



**Eastern Riverside County
Community Health Monitor
2007**

Executive Report

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“The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.”

*-Benjamin Disraeli,
Earl of Beaconsfield
Speech [July 24, 1877]*



Preface

The Health Assessment Resource Center (HARC), a nonprofit, community-based organization, was developed by a collaboration of community agencies and individuals in response to a scarcity of objective, timely and comprehensive health needs data for the Coachella Valley and Eastern Riverside County, California.

HARC has designed and implemented the region's first comprehensive community-wide survey designed to provide timely and useful data as well as a baseline for measuring change in subsequent surveys. HARC recognizes that there may be a high level of community interest in follow-up and researching in more depth many of the issues raised in the survey, as well as researching additional topics of special interest to the community. Given that this is the first time such a survey has been conducted in this region, it is necessarily broader in scope than in depth to reflect the range of topics that need to be considered in the overall health and quality of life in our community.

Over the next year, HARC, is planning to issue several additional reports based on the survey, e.g., by subregion, age group or specific health-related topics. As well, community organizations may seek out HARC as the independent, locally based, assessment center for their choice of surveys and studies on health and quality of life topics.

This Executive Report of the HARC Community Health Monitor – 2007 includes many of the key findings from the HARC survey. In addition, it incorporates in one document both primary and secondary data from a number of other related sources to make this report on Eastern Riverside County as useful as possible. The Executive Report highlights and frames the discussion of our community's health needs in the context of geographic, demographic, economic and environmental profiles of Eastern Riverside County. It should be noted that, certain demographic criteria and racial/ethnic groups could not be reported given small and therefore statistically inconclusive sample sizes. (see "notes" on page 5).

HARC anticipates many readers may want to review the complete Community Health Monitor report that is available on the CD attached at the end of this report or by going to HARC's website, www.harcddata.org. The complete data report on the CD and website includes the comprehensive source for all data and findings from the HARC 2007 survey.

The Board of Directors, Steering Committee, Community Supporters and staff of HARC hope you find our first Community Health Monitor a helpful reference in understanding many of the health and quality of life issues in our region. In future years, we pledge to continue the Community Health Monitor as a dynamic report that will strive to keep pace with the diverse and ever-changing health-related needs in Eastern Riverside County.



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Introduction

Two years ago, several community leaders began a discussion about an underappreciated gap in the Coachella Valley, one that frequently impeded efforts to improve the health status of the area's residents. Specifically, few really knew in a quantitative sense the health status dimensions of the population. Qualitatively, it was intuitive that the health, lifespan, and overall quality of life of our residents were less than optimal, but to what degree and in what ways? How disparate were health status and quality of life between the young and the old, between the undereducated and the extensively educated, among various races and ethnicities, between the rich and the poor, and between recommended standards, national experience, and local data?



How could we claim to be taking an educated and scientific approach to creating interventions to improve community health and wellness if we did not truly know the current, baseline status of our community's health and wellness in the first place? And how would any of us know if our best efforts were appropriate and successful, let alone to what degree?

We got it!

What we really needed in our community was a systematic, data-driven approach to *quantitatively* determining the true health status, behaviors, and needs of our residents. Subsequently, this information could be used to formulate specific strategies to improve community health and wellness. And, if this approach were repeated at regular intervals, we could finally determine the real effectiveness of our interventions and, when necessary, re-direct our efforts if they were less than optimal.

In January 2006, the Desert Healthcare Foundation was awarded a \$200,000 grant by The California Wellness Foundation, a portion of which was to establish a regional data collection system. The Foundation chose to use those funds to form a broad-based collaborative of interested parties and organizations and allow this collaborative to create the desired system. Early support was also provided by the Regional Access Project Foundation. From this community-based beginning, the Health Assessment Resource Center (HARC) was born. The Merriam-Webster Dictionary tells us that the homonym "hark" means "to pay close attention." And we have.

A Steering Committee made up of 35 community partners, leaders, hospitals, school districts, governmental agencies, public safety, and private sector interests was formed—the largest community collaboration in our collective memory. All Steering Committee members have contributed not only their time and expertise, but also the financial and/or human resources necessary to achieve our goals.

