

# Community Engagement Summary

## KFH-Fontana and Ontario

2019 Community Health Needs Assessment

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## Community Engagement Overview

KFH-Fontana and Ontario has conducted a rigorous and transparent Community Health Needs Assessment that strives to include a broad range community residents and organizations to amplify the voice of those served. Input was provided by community members through interviews and focus groups. Individuals were consulted who had knowledge, information, and expertise relevant to the health needs of the community and the lived experiences of residents. Engagements sought to understand the lived experience of residents and identify health outcomes and health drivers, as well as assets and barriers to accessing resources across five distinct geographic regions in the service area.

The majority of experts interviewed represented local and county public health agencies (57%), school educators (29%), and city officials (14%), serving primarily low income and racial and ethnic minority populations.

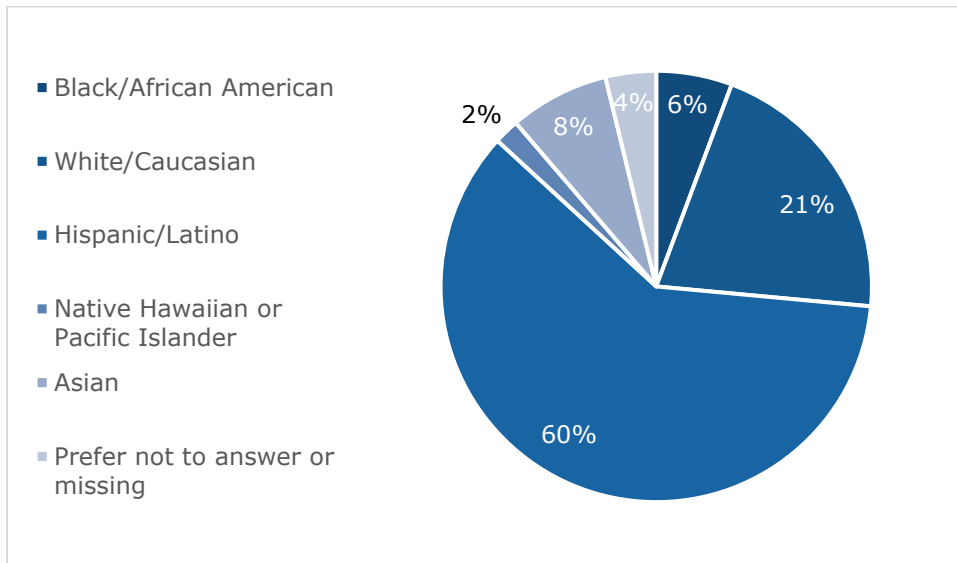
Community members represented 40% of focus group individuals. There were 53 members across the Central, East, West, High Desert, and the Mountains areas. The majority of experts that participated in focus groups represented public health providers and local department agencies (50%), community-based or faith-based organizations (48%), and school educators (9%), serving primarily low-income and racial and ethnic minority populations. (Note: focus groups participants could select more than one groups to represent, so percentages do not add up to 100%.)

Community members were represented from the cities of:

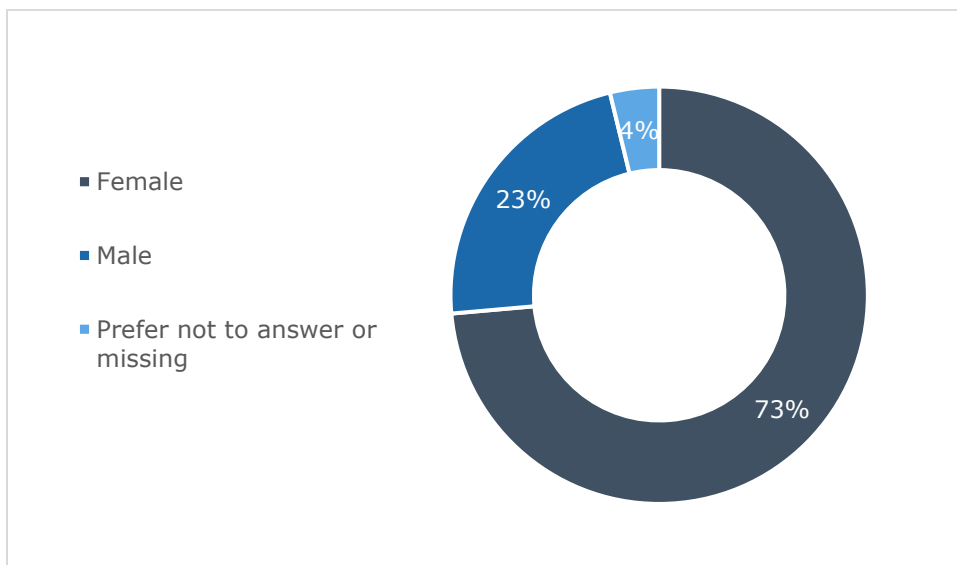
- Apple Valley
- Big Bear City
- Chino
- Chino Hills
- Colton
- Fontana
- Hesperia
- Lake Arrowhead
- Loma Linda
- Montclair
- Ontario
- Pomona
- Rancho Cucamonga
- Redlands
- Running Springs
- San Bernardino
- Victorville
- Yucaipa

Focus group participation by race and age is shown in Exhibits 1 and 2, below.

**Exhibit 1. Focus group participation by race (n=53)**



**Exhibit 2. Focus group participation by gender (n=53)**



# Heard Across the San Bernardino County Service Area

Throughout the community engagement process, important stories emerged across regions, types of engagements, and conversation participants. Highlighted below are themes that came up prevalently and consistently.

## **The service area's diverse and expansive geography dramatically impacts access to care and resources**

- Primary and specialty resources are relatively abundant in more geographically compact and densely populated parts of the county, but difficult to access in the Mountains and High Desert.
- Lack of transportation options and long distances make travel to services and resources in other areas difficult and costly for people living in more remote regions.
- More remote areas are not seen as attractive places for young doctors to practice, as they can get better money, facilities, and quality of life elsewhere, exacerbating the problem of limited services.

## **Limited access to care leads to worsening health outcomes for many population groups**

- Some people struggling with mental health challenges or crises who cannot find care or support chose to self-medicate, leading to substance abuse problems and a downward health spiral.
- Women without access to health care during and after pregnancy can develop post-partum depression, along with negative health, behavior, and attachment outcomes for their children.

## **Across the service area, lack of sufficient providers for mental health and substance use needs leads to an overreliance on emergency and crisis services**

- Long wait times for routine services lead people seeking help to turn to crisis centers or hotlines, which are also often under-resourced or poorly equipped to meet their needs.
- Stigma around seeking treatment for mental health and substance use also prevents people from seeking the care they need.

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**“If you go to a county meeting or the county talks about services that the county has available, those aren't available to us on the Mountain.”**

**– Service Provider**

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**“There are a number of cases that come through our doors who, the way they ended up with the substance abuse problem was trying to self-medicate their mental health issues because they didn't have access to mental healthcare and proper diagnosis and treatments.”**

**– Service Provider**

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### **Alternative care settings such as schools and mobile units would increase reach of services without major investments in infrastructure**

- More partnership is needed across sectors including players from the health system, education system, county agencies, non-profits, and communities in order to better embed services within existing infrastructure.
- Co-locating services within schools or other trusted community centers would help centralize resources and limit stigma of seeking out a specialized care provider for sensitive issues such as mental health or substance use.
- Mobile units, especially in geographically remote areas of the county currently under-served by both traditional and mobile resources, would bring much needed care and resources to places that have a hard time attracting providers.

