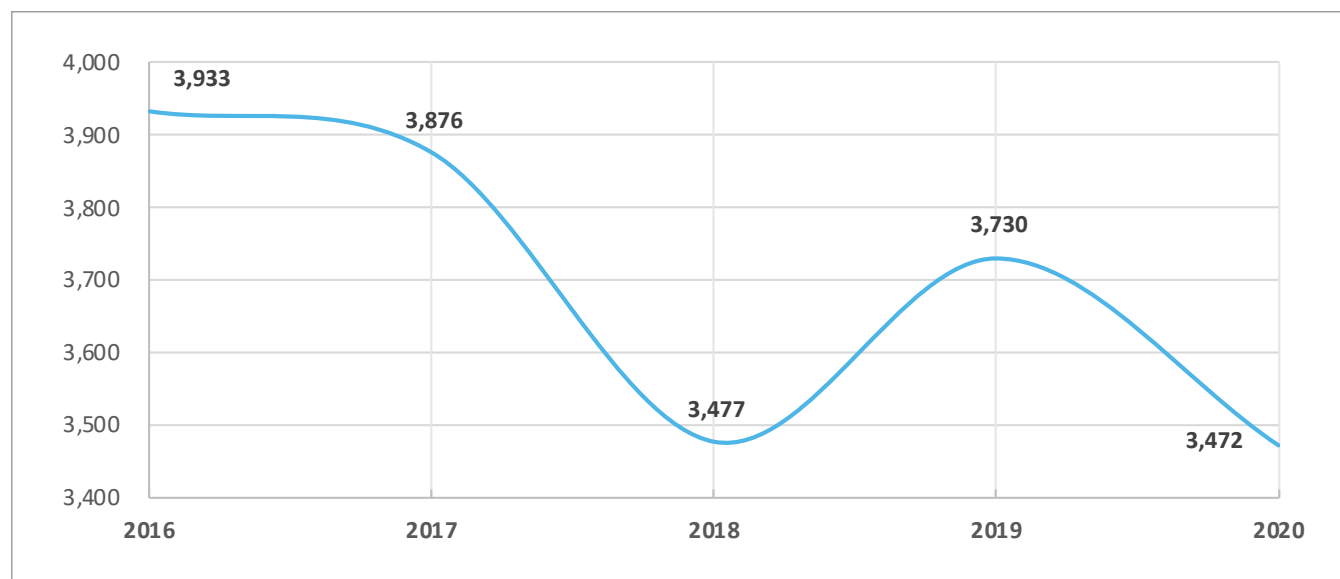
San Antonio Regional Hospital

San Antonio Regional Hospital PSA
Chronic Conditions — Males

For males 18–34 in the San Antonio Regional Hospital PSA, the most common chronic conditions in all ethnicities are drug use disorders, tobacco use and schizophrenia and other psychotic disorders. Leading chronic conditions in males 35–64 and 65+ are hypertension, kidney disease, diabetes and hyperlipidemia.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Tobacco Use	25.1%	Drug Use Disorders	40.1%	Drug Use Disorders	32.1%	Drug Use Disorders	37.7%
Drug Use Disorders	22.8%	Schizophrenia and Other Psychotic Disorders	30.2%	Tobacco Use	21.6%	Tobacco Use	29.0%
Hypertension	21.2%	Tobacco Use	27.0%	Schizophrenia and Other Psychotic Disorders	17.4%	Depression	22.4%
Schizophrenia and Other Psychotic Disorders	18.9%	Anemia	21.9%	Chronic Kidney Disease	17.2%	Depressive Disorders	19.0%
Chronic Kidney Disease	18.2%	Hypertension	21.7%	Depression	17.1%	Schizophrenia and Other Psychotic Disorders	17.4%
Depression	18.0%	Chronic Kidney Disease	20.3%	Alcohol Use Disorders	17.0%	Alcohol Use Disorders	17.2%
Obesity	17.1%	Schizophrenia	19.4%	Hypertension	15.7%	Anxiety Disorders	15.2%
Anemia	16.6%	Asthma	15.9%	Obesity	15.6%	Chronic Kidney Disease	12.8%
Depressive Disorders	16.1%	Depression	14.3%	Depressive Disorders	14.8%	Hypertension	12.7%
Schizophrenia	15.0%	Diabetes	12.1%	Anemia	14.4%	Bipolar Disorder	12.0%

35–64 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	61.5%	Hypertension	67.6%	Hypertension	58.3%	Hypertension	56.3%
Diabetes	42.0%	Chronic Kidney Disease	41.9%	Diabetes	44.1%	Hyperlipidemia	31.2%
Hyperlipidemia	41.9%	Diabetes	34.9%	Chronic Kidney Disease	40.4%	Chronic Kidney Disease	29.6%
Chronic Kidney Disease	40.4%	Anemia	29.5%	Hyperlipidemia	31.5%	Diabetes	29.1%
Anemia	32.5%	Hyperlipidemia	28.6%	Anemia	28.2%	Tobacco Use	22.6%
Ischemic Heart Disease	23.4%	Tobacco Use	22.2%	Obesity	22.2%	Anemia	22.0%
Tobacco Use	16.4%	Heart Failure	19.9%	Ischemic Heart Disease	16.5%	Obesity	21.7%
Heart Failure	15.9%	Obesity	18.9%	Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	16.1%	Ischemic Heart Disease	18.5%
Obesity	13.8%	Ischemic Heart Disease	18.2%	Alcohol Use Disorders	15.7%	Drug Use Disorders	14.8%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	12.3%	Drug Use Disorders	17.2%	Tobacco Use	15.3%	Heart Failure	14.3%

65+ Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	82.3%	Hypertension	85.7%	Hypertension	79.5%	Hypertension	77.9%
Chronic Kidney Disease	55.8%	Chronic Kidney Disease	60.8%	Diabetes	55.1%	Hyperlipidemia	50.9%
Hyperlipidemia	52.4%	Anemia	51.4%	Chronic Kidney Disease	54.0%	Chronic Kidney Disease	48.9%
Diabetes	52.2%	Hyperlipidemia	50.4%	Hyperlipidemia	46.2%	Anemia	42.3%
Anemia	48.5%	Diabetes	50.0%	Anemia	45.4%	Ischemic Heart Disease	40.1%
Ischemic Heart Disease	39.3%	Ischemic Heart Disease	34.8%	Ischemic Heart Disease	34.0%	Diabetes	37.8%
Benign Prostatic Hyperplasia	27.6%	Heart Failure	30.6%	Heart Failure	28.0%	Heart Failure	30.5%
Heart Failure	26.9%	Peripheral Vascular Disease (PVD)	24.4%	Benign Prostatic Hyperplasia	25.1%	Benign Prostatic Hyperplasia	25.6%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	17.1%	Benign Prostatic Hyperplasia	23.5%	Peripheral Vascular Disease (PVD)	19.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	25.1%
Peripheral Vascular Disease (PVD)	16.4%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	21.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	14.9%	Peripheral Vascular Disease (PVD)	19.1%

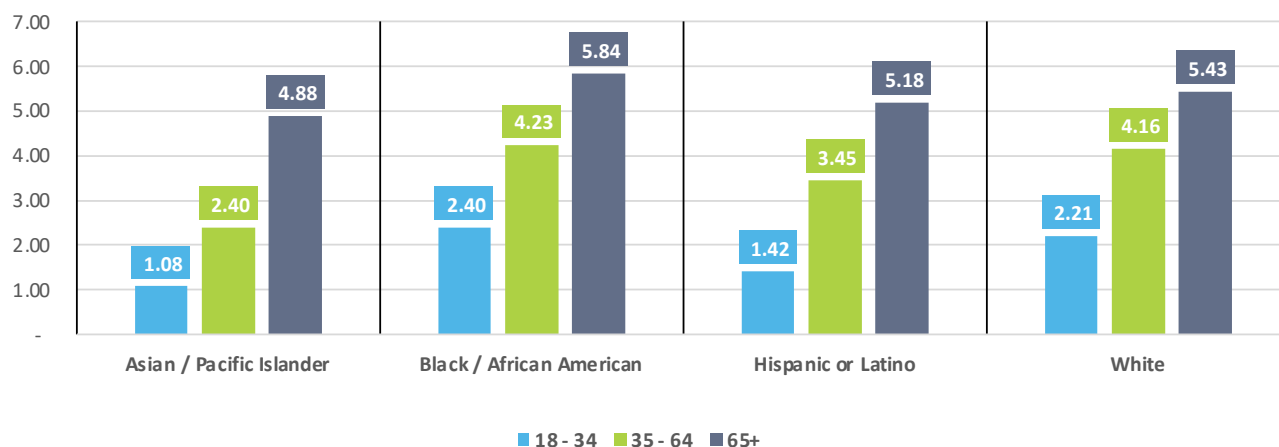From 2016 to 2019, Black/African American males over age 65 in the San Antonio Regional Hospital PSA had 6.11 chronic conditions per individual, on average; this is higher than the other hospital PSAs in this CHNA. Black/African American males ages 35–64 also have higher numbers, followed by White and Hispanic/Latino males.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges
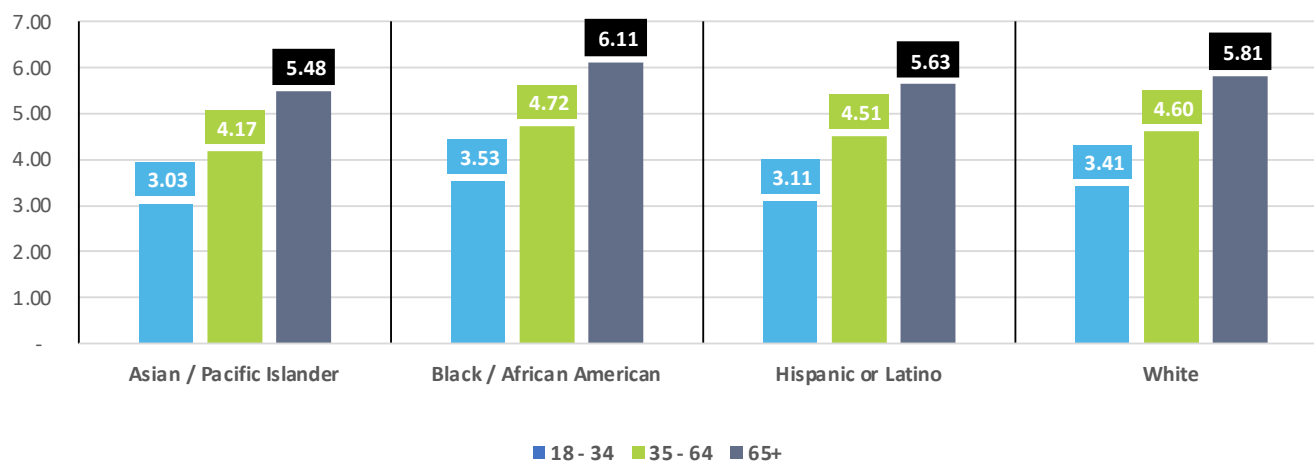
Chronic conditions among males in most ethnic groups declined somewhat in 2020, except for the Asian / Pacific Islander and White 35–64 groups.

Male Average Number of Chronic Conditions by Race and Age Range 2020 Discharges
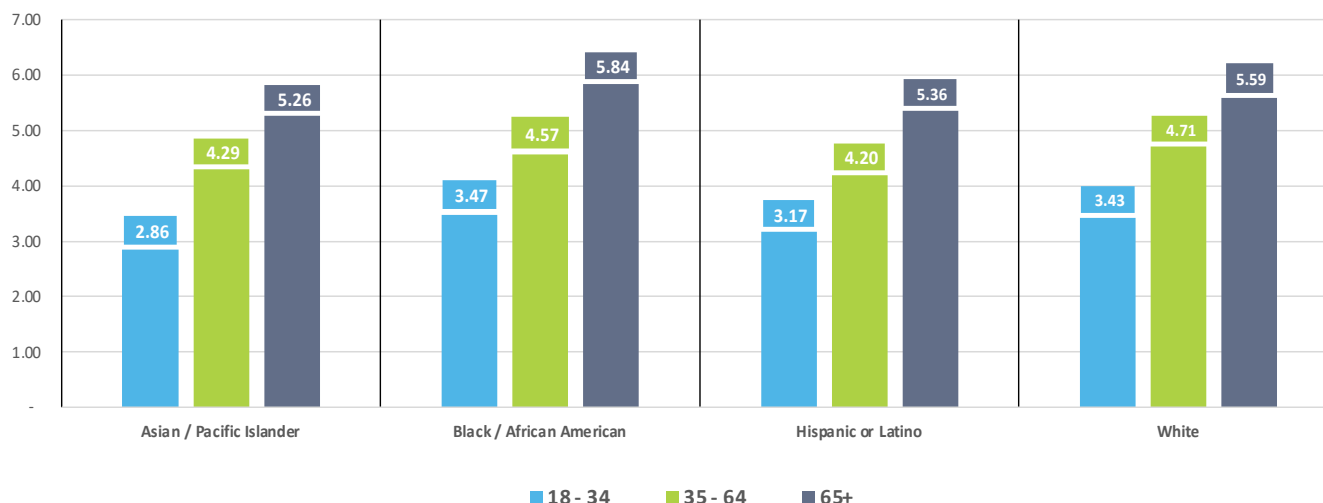
Race	18 - 34	35 - 64	65+
Asian / Pacific Islander	2.86	4.29	5.26
Black / African American	3.47	4.57	5.84
Hispanic or Latino	3.17	4.20	5.36
White	3.43	4.71	5.59

