To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org.
Incorporated in 1952, Special Service for Groups (SSG) is a nonprofit multi-service agency that serves some of the hardest-to-reach populations across Los Angeles County. Our Research and Evaluation Team works with other nonprofit organizations and community residents to collect and analyze information they need for planning and action. We believe that information is power, and we invest in developing these research skills within our communities.

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Children's Fund
City of Chino
City of Montclair
City of Ontario Planning Department
City of Pomona
Community Action Partnership of San Bernardino County
Community Clinic Association of San Bernardino County
County of San Bernardino Department of Behavioral Health
County of San Bernardino Department of Public Health
County of San Bernardino Economic Development Agency
County of San Bernardino Public Defender's Office
Foothill AIDS Project
Inland Empire Alzheimer's Association
Inland Empire United Way
Inland Valley Hope Partners
Kids Come First Community Health Center
Latino Health Collaborative
Loma Linda University, Institute for Community Partnerships
Mercy House
Montclair Medical Clinic
Network for a Health California-African American Campaign
Ontario Police Department
Ontario-Montclair Unified School District
Reach Out
Riverside-San Bernardino County Indian Health
San Antonio Community Hospital
San Bernardino County Medical Association
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Glossary of Terms

The following terms are used throughout the Community Health Needs Assessment report. They represent concepts that are important to understanding the findings and analysis in this report.

**Age-adjusted rate**
The incidence or mortality rate of a disease can depend on the age distribution of a community. Because chronic diseases and some cancers affect older adults disproportionately, a community with a higher number of older adults might have a higher mortality or incidence rate of some diseases than another community that may have a higher number of younger people. An incidence or mortality rate that is age-adjusted takes into the consideration of the proportions of persons in corresponding age groups, which allows for more meaningful comparison between communities with different age distributions.

**Benchmarks**
A benchmark serves as a standard by which a community can determine how well or not well it is doing in comparison for specific health outcomes. For the purpose of this report, one of two benchmarks is used to make comparison with the medical center area. They are Healthy People 2020 objectives and state (California) averages.

**Death rate**
See *Mortality rate*.

**Disease burden**
Disease burden refers to the impact of a health issue not only on the health of the individuals affected by it, but also the financial cost in addressing this health issue, such as public expenditures in addressing a health issue. The burden of disease can also refer to the disproportionate impact of a disease on certain populations, which may negatively affect their quality of life and socioeconomic status.

**Health disparity**
Diseases and health problems do not affect all populations in the same way. Health disparity refers to the disproportionate impact of a disease or a health problem on specific populations. Much of research literature on health disparity focuses on racial and ethnic differences in how these communities experience the diseases, but health disparity can be correlated with gender, age, and other factors, such as veteran, disability, and housing status.

**Health driver**
Health drivers are behavioral, environmental, social, economic and clinical care factors that positively or negatively impact health. For example, smoking (behavior) is a health driver for lung cancer, and access to safe parks (environmental) is a health driver for obesity/overweight. Some health drivers, such as poverty or lack of insurance, impact multiple health issues.
Health outcome
A health outcome is a snapshot of a disease in a community that can be described in terms of both morbidity and mortality (e.g. breast cancer prevalence, lung cancer mortality, homicide rate, etc.).

Hospitalization rate
Hospitalization rate refers to the number of patients being admitted to a hospital and discharged for a disease, as a proportion of total population.

Incidence rate
Incidence rate is the number of new cases for a specific disease or health problem within a given time period. It is expressed either as a fraction (e.g. percentage) or a density rate (e.g., \( x \) number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with prevalence rate, which measures the proportion of people found to have a specific disease or health problem.

Morbidity rate
Morbidity rate refers to the frequency with which a disease appears within a population. It is often expressed as a prevalence rate or incidence rate.

Mortality rate
Mortality rate refers to the number of deaths in a population due to a disease. It is usually expressed as a density rate (e.g. \( x \) number of cases per 10,000 people). It is also referred to as “death rate.”

Prevalence rate
Prevalence rate is the proportion of total population that currently has a given disease or health problem. It is expressed either as a fraction (e.g. percentage) or a density rate (e.g. \( x \) number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with incidence rate, which focuses only on new cases. For instance, a community may experience a decrease in new cases of a certain disease (incidence) but an increase in the total of number suffering that disease (prevalence) because people are living longer due to better screening or treatment for that 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 Community Health Needs Assessment, primary data were collected through focus groups and interviews with key stakeholders. These primary data describe what is important to the people who provide the information and are useful in interpreting secondary data.

Secondary data
Secondary data are data that have been collected and published by another entity. They are typically quantitative (numerical) in nature. Secondary data are useful in highlighting in an objective manner health outcomes that significantly impact a community.
I.  Executive Summary

A.  Community Health Needs Assessment (CHNA)  
   **Background**

   The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, added new requirements, which nonprofit hospital organizations must satisfy to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) at least once every three years. As part of the CHNA, each hospital is required to collect input from designated individuals in the community, including public health experts as well as residents, representatives or leaders of low-income, minority, and medically underserved populations and individuals with chronic conditions.

   While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, this new legislation has provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2013 and described in this report was conducted in compliance with these new federal requirements.

B.  Geographic Description of the Medical Center Service Area (MCSA)

   The Kaiser Foundation Hospital (KFH) – Ontario Medical Center Service Area (MCSA) includes the Western part of San Bernardino County and a small portion of the far Eastern part of Los Angeles County. The service area includes the communities of Chino, Chino Hills, Claremont, Diamond Bar, La Verne, Mira Loma, Montclair, Mt. Baldy, Ontario, Pomona, Rancho Cucamonga, San Antonio Heights, and Upland.

C.  Summary of Needs Assessment Methodology

   The CHNA included a collection and analysis of secondary and primary data. The Assessment began with a review of a list of roughly 100 national common indicators identified by Kaiser Permanente to be used by all of its regions. The national common indicators included demographic data, social and economic factors, health behaviors, physical environment, clinical care, and health outcomes. This list of indicators was complemented by additional literature review of research data conducted in San Bernardino County. Based on the review of the secondary data, the consultant team developed a primary data collection guide used in focus groups and key stakeholder interviews to gather community input. Between September 18 and November 2, 2012, one focus group and 15 key stakeholder interviews were conducted. Overall,
the community input process engaged and solicited input from 25 providers and community leaders who represent broad geographic, public health, and population interests, in compliance with ACA requirements. In addition, the consultant team conducted two methods to enrich the demographic profile of San Bernardino County. First, the consultant team used an online survey to gather nutrition and operations information from agencies providing food assistance to San Bernardino County residents. Second, the consultant team collected and analyzed de-identified caller data from the Inland Empire United Way 2-1-1 database. 2-1-1 in San Bernardino County is a hotline where community residents can call anytime and ask about resources they need. 2-1-1 calls are free and anonymous. The call center is staffed by professionals who give information and referrals to appropriate resources, including free and low-cost health and social services.

The consultant team used a modified content analysis to determine general themes that emerged from the review of secondary data and community input. Based on severity, trends, and relationships among health outcomes and drivers, 16 health needs were identified. For this Community Health Needs Assessment (CHNA) process, to be considered a health need, a health outcome or driver has to meet two conditions: (1) existing or secondary data has to demonstrate that the medical center service area (MCSA) fares worse than a comparison benchmark; and (2) the health outcome or driver has to be substantially mentioned in at least two data sources from primary data collection.

Following the identification of the health needs, the consultant team conducted one community forum in the KFH – Ontario MCSA to validate the assessment findings and prioritize the health needs. Twenty-two (22) community stakeholders took part in the community forum. Many of the forum participants had been engaged in the focus group or key stakeholder interviews during the CHNA process. After a group discussion about the assessment findings, forum participants were given an opportunity to rate each health need in a written survey.

D. Summary of Needs Prioritized by the Community

The surveys from the community forum resulted in the ranking of the following health needs for the KFH-Ontario MCSA (from the highest priority to the lowest).

1. Substance Use
2. Mental Health
3. Economic Instability
4. Oral Health
5. Health Care Access and Utilization
6. Community Violence
7-Tied. Diabetes
7-Tied. Overweight/Obesity
9-Tied. Service Infrastructure
9-Tied. Cardiovascular Disease
11. Asthma
The following statements summarize each of the prioritized health needs and are based on data and information gathered through the CHNA. More detail about the health needs, including the data and their sources, are provided in their respective health need profile in the Appendix A.

1. **Substance Use**: Although deaths due to drug and alcohol use have decreased in San Bernardino County, admissions to county treatment facilities rose 11% from 2009 to 2011. Methamphetamine-related treatment had the highest admissions, accounting for 44% of all admissions. A newer trend is the use of prescription and synthetic drugs (e.g. spice and bath salts). Substance use impacts older adults, re-entry population, veterans, victims of domestic abuse, and the homeless. Substance use is linked to mental health, community violence, cancer, oral health, cardiovascular disease and hepatitis.

2. **Mental Health**: The KFH-Ontario MCSA suicide rate (7.6 per 100,000 population) is better than the state average (9.8). Overall, 14.21% of the population self-reported a need for mental or behavioral health services in the past 12 months. Mental health issues are seen in the homeless, seniors, veterans and children. Mental health is linked to obesity, chronic and infectious diseases and is exacerbated by economic instability and lack of access to health care.

3. **Economic Instability**: CalFresh and CalWORKS enrollment and homelessness in San Bernardino County has increased. The proportion of people in poverty living below 100% of the Federal Poverty Level in the KFH—Ontario MCSA is 10.38%. Unemployment, poverty, and lower educational attainment pose as major barriers for people to access and utilize health care services, which impacts overall health and well-being.

4. **Oral Health**: The KFH—Ontario MCSA reported worse dental health than the state due to a lower percentage of dental care utilization among adults (35.27%) and youth (15.03%). Dental disease is the number one chronic disease for children and youth, as many lack dental insurance and parents are not aware of the importance of dental care. Poor oral health is linked with poor diet and nutrition, substance use, lack of dental prevention and dental health professionals, poor pregnancy outcomes, heart disease and stroke.

5. **Health Care Access and Utilization**: Of the people living in the KFH—Ontario MCSA, 21% are uninsured and 56.36% are living in a Health Professional Shortage Area, lower than the 57.14% state average. Of particular concern for all stakeholders is the impact of economic instability, unemployment, homelessness and transportation, and the ways they contribute to the lack of health care access, health insurance coverage, and continuity of care. Undocumented
immigrants and people of color are disproportionately affected by issues connected with access to health care.

6. Community Violence: The homicide death rate in the KFH—Ontario MCSA (5.7 per 100,000 population) is higher than the California benchmark (5.15 per 100,000 population). Domestic violence and gang activity are also significant issues in the community. Community violence may be triggered by stress (due to unemployment and financial issues), alcohol and substance abuse, and mental health issues. The re-entry population, who is released into the community without adequate support systems, is also contributing to the increase in violence.

7-Tied. Diabetes: Diabetes prevalence is increasing in San Bernardino County. Diabetes prevalence in adults in the KFH—Ontario MCSA (8.03%) is higher than California (7.57%). Diabetes is prevalent in African American, Hispanic/Latino, Native American/Alaskan Native, undocumented immigrant, and low-income communities due to a combination of cultural diet, American fast food, lower physical activity, stress, lack of access to healthy foods, and lack of access to health care services. Obesity is often a precursor to diabetes, and it is linked to mental health, prenatal/perinatal health, economic instability, and service infrastructure.

7-Tied. Obesity/Overweight: Overweight and obesity is rising in the KFH—Ontario MCSA. The MCSA reported higher obesity prevalence for adults (26.29%) and youth (36.28%) compared to the California benchmark (23.25% for adults and 29.82% for youth). Obesity and overweight spans across all income levels and racial/ethnic groups, but disproportionately affects Hispanic/Latinos, African Americans, Native Americans/Alaska Natives, Asian and Pacific Islanders, and low-income populations. Obesity is linked to cardiovascular disease, diabetes, cancer, prenatal/perinatal health, premature death, musculoskeletal conditions, and mental health.

9-Tied. Service Infrastructure: San Bernardino County lags in nonprofit funding and growth, as the number of nonprofit organizations has decreased from 6,118 in 2010 to 5,644 in 2011. In addition, San Bernardino County receives $3 of foundation funds per capita, which is significantly less than the California average of $119. As such, alignment of efforts among existing collaboratives and networks is needed and will require more coordination among health care and other service providers, including smaller, more community-based organizations. Capacity building can also strengthen existing organizations, as there is a lack of leadership to adequately address the health needs of county residents. Service infrastructure is linked with access to health care and economic instability of the county, thus impacting many of the identified health needs.

9-Tied. Cardiovascular Disease: The death rates due to coronary heart disease and stroke have improved significantly in San Bernardino County. However, the age-adjusted mortality rates due to CHD (168.3 per 100,000 population) and stroke (40.6 per 100,000 population) for the KFH—Ontario MCSA are higher than the state rates (131.34 and 39.46 per 100,000 population, respectively). Native American/Alaskan Natives were more affected by high blood pressure than other populations (50%). Cardiovascular disease is linked to substance use, oral health, prenatal/perinatal health, stress, smoking, obesity, diabetes, and other chronic health conditions.
11. **Asthma**: Asthma prevalence has been decreasing in San Bernardino County. Adult (6.86 per 10,000 hospitalization events) and youth (12.97 per 10,000 hospitalization events) asthma hospitalization rates in the KFH—Ontario MCSA are lower than the California benchmark (8.9 for adults and 19.18 for youth per 10,000 hospitalization events). Asthma remains a top chronic health issue for children in the County as the County has some of the highest average annual pollutant concentrations in Southern California. Asthma is linked with access to health care, economic instability, service infrastructure, overweight/obesity, diabetes, and mental health.

12. **Cancer**: The age-adjusted death rate due to all cancers in the KFH—Ontario MCSA (113.2 per 100,000 population) is lower compared to the state average (149.6). However, it still remains the second leading cause of death in the County. In addition, certain cancers are much higher in particular areas in San Bernardino County, especially in low-income areas and where there is high exposure to environmental pollutants (e.g. particulate matter from diesel trucks and rail yards). Cancer is linked with economic instability, obesity, poor diet, and alcohol.

13. **HIV/AIDS and Other STDs**: Chlamydia and gonorrhea in the KFH—Ontario MCSA is increasing, as the incidence rate of chlamydia is 438.7 per 100,000 population and gonorrhea incidence is 68.7 per 100,000 population. While HIV prevalence in the MCSA is below the state average, 58% of the population in San Bernardino County reported they had never had an HIV screening. HIV/AIDS and other STDs are linked to mental health, substance abuse, prenatal/perinatal health, teen pregnancy, cardiovascular disease, and other chronic diseases.

14. **Teen Pregnancy**: The teen birth rate has decreased in all racial/ethnic groups in San Bernardino County. However, the KFH—Ontario MCSA teen birth rate (9.0 per 1,000 females under the age of 20) is still higher than the state average (8.46 per 1,000 females under the age of 20). Teen pregnancy disproportionately impacts African Americans and Hispanic/Latinos. Teen pregnancy results in poor pregnancy outcomes and economic instability, and has social and educational consequences. It is linked with domestic violence, child neglect, HIV/AIDS and other STDs, transportation, stress, and prenatal/perinatal health.

15. **Prenatal/Perinatal Health**: The KFH—Ontario MCSA reported a lower percentage of low birth weight (LBW) babies (6.74%) but a higher infant mortality rate (6.30 per 1,000 births) compared to California. Women of color continue to experience disparities in prenatal care, especially African American women who receive the least amount of prenatal care and have higher incidence of LBW, very LBW, and infant mortality. Prenatal/perinatal health is linked with chronic disease, economic instability, substance use, service infrastructure, access to health care, oral health, mental health, HIV/AIDS and STDs.

16. **Hepatitis**: The age-adjusted hospitalization rate due to hepatitis in San Bernardino County adults is 3.6 per 10,000 population. Hepatitis infection has declined in African American and Native American/Alaskan Native populations, but continues to increase in Hispanic/Latino, Asian and Pacific Islander populations. Hepatitis is linked with access to health care, service infrastructure, substance use, risky sexual behavior and teen pregnancy.
II. Introduction and Background

A. Purpose of Community Health Needs Assessment Report

Kaiser Permanente is dedicated to enhancing the health of the communities it serves. The findings from this CHNA report will serve as a foundation for understanding the health needs found in the community and will inform the Implementation Strategy for Kaiser Foundation Hospitals as part of their Community Benefit planning. This report complies with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a Community Health Needs Assessment at least once every three years. The required written plan of Implementation Strategy is set forth in a separate written document. At the time that hospitals within Kaiser Foundation Hospitals conducted their CHNAs, Notice 2011-52 from the Internal Revenue Service provided the most recent guidance on how to conduct a CHNA. This written plan is intended to satisfy each of the applicable requirements set forth in IRS Notice 2011-52 regarding conducting the CHNA for the hospital facility.

B. About Kaiser Permanente

The Kaiser Health Plan and hospitals were established in 1942 to serve the employees of the Kaiser West coast shipyards, and shortly thereafter in 1943, the Kaiser Ontario steel workers. Kaiser Permanente opened to the public in the summer of 1945 at the end of World War II. Kaiser Permanente was created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and physicians in the Permanente Medical Groups. Today we serve more than 9 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their total health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease
management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

C. About Kaiser Permanente Community Benefit

For more than 65 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor’s office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we’ve focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we’ve worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we’ve conducted Community Health Needs Assessments to better understand each community’s unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

D. Kaiser Permanente’s Approach to the Community Health Needs Assessment

About the new federal requirements

Federal requirements included in the ACA, which was enacted March 23, 2010, stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations, one of which is conducting a CHNA every three years. With regard to the CHNA, the ACA specifically requires nonprofit hospitals to: collect and take into account input from public health experts as well as community leaders and representatives of high need populations—this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions; identify and prioritize community health needs; document a separate CHNA for each individual hospital; and make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an Implementation Strategy to address the identified community health needs and submit a copy of the Implementation Strategy along with the organization’s annual Form 990.
SB 697 and California’s history with past assessments

For many years, Kaiser Permanente hospitals have conducted needs assessments to guide our allocation of Community Benefit resources. In 1994, California legislators passed Senate Bill 697 (SB 697), which requires all private nonprofit hospitals in the state to conduct a CHNA every three years. As part of SB 697 hospitals are also required to annually submit a summary of their Community Benefit contributions, particularly those activities undertaken to address the community needs that arose during the CHNA. Kaiser Permanente has designed a process that will continue to comply with SB 697 and that also meets the new federal CHNA requirements.

Kaiser Permanente’s CHNA framework and process

Kaiser Permanente Community Benefit staff at the national, regional, and hospital levels worked together to establish an approach for implementing the new federally legislated CHNA. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente, in partnership with the Institute for People, Place and Possibility (IP3) and the Center for Applied Research and Environmental Studies (CARES), developed a web-based CHNA data platform to facilitate implementation of the CHNA process. More information
about the CHNA data platform can be found at [http://www.CHNA.org/kp/](http://www.CHNA.org/kp/). Because data collection, review, and interpretation are the foundation of the CHNA process, each CHNA includes a review of secondary and primary data.

To ensure a minimum level of consistency across the organization, Kaiser Permanente included a list of roughly 100 indicators in the data platform that, when looked at together, help illustrate the health of a community. California data sources were used whenever possible. When California data sources weren’t available, national data sources were used. Once a user explores the data available, the data platform has the ability to generate a report that can be used to guide primary data collection and inform the identification and prioritization of health needs.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each Kaiser Permanente hospital collected primary data through key informant interviews, focus groups, and surveys. They asked local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. They also inventoried existing community assets and resources.

Each hospital/collaborative used a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on a second set of criteria. This process resulted in a complete list of prioritized community health. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, Kaiser Permanente will examine the list of prioritized health needs and develop an implementation strategy for those health needs it will address. These strategies will build on Kaiser Permanente’s assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H.
III. Community Served

A. Kaiser Permanente’s Definition of Community Served by Hospital Facility

Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Description and Map of Community Served by Hospital Facility

Geographic Description of the Ontario Medical Center Service Area (MCSA)

The Kaiser Foundation Hospital-Ontario Medical Center Service Area includes the Western part of San Bernardino County and a small portion of the far Eastern part of Los Angeles County. The service area includes the communities of Chino, Chino Hills, Claremont, Diamond Bar, La Verne, Mira Loma, Montclair, Mt. Baldy, Ontario, Pomona, Rancho Cucamonga, San Antonio Heights, and Upland. The map on the following page describes the geographic area covered by the KFH-Ontario MCSA.
The following zip codes and cities are included in the KFH – Ontario MCSA:

<table>
<thead>
<tr>
<th>City</th>
<th>Zip Codes</th>
</tr>
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<tbody>
<tr>
<td>Chino</td>
<td>91708, 91710</td>
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<td>91711</td>
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<td>Mira Loma</td>
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<td>91701, 91730, 91737, 91739</td>
</tr>
<tr>
<td>Upland</td>
<td>91784, 91786</td>
</tr>
</tbody>
</table>

Demographic Profile of Community Served

This section describes the community served by KFH-Ontario Medical Center Service Area. The description of the community includes the following:

1. Demographic and Socio-Economic Factors
2. Access to Care
3. Burden of Chronic Disease and Other Health Conditions
4. Basic Needs

1. Demographic and Socio-Economic Factors

These factors include: Total population and population growth, gender, age, race/ethnicity, limited English proficiency, education, poverty, unemployment, and family and social support.

1.1. Total Population and Population Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Ontario MCSA</td>
<td>721,115</td>
<td>834,608</td>
<td>15.74%</td>
<td>3074.28</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>1,709,434</td>
<td>2,035,210</td>
<td>19.06%</td>
<td>101.5</td>
</tr>
<tr>
<td>California</td>
<td>33,871,648</td>
<td>37,253,956</td>
<td>10.0%</td>
<td>235.19</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>281,421,906</td>
<td>9.7%</td>
<td>86.06</td>
</tr>
</tbody>
</table>

This indicator reports the total number of people in a specific geographic area. This indicator is relevant because population counts are necessary to quantify the community as defined. Hispanics/Latinos make up 53.7% of the 2010 Census Total Population above. (Source: U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1., Census 2010 data).
This indicator reports the percent difference in population counts from the 2000 Census population estimate to the 2010 Census population estimate. This indicator is relevant because a positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources. (Source: U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1)

1.2. Gender

This indicator reports the percentage of males in a specific geographic area. This indicator is relevant because it is important to understand the percentage of males in the community, as males have unique health needs which should be considered separately from female health needs. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates.)
## 1.3. Age

### Total Population, by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-4</th>
<th>5-17</th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Ontario MCSA</td>
<td>7.31%</td>
<td>21.01%</td>
<td>12.06%</td>
<td>14.55%</td>
<td>14.72%</td>
<td>13.88%</td>
<td>8.86%</td>
<td>7.60%</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>7.97%</td>
<td>21.98%</td>
<td>11.13%</td>
<td>13.89%</td>
<td>13.92%</td>
<td>13.52%</td>
<td>9.05%</td>
<td>8.55%</td>
</tr>
<tr>
<td>California</td>
<td>6.95%</td>
<td>18.51%</td>
<td>10.41%</td>
<td>14.29%</td>
<td>14.43%</td>
<td>14.05%</td>
<td>10.28%</td>
<td>11.08%</td>
</tr>
</tbody>
</table>

This indicator reports the percentage of people in a specific age group in a specific geographic area. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates)

## 1.4 Race/Ethnicity

### Total Population, by Race (Non-Hispanic)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Ontario MCSA</td>
<td>61.00%</td>
<td>15.97%</td>
<td>17.14%</td>
<td>0.43%</td>
<td>0.35%</td>
<td>0.72%</td>
<td>4.40%</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>66.53%</td>
<td>16.31%</td>
<td>11.51%</td>
<td>0.75%</td>
<td>0.52%</td>
<td>3.66%</td>
<td>3.83%</td>
</tr>
<tr>
<td>California</td>
<td>65.17%</td>
<td>9.33%</td>
<td>20.21%</td>
<td>0.66%</td>
<td>0.57%</td>
<td>2.21%</td>
<td>3.59%</td>
</tr>
</tbody>
</table>

This indicator reports the percentage of people in a specific racial group in a specific geographic area. Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates)
This indicator reports the percentage of people who ethnically identify as Hispanic or Latino. Census data does not recognize Hispanic/Latino as a race, so individuals may have identified Hispanic/Latino as their ethnicity, but “White” or “Some Other Race” as their race. (Source: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data, 2008)

**1.5. Limited English Proficiency (LEP)**

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well." This indicator is relevant
because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates)

**Percent LEP Population, by Race/Ethnicity**

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Ontario MCSA</td>
<td>16.61%</td>
<td>1.21%</td>
<td>35.18%</td>
<td>20.18%</td>
<td>4.68%</td>
<td>31.99%</td>
<td>8.73%</td>
<td>31.48%</td>
<td>7.69%</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>15.75%</td>
<td>1.14%</td>
<td>32.38%</td>
<td>14.32%</td>
<td>19.47%</td>
<td>31.48%</td>
<td>7.80%</td>
<td>32.63%</td>
<td>5.29%</td>
</tr>
<tr>
<td>California</td>
<td>14.02%</td>
<td>2.16%</td>
<td>37.04%</td>
<td>13.52%</td>
<td>14.22%</td>
<td>39.85%</td>
<td>8.13%</td>
<td>37.57%</td>
<td>10.08%</td>
</tr>
<tr>
<td>United States</td>
<td>5.82%</td>
<td>2.72%</td>
<td>35.37%</td>
<td>8.58%</td>
<td>13.05%</td>
<td>40.45%</td>
<td>6.91%</td>
<td>36.89%</td>
<td>3.70%</td>
</tr>
</tbody>
</table>

This indicator reports the percentage of the population who are limited English proficient by race and ethnicity. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates)

### 1.6. Education

**Percent Population with No High School Diploma**

![Bar chart showing percent population with no high school diploma](chart.png)

This indicator reports the percentage of the population aged 25 and older without a high school diploma (or equivalency) or higher. This indicator is relevant because low levels of education
are often linked to poverty and poor health. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates)

1.7. Poverty

This indicator reports the percentage of the population living below 100% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates)

Percent Population Below 100% FPL

This indicator reports the percentage of the population living below 100% of the Federal Poverty Level (FPL) by race and ethnicity. (Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates)
1.8. Unemployment

This indicator reports the percentage of the civilian noninstitutionalized population age 16 and older that is unemployed (non-seasonally adjusted). This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status. (Source: U.S. Bureau of Labor Statistics, July, 2012 Local Area Unemployment Statistics)

1.9. Family and Social Support

<table>
<thead>
<tr>
<th>Grandparents responsible for own grandchildren under 18 (as a % of grandparents living with their own grandchildren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
</tr>
<tr>
<td>33.40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Families headed by single mothers (as a % of families with children under 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
</tr>
<tr>
<td>22.90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Families headed by single fathers (as a % of families with children under 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
</tr>
<tr>
<td>8.70%</td>
</tr>
</tbody>
</table>

This indicator reports the percent of households with different living arrangements: grandparents living with their own grandchildren as their caregivers; families headed by single mothers with
children under 18; and families headed by single fathers with children under 18. (Source: 2007-2011 5-year ACS Estimates) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

2. **Access to Care**

These factors include: Health insurance status and medically underserved populations. More information on these and related factors can be found in the “Health Care Access and Utilization” and “Service Infrastructure” health need profiles in Appendix A.

2.1. **Health Insurance Status**

![Lack of Health Insurance](image)

This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status. (Source: U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates)
2.2 Medically Underserved

The indicator on the previous page reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. (Source: U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012)

3. Burden of Chronic Diseases and Other Health Conditions

These factors include: Asthma, overweight/obesity, diabetes, cardiovascular disease, mental health, violent crimes, and homicides. More information about the following health issues can be found in the health need profiles in Appendix A.

3.1. Asthma
This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma. This indicator is relevant because asthma is a prevalent problem in the U.S. that is often exacerbated by poor environmental conditions. (Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010.)

3.2. Overweight and Obesity

![Chart showing adult overweight and obesity percentages]

This indicator reports the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight) and greater than 30.0 (obese). (Sources: Centers for Disease Control and Prevention [CDC], Behavioral Risk Factor Surveillance System, 2006-2010; CDC, National Diabetes Surveillance System, 2009)

3.3. Diabetes

![Chart showing percent with diabetes]

This indicator reports the percentage of adults aged 18 and older who self-report that they have diabetes.
This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. (Source: Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009)

3.4. Cardiovascular Disease

This indicator reports the percentage of adults who have ever been told by a doctor that they have any kind of heart disease. (Source: California Health Interview Survey (CHIS), 2009)

3.5. Mental Health

This indicator measures the percentage of adults who self-reported the need to see a professional because of problems with their mental health, emotions, and nerves, during the last 12 months. (Source: California Health Interview Survey (CHIS), 2009)
### 3.6. Community Violence

#### Violent Crime

This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. (Source: U.S. Federal Bureau of Investigation, Uniform Crime Reports, 2010)

#### Homicide Rates

This indicator reports the homicide rate per 100,000 population, age-adjusted to the year 2000 standard. (Source: California Department of Public Health, Death Statistical Master File, 2008-2010)
4. Basic Needs

This section contains the analyzed data from the Inland Empire United Way 2-1-1 database and the Food Bank Survey. The two methods were conducted to enrich the demographic profile of San Bernardino County.

4.1. United Way 2-1-1 Caller Data

<table>
<thead>
<tr>
<th>Reasons for 2-1-1 Calls in San Bernardino County*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Consumer Services</td>
</tr>
<tr>
<td>Environmental Quality</td>
</tr>
<tr>
<td>Individual and Family Life</td>
</tr>
<tr>
<td>Income Security</td>
</tr>
<tr>
<td>Mental Health Care and Counseling</td>
</tr>
<tr>
<td>Criminal Justice and Legal Services</td>
</tr>
<tr>
<td>Health Care</td>
</tr>
<tr>
<td>Organizational/Community Services</td>
</tr>
<tr>
<td>Basic Needs</td>
</tr>
<tr>
<td><strong>Total Number of Calls: 200,756</strong>*</td>
</tr>
</tbody>
</table>

Source: United Way 2-1-1 San Bernardino County, Stats and Services, Caller Data 2010-2012.

This graph reports the reasons for 2-1-1 calls made in San Bernardino County from November 2010 to June 2012. NOTE: San Bernardino County data is used where MCSA-specific data could not be found.
4.2. Food Distribution Agencies of San Bernardino County—Food Agency Survey Results

Secondary data analysis indicated food insecurity to be an important health issue in the KFH – Ontario MCSA. Subsequently, the consulting team conducted a short survey with seven food agencies recruited by the Community Benefits staff. The survey included questions about the quantities and quality of food they provide, as well as the population they serve.

When asked what type of food agency they are, the majority of respondents (85.7%) categorized their organization as a “Food Pantry.” The food agencies reported serving a wide range of clients each day (35 to 416 people daily). Community Action Partnership of San Bernardino County (CAPSBC) states serving approximately 23,000 households per month, with their Soup Kitchens serving approximately 76,000 meals per month. All respondents stated their food agency distributes food at least once a day. Nearly half (3 of 7) of the agencies distribute food for take-home purposes. The other four agencies serve prepared meals to clients once a day, for up to 6 days per week.
Many food agencies indicated a higher demand for food in their community. They identified an increase in the following populations served: veterans, disabled, homeless, seniors, and children. One respondent stated, “Need is increasing; children are more dependent on the food we provide.” In addition to food, some agencies provide essential household items, such as paper towels, toilet paper and diapers.

The food distribution agencies cited several factors on which they base their decisions of the type of food they serve or distribute, including: price, storage, refrigeration, transportation, and the constraints of the populations served. One respondent explained, “Most nutritional food is expensive. Not all of our distribution sites have refrigeration for storage.” Another respondent stated, “Our program budget currently limits us to spending approximately $2 per child for a weekend worth of food. The constraints of the population we serve also dictate our food menu, such as clients living in cars or motels, no electricity, etc.” Most of the food agencies (4 of 7) have policies to increase healthy foods (e.g. fresh fruits and vegetables, low-fat dairy, whole grains, etc.) distributed. When asked if agencies have policies or guidelines to decrease foods of minimal nutritional value, most of the food agencies surveyed (4 of 7) responded “No.” One respondent stated, “Since food is limited, we distribute as much food as possible, unless it’s clearly detrimental.” Almost all food agencies (6 of 7) indicated their organization’s nutritional policy has not changed the way they provide food to clients. Many of the food agencies indicated much of the food distributed comes from “Local/Community Donations” and other “Food Banks”; little or none comes from “Funds Raised” or “Government Donations”.

Almost all food agencies surveyed (6 of 7) indicated that “Lack of Staff/Volunteers” was not a challenge for their organization. All agencies indicated the clients never complain about the food received. The responses regarding food shortages were mixed. Nearly half of agencies surveyed indicated their organizations never experience lack of food to serve/distribute because of careful practice in obtaining and purchasing food. Other agencies face shortages “on a regular basis” and have had “to cut back our purchases.” When food shortages occur, most agencies indicated the clients are greatly impacted and people may go hungry. To help remedy shortage issues, one agency contacts other food agencies, vendors, and donors when their supply runs low.

All food agencies surveyed indicated “Employment/Job Training” and “Physical Healthcare” are the greatest needs to the populations they serve. In addition, most of the respondents indicated their clients also needed assistance in “Financial”, “Housing” and “Mental Health/Counseling” services.
IV. Who Was Involved in the Assessment

Special Service for Groups (SSG) is the consultant (hereafter referred to as “consulting team”) who conducted this Community Health Needs Assessment. Incorporated as a nonprofit organization in 1952, SSG specializes in helping grassroots communities develop solutions to problems they identify as the most pressing. SSG operates more than 20 direct service programs and also supports several affiliated organizations in Southern California. These programs and affiliated organizations range in staff and budget size and address issues as diverse as child and youth development, mental health, hunger and homelessness, substance use, reentry integration, health care access and disparities, HIV/AIDS, and dental health.

SSG has excelled in the last decades in building the capacity of its diverse programs and their community partners, regardless of where they are in their organizational development, so that they can serve their populations more effectively and holistically. The components of “special service” to these programs and their community partners include: fiscal accountability, human resources management, resource development, program design, community engagement, cultural and linguistic competence, risk management, and strategic planning. Another capacity building component provided by SSG is research and evaluation.

Since 2003, the SSG Research & Evaluation Team (R&E) has provided capacity building to our programs and partners in Southern California (including grantmakers, hospitals/clinics, and community-based organizations) by: conducting mixed-methods community health assessments; conducting a series of workshops on various research and evaluation topics; participating in program and evaluation development using logic models; designing research or evaluation instruments and protocols; conducting data analysis; participating in quality assurance activities; disseminating and using data to improve program effectiveness and leverage resources; and compiling secondary data for policy advocacy.

SSG was involved in the Community Health Needs Assessments (CHNA) for two hospital collaboratives in 2010. During that year, SSG collaborated with Healthy City/Advancement Project to conduct the CHNA for five (5) Kaiser Foundation Hospitals, including Downey, Fontana, Riverside, South Bay, and West L.A. At the same time, SSG also partnered with the Center for Nonprofit Management to conduct CHNA for a collaborative of five (5) hospitals in Metro Los Angeles that included Kaiser Foundation Hospital – Los Angeles. In 2012, in addition to Kaiser Foundation Hospital—Ontario, the SSG R&E Team also conducted CHNA for Kaiser Permanente Medical Centers in Fontana, Anaheim, Irvine, Moreno Valley, and Riverside.
V. Process and Methods Used to Conduct the CHNA

The Community Health Needs Assessment (CHNA) utilized a mixed-methods approach that includes the collection of secondary (or quantitative) data from existing data sources and community input (or primary data) from focus groups and interviews with CHNA participants. The process was reiterative (non-linear) as both the secondary and primary data were used to help inform each other. The advantage of using this approach is that it validates data by cross-verifying from a multitude of sources. This chapter describes the types of secondary data and community input collected and methodology for collecting and interpreting them for the CHNA. The next chapter describes how both quantitative data and community input are used to identify health needs for the Kaiser Foundation Hospital (KFH) - Ontario Medical Center Service Area.

A. Secondary Data

Kaiser Permanente has identified a list of data indicators to be used by all Kaiser Foundation Hospitals for their CHNA process, including this one for the KFH – Ontario Medical Center Service Area. The national common indicators list includes close to 100 nationally available indicators that together help us understand the health of a community. In California, Kaiser Foundation Hospitals relied on indicators comprised of national, state, and local data sources. State and local data sources were included because, compared to the national sources, they allowed for more granular or recent data, or the indicator was not available through a national data source. For a list of common indicators for California, please refer to Appendix C.