### **Increased support for *promotoras*, community health workers, and peer-to-peer supports would enhance community capacity to improve health**

- Workers from within the community (especially in more remote geographic areas and among racial/ethnic minorities) have an easier time building the trust and relationships needed to build ongoing relationships between residents and providers.
- Peer services can further help reduce barriers to care, as residents feel more comfortable working with people with a similar linguistic and cultural background, and who have faced similar challenges.

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**“That is very effective, having school-based treatment, so there's no stigma of having to go someplace else. I mean, if the families have to take a bus and a train and then walk six blocks to get to a clinic, that's just going to be much more challenging. But if [services are] where they are located in their community, it's going to be much easier.”**

**– Service Provider**

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# Understanding Community Health Needs

The community engagement process was driven by a set of core questions designed to better understand the lived experience of community members, causes and consequences of health needs, racial or geographic disparities in health needs, and the community resources available to address health needs. Based on existing secondary data available at the regional level illustrating prevalence and social predictors of various health needs (see the next section for more on this data), the following needs were identified as topics to explore within the community. Presented below are the stories, themes, and information that help understand community health needs.<sup>1</sup>

## Asthma

### High discharge rates in African American communities are impacted by environmental disparities and resource constraints

- **Proximity to freeways:** Minority and low-income communities often live in close proximity to freeways and logistics hubs with poor air quality that can cause and exacerbate asthma.
- **Poor air quality:** Due to causes in both the built environment (proximity to freeways, lower quality housing) and the natural environment (smog, dust, and pollutants), minority and low-income communities disproportionately experience poor air quality.
- **Lack of providers:** Community members in more remote geographies struggle to find providers specializing in asthma treatment and care. Some of these areas are currently out of the reach even of existing mobile care providers like the Breathmobile.

### Complicated diagnostic processes and lack of education impact parents' experience in managing their child's asthma

- **Diagnostic process:** According to parents and service providers, the process of receiving an asthma diagnosis can be complicated and time-consuming, requiring a series of office visits and tests with different specialists. Especially in remote areas with less access to care, this can be a strain on family resources as systems of care are difficult to navigate.
- **Lack of education and resources:** Also largely in more remote areas, particularly in the High Desert, service providers are concerned families do not receive the information and resources they need to successfully help manage their children's asthma.

### Lack of education and capacity constraints limit the ability of early childhood education and the K-12 educational systems to support parents with asthma management

- **Lack of education:** According to service providers, educators within the K-12 system are not receiving sufficient information about how to support students with asthma.
- **Capacity constraints:** In addition, service providers recognize that teachers and school personnel have limited capacity to deal with a number of competing priorities.

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**“Our population up here would have a hard time navigating. Having to navigate for their child in order to get [asthma] services. Again, if it's going to be a three to four appointment situation, that's three to four days.”**

**— Service Provider**

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**“The teachers do not have a lot of [health] education and they have so many kids they do not have time to really pay attention to kids with asthma.”**

**— Service Provider**

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<sup>1</sup> A full list of the assessment's core questions – known as Strategic Learning Questions – and the complete process of defining them can be found in the CHNA Report.

## Obesity and Diabetes

### Lack of access to healthy food and barriers within the built environment contribute to high obesity rates, especially among Black and Hispanic/Latino communities

- **Lack of access to healthy food:** Numerous barriers exist that limit the ability of families' to regularly buy and prepare healthy food. Fresh produce is often more expensive and harder to find, while fast food venues are prevalent in many parts of the service area. Long commutes, often to areas outside San Bernardino County, leave working families little time and often little energy to prepare fresh food every day, or to exercise.
- **Built environment and public safety:** The built environment and public safety limit opportunities for residents to go outdoors to play and exercise. Without safe streets or parks, which ideally provide free and accessible opportunities for exercise, people tend to stay inside, exacerbating both physical and emotional health problems.

### Normalization of obesity and diabetes and lack of awareness influence community members' understanding of obesity and its health

- **Normalizing obesity and diabetes:** Service providers and community members identified the prevalence of obesity and diabetes in certain communities as a challenge in fighting these diseases. In some areas, these diseases have become so widespread that their dangers are not fully appreciated. For many families, diabetes is already "running in the bloodlines," according to one community member, while optimal healthy eating and active living practices are not being modelled and normed.
- **Lack of awareness and appropriate resources:** Many communities lack educational resources on the long-term health effects of obesity and diabetes, as well as how to prevent them. Service providers identified nutrition classes on basics of finding and preparing healthy food options as a key resource to expand across the service area, however information and resources about healthy eating practices do not always align with cultural food traditions.

### Partnerships with organizations that promote a healthy lifestyle and culturally responsive programs would help promote healthy eating and active living (SLQ 6)

- **Partnerships with organizations that promote healthy lifestyle:** Both service providers and communities members recognized agencies and organizations that are providing crucial resources and supports for healthy eating and active living, and identified an opportunity to partner with and invest in these groups' capacity in order to expand services and reach more people.
- **Culturally responsive programs:** Additional investment is also needed to ensure resources are delivered in a way that best aligns with the needs and backgrounds of the community.

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**"We talk about making the healthy option the easy option, but right now that's not the case."**

**— Service Provider**

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**"I think that's also the challenge for the children. When they see [diabetes] so much and it's something that's so common...that may not be as scary because they see people living with it all the time. It's just something that I personally worry about, is the normalization of it and the fact that there isn't as much fear around diabetes and how horrible the disease is and certainly can be."**

**— Service Provider**

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## Maternal and Infant Health

### Access to care, cultural barriers, and insurance impact low birthweight and preterm births, especially in minority communities in the High Desert and Mountains

- **Access to care:** Communities in the High Desert and Mountains struggle with very limited resources to support pregnant women and new mothers. Women must travel considerable distances for labor and delivery, and often for high-quality prenatal care as well, leading to high stress and delays in care
- **Cultural barriers:** African-American women in the service area – and across the country – face significantly higher rates of poor birth outcomes, including preterm births and infant mortality. Service providers and community members called for more African American medical providers and providers of all backgrounds with more awareness to recognize that African American women face unique risks and resources to support them.
- **Insurance:** Insurance coverage, including Medi-Cal, is difficult to navigate in order to access needed care. Changes in eligibility, covered service, and available providers is not always communicated to pregnant women, adding another barrier to accessing care.

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**“I can't tell you how many times a client will come in and they'll say, 'Oh we can't see you today because your Medi-Cal is no longer eligible.' So, then what happens?...because they don't have the \$100 cash-pay fee”**

**— Service Provider**

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## Mental Health

### Suicide rates are higher in certain communities, and pose a challenge for existing systems and resources to address

- **Pressure on young people to excel in school and beyond:** Youth identified academic pressure as a key driver of stress, anxiety, and other mental health struggles. Students experience stress around excelling in high school and beyond, which at times escalates to anxiety, depression, and suicidal thoughts.
- **Lack of sufficient support in schools after a suicide makes it harder for students to confront issues head on and address their own mental health needs:** After a recent string of suicides, youth still felt their schools were ill-equipped to support their mental health needs. Youth shared that after this troubling and difficult time, their school leaders provided few if any opportunities for students to talk about mental health and seek out support.
- **School resources that are available don't always reach the people they need to:** Youth shared that the mental health supports their schools do provide do not align well with their needs. They expressed a need for more one-on-one supports in schools as students hesitant to speak up in a group setting, and shared that anti-bullying messages aren't presented in a way that appear to make an impact on students doing the bullying. In addition, they felt guidance counselors are unable provide the same support as mental health counselors and called for more support for actual school psychologists.

