

2022 Inland Empire

Community Health Assessment





2022 Inland Empire

Community Health Assessment

© 2022 Inland Empire Health Plan



With technical assistance from:

HC² Strategies, Inc.

IP3 (Institute for People, Place, and Possibility)

SpeedTrack, Inc.

Version 2, September 2022

Table of Contents

| | |
|---|----|
| Welcome | 05 |
| Executive Summary | 06 |
| 2022 Inland Empire CHA Stakeholder Committee | 06 |
| Vision for Collaboration | 08 |
| Background | 09 |
| Health Equity as an Emerging Issue | 09 |
| Public Health and Prevention | 09 |
| Demographic Data for the Inland Empire, Riverside County and San Bernardino County | 11 |
| Data Sources and Findings | 12 |
| Primary Data | 12 |
| Secondary Data | 15 |
| Stakeholder Prioritization Process to Determine Key Issues | 18 |
| Burden of Disease Priorities | 19 |
| Vital Conditions Priorities | 19 |
| Populations Disproportionately Impacted | 20 |
| Next Steps | 21 |
| Appendix A: Additional Demographic Information | 22 |
| Appendix B: Key Informants | 25 |
| Appendix C: Emergency Department (ED) Avoidable Visits and Volumes by Social Determinants | 25 |
| Appendix D: In-Depth Description of the IP3 Assess Tool | 29 |
| Appendix E: Stakeholder Committee Ranking of Priorities | 31 |

| | |
|---|----|
| Appendix F: Cardiovascular Disease and Diabetes Indicator Report | 33 |
| Appendix G: Mental and Behavioral Health Indicator Report | 36 |
| Appendix H: Maternal and Infant Health Indicator Report | 38 |
| Appendix I: Basic Needs for Health and Safety Indicator Report | 39 |
| Appendix J: Humane Housing Indicator Report | 42 |
| Appendix K: Meaningful Work and Wealth Indicator Report | 43 |
| Appendix L: IP3 Assess Burden of Disease Categories and Indicators with Source List | 45 |
| Appendix M: IP3 Assess Vital Conditions of Well-Being and Indicators with Source List | 52 |
| Appendix N: 2022 Inland Empire Priorities as Compared to 2019 Priorities | 57 |
| Appendix O: Stakeholder Committee Member Comments in Priority Session | 58 |
| Appendix P: Listening Session Report | 59 |
| Appendix Q: Consultant Qualifications | 75 |
| Appendix R: Glossary of Terms | 77 |

Welcome

Dear Friends,

Stewardship is the foundation of this Inland Empire Community Health Assessment (CHA). This document is not just a collection of data about our community. Rather, the CHA 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 CHA. 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.

Along with this CHA, 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. 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 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

Executive Summary

This 2022 Inland Empire Community Health Assessment (CHA) 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.

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.

2022 Inland Empire CHA Stakeholder Committee

The 2022 Inland Empire CHA Stakeholder Committee represented many key public health, health care delivery system 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.

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, MA
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
- Cecilia Arias, MPH, MCHES
Kaiser Permanente Riverside County
- Martha Valencia, MPH
Kaiser Permanente San Bernardino County
- 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 Geronio Memorial Hospital
- Ariel Whitley, MHA
San Geronio Memorial Hospital
- Kathleen McDonnell
St. Bernardine Medical Center
- Michelle Burroughs, MPH
University of California Riverside Medical School
- Maria Lemus
Visión y Compromiso

The 2022 CHA process followed these steps:

1. Key data were collected for the 2022 Inland Empire CHA 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 CHA. (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 CHA.
 - 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

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 CHA 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 assessment (CHA) refers to a geographical or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis with an emphasis on underserved populations often missed in traditional data collection methods. A community health assessment gives organizations and/or regions comprehensive information about the community's current health status, needs and issues. In turn, this information can help with developing a community health improvement plan by justifying how and where resources should be allocated to best meet community needs.

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 CHA took this "population level" approach in identifying priorities to support vibrant health in the community. This regional CHA 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 CHA 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 CHA, taking a public health approach will be critical.

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 CHA and setting priorities for action.

Demographics and population projections help tell the story. The demographic data for this CHA, 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 as well as Riverside and San Bernardino counties.