San Antonio Regional Hospital PSA
Chronic Conditions — Females

From 2016 to 2019, the top chronic conditions for females ages 18–24 in all ethnic groups in the San Antonio Regional Hospital PSA were anemia and obesity, followed by asthma, depression and substance use disorders. Obesity was especially prevalent in the Black/African American and Hispanic/Latina groups. Hypertension was the most common condition in both of the older groups. Anemia, diabetes, kidney disease and obesity were also issues for all females 35 and above.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	24.5%	Anemia	35.1%	Obesity	31.9%	Obesity	22.1%
Obesity	13.2%	Obesity	25.6%	Anemia	22.8%	Anemia	19.5%
Acquired Hypothyroidism	12.5%	Asthma	19.9%	Depression	11.0%	Depression	18.7%
Depression	8.7%	Drug Use Disorders	16.1%	Anxiety Disorders	10.7%	Anxiety Disorders	18.6%
Depressive Disorders	7.8%	Depression	16.0%	Asthma	10.0%	Depressive Disorders	16.4%
Asthma	6.8%	Depressive Disorders	13.9%	Depressive Disorders	9.9%	Drug Use Disorders	15.7%
Anxiety Disorders	6.2%	Anxiety Disorders	13.5%	Drug Use Disorders	8.5%	Asthma	13.2%
Viral Hepatitis (General)	4.1%	Sickle Cell Disease	9.0%	Chronic Kidney Disease	7.3%	Tobacco Use	11.1%
Chronic Kidney Disease	4.1%	Tobacco Use	8.7%	Diabetes	6.4%	Chronic Kidney Disease	8.5%
Hyperlipidemia	3.7%	Hypertension	8.5%	Hypertension	4.9%	Diabetes	8.1%

35–64 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	36.4%	Hypertension	60.1%	Hypertension	42.9%	Hypertension	44.1%
Anemia	31.3%	Anemia	35.9%	Diabetes	33.9%	Obesity	27.2%
Hyperlipidemia	23.1%	Obesity	32.4%	Obesity	30.5%	Anemia	24.5%
Diabetes	21.5%	Chronic Kidney Disease	28.6%	Anemia	30.1%	Hyperlipidemia	23.8%
Chronic Kidney Disease	19.5%	Diabetes	28.6%	Chronic Kidney Disease	28.2%	Diabetes	22.2%
Obesity	12.7%	Hyperlipidemia	26.4%	Hyperlipidemia	25.8%	Chronic Kidney Disease	22.0%
Acquired Hypothyroidism	12.2%	Anxiety Disorders	16.1%	Anxiety Disorders	14.3%	Anxiety Disorders	21.1%
Anxiety Disorders	8.2%	Heart Failure	15.0%	Depression	13.4%	Depression	21.1%
Asthma	7.0%	Depression	15.0%	Depressive Disorders	12.4%	Depressive Disorders	19.2%
Ischemic Heart Disease	6.4%	Fibromyalgia and Chronic Pain and Fatigue	14.5%	Acquired Hypothyroidism	11.9%	Acquired Hypothyroidism	17.5%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	81.7%	Hypertension	87.4%	Hypertension	81.3%	Hypertension	75.9%
Hyperlipidemia	50.1%	Chronic Kidney Disease	55.1%	Diabetes	52.4%	Hyperlipidemia	44.3%
Anemia	49.4%	Anemia	53.2%	Chronic Kidney Disease	49.3%	Anemia	44.1%
Diabetes	47.8%	Diabetes	48.2%	Anemia	47.4%	Chronic Kidney Disease	40.7%
Chronic Kidney Disease	47.3%	Hyperlipidemia	46.8%	Hyperlipidemia	45.9%	Diabetes	30.8%
Ischemic Heart Disease	25.0%	Heart Failure	31.9%	Heart Failure	25.8%	Acquired Hypothyroidism	28.1%
Heart Failure	24.6%	Ischemic Heart Disease	28.4%	Ischemic Heart Disease	24.4%	Heart Failure	25.8%
Rheumatoid Arthritis / Osteoarthritis	17.0%	Rheumatoid Arthritis / Osteoarthritis	23.5%	Acquired Hypothyroidism	21.8%	Ischemic Heart Disease	25.2%
Acquired Hypothyroidism	15.4%	Peripheral Vascular Disease (PVD)	20.7%	Rheumatoid Arthritis / Osteoarthritis	21.7%	Rheumatoid Arthritis / Osteoarthritis	24.7%
Peripheral Vascular Disease (PVD)	12.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	20.3%	Obesity	17.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	24.2%

Black/African American females ages 65+ in the San Antonio Regional Hospital PSA had an average of 6.03 chronic conditions per individual from 2016 to 2019, followed by White and Hispanic/Latina females. For ages 35-64, Black/African American and White females had the highest numbers of conditions.

Female Average Number of Chronic Conditions by Race and Age Range 2016 – 2019 Discharges

	Asian / Pacific Islander	Black / African American	Hispanic or Latino	White
18 - 34	1.32	2.59	1.76	2.47
35 - 64	2.71	4.55	3.70	4.39
65+	4.96	6.03	5.51	5.64
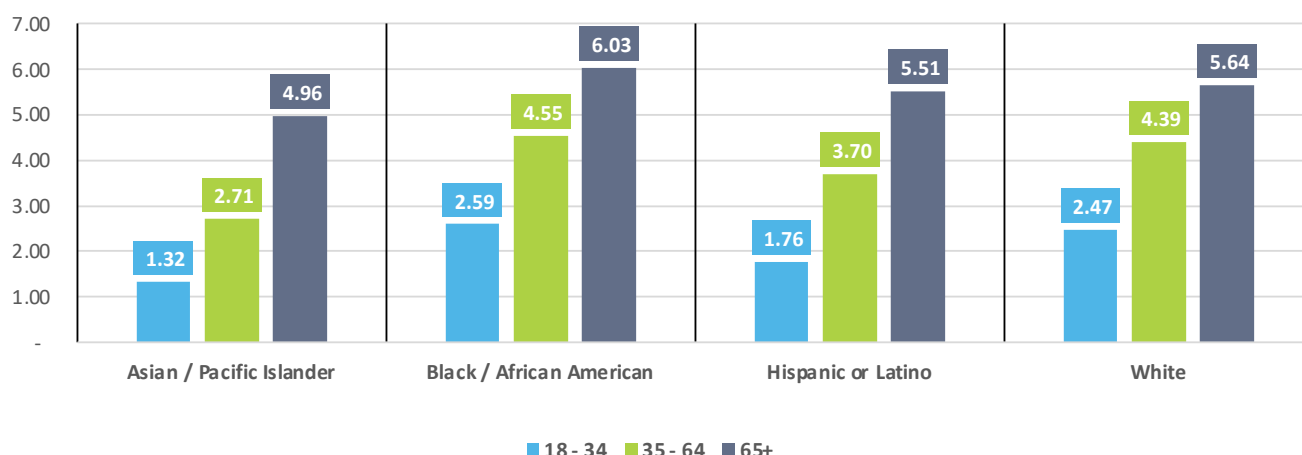
In 2020, Black/African American females over 65 had an average of 5.84 chronic conditions per individual; Asian/Pacific Islanders had the lowest rate in that age group at 4.88. Black/African American females also had the highest number in the 35 – 64 age group.

Female Average Number of Chronic Conditions by Race and Age Range 2020 Discharges

	Asian / Pacific Islander	Black / African American	Hispanic or Latino	White
18 - 34	1.08	2.40	1.42	2.21
35 - 64	2.40	4.23	3.45	4.16
65+	4.88	5.84	5.18	5.43

San Antonio Regional Hospital PSA
Chronic Conditions — Youth

For young females in all ethnic groups in the San Antonio Hospital PSA, depression and depressive disorder are the most common conditions, followed by anxiety and asthma. Young males also had high rates of depression and seemed to have higher rates of asthma than females.

1–17 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Depressive Disorders	19.4%	Depression	27.0%	Depression	24.1%	Depression	36.7%
Depression	19.4%	Depressive Disorders	25.5%	Depressive Disorders	22.6%	Depressive Disorders	35.0%
Anemia	13.7%	Asthma	19.6%	Asthma	12.3%	Anxiety Disorders	14.4%
Asthma	11.6%	Anemia	17.9%	Anemia	9.8%	Asthma	11.8%
Anxiety Disorders	8.5%	Anxiety Disorders	9.8%	Anxiety Disorders	9.3%	Anemia	8.4%
Chronic Kidney Disease	8.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.5%	Obesity	8.1%	Drug Use Disorders	7.5%
Hypertension	7.2%	Sickle Cell Disease	7.1%	Epilepsy	6.2%	Epilepsy	7.4%
Epilepsy	4.7%	Schizophrenia and Other Psychotic Disorders	6.4%	Drug Use Disorders	5.2%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.3%
Intellectual Disabilities and Related Conditions	3.6%	Diabetes	6.0%	Chronic Kidney Disease	5.0%	Obesity	5.9%
Obesity	2.6%	Drug Use Disorders	5.7%	Intellectual Disabilities and Related Conditions	4.7%	Schizophrenia and Other Psychotic Disorders	4.7%

1–17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Asthma	14.6%	Asthma	28.0%	Asthma	17.4%	Depression	21.6%
Anemia	11.1%	Depression	18.8%	Depression	13.0%	Depressive Disorders	19.9%
Depression	10.9%	Depressive Disorders	16.6%	Depressive Disorders	12.2%	Asthma	15.7%
Depressive Disorders	10.0%	Anemia	14.3%	Epilepsy	9.6%	ADHD Conduct Disorders and Hyperkinetic Syndrome	11.3%
Epilepsy	7.9%	ADHD Conduct Disorders and Hyperkinetic Syndrome	11.0%	Anemia	8.9%	Epilepsy	9.9%
Intellectual Disabilities and Related Conditions	7.1%	Chronic Kidney Disease	7.9%	Intellectual Disabilities and Related Conditions	7.2%	Anxiety Disorders	7.9%
Chronic Kidney Disease	6.1%	Epilepsy	7.6%	Obesity	6.3%	Drug Use Disorders	7.7%
Anxiety Disorders	5.4%	Drug Use Disorders	7.1%	Cerebral Palsy	5.8%	Anemia	7.3%
Other Developmental Delays	4.2%	Schizophrenia and Other Psychotic Disorders	5.8%	Drug Use Disorders	5.7%	Intellectual Disabilities and Related Conditions	5.3%
Autism Spectrum Disorders	4.2%	Obesity	5.8%	Chronic Kidney Disease	5.6%	Autism Spectrum Disorders	4.8%

San Antonio Regional Hospital PSA
Payers and ED Visits

Medi-Cal is the primary payer for Black/African American and Hispanic/Latino groups under age 65 in the San Antonio Regional Hospital PSA. Asian/Pacific Islander and White adults under age 65 have the highest rates of private insurance.

Percent Primary Payer by Race/Ethnicity and Age Range
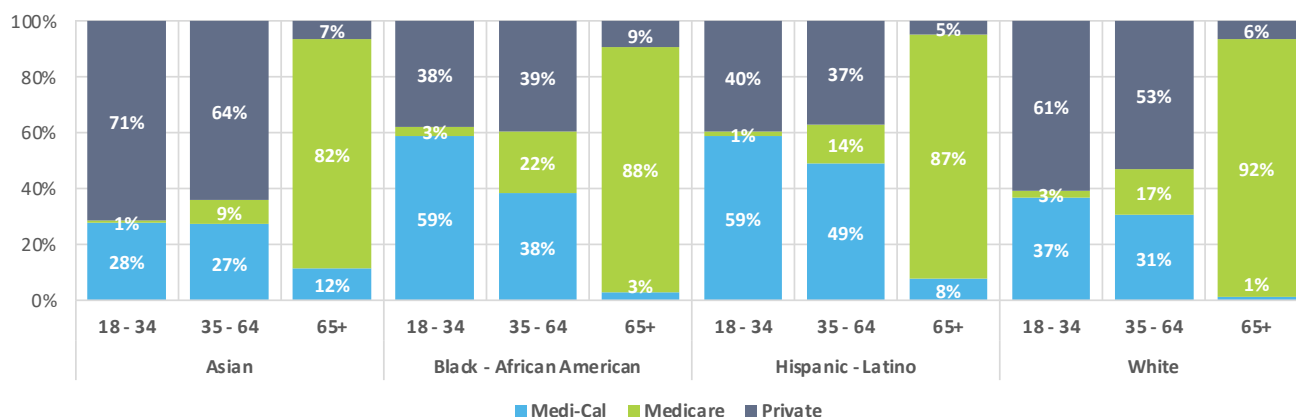

Avoidable ED Visits

The chart below shows avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. The primary payer for avoidable ED visits in the San Antonio Regional Hospital PSA is Medi-Cal; the most frequent users are adults 18–34 and 35–64. The primary determinants linked to these visits are primary support group and family, housing and economic, followed by employment and other psychosocial conditions (crime, incarceration, release from prison, legal issues, etc.). It is important to note that the Z codes for social determinants are significantly under-reported.