HARC's founding Board of Directors, made up of senior-level healthcare professionals, government, and business leaders, first met in October 2006, and 501(c)(3) tax status was granted the following February. Shortly thereafter, HARC's website went live, the Board's first strategic planning retreat was held, and the mission, vision, and values of the organization were adopted. The Board made a clear decision that HARC would maintain objectivity throughout its work and would not participate in advocating for any particular cause or issue. In this way, all documents published, including but not limited to the Community Health Monitor, can be accepted as objective and unbiased.

The Board and Steering Committee immediately recognized that HARC's first goal should be the completion of a rigorous, comprehensive, and scientifically-based survey of the status of health and well-being in our community. But, what should be the boundaries of this "community"? After some discussion, and the recommendations of some experienced local officials, we decided to broaden the scope to include the entire Eastern Riverside County ("ERC") from Calimesa to Blythe.



Beyond the concepts stated above, additional reasons to undertake this health needs assessment immediately became clear:

- ❖ The rapid population growth in ERC.
- ❖ The lack of timely and regionally-focused data from other sources.
- ❖ The need of many organizations to make strategic planning and business decisions based on current and reliable data.
- ❖ The expectation by local, regional, and national funding organizations that requests for support be based on current, scientifically collected and analyzed data regarding health needs and gaps in the community.
- ❖ The potential to bring new financial resources through grants and governmental funding to ERC based upon documented, validated need.
- ❖ The lack of available baseline data to help measure outcomes, effectiveness, and change resulting from funding decisions and initiatives.
- ❖ The desire to eliminate duplicative efforts by pooling resources.
- ❖ The opportunity for partners to reduce their need for research/planning staff.
- ❖ The provision of service-level data for individual partners.
- ❖ The absence of other community-wide, collaborative efforts to accomplish these goals.

Work soon began. The Steering Committee broke into Ad Hoc Teams to review, modify, and add to survey questions largely based on the CDC's Behavioral Risk Factor Surveillance Survey ("BRFSS") and the California Health Interview Survey ("CHIS"). HARC then contracted with Macro International, an organization that for two decades has conducted health-related surveys in over 70 countries on behalf of agencies including the CDC, WHO, UNICEF, and the World Bank. Macro staff conducted HARC's random digit dialed survey of over 55,000 households in ERC in order to achieve 3,150 completed 19-minute telephone interviews. These data were then analyzed, interpreted, and written-up by HARC staff and consultants from mid February through early April.

You hold the results in your hands—the first ever HARC Community Health Monitor. The process will be repeated triennially, such that the next complete Community Health Monitor survey will be conducted in 2010. Planning is already underway.

Until that time, HARC plans on issuing reports to the community multiple times per year on varying topics involving health, well-being, and quality of life in ERC. Our extensive database will be repeatedly analyzed looking for correlations among factors influencing the health of our community, and for information important to individual cities, regions, advocacy groups, and governmental agencies.

Of note, just prior to the initiation of the last survey, the City of Indio commissioned HARC to oversample their community so the City would have even more reliable data on the health needs of its residents. Other types of customized surveys, data analysis, reporting, and technical support are available to interested organizations and municipalities. Our staff stands ready to answer your questions and help you make use of this report to further your organizational ends. Please contact us at (760) 601-3663 or staff@harcdata.org.



In the end, it is our intention to provide policy makers, service providers, and community members with information to consider when developing effective interventions. In this way, they will be more likely to identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. It is our hope that this Community Health Monitor will serve as a tool used in the quest to reach three basic goals:

- ❖ To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- ❖ To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it is possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that have historically had a negative impact on residents' health.
- ❖ To increase accessibility to preventative and clinical services for all community residents. More accessible services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventative and clinical care.¹

On behalf of HARC's Board and Steering Committee, I thank you for reviewing this Community Health Monitor and considering the information it contains in formulating your own organization's plans and goals.

Glen Grayman, MD, MBA, CPE, FACEP
President
Health Assessment Resource Center

¹ Professional Research Consultants, Broward County, Florida.



Notes on Using This Report

TABLES, CHARTS, AND TEXT

This section provides examples of tables and charts you will see throughout this report and explains what they mean and how to interpret the information they contain.

TABLE TYPE 1: RESPONSE TABLE

These tables show the estimated population and the percentage of responses for each question being reported. Population estimates are derived using the most recent population numbers available for the region. They are calculated using a statistical weighting method that allows the actual survey responses to more accurately reflect the entire population of Eastern Riverside County.