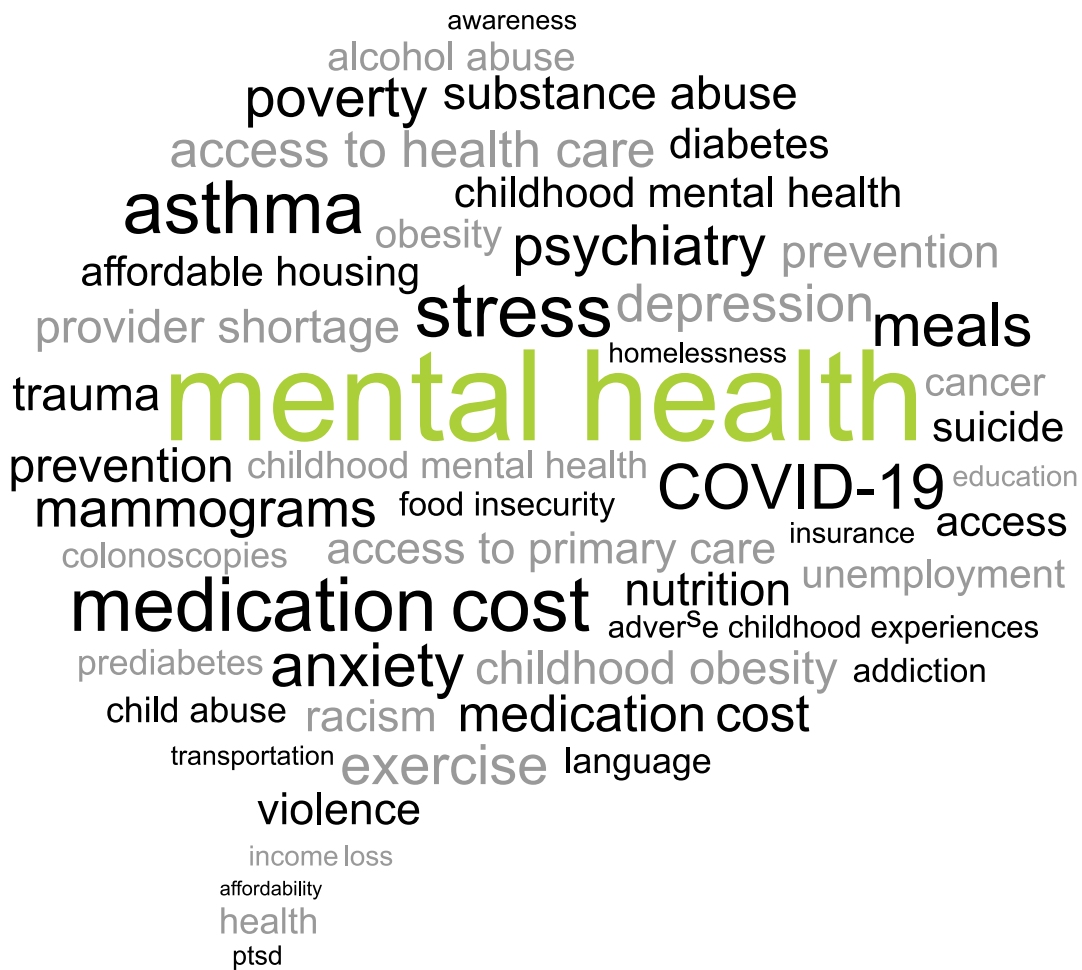
Data Sources and Findings

This Community Health 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 CHA 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 CHAs, publicly available secondary data) in advance of the primary data collection sessions.



Key Informant Interviews

The CHA 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 CHA 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 P 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.

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 CHA 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 CHAs 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.

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 CHA 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 CHA 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 Assessment and Research for Communities (HARC).