These indicators are closely aligned with the Mobilizing Action Toward Community Health (MATCH) model (see adjacent graphic). The following six data categories were developed to describe the indicators for the purpose of the CHNA:

- **Demographics** describe the population of interest by measuring its characteristics (e.g. total population, age breakdowns, limited English proficiency, etc.). Unlike other categories, demographic indicators are purely descriptive and not generally compared to benchmarks or viewed as positive or negative;

- **Social and Economic Factors** include measures of social status, educational attainment and income, all of which have a significant impact on an individual’s
health. This category includes our three Key Indicators (poverty, high school graduation, and health insurance coverage). The Key Indicators were differentiated from the other common indicators because: (1) they are among the most predictive indicators of poor health outcomes; (2) they are available at a sub-county geography, making it possible to examine and understand the specific areas and populations with greatest needs within each hospital service area; and (3) illustrating the areas of highest need through Key Indicators help communities target primary data collection with major populations the CHNA focuses on, including low-income, medically underserved, minority, and people with chronic diseases;

- Health Behavior refers to the personal behaviors that influence an individual’s health – either positively or negatively (e.g. breastfeeding, physical activity, eating fruits and vegetables, etc.);

- Physical Environment measures characteristics of the built environment of a community that can impact the health of that community either positively or negatively (e.g. parks, grocery stores, walkability, etc.);

- Clinical Care includes: (1) delivery, which measures clinical care being delivered to the community (e.g. rate of preventive screenings, ambulatory care sensitive discharges, etc.) and (2) access, which refers to factors that impact people’s access to timely, affordable clinical care (e.g. primary care physicians, number of federally qualified health centers, etc.); and

- Health Outcomes include: (1) morbidity, which refers to how healthy people are by measuring disease burden and quality of life (e.g. obesity rates, asthma incidence, and low birth weight babies, etc.); and (2) mortality, which measures causes of death by density rates (e.g. cancer mortality, motor vehicle deaths, etc.).

To support and facilitate the CHNA process and access to data, Kaiser Permanente partnered with the Center for Applied Research and Environmental Systems (CARES) at the University of Missouri to develop a web-based data mapping platform. The Kaiser Permanente CHNA data platform has been pre-loaded with the Kaiser Permanente common indicators. It allows users to view, map, and analyze the common indicators according to a specific hospital service area. Users are able to review the indicators and compare them against pre-defined benchmarks to determine how the hospital service area is performing on the respective indicator.

The secondary data for this report was obtained from the data platform in June 2012. The data platform is undergoing continual enhancements and certain data indicators may have been updated since the data was obtained for this report. As such, the most up-to-date data may not be reflected in the tables, graphs, and/or maps provided in this report. For the most recent data and/or additional health data indicators, please visit: http://www.chna.org/KP. The platform is available to the public and can be accessed using a username and password.
In addition, the consultant team analyzed de-identified 2-1-1 caller data compiled by Inland Empire United Way (IEUW). 2-1-1 in San Bernardino County is a hotline where community residents can call anytime and ask about resources they need. 2-1-1 calls are free and anonymous. The call center is staffed by professionals who give information and referrals to appropriate resources, including free and low-cost health and social services. By looking at the number of calls and the reasons for the calls, the consultant team was able to gain a better understanding of the needs of San Bernardino County. A data sharing agreement between The Inland Empire United Way, Kaiser Foundation Hospital – Ontario, and Special Service for Groups was established through a Memorandum of Understanding (MOU). IEUW provided San Bernardino County 2-1-1 caller data collected from November 2010 to June 2012 that were entered into a Microsoft Access database. The variables analyzed were gender, language, race/ethnicity, sources of income, internet access, and reasons for 2-1-1 calls. The IEUW also provided a taxonomy to assist in the analysis of the data. The consultant team conducted univariate analysis (i.e. frequencies) using Microsoft Excel. Analysis from this data is described in Section III of this report.

Methodology for Collection and Interpretation of Secondary Data

The consultant team queried data on the common indicators through the Kaiser Permanente CHNA data platform and obtained the data rates unique for the KFH-Ontario MCSA. The Kaiser Permanente common indicator data is calculated to obtain unique service area rates. In most cases, the service area values represent the aggregate of all data for geographies (ZIP Codes, counties, tracts, etc.) which fall within the service area boundary. When one or more geographic boundaries are not entirely encompassed by a service area, the measure is aggregated proportionally. The options for weighting “small area estimations” are based upon total area, total population, and demographic-group population. The specific methodology for how service area rates are calculated for each indicator can be found on the CHNA data platform.

The consultant team identified the indicators where the medical center service area (MCSA) performed poorly against the following benchmarks: state (California) averages and/or Healthy People 2020 objectives. The indicators that did not meet one of these two benchmarks represented potential health needs in the community. For example, the percent of adults with diabetes in the KFH – Ontario MCSA (8.03%) was higher than the California benchmark (7.57%), and thus demonstrated a potential need to look further into this health issue.

Subsequently, the consultant team conducted a literature review and collected and analyzed additional secondary data sources, including academic articles and community publications, such as recent reports published by The Community Foundation and the County of San Bernardino, as well as health assessments conducted by other hospitals and community-based organizations. Other reports were identified by a general search (mostly online) conducted by the consultant team. Together, these reports complemented the common indicators and provided a more comprehensive picture of community health needs found in the KFH – Ontario MCSA. For a
complete list of CHNA platform data sources and additional publications consulted, please refer to Appendix F.

B. Community Input

The KFH - Ontario Community Benefit staff identified and outreached to local stakeholders to solicit community input about the health needs and assets found in the medical center service area. Community input was solicited from stakeholders that represented broad interests in the community, including stakeholders with special knowledge or expertise in public health; stakeholders in Federal, tribal, regional, State, or local health departments of other departments or agencies with current data or other relevant information; leaders, representatives, or members of medically underserved persons, low income persons, minority populations and populations with chronic disease needs, and other stakeholders (e.g. academic experts, nonprofit organizations, etc). To increase the diversity of community input, the consultant team subsequently conducted focus groups and key informant interviews with youth and Native American/Alaska Native communities.

Local stakeholders participated in focus groups or key informant interviews to discuss health needs, health barriers, and health assets in their respective community. Between September 18 and November 2, 2012, one focus group and 15 key stakeholder interviews were conducted. Stakeholders provided information and perspective about the health needs specific to the KFH – Ontario Medical Center Service Area as well as the broader San Bernardino County.

The following tables list the local stakeholders involved who provided information about the health needs and assets found in the community.

1. **Individuals with Special Knowledge of or Expertise in Public Health**

<table>
<thead>
<tr>
<th>Name (Last, First, Academic Distinction)</th>
<th>Title</th>
<th>Affiliation</th>
<th>Description of public health knowledge/expertise</th>
<th>Date of Consult</th>
<th>Type of Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Fangerow, Kay</td>
<td>Public Health Program Manager</td>
<td>Montclair Medical Clinic</td>
<td>Knowledge of school age medical needs.</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
</tbody>
</table>
2. *Individuals Consulted from Federal, Tribal, Regional, State, or Local Health Departments or Other Departments or Agencies with Current Data or Other Relevant Information*

<table>
<thead>
<tr>
<th>Name (Last, First, Academic Distinction)</th>
<th>Title</th>
<th>Affiliation</th>
<th>Type of Department</th>
<th>Date of Consult</th>
<th>Type of Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellis, Meaghan RN, PHN, MSN</td>
<td>Chief of Nursing/Health Center Director</td>
<td>County of San Bernardino Department of Public Health</td>
<td>Health care settings, specialty care, psychiatry and chemical dependency for children and adults.</td>
<td>10/3/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Nickols, Patricia</td>
<td>CEO</td>
<td>Community Action Partnership of SB County</td>
<td>Food banks and food insecurity.</td>
<td>10/3/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Rico, Andrea</td>
<td>Youth and Family Services Manager</td>
<td>City of Pomona</td>
<td>Special knowledge of youth and family needs and resources</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Thomas, CaSonya MPA</td>
<td>Director</td>
<td>County of San Bernardino Department of Behavioral Health</td>
<td>Special knowledge of mental health issues.</td>
<td>10/9/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Trevino, Evelyn</td>
<td>Public Health Program Coordinator</td>
<td>County of San Bernardino Department of Public Health</td>
<td>Expertise in epidemiological data and special knowledge of San Bernardino health concerns.</td>
<td>9/28/2012</td>
<td>Key Informant Interview</td>
</tr>
</tbody>
</table>
3. **Leaders, Representatives, or Residents of MedicallyUnderserved Persons, Low-Income Persons, Minority Populations, and Populations with Chronic Disease Needs**

<table>
<thead>
<tr>
<th>Leader / Rep. Name (Last, First, or Participant Type/#)</th>
<th>Description of leadership, representative, or participant role</th>
<th>What group(s) do they represent? (medically underserved, low income, minority population, population with chronic disease)</th>
<th>Date of Consult</th>
<th>Type of Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fox, Diana</td>
<td>Executive Director, Reach Out</td>
<td>Special knowledge of community and their health needs.</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Luna, Cynthia</td>
<td>Director, Latino Health Collaborative</td>
<td>Access to health and decrease health disparities for Latino communities.</td>
<td>9/28/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Peterson, Jim</td>
<td>Executive Director, San Bernardino County Medical Association</td>
<td>Special knowledge of health care providers.</td>
<td>9/20/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Saul, Judy</td>
<td>Program Director, Mercy House</td>
<td>Provides services to homeless populations.</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Soucy, Wayne</td>
<td>Executive Director, Community Clinic Association of San Bernardino County</td>
<td>Special knowledge of community clinics and Federally Qualified Health Centers.</td>
<td>10/9/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Thomsen, Bill</td>
<td>Chief Operations Officer, Riverside-San Bernardino County Indian Health</td>
<td>Tribal Health</td>
<td>10/24/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Vega, Isaac</td>
<td>Food Securities Program Manager, Inland Valley Hope Partners</td>
<td>Special knowledge of homeless and low income population needs</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
</tbody>
</table>
4. Other Sources of Community Input

Other sources of community input (can include consumer advocates, non-profit organizations, academic experts, local government officials, community-based organizations, health care providers, private businesses and/or health insurance and managed care organizations)

<table>
<thead>
<tr>
<th>Name (Last, First)</th>
<th>Title</th>
<th>Affiliation</th>
<th>Date of Consult</th>
<th>Type of Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alvarez, Fred</td>
<td>Police Officer</td>
<td>Ontario Police Department</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Barragan, Christian</td>
<td>Operations Manager</td>
<td>Bilingual Family Counseling Services</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Cross, Stafford</td>
<td>Police Officer</td>
<td>Ontario Police Department</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Earl, Beverly</td>
<td>Director, Family and Community Services Department</td>
<td>Catholic Charities, San Bernardino County</td>
<td>9/21/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Martindale, Bronica Rev.</td>
<td>Community Advocate</td>
<td>Network for a Healthy California-African American Campaign</td>
<td>11/2/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Mooney, Bonnie</td>
<td>Safe Schools/Healthy Schools Coordinator</td>
<td>Ontario-Montclair Unified School District</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Olhasso, Mary Jane</td>
<td>Administrator</td>
<td>County of San Bernardino Economic Development Agency</td>
<td>9/21/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Phillips, Erin D.</td>
<td>President and CEO</td>
<td>Children's Fund</td>
<td>9/20/2012</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>Sturgis, Robert</td>
<td>Police Officer</td>
<td>Ontario Police Department</td>
<td>9/18/2012</td>
<td>Focus Group</td>
</tr>
</tbody>
</table>

Methodology for Collection and Interpretation of Community Input

Focus groups were conducted at sites in the community. All key stakeholder interviews were conducted at the offices of the participants except for three, which were conducted over the phone at the request of the participants. In two cases, the participants were joined by other staff members of the organizations. In almost all instances, there were two members of the consultant team at each data collection, one to facilitate the conversation and the other to take notes. With the permission of the participants, all focus groups and interviews were audio-recorded. The note-taker for each data collection was responsible for transcribing the focus group or interview. A focus group guide, which is included in Appendix D in this report, was developed to support facilitation of discussion, with questions in the following broad categories: (1) health needs; (2) health barriers; and (3) health assets. The interview guide adhered to the same framework, but was tailored to the specific expertise of the participants and included probing questions in order
to gather more specific information about health issues where the indicators on the CHNA data platform show disparities in the medical center service area. The following provides details about the health categories explored:

- **Health Needs**
  Major health issues in the community, including health trends and contributing factors (both positive and negative). This may include, but not limited to: obesity and related diseases, such as diabetes; older adults’ health; mental health, substance abuse, and HIV/AIDS; and domestic/family violence;

- **Health Barriers** (both individual and community levels)
  Challenges that impact an individual’s ability to engage in healthy behaviors and/or seek help, including accessibility and affordability of services, environmental or structural factors, social norms, service infrastructure, economic trends, regional disparities, public safety, etc.;

- **Health Assets** (both individual and community levels)
  Resources and factors that positively impact health, including cultural or community values, effective program models, existing institutions, collaboratives and networks, etc.

In addition, the consultant team conducted an online survey to gather data from several food distribution agencies in San Bernardino County on matters related to nutrition and operational practices of food banks, pantries, distribution centers, and soup kitchens. The online survey was conducted between August 29 and September 25, 2012. Survey participants were recruited through convenient sampling by KFH – Ontario Community Benefits staff and represented broad regions of San Bernardino County, including the KFH – Ontario MCSA. However, participation of food distribution agencies was not fully representative of all food distribution facilities in San Bernardino County, as there are over 100 food distribution centers, pantries, soup kitchens, and other agencies that provide food assistance. An e-mail was sent to seven participants with an explanation of and a hyperlink to the survey. Participating agencies ranged from small local soup kitchens to larger county-wide food distribution centers. The consultant team conducted univariate analysis (i.e. frequencies) using Microsoft Excel. Key findings from this data are described in Section III of this report.

The consulting team used a modified content analysis to determine general themes that emerged from community input. Immediately after each focus group or key stakeholder interview, the consulting team members (facilitators and note-takers) debriefed to identify general consensus and disagreements in findings around health needs, barriers, and assets, paying close attention to community input that reinforced or contradicted secondary data. Based on this discussion, the consulting team developed a series of key themes that informed an initial list of health needs found in the community. Because of the inter-relatedness of needs, barriers and assets, the analysis also focused on relationships among key themes and nuances within
each. As a next stage, the consultant team developed key words for each key theme and coded for each focus group or interview transcript accordingly. Then, the consulting team grouped similar comments on a health need, often using specific quotes from focus groups and interviews to illustrate how each health need is manifested in various communities in the medical center service area. For instance, the consulting team pulled out comments from various focus groups and interviews about diabetes and combined community input on this health need that was specific to Hispanic/Latinos, Native American/Alaskan Natives, and low-income communities, respectively, and input related to conditions that co-occur with diabetes. Using this process, additional health needs emerged. For example, initially, substance use was subsumed under the broader health need of mental health. Deeper relational analysis revealed that though the two are related (i.e. co-occurring), there was sufficient data identifying substance use as a distinct health need.

C. Data Limitations and Information Gaps

The Kaiser Permanente common indicators include a robust set of nearly 100 secondary data indicators that, when taken together, enable an examination of the broad health needs faced by a community. However, there are some limitations with regard to this data, as is true with any secondary data available. First, a small number of indicators are only available at the county level, making an assessment of health needs at a neighborhood level challenging. Second, disaggregated data around age, ethnicity, race, and gender are not available for all indicators, which limits the ability to examine disparities of health issues in underserved communities that may be masked by the overall population data. Third, data are not always collected on a yearly basis or the most recent data collected are not yet available to the public, meaning that some data are several years old. For instance, the California Health Interview Survey, one of the data sources for several indicators on the CHNA data platform, is administered once every two years, and the most recent data available were collected in 2009. Fourth, the number of indicators for some health issues is limited. For instance, the primary indicators for mental health on the CHNA data platform only include suicide incidence rate (California Department of Public Health) and self-report of adults needing mental health during past 12 months (California Health Interview Survey). Finally, the CHNA data platform does not include trend data for each indicator, which makes it challenging to demonstrate if any indicators, while performing better than a benchmark, may be experiencing a downward trend in recent years.

For primary data collection, the consultant team primarily relied on service providers, community leaders, and public agency officials for community input. While these stakeholders are knowledgeable about the communities they serve and work with, engagement with more community residents throughout the CHNA process may have provided richer data.
VI. Identification and Prioritization of Community’s Health Needs

A. Identifying Community Health Needs

For this Community Health Needs Assessment (CHNA) process, Kaiser Permanente defines a health need as a poor health outcome and its associated health driver(s) or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need. Health needs are identified through the combined analysis of secondary data and community input. Secondary and primary data findings were inter-related and informed each other during the process of identifying the health needs. Secondary data collection and analysis were instrumental in informing primary data collection of community input. For example, health issues identified through secondary data, where the medical center service area performed poorly against a benchmark were used to inform “probing questions” in focus group and key informant interview guides and to inform the list of key stakeholders with knowledge of those health issues. Community input informed secondary data collection and analysis in two ways. During focus groups and interviews, the consultant team collected information about additional reports referred to by participants. The consultant team also searched for additional secondary data to validate health needs that were brought up by only a few key stakeholders during community input and/or which were not initially identified by the analysis of KP common indicators, such as hepatitis and service infrastructure.

To be a considered a health need, a health outcome or a health driver has to meet two criteria that are applied in the secondary and primary data analysis. Both criteria have to be met in order to be considered a health need. First, existing or secondary data has to demonstrate that the medical center service area data rate fares worse than the Healthy People 2020 objectives and/or state (California) averages OR demonstrate a worsening trend when compared to local data in recent years. Second, the health outcome or driver has to be mentioned in a substantial way in at least two sources of community input (i.e. primary data through focus groups or key stakeholder interviews) to be considered a health need, such as a description of its severity and trend, a description of subpopulations that are most impacted, challenges in addressing the issue, and/or possible links to other health needs.

Based on these criteria, the following 16 health needs were identified, in alphabetical order. More details about each health need are described in the issue statements in the following section and in the health need profiles in Appendix A.

1. Asthma
2. Cancer
3. Cardiovascular Disease
4. Community Violence
5. Diabetes
6. Economic Instability  
7. Health Care Access  
8. Hepatitis  
9. HIV/AIDS & STDs  
10. Mental Health  
11. Oral Health  
12. Overweight/Obesity  
13. Prenatal/Perinatal Health  
14. Service Infrastructure  
15. Substance Use  
16. Teen Pregnancy  

B. Process and Criteria for Prioritization  

The prioritization process relied on two key prioritization methods: nominal group planning process for a community-wide discussion about identified health needs and simplex method for the voting process to prioritize health needs. The nominal group planning process emphasized a deep discussion around the identified health needs. It enhanced the prioritization process by developing a shared understanding of the identified health needs among diverse CHNA participants and by explaining clearly the criteria in or by which CHNA participants would apply to each health need during the simplex method. CHNA participants were convened in a community forum to review and discuss CHNA findings, leading to a final prioritization through a voting process. The simplex method was a strategy for quantitatively gathering individual input via a survey with close-ended questions for each health need based on selected criteria. The scores for each question on the questionnaire were averaged in order to produce a prioritized list of needs.  

Kaiser Foundation Hospital (KFH) – Ontario Community Benefits staff and the consulting team decided to apply both the nominal group planning process and simplex voting method through a community forum in the KFH – Ontario Medical Center Service Area (MCSA). The KFH - Ontario MCSA forum was held on January 23, 2013. Twenty two (22) community stakeholders attended the forum. Stakeholders who participated in the community forums represented the health care sector (e.g. hospitals, clinics and providers), nonprofit and community-based organizations (e.g. churches, grassroots, food pantries, coalitions), county and city agencies and programs (e.g. police, public health and behavioral health departments, criminal justice, school districts), public health experts and professionals, social service providers (e.g. family assistance, children services, domestic violence, mental health) and academic institutions (e.g. colleges and universities). In order to broaden community input into the prioritization process, each participant also had the option to invite a community partner (from another agency) to attend the forum.
Prior to the forum, an online “straw poll” and the issue statements of the 16 health needs were sent to those who responded they would attend the forum. The participants were asked to review the summary of health needs and then respond to the online “straw poll” in order to maximize time for the nominal group process discussion during the community forum. The straw poll asked participants to pick the top five most important health needs for their community to address. The straw poll also had two open-ended questions. The first question asked if there were any other health needs that should have been part of the list. The second question asked if the participants had any questions about any of the health needs in the summary.

The nominal group planning process was applied at the onset of the community forum. Straw poll results were shared at the community forum during the discussion to stimulate reaction and feedback. Participants were asked if they found the straw poll results affirming or surprising, i.e. whether some health needs should be ranked higher and why. Facilitators also devoted some time during this segment of the forums to address any questions that were submitted by participants through the straw poll.

The nominal group planning process was chosen because many focus group and interview participants expressed appreciation for the opportunity to have community conversations about health needs and solutions and were interested in learning the results of the assessment as soon as possible. The facilitated discussion allowed a democratic process where participants had an opportunity to share their reflections, reactions, ideas, experiences, and resources with each other. The discussion was also intended to reduce bias in the next phase of the prioritization process using the simplex method. For the qualitative highlights of the discussion at the community forum, please refer to Appendix E.

The simplex method began immediately after the discussion, towards the end of the community forum. Each agency present was given a final prioritization survey to rate each health need according to the following criteria on a 1-4 scale (from less severe to more severe, from getting better to getting worse, and from few/no assets to many assets).

1. **Severity** – participants discussed which health needs had the most severe impact on the quality of life of those affected directly or indirectly (e.g. caregivers, other household members, etc.). For this criterion, participants also considered which health needs affected or complicated other health outcomes and how.

2. **Trend** – participants discussed which health needs had improved or worsened in the past several years and their outlook in the foreseeable future. For this criterion, participants also considered external events that might influence these trends, such as economic conditions, demographic shifts, and policy change, including the Affordable Care Act.

3. **Assets** – participants discussed which health needs do or do not have adequate attention, such as programs, policies, and initiatives. For this criterion, participants also discussed the type of resources that would be necessary in order to improve the health needs.
Each question had an “I don’t know” response for participants who did not feel comfortable rating a health need that they were not familiar with, even after the group discussion. In cases where more than one representative was participating from an agency, only one survey was given. Participants filled out final prioritization surveys anonymously. Completed surveys were collected before participants left the forum.

After the forum, the consultant team coded the completed surveys and entered responses into a database for analysis. Each health need received a composite score that is the sum of the averages of the first two criteria (severity and trend). The higher the composite score, the higher the health need ranked on the prioritized list. The third criterion (assets) was not used in this calculation. This information will be more useful during the “Implementation Strategy” process as KFH – Ontario makes strategic decisions about resource allocation.
C. Prioritized Description of All the Community Health Needs (Issue Statements)

Through the community forum, community stakeholders evaluated the severity and trend for each of the 16 health needs, which resulted in the following prioritized ranking of the health needs. Because KFH-Ontario Medical Center Service Areas (MCSA) and KFH-Fontana MCSA cover most of the geographic areas in San Bernardino County, the consulting team also averaged the scores from both MCSAs to produce a combined rating for San Bernardino County, as a comparison. The health need profiles, which are a more thorough description of each health need with secondary data and community input from the CHNA process, can be found in in Appendix A. The health need profiles also include data from both KFH-Fontana MCSA and San Bernardino County for comparison purposes.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Health Need</th>
<th>Severity</th>
<th>Trends</th>
<th>KFH-Ontario MCSA Total</th>
<th>San Bernardino County Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Substance Use</td>
<td>3.53</td>
<td>3.47</td>
<td>7.00</td>
<td>6.98</td>
</tr>
<tr>
<td>2</td>
<td>Mental Health</td>
<td>3.57</td>
<td>3.33</td>
<td>6.90</td>
<td>6.98</td>
</tr>
<tr>
<td>3</td>
<td>Economic Instability</td>
<td>3.50</td>
<td>3.18</td>
<td>6.68</td>
<td>6.76</td>
</tr>
<tr>
<td>4</td>
<td>Oral Health</td>
<td>3.39</td>
<td>3.28</td>
<td>6.67</td>
<td>6.62</td>
</tr>
<tr>
<td>5</td>
<td>Health Care Access</td>
<td>3.45</td>
<td>3.05</td>
<td>6.50</td>
<td>6.75</td>
</tr>
<tr>
<td>6</td>
<td>Community Violence</td>
<td>3.23</td>
<td>3.19</td>
<td>6.42</td>
<td>6.27</td>
</tr>
<tr>
<td>7-Tied</td>
<td>Diabetes</td>
<td>3.18</td>
<td>3.18</td>
<td>6.36</td>
<td>6.31</td>
</tr>
<tr>
<td>7-Tied</td>
<td>Overweight/ Obesity</td>
<td>3.27</td>
<td>3.09</td>
<td>6.36</td>
<td>6.42</td>
</tr>
<tr>
<td>9-Tied</td>
<td>Service Infrastructure</td>
<td>2.94</td>
<td>2.72</td>
<td>5.67</td>
<td>6.07</td>
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<tr>
<td>9-Tied</td>
<td>Cardiovascular Disease</td>
<td>2.83</td>
<td>2.83</td>
<td>5.67</td>
<td>5.68</td>
</tr>
<tr>
<td>11</td>
<td>Asthma</td>
<td>2.94</td>
<td>2.65</td>
<td>5.59</td>
<td>5.31</td>
</tr>
<tr>
<td>12</td>
<td>Cancer</td>
<td>2.75</td>
<td>2.65</td>
<td>5.40</td>
<td>5.24</td>
</tr>
<tr>
<td>13</td>
<td>HIV/AIDS &amp; STDs</td>
<td>2.62</td>
<td>2.54</td>
<td>5.15</td>
<td>5.32</td>
</tr>
<tr>
<td>14</td>
<td>Teen Pregnancy</td>
<td>2.50</td>
<td>2.61</td>
<td>5.11</td>
<td>5.33</td>
</tr>
<tr>
<td>15</td>
<td>Prenatal/ Perinatal Health</td>
<td>2.36</td>
<td>2.38</td>
<td>4.74</td>
<td>5.00</td>
</tr>
<tr>
<td>16</td>
<td>Hepatitis</td>
<td>2.50</td>
<td>2.38</td>
<td>4.68</td>
<td>4.68</td>
</tr>
</tbody>
</table>

This section also provides issue statements of the 16 health needs in the order of highest priority to lowest for the KFH - Ontario MCSA. Each issue statement, found on the following page, is a summary of the health need profile containing secondary data and community input and was shared with participants during the community forum. More details about the health needs, including the data and their sources, are provided in their respective health need profile in the Appendix A.
1. Substance Use

According to San Bernardino County CalOMS data, admissions to County substance abuse treatment facilities rose 11% from 2009 to 2011. Of all drug and alcohol-related admissions to substance abuse treatment services in the County, methamphetamine-related treatment had the highest, accounting for 44% of all admissions. Youth also have drug and alcohol issues as the percentages of high school 9th graders who binge drink (17%), currently use alcohol (28%) and use alcohol and other drugs in their lifetime (55%) are higher than the state percentages (15%, 25%, and 50%, respectively). Although men struggle more with addiction than women, CHNA participants expressed concern for pregnant women using drugs and alcohol. In general, alcohol is a commonly abused drug. The highest incidence of alcohol-related deaths in the U.S. was due to alcoholic liver disease, which implies long term use of alcohol. This is especially problematic in low-income communities, which typically live in areas with higher density of liquor stores.

Substance use is reported for specific populations, such as older adults (for depression and bereavement), re-entry population, veterans, and victims of domestic abuse. In 2011, 31.1% of the homeless population had an alcohol or drug problem. Moreover, there is an increase in prescription medication abuse, and a newer trend is the use of synthetic drugs (e.g. spice and bath salts). Screening for synthetic drug use is expensive, and there is a lack of training in identifying symptoms of synthetic drug use; indicating that synthetic drug use is likely higher.

Substance use is linked to mental health, community violence, cancer, oral health, cardiovascular disease and hepatitis.

2. Mental Health

According to state data, the KHF—Ontario MCSA suicide rate (7.6 per 100,000 population) is better than the state average (9.8 per 100,000 population). Suicide incidence is highest in the male population, and Whites are twice as likely to die of suicide as people of other racial/ethnic backgrounds. Overall, 14.69% of the KFH—Ontario MCSA’s population self-reported they felt the need to see a mental or behavioral health professional in the past 12 months. According to CHNA participants, the following mental health trends were identified for various populations, including depression and dementia in older adults (which will continue to increase with the aging of the Baby Boomer generation), post-traumatic stress disorder (PTSD) for veterans, post-partum depression for new mothers, autism for children, substance abuse and general mental health issues for the re-entry population, as well as children who are under extreme stress and exhibit self-induced harm. In addition, the 2011 Homeless Count of San Bernardino County reported that 30% of people interviewed had a mental illness and 22% had a developmental disability. Mental health is linked to obesity, chronic diseases (such as cardiovascular disease and diabetes), and infectious diseases (such as HIV/AIDS). Mental health is also exacerbated by economic instability and lack of access to health care services.

3. Economic Instability

Economic instability includes poverty, unemployment, public assistance, food insecurity, home foreclosures, homelessness, and educational attainment. According to the U.S. Census, the
percent of people living below 100% of the Federal Poverty Level in the KFH—Ontario MCSA (10.38%) is lower than the state (13.71%). However, almost one-fourth (23%) of the community residents in the KFH—Ontario MCSA have no high school diploma, which is higher than the state (19%). Some participants stated that the lack of educational attainment contributed to poverty, since it limits access to higher paying jobs. According to many CHNA participants, unemployment and poverty are major health barriers for San Bernardino County residents. The stress caused by rising unemployment, underemployment, financial hardship, and lack of opportunities impacts the health and well-being of all people, especially those with mental health issues (such as depression) and chronic illnesses (such as heart disease). Moreover, homelessness (in youth and adults) has been increasing in San Bernardino County due to economic instability. Many CHNA participants linked poverty to many of the major health needs, including overweight/obesity, asthma, diabetes, cancer, oral health, prenatal/perinatal health, teen pregnancy, access to health care, community violence and safety, and substance use. Populations disproportionately impacted and affected by economic instability are low-income and disenfranchised communities, including seniors, children and youth, the disabled, re-entry population, undocumented immigrants and people of color.

4. Oral Health

The Health Resources and Services Administration (HRSA) has identified 8 geographical Dental Health Professional Shortage Areas in San Bernardino County. According to CDC and state data, the KFH—Ontario MCSA reported slightly worse dental health than the state. Contributing to poor dental health is a lower percentage of dental care utilization among adults (35.27%) and youth (15.03%) in the MCSA who have not visited a dentist or dental clinic in the past year as compared to the state (30.51% in adults and 10.07% in youth). Cost of dental services was cited as the top reason for low dental care utilization, especially early prevention and dental screenings for children. About 20% of children in San Bernardino County do not have any form of dental insurance. According to CHNA participants and national reports, dental disease is the number one chronic disease for children and youth. Children in the foster care system are also greatly affected by poor oral diseases and dental malformations due to lack of basic dental services, abuse and neglect. Other populations disproportionately affected by poor oral health are seniors, undocumented immigrants, low-income, and high-risk individuals (e.g. pregnant women, homeless, HIV-infected, and prison re-entry population). In addition, the general population does not understand the health issues that can stem from poor oral health, and oral care is not integrated into the overall health delivery system. As a result, many dental diseases are left untreated. Poor oral health is linked with poor prenatal health, cardiovascular and stem from risk factors, such as poor diet and nutrition, substance use, economic instability, and limited availability and accessibility to oral health services.

5. Health Care Access and Utilization

Factors related to health care access and utilization include health care professional shortages, the number of Federally Qualified Health Centers (FQHC) in the County, language and cultural
barriers, health insurance, transportation, cost barriers, and knowledge of resources. Of the people living in the KFH—Ontario MCSA, 56% are living in a Health Professional Shortage Area, slightly lower than the 57.14% state average. The shortage of health professionals, particularly primary care providers and any providers who are bilingual and bicultural, contributes to access and health status issues. The number of primary care physicians in the KFH—Ontario MCSA (66.1 per 100,000 population) was substantially lower when compared to the state benchmark (83.17 per 100,000 population). This translated into 97.14 preventable hospital events per 10,000 population that could have been prevented if adequate primary care was available, which is higher when compared to the state benchmark (83.17 per 10,000 population). The shortage is further compounded by disparities that are unique to San Bernardino County, which include: education attainment, poverty level, insurance and employment. Approximately 21% of the KFH—Ontario MCSA population was uninsured. CHNA participants also reported that people do not understand how to navigate and appropriately use the medical system (e.g. primary care vs. emergency room). Undocumented immigrants, older adults, and people of color are disproportionately affected by issues connected with access to health care. Chronic conditions and mental illness often impair people from accessing care.

6. Community Violence

Community violence includes domestic violence, gang violence, and other social insecurities in one’s community. According to state data, the homicide death rate in the KFH—Ontario MCSA (5.70 per 100,000 population) is higher than the California benchmark of 5.15 per 100,000 population. Forty-nine percent of homicide victims were Hispanic/Latino. However, the rate of violent crimes overall in the KFH—Ontario MCSA is substantially lower than the state benchmark. CHNA participants also shared that domestic violence is an issue in the community. Stress (due to unemployment and financial issues) is one of the main triggers for violence and may be linked to alcohol and substance use. Moreover, in 2011, 25% of homicide and 5% of all felonies in San Bernardino County were gang-related. Although the total number of gang-related filings is down, the number of gangs in the County rose 7% between 2007 and 2011. CHNA participants have witnessed more youth and young adults participating in gang-related crimes. County Sheriff’s Department data revealed youth in San Bernardino County are more likely to consider themselves gang members compared to youth in neighboring counties. The re-entry population, who is released into the community without adequate support systems, is also contributing to the increase in violence. Poverty, unemployment, and lack of educational achievement contribute to community violence and gang activity. Community violence disproportionately affects women, children and youth, low-income communities, and people of color. Without a network of support and a safe community, families cannot thrive.

7. Tied. Diabetes

According to county and CDC data, diabetes prevalence among adults and children is increasing in San Bernardino County, which has the second highest proportion of diabetes in adults in the
state. Diabetes prevalence in adults in the KFH—Ontario MCSA (8.03%) is higher than the California benchmark of 7.57%. Diabetes hospitalization rate for adults is higher in the KFH—Ontario MCSA (11.59 per 10,000 hospitalizations) than the California benchmark (9.66 per 1,000 hospitalizations). The youth diabetes hospitalization rate is also higher in the KFH-Ontario MCSA (5.40 per 10,000 hospitalizations) compared to the California benchmark (4.80 per 10,000 hospitalizations). According to CHNA participants, diabetes is noticeably prevalent in African American, Hispanic/Latino, Native American/Alaskan Native, undocumented immigrant, and low-income communities due to a combination of cultural diet, the abundance of American fast food outlets, lower physical activity, stress, lack of access to healthy foods, and lack of access to health care services (shortage of primary care physicians). Obesity is often a precursor to diabetes. Diabetes is linked to mental health, prenatal/perinatal health, economic instability, and service infrastructure.

7-Tied. Overweight/Obesity

According to CDC and state data, overweight and obesity is rising. The KFH—Ontario MCSA reported higher obesity prevalence for adults (26.29%) and youth (32.62%) compared to the California benchmark (23.25% for adults and 29.82% for youth). Overweight prevalence for adults is also slightly higher in the MCSA compared to the California benchmark. Obesity and overweight spans across all income, age and racial/ethnic groups, but disproportionately affects Hispanic/Latinos, African Americans, Native American/Alaskan Natives, Asian and Pacific Islanders, as well as low-income populations. According to CHNA participants, lack of health and nutrition education (public health infrastructure), poverty, food insecurity, stress, busy work schedules, and poor food environment (e.g. high density of liquor stores, convenient stores, and fast food) are correlated with being obese and overweight. The food that people can afford is usually high in sugar, fat, sodium, and preservatives. Geography is another associated factor, especially when it comes to access to parks and a safe environment. Obesity is linked to cardiovascular disease, diabetes, cancer, prenatal/perinatal health, musculoskeletal conditions, premature death, and mental health.