### Social media can have negative impacts on mental health, but provides some avenues for positive support

- **Bullying and fake social media accounts:** Youth shared that social media is being used in troubling ways. Social media provides another avenue for bullying, in a way that is (or feels like it can be) anonymous, while young people "guide themselves based on what they see on Facebook or Instagram," according to one youth service provider.
- **Young people are connecting with each other through social media but don't necessarily have the skills or resources to be able to support each other:** Social media can be positively used to connect young people with others struggling with similar issues, and young people value the connections they make across social media platforms. However, they don't have enough knowledge or resources to fully support one another, especially when trying to cope with complex mental and emotional health needs.
- **Social media can provide another avenue for connecting with available community supports:** Social media provides ways for young people – and all people – to access available resources within the community without the stigma they may fear from seeking out help in person. Established providers and resource centers can make use of social media to connect to young people, and all people, who need help.

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"So everyone's kind of really stressed to fulfill that expectation [of academic success], and that causes a lot of anxiety. I know most of my friends have had a few panic attacks around finals time, and no one really knows how to deal with it, and no one knows how to talk to their parents about it"

– High School Student

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"There's all kinds of counseling programs...available to people. And if you don't want to talk to somebody face to face, you can get a virtual person to talk to you. I mean there's apps nowadays...You can talk to a computer about your problem if you wanted to."

– Service Provider

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## Substance Abuse

**Populations with co-occurring disorders, people experiencing homelessness, and young people are experiencing the greatest challenges with opioid abuse, with serious impacts on individuals and communities**

- **Populations with co-occurring disorders (substance abuse and mental health or severe health issues):** Mental health challenges often co-occur with substance abuse issues, as well as other health and broader challenges, making them complex to effectively treat.
- **Homeless population:** Substance abuse within the homeless population are especially difficult to treat, given the numerous barriers people experiencing homelessness face to accessing services.
- **Young adults:** Service providers are seeing an increase in substance abuse among young adults, often stemming from medication withdrawal without sufficient planning by their health care provider.
- **Community impact:** In especially hard-hit communities, services providers and community members report an outflow of residents to less-impact areas, community trauma, loss of business and economic development, and equity issues when seeking opportunities for community recovery and stability. Service providers and community members identified poverty, lack of economic opportunity, and lack of recreational and family activities, especially in remote areas, as contributors to growing substance abuse problems,

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**“Another issue is young people. They don't have nothing to do. I have a very close relationship with the community young people and they get a lot of drugs, just because they manifest it. They don't have nothing to do, [and no] community resources like parks... It's very bad.”**

**— Community Member  
living in the High Desert**

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## Telling a Regional Story

Because of the service area's expansive geography, community engagement took a purposefully regional approach, with one focus group held in each of the service area's five distinct geographic regions and interviews with local service providers and experts who could speak within this regional context. In the process of developing Strategic Learning Questions and understanding how to answer these questions within each region, both disease prevalence indicators and social predictors of health were considered. Exhibit 3 maps prevalence indicators to the service areas five regions, and exhibit 4 links social predictors of health to health outcomes associated with these prevalence indicators. Finally, exhibit 5 provides data for the five regions, and San Bernardino County as a whole, for six key social predictors of health. The section concludes with five regional community profiles that highlight: the geographic area served, including under-resourced communities; data for social predictors of health; and, key themes that emerged through community engagement.

**Exhibit 3. Prevalence indicators across geographic regions**

San Bernardino County Service Area Region					
Prevalence Indicator <sup>2</sup>	Central	East	High Desert	Mountain	West End
<i>High asthma prevalence</i>	X		X		
<i>High diabetes prevalence</i>			X	X	
<i>Low proximity to supermarkets</i>			X	X	
<i>High prevalence of low birthweight infants</i>	X		X	X	
<i>High infant mortality among African-Americans</i>	X		X		
<i>Low number of mental health providers</i>			X	X	
<i>High number of poor mental health days</i>			X		X
<i>Low number of substance abuse treatment centers</i>			X	X	
<i>Low number of substance abuse response teams</i>				X	
<i>Low health insurance coverage</i>	X			X	
<i>Low automobile access</i>	X		X		

<sup>2</sup> **Definitions and sources for prevalence indicators:**

**High asthma prevalence** is defined as the percentage of people with asthma. Source: 2016 CDC 500 Cities/BRFSS, via <http://healthyplacesindex.org/>.

**High diabetes prevalence** is defined as the percentage of adults diagnosed with diabetes, other than diabetes during pregnancy. Source: 2016 CDC 500 Cities/BRFSS, via <http://healthyplacesindex.org/>.

**Low supermarket access** is defined as the percentage of the population that do not live in close proximity to a large grocery store or supermarket. Source: 2014 USDA – Food Access Research Atlas, via <https://kp-chna.ip3app.org/>.

**High prevalence of low birthweight infants** is defined as the percentage of babies born with a low birth weight. Source: 2006-2012 CalEnviroScreen 3.0, via <http://healthyplacesindex.org/>.

**High infant mortality among African-Americans** is defined as the infant mortality rate per 1,000 live births. Source: 2014-2016 California Center for Health Statistics, Birth and Death Statistical Master files.

**Low number of mental health providers** is defined as the number of psychiatrists, psychologists, clinical social workers, and counsellors per 100,000 population. Source: 2016 Area Health Resource File, via <https://kp-chna.ip3app.org/>.

**High number of poor mental health days** is defined as the number of self-reported poor mental health days per month among adults. Source: 2016 CDC 500 Cities/BRFSS, via <https://kp-chna.ip3app.org/>.

**Low number of substance abuse treatment centers** is defined as the number of established community resources available for substance use treatment, as described by CHNA interview and focus group participants.

**Low number of substance abuse response teams** is defined as the number of established community resources available for substance use crisis treatment, as described by CHNA interview and focus group participants.

**Low health insurance coverage** is defined as the percentage of adults with health insurance. Source: 2011-2015 American Community Survey, via <http://healthyplacesindex.org/>.

**Low automobile access** is defined as the percentage of households with access to an automobile. Source: 2011-2015 American Community Survey, via <http://healthyplacesindex.org/>.

**Exhibit 4. Social predictors of health and associated health outcomes**

Social Predictors of Health <sup>3</sup>	Health Outcomes					
	Less Access to Care	Higher Asthma Prevalence	Higher Diabetes & Obesity Prevalence	Poorer Maternal & Infant Health Outcomes	Poorer Mental Health Outcomes	Higher Substance Abuse Prevalence
<i>Less racial integration</i>	X	X	X	X	X	
<i>Lower income</i>	X	X				
<i>More crowded housing</i>		X	X		X	X
<i>Less employment</i>	X	X				
<i>Fewer two parent households</i>	X					
<i>Lower socioeconomic status</i>			X		X	X
<i>Less park access</i>			X			
<i>Less supermarket access</i>			X			
<i>Less homeownership</i>	X			X	X	X
<i>Worse air quality</i>				X		
<i>Less health insurance</i>					X	

<sup>3</sup> Explanations and sources for social predictors of health:

**Less racial integration** can limit the ability of certain groups to access equal opportunities and resources needed to achieve good health.