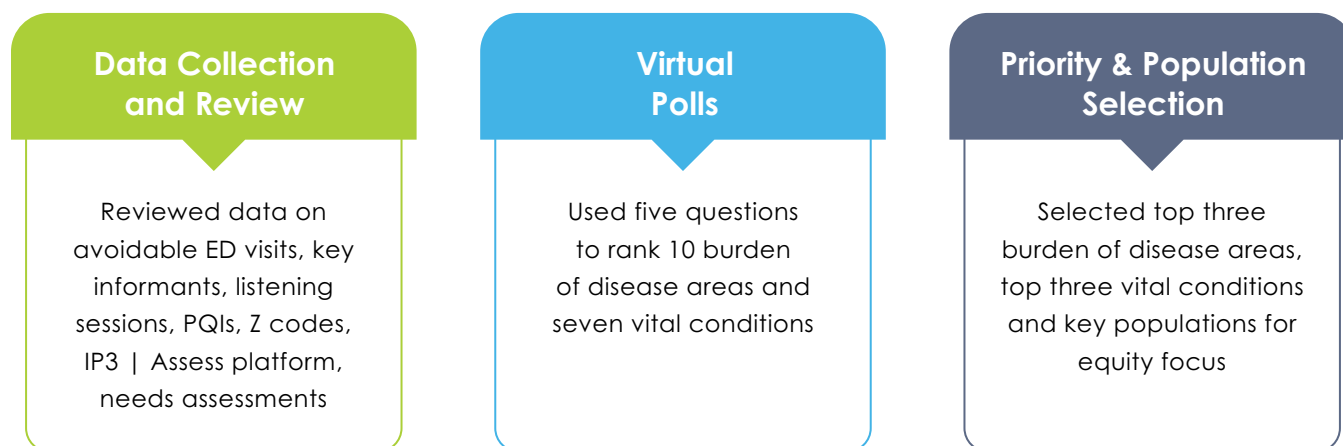
The assessment consisted of surveys with 9,200 county residents regarding fear of being sick, hospitalized or dying; COVID-19's impact on social life and work/school participation; travel avoidance; financial losses; delays in health and dental care; vaccination status and beliefs; and the burden of 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 CHA 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.



In the April 19 strategy session, the stakeholders considered 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 CHA 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
- Remote and rural communities
- Individuals identifying as Black/African American, Latinx and/or Pacific Islander
- Senior citizens

Appendix O contains stakeholder comments from the strategy meeting.

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 above and in Appendices F–K in this report as well as many other resources at [ConnectIE.org](https://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 | 2023 | 2024 | 2025 | 2026 | 2027 | % Change |
|------------------------|------------------|------------------|------------------|------------------|------------------|-------------|
| | 4,732,855 | 4,777,505 | 4,822,472 | 4,866,383 | 4,908,594 | 3.7% |

California Department of Finance.

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% |
|-------------------------------|------------------|------------------|------------------|------------------|------------------|-------------|

California Department of Finance.

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% |
|-------------------------------|------------------|------------------|------------------|------------------|------------------|-------------|

California Department of Finance.

Appendix B: Key Informants

The key informants interviewed for this CHA 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 San Bernardino 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, 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

| Visits by Volume | | | | | | Avoidable Visits | | | | |
|------------------------|---------|---------|---------|---------|----------------------|------------------|------|------|------|--------------|
| Category | 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 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 Assessment (CHA) 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.

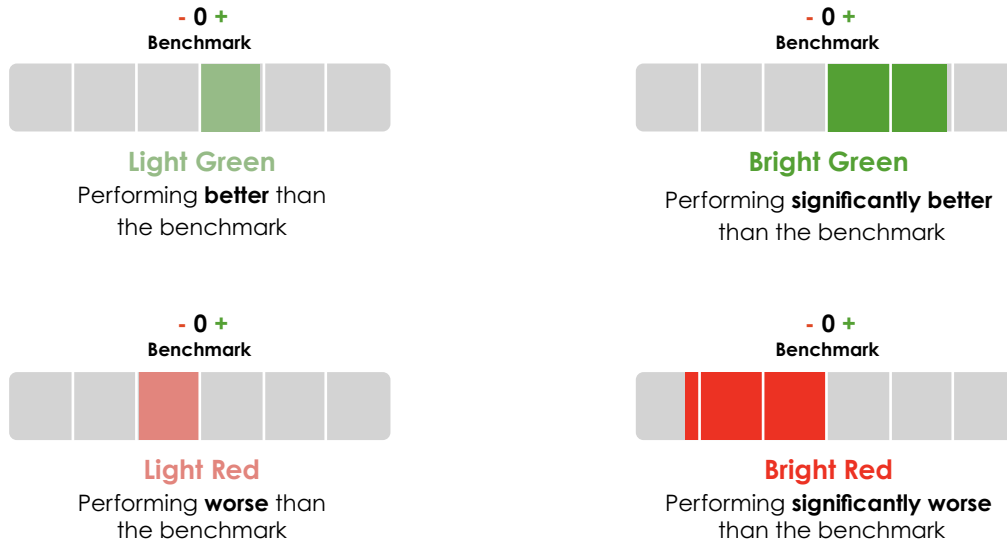
Users can also drill down indicators in each domain (see Appendix D) to identify specific focus areas and prioritize efforts. They can toggle between different geographies to see how scores vary across service areas and explore any different driving factors for good and bad composite domain scores.