9-Tied. Service Infrastructure

Service infrastructure includes aspects of the non-profit sector, funding to community organizations, public health infrastructure, coordination/collaboration amongst service providers, capacity building, leadership and advocacy. Secondary data on service infrastructure specific to the KFH—Ontario MCSA is limited. Existing county data reveals that San Bernardino County lags in nonprofit funding and growth, as the number of registered nonprofit organizations in the County has decreased from 6,118 in 2010 to 5,644 in 2011. In addition, San Bernardino County receives $3 of foundation funds per capita, which is significantly less than the California average of $119. As such, alignment of efforts among existing collaboratives and networks is needed and will require more coordination among health care and other service providers, including smaller, more community-based organizations. Capacity building can also strengthen existing organizations, as there is a lack of leadership to adequately address the health needs of county
residents. More emphasis is also needed in addressing the lack of public health infrastructure in
the County; including health education, prevention, and screenings. The issue of service
infrastructure affects all regions of San Bernardino County, particularly low-income and rural
communities. Service infrastructure is linked with access to health care, which in turn is related
to many of the identified health needs.

9-Tied. Cardiovascular Disease

Coronary heart disease (CHD) and stroke, which are part of cardiovascular disease (CVD), have
improved significantly in San Bernardino County from 2002 to 2010, which is consistent with
the state trend. The prevalence of CHD in the KFH—Ontario MCSA (5.87%) is similar to the
state (5.88%). However, the age-adjusted mortality rates due to CHD (168.3 per 100,000
population) and stroke (40.6 per 100,000 population) for the KFH—Ontario MCSA are higher
than the state rates (131.34 and 39.46 per 100,000 population for CHD and stroke in 2010,
respectively). Heart disease is still the leading cause of death in the U.S. Hospitalization due to
congestive heart failure increases exponentially with age. Although all racial/ethnic groups in
San Bernardino County had higher CHD mortality rates than their state counterparts, Native
American/Alaskan Native and Hispanic/Latino populations had significantly higher heart disease
mortality rates than all other racial/ethnic groups. CHNA participants named stress, smoking,
and obesity as potential risk factors in heart cardiovascular disease (CVD). People who have
CVD are more likely to have other chronic health conditions (such as diabetes), especially
among older adults and people with HIV/AIDS. Cardiovascular disease is also linked to
substance use, poor oral health and poor prenatal/perinatal outcomes.

11. Asthma

According to CDC data, asthma prevalence has been decreasing in the KFH—Ontario MCSA.
Asthma prevalence for the KFH—Ontario MCSA (12.64%) is lower than the state (13.12%).
However, adult (6.86 per 10,000 hospitalizations) and youth (12.97 per 10,000 hospitalizations)
asthma hospitalization rates in the KFH—Ontario MCSA are higher than the California
benchmark (8.9 for adults and 19.18 for youth per 10,000 hospitalizations). San Bernardino
County, especially the West Region, has some of the highest average annual pollutant
concentrations in Southern California. According to a USC study, children ages 1-17 in San
Bernardino County had the highest prevalence of asthma (13%) in Southern California. In
addition, children near the West End had one of the slowest lung growth and weakest lung
capacity of all children compared to 11 other Southern California communities studied. CHNA
participants have witnessed an increase of asthma among school children in San Bernardino
County, and it remains a top chronic health issue for children as some residents are unable to
access health care services or afford asthma treatment and medications needed to control their
symptoms. School-based interventions and health education programs that screen children for
asthma and teach them how to manage their asthma early are scarce due to budget cuts, which
have caused a reduction in the number of school nurses and screening efforts. Other populations
being disproportionately affected by asthma are low-income communities, Hispanic/Latinos,
African Americans, undocumented immigrants, and Native American/Alaskan Natives. In addition to being linked with **access to health care**, **economic instability**, and **service infrastructure**, asthma is linked with **obesity/overweight and diabetes** because asthmatic episodes are a barrier to exercise. Asthma is also linked with **mental health** because of the added stress due to barriers to health care utilization.

12. Cancer

According to state data, the age-adjusted death rate due to cancer in San Bernardino County has decreased from 2005 to 2010, yet it still remains the second leading cause of death. The age-adjusted death rate due to all cancers in the KFH—Ontario MCSA (113.2 per 100,000 population) is lower compared to the state average (149.6 per 100,000 population). However, the KFH—Ontario MCSA has higher incidence rates of lung cancer, prostate cancer, colorectal cancer, and cervical cancer when compared to California and/or the Healthy People 2020 benchmarks. In addition, certain cancers are much higher in particular areas of San Bernardino County and may correspond with the exposure of particular environmental pollutants (e.g. particulate matter from diesel trucks and rail yards) in those areas. **Economic instability** is also a contributing factor to these types of cancers, since often families are unable to take environmental factors in mind when they choose a place to live and have homes that are closest to highly polluted areas. African Americans, Whites, men and people over 50 are also disproportionately affected by cancers overall, while Hispanic/Latinos are affected more by cervical cancer. Hispanic/Latinos and Asian and Pacific Islanders are also more affected by liver and bile duct cancers. **Obesity** and **alcohol use** increase the chance of getting colon, rectal, and esophageal cancers.

13. HIV/AIDS and other STDs

Though incidences of chlamydia have fluctuated, it is currently on the rise. According to state data, the incidence rate of chlamydia in the KFH—Ontario MCSA (438.7 per 100,000 population) is much higher than the state (400.0 per 100,000 population). Women in general are disproportionately impacted by chlamydia compared to men. Gonorrhea has also been on the rise in the County since 2009, even though currently the incidence is below the state average (68.7 per 100,000 population compared to California’s 73.1 per 100,000 population). While HIV prevalence (259 per 100,000 population) and hospitalization discharge rate (0.87 per 10,000 population) for the KFH—Ontario MCSA are below the state average (345.4 per 100,000 population and 1.98 per 10,000 population, respectively), more than half (58%) of the population in San Bernardino County reported that they had never had an HIV screening. Men who have sex with men, especially African American and Hispanic/Latino men, are disproportionately affected by HIV. HIV and STD infection is also on the rise in the older adult (50 and older) population. Furthermore, HIV/AIDS and other STDs are linked to **mental health**, **substance use**, **prenatal/perinatal health**, **teen pregnancy** and **cardiovascular disease**. Because of advances in HIV treatment, people with HIV are living longer, though their health can be compromised by other chronic diseases.
14. Teen Pregnancy

According to county data, the teen birth rate has decreased in all racial/ethnic groups in San Bernardino County. However, the teen birth rates for the KFH—Ontario MCSA (9.0 births per 1,000 females under the age of 20) is still higher than the state average of 8.46 births per 1,000 females under the age of 20. CHNA participants expressed that African American, Hispanic/Latino, and low-income communities are disproportionately affected by teen pregnancy. In 2010, Hispanic/Latina teen birth rates were 65.5 births per 1,000 females aged 15-19 and African American teen birth rates were 50.4 per 1,000 females aged 15-19; higher than their White counterparts and state birth rates. Teen pregnancy is linked to poor pregnancy outcomes (e.g. preterm delivery, low birth weight and infant mortality) and social and educational consequences (e.g. low educational attainment, higher public assistance, and rapid repeat pregnancies). Teens are also less likely to receive prenatal care. According to CHNA participants, lack of access to contraception and sex education in the schools and community are major barriers to reducing teen pregnancy, especially in politically conservative parts of the County. Moreover, children of teen parents are more likely to have poorer academic and social outcomes, have increased risk of incarceration, and experience multigenerational cycles of becoming adolescent parents. Transportation and child care are challenges to teen parents who want to continue with their education and access other services. Other factors linked to teen pregnancy are domestic violence and childhood neglect, higher risk of contracting HIV/AIDS and STDs, and economic instability due to low educational attainment, and stress.

15. Prenatal/Perinatal Health

According to CDC and state data, the KFH—Ontario MCSA reported a lower percentage of low birth weight (LBW) babies (6.74%) compared to California (6.80%). Although the infant mortality rate in San Bernardino County is decreasing, the KFH—Ontario MCSA reported a higher infant mortality rate (6.30 per 1,000 births) compared to California (5.14 per 1,000 births). The percentage of mothers breastfeeding after birth in the MCSA (87.63%) is lower than the California benchmark (91.74%). Breastfeeding is associated with children having significantly lower blood pressure and decreased risk of cardiovascular disease and chronic diseases later in life. Although there have been advancements in prenatal and perinatal health, women of color, especially African American women, continue to experience disparities in prenatal care and outcomes in San Bernardino County. African American women in general receive the least amount of prenatal care and have higher incidence of LBW, very LBW, and infant mortality. According to CHNA participants, mothers using substances during pregnancy and not receiving adequate dental care are also an issue. Pregnancy-related health outcomes are influenced by poor health, poor eating habits, poor quality housing and neighborhood characteristics, low socioeconomic status, having HIV/AIDS and STDs, drug and alcohol use, and exposure to environmental risk factors (e.g. air pollution, lead, mercury, pesticides, and household chemicals) during pregnancy. This can lead to poor fetal development and later translate into poor child health, such as diabetes, overweight, obesity, and cardiovascular
disease. Prenatal/perinatal health is also linked with service infrastructure and access to health care as some communities lack OB/GYN physicians, maternal health professionals and health insurance.

16. Hepatitis

The age-adjusted hospitalization rate due to hepatitis in San Bernardino County adults is 3.6 per 10,000 population. CHNA participants stated there is a lack of health education, knowledge, and screenings regarding hepatitis. Since hepatitis can be asymptomatic, many community residents are infected at birth, do not get tested, or unknowingly spread hepatitis. Nationwide statistics indicate that hepatitis infection has declined in African American and Native American/Alaskan Native populations, but continues to increase in Hispanic/Latino, Asian and Pacific Islander populations. County data on hepatitis also supports that high disparities exist among specific ethnic groups, such as chronic hepatitis-B among Asian and Pacific Islanders and chronic hepatitis-C among Hispanic/Latino and White populations. Hispanic/Latinos are twice as likely to be diagnosed with hepatitis-A, Asian Americans are 2.8 times more likely to contract hepatitis-A, and Native American/Alaskan Natives are almost three times as likely to develop hepatitis-C (HCV), as compared to the White population. In addition, the re-entry and veteran subpopulations have higher rates of hepatitis-C. Moreover, nationwide data reports the Department of Veterans Affairs is the highest single provider of hepatitis-C care with men being the most infected. Factors for contracting hepatitis-C in some cases include substance use (i.e., cocaine and injection drug use) and risky sexual behavior (e.g., unprotected sex and more than 20 sexual partners).
VII. Community Assets and Resources Available to Respond to the Identified Health Needs of the Community

A. Existing Health Care Facilities

The following is a list of Federally Qualified Health Centers (FQHC) in the KFH – Ontario Medical Center Service Area.

**Federally Qualified Health Centers (Ontario MCSA)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Valley Community Health Center, Inc.</td>
<td>680 Fairplex Drive</td>
<td>Pomona</td>
<td>CA</td>
<td>91768</td>
</tr>
<tr>
<td>Mission City Community Network, Inc.</td>
<td>845 East Arrow Highway</td>
<td>Pomona</td>
<td>CA</td>
<td>91767</td>
</tr>
</tbody>
</table>

The following is a list of hospitals in the KFH – Ontario Medical Center Service Area:

**Hospitals (Ontario MCSA)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canyon Ridge Hospital</td>
<td>5353 G Street</td>
<td>Chino</td>
<td>CA</td>
<td>91710</td>
</tr>
<tr>
<td>Casa Colina Hospital for Rehabilitation Medicine</td>
<td>255 E Bonita Avenue</td>
<td>Pomona</td>
<td>CA</td>
<td>91767</td>
</tr>
<tr>
<td>Chino Valley Medical Center</td>
<td>5451 Walnut Avenue</td>
<td>Chino</td>
<td>CA</td>
<td>91710</td>
</tr>
<tr>
<td>CPC Horizon Hospital</td>
<td>566 N Gordon Street</td>
<td>Pomona</td>
<td>CA</td>
<td>91768</td>
</tr>
<tr>
<td>Heritage Hospital /Kindred Hospital Rancho</td>
<td>10841 White Oak Avenue</td>
<td>Rancho Cucamonga</td>
<td>CA</td>
<td>91730</td>
</tr>
<tr>
<td>Montclair Hospital Medical Center</td>
<td>5000 San Bernardino Street</td>
<td>Montclair</td>
<td>CA</td>
<td>91763</td>
</tr>
<tr>
<td>Pomona Valley Hospital Medical Center</td>
<td>1798 N Garey Avenue</td>
<td>Pomona</td>
<td>CA</td>
<td>91767</td>
</tr>
<tr>
<td>Rancho Specialty Hospital</td>
<td>10841 White Oak Avenue</td>
<td>Rancho Cucamonga</td>
<td>CA</td>
<td>91730</td>
</tr>
<tr>
<td>San Antonio Community Hospital</td>
<td>999 San Bernardino Road</td>
<td>Upland</td>
<td>CA</td>
<td>91786</td>
</tr>
</tbody>
</table>
B. Other Existing Community Resources

San Bernardino County has overarching programs that support many of the current health conditions. These programs can be applicable to multiple health needs as many of them address health in general, and many health needs are linked. The following assets were identified by CHNA participants during the community input process:

- The San Bernardino County Vision Project has brought together stakeholders and community members to “partner with all sectors of the community to support the success of every child from cradle to career”.
- CalFresh promotes healthy food and increases access to healthy foods for those in poverty.
- Inland Empire Health Plan (IEHP) and Molina are working towards providing health care to children. IEHP is utilizing the *promotora* model to address health needs in the community.
- San Bernardino County Housing Authority is trying to collaborate with community partners to add gardens, health and human services and health education programs to their housing units.
- Farmers markets are increasing in many communities throughout San Bernardino County. While seen as a positive thing by many in the community, some farmers markets have become more like entertainment venues instead of promoting fresh fruit and vegetables. Also, farmers markets have not been established in many impoverished neighborhoods.
- Inland Empire United Way’s 2-1-1 helps pull resources together and provide service information for the residents of San Bernardino County.

Other strong key coalitions include the following:

- "Healthy Communities" is a program led by San Bernardino County Department of Public Health, which brings city partners together to share their efforts around improving nutrition and increasing physical activity.
- Inland Empire Children’s Health Initiative convenes to expand outreach and enrollment for children’s health insurance programs (i.e. Healthy Kids) to cover otherwise ineligible children in San Bernardino.
- The Community Clinic Association of San Bernardino County is the lead agency of the Specialty Care Coalition that received grant funding for 5 years from Kaiser Permanente
Southern California Region to address the needs and gaps around specialty care access and utilization of services.

- HEAL Zone is a Kaiser Permanente program designed to support communities to be more healthy.

All of the aforementioned programs help to address some of the issues in San Bernardino County. CHNA participants also identified the following community assets that address specific health needs. The health needs are listed as prioritized by the community. More information about these assets is described in their respective health needs profiles in Appendix A.

**Substance Use**

- Healthy Pomona has created sub-groups to address mental illness and substance use.
- The Ontario Police Department’s COPS program (Community Outreach and Problem Solving) works with the Department of Alcohol and Beverage Control to moderate concentrations of alcohol throughout the city.
- Youth Hope Inc. is a non-profit working in drug and alcohol prevention and treatment. They offer parenting classes, anger management, and counseling.
- Matrix Institute on Addictions provides substance use treatment, education and training, and research to improve the lives of individuals and families affected by alcohol and other drug use.

**Mental Health**

- The Association for Community-Based Organizations (ACBO) offers mental health and substance use programs in San Bernardino County.
- Catholic Charities, San Bernardino County takes families on outings as a way to help them combat stress.
- The Inland Empire Perinatal Mental Health Coalition covers both Riverside and San Bernardino areas and provides mental health services to expectant mothers.

**Economic Instability**

- San Bernardino Homeless Partnership works in collaboration with other agencies to help end chronic homelessness.
- Food distribution agencies meet food needs and encourage people to eat healthy. The United Way and Community Action Partnership of San Bernardino County work with school districts and local non-profit agencies to organize backpack programs and back-to-school events to help meet the basic needs of low-income students.
- Catholic Charities, San Bernardino County helps people in crisis through their food pantry and by providing other resources. They run Ken’s Café, an evening family meal program which feeds families the last 7 to 9 days of the month.
- Riverside-San Bernardino County Indian Health’s Senior Nutrition Program provides meals to seniors that are homebound in on reservations in the two counties.
• Our House Youth Shelter and Youth Hope are both homeless shelters for youths.
• The Homeless Outreach Faith-Based Collaborative combats issues related to homelessness.

Oral Health

• State programs provide dental services to low-income populations and children. The California Medi-Cal Dental program, Denti-Cal, is a program for low-cost dental services.
• First 5 San Bernardino provides grant funding for fluoride varnishing, dental services, dental education, and transportation to dental facilities. First 5 San Bernardino partners with stakeholders, such as the Center for Oral Health, Arrowhead Regional Medical Center (ARMC) First 5 Dental Program, and Preschool Services to provide dental outreach to the children of San Bernardino County.
• Smile in Style in San Bernardino County provides a continuum of services and dental safety net for children from infants to sixth grade.
• The San Bernardino County Department of Public Health provides oral health education, dental screening, fluoride varnish, and dental sealants.
• The Tri-County Dental Society is a coalition of dentists throughout San Bernardino, Riverside, and Los Angeles Counties that pull together resources to help those in need.
• Mercy House provides services that address oral health in the homeless population, including hygiene supplies and referrals to dental services.
• The Children’s Fund provides dental and orthodontic services to foster youth.

Healthcare Access and Utilization

• Riverside-San Bernardino County Indian Health has 7 health clinics throughout San Bernardino County that provide healthcare services, such as medical, dental, optical, mental health and nutrition services, to the Native American population.
• Mercy House provides medical care to the homeless population.
• School-based health centers (SBHC) provide a range of comprehensive services that meet the specific physical and behavioral health needs of the young people in the community as well as community residents who face barriers in seeking health care services in low-income areas.
• ArrowCare is a federally funded health program that provides affordable health insurance for qualified San Bernardino County residents.
• The Latino Health Collaborative works with hundreds of different organizations to improve the health of Latinos and to address barriers within the public and private health systems that impact access to health care.
Community Violence

- Youth Hope Inc. is a non-profit organization working in drug and alcohol prevention and treatment. They offer parenting classes, anger management, and counseling.
- House of Ruth assists women and children victimized by domestic violence by providing shelter, programs, opportunities and education.
- Soroptimist offers programs for middle school girls to teach them about relationship and violence prevention.

Diabetes

- The Sweetness Program at Pomona Valley Hospital Medical Center has a Diabetes and Pregnancy Program that assists pregnant women with managing their diabetes.

Overweight/Obesity

- The Healthy Eating Active Living (HEAL) projects are aimed to “reduce childhood obesity, and increase healthy food choices and overall health education”.
- Network for a Healthy California – African American Campaign is designed to improve the health of the low-income African American community by providing education about healthy eating and physical activity through faith-based projects and regional networks.
- Churches or community organizations offer cooking demonstrations that show communities how to cook healthy meals and make modifications to their diets, as well as provide safe green spaces for families to use.
- The West End Children’s Activity Resource Coalition (WE CARE) brings together many community organizations to identify and promote childhood obesity prevention programs in the West region of San Bernardino County by empowering organizations to make healthy changes in the region through assessment findings and recommendations.
- Recreational sports leagues keep children exercising, keep them busy, and keep them out of trouble. Some organizations have partnered with sports leagues to provide health education and nutrition.
- San Bernardino County has the highest per capita access to recreation with 2.5 million acres of recreational land and one in four residents living within one mile of a local park.
- Partnering with food banks can meet food needs, as well as get people to eat healthy.
- Farmers markets provide access to fresh and healthy fruits and vegetables and can be community assets in addressing overweight and obesity. The certified farmers’ markets (CFM) listed on the following page are located in or near KFH – Ontario MCSA:
**Farmers Markets (Ontario MCSA)**

<table>
<thead>
<tr>
<th>Market Name</th>
<th>Market Address/ Location</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Avenue Market Night</td>
<td>Historic Downtown Upland Ca., 2nd Ave/9th Street,</td>
<td>Upland</td>
<td>CA</td>
<td>91786</td>
</tr>
<tr>
<td>Chino Certified Farmers Market</td>
<td>In front of City Hall on D Street/ Central Avenue, Chino</td>
<td>Chino</td>
<td>CA</td>
<td>91710</td>
</tr>
<tr>
<td>Chino Hills Certified Farmers Market</td>
<td>14000 City Center Drive, Chino Hills (Grand Ave &amp; Peyton Drive)</td>
<td>Chino Hills</td>
<td>CA</td>
<td>91709</td>
</tr>
<tr>
<td>Chino Hills CFM</td>
<td>The Shoppes in Chino Hills - City Center Dr., Chino Hills (between Main St &amp; Shoppes Dr.)</td>
<td>Chino Hills</td>
<td>CA</td>
<td>91709</td>
</tr>
<tr>
<td>Heritage Harvest Certified Farmers Market @ Terra Vista</td>
<td>Terra Vista 10570 Foothill Blvd.</td>
<td>Rancho Cucamonga</td>
<td>CA</td>
<td>91711</td>
</tr>
<tr>
<td>(Accepts: WIC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente Ontario CFM</td>
<td>Kaiser Permanente Ontario Medical Center, 2295 S Vineyard Ave (in front of bldg. D)</td>
<td>Ontario</td>
<td>CA</td>
<td>91761</td>
</tr>
<tr>
<td>Ontario Mills Certified Farmers Market</td>
<td>1 Mills Circle (Between 4th Ave/Franklin)</td>
<td>Ontario</td>
<td>CA</td>
<td>91764</td>
</tr>
<tr>
<td>Terra Vista Town Center Saturday CFM</td>
<td>10788 Foothill Blvd (in Terra Vista Town Center)</td>
<td>Rancho Cucamonga</td>
<td>CA</td>
<td>91730</td>
</tr>
<tr>
<td>The Heritage Harvest CFM</td>
<td>11960 Foothill Blvd (Four Points by Sheraton- cross street: Rochester Ave.)</td>
<td>Rancho Cucamonga</td>
<td>CA</td>
<td>91739</td>
</tr>
<tr>
<td>Upland CFM (Accepts: WIC)</td>
<td>Corner of A Street and 3rd Avenue</td>
<td>Upland</td>
<td>CA</td>
<td>91786</td>
</tr>
<tr>
<td>Victoria's Farmers Market</td>
<td>12505 N Main St (Alcazar Pl &amp; S. Main St)</td>
<td>Rancho Cucamonga</td>
<td>CA</td>
<td>91739</td>
</tr>
<tr>
<td>Wrightwood CFM (Location 2)</td>
<td>12505 N Main St</td>
<td>Rancho Cucamonga</td>
<td>CA</td>
<td>91739</td>
</tr>
</tbody>
</table>

Source: California Department of Food and Agriculture, Certified Farmers Market Program (see Certified Farmers Markets by County, 2012).
Service Infrastructure

- The Community Clinic Association of San Bernardino County acts as an advocacy program that provides education and shared services for continuity of care. A few clinics provide of primary care, mental health and WIC services under one roof.
- The San Bernardino Department of Public Health has a program called the San Bernardino County Reentry Collaborative that focuses on individuals re-entering the mainstream population. They offer assistance with education, job skills, health and focus on successful integration.

Cardiovascular Disease

See resources for Obesity/Overweight.

Asthma

- Primary and secondary school nurses and health aides help manage medical problems for students.
- Open Airways for Schools, a program from the American Lung Association, goes out to schools and teaches children how to manage their asthma, how to detect warning signs of asthma, and how to avoid asthma.
- The Breathmobile is an “asthma clinic on wheels” that goes out to the schools and provides coordinated case management, diagnostic testing, physical exams, medication and child/family education.
- Community Action Partnership of San Bernardino County partnered with the Center for Community Action and Environmental Justice to help organize and build community power around creating safer, healthier, and toxic-free places for low-income communities to live, work, learn and play.
- Some organizations continue to push for smoke-free zones around hospitals and clinics to help with patient safety.
- Community organizations have tobacco cessation programs.

Cancer

- Susan B. Komen supports cancer research, education and treatment.

HIV/AIDS and Other STDs

- The San Bernardino County Department of Public Health runs several programs, such as communicable disease prevention and treatment of STDs and HIV/AIDS, and safe sex programs. At their reproductive health clinics, they provide STD and HIV counseling.
- Planned Parenthood provides reproductive health care and sexual health information for low-income individuals and young men and women in the County.
• HOPWA (Housing Opportunities for People with AIDS) works in collaboration with Catholic Charities, San Bernardino County to address the housing needs of people living with AIDS.

• The Foothill AIDS Project has 3 sites in San Bernardino County that provide services to the community, including HIV/AIDS medical care management and supportive services, HIV education and risk reduction to communities of color, HIV/AIDS housing, and housing to the general homeless population.

• The Inland AIDS Project helps to address the needs of the LGBTQ population.

Teen Pregnancy

• The Riverside-San Bernardino County Indian Health provides a Breastfeeding Program for young Native American mothers and a Teen Pregnancy Prevention program.

• The San Bernardino County Department of Public Health runs several programs, such as safe sex programs to teach young people how to avoid the pressures of becoming sexually active. At their reproductive health clinics, they provide STD and HIV counseling.

• Federally Qualified Health Centers (FQHC) provide prenatal and maternal care, reproductive health, and STD services for low-income and young families.

• Primary and secondary schools can administer sexual education programs to improve teen sexual health and reduce teen pregnancy.

• School-based health centers (SBHC) provide a range of comprehensive services, including reproductive health, that meet the specific physical and behavioral health needs of the young people in the community.

• Planned Parenthood provides care for reproductive health care and sexual health information for low-income individuals and young men and women in the country. Planned Parenthood goes out into the community and provides education around teen sexual health and teenage pregnancy prevention.

• Project Cuidar provides a specialized teen pregnancy program that focuses on African American teens to help with issues of pregnancy and substance abuse.

• The County Coalition Against Sexual Exploitation provides education, prevention, intervention, referrals and direct services to teenagers who have been sexually exploited or at high-risk of being sexually exploited.

Prenatal/Perinatal Health

• The Riverside-San Bernardino County Indian Health provides a Breastfeeding Program for young Native American mothers and the Tribal Maternal Home Visitation program where trained employees make home visits to young, single mothers or families with children from 0-5 years old to provide child education opportunities or provide parent education to improve parenting skills.
• State programs, such as Medi-Cal, Healthy Kids, WIC and CalFresh, increase access to health care and nutritious food for women who are pregnant. Programs, such as the Special Supplemental Food Program for Women, Infants, and Children (WIC), provide food supplements, nutrition education, and health care to pregnant and postpartum low-income women and to infants and children up to age 5 who have health and nutritional risks.
• First 5 San Bernardino provides and funds parent education and other programs to improve maternal and child health.
• The San Bernardino County Department of Public Health provides maternal health, immunizations, and safe sex programs. Family support services include prenatal care, child health, maternal health, and WIC services on site among other services.
• Inland Empire Perinatal Mental Health Coalition is a diverse group of healthcare professionals, individuals and agencies that raise awareness and increase access to mental health services for women and their families during and after pregnancy.
• Federally Qualified Health Centers (FQHC) can provide prenatal and maternal care, reproductive health, and STD services for low-income families.
• Probation offers Parents Matter, which provides free parenting classes for high-risk families that do not have a stable home or structure needed for a healthy lifestyle and healthy relationships. This could help prevent teen pregnancy, unwanted pregnancies, abuse, neglect, and improve prenatal and perinatal health outcomes.

**Hepatitis**

See HIV/AIDS and other STDs and Substance Use for resources. CHNA participants did not discuss assets specifically for hepatitis.
Appendix A. Health Need Profiles

The health need profiles are a more thorough description of each health need with secondary data and community input from the CHNA process.
Asthma

About Asthma — Overview and importance

Asthma is a chronic respiratory health issue that causes episodes of wheezing, chest tightness, coughing, and shortness of breath. Currently in the United States, more than 23 million people have asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors. Low income and minority populations such as children, women, African Americans, people living below the Federal poverty level, and employees with certain exposures in the workplace have the highest rates. The cost of asthma is paid for in higher insurance rates, lost productivity, and tax dollars. Annual health care expenditures for asthma alone are estimated at $20.7 billion. Risk factors for asthma include: having a parent with asthma, sensitization to irritants and allergens, respiratory infections in childhood, and overweight (Source: Healthy People 2020).

Statistical Data — Asthma measurement, prevalence, and incidence

| Percent Population with Asthma |
|-------------------------------|-------------------------|
| Fontana MCSA                  | 13.10%                  |
| Ontario MCSA                  | 12.64%                  |
| San Bernardino County         | 13.13%                  |
| California                    | 13.12%                  |

This indicator shows the percentage of adults aged 18 and older who self-report that they have ever been told they had asthma by a doctor, nurse, or other health professional. (Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010)
This indicator shows the patient discharge rate for asthma and related complications in adults aged 18 and older in the past year, per 10,000 hospitalization events. (Source: California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010)

This indicator shows the patient discharge rate for asthma and related complications in children under the age of 18 in the past year, per 10,000 hospitalization events. (Source: California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010)

Children are more susceptible to air pollution because they take up 20-50% more air than adults during high levels of physical activity and thus more pollution; are physically active when air pollution is at its highest; and air pollution can damage functional parts of the lungs during a child’s lung development (Kleinman, 2000).
Geographic areas of greatest impact/ disparities

Adult Asthma Hospitalization Rate in KFH-Fontana MCSA (Per 10,000)  

Adult Asthma Hospitalization Rate in KFH-Ontario MCSA (Per 10,000)

Over 18.0%  15.1 - 18.0%  12.1 - 15.0%  9.1 - 12.0%  Under 9.1%

In the KFH – Ontario MCSA, adult asthma most strongly impacts Montclair, Chino, and communities north of Rancho Cucamonga.

Youth Asthma Hospitalization Rate in KFH-Fontana MCSA (Per 10,000)  

Youth Asthma Hospitalization Rate in KFH-Ontario MCSA (Per 10,000)

Over 30.0  20.1 - 30.0  10.1 - 20.0  5.1 - 10.0  Under 5.1

In the KFH – Ontario MCSA, youth asthma is worse in Montclair and Mira Loma.
Related Data Indicators Associated with Asthma

The following table outlines some of the data indicators associated with asthma in the community. These data indicators represent factors known to contribute to or which are correlated with asthma in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at http://www.chna.org/KP/.

<table>
<thead>
<tr>
<th>Associated Health Outcomes</th>
<th>Environmental</th>
<th>Socioeconomic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Birth Weight*</td>
<td>Tobacco Usage (Adult)*</td>
<td>Poverty Rate (&lt; 100% FPL) *</td>
</tr>
<tr>
<td>Obesity (Adult) *</td>
<td>Tobacco Expenditures*</td>
<td>Population Below 200% of Poverty Level*</td>
</tr>
<tr>
<td>Overweight (Adult) *</td>
<td>Poor Air Quality (Particulate Matter 2.5)</td>
<td>Children in Poverty*</td>
</tr>
<tr>
<td>Obesity (Youth) *</td>
<td>Pneumonia Vaccinations (Age 65+)</td>
<td></td>
</tr>
<tr>
<td>Overweight (Youth)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Community Input - What do CHNA participants think about the issue of asthma?

CHNA participants noticed an increase in asthma cases and asthma medications in their clients, patients, and school children over the past few years. This trend has also been shown nationally as asthma prevalence has increased from 2001 to 2010 (Akinbami, 2012).

What populations are most affected by asthma?

Many of the groups listed here have difficulty accessing health care services, lack health insurance, or their families cannot afford asthma medication and treatments. This makes managing asthma symptoms more difficult. Poverty and unemployment exacerbate these issues.

- **Children** are disproportionately affected by air pollution, asthma, allergies, and other respiratory conditions (Kleinman, 2000), especially those from low-income families. This may result in some children having asthma attacks while at school and/or being taken to the emergency department. Children are at much greater risk of increased asthma symptoms when they live in communities with higher levels of ozone and air pollution particles (Gauderman et al., 2000; Kleinman, 2000).

- **Native American/Alaskan Natives** are disproportionately affected by asthma and respiratory conditions due to high tobacco use. Tobacco is a major health issue in this community as it has historical and cultural significance and use, and there has been...
increased advertisement by tobacco companies to Native Americans (American Lung Association [ALA], 2013; ALA, 2011).

- San Bernardino County health data has shown that **African American** adults have a higher percentage of asthma than other racial/ethnic groups (Healthy San Bernardino County [HSBC], 2012).

- **Undocumented immigrants** are disproportionately affected by asthma as they face many barriers to health care. Due to these barriers, many undocumented immigrants seek health care services for their asthma from *curanderas* (natural healers), treat themselves through household remedies, obtain medications from their country of origin, and/or use the free community clinics to receive low cost care.

> “I can’t afford to get sick. I barely get any healthcare because my parents don’t have insurance. So I go to the free clinic when I get sick. I have asthma and I would borrow my cousin’s inhaler. They had an asthma machine (asthma nebulizer), but they wouldn’t let me borrow it because medicine for the asthma machine is too expensive.”

- Some CHNA participants also recognize that **homeless** individuals have asthma and are in need of healthcare services to manage their asthma and other co-occurring health conditions.

**What are the challenges to addressing asthma?**

- Poor air quality and air pollution are major contributors to asthma in San Bernardino County (California Air Resources Board [CARB], 2008). Residents in the South Coast Air Basin (which includes San Bernardino County) had higher estimates of risk than elsewhere in the state (CARB, 2008). The areas along the I-10, I-15, and I-215 Freeways are the most affected by poor air pollution (Gauderman et al., 2000; CARB, 2008). These freeways and communities are the busiest routes of transportation in the country as the increased growth of the warehouse and logistics industry handles shipments that come through the L.A. and Long Beach ports (South Coast Air Quality Management District [SCAQMD] Clean Communities Plan, 2010; Newman, 2012; Warehouse Workers United & Cornelio, 2011; CARB, 2008). The increased movement of goods through the Inland Valley contributes to increased traffic and air particulate matter from diesel trucks and trains from the BNSF railyard.

> “Respiratory problems are a big issue here with the air quality in San Bernardino County being pretty bad. Everybody knows you can’t see the mountains some days. Physicians have talked about this being a problem too because it’s going to bring on problems with asthma and other issues.”
• Asthma is correlated with higher risks of low birth weight, cancer, pulmonary congestive heart failure and cardiovascular disease, bronchitis, lost days at work and school, premature mortality, and increased medical costs, as air particles from diesel trucks and railyards have been associated with these health issues (SCAQMD Clean Communities Plan, 2010; Kleinman, 2000; Newman, 2012; CARB 2008). Moreover, poor air quality can reduce the amount of outside physical activity people can have, which can increase the likelihood of being overweight and obese, and obesity-related health conditions.

“The trains go through a lot of low-income communities. They tend to place those [train routes] in low-income areas and [community groups] were concerned about the environmental conditions they produced.”

• Another factor that contributes to air pollution and traffic is residents having to commute for work, including traveling outside of San Bernardino County (County of San Bernardino, 2011b; Johnson, Reed, & Hayes, 2008). Many CHNA participants felt that improving the transportation infrastructure (i.e. public transit system, bicycle lanes, carpool, safe walking routes) can help reduce smog and air pollution in the Inland Valley (San Bernardino Countywide Vision, 2011; Trevino et al., 2012).

• More health education to parents and children about asthma, treatment and the importance of medication adherence is needed to help people control their asthma and to prevent asthma attacks. However, individual behavior change is not sufficient. Efforts are also needed to increase asthma screenings, improve access to health care providers, increase knowledge about available resources, and increase affordability of medications (e.g. inhalers) so that adults and children can monitor their asthma better. Moreover, continued tobacco prevention and cessation programs can combat the increase in tobacco use.

“The trains go through a lot of low-income communities. They tend to place those [train routes] in low-income areas and [community groups] were concerned about the environmental conditions they produced.”

Assets - What are the community assets that can address asthma?

• There are signs suggesting a slight improvement in asthma recently due to concerted efforts by the state, county and regional agencies like the South Coast Air Quality Management District (SCAQMD Clean Communities Plan, 2010; Air Quality Management District [AQMD] Inland Valley Clean Air Summit, 2012). The State of California and efforts like Healthy Communities have introduced measures to reduce emissions, such as having pollution control devices on cars and factories, and ordinances to have diesel and delivery trucks shift to cleaner fuels (SCAQMD Clean Communities Plan, 2010).
Plan, 2010). More innovative efforts must also be made to help companies make the transition to cleaner fuels so that companies do not go out of business and residents are not left without a job. A shift towards green jobs can help improve air quality and increase employment (Johnson et al., 2008).