	Weighted Percent	Population Estimates
Yes	22.4	122,279
No	77.6	423,381
Total	100.0	545,660

CHART TYPE 1: DISTRIBUTION OF THOSE AFFECTED OR NOT AFFECTED

These “pie charts” examine the number affected (e.g., those who are without dental coverage) by a demographic variable; in this case, racial/ethnic background. Therefore, the chart is correctly read, “Of the adults without dental coverage, 67.5% are White.” It is important to note that this chart does not say that White adults are *more likely* to be without dental coverage; larger populations in the region as a whole will often have a larger piece of the pie, in part, because there are more of them.

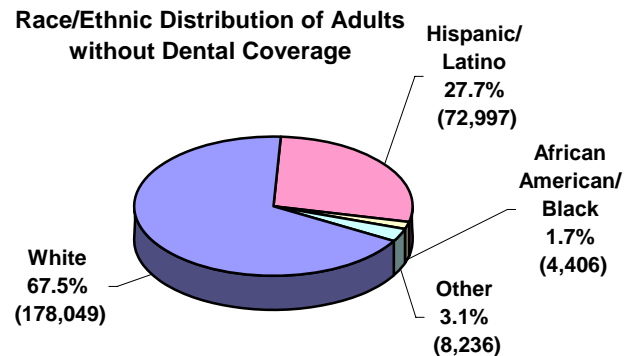


CHART TYPE 2: WITHIN A CERTAIN POPULATION OR DEMOGRAPHIC CATEGORY

These “bar charts” reflect the proportion affected (e.g. proportion of Hispanic/Latinos and Whites who are without dental coverage) within a demographic variable. Hence, the chart is correctly read, “Of White respondents, 6.9% are without dental coverage, compared to 33.2% of Hispanic/Latinos who are without dental coverage.” These charts can tell us which demographic categories are more likely to be affected by the condition or circumstance in question.

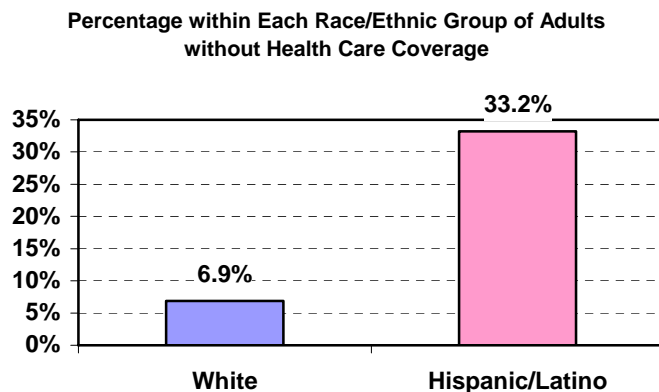
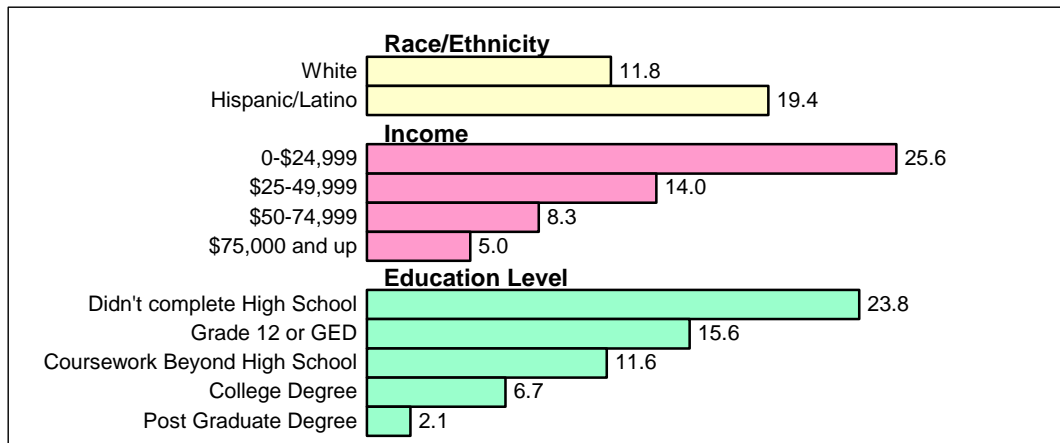




CHART TYPE 3: WITHIN MANY DEMOGRAPHIC CATEGORIES

These “bar charts” are a variation of Chart Type 2 where data within several different demographic categories are presented in one combination chart.