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



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 CHA 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 CHA. 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 disproportionately 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 | Lifelong learning |
| Humane housing | Thriving natural world |
| Meaningful work and wealth | |

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

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

Q3. Does the issue disproportionately affect certain populations?

(Consider race, ethnicity, income, geography and education)

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

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 | Reliable transportation |
| Humane housing | Civic muscle and belonging |
| Meaningful work and wealth | |

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

| | |
|-----------------------------------|----------------------------|
| Basic needs for health and safety | Civic muscle and belonging |
| Meaningful work and wealth | Reliable transportation |
| Humane housing | |

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 |
|---|---------------|------------------|-----------------------|
| Obesity - percentage of adults 18+ with BMI of 30 or above | | | |
| 27.5 | 32.6 | 31.2 | 32.6 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| High cholesterol - percentage of adults 18+ reporting high cholesterol | | | |
| 30.2 | 36.2 | 36.2 | 30.1 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Hypertension deaths - Number of deaths due to hypertensive heart disease per 100,000 people | | | |
| 14.0 | 22.7 | 20.8 | 24.5 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Heart attack deaths - number of deaths due to acute myocardial infarction per 100,000 people | | | |
| 25.8 | 25.8 | 27.0 | 24.8 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Heart failure deaths - number of deaths due to heart failure per 100,000 people | | | |
| 19.4 | 21.8 | 22.8 | 20.8 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Diagnosed stroke - percentage of adults 18+ who have ever been diagnosed with a stroke | | | |
| 3.2 | 3.1 | 4.0 | 3.0 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| High blood pressure - percentage of adults 18+ who have been told they have hypertension | | | |
| 28.7 | 29.9 | 36.3 | 28.0 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| High blood pressure management - percentage of adults 18+ with diagnosed hypertension who report taking hypertension medication | | | |
| 67.1 | 67.4 | 72.6 | 66.6 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Heart disease among Medicare beneficiaries - percentage of Medicare beneficiaries with ischemic heart disease | | | |
| 22.2 | 24.5 | 25.0 | 24.0 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Diagnosed diabetes - percentage of adults 20+ who have been told they have diabetes (including gestational) | | | |
| 9.4 | 10.4 | 10.4 | 10.4 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Diabetes management - percentage of diagnosed Medicare beneficiaries having an annual A1c test | | | |
| 81.9 | 78.6 | 80.4 | 76.0 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Diabetes deaths - number of deaths due to type 2 diabetes per 100,000 people | | | |
| 17.7 | 22.8 | 15.7 | 29.8 |

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 |
|--|---------------|------------------|-----------------------|
| Poor mental health days - age-adjusted number of reported mentally unhealthy days per month | | | |
| 4.2 | 4.5 | 4.5 | 4.5 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Self-harm deaths - age-adjusted number of self-harm deaths per 100,000 people | | | |
| 14.7 | 10.7 | 10.5 | 11.0 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Mental health care providers — number of mental health care providers per 100,000 people | | | |
| 373.3 | 229.9 | 217.1 | 242.7 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Drug use disorder deaths - <i>age-adjusted number of drug use disorder deaths per 100,000</i> | | | |
| 8.8 | 10.1 | 10.9 | 9.1 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Depression among Medicare beneficiaries - <i>percentage of Medicare beneficiaries with diagnosed depression</i> | | | |
| 14.7 | 15.0 | 15.0 | 15.0 |

Appendix H: Maternal and Infant 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 |
|--|---------------|------------------|-----------------------|
| Infant deaths - number of deaths in infants younger than one year per 1,000 live births | | | |
| 4.2 | 5.1 | 4.2 | 5.9 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Low birthweight - percentage of births with low birthweight | | | |
| 6.9 | 7.1 | 6.8 | 7.4 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Tobacco use during pregnancy - percentage of births for which tobacco use is a maternal risk factor | | | |
| 1.3 | 2.0 | 1.7 | 2.2 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Pre-term births - percentage of births occurring before the 37th week of pregnancy | | | |
| 9.1 | 9.5 | 9.1 | 10.0 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Early prenatal care - percentage of births for which prenatal care began in the first trimester | | | |
| 85.5 | 84.5 | 84.7 | 84.2 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Teen births - number of infants per 1,000 to females aged 15–19 | | | |
| 26.2 | 23.5 | 20.7 | 26.3 |