**Lower income**, low economic opportunity and poverty limit the ability of residents to afford the goods and services needed to achieve good health.

**More crowded housing**, with more than one person per room, negatively impacts both physical and mental health.

**Less employment**, unemployment, underemployment, and unstable employment limit the ability of residents to afford the goods and services needed to achieve good health.

**Fewer two parent households** can indicate households with fewer caregivers who are facing economic challenges that limit their ability to afford the goods and services needed to achieve good health.

**Lower socioeconomic status**, and lower economic opportunity – including lower education, income, and employment levels – can impact the ability to access healthy food and chronic disease prevention and management services.

**Less park access** impacts the walkability, bike-ability, and overall ability to be physically active

**Less supermarket access**, high food prices, high numbers of fast food restaurants, low nutrition assistance program participation, and availability of local food impact the ability to eat healthy foods and chronic disease prevention and management.

**Less homeownership** is linked with lower economic and residential stability, which can limit the ability of residents to afford the services needed to achieve good health.

**Worse air quality** is tied to many negative health effects including poor birth outcomes.

**Less health insurance** can prevent people from accessing the high-quality, regular care needed to achieve good health.

**Exhibit 5. Select social predictors of health by region**

San Bernardino County Service Area Region						
Social Predictors of Health <sup>4</sup>	Central	East	High Desert	Mountain	West End	San Bernardino County
<i>Racial integration</i>	.44	.53	.39	.94	.39	.45
<i>Income</i>	\$52,000	\$60,000	\$48,200	\$52,200	\$69,100	\$57,210
<i>Crowded housing</i>	14.8%	5.4%	7.0%	4.6%	8.8%	9.4%
<i>Employment</i>	62.8%	65.2%	57.4%	65.3%	70.1%	63.6%
<i>Education</i>	12.7%	26.9%	11.6%	24.7%	27.4%	18.4%
<i>Poverty</i>	50.9%	34.4%	48.6%	38.3%	33.5%	42.8%

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**<sup>4</sup> Definitions and sources for social predictors of health:**

**Racial integration** is defined as a dissimilarity value, where .60 and above may indicate significant residential segregation. Source: 2010 Decennial Census via <http://healthyplacesindex.org/>.

**Income** is defined as median household income. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.

**Crowded housing** is defined as the percentage of households with more than 1 occupant per room. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.

**Employment** is defined as the percentage of people aged 25-64 who are employed. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.

**Education** is defined as the percentage of people over age 25 with a bachelor's education or higher. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.

**Poverty** is defined as the percent of people earning more than 200% of the federal poverty level. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.

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# Central Region Community Profile

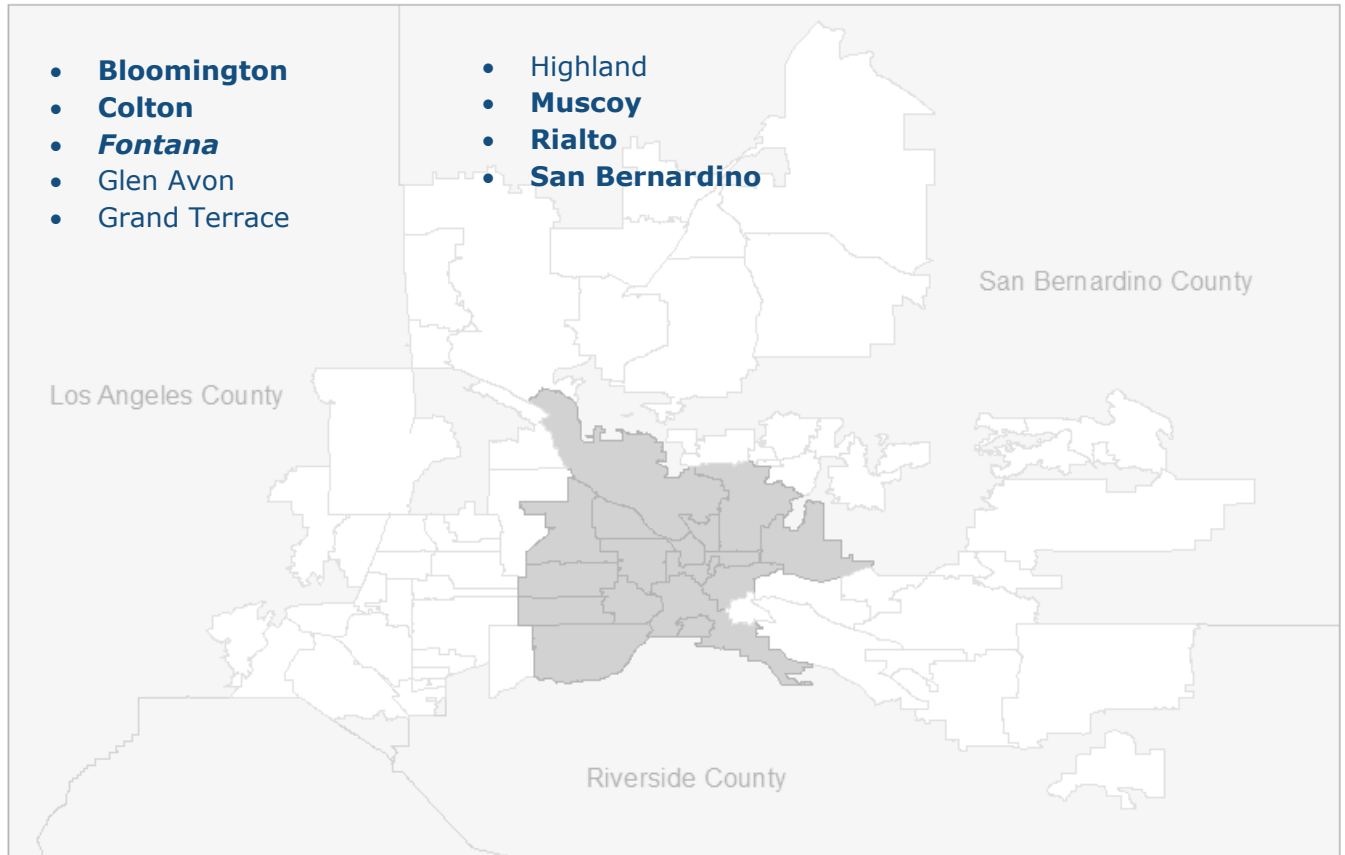
San Bernardino County Service Area

## Regional Background

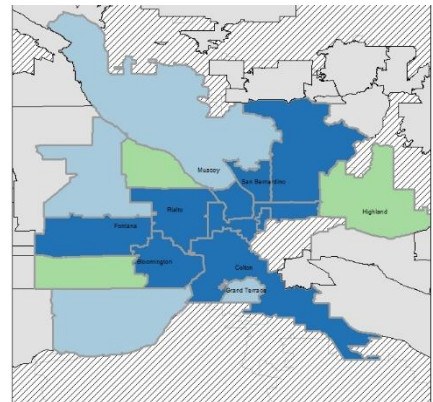
The Central region of the San Bernardino County service area includes largely urban and suburban communities in and around the major cities of San Bernardino and Fontana. The region stretches from the southern edge of San Bernardino County bordering Riverside County to the foothills below Glen Helen Regional Park.