Category	Visits by Volume					Avoidable Visits				
	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total	265,460	266,312	281,471	220,847	-60,624	52%	52%	52%	48%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	117,406	115,637	117,757	85,293	-32,464	57%	56%	56%	52%	-5
Health Maintenance Organization (HMO)	47,627	48,031	52,206	44,810	-7,396	51%	51%	53%	48%	-4
Health Maintenance Organization (HMO) Medicare Risk	35,343	36,149	39,921	32,412	-7,509	48%	48%	49%	47%	-1
Self-Pay	19,047	19,189	20,418	15,377	-5,041	50%	49%	51%	47%	-3
Preferred Provider Organization (PPO)	15,211	15,353	16,321	12,982	-3,339	49%	49%	49%	46%	-3

| | **Visits by Volume** | | | | | **Avoidable Visits** | | | | |
Age Groups	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	7,430	6,984	7,462	4,067	-3,395	66%	65%	64%	60%	-6
1 – 17 Years	55,448	52,510	55,232	30,729	-24,503	57%	56%	57%	51%	-6
18 – 34 Years	73,985	74,443	77,971	65,901	-12,070	50%	50%	50%	46%	-4
35 – 64 Years	92,443	94,605	98,575	86,774	-11,801	52%	52%	52%	49%	-3
65 Years or Greater	36,154	37,770	42,231	33,376	-8,855	48%	48%	49%	47%	-2

Social Determinants	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Other Psychosocial Circumstances	43	140	576	395	-181	40%	26%	31%	31%	-8
Primary Support Group and Family	68	104	149	155	6	28%	30%	33%	32%	4
Housing and Economic	556	321	132	147	15	33%	38%	35%	33%	0
Employment	18	26	47	85	38	39%	23%	32%	35%	-4
Social Environment	42	61	103	47	-56	26%	34%	30%	34%	8
Upbringing	35	45	44	44	-	26%	20%	23%	14%	-12
Occupational Risk	37	32	22	22	-	14%	9%	14%	18%	5
Psychosocial Circumstances	2	2	11	11	-	50%	50%	27%	36%	-14
Education and Literacy	3	7	6	9	3	100%	14%	17%	22%	-78

Race/Ethnicity	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	11,172	11,782	12,816	10,238	-2,578	51%	50%	51%	47%	-4
Black / African American	27,377	27,580	29,082	22,710	-6,372	54%	54%	54%	51%	-3
Hispanic or Latino	146,840	146,968	156,746	122,485	-34,261	54%	54%	54%	50%	-5
White	65,951	63,998	64,599	50,377	-14,222	47%	47%	47%	44%	-3

Mental health ED primary diagnoses in the San Antonio PSA peaked in mid-2019 but dropped in 2020.

ED Visits for Mental Health Conditions
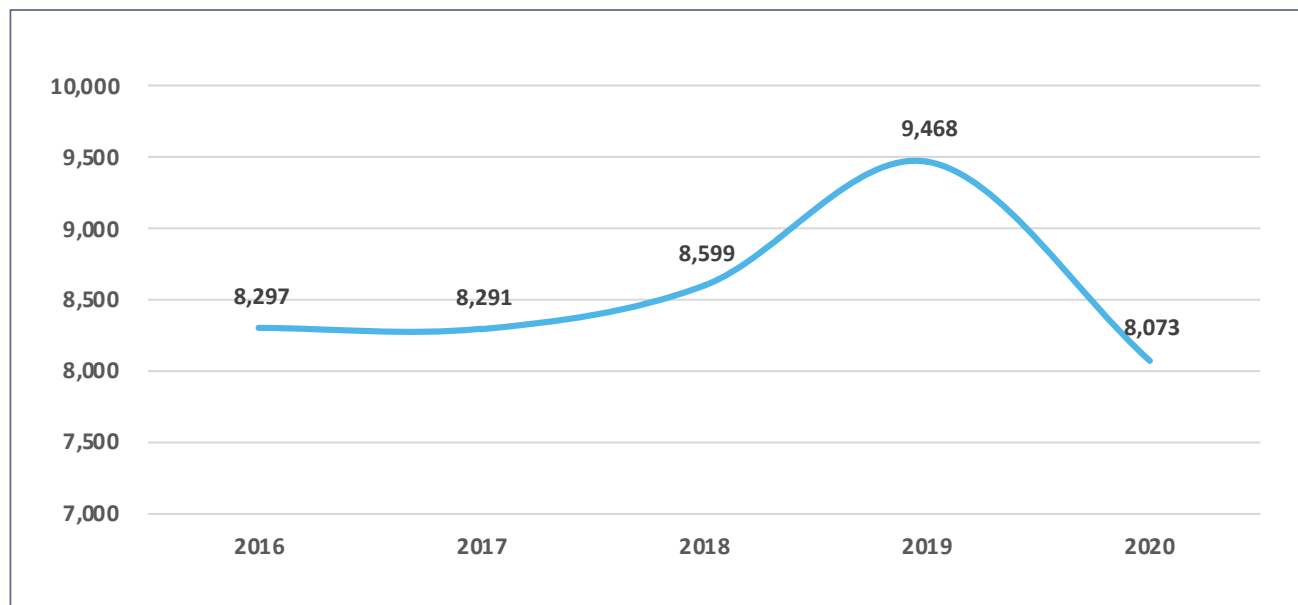
San Gorgonio Memorial Hospital

San Gorgonio Memorial Hospital PSA
Chronic Conditions — Males

The primary chronic conditions in males in the San Gorgonio Memorial Hospital PSA vary by age. Young males of all ethnicities have substance use disorders, followed by mental health and tobacco use. Hypertension is the primary chronic condition for males 35-64, followed by diabetes, kidney disease and hyperlipidemia. This is the same for males 65+, many of whom also have heart disease and prostate issues.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	27.3%	Tobacco Use	37.2%	Drug Use Disorders	32.5%	Drug Use Disorders	38.9%
Drug Use Disorders	22.7%	Schizophrenia and Other Psychotic Disorders	33.9%	Tobacco Use	28.1%	Tobacco Use	35.2%
Chronic Kidney Disease	22.7%	Drug Use Disorders	33.3%	Alcohol Use Disorders	19.6%	Alcohol Use Disorders	18.8%
Tobacco Use	18.2%	Schizophrenia	27.2%	Diabetes	19.4%	Hypertension	17.7%
Schizophrenia and Other Psychotic Disorders	18.2%	Diabetes	26.7%	Chronic Kidney Disease	17.6%	Depression	16.4%
Schizophrenia	13.6%	Chronic Kidney Disease	18.9%	Depression	16.0%	Diabetes	15.1%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	13.6%	Depression	17.2%	Schizophrenia and Other Psychotic Disorders	15.8%	Schizophrenia and Other Psychotic Disorders	14.8%
Intellectual Disabilities and Related Conditions	13.6%	Bipolar Disorder	16.7%	Hypertension	15.8%	Anxiety Disorders	13.8%
Alcohol Use Disorders	13.6%	Hypertension	15.6%	Depressive Disorders	13.5%	Depressive Disorders	13.5%
Sensory — Deafness and Hearing Impairment	9.1%	Depressive Disorders	15.6%	Anxiety Disorders	13.1%	Chronic Kidney Disease	12.4%

35–64 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	75.4%	Hypertension	71.8%	Hypertension	62.9%	Hypertension	59.0%
Chronic Kidney Disease	49.7%	Chronic Kidney Disease	52.8%	Diabetes	45.9%	Diabetes	31.0%
Hyperlipidemia	47.7%	Diabetes	38.5%	Chronic Kidney Disease	38.1%	Hyperlipidemia	28.1%
Diabetes	45.7%	Anemia	30.0%	Anemia	29.2%	Tobacco Use	27.1%
Anemia	29.6%	Hyperlipidemia	28.6%	Hyperlipidemia	28.8%	Chronic Kidney Disease	26.9%
Ischemic Heart Disease	27.6%	Heart Failure	28.6%	Obesity	18.8%	Obesity	21.8%
Peripheral Vascular Disease (PVD)	14.6%	Tobacco Use	22.4%	Heart Failure	17.8%	Ischemic Heart Disease	21.4%
Tobacco Use	12.6%	Obesity	19.0%	Ischemic Heart Disease	17.8%	Anemia	20.1%

35–64 Males (continued)

Asian / Pacific Islander	%	Black / African American	%	Hispanic or Latino	%	White	%
Heart Failure	11.1%	Ischemic Heart Disease	16.8%	Tobacco Use	16.4%	Heart Failure	18.7%
Obesity	10.1%	Drug Use Disorders	14.1%	Alcohol Use Disorders	14.7%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	17.1%

65+ Males

| Asian / Pacific Islander	%	Black / African American	%	Hispanic or Latino	%	White	%
Hypertension	79.9%	Hypertension	81.4%	Hypertension	81.3%	Hypertension	76.3%
Chronic Kidney Disease	55.4%	Chronic Kidney Disease	54.2%	Diabetes	51.7%	Chronic Kidney Disease	46.2%
Diabetes	49.6%	Anemia	51.0%	Chronic Kidney Disease	47.9%	Hyperlipidemia	44.3%
Anemia	42.9%	Hyperlipidemia	46.7%	Hyperlipidemia	43.4%	Ischemic Heart Disease	39.9%
Ischemic Heart Disease	40.2%	Diabetes	46.7%	Anemia	39.7%	Anemia	36.1%
Hyperlipidemia	37.5%	Heart Failure	33.0%	Ischemic Heart Disease	33.8%	Diabetes	34.4%
Heart Failure	33.9%	Ischemic Heart Disease	29.2%	Benign Prostatic Hyperplasia	29.1%	Heart Failure	29.8%
Benign Prostatic Hyperplasia	26.8%	Benign Prostatic Hyperplasia	27.5%	Heart Failure	28.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	28.3%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	18.3%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	22.3%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	18.3%	Benign Prostatic Hyperplasia	28.1%
Peripheral Vascular Disease (PVD)	11.6%	Rheumatoid Arthritis / Osteoarthritis	16.9%	Rheumatoid Arthritis / Osteoarthritis	15.0%	Rheumatoid Arthritis / Osteoarthritis	17.5%

Black/African American males 65+ in the San Gorgonio Memorial Hospital PSA had an average of 5.89 chronic conditions from 2016 to 2019. Black/African American, Hispanic/Latino and White males had similar rates of disease in the 35–64 age group. Males 65+ averaged the highest number of chronic conditions across all ethnic groups.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges

Chart: Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges

Race	18 - 34	35 - 64	65+
Asian / Pacific Islander	2.73	4.50	5.06
Black / African American	3.42	4.79	5.89
Hispanic or Latino	3.10	4.72	5.40
White	3.49	4.80	5.56
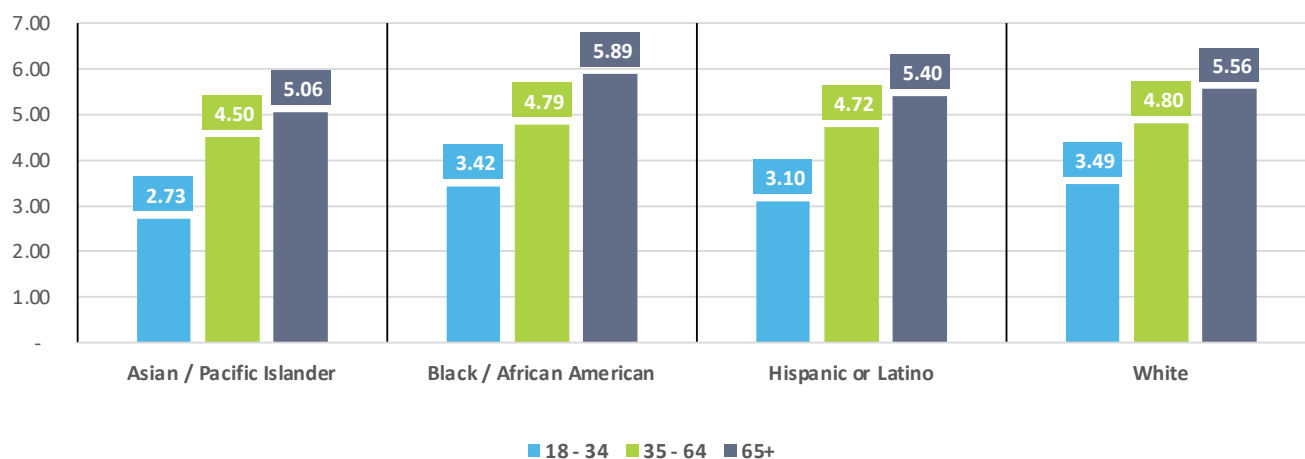
In 2020, the distribution among race/ethnicity groups was higher than in 2016–2019, especially in Black/African American males 65+. Overall, the number of conditions in Asian/Pacific Islander males rose significantly, especially in the 18–34 age group, which jumped from 2.73 to 5.00.