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. Unless otherwise noted, 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 |
|---|---------------|------------------|-----------------------|
| Grocery stores - number of grocery stores per 1,000 population | | | |
| 0.2 | 0.1 | 0.1 | 0.1 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Food insecurity - percentage of the population that is food insecure | | | |
| 10.0 | 9.3 | 9.0 | 9.6 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| insured adults - percentage of uninsured adults 18–65 | | | |
| 88.0 | 85.7 | 85.6 | 86.2 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Exercise opportunities - percentage of population with access to areas for physical activity | | | |
| 86.1 | 86.6 | 88.9 | 84.4 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Population with any disability – percentage of the population with a disability (September 2022 data) | | | |
| 10.6 | 11.1 | 11.4 | 10.8 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Life expectancy at birth – estimated life expectancy at birth | | | |
| 81.7 | 79.9 | 80.9 | 78.8 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Violent crimes – number of reported violent crimes per 100,000 people | | | |
| 418 | 358.8 | 291.0 | 442.0 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| 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 |

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 |
|---|---------------|------------------|-----------------------|
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Multi-family housing - percentage of housing structures with two or more units per structure | | | |
| 23.5 | 18.2 | 11.9 | 19.8 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Incomplete plumbing or kitchen facilities - percentage of occupied housing units that lack plumbing or kitchen facilities | | | |
| 1.3 | 1.0 | 0.9 | 1.1 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Overcrowded housing - percentage of housing units with more than one occupant per room | | | |
| 12.0 | 8.4 | 10.7 | 9.4 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| 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 |

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 |
|---|---------------|------------------|-----------------------|
| 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 |
| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
| 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 |
| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
| 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 |
| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
| 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 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Unemployment - annual percentage of the labor force that is unemployed | | | |
| 10.0 | 9.7 | 9.9 | 9.4 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Median household income - median household income for the population | | | |
| \$83,398 | \$67,326 | \$69,261 | \$64,943 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|--|---------------|------------------|-----------------------|
| Homeownership - percentage of occupied housing units with owner occupants | | | |
| 54.8 | 62.9 | 66.3 | 59.6 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Poverty - percentage of adults over 18 whose incomes are below the federal poverty level | | | |
| 13.4 | 15.5 | 14.5 | 16.7 |

| State Benchmark | Inland Empire | Riverside County | San Bernardino County |
|---|---------------|------------------|-----------------------|
| Child poverty - percentage of children under 18 who live below the federal poverty level | | | |
| 16.9 | 18.3 | 18.3 | 18.3 |

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 |
| 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 | 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. In 2019, eight Inland Empire hospitals joined with the Hospital Association of Southern California (HASC) and Communities Lifting Communities on a regional CHNA. Participating hospitals included: Desert Regional Medical Center, Hi-Desert Medical Center, Inland Valley Medical Center, JFK Memorial Hospital, Rancho Springs Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and Mountains Community Hospital. 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 CHA 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.

CHA Action Plans

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

Appendix P: Listening Session Report



Community Listening Session Report

May 10, 2022

Project Description: The Inland Empire Health Plan, HC² Strategies and regional hospitals conducted a collective health and equity assessment to identify systems and policy improvements with dedicated resource flows to address inequities in San Bernardino and Riverside counties. HC² 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. *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.

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:** HC² 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 | High blood pressure | Mental health | Domestic violence/ community violence | Cancer | Substance abuse/ vaping |
| Homelessness/ housing | Substance abuse | COPD (especially seniors) | High blood pressure | High blood pressure | Allergies | Stress |
| Cardiovascular disease | Allergies | Allergies | Cancer | Cancer | Effects of COVID-19 | Overweight/ obesity |

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 | <i>The top six issues of both focus groups are combined below.</i> | 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 Permanente. 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 it is 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 Permanente, 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 Q: 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 CHA, 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 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 R:

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 Assessment (CHA)

A CHA 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 CHA, 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 CHA, 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 CHAs 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 CHA, 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.