The region includes the cities and communities of:

- **Bloomington**
- **Colton**
- **Fontana**
- Glen Avon
- Grand Terrace
- Highland
- **Muscoy**
- **Rialto**
- **San Bernardino**



Communities listed above in bold, and displayed to the right in dark blue, are **under-resourced communities**. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.), which can limit residents' opportunities to live long and healthy lives. Communities (or, where italicized, neighborhoods within communities) rank in the bottom 25 percent of all California communities on the Public Health Alliance's Healthy Places Index.



Source: [Southern California Public Health Alliance's Healthy Places Index](#).

## Social Predictors of Health

Social predictors of health include the most basic conditions in the places where people live and work. These factors impact health, well-being, and opportunity, and can be measured in many ways. Six key social predictors of health and demographic factors are shown below. Those in **blue** represent indicators where the Mountain region measures equal to or better than San Bernardino County as a whole, while those in **orange** represent those where the region measures worse.



15%

**Crowded housing**<sup>1</sup>



13%

**Education**<sup>2</sup>



63%

**Employment**<sup>3</sup>



\$52k

**Income**<sup>4</sup>



51%

**Poverty**<sup>5</sup>



.44

**Racial integration**<sup>6</sup>

## Community Engagement Themes

During community engagement with residents, service providers, and other key stakeholders in the Central region, the following themes related to health outcomes, social predictors of health, and overall well-being emerged most prevalently and consistently:

- Concerns about immigration status keep people from seeking care for themselves and their family members, including children
- Physical and built environment limits ability to be as healthy as can be (lack of walkability, prevalence of fast food)
- Concerns about senior population: economic security as seniors on social security can't afford health food, language barriers between PCPs and mono-lingual older patients, limited transportation options
- "Brain drain" as people commute out of the region for better employment opportunities, limiting investment within the community and putting a strain on their health

## Definitions and References

1. **Crowded housing** is defined as the percentage of households with more than 1 occupant per room. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
2. **Education** is defined as the percentage of people over age 25 with a bachelor's education or higher. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
3. **Employment** is defined as the percentage of people aged 25-64 who are employed. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
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5. **Poverty** is defined as the percent of people earning more than 200% of the federal poverty level. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
6. **Racial integration** is defined as a dissimilarity value, where .60 and above may indicate significant residential segregation. Source: 2010 Decennial Census via <http://healthyplacesindex.org/>.

# East Region Community Profile

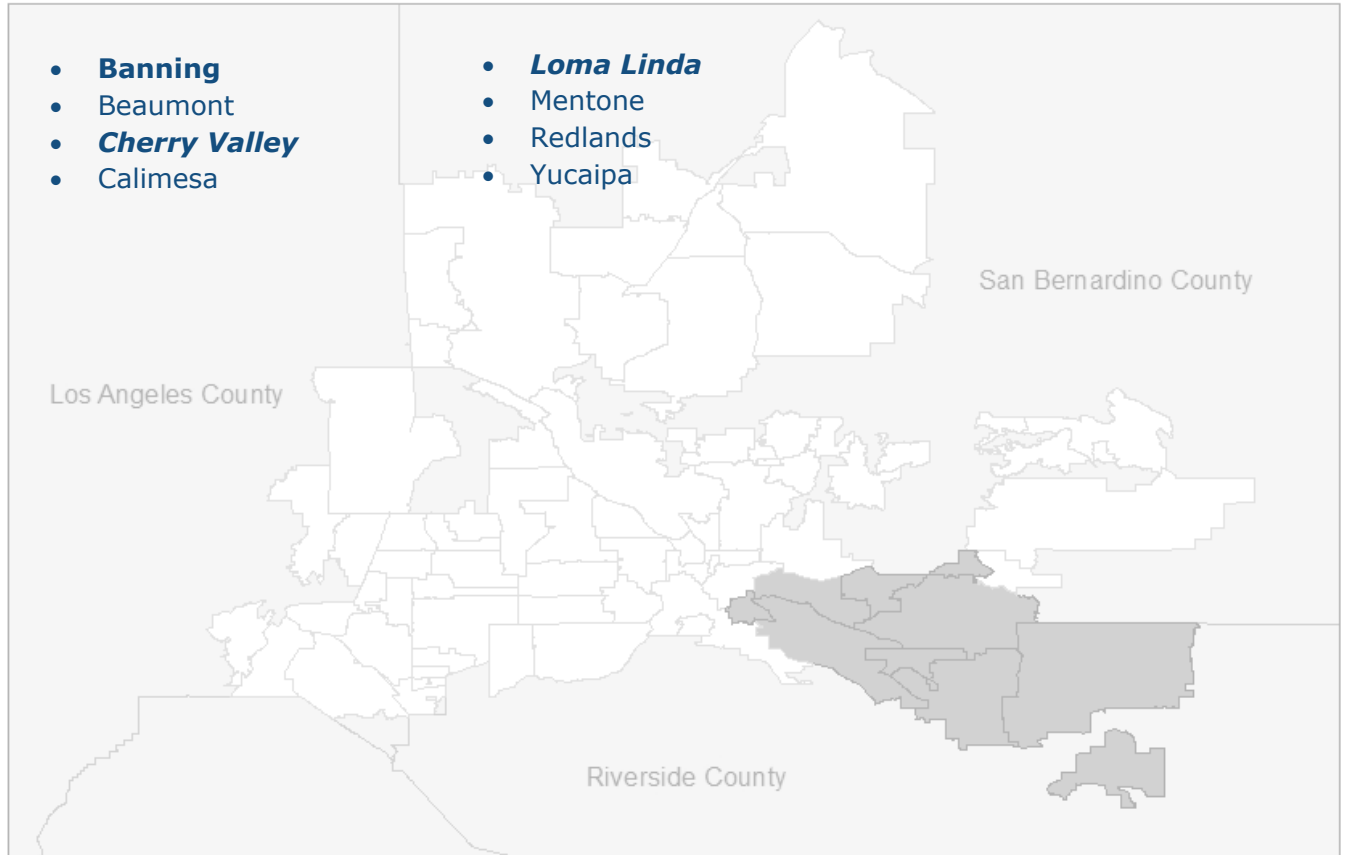
San Bernardino County Service Area

## Regional Background

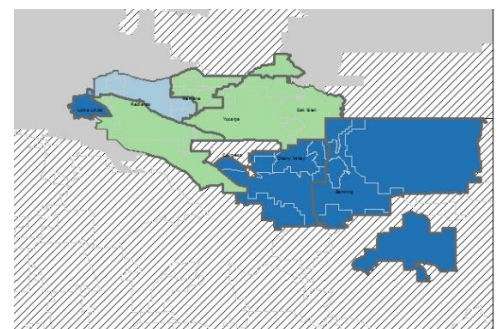
The East region of the service area includes largely urban and suburban communities east of the city of San Bernardino and west of the Morongo Reservation. The region spans the southern edge of San Bernardino County and the northern edge of Riverside County.