- Better urban planning can keep schools, parks, and homes away from freeways or areas with high particulate matter to help mediate asthma and other respiratory incidences. One key informant interview participant hopes that their “Healthy Communities movement leads to better walking paths and more extensive networks for bike lanes. I think we need to change our mindset to walk more and drive less.”

- Primary and secondary schools can be an asset in addressing childhood asthma. School nurses and health aides manage medical problems for students – they communicate with doctors’ offices, make referrals, and provide health education to students and parents. Strengthening school-based health care services has been shown to address health needs in low-income areas and communities who lack access to health care and lack health insurance (Allison et al., 2007; Geierstanger & Amaral, 2005). However, school nurses and other school health professionals are already strained because of the poor economy; there are less material and financial resources and fewer nurses and health aides to do the work. Schools also have programs like Walk to School Days, which are primarily focused on safety, but can help decrease dependence on vehicles and reduce traffic and air pollution around neighborhoods with schools.

- **School-based programs:** Open Airways for Schools, a program from the American Lung Association (ALA), goes out to schools and teaches children how to self-manage their asthma, detect warning signs of asthma, and how to avoid asthma triggers (ALA, 2012). The Breathmobile is an “asthma clinic on wheels” that goes to the schools and provides coordinated case management, diagnostic testing, physical exams, medication and child/family education for better asthma management (HSBC, 2012). Through the program, hospitalizations and emergency room visits related to asthma have decreased in the past few years (HSBC, 2012). CHNA participants see a benefit of having the Breathmobile come to their area and are more likely to take advantage of it. A mobile clinic can also be an opportunity for children or residents to be seen for other conditions too, such as diabetes and obesity. This can help reduce the stigma and reluctance of seeing a healthcare provider for conditions like obesity because people don’t feel “singled-out”.

“The Lung Association’s *Open Airways* helps by teaching classes to educate the kids and help manage their asthma better. That’s really helpful. I had a kid that was in a class and she drew a picture when she started the class. She felt like she was choking, and at the end of the class she had a picture of her jumping up in the air like she was free.”
• Some hospitals and organizations continue to push for smoke-free zones around hospitals and clinics to help with patient safety. For example, all Kaiser Foundation Hospital campuses are smoke-free zones.

• **Community Networks:** Community Action Partnership of San Bernardino County partnered with the Center for Community Action and Environmental Justice (CCAEJ) to organize and build community power around creating safer, healthier, and toxic-free places for low-income communities to live, work, learn and play (CCAEJ, 2012).

  “Corporations make the decisions in placing toxic dump sites and huge transportation hubs in communities where people have very little political voice. They would not be able to put the San Bernardino railyard in the City of Rancho Cucamonga because people vote and people are politically active. In the City of San Bernardino and around that area, [many] citizens are undocumented. They have no voice…It has to do with the political capital and with the people’s organized ability to address policies.”

• **Universities:** Loma Linda University (LLU), California State University San Bernardino, and University of California Riverside have a Department of Environmental Sciences and/or Departments/Schools of Public Health. Universities can conduct research to monitor air pollution in parts of San Bernardino County, monitor health outcomes caused by poor air quality and pollution, and address some of the health needs and health inequities in disadvantaged communities. Community programs could also see greater success if they were conducted at night or on the weekends when residents are more available to take advantage of these assets.
Summary

According to CDC data, asthma prevalence has been decreasing in the KFH—Ontario MCSA. Asthma prevalence for the KFH—Ontario MCSA (12.64%) is lower than the state (13.12%). However, adult (6.86 per 10,000 hospitalizations) and youth (12.97 per 10,000 hospitalizations) asthma hospitalization rates in the KFH—Ontario MCSA are higher than the California benchmark (8.9 for adults and 19.18 for youth per 10,000 hospitalizations). San Bernardino County, especially the West Region, has some of the highest average annual pollutant concentrations in Southern California. According to a USC study, children ages 1-17 in San Bernardino County had the highest prevalence of asthma (13%) in Southern California. In addition, children near the West End had one of the slowest lung growth and weakest lung capacity of all children compared to 11 other Southern California communities studied. CHNA participants have witnessed an increase of asthma among school children in San Bernardino County, and it remains a top chronic health issue for children as some residents are unable to access health care services or afford asthma treatment and medications needed to control their symptoms. School-based interventions and health education programs that screen children for asthma and teach them how to manage their asthma early are scarce due to budget cuts, which have caused a reduction in the number of school nurses and screening efforts. Other populations being disproportionately affected by asthma are low-income communities, Hispanic/Latinos, African Americans, undocumented immigrants, and Native American/Alaskan Natives. In addition to being linked with access to health care, economic instability, and service infrastructure, asthma is linked with obesity/overweight and diabetes because asthmatic episodes are a barrier to exercise. Asthma is also linked with mental health because of the added stress due to barriers to health care utilization.
Cancer

About Cancer – Overview and importance
Cancer remains a leading cause of death in the United States, second only to heart disease. Complex and interrelated factors contribute to the risk of developing cancer. These same factors contribute to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups. The most obvious factors are associated with a lack of health care coverage and low socioeconomic status (SES). Many cancers are preventable by reducing risk factors such as use of tobacco products, physical inactivity, poor nutrition, obesity, and ultraviolet light exposure. Early detection through evidence-based screening is key to reducing mortality for most cancers, including cervical, colorectal and breast cancers. Early detection must include the continuum of care from screening to appropriate follow-up of abnormal test results and referral to cancer treatment. (Source: Healthy People 2020)

Statistical Data – Cancer measurement, prevalence, and incidence

<table>
<thead>
<tr>
<th>Oxygen</th>
<th>HP 2010 Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-2004</td>
<td>187.7</td>
</tr>
<tr>
<td>2005-2007</td>
<td>175.8</td>
</tr>
<tr>
<td>2008-2010</td>
<td>160.0</td>
</tr>
<tr>
<td>HP 2010 Objectives</td>
<td>158.6</td>
</tr>
</tbody>
</table>

This indicator reports the rate of death due to cancer per 100,000 population, age-adjusted to year 2000 standard. (Source: The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009)
These indicators report the mortality rate for different types of cancer in San Bernardino County and their trend from 2002-2004 to 2008-2010, and as compared to the Healthy People 2010 Objectives. Source: California Department of Health Services, County Health Status Profiles, 2010. NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

Cancer Incidence, 2005-2009 (Annual Incidence Rate per 100,000 Population)

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>KFH-Fontana MCSA</th>
<th>KFH-Ontario MCSA</th>
<th>San Bernardino County</th>
<th>California</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>114.80</td>
<td>115.40</td>
<td>114.60</td>
<td>123.20</td>
<td>--</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>9.40</td>
<td>9.50</td>
<td>9.50</td>
<td>8.30</td>
<td>≤ 7.1</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>47.10</td>
<td>46.70</td>
<td>47.30</td>
<td>43.70</td>
<td>≤ 38.6</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>150.60</td>
<td>148</td>
<td>150.70</td>
<td>146.50</td>
<td>--</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>56.90</td>
<td>54.40</td>
<td>56.90</td>
<td>52.40</td>
<td>--</td>
</tr>
</tbody>
</table>


Populations disproportionately impacted (disparities)

The following populations have the greatest disparity in cancer incidence and cancer mortality in San Bernardino County:

- **Cancer Incidence, by Race/Ethnicity and gender-** Males have a significantly higher incidence of cancer than females in San Bernardino County with 512.9 versus the 381.6 total cases per 100,000 population. In all incidences, cancer occurs most frequently in Black male residents (507.6 cases) followed closely by Non-Hispanic White male residents (440.6 cases). (National Cancer Institute, Incidence Rate Report for California by County, rate period 2005-2009).

Cancer Mortality Rate by Race/Ethnicity (Per 100,000 Population)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American/Alaskan Native</th>
<th>Native Hawaiian/Pacific Islander</th>
<th>Other Race</th>
<th>Multiple Races</th>
<th>Hispanic/Latino</th>
<th>Non-Hispanic/Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
<td>188.9</td>
<td>218.1</td>
<td>108.2</td>
<td>606.2</td>
<td>29.4</td>
<td>4.3</td>
<td>76.5</td>
<td>133.2</td>
<td>190.0</td>
</tr>
<tr>
<td>California</td>
<td>170.3</td>
<td>214.8</td>
<td>117.9</td>
<td>235.2</td>
<td>70.3</td>
<td>4.1</td>
<td>71.0</td>
<td>125.6</td>
<td>169.5</td>
</tr>
</tbody>
</table>
Geographic areas of greatest impact (disparities)

Cancer Death Rate in KFH-Fontana MCSA (Per 100,000)

Cancer Death Rate in KFH-Ontario MCSA (Per 100,000)

Death Rate (Per 100,000 Pop.), By ZCTA, CDPH, 2008-2010

- Over 250.0
- 200.1 - 250.0
- 150.1 - 200.0
- 100.1 - 150.0
- Under 100.1

Rancho Cucamonga has the highest cancer death rates for the KFH – Ontario Medical Center Service Area.
Related Data Indicators Associated with Cancer

The following table outlines some of the data indicators associated with cancer in the community. These data indicators represent factors known to contribute to or which are correlated with cancer in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Associated Health Outcomes</th>
<th>Environment</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Outcomes</strong></td>
<td><strong>Physical Environment</strong></td>
<td><strong>Physical Activity &amp; Nutrition</strong></td>
</tr>
<tr>
<td><strong>Cervical, Colorectal, Breast:</strong></td>
<td>Population Living in Food Deserts *</td>
<td>Fruit/Vegetable Expenditures</td>
</tr>
<tr>
<td>Obesity*</td>
<td>WIC-Authorized Food Store Access*</td>
<td>Inadequate Fruit/Vegetable Consumption (Adult) *</td>
</tr>
<tr>
<td>Overweight*</td>
<td>Grocery Store Access*</td>
<td><strong>Colorectal, Lung:</strong></td>
</tr>
<tr>
<td><strong>Colorectal:</strong></td>
<td>Park Access*</td>
<td>Physical Inactivity (Adult) *</td>
</tr>
<tr>
<td>Diabetes Prevalence*</td>
<td>Recreation/ Fitness Facility Access*</td>
<td></td>
</tr>
<tr>
<td><strong>Cervical:</strong></td>
<td>Walkability</td>
<td><strong>Colorectal:</strong></td>
</tr>
<tr>
<td>Chlamydia Incidence*</td>
<td>Poor Air Quality (Particulate Matter 2.5)</td>
<td></td>
</tr>
<tr>
<td>HIV Prevalence*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Hospitalizations*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teen Births*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Access to Care</strong></td>
<td><strong>Socioeconomic Factors</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer Screenings</strong></td>
<td><strong>Poverty</strong></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening (Pap Test) *</td>
<td>Population Below 100% of FPL*</td>
<td></td>
</tr>
<tr>
<td>Colon Cancer Screening (Sigmoid/Colonoscopy)</td>
<td>Population below 200% of FPL*</td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening (Mammogram)</td>
<td>Children in Poverty*</td>
<td></td>
</tr>
</tbody>
</table>
**Community Input** - *What do CHNA participants think about the issue of cancer?*

While secondary data shows that cancer is a key concern for this area, it was only sparingly mentioned by CHNA participants. In comparison to other counties in California, San Bernardino has higher deaths due to breast cancer, colorectal cancer, and prostate cancer (Healthy San Bernardino County [HSBC], 2012). They also have a higher rate of liver and bile duct incidence rate than other counties in California (HSBC, 2012). Obesity, alcohol and lifestyle factors (i.e. smoking, physical inactivity) and environmental exposures are known to increase the risk of getting cancer (American Cancer Society [ACS], 2012).

**What populations are most affected by cancer?**

Cancer can happen at any age; however, the likelihood of a cancer diagnosis increases with age (Centers for Disease Control and Prevention [CDC], 2012e).

- **People over 50** are more likely to be at risk for cancer.
- **Men are more at risk for cancer than women.** For example, men are four times more likely to be diagnosed with bladder cancer than women.
- **Economically disadvantaged families** living close to freeways and transportation systems are at greater risk for contracting cancers. Many times, a family’s economic limitations dictate where they can live. This puts families at risk for cancers associated with these types of carcinogens.
- **African Americans** are more likely to be diagnosed with cancer. African American women have a higher incidence of breast cancer. African American men have a higher incidence of colorectal cancer and lung and bronchus cancer and prostate cancer (HSBC, 2012) when compared to people of other ethnic backgrounds.
- **Asian and Pacific Islanders** are affected by liver and bile duct cancers.
- **Latino and Hispanic** populations have a higher incidence of cervical cancer. Hispanic women are more likely to get PAP tests. The Hispanic and Latino population also has a higher incidence of liver and bile duct cancer, as well as Non-Hodgkin Lymphoma (HSBC, 2012). Latinos feel that healthcare providers do not understand their culture, do not speak their language, and therefore are uncomfortable sharing their experiences, symptoms, and barriers to treatment.
- **White** populations are more susceptible to cervical and colorectal cancers. They also have a high rate of melanoma incidence, oral cavity, and pharynx cancer. As with Hispanic women, they have a higher rate of PAP tests (HSBC, 2012).
- **Homeless** individuals who have cancer do not have steady access to health that will enable them to monitor their health.
What are the challenges to addressing cancer?

• The poor air in San Bernardino is well-documented. Despite improvements in air quality, CHNA participants expressed concern over the air quality in their communities. San Bernardino county has a greater than average amount of carcinogens being put into the air, when compared to other counties in California (HSBC, 2012).

“Every product that comes from Asia comes down the 10 freeway and stops in a warehouse in Ontario or San Bernardino. That’s why we have high cancer rates, low birth, lower life expectancy for families of color that live near the transportation hubs.”

• The community’s physical environment is a barrier to healthy eating behaviors and physical activity, which increases the chance of many types of cancers in San Bernardino County.

Assets - What are the community assets that can address the health need?

Since inactivity and diet can increase the incidence of cancer, it is important to keep in mind the assets communities have in these areas. (See “Obesity” health profile for more information). Also of importance is a family’s access to healthcare. Some assets in Prenatal/Perinatal might be applicable to women looking for cancer screenings.

• Community based agencies can aid in prevention and diagnosis. Planned Parenthood is a resource for breast and ovarian cancers (Planned Parenthood, 2012). They work in partnership with Susan G. Komen for the Cure Foundation to provide breast exams for women with low-income.

• CHNA participants also mentioned resources outside of the community, such as the USC’s Norris Comprehensive Cancer Center for detecting colorectal cancers; UCLA Cancer Center; and City of Hope.

Summary

According to state data, the age-adjusted death rate due to cancer in San Bernardino County has decreased from 2005 to 2010, yet it still remains the second leading cause of death. The age-adjusted death rate due to all cancers in the KFH—Ontario MCSA (113.2 per 100,000 population) is lower compared to the state average (149.6 per 100,000 population). However, the KFH—Ontario MCSA has higher incidence rates of lung cancer, prostate cancer, colorectal cancer, and cervical cancer when compared to California and/or the Healthy People 2020 benchmarks. In addition, certain cancers are much higher in particular areas of San Bernardino County and may correspond with the exposure of particular environmental pollutants (e.g. particulate matter from diesel trucks and rail yards) in those areas. Economic instability is also
a contributing factor to these types of cancers, since often families are unable to take
environmental factors in mind when they choose a place to live and have homes that are closest
to highly polluted areas. African Americans, Whites, men and people over 50 are also
disproportionately affected by cancers overall, while Hispanic/Latinos are affected more by
cervical cancer. Hispanic/Latinos and Asian and Pacific Islanders are also more affected by liver
and bile duct cancers. **Obesity** and **alcohol use** increase the chance of getting colon, rectal, and
esophageal cancers.
Cardiovascular Disease

About Cardiovascular Disease – Overview and importance

Currently more than 1 in 3 adults (81.1 million) live with 1 or more types of cardiovascular disease. In addition to being the first and third leading causes of death, heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. Risk factors for cardiovascular disease include: high blood pressure, high cholesterol, cigarette smoking, diabetes, poor diet and physical inactivity, and overweight and obesity. The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status. (Source: Healthy People 2020)

Statistical Data – Cardiovascular disease measurement, prevalence, and incidence

This indicator reports the percentage of adults who have ever been told by a doctor that they have any kind of heart disease. (Source: California Health Interview Survey (CHIS), 2009.)
Heart disease is a leading cause of death in the U.S. This indicator reports the rate of death due to coronary heart disease per 100,000 population, age-adjusted to year 2000 standard. (Source: California Department of Public Health, Death Statistical Master File, 2008-2010.)

Heart Disease Mortality Death Rate
(Per 100,000 population)

Fontana MCSA  Ontario MCSA  San Bernardino County  California  HP 2020 Target
158.6  168.3  175.28  131.34  100.8

This indicator reports the rate of death due to stroke (or cerebrovascular disease) per 100,000 population, age-adjusted to the 2000 standard. (Source: California Department of Public Health, Death Statistical Master File, 2008-2010.)

Stroke Mortality Rate
(Per 100,000 population)

Fontana MCSA  Ontario MCSA  San Bernardino County  California  HP 2020 Target
45.5  40.6  47.8  39.46  33.8
San Bernardino County Cardiovascular Mortality from 2002-2010 (Age-adjusted death rate per 100,000)

<table>
<thead>
<tr>
<th></th>
<th>Heart Disease Mortality</th>
<th>Stroke Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-2004</td>
<td>233.7</td>
<td>58.5</td>
</tr>
<tr>
<td>2005-2007</td>
<td>197.2</td>
<td>47.1</td>
</tr>
<tr>
<td>2008-2010</td>
<td>159.0</td>
<td>41.2</td>
</tr>
<tr>
<td>HP 2010 Objectives</td>
<td>162.0</td>
<td>50.0</td>
</tr>
</tbody>
</table>

Source: California Department of Health and Human Services, County Health Status Profiles, 2002-2010. NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

Populations disproportionately impacted (disparities)

Heart Disease Mortality Rate, by Race/Ethnicity (per 100,000)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White (Non-Hispanic)</th>
<th>Black (Non-Hispanic)</th>
<th>Asian (Non-Hispanic)</th>
<th>American Indian / Alaskan Native (Non-Hispanic)</th>
<th>Hispanic / Latino</th>
<th>Multi-Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
<td>165.61</td>
<td>218.89</td>
<td>96.36</td>
<td>895.03</td>
<td>387.59</td>
<td>140.82</td>
</tr>
<tr>
<td>California</td>
<td>123.54</td>
<td>196.56</td>
<td>86.94</td>
<td>230.36</td>
<td>123.54</td>
<td>62.31</td>
</tr>
</tbody>
</table>

Source: California Department of Public Health, Death Statistical Master File, 2008-2010.

Geographic areas of greatest impact (disparities)

Heart Disease Mortality Rate in KFH-Fontana MCSA

Heart Disease Mortality Rate in KFH-Ontario MCSA

Death Rate (Per 100,000 Pop.), By ZCTA, CDPH, 2008-2010

- Over 200.0
- 160.1 - 200.0
- 120.1 - 160.0
- 80.1 - 120.0
- Under 80.1
Death Rate (Per 100,000 Pop.), By ZCTA, CDPH, 2008-2010

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 90.0</td>
<td></td>
</tr>
<tr>
<td>60.1 - 90.0</td>
<td></td>
</tr>
<tr>
<td>30.1 - 60.0</td>
<td></td>
</tr>
<tr>
<td>Under 30.1</td>
<td></td>
</tr>
<tr>
<td>No Deaths</td>
<td></td>
</tr>
</tbody>
</table>

In the KFH – Ontario MCSA, heart disease mortality is highest in Ontario and Rancho Cucamonga. The stroke mortality rate is highest in Pomona, Ontario, and east of Rancho Cucamonga.

**Related Data Indicators Associated with Cardiovascular Disease**

The following table outlines some of the data indicators associated with cardiovascular disease in the community. These data indicators represent factors known to contribute or which are correlated with cardiovascular disease in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).
Cardiovascular disease is a major health issue in San Bernardino County (County of San Bernardino, 2011b). CHNA participants did not believe that issues of cardiovascular disease are getting better. While there are programs focusing on education and wellness, cardiovascular health needs a multipronged approach that addresses: smoking, poor diet, diabetes, obesity, physical inactivity, stress, and poor hygiene.

**What populations are most affected by cardiovascular disease?**

Cardiovascular disease encompasses all age groups: Obesity in youth and children are associated with the same types of health risks as adults, indicating that children are at risk for high cholesterol and high blood pressure as well as diabetes. Furthermore, children that are obese become adults who are obese (Babey, Wolstein, Diamant, Bloom, & Goldstein, 2012).

- **Youths and children** are disproportionately affected because they do not have the education, and power to control what they eat. Schools and parents do not always provide healthy eating options. Additionally, youths reported to being bombarded by poor foods choices, such as McDonald’s, liquor stores and other fast foods. Furthermore, liquor stores are just as likely to sell cigarettes and liquor to adults as to children. Obesity in youth and children are associated with the same types of health risks as adults, indicating...
that children are at risk for high cholesterol and high blood pressure as well as diabetes. Furthermore, children that are obese become adults who are obese (Babey, Wolstein, Diamant, Bloom, & Goldstein, 2012).

- The elderly are disproportionately affected by heart disease. Seniors are more likely to struggle with congestive heart failure. People over 65 are twice as likely to get a heart attack as people 64 or younger. People over 85 are almost 3 times more likely to get a heart attack than people 84 years of age and younger.

- Certain populations in San Bernardino County are affected more by cardiovascular disease than others. Hispanic, African American and low-income populations are disproportionately affected by overweight and obesity due to lack of education on healthy eating and healthy living, as well as lack of access to healthy foods.

- Asian Americans, a population that is usually not thought of as having problems with overweight and obesity, are affected by the related conditions of unhealthy eating, such as high blood pressure, hypertension, high cholesterol, and diabetes; which goes against the stereotypes of the body image of Asian Americans.

- Native American communities are disproportionately affected by cardiovascular disease, which is a result of unhealthy eating, overweight and obesity. Many also lack access to culturally appropriate health care services that don’t effectively address risk factors.

- Homeless individuals do not have steady access to health that will enable them to monitor their cholesterol and high blood pressure. They are also limited in food choices.

What are the challenges to addressing cardiovascular disease?

- There is a lack of health education and promotion and a lack of knowledge about healthy eating. People do not have the resources to access information, and rely on their friends and family for health information, which may not always be accurate.

- There are not enough health care facilities throughout the county, and there is a shortage of primary care and specialty care physicians in the area. Community residents cannot afford medication for high blood pressure. Often, they could afford labs but not medications, or vice-versa.

- Unemployment and poverty rates are high, which influence what people buy and eat, and how or if they can access care or programs for their health conditions. Additionally, it is likely that the stress causes community residents to self-medicate through smoking or drug use, which increases their likelihood of heart disease.

- Physical environment is a barrier to healthy eating behaviors and physical activity, which increase likelihood of cardiovascular disease in San Bernardino County. CHNA participants expressed that there is not a high investment in creating an environment that
provides access to healthy foods, provides adequate and safe green space, and provides positive development for families.

- Some communities in San Bernardino County are considered food deserts. There is an abundance of fast food restaurants in low-income communities, but there is a lack of access to healthy foods for many people of color and low-income communities. San Bernardino County has the one of the worst food environments in California. There are 6 times more unhealthy outlets than healthy ones. There are 8 fast food and convenience stores for every food outlet (Trevino et al., 2012).

**Assets - What are the community assets that can address the health need?**

Since overweight, obesity, and eating habits affects CVD, some of the same resources are listed below, for a full list, please refer to Overweight/Obesity.

- Education and prevention in San Bernardino can combat obesity at an early age. Loma Linda University’s (LLU) obesity task force partners with the San Bernardino County Department of Public Health to decrease childhood obesity. Cooking demonstrations at local churches or community organizations can be useful in showing communities how to cook healthy meals and make modifications to their diets. They can also provide exercise classes for youth and seniors.

- City and county-wide programs such as The Healthy Eating Active Living (HEAL) projects in places like Ontario “reduce childhood obesity, and increase healthy food choices and overall health education.” This prevention-oriented initiative works with schools, worksites, neighborhoods, and the healthcare sector to stimulate change (Healthy Ontario, 2012).
Summary

Coronary heart disease (CHD) and stroke, which are part of cardiovascular disease (CVD), have improved significantly in San Bernardino County from 2002 to 2010, which is consistent with the state trend. The prevalence of CHD in the KFH—Ontario MCSA (5.87%) is similar to the state (5.88%). However, the age-adjusted mortality rates due to CHD (168.3 per 100,000 population) and stroke (40.6 per 100,000 population) for the KFH—Ontario MCSA are higher than the state rates (131.34 and 39.46 per 100,000 population for CHD and stroke in 2010, respectively). Heart disease is still the leading cause of death in the U.S. Hospitalization due to congestive heart failure increases exponentially with age. Although all racial/ethnic groups in San Bernardino County had higher CHD mortality rates than their state counterparts, Native American/Alaskan Native and Hispanic/Latino populations had significantly higher heart disease mortality rates than all other racial/ethnic groups. CHNA participants named stress, smoking, and obesity as potential risk factors in heart cardiovascular disease (CVD). People who have CVD are more likely to have other chronic health conditions (such as diabetes), especially among older adults and people with HIV/AIDS. Cardiovascular disease is also linked to substance use, poor oral health and poor prenatal/perinatal outcomes.
Community Violence

About Community Violence - Overview and importance

Community violence can include experience of and exposure to crimes, gangs, drugs, graffiti, acts of interpersonal violence, or racial conflicts in a community. Injuries and violence have a significant impact on the wellbeing of Americans by contributing to premature death, disability, poor mental health, high medical costs, and lost productivity. The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities. For children, exposure to community violence can have negative impact on emotional, behavioral, substance use and academic development. (Source: Healthy People 2020)

Statistical data – Community violence measurement, prevalence and incidence

<table>
<thead>
<tr>
<th>Homicide Death Rate (Per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fontana MCSA: 8.8</td>
</tr>
</tbody>
</table>

This indicator reports the homicide rate per 100,000 population, age-adjusted to the year 2000 standard. (Source: California Department of Public Health, Death Statistical Master File, 2008-2010.)
This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. (Source: U.S. Federal Bureau of Investigation, Uniform Crime Reports, 2010.)

- **Crime Rate** - Over the past five years, reported crime dropped 22% in the San Bernardino-Riverside metro area, or an average of 6% each year. San Bernardino County ranks in the middle among peer regions compared and has a lower crime rate than both the state and nation (County of San Bernardino, 2012).

- **Gang Related Homicide** - In 2011, 25% of homicide and 5% of all felony filings in San Bernardino County were gang-related. There were a total of 845 gang-related filings in 2011, down from 953 in 2010 and 1,253 in 2009. However, between 2007 and 2011, the number of gangs rose 7% to 748 known gangs in the county as of 2011. During the same period, gang membership rose 38% to 17,401 known gang members in the county as of 2011 (County of San Bernardino, 2012).

**Populations disproportionally impacted (disparities)**

The following population has the greatest impact of community violence in San Bernardino County:

- **Homicide Victims** - In 2009, 49% of homicide victims were Hispanic, 26% were White, and 22% were African American. There was a 24% drop in the number of homicide victims between 2007 and 2009, falling from 159 victims in 2007 to 121 in 2009 (County of San Bernardino, 2011b).

- **Youth in Gangs** – From 2007 to 2009, 11% of 7th and 9th graders and 9% of 11th graders said they are members of a gang. These rates are above the statewide averages for 7th and 9th graders, and the same as the statewide average for 11th graders (County of San Bernardino, 2011b).
Geographic areas of greatest impact (disparities)

KFH-Fontana MCSA Homicide Rate (Per 100,000)

KFH-Ontario MCSA Homicide Rate (Per 100,000)

Death Rate (Per 100,000 Pop.), By ZCTA, CDPH, 2008-2010

<table>
<thead>
<tr>
<th>Category</th>
<th>Over 25.0</th>
<th>10.1 - 25.0</th>
<th>5.1 - 10.0</th>
<th>Under 5.1</th>
<th>No Deaths</th>
</tr>
</thead>
</table>

In the KFH – Ontario MCSA, Pomona has the highest rate of homicide.

Related Data Indicators Associated with Community Violence

The following table outlines some of the data indicators associated with community violence in the community. These data indicators represent factors known to contribute to or which are correlated with community violence in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Socioeconomic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse</td>
<td>Education</td>
</tr>
<tr>
<td>Liquor Store Access</td>
<td>Population with No High School Diploma*</td>
</tr>
<tr>
<td>Heavy Alcohol Consumption*</td>
<td>High School Graduation Rate*</td>
</tr>
<tr>
<td>Alcohol Expenditures</td>
<td>Student Reading Proficiency (4th Grade)*</td>
</tr>
<tr>
<td></td>
<td>Poverty</td>
</tr>
<tr>
<td></td>
<td>Poverty Rate (&lt; 100% FPL) *</td>
</tr>
<tr>
<td></td>
<td>Population Below 200% of Poverty Level*</td>
</tr>
<tr>
<td></td>
<td>Children in Poverty*</td>
</tr>
</tbody>
</table>
Community input - *What do CHNA participants think about the issue of community violence?*

Community Violence is a major health concern in San Bernardino County. Of particular concern for CHNA participants is the impact poverty, gang violence, child abuse, and domestic violence have on good health.

**What populations are most affected by community violence?**

- **Latinos** are disproportionately likely to become homicide victims when compared to people of other groups. In 2009, 49% of homicide victims were Hispanic.
- **Men** are more likely to come in contact with violence than women. They are more at risk for physical attacks. This is particularly the case if they are involved in a gang.
- **Females** are more likely to be targeted for sexual assault.
- **Living in poverty** and/or high stress situations makes violence more likely.

**What are the challenges to addressing community violence?**

- CHNA participants linked community violence with alcohol and drug use. In some areas, the police department in Ontario is working with the planning department to reduce and control the number of liquor stores to reduce oversaturation of retail outlets.
- Gang activity is a serious concern for many of the participants. Participants stated the level of gang activity has increased due to the lack of jobs. Youths in San Bernardino County are more likely to say they are a gang member. The other factor is the newly released inmates coming back into the San Bernardino communities due to prison overcrowding.
- The built environment in many areas of San Bernardino County is considered unsafe by community residents. CHNA participants mentioned parks as places where they do not feel safe. In their communities people “stay inside their house”. Some communities do not have sidewalks or street lights for people to safely walk around the neighborhood.
- Participants shared there is an issue of domestic abuse in the community. This includes both child abuse as well as domestic violence. One of the main triggers is stress.
- Some participants shared there is a lack of a sense of community connection. Youth participants stated people in their community do not speak to each other for fear of being assaulted or simply do not want to engage in community activities.

**Assets - What are the community assets that can address the health need?**

Because community violence is connected with substance use, poverty, and stress, it is important to keep community assets in mind that work to address those issues. (For more assets, please...
also refer to “Substance Use”, “Economic Instability”, and “Mental Health” health need profiles.)

• The Ontario Police Department is working with the Ontario Planning Department to reduce and control the number of liquor stores, which will help decrease crime.

• Because parents are more open to take information at places where they feel safe, schools and school districts are a safe and neutral venue for imparting information to help students with health. Soroptomist offers programs at school sites to empower middle school girls with relationships and violence prevention.

• House of Ruth assists women and children victimized by domestic violence by providing shelter, programs, opportunities and education.

• Community based organizations can help improve unsafe home and community environments. Youth Hope Inc. is a non-profit working in drug and alcohol prevention and treatment. They offer parenting classes, anger management, and counseling. Their domestic violence classes focus on self-esteem, self-control, anger management and empowerment (Youth Hope Inc., 2013).

Summary

Community violence includes domestic violence, gang violence, and other social insecurities in one’s community. According to state data, the homicide death rate in the KFH—Ontario MCSA (5.70 per 100,000 population) is higher than the California benchmark of 5.15 per 100,000 population. Forty-nine percent of homicide victims were Hispanic/Latino. However, the rate of violent crimes overall in the KFH—Ontario MCSA is substantially lower than the state benchmark. CHNA participants also shared that domestic violence is an issue in the community. Stress (due to unemployment and financial issues) is one of the main triggers for violence and may be linked to alcohol and substance use. Moreover, in 2011, 25% of homicide and 5% of all felonies in San Bernardino County were gang-related. Although the total number of gang-related filings is down, the number of gangs in the County rose 7% between 2007 and 2011. CHNA participants have witnessed more youth and young adults participating in gang-related crimes. County Sheriff’s Department data revealed youth in San Bernardino County are more likely to consider themselves gang members compared to youth in neighboring counties. The re-entry population, who is released into the community without adequate support systems, is also contributing to the increase in violence. Poverty, unemployment, and lack of educational achievement contribute to community violence and gang activity. Community violence disproportionately affects women, children and youth, low-income communities, and people of color. Without a network of support and a safe community, families cannot thrive.
Diabetes

About Diabetes – Overview and importance

Diabetes affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. There are three types of diabetes: Type 1, Type 2, and gestational diabetes (a common complication of pregnancy). The rate of diabetes continues to rise steadily in the United States. In addition, the onset of Type 2 diabetes has become earlier in recent years, affecting even children and adolescents, which can lead to substantial increase in diabetes-related complications. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by 2 to 4 times, is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness. In addition to these human costs, the estimated total financial cost of diabetes in the United States in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death. (Source: Healthy People 2020)

Statistical Data (Secondary Data) – Diabetes measurement, prevalence, and incidence

This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. (Source: Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009)

- **Increases in Type 2 Diabetes** - According to 2009 data, 10.6% of adults in San Bernardino County have been diagnosed with diabetes, of which 71% have type 2 diabetes. This marks a five year increase of 47% and is the highest rate among all counties in California, except Los Angeles County (10.9%). (Source: County of San Bernardino, 2012)

- **Diabetes Mortality** - In San Bernardino County the age-adjusted death rate for diabetes has remained steady since 2002-2004, from 30.5 to 30.3 per 100,000 population in 2008-2010. However, the death rate is still substantially higher compared to the California rate
of 19.5 in 2008-2010. (Source: California Department of Public Health, Office of Health Information and Research, 2010)

This indicator reports the adult (age 18 and older) patient discharge rate (per 10,000 hospitalization events) for diabetes-related complications in the past year. (Source: California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010)

### Adult Diabetes Hospitalization Rate per 10,000

<table>
<thead>
<tr>
<th></th>
<th>Fontana MCSA</th>
<th>Ontario MCSA</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>11.93</td>
<td>11.59</td>
<td>9.66</td>
</tr>
</tbody>
</table>

This indicator reports the patient discharge rate (per 10,000 hospitalization events) of children under age 18 for diabetes-related complications in the past year. (Source: California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010)

### Youth Diabetes Hospitalization Rate per 10,000

<table>
<thead>
<tr>
<th></th>
<th>Fontana MCSA</th>
<th>Ontario MCSA</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>8.55</td>
<td>5.4</td>
<td>4.8</td>
</tr>
</tbody>
</table>
## Populations disproportionately impacted (disparities)

### Patient Discharges for Diabetes, by Race/Ethnicity (Percentage of Total Discharges)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian and Pacific Islander</th>
<th>Native American / Alaskan Native</th>
<th>Other Race</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td>1.02%</td>
<td>1.49%</td>
<td>1.35%</td>
<td>No data</td>
<td>0.84%</td>
<td>1.15%</td>
<td>0.99%</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>0.94%</td>
<td>1.87%</td>
<td>1.38%</td>
<td>No data</td>
<td>0.97%</td>
<td>1.11%</td>
<td>0.93%</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>1.00%</td>
<td>1.53%</td>
<td>1.32%</td>
<td>No data</td>
<td>0.94%</td>
<td>1.14%</td>
<td>0.97%</td>
</tr>
<tr>
<td>California</td>
<td>0.77%</td>
<td>1.62%</td>
<td>0.93%</td>
<td>0.53%</td>
<td>0.87%</td>
<td>0.91%</td>
<td>0.79%</td>
</tr>
</tbody>
</table>


### Geographic areas of greatest impact (disparities)

**Adult Diabetes Discharge Rate in KFH-Fontana MCSA**

**Adult Diabetes Discharge Rate in KFH-Ontario MCSA**

Adult Diabetes Discharge Rate (Per 10,000 Hospitalization Events), By ZCTA, OSHPD, 2010-11

- **Over 14.00**
- **10.01 - 14.00**
- **6.01 - 10.00**
- **2.01 - 6.00**
- **Under 2.01**

In the FKH – Ontario MCSA, diabetes strongly impacts Pomona and Montclair.
Related Data Indicators Associated with Diabetes

The following table outlines some of the data indicators associated with diabetes in the community. These data indicators represent factors known to contribute to or which are correlated with diabetes in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Health outcomes</th>
<th>Environment</th>
<th>Behavior</th>
<th>Clinical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight/Obesity</td>
<td>Nutrition access</td>
<td>Nutrition</td>
<td>Care Delivery</td>
</tr>
<tr>
<td></td>
<td>Physical activity access</td>
<td>Inadequate Fruit/vegetable</td>
<td>Access to Primary Care*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>consumption (Adult)*</td>
<td>Diabetes Management (Hemoglobin A1c Test)*</td>
</tr>
<tr>
<td>Overweight* Obesity*</td>
<td>Fast food restaurant access</td>
<td>Park Access*</td>
<td>Uninsured Population*</td>
</tr>
<tr>
<td></td>
<td>Grocery store access *</td>
<td>Walkability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WIC Authorized food store access*</td>
<td>Recreation and Fitness Facility*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Population living in food deserts*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breastfeeding*</td>
<td>Fruit/vegetable expenditures</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Soft drink expenditures*</td>
<td></td>
</tr>
</tbody>
</table>

### Socioeconomic Factors

#### Poverty

<table>
<thead>
<tr>
<th>Poverty Rate (&lt; 100% FPL)*</th>
<th>Children in Poverty*</th>
<th>Free and Reduced Price School Lunch Eligibility*</th>
<th>Supplemental Nutrition Assistance Program (SNAP) Recipients*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (&lt; 200% FPL)*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Community input - What do CHNA participants think about the issue of diabetes?**

A majority of CHNA participants felt that diabetes is increasing. Diabetes is associated with many health complications, such as heart disease and stroke, high blood pressure, diabetic retinopathy, neuropathy, hearing loss, foot or leg amputations, skin infections, and mental health (American Diabetes Association [ADA], 2013).