Male Average Number of Chronic Conditions by Race and Age Range 2020 Discharges

Chart: Male Average Number of Chronic Conditions by Race and Age Range 2020 Discharges

Race	18 - 34	35 - 64	65+
Asian / Pacific Islander	5.00	4.95	5.36
Black / African American	3.96	4.60	6.33
Hispanic or Latino	3.25	4.93	5.54
White	4.50	4.86	5.78
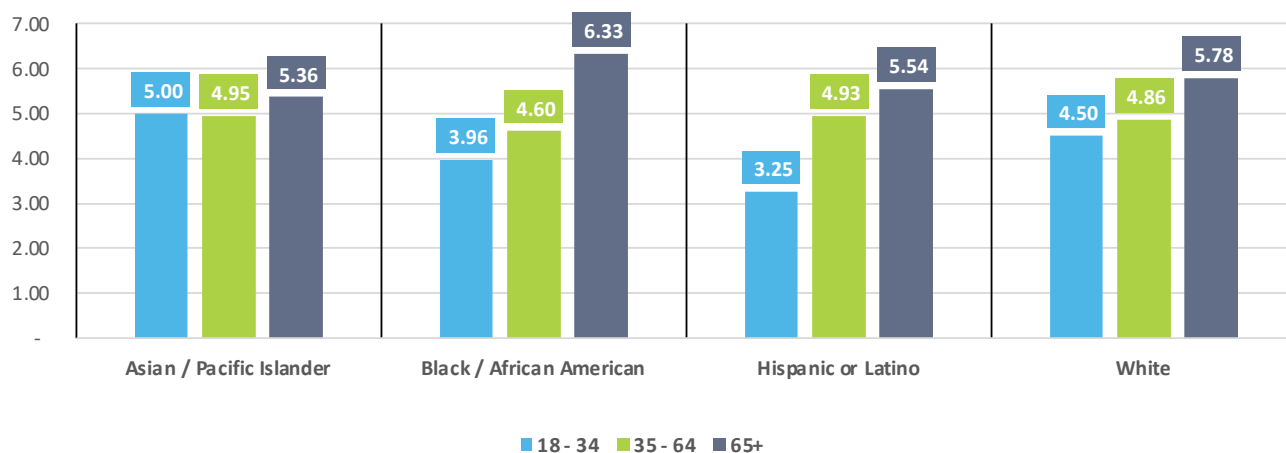
San Gorgonio Memorial Hospital PSA
Chronic Conditions — Females

The top chronic conditions for females in the 18–34 age group were anemia and obesity, followed by depression and anxiety. Hypertension levels were high in females 35–64 and 65+, followed by diabetes, obesity, anemia, depression and kidney disease.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	34.5%	Anemia	41.2%	Anemia	37.0%	Anemia	31.1%
Chronic Kidney Disease	13.3%	Asthma	24.7%	Obesity	26.2%	Obesity	21.1%
Obesity	12.4%	Obesity	19.8%	Anxiety Disorders	9.8%	Depression	13.2%
Hypertension	10.6%	Drug Use Disorders	14.9%	Asthma	9.4%	Asthma	12.9%
Depression	10.6%	Depression	12.5%	Drug Use Disorders	8.8%	Depressive Disorders	12.0%
Depressive Disorders	9.7%	Tobacco Use	12.2%	Depression	8.7%	Anxiety Disorders	11.5%
Acquired Hypothyroidism	9.7%	Anxiety Disorders	11.9%	Depressive Disorders	8.2%	Drug Use Disorders	10.8%
Heart Failure	7.1%	Sickle Cell Disease	11.6%	Diabetes	7.3%	Tobacco Use	9.7%
Schizophrenia and Other Psychotic Disorders	5.3%	Diabetes	11.6%	Chronic Kidney Disease	6.1%	Hypertension	5.4%
Hyperlipidemia	5.3%	Depressive Disorders	11.0%	Tobacco Use	5.2%	Acquired Hypothyroidism	5.4%

35–64 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	41.5%	Hypertension	63.7%	Hypertension	41.7%	Hypertension	45.4%
Anemia	30.2%	Diabetes	38.7%	Diabetes	32.5%	Obesity	26.6%
Hyperlipidemia	25.9%	Chronic Kidney Disease	35.0%	Obesity	29.6%	Depression	23.0%
Diabetes	24.4%	Obesity	34.2%	Anemia	29.6%	Anemia	22.3%
Chronic Kidney Disease	24.4%	Anemia	33.0%	Chronic Kidney Disease	22.0%	Diabetes	22.1%
Heart Failure	9.3%	Tobacco Use	23.4%	Hyperlipidemia	20.3%	Anxiety Disorders	22.1%
Obesity	8.8%	Hyperlipidemia	23.2%	Depression	15.7%	Tobacco Use	21.7%
Asthma	8.3%	Heart Failure	20.4%	Depressive Disorders	14.5%	Depressive Disorders	21.3%
Tobacco Use	7.8%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.7%	Anxiety Disorders	14.1%	Hyperlipidemia	19.7%
Fibromyalgia and Chronic Pain and Fatigue	7.8%	Ischemic Heart Disease	15.5%	Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	12.7%	Fibromyalgia and Chronic Pain and Fatigue	18.8%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	85.9%	Hypertension	87.3%	Hypertension	81.4%	Hypertension	74.1%
Anemia	46.4%	Chronic Kidney Disease	51.4%	Diabetes	51.2%	Hyperlipidemia	38.5%
Diabetes	46.1%	Anemia	46.1%	Chronic Kidney Disease	41.5%	Chronic Kidney Disease	37.7%
Chronic Kidney Disease	44.6%	Diabetes	41.6%	Anemia	41.1%	Anemia	36.6%
Hyperlipidemia	39.5%	Hyperlipidemia	38.5%	Hyperlipidemia	39.9%	Acquired Hypothyroidism	26.5%
Heart Failure	32.6%	Heart Failure	33.6%	Heart Failure	27.3%	Diabetes	25.5%
Ischemic Heart Disease	26.6%	Ischemic Heart Disease	25.4%	Ischemic Heart Disease	25.1%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	25.4%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	21.3%	Rheumatoid Arthritis / Osteoarthritis	24.3%	Rheumatoid Arthritis / Osteoarthritis	22.2%	Heart Failure	24.7%
Acquired Hypothyroidism	17.7%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	20.9%	Acquired Hypothyroidism	21.4%	Rheumatoid Arthritis / Osteoarthritis	23.5%
Rheumatoid Arthritis / Osteoarthritis	16.2%	Obesity	16.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	19.0%	Ischemic Heart Disease	22.4%

Older Black/African American females in the San Gorgonio Memorial Hospital PSA had an average of 5.47 chronic conditions from 2016 to 2019; their numbers were also the highest for ages 35–64. For all ethnicities, the number of chronic conditions in females 65+ ranged from 5.07 to 5.47. Younger (18–34) Hispanic/Latina and Asian/Pacific Islander women had the lowest numbers of chronic conditions.

Female Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges
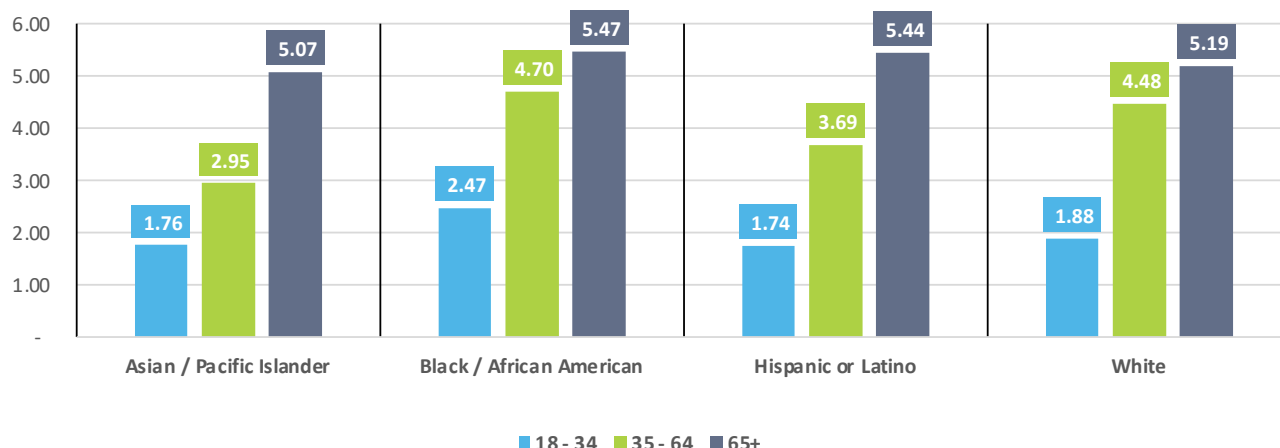
The average number of chronic conditions increased across all races for the 65+ group in 2020. Both Asian/Pacific Islander and Hispanic or Latina females in the 18–34 group saw decreases in the number of chronic conditions while Black/African American and White females in that age group saw increases.

Female Average Number of Chronic Conditions by Race and Age Range 2020 Discharges
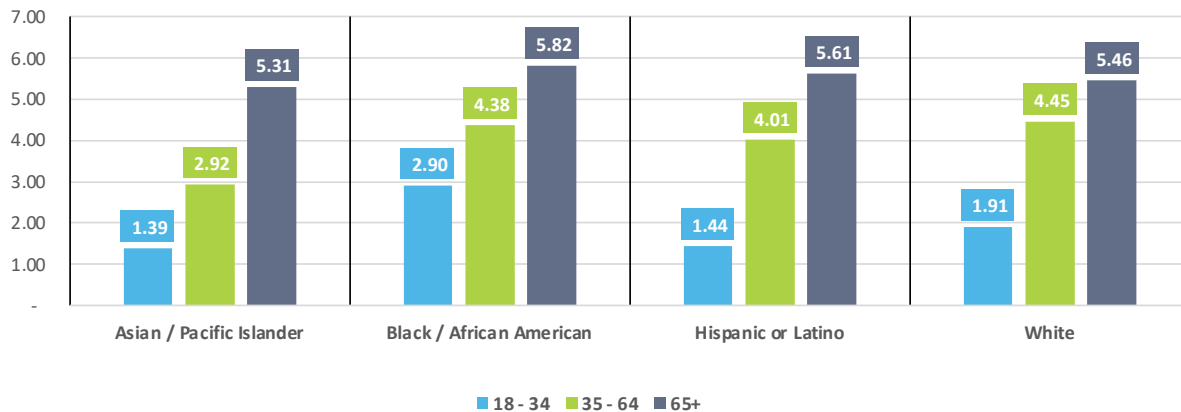
San Gorgonio Memorial Hospital PSA
Chronic Conditions — Youth

Asthma was the most common chronic condition in males ages 0–17, followed by depression, drug use disorders and certain mental/behavioral health issues such as ADHD and bipolar disorders. For females, the most common conditions were depression/anxiety, followed by asthma and anemia. Young Asian/Pacific Islander males had a high rate of chronic kidney disease.

1–17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Chronic Kidney Disease	30.0%	Asthma	36.4%	Asthma	25.5%	Asthma	25.1%
Sensory — Deafness and Hearing Impairment	23.3%	ADHD Conduct Disorders and Hyperkinetic Syndrome	32.5%	Depression	20.7%	Depression	24.2%
Intellectual Disabilities and Related Conditions	23.3%	Drug Use Disorders	22.1%	Depressive Disorders	19.7%	Depressive Disorders	23.8%
Obesity	13.3%	Bipolar Disorder	22.1%	ADHD Conduct Disorders and Hyperkinetic Syndrome	15.6%	ADHD Conduct Disorders and Hyperkinetic Syndrome	17.7%
Depressive Disorders	13.3%	Epilepsy	19.5%	Obesity	10.8%	Anemia	12.1%
Depression	13.3%	Depressive Disorders	18.2%	Epilepsy	10.5%	Epilepsy	11.3%
Asthma	13.3%	Depression	18.2%	Drug Use Disorders	9.9%	Drug Use Disorders	11.3%
Epilepsy	10.0%	Schizophrenia and Other Psychotic Disorders	11.7%	Autism Spectrum Disorders	9.2%	Intellectual Disabilities and Related Conditions	9.1%
Cerebral Palsy	6.7%	Anemia	11.7%	Anemia	8.3%	Anxiety Disorders	9.1%
Traumatic Brain Injury and Nonpsychotic Mental Disorders Due to Brain Damage	3.3%	Intellectual Disabilities and Related Conditions	10.4%	Spina Bifida and Other Congenital Anomalies of the Nervous System	7.3%	Autism Spectrum Disorders	8.7%

1–17 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Asthma	29.2%	Depression	52.5%	Depression	35.7%	Depression	40.4%
Depressive Disorders	20.8%	Depressive Disorders	46.3%	Depressive Disorders	35.4%	Depressive Disorders	38.3%
Depression	20.8%	Asthma	28.8%	Anemia	17.0%	Anxiety Disorders	18.3%
Anemia	16.7%	Epilepsy	22.5%	Anxiety Disorders	15.0%	Asthma	13.6%
Mobility Impairments	12.5%	ADHD Conduct Disorders and Hyperkinetic Syndrome	18.8%	Asthma	13.6%	Epilepsy	11.5%
Intellectual Disabilities and Related Conditions	12.5%	Drug Use Disorders	15.0%	Chronic Kidney Disease	10.9%	Drug Use Disorders	9.8%
Acquired Hypothyroidism	12.5%	Anxiety Disorders	11.3%	Obesity	9.9%	ADHD Conduct Disorders and Hyperkinetic Syndrome	9.8%
Spina Bifida and Other Congenital Anomalies of the Nervous System	8.3%	Other Developmental Delays	10.0%	Leukemias and Lymphomas	7.5%	Intellectual Disabilities and Related Conditions	9.4%
Schizophrenia and Other Psychotic Disorders	8.3%	Intellectual Disabilities and Related Conditions	10.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.5%	Migraine and Chronic Headache	6.4%
Muscular Dystrophy	8.3%	Schizophrenia and Other Psychotic Disorders	6.3%	Drug Use Disorders	7.1%	Anemia	6.4%

San Gorgonio Memorial Hospital PSA
Payers and ED Visits

Medi-Cal is the primary payer for Hispanic or Latino and Black/African American patients ages 18–34 and 35–64 in the San Gorgonio Memorial Hospital PSA. People over age 65 in all ethnic groups are generally covered by Medicare, with a small percentage of Medi-Cal payers in people 65+.