The region includes the cities and communities of:

- **Banning**
- Beaumont
- ***Cherry Valley***
- Calimesa
- ***Loma Linda***
- Mentone
- Redlands
- Yucaipa



Communities listed above in bold, and displayed to the right in dark blue, are **under-resourced communities**. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.), which can limit residents' opportunities to live long and healthy lives. Communities (or, where italicized, neighborhoods within communities) rank in the bottom 25 percent of all California communities on the Public Health Alliance's Healthy Places Index.



Source: [Southern California Public Health Alliance's Healthy Places Index](#).



## Social Predictors of Health

Social predictors of health include the most basic conditions in the places where people live and work. These factors impact health, well-being, and opportunity, and can be measured in many ways. Six key social predictors of health and demographic factors are shown below. Those in **blue** represent indicators where the Mountain region measures better than San Bernardino County as a whole, while those in **orange** represent those where the region measures worse.



5%

**Crowded housing**<sup>1</sup>



27%

**Education**<sup>2</sup>



65%

**Employment**<sup>3</sup>



\$60k

**Income**<sup>4</sup>



34%

**Poverty**<sup>5</sup>



.53

**Racial integration**<sup>6</sup>

## Community Engagement Themes

During community engagement with residents, service providers, and other key stakeholders in the East region, the following themes related to health outcomes, social predictors of health, and overall well-being emerged most prevalently and consistently:

- Service gaps exist for certain populations including children and young adults needing behavioral and developmental supports and teenagers aging out of programs
- More investment is needed in the resources that already exist within the community, as often services are available but wait times for appointments or eligibility are too long, transportation is not available, and childcare is not offered for parents needing services for themselves
- More coordination is needed among providers across the system (both administratively and physically, such as through one-stop resource centers) to bridge service gaps and limit time and transportation burdens on families seeking services, such as through “resource homes” analogous to medical homes
- Economic conditions drive downstream impacts on health, including lack of affordable housing leading to homelessness and family budgets squeezed by high housing costs

## Definitions and References

1. **Crowded housing** is defined as the percentage of households with more than 1 occupant per room. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
2. **Education** is defined as the percentage of people over age 25 with a bachelor’s degree or higher. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
3. **Employment** is defined as the percentage of people aged 25-64 who are employed. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
4. **Income** is defined as median household income. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
5. **Poverty** is defined as the percent of people earning more than 200% of the federal poverty level. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
6. **Racial integration** is defined as a dissimilarity value, where .60 and above may indicate significant residential segregation. Source: 2010 Decennial Census via <http://healthyplacesindex.org/>.

# High Desert Region Community Profile

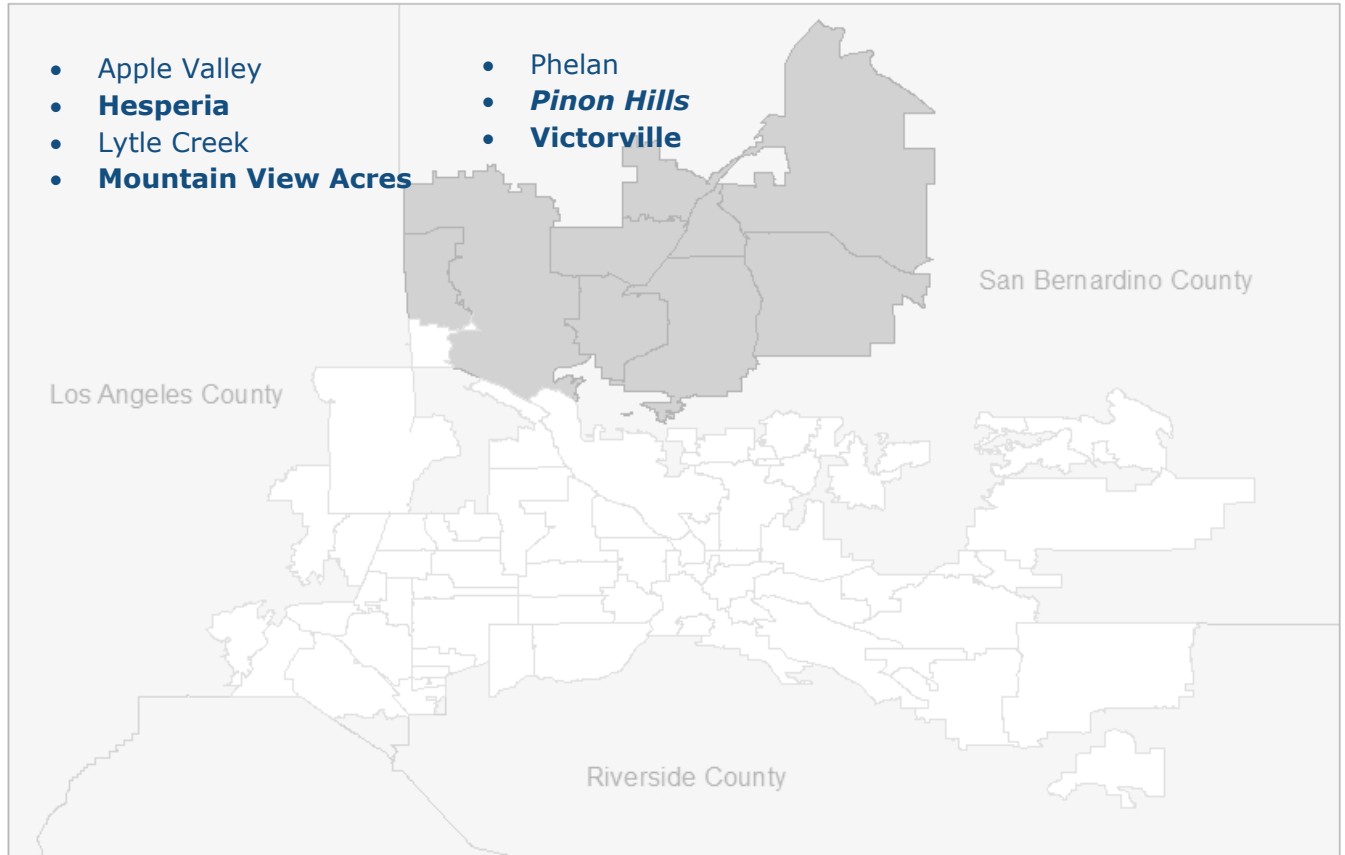
San Bernardino County Service Area

## Regional Background

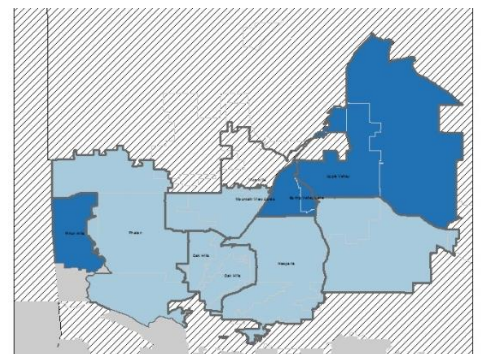
The High Desert region of the San Bernardino County service area includes incorporated cities and rural communities in the Victor Valley of the Mojave Desert. The region stretches from Phelan on the western edge of San Bernardino County to Apple Valley on the edge of the Lucerne Valley.

The region includes the cities and communities of:

- Apple Valley
- **Hesperia**
- Lytle Creek
- **Mountain View Acres**
- Phelan
- ***Pinon Hills***
- **Victorville**



Communities listed above in bold, and displayed to the right in dark blue, are **under-resourced communities**. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.), which can limit residents' opportunities to live long and healthy lives. Communities (or, where italicized, neighborhoods within communities) rank in the bottom 25 percent of all California communities on the Public Health Alliance's Healthy Places Index.