- **Obesity** is a precursor to diabetes. The rise in obesity has led to an epidemic of type 2 diabetes in children, which was primarily seen in adults (Diamant, Babey, Wolstein, & Jones, 2010; ADA, 2013). San Bernardino County is one of the worst places for
childhood obesity in the state (County Health Rankings and Roadmaps, 2013; County of San Bernardino, 2013a; Ramal, Peterson, Ingram, Champlin, 2012). As such, service providers, healthcare providers, and school staff have witnessed an increase in insulin prescriptions and utilization among young people.

What populations are most affected by diabetes?

- **Native American/Alaskan Natives** have the highest diabetes rates of all racial/ethnic groups in San Bernardino County (Healthy San Bernardino County, 2012). Some health care services and programs lack culturally appropriate and sensitive strategies to combat diabetes. Many are stricken by poverty and high unemployment rates, which impacts access to and availability of healthy foods and fresh produce.

- **Hispanic/Latino** and **African American** populations are also impacted by high rates of diabetes as they have high rates of obesity and overweight (Ramal et al., 2012).

- CHNA participants have seen an increase in diabetes cases in children and youth in the school setting. School nurses are going above and beyond managing and treating type 2 diabetes in children and conducting other procedures usually done by doctors. Because of budget cuts to the education system and the pressure to academically perform, physical education and activity has been a low priority or non-existent, and the nursing staff has been reduced. These cuts have led to children being at high risk of getting diabetes or having diabetes-related complications. **Undocumented children** are further affected because of the myriad of challenges they face when accessing health care services.

- **Seniors** are impacted by diabetes because many have difficulties paying for their diabetes-related medical expenses (i.e. laboratory work, insulin prescription, and blood glucose strips). Medicare has also reduced vision services for seniors and no longer covers routine eye exams (Centers for Medicare and Medicaid Services [CMS], 2013). Although seniors can visit an eye doctor for diabetes-related eye conditions (e.g. Diabetic Retinopathy), lack of routine eye exams can decrease the chance of catching vision problems early (ADA, 2013).

- Some providers have seen many **homeless** individuals affected by diabetes and diabetes-related complications. Because of the barriers homeless individuals face, their medical conditions worsen.
What are the challenges to addressing diabetes?

- Knowledge, attitudes, and beliefs of community residents can act as a barrier to preventing and treating diabetes. Parents and children should be educated on the importance of making healthier food choices and exercise to help their family prevent diabetes. The acceptance of some parents to feed their families unhealthy food options can lead diabetes later in life (Institute of Medicine [IOM], 2012).

- Cultural norms can also increase the risk of diabetes, as some cultural foods are cooked in unhealthy ways. Cooking and nutrition classes should work with cultural norms to help people cook and eat healthier while continuing to enjoy their traditional foods. An explanation of how cultural norms can impact health is further explained in the “Overweight/Obesity” profile.

- Neighborhood characteristics can act as structural barriers to preventing or managing diabetes. The lack of available green space, adequate parks, public safety in neighborhoods, and healthy foods in San Bernardino County discourages people from incorporating health behaviors that can prevent diabetes.

- Socioeconomic issues, such as poverty, unemployment, and lack of health insurance play a significant role in decreasing access to healthcare services that are essential to managing and treating diabetes.

---

Assets - What are the community assets that can address diabetes?

- **City and countywide programs:** Healthy Ontario has helped communities create visions to address two of the most pressing issues for the county: access to healthy food and physical activity. This is an important aspect to address because diet and physical inactivity can exacerbate diabetes.

- **Medical Centers:** The Sweetness Program at Pomona Valley Hospital Medical Center (PVHMC) has a Diabetes and Pregnancy Program that assists pregnant women with
managing their diabetes (PVHMC, 2013). The Arrowhead Regional Medical Center (ARMC) provides glucose and other general health screenings (ARMC, 2012).

- **Schools**: School nurses are managing and treating type 2 diabetes in children by providing insulin shots, teaching students how to give themselves insulin shots, and teaching them how to eat more healthy food. An effort is needed to increase the number of school nurses and to provide them more support.

**Summary**

According to county and CDC data, diabetes prevalence among adults and children is increasing in San Bernardino County, which has the second highest proportion of diabetes in adults in the state. Diabetes prevalence in adults in the KFH—Ontario MCSA (8.03%) is higher than the California benchmark of 7.57%. Diabetes hospitalization rate for adults is higher in the KFH—Ontario MCSA (11.59 per 10,000 hospitalizations) than the California benchmark (9.66 per 1,000 hospitalizations). The youth diabetes hospitalization rate is also higher in the Ontario MCSA (5.40 per 10,000 hospitalizations) compared to the California benchmark (4.80 per 10,000 hospitalizations). According to CHNA participants, diabetes is noticeably prevalent in African American, Hispanic/Latino, Native American/Alaskan Native, undocumented immigrant, and low-income communities due to a combination of cultural diet, the abundance of American fast food outlets, lower physical activity, stress, lack of access to healthy foods, and lack of **access to health care services** (shortage of primary care physicians). **Obesity** is often a precursor to diabetes. Diabetes is linked to **mental health**, **prenatal/perinatal health**, **economic instability**, and **service infrastructure**.
Economic Instability

About Economic Instability - Overview and importance

Poverty is a primary social determinant of health. Indicators of poverty include lack of education, unemployment, low income, housing instability, and use of public programs. Economic instability creates barriers to access health services, healthy food, safe spaces for physical activities, and other necessities that contribute to good health status. Poverty is linked to increased risk of chronic diseases, mental health problems (such as stress, anxiety, and depression), deprived child development, and premature death. Conversely, good health can lead to better productivity and improve one’s economic status.

Statistical data - Economic instability measurement, prevalence and incidence

<table>
<thead>
<tr>
<th>Percent Population Poverty</th>
<th>Fontana MCSA</th>
<th>Ontario MCSA</th>
<th>San Bernardino County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17.74%</td>
<td>10.38%</td>
<td>14.84%</td>
<td>13.71%</td>
</tr>
</tbody>
</table>

This indicator reports the percentage of the population living below 100% of the Federal Poverty Level (FPL). (Source: 2006-2010 American Community Survey 5-Year Estimates.)
This indicator reports the percentage of children aged 0-17 living under 100% of the Federal Poverty Level (FPL). (Source: 2006-2010 American Community Survey 5-Year Estimates.)

![Percent Children in Poverty](chart)

This indicator reports the percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted). (Source: U.S. Bureau of Labor Statistics, July, 2012 Local Area Unemployment Statistics.)

![Unemployment Rate](chart)
This indicator reports the average percentage of the population receiving the CalFresh benefits from the months of July 2008 to July 2009. (Source: U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009.)

This indicator reports the percentage of public school students eligible for free or reduced price lunches. (Source: U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2010-2011.)
This indicator reports the percentage of the population that is enrolled in Medicaid. (Source: 2008-2010 American Community Survey 3-Year Estimates.)

### Additional Economic Instability Indicators

This indicator reports the percentage of change in annual income per capita in each region between 2001 and 2010. (Source: County of San Bernardino, 2012) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.
This indicator measures the hourly wage a resident would need to afford “Fair Market Rent.” A long-term shortage of affordable housing for renters can perpetuate and aggravate a cycle of poverty. (Source: County of San Bernardino, 2012) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

This indicator shows a comparison of new housing permits. Given San Bernardino County’s location and relative housing affordability, it has become a supplier of housing for the Southern California region. (Source: County of San Bernardino, 2012) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

In the third quarter of 2011, 44% of homes carrying mortgages in the Riverside-San Bernardino metro area were “under water”, where the market value of a home is less than the amount owed on the home. (Source: County of San Bernardino, 2012)

- **Renting Remains Less Affordable than Buying:** Although less hourly wage is required for fair market rent, when compared to other regions, rental costs in the Riverside-San
Bernardino metro area are still high relative to the costs of owning a home. (Source: County of San Bernardino, 2012)

**Populations disproportionately impacted (disparities)**

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td>15.55%</td>
<td>25.55%</td>
<td>13.22%</td>
<td>25.06%</td>
<td>5.15%</td>
<td>22.25%</td>
<td>18.37%</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>9.15%</td>
<td>9.61%</td>
<td>9.60%</td>
<td>16.30%</td>
<td>3.79%</td>
<td>14.02%</td>
<td>8.01%</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>13.41%</td>
<td>20.88%</td>
<td>9.65%</td>
<td>23.11%</td>
<td>3.11%</td>
<td>18.16%</td>
<td>14.73%</td>
</tr>
<tr>
<td>California</td>
<td>11.98%</td>
<td>20.49%</td>
<td>10.52%</td>
<td>20.53%</td>
<td>12.32%</td>
<td>20.88%</td>
<td>12.69%</td>
</tr>
</tbody>
</table>


**Population in Poverty, by Race**

**Population in Poverty, by Ethnicity**

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Hispanic / Latino</th>
<th>Non-Hispanic / Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td>21.42%</td>
<td>14.12%</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>13.20%</td>
<td>7.09%</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>18.02%</td>
<td>11.89%</td>
</tr>
<tr>
<td>California</td>
<td>19.95%</td>
<td>10.08%</td>
</tr>
</tbody>
</table>


- **Homeless students** - For the 2009/2010 school year, San Bernardino County had 22,658 children/youths who were identified as homeless (4.9% of the total district enrollment). The term *homeless children/youth* identifies individuals who lack a fixed, regular, and adequate residence. This definition also includes children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason. In San Bernardino County, 86.2% youth who were “homeless” were “doubled up” (meaning more than one family was living in one home), 6.3% lived in shelters, 4.8% were unsheltered and 2.7% lived in hotels/motels (Community Hospital of San Bernardino, 2011).

- **Veteran Services** - The demand for veterans’ services is steadily increasing. Between 2004 and 2011, there was a 116% increase in the number of completed applications for
federal benefits. During the same period, San Bernardino County’s Department of Veterans Affairs caseload grew by 147% (County of San Bernardino, 2012).

- **Public Assistance is Rising** – In 2011, the number of people enrolled in CalFresh (306,304) rose 22% in a single year, while CalWORKS cash assistance enrollment rose 6% to 128,992 recipients (County of San Bernardino, 2012).

### Geographic areas of greatest impact (disparities)

<table>
<thead>
<tr>
<th>Percent of Population in Poverty- KFH- Fontana MCSA (below 100% FPL)</th>
<th>Percent of Population in Poverty- KFH- Ontario MCSA (below 100% FPL)</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Map of KFH-Fontana MCSA" /></td>
<td><img src="image2.png" alt="Map of KFH-Ontario MCSA" /></td>
</tr>
</tbody>
</table>

**Percentage of Total Population, By Tract, ACS 2006-2010 5-Year Estimate**

- Over 40.0%
- 30.1 - 40.0%
- 20.1 - 30.0%
- 10.1 - 20.0%
- Under 10.1%

In the KFH – Ontario MCSA, Pomona has the highest percentage of people living below 100% FPL.

- **Families in Poverty** - San Bernardino County has the largest percentage of families living in poverty, ranging from 13.6% to 36.4% of families in poverty (Community Hospital of San Bernardino, 2011)
Related Data Indicators Associated with Economic Instability

The following table outlines some of the data indicators associated with economic instability in the community. These data indicators represent factors known to contribute to or which are correlated with economic instability in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at http://www.chna.org/KP/.

<table>
<thead>
<tr>
<th>Socioeconomic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Insurance Status</td>
</tr>
<tr>
<td>Employment</td>
</tr>
<tr>
<td>Population Below 100% of FPL*</td>
</tr>
<tr>
<td>Population below 200% of FPL*</td>
</tr>
<tr>
<td>Children in Poverty*</td>
</tr>
<tr>
<td>Population with No High School Diploma*</td>
</tr>
<tr>
<td>High School Graduation Rate*</td>
</tr>
<tr>
<td>Uninsured Population*</td>
</tr>
<tr>
<td>Medicaid*</td>
</tr>
<tr>
<td>Unemployment Rate*</td>
</tr>
</tbody>
</table>

Community input - What do CHNA participants think about the issue of economic instability?

CHNA participants voiced a number of concerns regarding economic instability. Of particular concern was the ways in which the economic downturn has increased unemployment, poverty, homelessness, lack of insurance, foreclosures, and food security. All of these factors have impacted the health of its community residents.

What populations are most affected by economic instability?

While economic instability affects everyone in the community, some populations are more heavily impacted than others.

- The homeless population has increased since 2009. The Homeless Count of 2011, reported 2,876, from 1,736 in 2009. (County of San Bernardino, 2011c; Hi-Desert Star, 2009)

- Participants shared that recently released inmates or parolees in San Bernardino County have increased in numbers due to overcrowding in the prison system. This has become a challenge for families since there are policies in place that prevent the parolee from obtaining employment and living in a home with other members of the household who also have previous convictions. Many of the parolees become homeless and re-offenders.

- The undocumented residents living in San Bernardino do not qualify for health insurance such as Medi-Cal and cannot afford to pay for high cost premiums on their
own. Some Latino families opt for alternative care—herbs and massage—to treat illnesses.

- **Seniors** are struggling to make ends meet with their limited sources of income. CHNA participants shared that seniors cannot afford to pay for their basic needs such as housing and food, let alone pay for their medications to maintain their health.

**What are the challenges to addressing economic instability?**

- Poverty impacts options individuals have.
  - Poverty is linked to lack of access to health care, lack of health insurance coverage, lack of access to healthy foods, increased stress, and lack of access to educational opportunities.
  - Participants shared that good quality food is expensive and often physically inaccessible.
  - Poverty affects access to transportation. With limited transportation, community residents lack access to programs and services that can help them with improving their health and health behaviors.

- CHNA participants stated that, compared to neighboring counties, a higher percentage of San Bernardino County residents delayed care because of their inability to pay for medical services. Many times, medical problems are addressed only when they become severe.

- Some participants shared the lack of educational attainment in San Bernardino is one factor to economic instability in the community. It limits the access to higher paying jobs. Furthermore, lack of education and know-how regarding the use of medical facilities are an issue.

“The California Endowment did a survey, and it was very clear. If you want to impact health, you get people working again—they can afford healthier foods, or they can access the clinics.”

- There is also a definite stigma associated with being poor and what that might mean. Community residents feel “blamed” for being poor.

**Assets - What are the community assets that can address economic instability?**

San Bernardino has many assets that if coordinated, can help to better support issues related to economic instability. These assets include resources meant to alleviate the impacts of economic instability.

- City and county-wide programs can help in supporting community residents during periods of economic instability. CalFresh is a government program that promotes healthy food and increases access to foods for those in poverty. San Bernardino County Housing
Authority is trying to collaborate to add community gardens to their housing units, as well as health and human services and education programs. This can help increase access to healthy nutritious foods and health and wellness programs in underserved communities. Home Energy Assistance Program (HEAP) is a federally funded program that supplements a family’s annual energy cost (County of San Bernardino, 2013b).

- Faith-based organizations such as Catholic Charities of San Bernardino County can make a difference in supporting families with basic needs during times of hardship. Catholic Charities provides meals in the last 7 to 9 days of the month, when it is more likely for families to have run out of money. Catholic Charities also helps families pay utilities.
- Schools can be a venue for helping families during hard economic times. Backpack programs and back-to-school events with the food distribution agencies have been helpful in meeting the basic needs of low-income residents. Nutritional foods and nutrition education were placed in the backpacks so children can take home these items, share with their families, and have enough to eat for 2-3 days.

**Summary**

Economic instability includes poverty, unemployment, public assistance, food insecurity, home foreclosures, homelessness, and educational attainment. According to the U.S. Census, the percent of people living below 100% of the Federal Poverty Level in the KFH—Ontario MCSA (10.38%) is lower than the state (13.71%). However, almost one-fourth (23%) of the community residents in the KFH—Ontario MCSA have no high school diploma, which is higher than the state (19%). Some participants stated that the lack of educational attainment contributed to poverty, since it limits access to higher paying jobs. According to many CHNA participants, unemployment and poverty are major health barriers for San Bernardino County residents. The stress caused by rising unemployment, underemployment, financial hardship, and lack of opportunities impacts the health and well-being of all people, especially those with mental health issues (such as depression) and chronic illnesses (such as heart disease). Moreover, homelessness (in youth and adults) has been increasing in San Bernardino County due to economic instability. Many CHNA participants linked poverty to many of the major health needs, including overweight/obesity, asthma, diabetes, cancer, oral health, prenatal/perinatal health, teen pregnancy, access to health care, community violence and safety, and substance use. Populations disproportionately impacted and affected by economic instability are low-income and disenfranchised communities, including seniors, children and youth, the disabled, re-entry population, undocumented immigrants and people of color.
Health Care Access and Utilization

About Health Care Access and Utilization – Overview and importance

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires: gaining entry into the health care system, accessing a health care location where needed services are provided, and finding a health care provider with whom the patience can communicate and trust. Access to health care impacts an individual’s overall physical, social, and mental health status, prevention of disease and disability, detection and treatment of health conditions, quality of life, and life expectancy. Disparities in access to health services affect individuals and society. Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. Barriers to services include lack of availability, high cost, and lack of insurance coverage. These barriers can lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented. Health insurance coverage is a major factor in health care access. People who are uninsured are less likely to receive medical care, more likely to die early, and more likely to have poor health status. Another health care access factor is the number of medical professionals in a community, particularly primary care doctors (Source: Healthy People 2020).

Statistical Data – Health care access and utilization measurement, prevalence, and incidence

<table>
<thead>
<tr>
<th>Percent of Designated Population Underserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fontana MCSA</td>
</tr>
<tr>
<td>64.27%</td>
</tr>
</tbody>
</table>

This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), which is defined as having a shortage of primary medical care, dental or mental health professionals. (Source: U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012.)
This indicator reports the number of primary care physicians per 100,000 population. (Source: U.S. Health Resources and Services Administration Area Resource File, 2011.)

This indicator reports the patient discharge rate (per 10,000 total population) for conditions that are ambulatory care sensitive—admissions which could have been prevented if adequate primary care resources were available and accessed by those patients. (Source: California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010-2011.)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Number of Federally Qualified Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td>6</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>2</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>5</td>
</tr>
<tr>
<td>California</td>
<td>637</td>
</tr>
<tr>
<td>U.S.</td>
<td>5,459</td>
</tr>
</tbody>
</table>
Facilities Designated as Health Professional Shortage Areas

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Facilities</th>
<th>Primary Care Facilities</th>
<th>Mental Health Care Facilities</th>
<th>Dental Care Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td>12</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>18</td>
<td>8</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. (Source: U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012.)

Transportation to Care- The ability of residents and workers to move efficiently within San Bernardino County contributes to a high quality of life and access to services and care. (Source: San Bernardino County Community Indicators Report 2012- Mobility/Transit)

- In 2010, the average commute time to work for San Bernardino County residents was 29.3 minutes, essentially the same as in 2009 (29.0) and 2008 (29.2). San Bernardino County’s average commute time is the second highest among comparable regions and higher than both California (26.9) and the U.S. (25.2).

- In 2010/11, ridership on all commuter rail lines (Metrolink) serving San Bernardino totaled 6.13 million riders, down from 6.2 million the previous year. This represents a decline of 1.2%, compared with the 9% drop in ridership between 2008/09 and 2009/10.

- In 2010/2011 total bus passenger boardings were 17,450,105– down less than 1% from 17,592,190 in 2009/2010. San Bernardino County’s bus ridership per capita is on the low end compared to neighboring counties.
Populations disproportionately impacted (disparities)

In the Ontario Medical Center Service Area, the Hispanic/Latino, “Some Other Race”, Black and White populations have the disproportionately high population of uninsured.

Uninsured Population, by Race and Ethnicity

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multipl e Race</th>
<th>Hispanic / Latino</th>
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<tr>
<td>KFH-Fontana MCSA</td>
<td>60.06%</td>
<td>7.54%</td>
<td>3.42%</td>
<td>1.14%</td>
<td>0%</td>
<td>25.27%</td>
<td>2.57%</td>
<td>66.26%</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>56.43%</td>
<td>6.22%</td>
<td>7.01%</td>
<td>0.37%</td>
<td>0%</td>
<td>26.56%</td>
<td>3.41%</td>
<td>73.05%</td>
</tr>
<tr>
<td>California</td>
<td>55.69%</td>
<td>5.04%</td>
<td>10.34%</td>
<td>1.03%</td>
<td>0.39%</td>
<td>24.66%</td>
<td>2.85%</td>
<td>59.84%</td>
</tr>
</tbody>
</table>


Geographic areas of greatest impact (disparities)

Population Living in a Health Professional Shortage Area in KFH-Fontana MCSA

Underserved Population in HPSA for Primary Care Providers, 2011

- Over 80.0%
- 70.1 - 80.0%
- 60.1 - 70.0%
- 50.1 - 60.0%
- Under 50.1%
In the KFH – Ontario MCSA, Wrightwood/Mt. Baldy has the highest percentage of people living in a Health Professional Shortage Area (HPSA). Chino has primary care, dental care, and mental health facilities designated as HPSAs.

**Related Data Indicators Associated to Health Care Access and Utilization**

The following table outlines some of the data indicators associated with Health Care Access and Utilization in the community. These data indicators represent factors known to contribute or which are correlated with Health Care Access and Utilization in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Socioeconomic Factors</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td>Education</td>
<td>Insurance Status</td>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Population Below 100% of FPL*</td>
<td>Population with No High School Diploma*</td>
<td>Uninsured Population*</td>
<td>Unemployment*</td>
<td></td>
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<tr>
<td>Population below 200% of FPL*</td>
<td>High School Graduation Rate*</td>
<td>Medicaid*</td>
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</table>
Community input- *What do CHNA participants think about the issue of health care access and utilization?*

CHNA participants all voiced a number of concerns regarding access to healthcare, especially for those who are unemployed.

**What populations are most affected by health access and utilization?**

- **Undocumented immigrants** are affected because of their ineligibility for most public programs, their fear of deportation and retaliation, and the perception of accepting public assistance impacting their quest for citizenship.

- **Men over 18**, especially if unemployed are affected by lack of access to health care services. Many CHNA participants stated that youth health issues continue into adulthood, and that there are few services geared towards men.

- **Individuals with chronic or mental illness** and the elderly are impeded by their illnesses to access care and struggle to get to their appointments.

- **The re-entry population** often reenters the mainstream population without health care. They either do not have the skills, jobs, or education to access care.

**What are the challenges to addressing economic instability?**

- Poverty limits the options communities have, and influences how or if people can access care or programs for their health conditions. Community residents may not have a job or if they work, do not have employment that offers health insurance. Furthermore, poverty affects access to transportation. Being impoverished often means community residents do not have a car. Patients cannot get to doctors easily or have to ride many hours on the bus to get medical care. This is particularly difficult for families with small children and for the elderly. Transportation also affected whether community residents could get to medical appointments on time. Often, community residents got to their appointments too late and missed their opportunity to get care. Some CHNA participants, however, saw the transportation issue as an excuse for community residents not wanting to address health related issues or topics that made them uncomfortable.

- CHNA participants discussed how community residents do not have the know-how or life skills to navigate the system. Sometimes, community residents are not aware of what resources are out there. Other times, they do not know how to appropriately use the medical system. For example, community residents often use emergency room when they could have used primary or urgent care. CHNA participants speculated that it may have been an issue of culture and community residents either are confused or continue to use care the way they had in their countries of origin.

- Delayed medical care is a major issue discussed by CHNA participants. Compared to neighboring counties, a higher percent of San Bernardino County residents delay care.
According to a 2009 California Health Interview Survey, 17.4% of San Bernardino County residents under age 65 delayed or did not get the medical care that they needed, higher than the state and all neighboring counties compared (CHIS, 2012). As a result, community residents do not have continuity of healthcare.

- CHNA participant was concerned about the limited number of primary care doctors and specialists. Of equal importance is having doctors who are bilingual and bi-cultural, as language is a barrier to health for many patients.

- Fear of stigma played a role for people that had certain illnesses or conditions. People having mental illness feared the stigma of being “crazy”. People were less likely to get screening for HIV or STDs because they didn’t want to know there is something wrong with them.
Assets - *What are the community assets that can address health care access and utilization?*

CHNA participants identified the following community assets that improve health care access and utilization:

- **Medical centers**: Insurance companies like Inland Empire Health Plan (IEHP) and Molina are working towards keeping children insured and providing access to health care. IEHP is also utilizing the *promotora* model to address health needs in the community, which has seems to be successful thus far. Healthy Families and Medi-Cal are public programs that provide health insurance coverage to low-income eligible low-income individuals. Arrow Care is a low-cost health insurance for individuals 19-64 who are not eligible for either Medi-Cal or Healthy Families.

- **County and city programs**: Inland Regional Center offers information and education to support children with special needs in San Bernardino County. 2-1-1 also works to connect people with affordable health care resources in their areas.

**Summary**

Factors related to health care access and utilization include health care professional shortages, the number of Federally Qualified Health Centers (FQHC) in the County, language and cultural barriers, health insurance, transportation, cost barriers, and knowledge of resources. Of the people living in the KFH—Ontario MCSA, 56% are living in a Health Professional Shortage Area, slightly lower than the 57.14% state average. The shortage of health professionals, particularly primary care providers and any providers who are bilingual and bicultural, contributes to access and health status issues. The number of primary care physicians in the KFH—Ontario MCSA (66.1 per 100,000 population) was substantially lower when compared to the state benchmark (83.17 per 100,000 population). This translated into 97.14 preventable hospital events per 10,000 population that could have been prevented if adequate primary care was available, which is higher when compared to the state benchmark (83.17 per 10,000 population). The shortage is further compounded by disparities that are unique to San Bernardino County, which include: education attainment, poverty level, insurance and employment. Approximately 21% of the KFH—Ontario MCSA population was uninsured. CHNA participants also reported that people do not understand how to navigate and appropriately use the medical system (e.g. primary care vs. emergency room). Undocumented immigrants, older adults, and people of color are disproportionately affected by issues connected with access to health care. Chronic conditions and **mental illness** often impair people from accessing care.
Hepatitis

About Hepatitis - Overview and importance

Hepatitis refers to an inflammation of the liver resulting from a viral or non-viral infection, an autoimmune or metabolic condition, or alcohol or drug use. About 2% of the U.S. population (up to 5.3 million people) has chronic hepatitis-B or hepatitis-C virus. Hepatitis can also result from obstruction of the bile duct, for example due to gallstones. The disease may be acute or chronic. Chronic forms can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. Certain types of hepatitis are extremely contagious; some are spread via blood or sexual contact, while others are spread via fecal-oral contact. Vaccines are available for some types of hepatitis, and it is now recommended that all children and adults receive the hepatitis-B vaccine. The major factor impeding efforts to control hepatitis is lack of knowledge and awareness among health care providers, social service professionals, members of the public, and policymakers. (Source: Institute of Medicine, 2010)

Statistical data - Hepatitis measurement, prevalence, and incidence

This indicator describes the hospitalization rates for hepatitis in San Bernardino County between 2003-2005 and 2008-2010. Source: California Office of Statewide Health Planning and Development. NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

Populations disproportionately impacted (disparities)

High disparities exist among specific ethnic groups, such as Non-White Hispanics, Asian and Pacific Islanders, Native Americans and Non-Hispanic Blacks, when compared to the White population. (Source: U.S. Department of Health and Human Services Office of Minority Health- Data/Statistics on Hepatitis, 2013)
• **Hepatitis-A** - Hispanic/Latinos are twice as likely to be diagnosed with hepatitis-A as non-Hispanic Whites. The rate of hepatitis-A among Hispanic/Latinos (especially in children) living in California is at an epidemic level. In 2000, there were 2.3 million children in five South California counties analyzed in a hepatitis study – including San Bernardino County – and data suggests that the rates of Hispanic/Latino children with hepatitis are projected to increase to 74 percent by 2020 (Source: Hayes-Bautista, Hsu, Perez, Sosa, & Gamboa, 2005). In 2010, Asian Americans were 2.8 times more likely to contract hepatitis-A, as compared to Whites.

• **Hepatitis-B** - Asian and Pacific Islanders have the highest risk of being infected with hepatitis-B. Many are infected at birth but are asymptomatic. Their rate of infection is 20 times higher than the general population. In the United States, approximately half of the 1 million persons with chronic hepatitis-B virus (HBV) infection are Asian and Pacific Islanders, most of whom became infected with HBV before arriving in the United States. The HBV-related death rate among Asian and Pacific Islanders is seven times greater than the rate among Whites (Centers for Disease Control and Prevention, 2007a).

• **Hepatitis-C** - The Department of Veterans Affairs is the highest single provider of hepatitis-C care. Most infected veterans are men. Markers for hepatitis infection include: cocaine use, injection drug use, and more than 20 sexual partners (Department of Veterans Affairs, 2010). Within the first 3 months of incarceration, an inmate’s Medicaid benefits and eligibility is terminated. Because people of color are more likely to be incarcerated, they are disproportionately affected. Upon release, the re-entry population often has communicable diseases that are untreated because they do not have insurance. Once released, they will have unprotected sex with 1-3 partners within 6 days. Many will also use drugs within 72 hours of re-entry (Rennie, S., Eggleston, C., & Riggs, M., 2008). In 2010, American Indian/Alaska Natives were almost three times as likely to develop a case of hepatitis-C, as compared to the White population.
**Geographic areas of greatest impact (disparities)**

This indicator illustrates the average annual age-adjusted hepatitis-C mortality rates by county in California (Per 100,000 Hospitalizations), By ZCTA, OSHPD, 2010

Map Source: UCLA Data Collection and Analysis Unit and LA County Department of Public Health. NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

**Community Input - What do CHNA participants think about the issue of hepatitis?**

**What populations are most affected by hepatitis?**

- CHNA participants named the re-entry population as having high incidences of hepatitis.

> “Hepatitis is big. There’s concern from Public Health that without knowing those health risks, of HIV or hepatitis, ex-offenders are coming to the community, and we’re not prepared to help them, because of lack of access to medical records.”

**What are the challenges to addressing hepatitis?**

- Vaccinations are available for both hepatitis-A and B. Currently hepatitis-A vaccines are not part of California’s immunization policy.
- There is a lack of health education, lack of knowledge, and screening regarding hepatitis. Since forms of hepatitis are asymptomatic, many community residents unknowingly spread hepatitis. Education regarding drug use, safe sex practices, and hygiene are critical in reducing incidences of hepatitis (Center for Disease Control and Prevention, 2010b).
- Re-entry individuals returning to the general population often do so without health insurance and with communicable diseases (Rennie et al. 2008).

**Assets - What are the community assets that can address hepatitis?**

CHNA participants did not mention resources for hepatitis.
Summary

The age-adjusted hospitalization rate due to hepatitis in San Bernardino County adults is 3.6 per 10,000 population. CHNA participants stated there is a lack of health education, knowledge, and screenings regarding hepatitis. Since hepatitis can be asymptomatic, many community residents are infected at birth, do not get tested, or unknowingly spread hepatitis. Nationwide statistics indicate that hepatitis infection has declined in African American and Native American/Alaskan Native populations, but continues to increase in Hispanic/Latino, Asian and Pacific Islander populations. County data on hepatitis also supports that high disparities exist among specific ethnic groups, such as chronic hepatitis-B among Asian and Pacific Islanders and chronic hepatitis-C among Hispanic/Latino and White populations. Hispanic/Latinos are twice as likely to be diagnosed with hepatitis-A, Asian Americans are 2.8 times more likely to contract hepatitis-A, and Native American/Alaskan Natives are almost three times as likely to develop hepatitis-C (HCV), as compared to the White population. In addition, the re-entry and veteran subpopulations have higher rates of hepatitis-C. Moreover, nationwide data reports the Department of Veterans Affairs is the highest single provider of hepatitis-C care with men being the most infected. Factors for contracting hepatitis-C in some cases include substance use (i.e., cocaine and injection drug use) and risky sexual behavior (e.g., unprotected sex and more than 20 sexual partners).
HIV/AIDS and Other STDs

About HIV/AIDS and Other Sexually Transmitted Diseases—Overview and importance

Sexually The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. Women tend to suffer more frequent and more serious STD complications than men do, except for HIV, where nearly 75% of new infections occur in men and more than half occur in gay and bisexual men, regardless of race or ethnicity. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the United States. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care. STDs cause many harmful, often irreversible, and costly clinical complications, such as reproductive health problems, fetal and perinatal health problems, cancer, and facilitation of the sexual transmission of HIV infection. STD prevention is an essential primary care strategy for improving reproductive health. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. (Source: Healthy People 2020)

Statistical data—HIV and other STDs measurement, prevalence and incidence

This indicator reports the incidence rate of Chlamydia cases per 100,000 population. (Source: Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008.)
This indicator reports the incidence rate of Gonorrhea cases per 100,000 population. (Source: Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008.) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

This indicator reports the incidence rate of primary and secondary stage Syphilis cases per 100,000 population. (Source: Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008.) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.
This indicator reports the prevalence rate of HIV per 100,000 population. (Source: Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008.)

This indicator reports the rate of HIV hospitalization discharges per 10,000 population. (Source: Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008.)
The graph above the percentage of teens and adults age 12-70 who self-report that they have never been screened for HIV. (Source: Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008.) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

San Bernardino County Residents Living with HIV/AIDS (by Date of Diagnosis 2008-2012*) (Source: California Department of Public Health, Office of AIDS, 2012) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

<table>
<thead>
<tr>
<th>Demographics</th>
<th>HIV/ AIDS Total**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Surviving (%)</strong></td>
<td>3,531 (60.0%)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Age Group (current)</td>
<td></td>
</tr>
<tr>
<td>Under 13 years of age</td>
<td>5</td>
</tr>
<tr>
<td>13-24 years of age</td>
<td>122</td>
</tr>
<tr>
<td>25-44 years of age</td>
<td>1,103</td>
</tr>
<tr>
<td>45-64 years of age</td>
<td>1,460</td>
</tr>
<tr>
<td>65 + years</td>
<td>122</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
</tr>
<tr>
<td>Risk Category</td>
<td>Male</td>
</tr>
<tr>
<td>MSM (men who have sex with men)</td>
<td>1,711</td>
</tr>
<tr>
<td>IDU (intravenous drug users)</td>
<td>296</td>
</tr>
<tr>
<td>MSM/IDU</td>
<td>278</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>196</td>
</tr>
<tr>
<td>Receipt of blood products/tissue</td>
<td>12</td>
</tr>
<tr>
<td>Perinatal</td>
<td>17</td>
</tr>
<tr>
<td>Not Reported</td>
<td>302</td>
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</table>

*All 2012 diagnoses may not have been reported at the time of this report.
**HIV has been reportable since 2002 by non-name code and by name since 2006. AIDS has been reportable since 1983.