Percent Primary Payers by Race/Ethnicity and Age Range
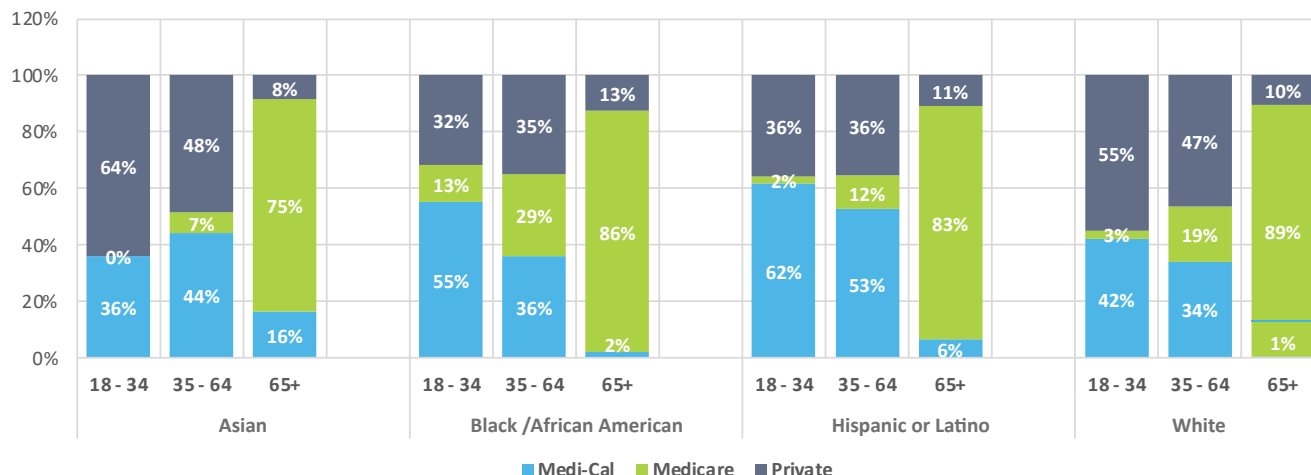
Avoidable ED Visits

The charts below show avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. The top payer for avoidable ED visits at San Gorgonio Memorial Hospital is Medi-Cal, followed by Medicare HMOs. Youth 1–17 have been the greatest users of the ED, but the numbers declined slightly in 2020, as did visits for all age groups. The numbers for the social drivers for these ED visits are very low, likely due to tracking methodology. Z codes, which are used to identify social determinants, are severely underreported (as with other hospitals). Hispanic/Latino people have the highest rate of ED use.

| | Visits by Volume | | | | | Avoidable Visits | | | | |
Category	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total	40,287	39,684	40,760	31,882	-8,878	52%	53%	53%	52%	0

Top 5 Payers by Volume	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	20,448	19,336	19,445	13,700	-5,745	58%	57%	57%	52%	-6
Health Maintenance Organization (HMO) Medicare Risk	8,380	8,500	8,756	7,167	-1,589	48%	48%	47%	45%	-3
Health Maintenance Organization (HMO)	2,189	2,476	2,764	3,144	380	48%	51%	50%	45%	-2
Preferred Provider Organization (PPO)	3,202	3,119	3,471	2,377	-1,094	50%	49%	50%	47%	-3
Self-Pay	2,330	2,349	2,399	2,034	-365	49%	49%	49%	44%	-4

Age Groups	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	1,120	984	974	568	-406	63%	67%	68%	63%	1
1–17 Years	8,320	7,740	8,197	4,630	-3,567	58%	58%	58%	52%	-6
18–34 Years	9,776	9,371	9,534	7,869	-1,665	53%	51%	51%	47%	-6
35–64 Years	12,858	13,160	13,417	11,394	-2,023	52%	52%	52%	49%	-3
65 Years or Greater	8,213	8,429	8,638	7,421	-1,217	48%	48%	47%	45%	-4

Social Determinants	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	80	67	10	11	1	44%	52%	50%	18%	-26
Primary Support Group and Family	2	9	9	10	1	50%	11%	22%	40%	-10
Other Psychosocial Circumstances	3	-	1	10	9	0%	0%	0%	30%	30
Upbringing	5	5	2	5	3	20%	60%	50%	40%	20
Occupational Risk	6	4	6	4	-2	17%	25%	17%	0%	-17
Social Environment	2	3	3	-	-3	0%	33%	0%	0%	0
Employment	1	2	1	-	-1	0%	0%	0%	0%	0
Education and Literacy	1	4	2	-	-2	100%	0%	0%	0%	-100

Race/Ethnicity	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	1,212	1,185	1,269	918	-351	54%	55%	53%	51%	-3
Black / African American	4,256	4,291	4,325	3,171	-1,154	55%	56%	56%	52%	-4
Hispanic or Latino	15,308	15,258	15,783	12,336	-3,447	56%	55%	55%	50%	-6
White	18,179	17,682	17,863	14,147	-3,716	50%	49%	49%	46%	-4

Mental health ED primary diagnoses in the San Gorgonio Memorial Hospital PSA have dropped since 2016, and most significantly in 2020.

ED Visits for Mental Health Conditions
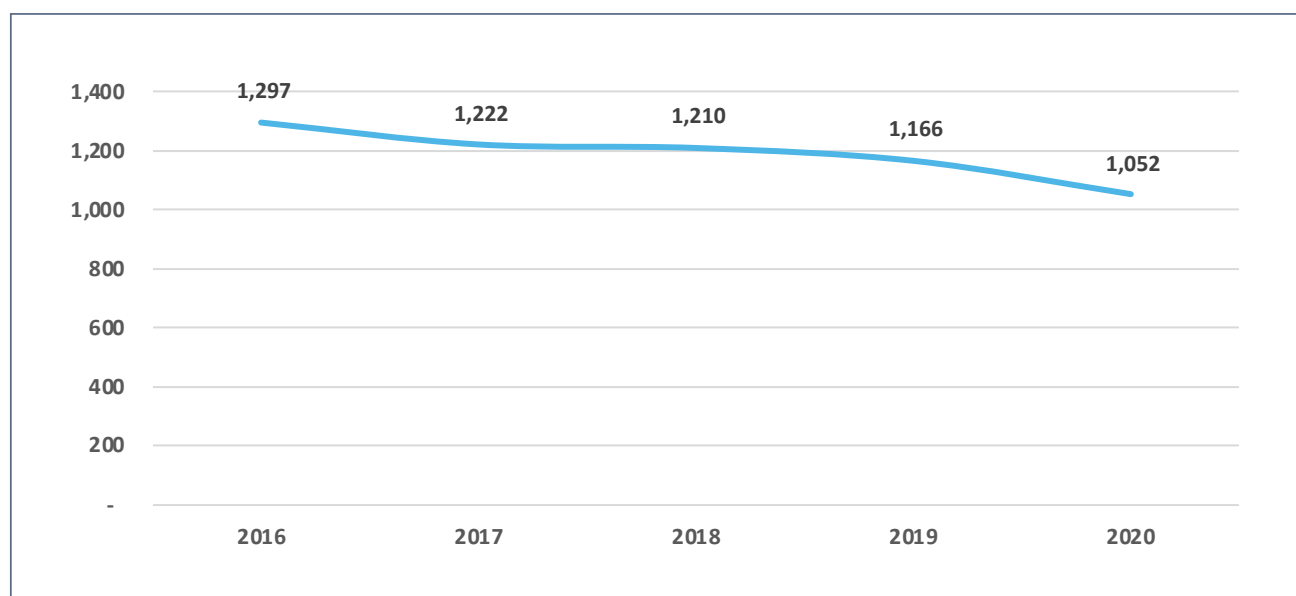
Appendix Q: Listening Session Report

Community Listening Session Report

May 10, 2022

Project Description: The Inland Empire Health Plan, HC[2] Strategies and regional hospitals conducted a collective health and equity needs assessment to identify systems and policy improvements with dedicated resource flows to address inequities in San Bernardino and Riverside counties. HC[2] engaged The Social Impact Artists (SIA) on April 6, 2022, to conduct seven focus groups in under-resourced areas to talk with residents and workers who do not typically engage in traditional regional needs assessments, including immigrants, youth, working-class individuals and those identifying as BIPOC (Black, indigenous and people of color). Focal points of our community-participatory process included health care access and usage, humane housing, mental health needs, substance use, and chronic disease. To effectively engage BIPOC people, whose opinions, experiences, and proposed solutions are vital to addressing systemic inequity, SIA deployed four immigrant, bilingual community engagement workers who are well-trained in effectively and compassionately conducting outreach to and dialoguing with underserved communities in Spanish and English. SIA trained the team about project goals, with a particular focus on incorporating the Vital Conditions for Well-Being Framework and Framework of Disease.

Executive Summary: To better understand the root causes of disease and inequity as well as the lived experience of residents and health care end users (or future users) in the Inland Empire, SIA conducted eight focus groups across the Inland region with a total of 49 unique participants from April 11 to May 9, 2022 (see Figure 1). SIA conducted 22 hours of outreach to target underrepresented, under-engaged people living in hard-to-reach or isolated geographic areas, including specific underserved neighborhoods (Transformative Climate Communities zone in Ontario, California). When possible, SIA also used its trusted network of resident leaders and community-based organizations to work strategically, timely and effectively.

Youth and adult residents and workforce members made up the focus groups with outreach and research occurring in the geographic areas of:

- San Bernardino County: Ontario, Rialto, Big Bear/Arrowhead, Victorville/Hesperia

- Riverside County: Hemet, Perris, Menifee, Moreno Valley, Homeland (unincorporated area)

SIA also conducted outreach in Needles, California, but the execution of quality focus groups in this area proved to be unattainable within the timeline specified by the Stakeholder Committee for the project.

SIA designed the project to improve the understanding of the following:

- Current experiences and viewpoints of health care end users not usually "heard" in traditional regional needs assessment processes

- Current needs and tenable solutions in areas without or with sub-optimal services

- How to incorporate residents' voices to support regional conditions for well-being and improved resource flows

- How residents might co-create a collective health stewardship model for the Inland region

Across the region, focus group participants — outside of the few who were born and raised in the region — shared that they moved to the Inland Empire area because housing was affordable, and the area was peaceful and more "calm" than Los Angeles or other urban areas from which they came. One participant who has lived in Moreno Valley for 25 years said, *"[She] saw that children were on their bikes in the streets, and it was peaceful, and the schools were great."*

Participants made it clear during the conversations that they are invested in the region, clearly see the need for improvements and want to take some level of leadership to improve it for themselves and for their children and/or grandchildren. P*articipants were adamant that fundamental, actionable changes in their community are needed immediately*. The immediacy seemed partially related to having just exited what participants hoped would be the worst part of the COVID-19 pandemic and related to their perceptions that their communities are unhealthy and that immediate solutions are critical.

Participants also expressed that over the last five years [see pages below for data]:

- Youth quality of life must be improved at all levels; need more youth interventions.

- Anxiety, stress, depression and mental health issues have become the number one priority.

- Systemic discrimination against individuals identifying as Black/African American and Latinx persists.

- The region has become too crowded and there are too many factories/warehouses.

- Health care: need facilities, better quality of care, faster response and warmer interactions.

- Traffic has become unbearable.

- Homelessness has become a significant public health issue.

- Violence and crime have increased and adults fear for their children's safety and future.

- There has been a steady and significant decline in free or low-cost community-based programming with a simultaneous decrease in social cohesion.

Participants resoundingly expressed high levels of commitment to improving their communities, and prioritized the following health issues:

- Improved youth programming: mental health, health, schools, arts and entertainment.

- Access to health care with improved user experiences.

- Diabetes, obesity, high blood pressure and cancer.

- Free and low-cost mental health and substance use recovery resources.

- Addressing the affordable housing shortage

- Improving safety in their communities

Because the region is experiencing growth while recovering from the economic and social impacts of the COVID-19 pandemic, participants also demonstrated *frustration, disillusionment, fatigue and a general mistrust of government and systems.* They made it clear that they want to see improvements across the following domains:

- Free or low-cost mental health resources embedded in neighborhoods and within traditional health care settings coupled with better training for school-based counselors

- Increased affordable housing stock and/or rental assistance programs

- Appropriate, quality and person-centered health care services that are geographically equitable

- Improved access to and more positive user experiences in health care

- More *health* and youth programming at schools, within community centers and in health care

- Investments in community cohesion programs and a return of robust Healthy Communities programming (provided through the San Bernardino County – Department of Public Health)

- Safer and more walkable communities; also explore localized transportation options

- Traffic remediation solutions

- Increased access to healthy foods (fresh, affordable produce) and nutrition and fitness education

- More resources, higher accountability and better training for teachers and school staff

- More community safety investments

1. **Methodology:** This study employed focus groups to examine the experiences and opinions of residents and workforce in the Inland Empire. The SIA team conducted extensive outreach and then held eight focus group conversations led by five Inland region residents, three of whom are female multilingual immigrants who are trained and experienced community engagement leaders and community health workers. Evette De Luca, who holds a master's degree in social impact and has led multilingual community engagement work in the Inland Empire and South L.A. for 17 years, spearheaded the project and conducted three sessions to train focus group leaders on the objectives, focus group tools, regional logistics and record keeping.