Percentages of Children who Lack Primary Health within Demographic Categories



TEXT

Text descriptions that accompany the pie and bar charts often state something like, “Hispanic/Latinos are more likely than Whites to be without dental coverage.” Given these are self-reported data, it might be more appropriate to report, “Hispanic/Latinos are more likely than Whites to report being without dental coverage.” For readability, we have often omitted reference to “reporting” in favor of supposing that respondents have been candid in their responses.

NOTES

- ❖ Report sections cover different populations, often determined by age. For instance, report sections may cover all adults, adults 55 and older, all children, or only children 0-5.
- ❖ Within a report section, particular questions may have been asked only to a subset of respondents; for instance, only adults with a child one year of age or older were asked how often their child drinks milk. However, this information is presented in the report section for children 0-17.
- ❖ These report data were collected in 2007, and are considered primary data. HARC has used the most recent data available, however, some secondary data, such as 2000 Census data, are from many years ago. Most national, state and county data are two or more years behind, so a report done in 2004 will most likely be using data from 2002 or earlier.
- ❖ Pie charts (described above) contain proportions and population estimates for all racial/ethnic groups (White, Hispanic/Latino, Black/African American, and Other); however, comparisons between persons of different racial/ethnic backgrounds are conducted only for Whites and Hispanic/Latinos due to the small number of Black/African American and “other race/ethnicity” respondents included in the sample—because of their small proportion in Eastern Riverside County as a whole.
- ❖ All efforts have been taken to ensure that source material is well documented and up-to-date. However, Internet web pages change frequently. If you visit a linked website outside the report and are unable to connect to the information you desire, please “back up” in the URL address until you arrive at the root website page. Once you arrive at the organization’s “home page,” search for the information or statistics you desire.
- ❖ The California Health Interview Survey (CHIS)¹ data reference in this document is not an independent sample relative to the HARC survey sample since the sample population for Eastern Riverside County is included in both the Riverside County and California state results published by CHIS.