**Populations disproportionately impacted (disparities)**

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>Native American/Alaskan Native</th>
<th>Other Race</th>
<th>Hispanic/Latino</th>
<th>Non-Hispanic/Latino</th>
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<tbody>
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<td>KFH-Fontana MCSA</td>
<td>0.85</td>
<td><strong>4.57</strong></td>
<td>0.53</td>
<td>--</td>
<td>0.35</td>
<td>1.05</td>
<td>1.33</td>
<td><strong>4.89</strong></td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>0.88</td>
<td><strong>4.36</strong></td>
<td>0</td>
<td>--</td>
<td>1.43</td>
<td>1.06</td>
<td>1.27</td>
<td><strong>4.34</strong></td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>0.83</td>
<td><strong>4.34</strong></td>
<td>0.23</td>
<td>0</td>
<td>0.85</td>
<td>1.0</td>
<td>1.29</td>
<td><strong>4.23</strong></td>
</tr>
</tbody>
</table>

*Hospitalization Rates above do not include patients categorized as “Race or Ethnicity Suppressed”. Source: The California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data File Documentation (2011).

Certain behaviors are linked with at-risk populations. People who had a low perception of their susceptibility to HIV and other STDs, women who continued to hold gender role beliefs and gender based power dynamics that influenced sexual behavior, people who were influenced by the stigma attached to HIV/AIDS, people lacking in knowledge regarding HIV/AIDS and risky sexual behavior, and older adults with low rates of HIV testing have higher risk of getting HIV/AIDS (Garcia, 2012). This also includes IV drug users, men having sex with men, and postmenopausal women.

- **Youths** are disproportionately affected because they do not have the education and know-how to maintain sexual health. Girls were less likely to use condoms than boys. Girls between the ages of 15-19 had the highest rate of gonorrhea compared to any other group (Center for Disease Control [CDC], 2010b). Many times, provision of birth control and STD screening in schools is controversial and limits their availability; however, students with school based health services reported for frequently having used contraception (Denny et al., 2012). A survey conducted by the Center for Disease Control for San Bernardino’s middle and high school population that showed about 49% of students are sexually active. Of those students, about half are not using condoms to prevent pregnancy or sexually transmitted diseases (CDC, 2012b).

- **Older populations** are more susceptible to STDs. Almost one-quarter of all infections in the US are of people 50 years and older. This may be because physicians are less likely to test older adults. Older adults tend to know less about HIV/AIDS than younger
populations and medical practitioners are less likely to discuss sex and drug use with them, including prevention and risk behaviors (National Institute on Aging, 2012).

- **Women** are more heavily affected by all STDs. Women have the highest rate of gonorrhea. In 2010, women age 15-24 reported having more incidents of gonorrhea in the US than any other group (CDC, 2012b). Woman can be constrained from making their own sexual choices, including use of condoms (CDC, 2012c).

- **African Americans** are disproportionately affected by STDs. In particular, African American women are heavily impacted because they don’t have access to the care they need for medications. Other social determinants such as poverty, racism and abuse may also be contributing to their high numbers. African Americans had the highest incidence of Chlamydia, Gonorrhea, and Syphilis (CDC, 2007b).

- **Latinos** are excessively affected by HIV/AIDS. In 2009, Latinos accounted for 20% of new infections. Latinos had the second highest incidence of chlamydia, gonorrhea, and syphilis (CDC, 2011).

- **MSM (men who have sex with men)** are strongly affected by HIV/AIDS infection. In 2010, they made up 78% of people diagnosed with HIV/AIDS. Because MSMs are the highest infected population, they are more likely to infect other MSMs as well as women. Risky sexual behavior accounts for most HIV infections. Along with HIV infection, MSMs are also at higher risk for Chlamydia, gonorrhea, and syphilis (CDC, 2012c).

According to the California Dept. of Public Health Centers for Disease Control and Prevention:

- **Younger Adults** - More HIV infections occur among young people under age 30 than any other age group. Incarcerated young men, ranging from 18-29 years of age, have a higher prevalence of HIV (and other STDs) than among the general population.

- **Drug Usage** - the subgroup of intravenous drug users (“IDU”) are at high risk of HIV infections.
Geographic areas of greatest impact (disparities)

Chlamydia rate in KFH-Fontana MCSA (Adults)

Chlamydia rate in KFH-Ontario MCSA (Adults)

Chlamydia Incidence (Per 100,000 Pop.), By County, CDC 2009

<table>
<thead>
<tr>
<th>Chlamydia Rate</th>
<th>Over 400.0</th>
<th>300.1 - 400.0</th>
<th>200.1 - 300.1</th>
<th>100.1 - 200.0</th>
<th>Under 100.1</th>
</tr>
</thead>
</table>

Source geography: County.

Chlamydia is prevalent in KFH – Ontario MCSA. All areas are heavily affected.

Related Data Indicators Associated with HIV/AIDS and Other STDs

The following table outlines some of the data indicators associated with HIV/STDs in the community. These data indicators represent factors known to contribute or which are correlated with HIV/STDs in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Socioeconomic Factors</th>
<th>Access to Care</th>
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<tbody>
<tr>
<td></td>
<td>Substance Use</td>
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<td>Access to Care</td>
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<tr>
<td></td>
<td>Poverty</td>
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</tr>
<tr>
<td></td>
<td>HIV Screenings</td>
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<td></td>
<td>[San Bernardino County*]</td>
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<td></td>
<td>[San Bernardino County*]</td>
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</tbody>
</table>

*San Bernardino County*
Community input - What do CHNA participants think about the issue of HIV/AIDS and other STDs?

Sexually transmitted diseases are a major health issue in San Bernardino County. San Bernardino has high rates of STDs such as chlamydia, gonorrhea, and syphilis. While the Department of Public Health is making efforts to control the spread of HIV and other STDs in San Bernardino County, STDs are on the rise.

What populations are most affected by HIV/AIDS and other STDs?

- Women middle age and older have the highest growing rate of STDs.

What are the challenges to addressing HIV/AIDS and other STDs?

- There is a lack of health education and promotion and a lack of knowledge about STDs and HIV. Youths reported an overall lack of support and know-how regarding safe sex practices. Screening and education are behaviors important to promote. It has been found that there is a correlation between availability and quality of school health services and reproductive health outcomes for sexually active students (Denny et al., 2012).

- There is a shortage of physicians in the area, including the lack of specialists in HIV/AIDS care.

- A study by the CDC showed that a strong link between poverty and HIV (CDC, 2010a). High rates of substance use is also more likely with populations living in poverty. Substance use, in particular use of needles, results in spread of HIV/AIDS (CDC, 2010a). High rate of incarceration in poverty areas can also influence high rates of STD and HIV. This is due not only to unsafe practices during incarceration, but the spread of diseases to domestic partners upon reentry and the lack of support services and health insurance for this population (Rennie, Eggleston, & Riggs, 2008).

- The stigma of HIV/AIDS and STDs often prevent people from receiving the care they need. Fear keeps people from being tested, treated, and from becoming better informed regarding STDs.

“In [school] nobody really cares. No teacher wants to go into that. They’d rather stay with teaching the material they have to.”
Assets - What are the community assets that can address HIV/AIDS and other STDs?

San Bernardino County has assets that can help to better support individuals with/or at risk for HIV/AIDS and STDs. Because HIV/AIDS and STDs is so closely connected with mental health, please refer to “Mental Health” health need profile for further resources.

- **Community-based organizations:** The Inland AIDS Project helps to address the needs of the LGBTQ population. Planned Parenthood has a program for middle and high school students and teaches about reproductive health (Planned Parenthood, 2012). They have support services for LGBTQ youths and their families. The Foothill AIDS Project has 3 sites in San Bernardino County that provides services to the community. They provide HIV/AIDS medical care management and supportive services, HIV education and risk reduction to communities of color, HIV/AIDS housing, and housing to the general homeless population (Foothill AIDS Project, 2012). The HOPWA (Housing Opportunities for People with AIDS) works in collaboration with Catholic Charities of San Bernardino County to address the housing needs of individuals living with AIDS.

- **Federal and state programs:** The Public Health Department of San Bernardino County has HIV prevention and other service programs to help the people affected with HIV/AIDS and ensure they get the services they need.

**Summary**

Though incidences of chlamydia have fluctuated, it is currently on the rise. According to state data, the incidence rate of chlamydia in the KFH—Ontario MCSA (438.7 per 100,000 population) is much higher than the state (400.0 per 100,000 population). Women in general are disproportionately impacted by chlamydia compared to men. Gonorrhea has also been on the rise in the County since 2009, even though currently the incidence is below the state average (68.7 per 100,000 population compared to California’s 73.1 per 100,000 population). While HIV prevalence (259 per 100,000 population) and hospitalization discharge rate (0.87 per 10,000 population) for the KFH—Ontario MCSA are below the state average (345.4 per 100,000 population and 1.98 per 10,000 population, respectively), more than half (58%) of the population in San Bernardino County reported that they had never had an HIV screening. Men who have sex with men, especially African American and Hispanic/Latino men, are disproportionately affected by HIV. HIV and STD infection is also on the rise in the older adult (50 and older) population. Furthermore, HIV/AIDS and other STDs are linked to mental health, substance use, prenatal/perinatal health, teen pregnancy and cardiovascular disease. Because of advances in HIV treatment, people with HIV are living longer, though their health can be compromised by other chronic diseases.
Mental Health

About Mental Health - Overview and importance

According to the National Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States, accounting for 25% of all years of life lost to disability and premature mortality. The resulting disease burden of mental illness is among the highest of all diseases. Moreover, suicide is the 11th leading cause of death in the United States. Mental health and physical health are closely connected. Mental health plays a major role in people’s ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people’s ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery. (Source: Health People 2020)

Statistical data - Mental health measurement, prevalence, and incidence

<table>
<thead>
<tr>
<th>Suicide Death Rate (Per 100,000 population)</th>
<th>Fontana MCSA</th>
<th>Ontario MCSA</th>
<th>San Bernardino County</th>
<th>California</th>
<th>HP 2020 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.3</td>
<td>7.6</td>
<td>11.27</td>
<td>9.79</td>
<td>10.2</td>
<td></td>
</tr>
</tbody>
</table>

This indicator reports the suicide rate per 100,000 population, age-adjusted to the year 2000 standard. (Source: California Department of Public Health, Death Statistical Master File, 2008-2010.)
This indicator measures the percentage of adults who self-reported the need to see a professional because of problems with their mental health, emotions, and nerves, during the last 12 months. (Source: California Health Interview Survey (CHIS), 2009.)

Populations disproportionately impacted (disparities)

- Based on 2007 age-adjusted death rates, **men** were nearly four times more likely to die of suicide than females, and **White** individuals were over two times more likely to die of suicide than black or Hispanic individuals. (California Department of Public Health, California Conference of Local Public Health Officer, 2012).

- **Youths and children** are particularly impacted by mental health issues, especially because children do not have the skills to care for their own needs. At times, these children are in foster care or in unhealthy family situations. Additionally, children of Asian and Latino backgrounds are less likely to obtain the mental health services they need, largely due to language barriers, lack of knowledge and access to resources, and stigma. According to a national study, about 24% of Latino children and 29% of Asian children who were identified as having serious emotional problems received mental health services, compared to 47% of White children and 50% of African American children (Banta, James, Haviland, & Andersen, 2013).

- **Individuals aged 25-44** were particularly psychological distress and reported having serious thoughts of suicide. They were also the most medicated age group (Healthy San Bernardino County [HSBC], 2012).

- **Seniors** are also vulnerable to the dangers of mental health. Seniors often do not have the resources to care for themselves. They are the highest group receiving mental health care (HSBC, 2012). Older Americans are disproportionately likely to die by suicide. An estimated eight to 25 attempted suicides occur for every suicide death.
• **African Americans** had a high incidence of suicidal thoughts. They suffered higher degrees of psychological stress and were under more medications for mental health than other groups (HSBC, 2012).

• **American Indians** also had high incidences of medication for mental health, though they had a low number of people having had thoughts of suicide and few seemed to be receiving behavioral healthcare (HSBC, 2012).

• **The indigent population** often has a high number of individuals needing support with mental health. San Bernardino County has over 2,875 homeless individuals (Homeless County Report, 2011). Of those persons included in the 2011 Homeless County, 30% has a severe mental illness, and 22% has a developmental disability.

**Geographic areas of greatest impact (disparities)**

<table>
<thead>
<tr>
<th>Suicide Death Rate in KFH-Fontana MCSA (Per 100,000)</th>
<th>Suicide Death Rate in KFH-Ontario MCSA (Per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Map of suicide death rate in KFH-Fontana MCSA]</td>
<td>![Map of suicide death rate in KFH-Ontario MCSA]</td>
</tr>
</tbody>
</table>

**Suicide Death Rate (Per 100,000 Pop.), By ZCTA, CDPH, 2008-2010**

- **Over 40.0**
- **20.1 - 40.0**
- **10.1 - 20.0**
- **Under 10.1**
- **No Deaths**

In the KFH – Ontario MCSA, suicide mortality rates are highest in Claremont, Montclair, Ontario, Rancho Cucamonga, and Upland.
Related Data Indicators Associated with Mental Health

The following table outlines some of the data indicators associated with mental health in the community. These data indicators represent factors known to contribute to or which are correlated with mental health in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at http://www.chna.org/KP/.

<table>
<thead>
<tr>
<th>Associated Health Outcomes</th>
<th>Environment</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcomes</td>
<td>Social Environment</td>
<td>Physical Environment</td>
</tr>
<tr>
<td>Low Birth Weight*</td>
<td>Adequate Social or Emotional Support*</td>
<td>Park Access* Walkability Recreation and Fitness Facility Access*</td>
</tr>
</tbody>
</table>

Socioeconomic Factors

<table>
<thead>
<tr>
<th>Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty Rate (&lt; 100% FPL)*</td>
</tr>
<tr>
<td>Population Below 200% of Poverty Level*</td>
</tr>
<tr>
<td>Children in Poverty*</td>
</tr>
<tr>
<td>Unemployment Rate*</td>
</tr>
</tbody>
</table>

Community Input - What do CHNA participants think about the issue of mental health?

CHNA participants voiced strong concern regarding mental health. While there may be attempts to alleviate the symptoms associated with mental health, many CHNA participants reported that mental health is getting worse and is the “number one challenge” in San Bernardino County.

What populations are most affected by mental health?

- **Youths** are affected by mental health. One CHNA participants stated that there are limited resources to help with mental care. One community resident stated that there is “no in-patient treatment facility for youth in the entire County.”
- CHNA participants also discussed seniors as a group that has depression and dementia.
- **Hispanic/Latinos** were also named as a group that has mental health issues and struggles to reach out for help due to the stigma of having mental health problems.
What are the challenges to addressing mental health?

- CHNA participants linked mental health and **substance use**. The Homeless Count revealed similar results, asserting that the “number of disabilities experienced by survey respondents is positively related to the presence of substance abuse, with the greatest proportion of substance abuse being observed among those with physical, developmental, and mental health disabilities.”

- CHNA participants discussed that the stigma with mental health is not only an issue overall population, but it is pronounced in racial/ethnic communities they work in.

- The mental health issues themselves are often a barrier to healthcare access. People with a mental health condition is not motivated to seek care for other health issues they may have. One CHNA participant shared that the barriers to health become more challenging if the patients have more than one diagnosis (i.e. co-occurring diagnosis).

**Assets - What are the community assets that can address mental health?**

Mental health is linked to substance use. For additional assets in treating co-occurring conditions, please refer to “Substance Use” health need profile. Below is a list of mental health resources mentioned by CHNA participants:

- Schools and school districts are already working with families that have children with mental illness or behavioral disorders such as autism, ADHD, etc. Often, they are the first to become aware that a child may have a problem. They offer resources, modifications, and counseling for children in need.

- Community based organizations in San Bernardino are working to address issues of mental health. Catholic Charities of San Bernardino County takes families on outings as a way to help them combat stress.

- The Association for Community-Based Organizations (ACBO) work as a bridge to educate county behavioral health and community on how to improve and strengthen mental health. They work with all mental health and substance use programs in San Bernardino County.
Summary

According to state data, the KHF—Ontario MCSA suicide rate (7.6 per 100,000 population) is better than the state average (9.8 per 100,000 population). Suicide incidence is highest in the male population, and Whites are twice as likely to die of suicide as people of other racial/ethnic backgrounds. Overall, 14.69% of the KFH—Ontario MCSA’s population self-reported they felt the need to see a mental or behavioral health professional in the past 12 months. According to CHNA participants, the following mental health trends were identified for various populations, including depression and dementia in older adults (which will continue to increase with the aging of the Baby Boomer generation), post-traumatic stress disorder (PTSD) for veterans, post-partum depression for new mothers, autism for children, substance abuse and general mental health issues for the re-entry population, as well as children who are under extreme stress and exhibit self-induced harm. In addition, the 2011 Homeless Count of San Bernardino County reported that 30% of people interviewed had a mental illness and 22% had a developmental disability. Mental health is linked to obesity, chronic diseases (such as cardiovascular disease and diabetes), and infectious diseases (such as HIV/AIDS). Mental health is also exacerbated by economic instability and lack of access to health care services.
Oral Health

About Oral Health – Overview and importance

Oral health is essential to overall health. Oral diseases, from cavities or tooth decay to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include tobacco use, excessive alcohol use, and poor dietary choices. Barriers that can limit a person’s use of preventive interventions and treatments include limited access to and availability of dental services, lack of awareness of the need for care, cost, and fear of dental procedures. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health. (Source: Healthy People 2020)

Statistical data – Oral health measurements, prevalence and incidence

<table>
<thead>
<tr>
<th></th>
<th>Percent with Poor Dental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fontana MCSA</td>
<td>11.88%</td>
</tr>
<tr>
<td>Ontario MCSA</td>
<td>11.81%</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>11.88%</td>
</tr>
<tr>
<td>California</td>
<td>11.27%</td>
</tr>
</tbody>
</table>

This indicator reports the percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection. (Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010)
Adult and Youth Dental Care Utilization

<table>
<thead>
<tr>
<th>Dental Care Utilization (Adult)</th>
<th>KFH-Fontana MCSA</th>
<th>KFH-Ontario MCSA</th>
<th>San Bernardino County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35.41%</td>
<td>35.27%</td>
<td>35.67%</td>
<td>30.51%</td>
</tr>
<tr>
<td>Dental Care Utilization (Youth)</td>
<td>15.59%</td>
<td>15.03%</td>
<td>--</td>
<td>10.07%</td>
</tr>
</tbody>
</table>

These indicators report the percentage of adults aged 18 and teens 12-17 years old who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year. (Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

The Health Resources and Services Administration (HRSA) has also identified 8 geographical Dental Health Professional Shortage Areas (HPSA) in San Bernardino County (HRSA, 2013). As mentioned in the Access to Health Care profile, these shortage areas are designated as having too few health professionals to meet the needs of the population and is another factor impacting oral health and dental care utilization in the County.

Populations disproportionately impacted (disparities)

Barriers to Children Accessing and Utilizing Dental Care

<table>
<thead>
<tr>
<th></th>
<th>San Bernardino County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with No Dental Insurance</td>
<td>19.9%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Children, Ages 2-19, Never Been to a Dentist</td>
<td>15.1%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Could Not Afford Dentist for Children, Ages 2-19</td>
<td>7.4%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

These indicators report the percentages of children age 2-19 with no dental insurance, never been to a dentist, and could not afford to see a dentist in the past year. (Source: California Health Interview Survey (CHIS), 2007) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

Major risk factors for accessing dental services for children and youth are ability to pay, lack of dental insurance coverage and limited availability of dental providers (California School Boards Association [CSBA], 2010).
Related Data Indicators Associated with Oral Health

The following table outlines some of the data indicators associated with oral health in the community. These data indicators represent factors known to contribute to or which are correlated with oral health in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at http://www.chna.org/KP/.

<table>
<thead>
<tr>
<th>Access to Care</th>
<th>Socioeconomic Factors</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Coverage/Affordability</strong></td>
<td><strong>Poverty</strong></td>
<td><strong>Nutrition</strong></td>
</tr>
<tr>
<td>Dental Care Utilization (Youth) *</td>
<td>Population Below 100% of FPL*</td>
<td>Soft Drink Expenditures*</td>
</tr>
<tr>
<td>Absence of Dental Insurance Coverage</td>
<td>Population below 200% of FPL*</td>
<td></td>
</tr>
<tr>
<td>Dental Care Affordability*</td>
<td>Children in Poverty*</td>
<td></td>
</tr>
<tr>
<td>Dental Care Utilization (Adult) *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Community Input - *What do CHNA participants think about the issue of oral health?*

Many CHNA participants stated that addressing dental care is one of the top priorities. There are associations between poor oral health status and other health risks and diseases, such as diabetes, premature and low-birth weight babies, heart disease and stroke (Allukian, 2000; Dye et al., 2007). Poor oral health impacts diet, nutrition, digestion, speech, self-esteem, and affects social activities (e.g. school and work).

**What populations are most affected by poor oral health?**

CHNA participants recognized that oral health disparities in certain populations continue to exist in San Bernardino County. Vulnerable populations (e.g. children, elderly, low-income, disabled, uninsured, and racial/ethnic minorities) face many barriers to dental care that are greater than the general population (Allukian, 2007; Formicula, 2004; Finlayson, 2010).

- Poor oral health has remained prevalent among children. Dental screenings have reduced drastically in many primary school settings. Children in the foster system also suffer from oral diseases and dental malformations for various reasons, impacting their self-esteem and ability to socialize with others. They lack the usual support structure to help them receive services and foster children sometimes need more than basic dental services as a result of abuse, negligence, or drug use during pregnancy.
Seniors are disproportionately affected by poor oral health and access to dental services. The costs of dental care and lack of dental service coverage under Medicare are the main reasons for poor oral health in seniors (Centers for Medicare and Medicaid Services [CMS], 2012; Marshall et al., 2009).

Undocumented individuals have difficulty accessing dental services because they do not qualify for particular public programs, such as Medi-Cal. The few programs that do provide dental insurance and services to undocumented immigrants are limited in scope, and some people do not know they exist. Some undocumented families travel outside of the county and even the country to seek dental care services.

Low-income individuals have difficulties affording co-pays, lab work, and medications, especially for more advanced dental procedures. Poor oral health in low-income individuals is also affected by limited access to dental care services (Dye et al., 2007; Allukian, 2007; Treadwell & Formicola, 2005).

Pregnant women on Medi-Cal do not have access to dental care. Peridontal disease has been associated with premature and low-birth weight babies (Allukian, 2007).

HIV-infected individuals are in need of dental services. Some communities in San Bernardino County do not have dental clinics specifically for HIV individuals.

Some participants expressed the importance of addressing dental services for the homeless. Homeless individuals have an array of medical issues that exacerbate their oral health issues.

CHNA participants noticed poor oral health in the re-entry population. Generally, prisoners have poor oral health and are likely to have extensive periodontal disease (Treadwell & Formicola, 2005). High risk factors in the prison population are poor oral hygiene and drug and alcohol use. The County does not have the capacity to deal with this population returning to society and there is a lack of health services, including dental, to re-entry individuals.
What are the challenges to addressing poor oral health?

- There is a need for oral health education that includes the importance of improving nutrition and reducing risk factors contributing to poor oral health and oral diseases, as well as education about dental services available. High caloric foods (e.g. sugary beverages, chips, candies, etc.) increase the risk of oral diseases (Dye et al., 2007; Peterson, 2005). Parents need to be educated to help their children floss, brush, and use mouthwash. CHNA participants expressed that providers and educators should consider factors that play into families not seeking dental services or having poor oral hygiene, such as lack of dental insurance. CHNA participants recommended that younger age groups (infants to teens) should be targeted to help reduce the incidence and severity of oral diseases.

- Substances, like drugs, alcohol, and tobacco, increase the risk of oral diseases (Allukian, 2000; Dye et al., 2007; Peterson, 2005). Some CHNA participants brought up the issue of methamphetamine causing oral abscesses and loss of teeth (a.k.a. “meth mouth”) (Donaldson & Goodchild, 2006). Tobacco use (including chew) contributes to the risk of oral disease (e.g. oral cancers).

- Oral health and dental public health infrastructure is lacking in San Bernardino County, including preventive services and programs, especially for vulnerable and high-risk populations (CSBA, 2010). Some organizations and medical facilities have cut back on providing volunteer dentists and free screenings. This has also been seen in California overall and the lack of prevention creates a greater burden of oral disease (Allukian, 2007; Goldberg, 2013).

- Medi-Cal and Medicare provide limited dental services. Medicare does not cover routine dental care or most dental procedures (e.g. cleanings, fillings, tooth extractions or dentures) (CMS, 2012). Although Medi-Cal covers dental services for children, there is no longer dental health coverage for adults.

- There is a gap in coordinating dental services. Some clinics and organizations that provide free or reduced dental services have difficulties recruiting patients for these services; possibly due to the information about these services not reaching the intended audiences and lack of dental referrals.

"We need to find a way to make that quantum leap for our Inland Region. It’s just taking too long and people’s lives are in jeopardy because of it. No dental care. Seriously? We should be able to do better.”

"Our clinic has a First 5 grant where we do dental treatment and dental screenings. But then there’s Arrowhead [Regional Medical Center] First 5 and the Center for Oral Health. I think we overlap each other sometimes and lose focus of who needs what and who’s doing what.”
• Geographic isolation is a barrier in San Bernardino County, especially in the Mountain communities (e.g. Mt. Baldy). These rural areas lack dental services when compared to other parts of the Inland Valley region. In order to receive certain dental services, residents must travel to the Valley, which is difficult for some.

**Assets - What are the community assets that can address oral health?**

• **State programs:** The California Medi-Cal Dental program, Denti-Cal, provides low-cost dental services (California Department of Health Care Services, 2012). First 5 San Bernardino (First 5 SB) provides grant funding for fluoride varnishing, dental services, dental education, and transportation to dental facilities (First 5 San Bernardino, 2012). First 5 SB partners with many stakeholders, such as the Center for Oral Health, Arrowhead Regional Medical Center’s First 5 Dental Program, and Preschool Services to provide dental outreach to the children of San Bernardino County. However, CHNA participants felt the services provided can be erratic and unreliable from year to year.

• **City and countywide programs:** Smiles in Style is a continuum of services and dental safety net for children from infants to sixth grade in the County (CSBA, 2010). Through the San Bernardino County Department of Public Health (SBCDPH), oral health education, dental screening, fluoride varnish, and dental sealants are provided (CSBA, 2010; SBCDPH, 2012). However, some school districts have seen this program go away completely.

• Dental associations can bring in dental providers into high-need communities to volunteer their time. These associations can support more strategic efforts in addressing service gaps, improving communication and reducing duplication of services. For example, the Tri-County Dental Society (2012) is a coalition of dentists throughout San Bernardino, Riverside, and Los Angeles Counties that can pull together resources.

• Mercy House provides services that address oral health, including hygiene supplies and referrals to dental services, to the homeless population.

• **Partnerships:** Smile in Style has built countywide partnerships with LLU School of Dentistry, other dental hygiene schools, the San Bernardino County Assistance League, California Child Health and Disabilities Prevention, the Black Infant Health Program, and Pregnant Minor Program to increase their capacity to provide dental services.

• **Community-based organizations:** The Assistance League makes referrals to their Dental Center by outreaching to low-income populations through thrift shops and schools, and partners with Smile in Styles to provide dental services for children (CSBA, 2010). The Children’s Fund provides dental and orthodontic services to foster youth.

• Schools can address oral health issues in children. School nurses and health aides conduct dental procedures (e.g. tooth cleanings) usually done by dental professionals.
• Local universities and colleges provide prevention and dental services in San Bernardino County. Local dental schools, such as Western University School of Dentistry, provide dental services to areas of need.

Summary

The Health Resources and Services Administration (HRSA) has identified 8 geographical Dental Health Professional Shortage Areas in San Bernardino County. According to CDC and state data, the KFH—Ontario MCSA reported slightly worse dental health than the state. Contributing to poor dental health is a lower percentage of dental care utilization among adults (35.27%) and youth (15.03%) in the MCSA who have not visited a dentist or dental clinic in the past year as compared to the state (30.51% in adults and 10.07% in youth). Cost of dental services was cited as the top reason for low dental care utilization, especially early prevention and dental screenings for children. About 20% of children in San Bernardino County do not have any form of dental insurance. According to CHNA participants and national reports, dental disease is the number one chronic disease for children and youth. Children in the foster care system are also greatly affected by poor oral diseases and dental malformations due to lack of basic dental services, abuse and neglect. Other populations disproportionately affected by poor oral health are seniors, undocumented immigrants, low-income, and high-risk individuals (e.g. pregnant women, homeless, HIV-infected, and prison re-entry population). In addition, the general population does not understand the health issues that can stem from poor oral health, and oral care is not integrated into the overall health delivery system. As a result, many dental diseases are left untreated. Poor oral health is linked with poor prenatal health, cardiovascular and stem from risk factors, such as poor diet and nutrition, substance use, economic instability, and limited availability and accessibility to oral health services.
Overweight/Obesity

About Overweight and Obesity – Overview and importance

Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. Individuals who are at a healthy weight are less likely to develop chronic disease risk factors, (such as high blood pressure), develop chronic diseases (such as type 2 diabetes and heart disease and some cancers), experience complications during pregnancy, and die at an earlier age. Changes in diet or physical activity can support weight improvement. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including heart disease, high blood pressure, and Type 2 diabetes. (Source: Healthy People 2020)

Statistical Data – Overweight and obesity measurements, prevalence, and incidence

<table>
<thead>
<tr>
<th>Percent Overweight and Obesity (Adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight (Adult)</td>
</tr>
<tr>
<td>Fontana MCSA</td>
</tr>
<tr>
<td>Ontario MCSA</td>
</tr>
<tr>
<td>San Bernardino County</td>
</tr>
<tr>
<td>California</td>
</tr>
</tbody>
</table>

This indicator reports the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight) and greater than 30.0 (obese). (Sources: Centers for Disease Control and Prevention [CDC], Behavioral Risk Factor Surveillance System, 2006-2010; CDC, National Diabetes Surveillance System, 2009)

San Bernardino County is one of the worst places for childhood obesity in the state and the fourth most obese region in the United States (County Health Rankings and Roadmaps, 2013; County of San Bernardino, 2013a; Ramal, Peterson, Ingram, Champlin, 2012). Children who are overweight or obese are often likely to be obese adults. Although preventable, the rise in obesity and related diseases has led experts to predict a decrease in life expectancy and productivity for today’s youth (CDC, 2012d).
This indicator reports the percentage of children in grades 5, 7, and 9 ranking within the "Needs Improvement" category (Overweight) and “High Risk” category (Obese) for body composition on the Fitnessgram physical fitness test. The percent body fat "needs improvement" threshold is 18.9%-23.7% for boys and 20.9%-31.4% for girls, depending on age. The BMI "needs improvement" threshold is 16.8-25.2 for boys and girls, depending on age. The percent body fat "high risk" threshold is 27%-35.1% for boys and 28.4%-38.6% for girls, depending on age. The BMI "high risk" threshold is 17.5-25.2 for boys and 17.3-27.2 for girls, depending on age. (Source: CA Department of Education, Fitnessgram Physical Fitness Testing Results, 2011)

**Populations disproportionately impacted (disparities)**

---

**Percentage of Students Overweight ("Needs Improvement" Fitness Zone), by Race / Ethnicity**

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>Native American/Alaskan Native</th>
<th>Hispanic/Latino</th>
<th>Multi-Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td><strong>13.12%</strong></td>
<td>14.87%</td>
<td>10.46%</td>
<td>6.14%</td>
<td>13.54%</td>
<td>12.98%</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>12.76%</td>
<td>14.69%</td>
<td>11.89%</td>
<td>0.88%</td>
<td>13.30%</td>
<td>12.63%</td>
</tr>
<tr>
<td>California</td>
<td>12.96%</td>
<td>15.28%</td>
<td>12.17%</td>
<td>7.96%</td>
<td>14.79%</td>
<td>13.03%</td>
</tr>
</tbody>
</table>
Percentage of Students **Obese** ("High Risk" Fitness Zone), by Race / Ethnicity

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>Native American/Alaskan Native</th>
<th>Hispanic/Latino</th>
<th>Multi-Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td>23.56%</td>
<td>30.78%</td>
<td>21.62%</td>
<td>21.30%</td>
<td>37.03%</td>
<td>23.36%</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>23.14%</td>
<td>27.46%</td>
<td>18.55%</td>
<td>2.65%</td>
<td>37.02%</td>
<td>28.94%</td>
</tr>
<tr>
<td>California</td>
<td>19.82%</td>
<td>30.27%</td>
<td>16.69%</td>
<td>19.97%</td>
<td>36.74%</td>
<td>23.89%</td>
</tr>
</tbody>
</table>

**Geographic areas of greatest impact (disparities)**

**Obesity in KFH-Fontana MCSA (Youth)**

**Obesity in KFH-Ontario MCSA (Youth)**

Pct. of Students In 'At High Risk' Body Composition Zone, By Elementary School District, CA Dept. of Education, 2011

- **Over 40.0%**
- **30.1 - 40.0%**
- **20.1 - 30.0%**
- **10.1 - 20.0%**
- **Under 10.1%**

(Source: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011)

In THE KFH – Ontario MCSA, the areas most affected by youth obesity are Pomona, Ontario, and Montclair.
**Related Data Indicators Associated with Overweight and Obesity**

The following table outlines some of the data indicators associated with overweight and obesity in the community. These data indicators represent factors known to contribute to or which are correlated with overweight and obesity in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Associated Health Outcomes</th>
<th>Environment</th>
<th>Socioeconomic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Outcomes</strong></td>
<td><strong>Physical Environment</strong></td>
<td><strong>Poverty</strong></td>
</tr>
<tr>
<td>Overweight</td>
<td>Nutrition access (Built environment)</td>
<td>Adults in Poverty</td>
</tr>
<tr>
<td>Overweight (adult)*</td>
<td>Fast food restaurant access</td>
<td>Population Below 100% of Poverty Level*</td>
</tr>
<tr>
<td>Overweight (youth)</td>
<td>Grocery store access*</td>
<td>Population Below 200% of Poverty Level*</td>
</tr>
<tr>
<td>Obesity</td>
<td>WIC Authorized food store access*</td>
<td>Children in Poverty</td>
</tr>
<tr>
<td>Obesity (adult)*</td>
<td>Food distributed by local food service agencies</td>
<td>Population Below 100% of Poverty Level*</td>
</tr>
<tr>
<td>Obesity (youth)*</td>
<td>Population living in food deserts*</td>
<td></td>
</tr>
<tr>
<td><strong>Behavior</strong></td>
<td>Physical activity access (Built environment)</td>
<td></td>
</tr>
<tr>
<td>Nutrition &amp; Physical Activity</td>
<td>Park Access*</td>
<td></td>
</tr>
<tr>
<td>Inadequate Fruit/vegetable consumption</td>
<td>Walkability</td>
<td></td>
</tr>
<tr>
<td>Fruit/vegetable expenditures</td>
<td>Recreation and Fitness Facility Access*</td>
<td></td>
</tr>
<tr>
<td>Soft drink expenditures*</td>
<td>Transportation</td>
<td></td>
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<tr>
<td>Physical inactivity (adult)*</td>
<td>Poor Air Quality (Particulate Matter 2.5)</td>
<td></td>
</tr>
<tr>
<td>Physical inactivity (youth)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Behavior</td>
<td>Breastfeeding (Any/Exclusive)</td>
<td></td>
</tr>
</tbody>
</table>
Community Input - What do CHNA participants think about the issue of overweight and obesity?

Overweight and obesity is a major health issue in San Bernardino County that is getting worse over time, according to a majority of CHNA participants, as well as local assessments (Babey, Wolstein, Diamante, Bloom & Goldstein, 2012; Community Hospital of San Bernardino, 2011; County of San Bernardino, 2011b).

“Chronic diseases are generally the big issues here (hypertension, diabetes, many related to overweight and obesity). These issues often are concurrent with mental health and substance abuse. We’re also seeing many kids with onset of diabetes and obesity, which is very concerning for us.”

What populations are most affected by overweight and obesity?

Overweight and obesity affects all income levels and age groups.