   SIA conducted in-person outreach to engage participants in Big Bear, Lake Arrowhead, Hemet, Perris, Ontario, Moreno Valley and Rialto. The organization conducted outreach through email and social media in Needles, Perris, Menifee and Rialto. They used their trusted partner network to take a system approach to outreach, including National CORE Renaissance, El Sol Neighborhood Educational Center and Rim Family Services.

a. **Instrument Development:** HC[2] Strategies provided a list of questions and a focus group script. SIA translated the script and questions into Spanish and developed a training curriculum to quickly train its team. The organization then beta-tested the script and questions within its team of resident leaders, and then within Focus Group #1 conducted in Ontario, California. SIA developed flyers for outreach, notetaking tools and protocol and focus group checklists; and purchased gift cards and refreshments.

b. **Site Selection:** Sites were selected using three criteria: 1) at least two were located within geographic priority areas; 2) all were easily accessible to the community participants (walking prioritized at the apartment complex and libraries; 3) all were able to be scheduled with focus groups occurring before the May 9, 2022, cut-off date. SIA conducted five focus groups *in-person* at libraries, community centers and an affordable housing complex; and three *virtual* focus groups. Participants received free refreshments, incentives and a $20 gift card for their participation. Virtual participants received electronic gift cards.

c. **Participant Selection:** SIA's team conducted extensive outreach through phone calls, emails, social media, at health fairs, hospitals, pharmacies, laundromats and libraries, and by door-to-door visits to businesses and dwellings. Participants were selected based on the following criteria: 1) Residents or workforce who had lived/worked in the Inland region for at least one year; 2) Residents or workforce who lived and/or worked in at least two of the low-service prioritized neighborhoods of the Mountain Communities, Perris, Hemet, Needles, Barstow, Trona or Blythe; 3) Spanish-speaking and BIPOC residents who sought services at libraries and affordable housing complexes; 4) English- and Spanish-speaking patients from Mountain community hospitals; 5) Residents who attended free health fairs; and 6) Youth or youth-serving organizations, including IE Immigrant Youth Coalition.

d. **Limitations:** As with all methodologies, qualitative research has benefits and limitations. Qualitative research allows for detailed, in-depth examinations of issues. In contrast to quantitative research, which aims at being generalizable across populations, qualitative research seeks to add texture and dimension through data collection focused on the nuances of human experience. As a complement to quantitative research, qualitative research can afford deeper insight into complex issues. The present study has several limitations that readers should consider while interpreting the results. First, the number of total focus group participants (n=49) only represents less than 1% of the approximately 4 million people who live in the region. Second, SIA asked individuals to participate in the focus groups based on their interest, willingness and availability. This may have introduced some degree of self-selection bias. Lastly, due to the project timeline stipulated by the Stakeholder Committee, the organization had about 30 days to execute. This timeline created some constraints regarding optimal adult and especially youth participation.

e. **Focus Groups:** SIA held eight focus groups addressing 12 questions.

This report describes the insights gathered from eight focus group discussions, cross-cutting themes and geographic variations. It also includes recommendations for the Stakeholder Committee. Additionally, SIA engagement team members are well-rooted and embedded deeply in their communities. The outreach team used their personal and professional networks to engage residents to participate in the focus groups.

Date/Time	Location	Language/ Target Audience	Outreach: # of People	# of People in Focus Group
April 11, 2022 12:30 p.m.	Ontario Ovitt Library	English and Spanish Adults	27	9
May 3, 2022 10 a.m.	Rialto: Citrus Grove & Vista Cascade Affordable apartments (National CORE)	Spanish	192 residents	6
May 4, 2022 8 a.m.	Mountain Communities, Rim Family Services/ Virtual	English Adults	36 businesses	9
May 5, 2022 12 p.m.	Valley Vista Community Center, Hemet	#1 Spanish #2 English	39 Hemet youth and adults	3 5
May 6, 2022 11 a.m.	Perris Library	Spanish Adults	128 (Perris Health Fair)	6
May 7, 2022 10 a.m	Menifee/Homeland — Virtual	English Youth	22	3
May 9, 2022 6 p.m.	Moreno Valley/ Victorville/Hesperia — Virtual	Spanish	48	8
Totals			**492**	**49**

Figure 1. Focus Group Information

2. **Participant Profiles:** All participants were residents of the Inland Empire with a range of 1–50+ years as Inland Empire renters or homeowners. Most participants work in the Inland Empire.

3. **Demographics:** All participants were residents of the Inland Empire with a range of 1–50+ years as Inland Empire renters or homeowners. Most participants work in the Inland Empire.
   a) Number of focus group participants: 49
   b) Age range: 1) three youth, ages 24 or younger; 2) 46 adults, ages 25 or older
   c) Gender: 90% (43) female; 10% (5) male.
   d) Other: SIA facilitated four English focus groups, four Spanish focus groups and one focus group in English and Spanish.

4. **Discussion Results:** In this summary, SIA focuses on the high-level, cross-cutting themes that emerged across communities in its key areas of inquiry. In addition, SIA details the most important community-specific findings that emerged in these conversations by city. Finally, the organization summarizes the most frequently discussed ideas for improvement raised by participants, shares salient community quotes by city and presents community recommendations. Two tables below summarize community health problems and challenges.

Community Health Problems (ranked in order of most responses)

Ontario	Perris	Mountain Communities	Rialto	Hemet (Two Focus Groups)	Moreno Valley/ Victorville	Menifee
Mental health	Diabetes	Substance abuse	Diabetes	Mental health/ childhood trauma	Diabetes	Anxiety
Diabetes	High blood pressure	Mental health/ anxiety/ childhood trauma (especially youth and seniors)	Heart disease	Substance abuse	Mental health	Depression
Obesity	Depression		Mental health	Domestic violence/ community violence	Cancer	Substance abuse/ vaping
Homelessness/ housing	Substance abuse	High blood pressure	High blood pressure	High blood pressure	Allergies	Stress
Cardiovascular disease	Allergies	COPD (especially seniors)	Cancer	Cancer	Effects of COVID-19	Overweight/ obesity
		Allergies				

Figure 2. Community Health Problems

Environmental and Community Issues (ranked in order of most responses)

Ontario	Perris	Mountain Communities	Rialto	Hemet (Two Focus Groups)	Moreno Valley/ Victorville	Menifee
More factories/ poor air quality	More factories	Affordable housing crisis (effect of Airbnb and short-term rentals)	Homelessness	*The top six issues of both focus groups are combined below.*	Increased crime	Poor public transportation
Affordable housing shortages	Increased traffic	Access to health care (higher quality health care)	Increased crime/violence (theft/shootings)	Community and school-based violence	Increased community violence	Lack of accessible outlets for youth
Homelessness	Illegal dumping in abandoned lots	Lack of community/ youth center	Poor air quality	Domestic violence	Excessive marijuana dispensaries, alcohol outlets, smoke shops (including e-cigarettes and paraphernalia)	School issues: lack of training for teachers and aids to cope with youth behavioral issues/ lack of effective mental health resources and youth campaigns
Increased crime	Poor air quality	Need substance abuse support groups	Increased community violence	Low-quality schools (low educational attainment; quality of teachers and programs; low-quality food)	Homelessness	Lack of entertainment for youth
Need substance abuse support groups	Excessive marijuana dispensaries	Low-quality schools / school under enrollment (decrease from 1,200 to 900 students)	High cost of healthy food	Affordable housing (especially for seniors)	Illegal dumping	Lack of sidewalks and walkability
				Access to health care (higher quality health care)		
				High cost of healthy food		

Figure 3. Environmental & Community Issues

General Overall Viewpoints

Assets: Most residents shared that they moved to the Inland Empire area because housing was affordable and the area was peaceful and more "calm" than Los Angeles or other urban areas from which they relocated (including Mexico City). One participant who has lived in Moreno Valley for 25 years said, *"[She] saw that children were on their bikes in the streets, and it was peaceful, and the schools were great."* Most participants would still recommend that friends and family move to the Inland region *"because there are many job opportunities, affordable homes, and it is peaceful."* They reported that the Inland region is still economically attractive even as the majority stated that there has been a steady decline in community safety, quality of life and services. *"You get more for your money. In Los Angeles, houses are smaller, older and more expensive."* Many participants also stated that the Inland region is attractive because the employment market is desirable. *"It is easy to find a job here, but more and more jobs are in warehouses… that is a problem."* Most participants worked in the Inland Empire and did not have to commute to Los Angeles, thus they felt more rooted in the community in which they lived.

Faith-based organizations: arose as vibrant assets across all regions and focus groups, both as maintainers of community fabric and providers of free resources and support. Several stated that they turn to their pastors and church families for mental health counseling and resilience support.

Improvements in the built environment: Ontario, Rialto and Menifee residents mentioned that they have seen growth in certain parts of their communities, especially related to green spaces, additional or renovated parks, walking paths and new food retail outlets.

Youth and adult residents and workforce members made up the focus groups with outreach and research occurring in the geographic areas of Ontario, Perris, mountain communities, Rialto, Hemet, Moreno Valley, Victorville/Hesperia and Menifee.

Community Assets

Ontario: Participants view their largest assets as the free Zumba classes and programming that community centers provide, strong faith-based organizations, great recreation centers and programming for children, good park systems and good schools and services. "You get more for your money. In Los Angeles, houses are smaller, older and more expensive." Many participants also stated that the Inland region is attractive because the employment market is desirable. "It is easy to find a job here, but more and more jobs are in warehouses…. that is a problem." Most participants worked in the Inland Empire and did not have to commute to Los Angeles, thus they felt more rooted in the community in which they lived.

Health Care: Participants stated that lack of health insurance is still a challenge in the city, primarily due to residents who do not have citizenship status. Several stated that they use urgent care facilities located in Ontario to access health care. Others used Kaiser Permanente Ontario Medical Center and expressed satisfaction with services. Access to mental health and dental services arose as the most significant needs.

Community: Mental health (anxiety, panic attacks and depression) referrals and services are most needed. One participant talked about 211 and the gaps in quality referrals, stating, *"211 is not enough. The referrals aren't very helpful. We need more. OMSD [Ontario Montclair School District] used to provide referrals and help, but they don't anymore."* Another mentioned domestic violence and that she had called House of Ruth, a local community-based organization, for help *"a month ago and they have not called me back."*

Solutions: 1) One participant mentioned how impactful Healthy Ontario had been and hoped *"that the city or another organization would bring the programs back. I wish the city had not gone away [sic] with Healthy Ontario."* 2) Another participant requested more peer support groups ("similar to 12 steps") for mental health, substance abuse and domestic violence; 3) Participants said it is too expensive to live in Ontario, and that assistance programs are needed (rent, utilities, food and affordable housing). 4) All participants requested more family and youth programming in the community.

Perris: Participants expressed reserved appreciation for the growth in their community. *"There are more shops, more fast-food restaurants and more factories." "The community has grown and progressed, and there are better schools." "I would persuade people to move here because it is a safe community." "It is a good area; I have been out at 2 a.m. by myself and do not feel afraid."* One participant mentioned the historical and systemic discrimination against Blacks and Latinos that persists in the city.

Health Care: Residents stated that they prefer to access health care at local clinics, with several saying that they go to Riverside clinics. However, many participants stated that they must wait at least three weeks to receive an appointment to see their doctor, which makes usage of emergency services more viable, *"unless I go to emergency and in emergency, I have to wait eight hours or longer."* One resident stated that she had IEHP for about 20 years, but when she turned 65, she switched to Kaiser. She said she missed IEHP because she *"preferred to get brand name medication and with Kaiser, she only gets generic brands."* She also stated that IEHP providers delivered better specialty care services.

Community Voices: Participants shared differing views about safety in their community. *"Five years ago, my neighborhood was calm; now every week there are shootings and parties." "My street has become a freeway. People do not respect the speed limit, cars are going more than 80 miles an hour and residents cannot even go outside for walks."* They also stated that youth have limited job opportunities. *"Yes, there are more jobs being created, but many times companies bring their own workers from other communities, which excludes locals living in Perris."*

Solutions: 1) Residents would like a community or resource center in Perris where they can access exercise and health education classes, especially exercise, nutrition and 12-step programs. *"Currently there are senior centers for the elderly and teen centers for the youth, but no centers for people ages 20–50. Currently, the closest center is Riverside or San Bernardino, and we would like to have a center in Perris. To go to these centers, we need transportation. There is no transportation that can take us to and from the centers." "[We] need more places where residents who want to better their lives, health, and recover from an addiction can attend. For example, there is an AA center, but only one."*

Mountain Communities: Participants view their largest assets as their neighbor and faith-based networks and stated that *"we have a lot of churches, and they take care of people."* A housing crisis exists for locals with many youths and adults *"couch surfing."* Due to supply shortages, residents are having to rely on Amazon as their supplier of personal and household items.