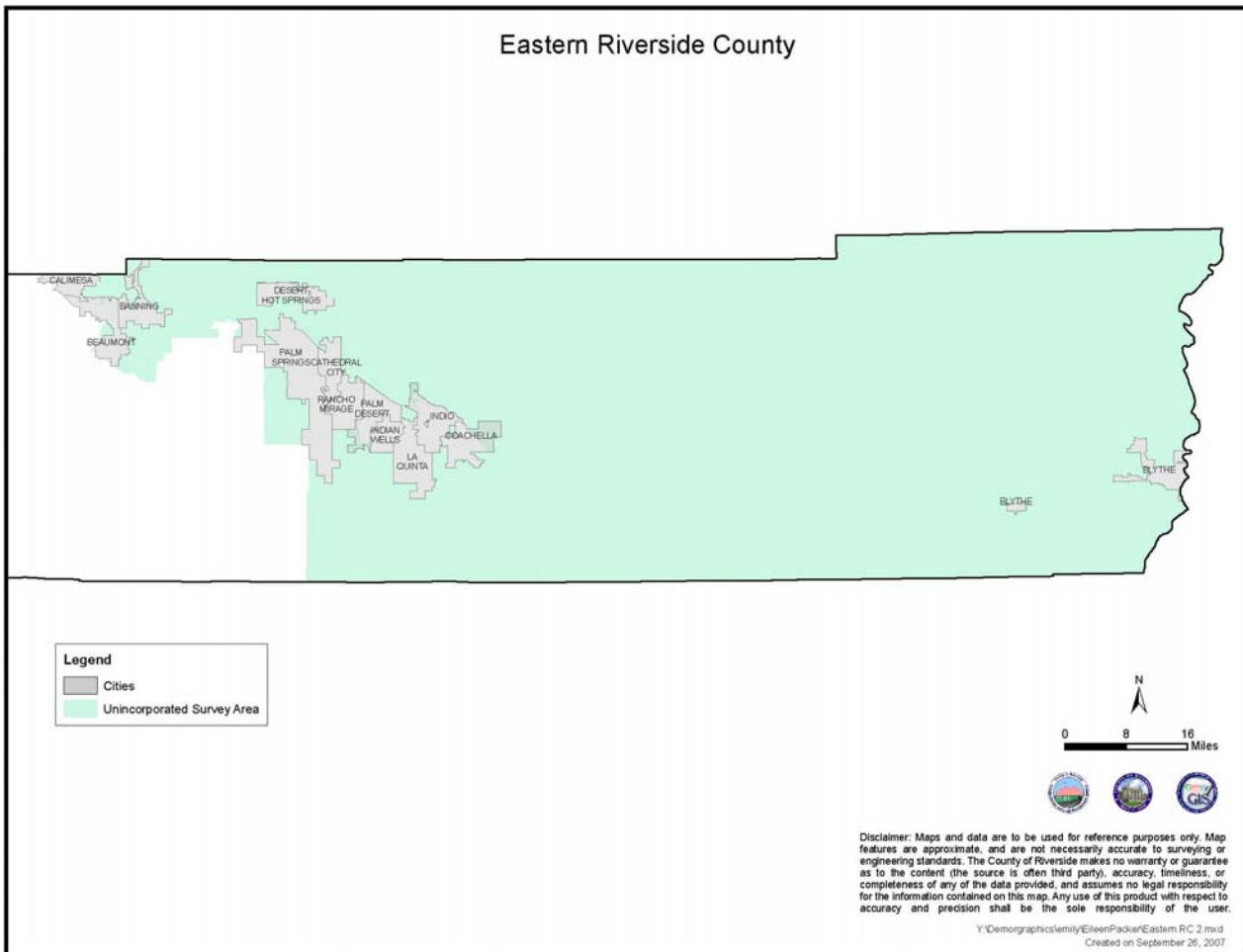
¹ www.chis.ucla.edu/



Eastern Riverside County Geography

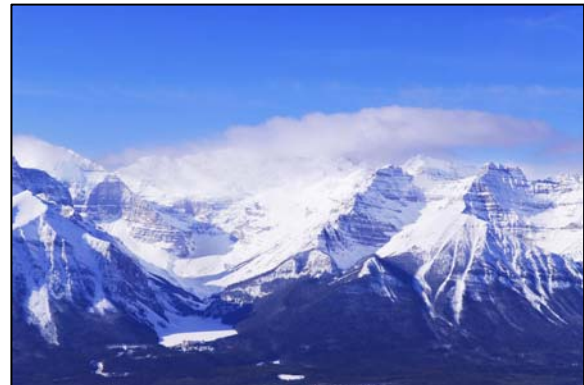
GEOGRAPHIC PROFILE

This Community Health Monitor focuses on the health status of Eastern Riverside County. The region includes 13 incorporated cities and a large, but sparsely populated, unincorporated area. Interstate Highway 10, which connects Los Angeles with Arizona, runs through the center of the area. Geographically, the cities are clustered around I-10 and a small number of feeder highways. The area is bounded by the San Gorgonio Pass on the west; the San Jacinto, Santa Rosa mountains, and San Diego County line on the south; the San Bernardino County line on the north; and the Arizona border on the east. This represents a large geographic area with a driving distance of over 150 miles from east to west.





- ❖ Starting from the west, the San Gorgonio Pass area includes the cities of Calimesa, Beaumont, and Banning.
- ❖ Moving east, there is the unincorporated area of Cabazon and the Morongo Band of Mission Indians reservation.
- ❖ Farther east is the Coachella Valley comprised of nine cities and significant unincorporated areas; it contains the majority of the population of the eastern county. Palm Springs, Desert Hot Springs, Cathedral City, Rancho Mirage, Palm Desert, Indian Wells, La Quinta, Indio, and Coachella are the incorporated cities.
- ❖ Unincorporated areas within the Coachella Valley include North Palm Springs, Sky Valley, Thousand Palms, Bermuda Dunes, Sun City Palm Desert, Thermal, and Mecca.
- ❖ Tribal areas within the Coachella Valley include the reservations of the Aqua Caliente Band of Cahuilla Indians, the Augustine Band of Mission Indians, the Cahuilla Band of Mission Indians, and the Torres-Martinez Desert Cahuilla Indians.
- ❖ Continuing towards the Arizona border, there are the unincorporated areas of Chiriaco Summit, Desert Center, and Eagle Mountain.
- ❖ On the Arizona border is the Palo Verde Valley which includes the city of Blythe and associated unincorporated areas.