Source: [Southern California Public Health Alliance's Healthy Places Index.](#)

## Social Predictors of Health

Social predictors of health include the most basic conditions in the places where people live and work. These factors impact health, well-being, and opportunity, and can be measured in many ways. Six key social predictors of health and demographic factors are shown below. Those in **blue** represent indicators where the Mountain region measures better than San Bernardino County as a whole, while those in **orange** represent those where the region measures worse.



7%

**Crowded housing**<sup>1</sup>



12%

**Education**<sup>2</sup>



57%

**Employment**<sup>3</sup>



\$48k

**Income**<sup>4</sup>



49%

**Poverty**<sup>5</sup>



.39

**Racial integration**<sup>6</sup>

## Community Engagement Themes

During community engagement with residents, service providers, and other key stakeholders in the Mountain region, the following themes related to health outcomes, social predictors of health, and overall well-being emerged most prevalently and consistently:

- Limited resources and services, including hospitals to deliver babies and clinics
- Lack of access and proximity to supermarkets, lack of affordable healthy food, and high number of fast food restaurants impact the ability to eat healthy foods and chronic disease prevention and management
- Concerns about the built environment, including lacks of parks and public safety, in urbanized areas
- High asthma prevalence linked in part to lack of ongoing support to help parents manage their child's asthma and lack of coordination between home and school

## Definitions and References

1. **Crowded housing** is defined as the percentage of households with more than 1 occupant per room. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
2. **Education** is defined as the percentage of people over age 25 with a bachelor's education or higher. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
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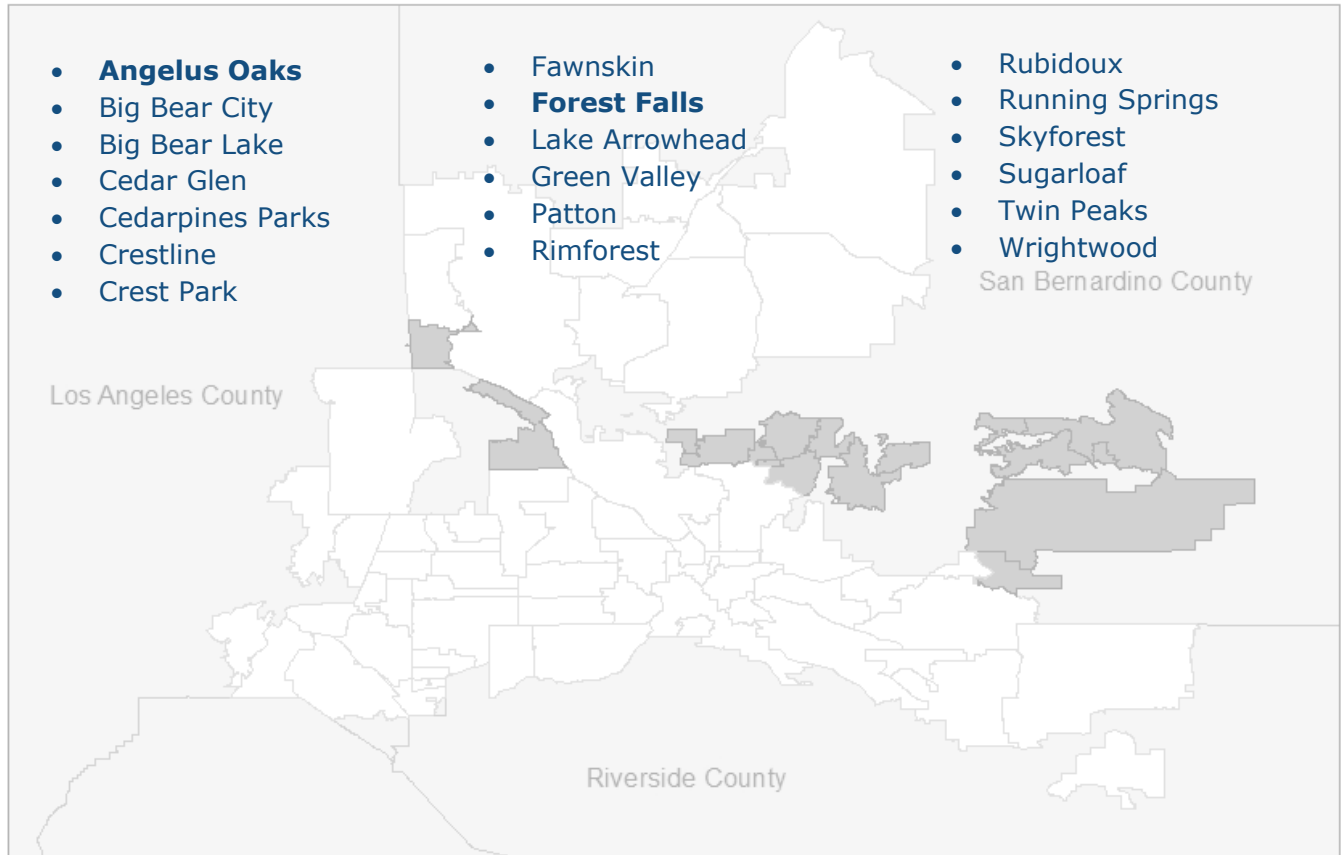
# Mountain Region Community Profile

San Bernardino County Service Area

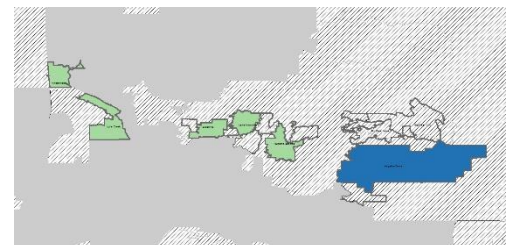
## Regional Background

The Mountain region of the San Bernardino County service area stretches between the eastern edge of Los Angeles County to the Lucerne Valley, encompassing communities from Mt. San Antonio to regions around Lake Arrowhead and Big Bear Lake. The majority of communities in the area are unincorporated, with resources, services, and oversight provided by San Bernardino County.

The region includes the cities and communities of:



Communities listed above in bold, and displayed to the right in dark blue, are **under-resourced communities**. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.), which can limit residents' opportunities to live long and healthy lives. Communities (or, where italicized, neighborhoods within communities) rank in the bottom 25 percent of all California communities on the Public Health Alliance's Healthy Places Index.



Source: [Southern California Public Health Alliance's Healthy Places Index.](#)

## Social Predictors of Health

Social predictors of health include the most basic conditions in the places where people live and work. These factors impact health, well-being, and opportunity, and can be measured in many ways. Six key social predictors of health and demographic factors are shown below. Those in **blue** represent indicators where the Mountain region measures better than San Bernardino County as a whole, while those in **orange** represent those where the region measures worse.