Health Care: All participants agreed that health care access and quality of care need to be improved in the mountain communities. Half stated that they either access virtual services through Kaiser Permanente or had to drive down to the Valley for emergency services at Loma Linda or Kaiser Permanente, but *"were grateful for KP's ability to meet online."* When discussing Bear Valley Community Hospital, participants became very energized. One stated that *"Bear Valley is hit or miss."* When discussing Mountains Community Hospital, one stated, *"Let's be honest, it is the joke on the mountain. It's better to wait for an ambulance at the hospital to take you down the mountain, than to get medical attention at the hospital."* A participant mentioned, and the group agreed, that the Mountain community needs more clinics and one member stated that she would like more *"clinics in grocery stores."*

Community Voices: Participants expressed frustration and low-level anger about the changes their communities are experiencing due to the impact of Airbnb and short-term rentals, as well as the increase in retail establishments that sell alcohol to the tourist trade. They feel like the *"ground has literally been taken out from under us."* They also expressed that youth are experiencing high stress and mental health issues. *"Schools could be more involved. Freshman students used to have a health class, where they would focus a whole unit on mental health, [we] need to bring these types of classes back to the curriculum…It is battle with funding and district employees."*

"Housing [shortages] have become chronic. Many people are 'couch surfing' and others have multiple generations living in one small place. Locals are struggling because rent is so high, and it is hard for them to find an affordable place to live…it used to be that it was cheaper to live up here on the mountains. That's no longer the case."

Solutions: 1) School enrollment at Rim schools has decreased by 25% due to a shift in home-schooling. A participant stated that all health classes have been eliminated at Rim schools. She suggested that adding health classes and youth Mental Health Days back into the school curriculum would benefit the community. Another stated that youth are *"over"* Zoom. They need to meet face-to-face, and interventions need to happen at school during the school programming. 2) One participant shared that Big Bear has no youth centers and requested that IEHP create a youth center like the resource centers that they have created in other areas. 3) Participants requested more support groups, community programming, town events and parades for locals, and community-based mental health programs.

Rialto: Participants view their community as generally healthy, especially new developments such as Renaissance Market Place and recently renovated parks. *"[There are] Excellent changes. [I'm] happy that there are more options in terms of shopping and places to eat nearby. Grateful for the new Renaissance Market Place and happy that is it nearby. I love it; I go often to get something to eat." "[The city] added several parks, and renovated parks off of Easton, [and] added a walking path."* However, one participant stated that community violence has increased greatly: *"Don't come here, if I can get away, I am gone. It is outrageous; there are too many people here."* She stated that she had seen a lot of community violence, crime and that there are growing issues with the homeless people.

> **Health Care:** All participants agreed that health care access and quality of care were relatively good in their community and that they didn't have to travel far for quality medical care. Pinnacle Medical Group/Urgent Care and Rialto Clinica Medica were listed as clinics that provided generally positive health care services. Participants mentioned Western Dental as a local resource for dental health care. Participants had many questions about IEHP, and the SIA team provided contact information for IEHP.

> **Community Voices:** Participants stated that the price of food is *"very high and it is harder and harder to afford to buy groceries and the healthy food is too expensive."* Another stated, *"I can only afford the unhealthy stuff because the healthy stuff is so expensive. If they make the healthy stuff affordable a lot of us would not have a lot of health problems that we have."*

> *"Find something to do for the kids…. Kids need to focus on something else instead of being bad."*

> (When probed about what *"being bad"* meant, she mentioned that the youth in her apartment complex acted out due to anger and depression.)

> **Solutions:** 1) Free youth mental health programming, art programs and sports programs. 2) Like many other communities, participants requested free Zumba classes, more community centers and free adult mental health counseling.

Hemet: Participants view their largest assets as affordable homes, peaceful, natural spaces with lots of areas where youth can bike and be active. *"The houses are cheaper than L.A., but the school district is not good." "The air is cleaner in Hemet. My son had allergies when we lived in L.A. They went away when we moved here."* Participants prioritized youth programming to alleviate community violence. *"It's quiet here but we need more than that. We need more programs for the kids. They are bored. But the existing programs are too expensive. We can't afford $800. And there are 200 kids in every program."*

> **Health Care:** All participants agreed that health care access and quality of care need to be improved in Hemet. Emergency care is a priority: Three participants expressed that they had to drive at least 30 minutes for their emergency care. *"We want a Kaiser emergency room here. I can go to the Target and make Kaiser appointments, but I must go to Murrieta or Temecula for emergency services."* Another stated that she and her family also had Kaiser, but the price is too high for her: *"We have Kaiser, but we have to pay $350 per week for Kaiser. It is not fair!"*

> Other participants had Medicare and went to Innercare at Hemet, but not recently. For dental services, some participants accessed low-cost care at Health System Inc.

Behavioral health services are desperately needed in the community: *"There is a place on Ramona Expressway where people with a mental health emergency can go, but they only receive medication and then they are sent back home. Moises Ponce had a clinic with occupational therapy. People suffering a mental health illness could learn artwork…. learn how to crochet and make scarfs, which they can later sell."*

Community Voices: All participants expressed appreciation for the open space and parks in the city, but also expressed that disillusionment, violence and crime prevented full access to these spaces. Significant attention must be paid to address school-based violence, participants said. Comments included: *"We are too fragmented. People don't show up to meetings. They aren't engaged." "In Hemet, people don't care. They don't want to help people." "We see violence, domestic violence in the families, and substance abuse, but our kids don't want us to tell anyone about these." "We urgently need a domestic violence treatment program here. Three of my daughters' friends' families are experiencing this now."*

"We want an IEHP resource center here. I've heard that IEHP made resource centers in other cities. Maybe in San Jacinto? But Hemet would be best."

"All we have here is food. We need activities. There is a skating park here, but it is $20 per person. We can't afford it."

We have beautiful parks here, but people are afraid to come here because of the violence."*

"The city doesn't have enough funds to keep the city services going. The funds are not there, so the streets aren't clean."

"My family moved here a year ago. Moved from L.A. County. I feel disappointed. The school is not good. My son said this is not what he wanted. We are planning to move back to L.A. if things don't get better. I couldn't afford to live in LA. But am I investing in a house, but not my child's education? I was renting a two-bedroom apartment for $1,475. It's cheaper here, but the education here is low. My kids finish their schoolwork in class, and they are bored. The other kids are not listening, playing around and the teachers don't care. My kids call the schools 'ratche.' My kids won't eat the food at school. They say it is 'nasty.'"

"I already see my son getting into trouble. He wasn't like this before. He had a cut on his arm, and he wouldn't tell me how it happened at school. I noticed on Friday that he was hiding from me, was in a bad mood and went in his room and wouldn't talk to me. He said, 'Kids are just bullies here. You need to defend yourself.' But he said: 'Don't tell anyone, Mom.' I don't know what to do. Bad things are happening in school, and the parents don't even know."

Solutions: 1) Residents would like more free programs (*"like there once was"*), including ESL classes for adults, computer classes for adults, mental health education in schools and free counseling at all levels. 2) More programs for the youth: mental health, sports, arts, entertainment. 3) Domestic violence and youth violence treatment programs or community-based programming. 4) An IEHP resource center or other community center. 5) Healthier school-based food options. 6) Improved teacher training: behavioral issues. 7) More health-care facilities, especially emergency or urgent care facilities.

Moreno Valley: Participants view their largest assets as the economic benefits of Moreno Valley. *"I recommend [people] to move to Moreno Valley because there are many job opportunities, affordable housing, and it is peaceful. You get more for your money. In Los Angeles County houses are more expensive, smaller and older."* Participants stated that schools, churches and the city departments are large assets in their community. Community violence is increasing.

Health Care: Participants stated that they access health care at Kaiser Permanente, Riverside University Health System Medical Center and private clinics. Some residents said that they have to travel to Riverside, because there are better medical and dental clinics there than those located in Moreno Valley, and these are far away.

Community Voices: Participants expressed that the peaceful qualities of their community are changing due to increases in traffic, poorer air quality, increased crime and increased outlets that sell marijuana and other substances. *"There should be more police surveillance, due to the fact that crime has increased. For example, in 2010 the case of Norma Lopez that was [sic] killed and her body was found in an abandoned lot. In one resident's neighborhood there was a drug raid last week. This used to be a tranquil and safe place."*

Solutions: 1) Residents request more public pools and a community center where residents can exercise. 2) Increased safety measures in the community. 3) Free after-school programs for youth.

Victorville/Hesperia: Participants view their largest assets as *"more affordable homes and cleaner air."* One participant who has lived in Victorville for 32 years stated that he *"decided to move to here, because housing was more affordable than it was in Los Angeles and the fact that I thought it was a safer place to raise my children. I saw a lot of gang activity in Los Angeles, and I didn't want my children to grow up around that. I also enjoyed the weather here when I first came."*

Health Care: Several participants accessed care at Kaiser Permanente and expressed satisfaction in the services and patient care. Others accessed care at local low-income medical clinics where *"the consultation and lab work are free."* Participants stated that there are no local dental clinics for low-income families and that local low-cost mental health support is desperately needed.

Community Voices: In general, residents see community changes as good. However, several stated that there have been *"bad"* changes to the community, such as increases in violence, (i.e., *"residents being assaulted with a gun at hand [sic] to take their personal belongings, teens between the ages of 14 and 15 years old are found dead after being reported missing"*). Residents reported that they do feel unsafe.

Like other communities, crowding is occurring: *"We only have one freeway, so traffic has increased."*

"There has been an incredible increase in homeless, vandalism, crime inside and outside of the mall, hate crimes against the African American community, increases in suicide rates, [and] illegal car racing on streets."

Menifee: Youth viewed their largest community assets as safety, clean communities, a growing economy and that *"people seem to respect their neighborhoods."* One youth whose family moved from Ontario to Menifee because housing was less expensive said she *"hated Menifee at first. There was nothing to do. Now there are too many people.*" Youth said that they also appreciated that there were a lot of places to get food, but that there are not enough places for entertainment. Another stated that *"if you don't drive, nothing is accessible."* A primary concern is that *"[youth] have too much stress without enough outlets."* School-based counselors are not effective in combating mental illness. Although awareness seems to be increasing, vaping and substance abuse are issues.

Health Care: Youth said that their experiences with health care was *"OK."* One stated that her doctor wasn't *"warm or friendly."* She said that she felt judged when she met with her doctor and asked about STD testing. Another said that her experience *"felt like a transaction, like getting my mom's oil changed. I didn't feel like the doctor really cared about me."* Another who has accessed care at Kaiser Permanente since a young child stated, *"It's stressful to go to the doctor and our co-pay is high. The lab work is expensive. The costs are high and unexpected. I see random people and I don't feel comfortable."*

Community Voices: One participant began working at Starbucks at age 16 and has had 20 free mental health sessions annually as one of her benefits. She stated that she wished all youth could have a similar benefit and wished similar resources were offered in schools. Another mentioned that she and her friends don't want to get driver's licenses even though Menifee is not a walkable community, because *"traffic causes us too much anxiety and stress. I don't want to get on the freeway."*

"In my generation, most youth have anxiety and depression. A lot smoke to feel better."

"In my high school there was a designated drug bathroom. It was very easy to get drugs."

"High school counselors aren't the best to share with…They aren't trained to handle the mental health needs of students. They aren't helpful with listening and don't have the resources to really help us."

"So many people are vaping because they are anxious. They would even vape in class…. but what else is there to do out here? [Vaping] is a casual, fun, petty thing."

"We have a lot of mental health problems because of social media and because of drugs. Anxiety is most prominent."

"There is a stigma that youth can't take things seriously. Also, adults designed the mental health campaigns, and they were too campy." When probed to unpack the term *"campy,"* the participant said the campaigns were *"dumb"* and trying too hard to be *"cool."* They mentioned that school-based youth mental health resources are *"superficial," "they do nothing to help us actually treat our problems."* She also shared that the school-based mental health outreach campaigns are ineffective and seem designed by adults *"or popular kids who don't understand the problems kids like us are really facing."*

"Youth have a betrayal mentality. If they confide in you and you share with an adult, they feel betrayed. Because they feel it's shameful to get [mental health] help. I remember in middle school, friendships would end if you shared about your friends' mental health problems."

Solutions: 1) Free quality therapy (can be virtual if needed) within schools or an increase in training resulting in more qualified school counselors. 2) More community and school-based arts programming and events. 3) Create peer support groups and programming in schools and communities. 4) More sidewalks in Menifee and surrounding areas. 5) More libraries, movie theaters and entertainment venues for youth and young adults.

5. **Recommendations: Community Care Model.** The idea of community care, essentially, is to use individual and collective power, privilege and resources to support people who are both in and out of one's scope of reach. That can be a friend, a neighbor, a colleague or a member of an organization that one frequents. It can also look like activism, practicing anti-racism, calling out injustices, donating to organizations or simply asking someone, "What do you need and how can I help you?" In turn, people also receive help from the very community they are a part of. Community care is the foundation of togetherness; by cultivating it, people are better able to support their well-being and that of their neighbors, co-workers and loved ones.

   This model is a meaningful solution given the observations that residents shared about the decline in community resources and services. While this model can run counter to the American cultural conditioning of independence over interdependence, even the most "conservative" of focus group participants ("conservative" was the word that Mountain Community participants used to describe themselves and their community) seemed interested in growing community cohesion and care. One Big Bear participant said, *"We've lost our connectedness. We want our sense of community back."* A Hemet participant who moved from Los Angeles County because she and her family could afford a home in Hemet, said, *"I don't think [Hemet] is healthy. We are too fragmented. People don't show up to meetings. They aren't engaged."* This model also makes sense given that many participants stated that their neighborhood and faith-based networks were the largest assets in their area. Participants in Ontario, the Mountain Communities and Hemet agreed that faith-based networks were one of their largest community assets. *"Churches are the only groups taking care of people."*

6. **Challenges and Pain Points:**

   Decline in Community Services: Across all focus groups, community members who had lived in the region for at least 10 years or more mentioned that they have experienced a steady decline in free community-based programming such as mental health and health resources for youth, ESL classes for adults, computer classes, school-based health and mental health education and civic education classes. This decline arose as a consistent pattern across all focus groups. This reflects a steadily increasing national trend of privatization of community services that were previously firmly in the hands of public entities. Participants stated that this is hurting their families and communities.