Highlights and Key Findings

INTRODUCTION

HARC’s Community Health Monitor (2007) survey has produced a significant amount of noteworthy information that can provide a foundation and baseline for understanding both the current and future health care needs and quality of life issues in Eastern Riverside County including the Coachella Valley. This section of the Executive Report discusses many of the important highlights and key findings that are contained in the full report, which is contained on both the CD inside the back cover of this report and on HARC’s website, www.harcddata.org.

HIGHLIGHTS OF THE ANALYSIS OF SOCIOECONOMIC STATUS

The household income and household size reported by each respondent were compared to the Department of Health and Human Services poverty guidelines for 2007.¹ Taking the poverty guideline and multiplying it by 2.0 provides the income at 200% above poverty, multiplying it by 2.5 provides the income for 250% above poverty, etc.

**Population at % of Poverty Guideline
(HARC, 2007)**

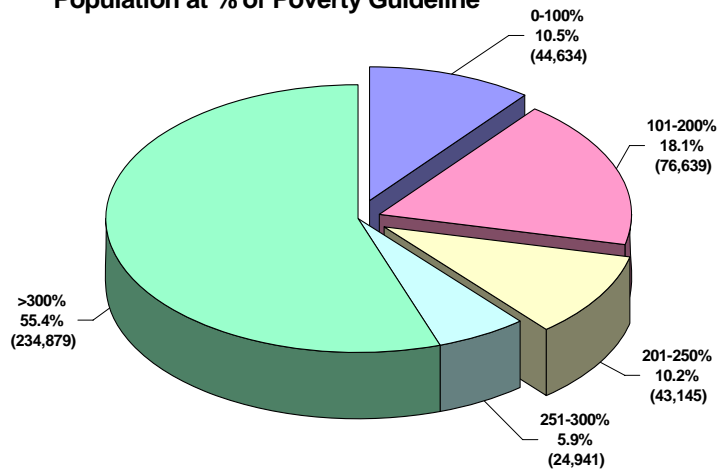
Percent of Poverty Guideline	Weighted Percent	Population Estimates
0-100%	10.5%	44,634
101-200%	18.1%	76,639
201-250%	10.2%	43,145
251-300%	5.9%	24,941
>300%	55.4%	234,879
Total	100.0%	424,237

Note: “Population Estimate” may not reflect actual population due to non-responses and/or rounding.

Over one-third (38.8%) of respondents reported being at or below 250% of the poverty guideline and would therefore likely be eligible for some type of federal or state assistance. Almost 165,000 residents are included in this group.

Within the 38.8% are 10.5% of survey respondents who reported a household income that was at or below the poverty guideline based on their household size. They represent more than 44,600 residents of Eastern Riverside County.

Population at % of Poverty Guideline



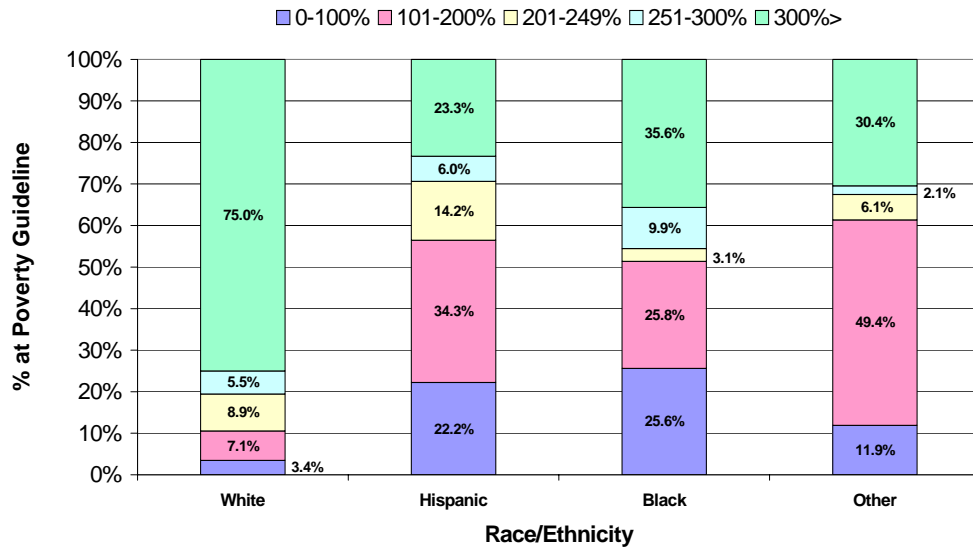
¹ United States Department of Health and Human Services 2007 HHS Poverty Guidelines <http://aspe.hhs.gov/poverty/07poverty.shtml>