- **Youth** often lack the education, tools, and power to control what they eat. They are impacted by poverty and lack of resources, which may result in some children eating high caloric foods to get full. Obesity contributes to poor school performance and other poor behavioral and health outcomes (Institute of Medicine [IOM], 2012; Levi, Segal, St. Laurent, & Kohn, 2011). The decreased emphasis of physical education and unhealthy lunches in schools has added to the overweight and obesity epidemic. Moreover, school nurses have seen many children with acanthosis nigricans, which is a darkening and thickening of the skin in the neck folds, armpits, and body creases, a sign of obesity-related insulin resistance (PubMed Health, 2012).

  “I would have to say childhood obesity is a major health issue. Confronting this issue really starts early; prevention with education and ensuring parents know best practices.”

- **Many seniors** have a low and fixed income, but can still be ineligible for CalFresh (also known as SNAP or food stamps) or other public assistance, so they are not able to afford healthier foods. They have mobility issues that impact physical activity and cannot travel as freely as others to get to grocery stores and farmers markets where fresh fruits and vegetables are sold.

  “The Older Adults Program we have here tries to set-up friendships and foster relationships with this population. However, many of them have severe health issues including mental health, obesity, cancer/cancer recovery, and financial issues due to fixed incomes. All of these indicators cause a lot of stress.”

- **Hispanic/Latino, African American** and **low-income** populations are disproportionately affected by overweight and obesity due to lack of culturally appropriate education on healthy eating and healthy living, as well as lack of access to healthy foods that are high
in fat and sugars, which increase the risk of being overweight and obese. Hispanic/Latinos and African Americans are also disproportionately in low-income areas without much access to healthy foods.

- **Asian Americans**, a population that is usually not thought of as having problems with overweight and obesity, are affected by these conditions due to eating unhealthy food. This goes against the perceived body image of Asian Americans.

- **Native American/Alaskan Native** communities are disproportionately affected by overweight and obesity as a result of unhealthy eating. Many are stricken by poverty and high unemployment rates, which impacts access and availability to healthy foods and fresh produce. They also lack access to culturally appropriate health interventions.

- **Immigrants** (documented or undocumented) have difficulty accessing healthy foods and health care services preventing overweight and obesity. This may be due to language barriers, difficulty with navigating the public health system, fear of deportation, and working low-wage jobs.

**What are the challenges to addressing overweight and obesity?**

- CHNA participants stated that healthy eating and exercise are the behaviors most important to promote. Healthy eating and exercise can be linked to chronic disease prevention. Providing these services and programs in a group setting can provide a good support system to encourage and motivate healthy behaviors (National Cancer Institute [NCI], 2005; Ramal, Peterson, Ingram, & Champlin, 2012). However, CHNA participants felt that these are also the hardest behaviors to promote because it is difficult for people to change these habits.

- A lack of health education, lack of knowledge, and cultural norms impact how people eat. Although cultural and racial/ethnic groups incorporate fruits and vegetables in their diet, people do not know how to cook or eat healthier, do not have the resources to access information, and rely on their friends and family for health information, which may not always be accurate. Cooking and nutrition classes should incorporate culture to help people cook healthier and to continue to enjoy their traditional foods. There is also a misconception that all healthy foods and fresh produce are expensive. Certain fruits and vegetables are affordable and are a good alternative to fast food. Health education at the community level can shift communities’ mindsets to prevention and health, and help link the influence of their environment to their health.

- Parents should be educated on the importance of making healthier food choices and exercise since they are the family decision makers and model behaviors for their children. Some parents also feel that a fat baby is a healthy baby, which allows the acceptance of feeding their infants and children unhealthy food options (National Public Radio, 2013). Studies have shown that unhealthy food and having an overweight baby can lead to health conditions later in life, such as diabetes (Institute of Medicine [IOM], 2012).
• CHNA participants felt that there should be an organizational change as well that promotes more healthy eating in the office and at public events (i.e. not having pizza, soda, and candy). Changing organizational culture can help model healthy behaviors to clients and other providers.

• The physical environment can be a barrier to healthy eating behaviors and physical activity. Some CHNA participants feel that there is not a high investment in creating an environment that provides access to healthy foods, provides adequate and safe green space, and provides positive development for families. There is evidence to suggest that modifying the built environment can improve physical activity, change behaviors, and decrease obesity rates (Dannefer, 2012; Ferdinand, Sen, Rahurkar, Engler, & Menachemi, 2012; Levi et al., 2011; Slater et al., 2013).

  o Some communities in San Bernardino County, especially low-income communities, are considered food deserts, having a high ratio of fast-food and convenient stores to grocery stores and produce vendors, making healthy food less accessible (California Center for Public Health Advocacy [CCPHA]; Community Hospital of San Bernardino, 2011; Hoffman, 2011; Trevino et al., 2012). CHNA participants also mentioned the lack of affordable and acceptable fresh produce. Community residents may have to travel outside of their community to get healthier foods.

  o Lack of community gardens, lack of safety in communities, and lack of cleanliness in the public parks have created a barrier to exercise and recreation. In some communities, people do not feel safe leaving their home or allowing their children to play outside.

  “There’s definitely a huge need for healthier food outlets and accessibility to healthier options to support healthy eating.”

  o Poor air quality could be a factor why some people do not exercise outside in San Bernardino County as smog and pollution in the Inland Empire is prevalent (Gauderman et al., 2000; CARB, 2008; Newman, 2012; Warehouse Workers United & Cornelio, 2011).

  o Lack of transportation is an issue for many communities to access healthy foods.

**Assets - What are the community assets that can address overweight and obesity?**

• Community residents are an asset. They are willing and looking to change, but need the tools, information, and a healthy environment to make those changes. They are willing to volunteer their limited time to help keep children and youth active in extracurricular activities and provide them healthier food. Children have also been effective at bringing home the message of healthy eating, healthy lifestyle, and exercise to parents and
families. Engaging demonstrations, modeling and cultural relevance can help change individual behaviors and beliefs, ultimately reducing the incidence of overweight and obesity (IOM, 2012; National Cancer Institute [NCI], 2005; Ramal et al., 2012).

- Understanding community and cultural norms can be helpful and effective in teaching people how to be healthier. Providing information to Hispanic/Latinos, African Americans, Native American/Alaskan Natives, and Asian and Pacific Islanders on how to make modifications to the food they eat and how to cook it can help reduce overweight and obesity. Examples are using sauces with less fat and salt content, less frying of foods, and using brown rice instead of white rice. In addition, teaching people how to read food labels and how to shop at the grocery stores could help move people to healthier options.

- Some CHNA participants feel that overweight and obesity is slightly improving through education and wellness programs run by state, city and county departments. CalFresh (also known as SNAP or food stamps) promotes healthy food and increases access to healthy foods for those in poverty. The San Bernardino County Department of Public Health promotes programs to reduce overweight and obesity. Many agencies, including WIC offices, are helping promote CalFresh and healthy eating.

“WIC has been making their visits up here - providing education for healthy living and proper eating, which has been great because it’s difficult for a lot of these families to do it on their own.”

- **Health care sector**: Pomona Valley Hospital Medical Center provides community nutrition programs to help adults and youth with weight management and improve overall health.

- **Multi-sector partnerships**: Loma Linda University (LLU) has an obesity task force and partners with the San Bernardino County Department of Public Health to decrease childhood obesity. San Bernardino County Housing Authority is collaborating with other agencies to add community gardens to their housing units to increase access to healthy foods and health programs in underserved communities. The Healthy Eating Active Living (HEAL) projects are collaboratives among Kaiser Foundation Hospitals, city representatives, educators, health advocates, and other community partners in many cities to “reduce childhood obesity, and increase healthy food choices and overall health education” (County of San Bernardino, 2013a; Healthy Ontario Initiative, 2012).

“In the fall, there’s a “Walk-to-School” day that promotes parents and children to walk to school and increase physical activity.”

- Food banks can get people to eat healthy. For example, backpack programs and back-to-school events organized by the food banks and school districts have been helpful in not
just meeting the basic needs of low-income residents, but also as a way for children to take home nutritional foods and nutrition education to share with their families.

- Faith-based and community-based organizations are incorporating health and wellness in their programs (e.g. parenting classes, youth groups, etc.). The goal is to not just address individual behavior, but the whole family dynamic. Churches, nonprofit organizations, police departments and city government are collaborating with school districts to develop and support joint-use projects where children and the community can use the schools’ green space for public health programs to prevent or reduce overweight and obesity.

- Recreational sports leagues (e.g. soccer, baseball, basketball) are an asset and have the potential of being a greater asset. The sports leagues keep children exercising, keep them busy, and keep them out of trouble. Some organizations have partnered with sports leagues to provide health education and nutrition. However, some sports leagues are becoming less affordable.

- Farmers markets are increasing in many communities throughout San Bernardino County. For example, Kaiser Foundation Hospitals have created farmers markets on their medical center campuses to sell fresh fruits and vegetables, and are seen as a positive thing by many in the community. However, the public may not know about many of these farmers markets, they are not established directly in needy areas, and some have become more like entertainment venues instead of promoting fresh fruits and vegetables.

> “There isn’t much to do recreationally around here, so it leaves a lot of idle time for kids and youth in the community. Farmers markets are a plus because it’s a place where people can go.”

- Parks and green space are assets depending on the region. San Bernardino County has the highest per capita access to recreation with 2.5 million acres of recreational land and one in four residents living within one mile of a local park (County of San Bernardino, 2011b). Bike routes, such as the Pacific Electric Trail, follow the foothill communities.
Summary

According to CDC and state data, overweight and obesity is rising. The KFH—Ontario MCSA reported higher obesity prevalence for adults (26.29%) and youth (32.62%) compared to the California benchmark (23.25% for adults and 29.82% for youth). Overweight prevalence for adults is also slightly higher in the MCSA compared to the California benchmark. Obesity and overweight spans across all income, age and racial/ethnic groups, but disproportionately affects Hispanic/Latinos, African Americans, Native American/Alaskan Natives, Asian and Pacific Islanders, as well as low-income populations. According to CHNA participants, lack of health and nutrition education (public health infrastructure), poverty, food insecurity, stress, busy work schedules, and poor food environment (e.g. high density of liquor stores, convenient stores, and fast food) are correlated with being obese and overweight. The food that people can afford is usually high in sugar, fat, sodium, and preservatives. Geography is another associated factor, especially when it comes to access to parks and a safe environment. Obesity is linked to cardiovascular disease, diabetes, cancer, prenatal/perinatal health, musculoskeletal conditions, premature death, and mental health.
Prenatal/Perinatal Health

About Prenatal and Perinatal Health – Overview and importance

Early prenatal care (i.e. care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Such problems as low birth weight and infant mortality, which are associated with late or no prenatal care, can be avoided. Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Monetary costs of caring for low birth weight babies and children are approximately $5-$6 billion during the first 15 years. Teenage mothers are particularly vulnerable, as children born to teenage mothers are more likely to suffer health, social, and emotional problems than children born to older mothers. Pregnant teens are also at a higher risk for premature labor and other complications. Increasing the number of women who receive prenatal and perinatal care can also lower health care costs by reducing the likelihood of complications during pregnancy and childbirth. (Source: California Department of Public Health, 2011)

Statistical data – Prenatal/perinatal health measurements, prevalence and incidence

The following secondary data indicators are used to understand rates of low birth weight and infant mortality:

**Infant Health Indicators**

<table>
<thead>
<tr>
<th></th>
<th>KFH-Fontana MCSA</th>
<th>KFH-Ontario MCSA</th>
<th>San Bernardino County</th>
<th>California</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Birth Weight Rate*</td>
<td>7.17%</td>
<td>6.74%</td>
<td>7.11%</td>
<td>6.80%</td>
<td>--</td>
</tr>
<tr>
<td>Very Low Birth Weight Rate*</td>
<td>1.37%</td>
<td>1.16%</td>
<td>1.3%</td>
<td>1.1%</td>
<td>--</td>
</tr>
<tr>
<td>Infant Mortality**</td>
<td>6.60</td>
<td>6.30</td>
<td>6.61</td>
<td>5.14</td>
<td>≤ 6.0</td>
</tr>
<tr>
<td>Breastfeeding (Any)***</td>
<td>86.87%</td>
<td>87.63%</td>
<td>86.55%</td>
<td>91.74%</td>
<td>--</td>
</tr>
</tbody>
</table>


- **Low Birth Weight Rate**—reports the percentage of total births that were low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems, such as cognitive deficits, motor delays, cerebral palsy, academic difficulties, language delays, behavioral difficulties, and psychological
problems (Bailey & Byrom, 2007). This indicator can also highlight the existence of health disparities.

- **Very Low Birth Weight Rate** – reports the percentage of total births in which the newborn weighed less than 1,500 grams (3 pounds, 5 ounces).

- **Infant Mortality**—reports the rate of deaths to infants less than one year of age per 1,000 births. This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- **Breastfeeding (Any)** – This indicator reports the percentage of mothers who are breastfeeding their infants at birth. This indicator is relevant because breastfeeding has positive health benefits for both infants and mothers and may lower infant mortality rates. Breastfeeding is associated with significantly lower blood pressure and decreased risk of cardiovascular disease risk factors and chronic diseases (e.g. diabetes, some childhood cancers, overweight and obesity) (Darnton-Hill, Nishida, & James, 2004).

### Populations disproportionately impacted (disparities)

#### Percent Low Birth Weight, Very Low Birth Weight, and Infant Mortality, by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent LBW* San Bernardino County</th>
<th>Percent Very LBW* San Bernardino County</th>
<th>Infant Morality (per 1000) San Bernardino County</th>
<th>Percent LBW* California</th>
<th>Percent Very LBW* California</th>
<th>Infant Morality (per 1000) California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>6.4%</td>
<td>1.2%</td>
<td>7.2</td>
<td>6.2%</td>
<td>1.1%</td>
<td>4.7</td>
</tr>
<tr>
<td>White</td>
<td>6.5%</td>
<td>1.1%</td>
<td>6.0</td>
<td>6.1%</td>
<td>1.0%</td>
<td>4.2</td>
</tr>
<tr>
<td>Black</td>
<td>12.3%</td>
<td>2.6%</td>
<td>14.8</td>
<td>12.2%</td>
<td>2.6%</td>
<td>10.3</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>8.1%</td>
<td>1.3%</td>
<td>6.8</td>
<td>7.8%</td>
<td>1.0%</td>
<td>4.2</td>
</tr>
<tr>
<td>Other Race</td>
<td>8.7%</td>
<td>0.5%</td>
<td>11.9</td>
<td>8.6%</td>
<td>1.5%</td>
<td>8.5</td>
</tr>
<tr>
<td>Overall</td>
<td>7.1%</td>
<td>1.2%</td>
<td>7.6</td>
<td>6.8%</td>
<td>1.1%</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Sources: *California Department of Public Health, 2010 Birth Statistical Master File.*  
**California Department of Public Health, 2009 Birth Cohort File.** NOTE: San Bernardino County data is used where MCSA-specific data could not be found.
Geographic areas of greatest impact (disparities)

Low Birth Weight Percentage in KFH-Fontana MCSA

Low Birth Weight Percentage in KFH-Ontario MCSA

Percentage of Newborns with Low Birth Weight, By ZCTA, CADPH, 2010

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Over 9.0%</th>
<th>7.1 - 9.0%</th>
<th>5.1 - 7.0%</th>
<th>3.1 - 5.0%</th>
<th>Under 3.1%</th>
</tr>
</thead>
</table>

In the KFH – Ontario MCSA, the areas most affected by low birth weight are Pomona, Upland, Rancho Cucamonga, Chino, Claremont and Ontario.

Related Data Indicators Associated with Prenatal/Perinatal Health

The following table outlines some of the data indicators associated with prenatal/perinatal health in the community. These data indicators represent factors known to contribute to or which are correlated with prenatal/perinatal health in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Associated Health Outcomes</th>
<th>Environment</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcomes</td>
<td>Physical Environment</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Teen Births*</td>
<td>Annual Hours of Delay due to Roadway Congestion</td>
<td>Tobacco Expenditures*</td>
</tr>
<tr>
<td>Preterm Births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure Prevalence</td>
<td></td>
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<table>
<thead>
<tr>
<th>Access to Care</th>
<th>Socioeconomic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screenings</td>
<td></td>
</tr>
<tr>
<td>Lack of Prenatal Care *</td>
<td>Population Below 100% of FPL*</td>
</tr>
<tr>
<td>HIV Screenings</td>
<td>Population below 200% of FPL*</td>
</tr>
<tr>
<td></td>
<td>Children in Poverty*</td>
</tr>
<tr>
<td></td>
<td>Infants Born to Mothers with &lt;12 Years Education</td>
</tr>
<tr>
<td></td>
<td>Infants Born to Fathers with &lt;12 Years Education</td>
</tr>
<tr>
<td></td>
<td>Student Reading Proficiency (4th Grade)</td>
</tr>
</tbody>
</table>
Community Input - *What do CHNA participants think about the issue of prenatal/perinatal health?*

Several CHNA participants expressed that prenatal and perinatal health is an important health issue in San Bernardino County. Although improvements have been made, San Bernardino County continues to fare the worst among all counties in California for infant mortality (California Department of Public Health [CDPH], 2013; Steinberg, 2012).

**What populations are most affected by prenatal/perinatal health?**

Pregnancy-related health outcomes are influenced by a mother’s health and other factors like race, ethnicity, age, and income (Centers for Disease Control and Prevention [CDC], 2012a).

- **Women of color** continue to experience disparities in prenatal care (Lorch, Kroelinger, Ahlberg, & Barfield, 2012; Webb, 2004). In particular, **African American** women in San Bernardino County receive the least amount of prenatal care and have higher incidence of low birth weight (LBW), very LBW, and infant mortality (County of San Bernardino, 2011b; Steinberg, 2012; Web, 2004). Compared to Whites, **Hispanic/Latinos** also have higher rates of infant mortality in San Bernardino County. African Americans and Hispanic/Latinos are also disproportionately affected by **teen pregnancy**. Barriers that face woman of color are access to adequate health care, lack of insurance coverage, lack of information and education, and poor socioeconomic conditions (Webb, 2004).

- **Grandparents** are increasingly more involved in “kinship care”. Participants have witnessed and experienced grandparents taking care of their grandchildren and great grandchildren because of issues with teen pregnancy, **substance use**, and grandparents living in multiple family households due to home foreclosures and unstable incomes (AARP, 2012; Tremblay, Barber, & Kubin, 2006).

**What are the challenges to addressing prenatal/perinatal health?**

- Risk factors associated with increased rates of fetal death are inadequate prenatal care and having chronic medical conditions. Improved access to care may help reduce fetal death rates (Lorch et al., 2012). Environmental risk factors that affect a woman’s and fetus’ health during pregnancy are exposure to air pollution, radiation, lead, mercury, arsenic, household chemicals, and pesticides. Maternal exposure to environmental risk factors can impede fetal development, and increase the risk of miscarriage, preterm birth, other pregnancy complications as well as the infant developing chronic conditions later in life, such as **coronary heart disease**, **stroke**, and **diabetes** (Darnton-Hill et al., 2004; Women’s Health, 2013).

- Poor health and poor eating habits (e.g. overeating, unhealthy foods) during pregnancy can affect the fetus in utero and can lead to poor child health, such as diabetes, **overweight**, **obesity**, and **cardiovascular disease** (Darnton-Hill et al., 2004). Poor
maternal diet can also increase the risk of gestational diabetes (CDC, 2012a). In addition, women can experience postpartum depression after giving birth.

- Poor quality housing and neighborhood characteristics have been associated with maternal mortality, preterm birth, and infant mortality (Laraia et al., 2006). Low-income and poor quality neighborhoods are bombarded with tobacco, liquor stores, and poor quality food, which affect a mother’s health and influence health behaviors, such as eating high-fat diets and being less physically active.

- Addressing **HIV and Sexually Transmitted Diseases (STD)** are important to decrease poor maternal and infant health outcomes. Young mothers are at additional risk of contracting HIV and STDs because they are less likely to use condoms and may have multiple new partners throughout pregnancy and the first year after giving birth (Wheeler, Earnshaw, Kershaw, & Ickovics, 2012). Some STDs can be passed to fetuses and newborns during birth, resulting in adverse fetal development, preterm birth, low birth weight, and fetal death (Gabbe et al., 2012).

- There is a lack of dental care for pregnant women, especially those who are low-income and/or enrolled in Medi-Cal. Pregnancy increases the risk of oral diseases, such as periodontal disease, dental caries, and gingivitis (Desrosiers & Meyer, 2012). Poor maternal oral health has been associated with inadequate nutritional intake during pregnancy, preeclampsia, low infant birth weight, and preterm birth. Due to lack of prenatal dental care in San Bernardino County some residents seek these services outside of the county.

- Substance use during pregnancy is an issue because it causes increases in LBW babies, preterm birth, infant and childhood behavioral problems, and intrauterine fetal death (Goler et al., 2012).

> “So if a woman has an abscess and it causes an infection and premature birth, there’s just nothing out there to prevent that. Not in this county anyways. They can go to perhaps Western Dental in Pomona, but not here.”

**Assets - What are the community assets that can address prenatal/perinatal health?**

- Parent education classes, including breastfeeding classes, and prenatal/perinatal health promotion in San Bernardino County can improve infant health. For example, Riverside-San Bernardino County Indian Health provides a breastfeeding program for young Native American mothers. The Tribal Maternal Home Visitation program trains employees make home visits to young, single mothers or young families with children 0-5 years old to provide child education or parent education to improve parenting skills. Moreover, some providers feel a need for increased awareness and education around using car seats and the potential dangers of co-sleeping.
• **Public programs:** WIC provides food supplements, nutrition education, and health care to pregnant and postpartum low-income women and to infants and children up to age 5 who have health and nutritional risks (U.S. General Accounting Office, 1984). Studies have shown that WIC significantly decreases the percent of low birth weight babies, premature births, and increases prenatal care (Kotelchuck, Schwartz, Anderka, & Finison, 1984; Stockbauer, 1987). California Children’s Services (CSS) provides health insurance to people under 21 years old who have congenital diseases or birth injuries. First 5 San Bernardino provides children’s health insurance and prenatal/perinatal education for families with children 0 to 5 years of age.

• The San Bernardino County Department of Public Health (SBCDPH) provides several services, such as immunizations, safe sex programs, and family support services include prenatal care, child health, and maternal health among other services (SBCDPH, 2012). Several of their clinics also have WIC clinics to improve referrals and to decrease transportation and time barriers. In addition, Healthy Communities can collaborate with cities to include services addressing prenatal and perinatal health issues and improve neighborhood characteristics.

• **Health care sector:** Federally Qualified Health Centers (FQHC) provide prenatal and maternal care and reproductive health services for low-income families. The Perinatal Screening, Assessment, Referral, and Treatment (SART) Program identifies pregnant women using drugs, alcohol, and tobacco and intervenes on their behalf to change behaviors (SBCDPH, 2012).

• **Community-based organizations:** Planned Parenthood is the leading provider of reproductive health care and sexual health information for low-income individuals and young men and women in the country (Planned Parenthood, 2012). Project Cuidar provides free parenting classes to promote healthy parent-child relationships and optimal child development.

• Probation offers the Parents Matter program that provides free parenting classes for high-risk families that do not have a stable home or structure needed for a healthy lifestyle and healthy relationships. This could help prevent unwanted pregnancies, abuse, and other poor prenatal and perinatal health outcomes.

• The Inland Empire Perinatal Mental Health Coalition (IEPMHC) is a diverse group of healthcare professionals, individuals and agencies that raise awareness and increase access to mental health services for women and their families during and after pregnancy (IEPMHC, 2012).

• **Alternative healthcare service methods:** Promotoras or Community Health Workers (CHW) can provide basic prenatal care services, breastfeeding classes, prenatal support services (e.g. transportation, interpretation, insurance enrollment), and peer counseling to reduce the risk of poor prenatal health outcomes (Bill, Hock-Long, Mesure, Bryer, &
Zambrano, 2009). CHNA participants also suggested that prenatal/perinatal health programs could incorporate more Nurse Practitioners to provide basic care, but still have obstetricians deliver the baby.

**Summary**

According to CDC and state data, the KFH—Ontario MCSA reported a lower percentage of low birth weight (LBW) babies (6.74%) compared to California (6.80%). Although the infant mortality rate in San Bernardino County is decreasing, the KFH—Ontario MCSA reported a higher infant mortality rate (6.30 per 1,000 births) compared to California (5.14 per 1,000 births). The percentage of mothers breastfeeding after birth in the MCSA (87.63%) is lower than the California benchmark (91.74%). Breastfeeding is associated with children having significantly lower blood pressure and decreased risk of **cardiovascular disease** and chronic diseases later in life. Although there have been advancements in prenatal and perinatal health, women of color, especially African American women, continue to experience disparities in prenatal care and outcomes in San Bernardino County. African American women in general receive the least amount of prenatal care and have higher incidence of LBW, very LBW, and infant mortality. According to CHNA participants, mothers using **substances** during pregnancy and not receiving adequate dental care are also an issue. Pregnancy-related health outcomes are influenced by poor health, poor eating habits, poor quality housing and neighborhood characteristics, low socioeconomic status, having **HIV/AIDS and STDs**, **drug and alcohol use**, and exposure to environmental risk factors (e.g. air pollution, lead, mercury, pesticides, and household chemicals) during pregnancy. This can lead to poor fetal development and later translate into poor child health, such as **diabetes**, **overweight**, **obesity**, and **cardiovascular disease**. Prenatal/perinatal health is also linked with **service infrastructure** and **access to health care** as some communities lack OB/GYN physicians, maternal health professionals and health insurance.
Service Infrastructure

About Service Infrastructure – Overview and importance

Service Infrastructure refers to both the public health system and the nonprofit sector in a community and is integral to a healthy and stable community. Public health infrastructure includes a capable and qualified workforce, up-to-date data and information systems, and health agencies that are capable of assessing and responding to public health needs. Government policies and funding priorities can also determine the availability of health services and the development of environments that promote good health. The non-profit sector is valuable to the local economy and overall quality of life for its community. Many non-profit agencies provide community support, health prevention and promotion, and linkage and referral services that support individuals in seeking the health care they need. Coordination between the public health system and the non-profit sector is an important factor in a strong service infrastructure. Foundations and federal grants can provide critical funding for community services and charitable organizations in bridging the gap between government programs and local needs. (Source: Healthy People 2020)

Statistical data – Service infrastructure measurements and indicators

Although secondary data on Service Infrastructure specific to the KFH – Ontario Medical Center Service Area is limited, existing county data reveals San Bernardino County lags in nonprofit funding, numbers and growth.

<table>
<thead>
<tr>
<th>Number of Nonprofits, 10-Year Growth Rate (2002-2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
</tr>
<tr>
<td>Los Angeles County</td>
</tr>
<tr>
<td>Orange County</td>
</tr>
<tr>
<td>Riverside County</td>
</tr>
</tbody>
</table>

This indicator assesses describes the growth of nonprofits in San Bernardino County and neighboring counties between 2002 and 2011. (Source: The Urban Institute, 2012)
According to the San Bernardino County Community Indicators Report (2012):

- Between 2010 and 2011, there was a decline in registered nonprofit organizations in San Bernardino County from 5,644 to 6,118.
- The largest category of nonprofits in the County in 2011 was Religion at 25%, followed by Human Services (24%), Public/Social Benefit (20%), and Education (14%).
- San Bernardino County has 2.7 nonprofit organizations per thousand residents, which is lower than all regions compared except Riverside County.
- Reported revenues for nonprofits increased 14% in the five-year period between 2007 and 2011, while total assets increased 54% during the same period.
- 38% of the nonprofits in San Bernardino County have revenues below $25,000.
- Local foundations award only $3 per capita in San Bernardino County. This is substantially less than all other counties and California compared $119.

### Additional Service Infrastructure Indicators

| Source: County of San Bernardino, 2012. NOTE: San Bernardino County data is used where MCSA-specific data could not be found. |
|---|---|---|---|---|
| **Foundation Funds Per Capita** | San Bernardino County | Los Angeles County | Orange County | Riverside County | California |
| $3 | $139 | $70 | $51 | $119 |

### Community Input - What do CHNA participants think about the issue of service infrastructure?

All CHNA participants discussed a number of reasons why they believed service infrastructure was an issue when addressing health needs in the community. The system as a whole does not fully address the health issues of San Bernardino County residents, and can sometimes make things worse.

### What populations are most affected by service infrastructure?

- **Racial/ethnic minorities, low-income individuals, and vulnerable populations** (e.g. children, seniors, the uninsured, and homeless) are strongly impacted by the inability of service agencies, nonprofit, and community-based organizations to respond to the public health needs of the community, decreasing their overall quality of life (Bodenheimer, 2008; Detmer, 2003).
- **Rural populations** (i.e. Mt. Baldy communities) are disproportionately affected by the lack of coordination of care, the lack of funding going to rural areas, and uneven distributions of organizations, agencies, and health care providers that are able to address all of the needs of rural communities. Low population density, geographic isolation, and
large distances between residences and services impact rural areas (Arcury, Preisser, Gesler, & Powers, 2005; Wang & Luo, 2005).

What are the challenges to addressing the lack of service infrastructure?

• CHNA participants stated that there is a lack of continuity of care, especially related to specialty care and moving patients from prevention to treatment to management of health conditions. Competition between providers and health plans, lack of communication, and lack of referrals between primary and specialty care providers are key elements related to this issue (Bodenheimer, 2008). One CHNA participant stated, "Patients who do not have any insurance have to go through the county system, which can be challenging."

“A big need along with access to health care is our ability to get our partner agencies—everything from IEHP to probation to child welfare services—to make referrals so that the system is more effective or it doesn’t ignore certain classes of problems or children that need those services.”

• To address continuity of care and service gaps, CHNA participants stated the need for more coordination among health care and other service providers, including smaller, more community-based organizations, as clients are coming in with multiple needs. Some CHNA participants also expressed being overwhelmed with the fragmentation of multiple coalitions addressing the same health issue and not knowing what one another is doing. Coordination can encourage identification and reduction of duplication and improve care and services (Bodenheimer, 2008; Institute of Medicine [IOM], 2012).

“One of our biggest issues that we are constantly addressing for children’s programs is the competition between community-based organizations. So, we may have a community provider who does TBS—Therapeutic Behavioral Support—which is a very high end type of service. A different provider in the same area may be doing Intensive School Based Programs (ISBP). It would be to the child’s interest to be referred from ISBP to TBS, but since it’s a different provider it doesn’t happen. So, it’s getting the CBOs to network and stop seeing each other as competitors, but to see each other as cooperatives.”

• CHNA participants stated there is a need for capacity building to strengthen existing organizations. This includes trainings, organizational and program evaluations, data management and providing more evidence-based practices (Detmer, 2003; IOM, 2012).
• More emphasis is also needed in addressing the lack of public health investment, especially in health education, prevention, and screenings, which has seen a decline due to the recession, policies, and lack of coordination. Missed opportunities in health education, prevention and screening can cost the County a lot of money (Bodenheimer, 2003; Detmer, 2003; IOM, 2012).

• County and city governments and nonprofit organizations have been greatly affected by the economic downturn and grant funding to the County is much lower than the state average. Some agencies and organizations have reduced their size and services, or have closed down all together.

“\textbf{We only have 4 nurses now for the school district due to cuts. It’s very difficult [to do our job]. Right now each nurse has between 4,400 and 5,000 students.}”

• The geography of San Bernardino County is a barrier to providing services to all residents. The county spans over 20,000 square miles with much of the land undeveloped (County of San Bernardino, 2011b). Thus, due to population density, the concentration of services is in the Inland Valley Region – West, Central and East regions.

• Many CHNA participants felt that the lack of political and organizational leadership in San Bernardino County makes it more difficult to effectively tackle the major health issues in the County. Also, many CHNA participants feel that policies are not aligned with improving the health of residents. Political and organizational leaders try to isolate problems in silos without seeing the whole picture, which does not allow someone to address the root causes of those problems.

\textbf{Assets - What are the community assets that can address service infrastructure?}

• \textbf{Community collaborations:} The San Bernardino Countywide Vision Project has brought together many organizations and community residents to establish and support healthy environments and infrastructure (County of San Bernardino, 2011b; County of San Bernardino, 2011a).
CHNA participants identified efforts that focus on coordination of health care and social services to improve continuity of care. Sharing information and data through an electronic health records system, a public health and service infrastructure that receives adequate funding, and integrating care among primary care physicians, specialists, hospitals, clinics, other social service agencies, patients and their families can improve quality of and facilitate appropriate delivery of health care services (Bodenheimer, 2008; Detmer, 2003). For example, the Community Clinic Association of San Bernardino County is a consortium of 26 community clinics in the County and serves as an advocacy, education, shared services and issues group for all of the clinics and the safety net population that they serve.

Summary

Service infrastructure includes aspects of the non-profit sector, funding to community organizations, public health infrastructure, coordination/collaboration amongst service providers, capacity building, leadership and advocacy. Secondary data on service infrastructure specific to the KFH—Ontario MCSA is limited. Existing county data reveals that San Bernardino County lags in nonprofit funding and growth, as the number of registered nonprofit organizations in the County has decreased from 6,118 in 2010 to 5,644 in 2011. In addition, San Bernardino County receives $3 of foundation funds per capita, which is significantly less than the California average of $119. As such, alignment of efforts among existing collaboratives and networks is needed and will require more coordination among health care and other service providers, including smaller, more community-based organizations. Capacity building can also strengthen existing organizations, as there is a lack of leadership to adequately address the health needs of county residents. More emphasis is also needed in addressing the lack of public health infrastructure in the County; including health education, prevention, and screenings. The issue of service infrastructure affects all regions of San Bernardino County, particularly low-income and rural communities. Service infrastructure is linked with access to health care, which in turn is related to many of the identified health needs.
Substance Use

About Substance Use - Overview and importance

Substance abuse has a major impact on individuals, families and communities. It contributes to costly social and public health problems, including teenage pregnancy, STDs and HIV, domestic violence, child abuse, crime, motor vehicle crashes, homicide, and suicide. In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95 percent of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. As a more recent trend, abuse of prescription drugs has continued to rise in recent years, especially among adolescents. For some individuals, substance abuse will develop into a chronic illness and/or a mental health disorder that will require lifelong monitoring and care. (Source: Healthy People 2020)

Statistical data - Substance use measurement, prevalence, and incidence

A variety of commonly used indicators are shown to help gauge the extent of alcohol and other drug (AOD) use. These include youth use of AOD, AOD-related deaths, admissions to treatment facilities, and serious (injury or fatal) alcohol-involved car collisions. The following secondary data indicators are used to understand Substance Use in San Bernardino County:

<table>
<thead>
<tr>
<th>Substance</th>
<th>2010-2011</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine/Crack</td>
<td>247</td>
<td>301</td>
</tr>
<tr>
<td>Heroin</td>
<td>1474</td>
<td>1295</td>
</tr>
<tr>
<td>Marijuana/Hashish</td>
<td>846</td>
<td>906</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>2842</td>
<td>2336</td>
</tr>
<tr>
<td>Alcohol</td>
<td>1000</td>
<td>945</td>
</tr>
</tbody>
</table>

This indicator reports the admission rates to publicly-funded and/or monitored alcohol and other drug treatment facilities in 2009-2010 and 2010-2011. Overall, the admissions to county treatment facilities rose 11% during this period, to just over 6,500 in 2010-11, with methamphetamine accounting for about 44% of the admissions. There was an increase in admissions due to methamphetamine, heroin and marijuana, but decrease in alcohol and cocaine/crack. (Source: San Bernardino County CalOMS dataset, 2011.) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.
Populations disproportionately impacted (disparities)

The San Bernardino County youth population tends to experience a higher substance use burden than the California average.

![Rates of Alcohol Use (Youths - 9th Grade)](image)

These indicators report the percent of high school 9th graders who engage in binge drinking, who currently use alcohol, and who has used alcohol in their lifetime. Ninth grade students in San Bernardino County tended to have higher alcohol consumption than their counterparts in the state. (Source: California Department of Education, 2013) NOTE: San Bernardino County data is used where MCSA-specific data could not be found.

**AOD Use among the Homeless Population** - Of those Homeless Count respondents who provided a response, a little over three in ten (31.1%) report having an alcohol or drug problem. This proportion does not differ significantly by age, gender, or location of survey administration. Of those who do report having a substance abuse problem, 29% report using cocaine, crack, heroin, PCP or LSD, uppers or speed, or downers/tranquilizers (Homeless Count, 2011).

**Alcohol Use among Older Adults** - One of the leading causes of death for high alcohol use is liver disease in people over age 45, which implies heavy alcohol use for an extended period of time (Center for Applied Research Solutions, 2012).
Community Input - *What do CHNA participants think about the issue of substance use?*

CHNA participants were very concerned about substance use in their communities. Of concern is not only the disorder of addiction, but also the consequences of having a substance use issue, which include: arrests for alcohol or drug related crimes, motor vehicle accidents, and hospitalization and deaths due to alcohol and drug use.