   Community Safety: Nearly all participants mentioned (or ranked) increased community violence (including domestic violence) and increased traffic and significant concerns in their communities with an overall perception of feeling unsafe in their communities. Parents expressed deep concern for the safety of their children. Many participants correlated the increase in violence with an increase in substance abuse and homelessness.

School-Based Issues: Many participants, including teachers who participated, stated that schools are no longer community hubs or assets, but have become accelerators of stress, anxiety, depression and even violence. One teacher stated that teachers and aides do not receive appropriate training to effectively address children's, youths' — and their own — mental health and behavioral issues. Parents, especially in the Mountain Communities and Hemet, echoed this opinion. One Hemet parent shared how violence has increased significantly at her son's school. Several participants share about increases in inappropriate sexual activities on school campuses.

Loss of Community: These decreases in service were coupled with a resounding opinion, most pointedly articulated in the Mountain Communities Focus Group, that the region has lost its "sense of community." At least two participants in each focus group articulated that they would like to see more community events tailored especially to residents with the goal of fostering deeper ties in the community with less focus on tourism. This point was most fervent in the Mountain Communities due to the negative impact that short-term rentals, such as Airbnb, have had on the mountain communities.

Cannabis/Marijuana: Nearly all participants described the increase of smoke retail outlets and "excessive use of marijuana" as both a negative community impact and a corollary with increased violence, homelessness, and substance abuse. *"There are many marijuana dispensaries and that is affecting the community. One resident called the police because she was ill, and her neighbors were using marijuana. The police came and told her there is nothing they can do because marijuana is legal and if she did not like it, she had to move elsewhere."* [Perris]

Fast-Food Retail Outlets: All participants stated (or agreed with statements made by the group) that there were too many fast-food retail outlets in their community. "[Victorville] *is unhealthy due to obesity, and nutrition education is much needed. There are many fast-food restaurants, and all foods have chemicals."* [Victorville]

7. **Conclusion:**

Decline in Community Services: Inland Empire residents and workforce are invested in the region, clearly see the need for improvements and want to take some level of leadership to improve it for themselves and for their children and/or grandchildren. *Participants were adamant that fundamental, actionable changes in their community are needed immediately*. The immediacy seemed partially related to having just exited what participants hoped would be the worst part of the COVID-19 pandemic and related to their perceptions that their communities are unhealthy and that immediate solutions are critical.

Investments in the recommendations listed below coupled with stewardship and investments in a community care model may help to alleviate the pain points and stressors identified in this report and augment the identified assets.

1. Invest in school-based health education and interventions that augment the capacity and quality of school education. Hire BIPOC administrators, teachers and counselors.

2. Engage BIPOC youth to co-design these strategies.

3. Provide walkable communities and improved local transportation systems to alleviate traffic, stress and anxiety.

4. Improve customer service when patients access health care facilities, including EDs (make interactions less "transactional").

5. Adult residents have become very comfortable with technology. Make virtual health-care services more accessible when possible.

6. Provide walkable communities and improved local transportation systems to alleviate traffic, stress and anxiety.

7. Increase community centers, resource centers and policies, environmental improvements, interventions and programs that connect local communities and bring cohesion.

8. Increase youth and family programming, centralized youth entertainment venues, libraries and theaters (arts programming).

9. Provide quarterly art programming and "night markets" tailored to neighborhood profiles, interests and demographics. Participants across the region requested more community parades and celebrations.

10. Improve mental health training, resource flows and accountability at local schools; return health education and programming for youth.

11. Improve the food retail environment with outlets that sell fresh produce and natural foods (less chemicals).

One final point is clear: Effective community engagement and resident leadership may be the most sustainable solution to combat the myriad of issues that negatively impact the Inland Empire. Investing in future and regular community conversations and engaging the leadership of residents will be impactful solutions for the region.

Appendix R: Consultant Qualifications

HC² Strategies, Inc.

HC² stands for Healthy Connected Communities. HC² Strategies is a team of influential health system and public health trailblazers. They are experts and thought leaders who are devoted to helping hospitals, health systems, community-based organizations and communities nurture holistic strategies that support community well-being and population health.

HC² Strategies goal is to integrate the clinical and social aspects of community health to ensure health equity and optimize community vitality. HC² Strategies services include strategy, innovation, community engagement, leadership development and executive coaching.

Institute for People, Place, and Possibility (IP3)

The mission of IP3 is to build capacity for communities to make real, lasting change. IP3 provides knowledge and know-how surrounding data and technology, rooted in a deep passion for community partnerships. The institute has a long history of working with large and small organizations to provide data and reporting tools to assess community needs, prioritize investment areas and efforts, share stories for inspiration and develop implementation plans for community improvement.

Over a decade ago, IP3 was privileged to take part in the many national community improvement efforts sparked by the CDC, the Robert Wood Johnson Foundation, Kaiser Permanente, the W.K. Kellogg Foundation, Y-USA, United Way and others. The organization became leaders in the Healthy Communities movement through developing and making publicly available, an online, public-good website bringing community data and stories of success to inspire and drive community change: CommunityCommons.org.

IP3 | Assess, which was used in this CHNA, is a web-based platform that allows the user to easily combine and compare data from multiple sources, surface community insights, align data across organizations and sectors, and move straight into concerted community action. The platform can also create reports that meld secondary quantitative data with primary qualitative data.

SpeedTrack, Inc.

SpeedTrack believes that human intelligence and its capacity for problem identification and resolution exceed the capacity of machines alone. When people are given access to relevant data, combined with SpeedTrack technology, they see data that have been transformed into useable information. This allows greater confidence in attacking and solving the most difficult problems that organizations and communities may be facing.

Over the past 10 years, SpeedTrack's scientific and research and development team has been led by Jerzy Lewak, PhD, a theoretical physicist. The team has invented and patented a series of computer methods that enable people to view, explore and discover information in any data regardless of size, structure or location.

The methods have been incorporated into a new software platform designed to perform search and analysis on any type of data with near unlimited dimensionality, regardless of data size.

For the purposes of this Community Health Needs Assessment, SpeedTrack compiled and stratified data from California's Department of Health Care Access and Information (HCAI), CMS, AHRQ, HCUP and the California Department of Finance to support quantitative analyses of population health trends associated with acute care inpatient discharges and ED visits.

These efforts create streams of information — not just numbers — that enable the discovery of key insights that are often overlooked.

The Social Impact Artists, Inc.

The Social Impact Artists, Inc. encourage positive transformation of local communities and the world through the development of strategic health and social impact strategies. Their goal is to make the world a better place.

They specialize in digital storytelling, proposal writing, social media-based fundraising, research and experience impact design, community engagement and outreach, network weaving, social research testing, search engine organization and the development of positive community-based health equity strategies. They work to simplify social complexities through film, visual design, digital content, the development of health strategies and narrative storytelling.

Appendix S:
Glossary of Terms

Avoidable ED visits

Avoidable hospital Emergency Department (ED) visits are defined as conditions managed in the ED that likely could have been treated in a primary care setting.

Benchmark

A benchmark is a measurement that serves as a standard by which other measurements and/or statistics may be measured or judged. A "benchmark" indicates a standard by which a community can determine whether the community is performing well in comparison to the standard for specific health outcomes.

Burden of disease

These data focus on hospital inpatient and emergency department utilization; top causes of death; morbidities (health conditions); and communicable and chronic disease burdens.

Community health needs assessment (CHNA)

A CHNA uses systematic processes to evaluate a community's assets and identify priorities for action.

Community resources

Community resources include organizations, people, partnerships, facilities, funding, policies, regulations and a community's collective experience. Any positive aspect of the community is an asset that can be leveraged to develop effective solutions.

Federal Poverty Level (FPL)

The Federal Poverty Level (FPL) is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the U.S. Department of Health and Human Services and used to determine financial eligibility for certain federal programs. To view and calculate 2022 poverty levels, go to https://aspe.hhs.gov.

Federally Qualified Health Center

Federally Qualified Health Centers are community-based health care providers that receive funds from the Health Resources & Services Administration Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. They must also accept Medi-Cal and Medicare. Types of Federally Qualified Health Centers vary; they may be community health centers, migrant health centers, health care for the homeless and health centers for residents of public housing.

Food insecurity

Food insecurity is a lack of consistent access to food resulting in reduced quality, variety or desirability of diet, or multiple indications of disrupted eating patterns and reduced food intake.

Health indicator

A single measure that is reported on regularly and that provides relevant and actionable information about population health and/or health system performance and characteristics. An indicator can provide comparable information as well as track progress and performance over time.

Healthy People 2020

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions and measure the impact of prevention activities.

Housing cost burden

Housing cost burden measures the percentage of household income spent on mortgage costs or gross rent.

The U.S. Department of Housing and Urban Development currently defines housing as affordable if housing for that income group costs no more than 30% of the household's income. Families who pay more than 30% of their income for housing are considered cost burdened; families who pay more than 50% of their income for housing are severely cost burdened.

Humane housing

Humane housing is about stable, safe places to live, and living in diverse, vibrant communities that lead to full, productive lives. Housing that is not considered humane has one or more of the following characteristics:

- Is dilapidated
- Does not have operable indoor plumbing
- Does not have a usable flush toilet inside the unit for the exclusive use of a family
- Does not have a usable bathtub or shower inside the unit for the exclusive use of a family
- Does not have electricity, or has inadequate or unsafe electrical service
- Does not have a safe or adequate source of heat
- Should, but does not, have a kitchen
- Has been declared unfit for habitation by an agency or unit of government

Inequity

Inequity is deep-seated health, racial and socioeconomic injustice or unfairness. It may also be called disparities.

Infant mortality rate

Infant mortality rate is expressed as a rate per 1,000 births, this is defined as the death of a child prior to its first birthday (should be read, for example, as 7.8 infant deaths for every 1,000 births).

IP3 | Assess

IP3 | Assess is a web-based data solution to community assessment and action with a robust list of indicators, interactive maps and simple, shareable reporting. Two of its frameworks are used in this report: Burden of Disease and Vital Conditions for Well-Being.

Key informant interviews

Key informant interviews are one-on-one interviews with selected community members and leaders with questions related to the components of a healthy community as well as issues in the community. For this CHNA, the questions also included the issues of housing, access to care, mental health and substance use.

Low birth weight

Expressed as a rate per 1,000 births, this refers to infants born with a weight between 1,500 and 2,500 grams or between 3.3 and 5.5 pounds. Very low birth weight infants are born with a weight less than 1,500 grams.

Morbidities

Morbidities are defined as a disease or a symptom of disease, or the amount of disease within a population. Morbidities may also refer to medical problems caused by treatments.

Mortality

Mortality refers to the state of being subject to death or death itself, especially on a large scale.

Prenatal care

Adequacy of prenatal care calculations is based on the Adequacy of Prenatal Care Utilization (APNCU) Index, which measures the utilization of prenatal care on two dimensions and four categories. The first dimension measures the timing of initiation of prenatal care. The second dimension is the adequacy of received services. The two dimensions are grouped into four categories:

Adequate-Plus: Prenatal care begun by the fourth month of pregnancy and 110% or more of recommended visits received.

Adequate: Prenatal care begun by the fourth month of pregnancy and 80%–109% of recommended visits received.

Intermediate: Prenatal care begun by the fourth month of pregnancy and 50%–79% of recommended visits received.

Inadequate: Prenatal care begun after the fourth month of pregnancy or less than 50% of recommended visits received.

Prevention Quality Indicators (PQIs)

Prevention Quality Indicators (PQIs) are a set of measures that are derived from inpatient discharge data to identify the quality of care for ambulatory care sensitive conditions (ACSC). These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Primary data

Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this CHNA, primary data were collected through listening sessions and key informant interviews.

Primary service area (PSA)

A primary service area (PSA) is a geographic area that covers the majority of patients served by a particular hospital.

Public health

Public health comprises federal, state and local government entities that are focused on disease prevention and health promotion.

Secondary data

Secondary data are data that were collected and published by another party. Typically, secondary data in CHNAs are quantitative (numerical) in nature and collected by a local or state department of health, the Centers for Disease Control and Prevention (CDC) or a state department of education.

SpeedTrack, Inc

SpeedTrack, Inc provides a platform that enables people to view, explore and discover information in any data regardless of size, structure or location. For the purposes of this CHNA, SpeedTrack focuses on hospital inpatient discharges and ED visits.

Teen birth rate

Teen birth rate is expressed as a rate per 1,000 births. This refers to the quantity of live births by teenagers who are between the ages of 15 and 19.

Thriving natural world

A thriving natural world is defined as clean air, water and land as well as a well-functioning ecosystem.

Vital conditions

Vital conditions are community conditions that we encounter throughout our lives. They strongly shape the way each person experiences the world. The IP3 | Assess Vital Conditions for Well-Being framework brings together major determinants of health, exposing how multi-faceted parts of a system produce population well-being.

- Basic needs for health and safety

- Lifelong learning

- Humane housing

- Meaningful work and wealth

- Reliable transportation

- Thriving natural world

- Belonging and civic muscle

Z codes

Hospitals can capture data on the social needs of their patient populations through "Z codes." These codes identify non-medical factors that may influence a patient's health status. These data are valuable not only for understanding a patient's health status but also for identifying unmet social needs in a community, which can inform and support community health investments.