POVERTY BY RACE/ETHNICITY

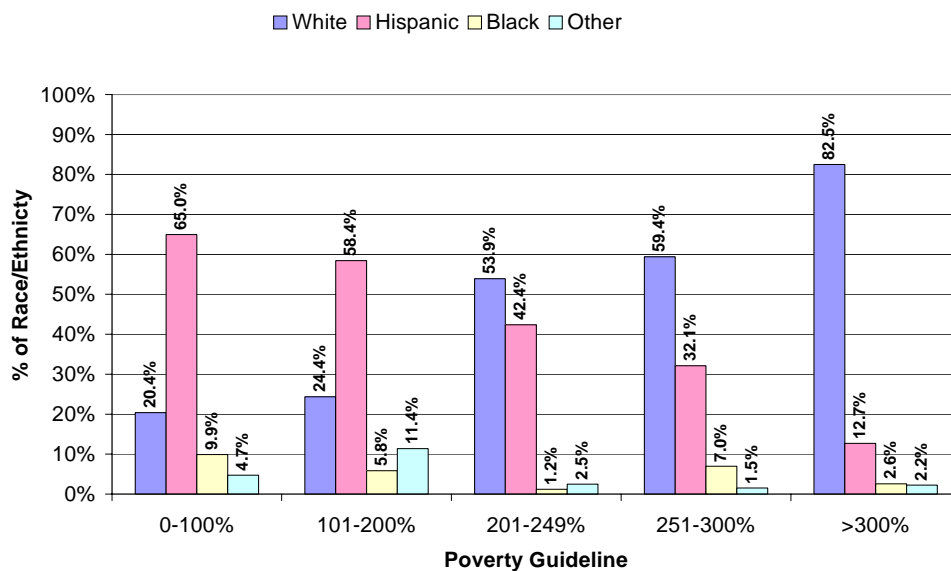
75% of White respondents live at more than 300% of the poverty guideline whereas only 23.3% of the Hispanic/Latino respondents reported having a household income over 300% of the poverty guideline.

Households at % of Poverty Guideline by Race/Ethnicity



Nearly 2/3 of those living at or below 100% of the poverty guidelines were Hispanic/Latino. Over half living between 100 and 200% of the poverty guidelines were Hispanic/Latino. Over 80% of Whites are living above 300% of the poverty guidelines.