5%

**Crowded housing**<sup>1</sup>



25%

**Education**<sup>2</sup>



65%

**Employment**<sup>3</sup>



\$52k

**Income**<sup>4</sup>



38%

**Poverty**<sup>5</sup>



.96

**Racial integration**<sup>6</sup>

## Community Engagement Themes

During community engagement with residents, service providers, and other key stakeholders in the Mountain region, the following themes related to health outcomes, social predictors of health, and overall well-being emerged most prevalently and consistently:

- Limited resources and services, including no hospital for labor and delivery
- Lack of distinction between communities – an organization might provide services in Big Bear and assume they are covering Mountain communities, but those resources are not actually accessible to people in Lake Arrowhead
- Limited transportation options to access resources “down the hill” – especially in inclement weather
- Community resistance to engaging with service providers, especially those from outside the region

## Definitions and References

1. **Crowded housing** is defined as the percentage of households with more than 1 occupant per room. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
2. **Education** is defined as the percentage of people over age 25 with a bachelor’s education or higher. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
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# West End Community Profile

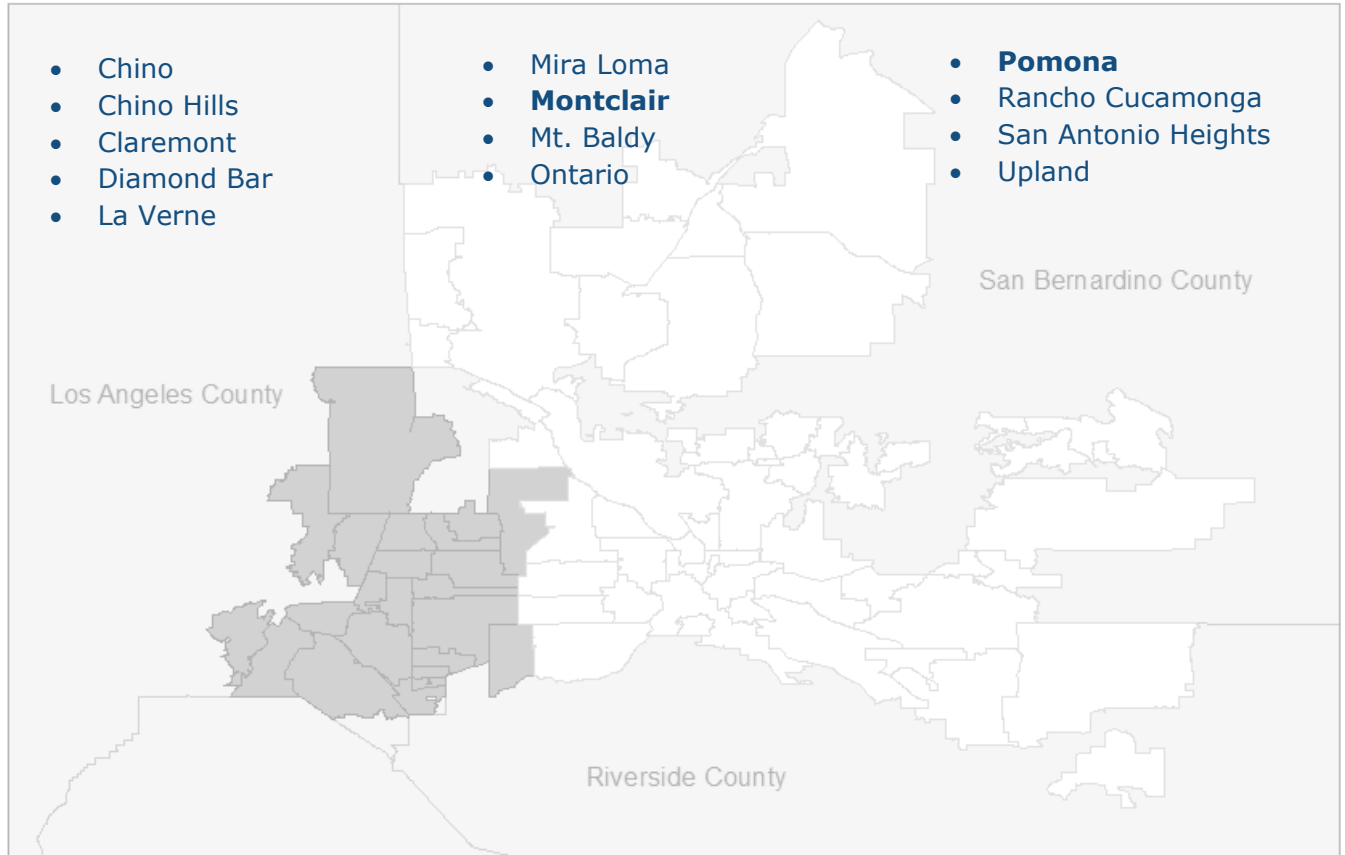
San Bernardino County Service Area

## Regional Background

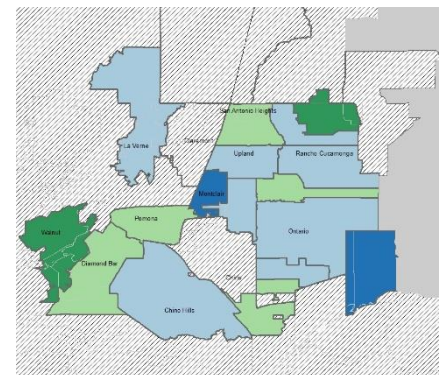
The West End of the San Bernardino County service area includes communities from the far eastern edge of Los Angeles County to the western side of the city of San Bernardino. These communities are largely urban or suburban, with sometimes dramatic differences in income and economic opportunity between areas.

The region includes the cities and communities of:

- Chino
- Chino Hills
- Claremont
- Diamond Bar
- La Verne
- Mira Loma
- **Montclair**
- Mt. Baldy
- Ontario
- **Pomona**
- Rancho Cucamonga
- San Antonio Heights
- Upland



Communities listed above in bold, and displayed to the right in dark blue, are **under-resourced communities**. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.), which can limit residents' opportunities to live long and healthy lives. Communities (or, where italicized, neighborhoods within communities) rank in the bottom 25 percent of all California communities on the Public Health Alliance's Healthy Places Index.



Source: [Southern California Public Health Alliance's Healthy Places Index.](#)

## Social Predictors of Health

Social predictors of health include the most basic conditions in the places where people live and work. These factors impact health, well-being, and opportunity, and can be measured in many ways. Six key social predictors of health and demographic factors are shown below. Those in **blue** represent indicators where the Mountain region measures better than San Bernardino County as a whole, while those in **orange** represent those where the region measures worse.



9%

**Crowded housing**<sup>1</sup>



27%

**Education**<sup>2</sup>



70%

**Employment**<sup>3</sup>



\$69k

**Income**<sup>4</sup>



34%

**Poverty**<sup>5</sup>



.39

**Racial integration**<sup>6</sup>

## Community Engagement Themes

During community engagement with residents, service providers, and other key stakeholders in the Mountain region, the following themes related to health outcomes, social predictors of health, and overall well-being emerged most prevalently and consistently:

- Lack of adequate resources and supports for youth struggling with mental health, particularly in schools
- Limited linguistically and culturally competent healthcare providers
- Administrative barriers make it difficult for vulnerable populations to access resources
- High number of fast food restaurants and limited availability of local food impact the ability to eat healthy foods, as well as chronic disease prevention and management

## Definitions and References

1. **Crowded housing** is defined as the percentage of households with more than 1 occupant per room. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
2. **Education** is defined as the percentage of people over age 25 with a bachelor's education or higher. Source: 2011-2015 American Community Survey via <http://healthyplacesindex.org/>.
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