**What populations are most affected by substance use?**

- CHNA participants stated that *people with mental health issues* are more likely to have issues with addiction. This includes *veterans* struggling with PTSD or individuals with depression, ADD, and stress.

> “I think we just can’t understate how much mental health underpins so many of the other issues that are happening – around the substance abuse issues, around alcoholism. There’s usually some type of underlying mental health issue that goes along with that.”

- **Males** are more likely to struggle with addiction than women. They are more likely to indulge in binge drinking. Males are at greater risk substance use related arrests and for alcohol involved accidents. Men also have the many times more alcohol and drug related deaths than women.

- While **women** are not as likely to have issues with addiction, they have a high incidence of hospitalization due to alcohol and drug related usage, because their systems handle drug and alcohol differently and they absorb more alcohol into their systems. Because women have a higher fat content than men, their organs are also more vulnerable to drug and alcohol exposure (Harvard Health Publications, 2010). *Expectant mothers* are particularly vulnerable to the effects of drug and alcohol usage because of the damage to the fetus.

- **Youths under 18 years of age** were more likely to be arrested for drug related crimes and driving under the influence. Of the illicit drugs used by youth, spice, a synthetic drug, is second only to marijuana. Spice is more popular among male youths than female youths. Spice is not detectable in standard drug tests. Additionally, synthetic drugs are expensive to test for and difficult to recognize the symptoms. It is also challenging to get ordinances to stop or regulate the use of synthetic drugs. Children have easy access to these types of drugs. In fact, they are packaged to appeal to children (National Institute for Drug Abuse, 2012; Lomardo, 2012).

- **Americans Indians** have a high incidence of binge drinking. At the same time, they are much less likely to admit themselves into drug and alcohol treatment programs and to be arrested for drug related crimes. They were also not likely to be hospitalized for alcohol or drug use.
• **Hispanic/Latinos** are also much more likely to get arrested for drug and alcohol related crimes. Hispanics are also more likely to be involved in alcohol related motor vehicle accidents. Hispanics also has a very high likelihood of death due to alcohol or drugs.

“When you look at leading causes of death, among Latinos liver issue, cirrhosis of the liver is higher on the list in terms of leading causes of death among Latinos than other groups.”

• **Whites** have the highest incidence of alcohol and drug related deaths. They have a high likelihood of being arrested for drug related crimes as well as alcohol related crime. Whites have a high likelihood to be involved in an alcohol related motor vehicle accident. They had the highest incidence of hospitalization due to alcohol or drug use (Center for Applied Research Solutions, 2012).

**What are the challenges to addressing substance use?**

• CHNA participants discussed the prevalence of prescription drug use. A few mentioned the easy access of prescription drugs purchased in Mexico and sold at swap meets. CHNA participants also mentioned synthetic drugs like spice and bath salts as well as marijuana use.

• CHNA participants also mentioned a lack of education regarding drug use. Communities have been desensitized to drug and alcohol in their areas and are apathetic about its consequences.

**Assets - what are the community assets that can address substance use?**

Because substance use is closely lined with mental health, please refer to “Mental Health” health need profile for additional assets.

• Healthy Pomona is beginning to address issues of mental illness and substance use.

• The Ontario Police department has a COPS program (Community Outreach and Problem Solving) that works with the Department of Alcohol and Beverage Control to help control the amount of alcohol concentrations throughout the city.

• Matrix Institute on Addictions provides substance use treatment, education and training, and research to improve the lives of individuals and families affected by alcohol and other drug use.
Summary

According to San Bernardino County CalOMS data, admissions to County substance abuse treatment facilities rose 11% from 2009 to 2011. Of all drug and alcohol-related admissions to substance abuse treatment services in the County, methamphetamine-related treatment had the highest, accounting for 44% of all admissions. Youth also have drug and alcohol issues as the percentages of high school 9th graders who binge drink (17%), currently use alcohol (28%) and use alcohol and other drugs in their lifetime (55%) are higher than the state percentages (15%, 25%, and 50%, respectively). Although men struggle more with addiction than women, CHNA participants expressed concern for pregnant women using drugs and alcohol. In general, alcohol is a commonly abused drug. The highest incidence of alcohol-related deaths in the U.S. was due to alcoholic liver disease, which implies long term use of alcohol. This is especially problematic in low-income communities, which typically live in areas with higher density of liquor stores. Substance use is reported for specific populations, such as older adults (for depression and bereavement), re-entry population, veterans, and victims of domestic abuse. In 2011, 31.1% of the homeless population had an alcohol or drug problem. Moreover, there is an increase in prescription medication abuse, and a newer trend is the use of synthetic drugs (e.g. spice and bath salts). Screening for synthetic drug use is expensive, and there is a lack of training in identifying symptoms of synthetic drug use; indicating that synthetic drug use is likely higher. Substance use is linked to mental health, community violence, cancer, oral health, cardiovascular disease and hepatitis.
Teen Pregnancy

**About Teen Pregnancy – Overview and importance**

Teen birth is of concern for the health outcomes of both the mother and the child. Pregnancy and delivery can be harmful to teenagers' health, as well as social and educational development. Babies born to teen mothers are more likely to be born preterm and/or low birth weight. Responsible sexual behavior reduces unintended pregnancies, and thus reduces the number of births to adolescent females. (Source: Healthy San Bernardino County, 2013)

**Statistical data – Teen pregnancy measurements, prevalence, and incidence**

This indicator reports the proportion of total births to mothers under the age of 20. (Source: California Department of Public Health, Birth Profiles by ZIP Code, 2010)

Teenagers in San Bernardino County have poor reproductive health outcomes (Boafo, Smith, Modeste, & Prendergast, 2004; California Department of Public Health [CDPH], 2013). Teen parents have unique social, economic, and health support services. Economic costs include expense of foster care, more-than-usual health care, and decrease tax revenue. Health consequences include poor maternal and neonatal outcomes, teen parents being less likely to receive prenatal care, increased risks for preterm delivery, lower infant birth weights, and higher neonatal mortality rates (Boafo, et al., 2004; Lachance, Burrus, & Scott, 2012). There are also social and educational consequences, such as half of adolescent parents not earning a high school diploma, one-third of adolescent mothers more likely dependant on various forms of public assistance, and adolescent mothers continuing to lead high-risk lifestyles (e.g. unsafe sex, rapid repeat pregnancies) (Lachance et al., 2012).
This indicator reports the rate of total births to women under the age of 20 per 1,000 female population. (Source: California Department of Public Health, Birth Profiles by ZIP Code, 2010)

The birth rate for females 15-19 years old in San Bernardino County has decreased from 56.2 live births per 1,000 females in 2000 to 45.6 live births per 1,000 females in 2010. (Source: California Department of Public Health, Birth Profiles by ZIP Code, 2010.)

**Populations disproportionately impacted (disparities)**

**Teen Birth Rate by Race / Ethnicity (Per 1,000 Female Under Age 20)**

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaskan Native</th>
<th>Hispanic / Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFH-Fontana MCSA</td>
<td>27.80</td>
<td>50.40</td>
<td>13.40</td>
<td>17.50</td>
<td>65.50</td>
</tr>
<tr>
<td>KFH-Ontario MCSA</td>
<td>25.00</td>
<td>48.20</td>
<td>11.20</td>
<td>15.70</td>
<td>63.80</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>28.30</td>
<td>51</td>
<td>13.40</td>
<td>16.90</td>
<td>65.30</td>
</tr>
<tr>
<td>California</td>
<td>15.30</td>
<td>42.10</td>
<td>12.50</td>
<td>21.20</td>
<td>65.40</td>
</tr>
</tbody>
</table>

Geographic areas of greatest impact (disparities)

In the KFH – Ontario MCSA, the areas most affected by teen pregnancy are Pomona, Ontario, and Montclair.

**Related Data Indicators Associated with Teen Pregnancy**

The following table outlines some of the data indicators associated with teen pregnancy in the community. These data indicators represent factors known to contribute to or which are correlated with teen pregnancy in the community. Data indicators marked in red and followed by * are not meeting the California State and/or Healthy People 2020 benchmark. For more information about specific data indicators for this community, please go to the Kaiser Permanente CHNA Data Platform at [http://www.chna.org/KP/](http://www.chna.org/KP/).

<table>
<thead>
<tr>
<th>Access to Care</th>
<th>Socioeconomic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screenings</td>
<td></td>
</tr>
<tr>
<td>Lack of Prenatal Care *</td>
<td>Population Below 100% of FPL *</td>
</tr>
<tr>
<td>HIV Screenings</td>
<td>Population below 200% of FPL *</td>
</tr>
<tr>
<td></td>
<td>Children in Poverty*</td>
</tr>
<tr>
<td></td>
<td>Infants Born to Mothers with &lt;12 Years Education</td>
</tr>
<tr>
<td></td>
<td>Infants Born to Fathers with &lt;12 Years Education</td>
</tr>
<tr>
<td></td>
<td>Student Reading Proficiency (4th Grade)</td>
</tr>
</tbody>
</table>
Community Input - What do CHNA participants think about the issue of teen pregnancy?

Several CHNA participants feel that teen pregnancy is an important issue to address. Although teen pregnancy in San Bernardino County has been decreasing over the past decade, it had the thirteenth highest 3-year average teen birth rate among all counties in California in 2011 (California Department of Public Health [CDPH], 2010).

What populations are most affected by teen pregnancy?

- CHNA participants have witnessed African American and Hispanic/Latino communities disproportionately affected by teen pregnancy.

- The children of teen parents are also most adversely affected from birth and throughout their lives (Lachance et al., 2012). They are more likely to be underweight, to be premature, to have lower health assessments, to have deficits in cognitive and academic outcomes, to have poorer social outcomes, to be subjected to abuse and neglect, to enter the foster care system, to have increased risk of incarceration, and to experience multigenerational cycles of becoming teen parents.

What are the challenges to addressing teen pregnancy?

- Youth who participated in the CHNA felt that teen pregnancy has increased because there is poor communication between parents and children about sex and pregnancy, sexual health education is not taught in school, and condoms and birth control are not easily accessible to teens who are sexually active. Sex education does not cover prevention strategies, including using negotiation skills with sexual partners. Increasing teen responsibility and sexual health education in San Bernardino County public schools has been suggested by youth and the Public Schools Project (Jose-Murray, 2007).

- Addressing HIV and Sexually Transmitted Diseases (STD) are important. Young mothers and pregnant teens are at additional risk of contracting HIV and STDs because they are less likely to use condoms and may have multiple new partners throughout pregnancy and the first year after giving birth (Wheeler et al., 2012).

- In addition, teen mothers using substances during pregnancy is an issue according to some CHNA participants.

Assets - What are the community assets that can address teen pregnancy?

Many of the assets mentioned in the “Prenatal/Perinatal Health” health need profile can also be useful in addressing teen pregnancy in San Bernardino County. Below are more specific assets to addressing teen pregnancy and teen sexual health.

- **Teen parent education classes and prevention**: The Riverside-San Bernardino County Indian Health provides a Teen Pregnancy Prevention program and a Tribal Maternal Home Visitation to help young, single mothers or young families with children from 0-5 years old.
• School-based health centers (SBHC) provide a range of comprehensive services that meet the specific physical and behavioral health needs of teens in the community, including providing reproductive health services (Brindis, et al., 2003; Keeton, Soleimanpour, & Brindis, 2012; NASBHC, 2013). School-based health services have been associated with fewer pregnancies among students and improved health for youth (Denny et al., 2012; NASBHC, 2013; Reynolds et al., 2007).

• **Community-based organizations**: Planned Parenthood outreaches to the community and provides education around teen sexual health and teen pregnancy prevention (Planned Parenthood, 2012). Project Cuidar provides free parenting classes, and has a specialized teen pregnancy program that focuses on African American teens to help with issues of pregnancy and substance abuse.

• The County Coalition Against Sexual Exploitation provides education, prevention, intervention, referrals and direct services to teenagers who have been sexually exploited or at high-risk of being sexually exploited (Consalvo, 2012).

• Peer health educators can promote teen sexual health by engaging youth in meaningful dialogue about their health, increase their knowledge and capacity about reproductive and sexual health, and provide youth opportunities to explore health careers (Keeton et al., 2012).

**Summary**

According to county data, the teen birth rate has decreased in all racial/ethnic groups in San Bernardino County. However, the teen birth rates for the KFH—Ontario MCSA (9.0 births per 1,000 females under the age of 20) is still higher than the state average of 8.46 births per 1,000 females under the age of 20. CHNA participants expressed that African American, Hispanic/Latino, and low-income communities are disproportionately affected by teen pregnancy. In 2010, Hispanic/Latina teen birth rates were 65.5 births per 1,000 females aged 15-19 and African American teen birth rates were 50.4 per 1,000 females aged 15-19; higher than their White counterparts and state birth rates. Teen pregnancy is linked to poor pregnancy outcomes (e.g. preterm delivery, low birth weight and infant mortality) and social and educational consequences (e.g. low educational attainment, higher public assistance, and rapid repeat pregnancies). Teens are also less likely to receive **prenatal care**. According to CHNA participants, lack of access to contraception and sex education in the schools and community are major barriers to reducing teen pregnancy, especially in politically conservative parts of the County. Moreover, children of teen parents are more likely to have poorer academic and social outcomes, have increased risk of incarceration, and experience multigenerational cycles of becoming adolescent parents. Transportation and child care are challenges to teen parents who want to continue with their education and access other services. Other factors linked to teen pregnancy are domestic violence and childhood neglect, higher risk of contracting HIV/AIDS and STDs, and economic instability due to low educational attainment, and stress.
Appendix B. Disparities by Population Matrix
CHNA participants recognized that people in the communities they serve experience more than one health need at any given time. The following matrices in this appendix highlight specific populations that were identified as being most affected by more than one health need. The first matrix includes racial and ethnic groups, and the second matrix focuses on other underserved populations. These disparities are based on available secondary data and community input for this CHNA process. Populations not identified for a specific health need does not mean that individuals within those populations do not experience that health need.

**Disparities of Identified Health Needs by Race and Ethnicities**

<table>
<thead>
<tr>
<th>Health Need</th>
<th>African American</th>
<th>American Indian/Alaskan Native</th>
<th>Asian and Pacific Islander</th>
<th>Hispanic/Latino</th>
<th>White</th>
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</thead>
<tbody>
<tr>
<td>Asthma</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Cardiovascular Disease</td>
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<tr>
<td>Community Violence</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Economic Instability</td>
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<tr>
<td>Health Care Access and Utilization</td>
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<td>Hepatitis</td>
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<tr>
<td>HIV/AIDS &amp; STDs</td>
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<tr>
<td>Mental Health</td>
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<td>Overweight/Obesity</td>
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<td>Prenatal/Perinatal</td>
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<td>Service Infrastructure</td>
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<td>Substance Use</td>
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<tr>
<td>Teen Pregnancy</td>
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### Disparities of Identified Health Needs by Other Populations (age, gender, etc.)

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<tr>
<th>Health Need</th>
<th>Children and Youths</th>
<th>Veterans</th>
<th>Re-entry population</th>
<th>Older Adults</th>
<th>Homeless</th>
<th>Undocumented/immigrants</th>
<th>Low income</th>
<th>Men</th>
<th>Women</th>
<th>Lesbians, Gay, Bisexual and Transgender (LGBT)</th>
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<td>Teen Pregnancy</td>
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Appendix C. List of Common Indicators
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<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<tr>
<td>Demographics</td>
<td>Total Female Population</td>
<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<td>Demographics</td>
<td>Median Age</td>
<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<td>Demographics</td>
<td>Change in Total Population</td>
<td>U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1</td>
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<td>Demographics</td>
<td>Linguistically Isolated Population</td>
<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<td>Adequate Social or Emotional Support</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010</td>
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<td>Social &amp; Economic</td>
<td>Children Eligible for Free/Reduced Price Lunch</td>
<td>U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2010-2011</td>
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<td>Children in Poverty</td>
<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<td>Social &amp; Economic</td>
<td>Population Below 200% of Poverty Level</td>
<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<td>Social &amp; Economic</td>
<td>Population Receiving Medicaid</td>
<td>U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates</td>
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<td>Social &amp; Economic</td>
<td>Population with No High School Diploma</td>
<td>U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates</td>
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<td>Social &amp; Economic</td>
<td>Student Reading Proficiency (4th Grade)</td>
<td>States' Department of Education, Student Testing Reports, 2011</td>
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<td>Supplemental Nutrition Assistance Program (SNAP) Recipients</td>
<td>U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009</td>
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<td>Teen Births</td>
<td>California Department of Public Health, Birth Profiles by ZIP Code, 2010</td>
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<td>Social &amp; Economic Factors</td>
<td>Uninsured Population</td>
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<td>Social &amp; Economic Factors</td>
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<td>U.S. Federal Bureau of Investigation, Uniform Crime Reports, 2010</td>
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<td>Fast Food Restaurant Access</td>
<td>U.S. Census Bureau, ZIP Code Business Patterns, 2009</td>
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<td>U.S. Census Bureau, County Business Patterns, 2010</td>
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<td>Liquor Store Access</td>
<td>California Department of Alcoholic Beverage Control, Active License File, April 2012</td>
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<td>Park Access</td>
<td>U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1; ESRI’s USA Parks layer (compilation of ESRI, National Park Service, and TomTom source data), 2012</td>
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<td>Poor Air Quality (Particulate Matter 2.5)</td>
<td>Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008</td>
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<td>Physical Environment</td>
<td>Recreation and Fitness Facility Access</td>
<td>U.S. Census Bureau, ZIP Code Business Patterns, 2009</td>
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<td>Absence of Dental Insurance Coverage</td>
<td>California Health Interview Survey (CHIS), 2007</td>
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<td>Clinical Care</td>
<td>Access to Primary Care</td>
<td>U.S. Health Resources and Services Administration Area Resource File, 2011</td>
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<td>Cervical Cancer Screening (Pap Test)</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010</td>
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<td>Colon Cancer Screening (Sigmoid/Colonoscopy)</td>
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<td>Dental Care Affordability</td>
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<td>Dental Care Utilization (Adult)</td>
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<td>Clinical Care</td>
<td>Dental Care Utilization (Youth)</td>
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<td>High Blood Pressure Management</td>
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<td>Pneumonia Vaccinations (Age 65+)</td>
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<td>Health Behaviors</td>
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<td>California Health Interview Survey (CHIS), 2009</td>
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<td>Health Behaviors</td>
<td>Alcohol Expenditures</td>
<td>Nielsen Claritas SiteReports, Consumer Buying Power, 2011</td>
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<td>Health Behaviors</td>
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<td>Health Behaviors</td>
<td>Breastfeeding (Exclusive)</td>
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<td>Indicator</td>
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<td>Physical Inactivity (Youth)</td>
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<td>Health Outcomes</td>
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<td>Health Outcomes</td>
<td>Poor General Health</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Poor Mental Health</td>
<td>California Health Interview Survey (CHIS), 2009</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Population with Any Disability</td>
<td>U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Premature Death</td>
<td>Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (As Reported in the 2012 County Health Rankings)</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Prostate Cancer Incidence</td>
<td>The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Stroke Mortality</td>
<td>California Department of Public Health, Death Statistical Master File, 2008-2010</td>
</tr>
<tr>
<td>Category</td>
<td>Indicator</td>
<td>Data Source</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Suicide</td>
<td>California Department of Public Health, Death Statistical Master File, 2008-2010</td>
</tr>
</tbody>
</table>
Appendix D. Primary Data Collection Tools
INTRODUCTION (5 minutes)

Thank you for coming to our focus group today. My name is ____ and I will be facilitating today’s group. This is [note-taker] and s/he will be taking notes and may also jump in with some additional questions throughout the focus group. We are from the Research/Evaluation Unit at Special Service for Groups (SSG). Kaiser Permanente has contracted us to help them with the Community Health Needs Assessment, which the federal government requires hospitals to conduct every 3 years. KP Fontana/Ontario will also use the findings from the assessment to help them develop their community benefits strategies starting in 2014.

Before today, we have collected and reviewed some existing data about the demographic and health status of San Bernardino County, which helped us come up with the questions that we’ll be asking you today. This is one of 5 focus groups we’re doing throughout San Bernardino County. We will also be conducting key informant interviews with County/City officials, public agencies, community leaders, and policymakers. All this data will be captured in a final report that KP Fontana-Ontario will make available to you and the public. So you can use data from the report for grant writing, policy advocacy, and program development.

Today’s focus group discussion is not intended to be about the services that Kaiser Permanente provides to its members. Instead, we ask that you frame your responses today using your experiences and knowledge about the community you serve.

There is a sign-in sheet that’s going around. Please find your name and put your initials in the right-hand column on that sheet. Please feel free to correct any misspelling or other mistakes on it as well.

We encourage you to be candid in your responses during the focus group. We will not attribute any statements directly to individuals or their organizational affiliations and everything will be reported in the aggregate. However, we may list your organizations (without your names) as participants in the focus groups, unless you inform us not to. We ask that you respect each other’s confidentiality and not repeat anything that is discussed in today’s focus group. We also ask that you respect others when they are talking by not talking over each other.

I also want to note that the focus group is meant to be a dialogue among all of you. It’s important that you talk and respond to one another as much as possible, rather than respond directly to me. My role as facilitator is to make sure to move the dialogue forward, connect the points you will be making, and cover as many questions as possible.

We will also tape record the focus group in addition to taking notes. The recording will only be used by the note-taker to ensure we convey your input accurately. We will only refer to the recording to clarify something or if there’s disagreement on our team about what was said. The recording will be deleted once the notes are complete.
Do you have any questions before we start?

The 3 areas that we’ll be discussing today are: 1) health needs, 2) health barriers, and 3) health assets.

WARM-UP QUESTIONS (5 minutes)

Let’s start by having each of you introduce yourself briefly-stating your name, organization, your role, and what areas or populations your organization predominantly serves. [Introductions-limit responses.]

Thank you again for being here and sharing your experience and knowledge with us. First, I’d like to start by asking you some questions regarding health needs.

HEALTH NEEDS (25 minutes)

1) What are some of the major health issues that impact individuals in this community overall?
   • Use highlights from secondary data as probes: asthma, obesity & overweight/diabetes, cancer, mental health.
   • Why do you think they’re the most important? Are their trends improving or worsening from 5 or 10 years ago?

2) What populations are most affected by these health issues? This can include groups such as the elderly, youth, a particular race/ethnicity, immigrants, the homeless, undocumented individuals, etc.
   • Why are these populations the most affected?
   • Use highlights from secondary data as probes: economic indicators, social factors, public safety, lack of health insurance, etc.

3) Are there any particularly high need geographic areas/communities in terms of health? [refer to map]
   • For example, this could be a certain city within the county or region (West/East/Central/Mountain/High Desert)?
   • Why would you say these areas are particularly high need?

HEALTH BARRIERS (25 minutes) – Questions in italics are not “core” questions and can be skipped if there is not enough time.

1) What health services are lacking or difficult to access in this community?
   • For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, mental health care, free health fairs, resources for pregnant women, etc.
   • Does this affect certain communities/geographic areas more than others? Which? How? Why?
   • Are there any health services that are lacking or difficult to access in this community for youth in particular? Which? What factors contribute to this?
• Are there any health services that are lacking or difficult to access in this community for the elderly in particular? Which? What factors contribute to this?

2) What other challenges keep individuals from seeking help?
• For example, this could be a lack of awareness of available resources, language barriers, lack of bilingual healthcare providers, immigration status/issues, lack of transportation or childcare, cultural values/beliefs, unsafe neighborhood, working multiple jobs/lack of time, commuting to work, etc.
• What are some of the differences in challenges in seeking help among different age groups? Races/ethnicities? Other groups? (i.e. immigrants, undocumented)

3) Are there certain geographic areas of this community that have less resources and services compared to other areas in this community?
• Resources and services could include anything that affects health, including healthcare facilities (i.e. hospitals, community clinics, dental clinics, mental health facilities), food assistance programs (i.e. WIC, free meal programs), public transportation (i.e. bus stops, train stations), daycare centers, afterschool programs, etc.
• How are these service gaps being addressed? Who is involved in addressing these service gaps?

4) Which healthy behavior is the most important to promote in this community?
• For example, healthy behaviors could include healthy eating, exercise, practicing safe sex, managing chronic diseases (i.e. having regular MD appointments, following MD’s instructions).
• Why do you think that is?
• Are there any healthy behaviors that are harder to promote for the community you serve? Which? Why? What community perceptions, knowledge, attitudes, beliefs need to be changed in order to promote these healthy behaviors?
• Are there any healthy behaviors that are easier to promote for the community you serve? Which? Why?
• Based on your knowledge of this community, what are some possibilities for addressing this?

5) Are there any environmental or structural factors that negatively impact the health of this community?
• For example, this could include poor air quality, pollution, lack of parks/green space, lack of gyms/safe spaces to exercise, proximity to hazardous waste site, healthcare facilities located far away, poor access to affordable healthy food, lack of major grocery stores, lack of affordable housing, poor public transit, overabundance of liquor stores/fast food restaurants, home foreclosures, etc.
• Do these affect certain communities/geographic areas more than others? Which? How?
• Do these have more of a negative impact on youth? The elderly? Certain races/ethnicities? Other groups (i.e. immigrants, undocumented, homeless, unemployed)?

HEALTH ASSETS (25 minutes) – Questions in italics are not “core” questions and can be skipped if there is not enough time.
1) Are there any community assets that help people live healthier?
   • Environmental/structural? (e.g. schools, healthcare facilities, community gardens, community-based organizations, grocery stores with fresh fruits/vegetables, farmer’s markets, land that could be converted to parks/green space, etc.)
   • Social networks (e.g. parent groups, informal/peer networks, faith-based organizations, neighborhood clubs, cultural groups, etc.)
   • Services or sources of information?
   • How can we increase access to these community assets?

2) How do culture and/or community norms influence the health behaviors community members engage in?
   • What characteristics do individuals who access help have that are different from those who don’t?
   • What motivates these individuals to access services? For example, this could include a cultural norm to maintain good health for the wellbeing of the entire family unit.
   • What are some creative ways that individuals use to practice healthy behaviors or maintain their health?

3) What existing health programs or models are effective in promoting health in this community? Why?
   • Please include programs that promote healthy behavior and access to health services. For example, this could include a promotor program for Latino populations, using churches to do outreach on health issues in the African American or Latino community.
   • Which models are not or no longer working? Why?
   • What health promotion models do you think would work well given your experience and knowledge of this community?
   • Are there certain models that would work better in certain communities/geographic areas? Why?
   • Are there certain models that would work better for certain age groups? Races/ethnicities? Other groups? (i.e. immigrants, undocumented)
   • What are the most effective ways to provide information to your service populations about the availability of health services?
   • How might these differ for the various populations within your service areas? (i.e. youth, elderly, immigrants, undocumented, certain races/ethnicities, limited English proficient, low literacy populations)

4) What are some key collaboratives or networks of organizations that are working to address health needs in this community?
   • What issues do they address?
   • What sectors of the community are involved? (i.e. hospitals/clinics, community residents, faith-based organizations, schools, government, businesses, nonprofits, nontraditional partners)
   • How long ago were they established? How did they form? (Who initiated them?)
   • Do they tend to concentrate on certain geographic areas of this community?
   • Do they tend to concentrate on certain populations within this community? (i.e. youth, elderly, undocumented, immigrant, certain races/ethnicities)
• What have been some of the outcomes of their work?
• Are there any potential areas for collaboration or coordination among service providers to better meet the needs of your service population?

WRAP-UP QUESTIONS (10 minutes)

1) Given everything we’ve discussed today, what are the top three priorities for this community in terms of health needs?
   • Why do you think these are the top three priorities?
2) What social issues affect the top three priority health needs?
   • For example, violence/crime, gangs, homelessness, poverty, unemployment, poor civic engagement, lack of education, etc.
3) What specifically could hospitals like Kaiser Permanente do to address these needs?
   • In addition to funding, how can Kaiser Permanente be more collaborative with you to make your work more effective?

CONCLUSION (2 minutes)

Thank you for sharing your insights with us. We really appreciate you taking the time to participate in the focus group. Before you leave today, we would like you to complete a short survey that will help us collect basic demographic data on focus group participants. The survey is anonymous and should only take a few minutes to complete.
Food Bank Questionnaire

Kaiser Permanente Fontana and Ontario Medical Centers: Community

FOOD SERVICE

Food Distribution and Trends

*1. What type of food agency is your organization (mark all that apply and type in organization name below)?

☐ Food Bank
☐ Food Pantry
☐ Soup Kitchen

What is the name of your organization?

☐ 2. How many people do you serve per day?

☐ 3. How often do you DISTRIBUTE food (i.e. unprepared/ take-home) to your clients?

# of times per day
# of days per week

☐ 4. How often do you SERVE food (i.e. prepared meals) to your clients?

# of times per day
# of days per week

* 5. Do you see certain trends in the people you serve (in both the number of people you serve and type of clients, e.g. race, income levels, age, household types, veteran status, etc.)?

☐ NO
☐ YES

If YES, please explain:
**HEALTHY AVAILABILITY**

**Food Bank Nutrition and Healthier Options**

*6. Which of the following foods does your organization usually distribute or prepare?*

<table>
<thead>
<tr>
<th>Food Type</th>
<th>Rarely or never</th>
<th>Sometimes</th>
<th>Usually or always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canned fruits and vegetables</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Fresh fruits (apples, oranges, bananas or other seasonal fruits)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Fresh vegetables</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Frozen fruits and vegetables</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Meat/poultry/fish</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Canned/dried beans and legumes</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Peanut butter</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Eggs</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Low-fat refrigerated milk</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Other low-fat dairy (e.g., cheese, yogurt)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Savory snack foods (e.g., chips, corn puffs, pretzels)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Sweet snack foods and desserts (e.g., cakes, candy, pastries) – from Food Finders who get from Costco, Trader Joe's</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Frozen meals (e.g., frozen pizza, frozen macaroni and cheese, frozen burritos)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Non-perishable, packaged meal options (e.g., macaroni and cheese, ramen noodles)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Soups</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Sugar-sweetened beverages (e.g., sodas, sports drinks, energy drinks, juices)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Whole grains (e.g., brown rice, oatmeal, dry cereal, whole wheat flour and bread)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Other (please specify)
7. About how much of the food that your organization distributes/prepares come from each of the following sources?

<table>
<thead>
<tr>
<th>Source</th>
<th>A lot (&gt;50%)</th>
<th>Some (25-50%)</th>
<th>A little (&lt;25%)</th>
<th>None (0%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Banks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Donations</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Local Community Donations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased with funds raised by food pantry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
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</tbody>
</table>

Guidelines and Procedures

8. To your knowledge, does your organization have a formal written or unwritten nutrition policy or guidelines designed to INCREASE HEALTHY FOODS (e.g. fresh fruits and vegetables, low-fat dairy, whole grains, etc.) obtained from any source?

If NO, what are the barriers for developing such a policy? If YES, was it approved by the board of directors?

Choose one:

Other (please specify)

9. To your knowledge, does your organization have a formal written or unwritten policy or guidelines designed to DECREASE FOODS OF MINIMAL NUTRITIONAL VALUE (e.g. snack foods, processed foods, sweetened beverages, etc.) obtained from any source and/or distributed to member agencies and clients?

If NO, what are the barriers for developing such a policy? If YES, was it approved by the board of directors?

Choose one:

Other (please specify)

*10. Has your organization's nutrition policy changed the way you provide food to your clients?

No

Yes (please specify below)

If YES, how so?
**BARRIERS TO HEALTHY FOOD DISTRIBUTION**

11. What difficulties/challenges, if any, do you face at your organization in providing healthier foods (e.g. fresh fruits and vegetables, low-fat dairy, whole grains, etc.)?  

- Costs too much  
- Pantry storage limitations  
- Clients cannot cook it  
- Clients cannot store it  
- Clients don’t like it  
- Inconsistent availability  
- Lack of refrigerated transportation  
- Lack of refrigerated storage  
- Lack of staff/volunteers  
- Other(s)  

If YES to any of the above, or to specify “Other”, please use this box below:

12. How frequently does your organization face food shortages?  

- Daily  
- Weekly  
- Monthly  
- Never experienced food shortages  
- Other (please specify)

13. What happens if/when you have no more food to serve/distribute?


14. What other kinds of services do you see your clients needing (choose all that apply)?

- Employment/Job Training
- Family Support
- Financial
- Healthcare - Physical
- Housing
- Legal Assistance
- Mental Health/Counseling
- Other (please specify)

15. In case there are further questions on your responses, we ask you provide us with your basic contact info:

Name: 
Email Address: 
Phone Number: 

Appendix E. Highlights from Community Forums
The consulting team conducted one community forum to validate preliminary CHNA findings and to solicit community feedback in prioritizing the health needs in the KFH – Ontario Medical Center Service Area (MCSA). This forum was held on January 23, 2013. A total of 22 CHNA participants attended the community forums. This appendix encapsulates highlights from the community forums that complement the preceding health need profiles.

1. **Other Health Issues in San Bernardino County**

   Community forum participants identified a few health issues that impact their communities but do not meet the definition of health needs in this CHNA report, primarily because the Kaiser Permanente common dataset does not include indicators for these health issues or because CHNA participants did not discuss these issues substantially during the community input process. A few forum participants discussed dementia as one of such health issue. It impacts the elderly and is likely to be on the rise with the aging of the Baby Boomers generation. This includes support for families caring for loved ones with dementia or other chronic illnesses. One forum participant stated dementia and Alzheimer’s “has dire effects on caregivers and their wellbeing.” Respite care, support groups, and educational services could go a long way to support families.

2. **Health Improvements in San Bernardino County**

   The CHNA report only identifies those health issues that fared worse than a benchmark as “health needs” and does not pay closer attention to health issues that have improved over the years, which may not be reflected in secondary data. A few community forum participants cited that the issue of obesity has improved recently, due to increased public awareness and responsive public policies. Because issues like obesity require efforts working in tandem, it is too early to see the long-term results of these efforts. One forum participant expressed hope that with the constant discussion of mental illness and substance use, it could also show improvement soon. While there are still issues with the affordability of dental care, some participants were excited about the improvements in quality of care, since previously any serious dental issues meant automatic extractions. Also, while there seems to be a rise in reported STDs, participants stated it was due to the increased testing, as some areas in San Bernardino have begun to promote testing for STDs. Forum participants also reported a decrease in the number of people smoking. They attributed the improvement to both public awareness and public policies that have banned smoking in many areas. Thus, it is equally important to look at what is working in San Bernardino County as well as what is not going well.

3. **Population Groups in San Bernardino**

   By ranking and reporting on these health needs individually, community forum participants were concerned that the combined impact of these health needs on many underserved populations
would be minimized in the CHNA report. For instance, the older adult population was often cited as a population group that is affected by many of the health needs identified in this report. According to forum participants, older adults are affected by many of the health needs, including mental health, economic instability, substance abuse, oral health, health care access, and cardiovascular disease. Their situation is often compounded by their inability to use transportation to access care for their health. Other forum participants echoed similar viewpoints about other underserved communities, particularly veterans, immigrants and/or undocumented populations, homeless, foster children, as well as the specific needs of HIV/AIDS communities whose health needs may be masked by the larger datasets that the CHNA report is based on. For a snapshot of how various populations experience multiple health needs, please refer to Appendix B.

4. Connections Among Health Needs

Needs cannot be addressed in isolation. While reviewing the list of identified health needs, many community forum participants commented on the links between health needs, one forum participant stated, “I think this snapshot is accurate. I think a lot of them are interrelated, so a linear prioritization is not accurate.” Another participant stated, “There is a lot of horizontal connecting. You can’t negate any of it, but you can’t address all of it yourself,” For instance, some forum participants cited “economic instability” as one of the root causes that covers food insecurity and access to healthy food, which leads to the “obesity/overweight” health need, which then leads to the various health needs identified in this report, including diabetes and cardiovascular diseases. Some forum participants cited “mental health” as it correlates to substance abuse. Other participants linked mental health with obesity/overweight, diabetes, and other chronic diseases. Some forum participants who work on issues such as HIV/AIDS agreed that many of the challenges in these health needs can be addressed if more attention is being paid to the health drivers, such as “health care access,” “economic instability,” and “service infrastructure.”
Appendix F. References
Data Sources from CHNA Data Platform


Other Data Sources


California School Boards Association, Dental Health Foundation. (2010). *Integrating oral health into school health programs and policies.* Sacramento, CA.


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