Households by Race/Ethnicity within each Poverty Guideline

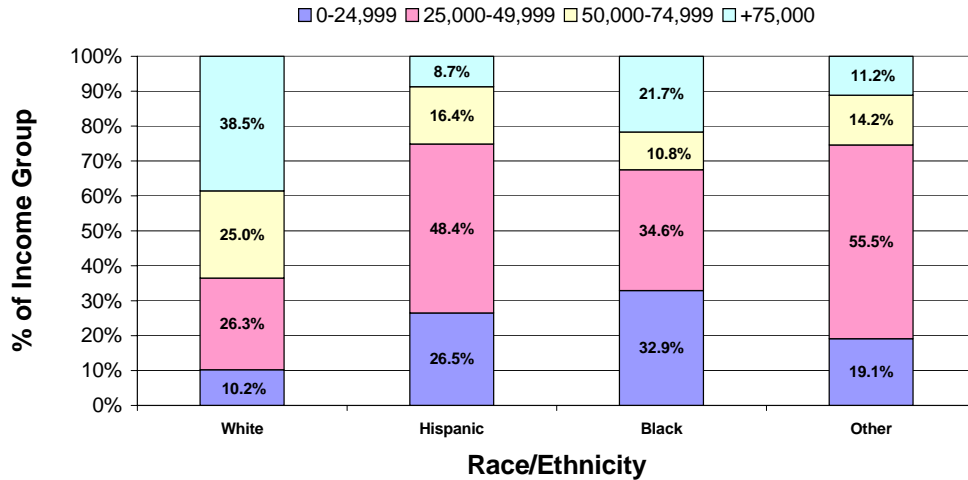




HOUSEHOLD INCOME BY RACE/ETHNICITY

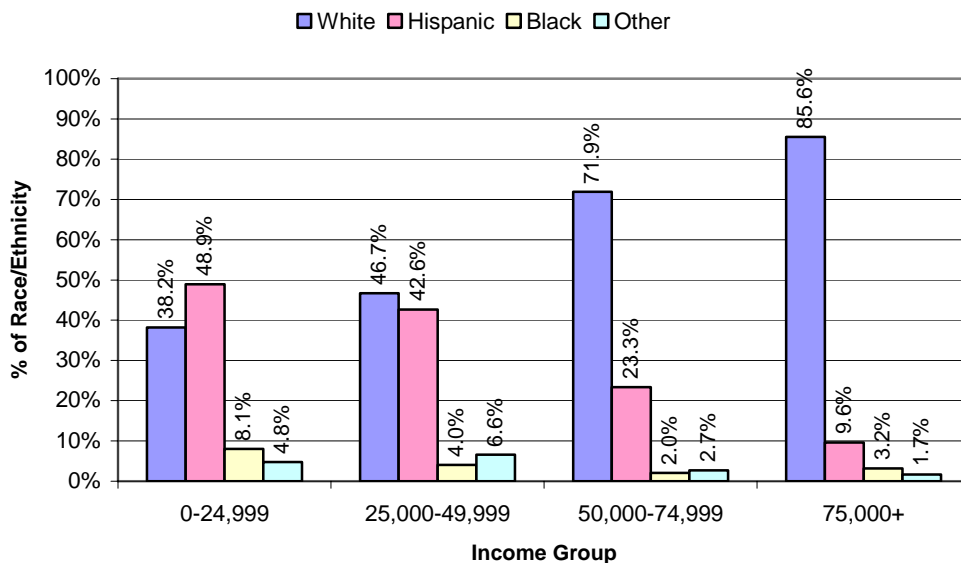
Nearly two-thirds (63.5%) of Whites reported household incomes of \$50,000 or more per year; 25.1% of Hispanic/Latino residents reported incomes in this range.

Household Income by Race/Ethnicity



Nearly one half (48.9%) of households reporting incomes less than \$25,000 are Hispanic/Latino. Slightly less than half (42.6%) of households reporting incomes between \$25,000 and \$50,000 are Hispanic/Latino. More than three quarters of households reporting incomes in excess of \$75,000 are White.

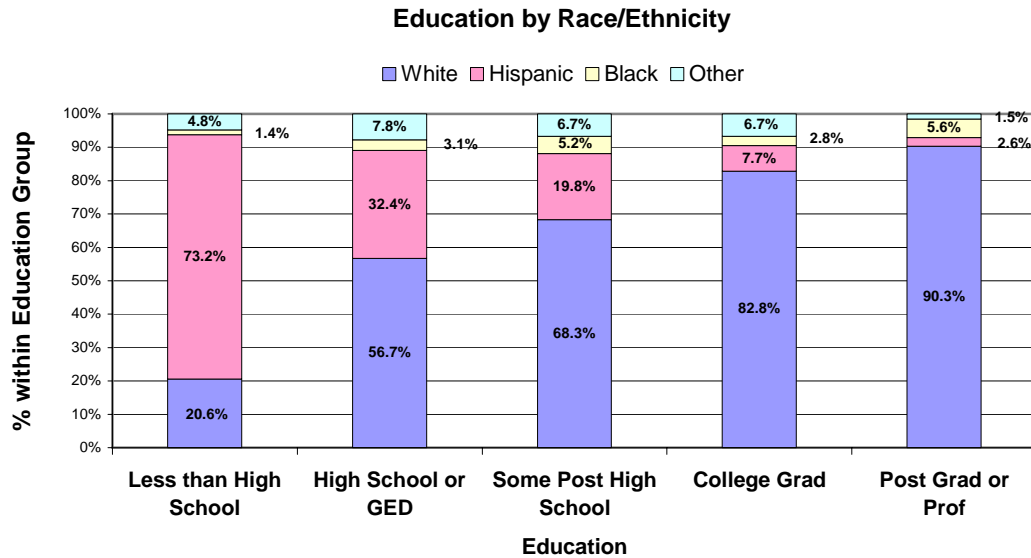
Households by Race/Ethnicity within each Income Group





EDUCATION BY RACE/ETHNICITY

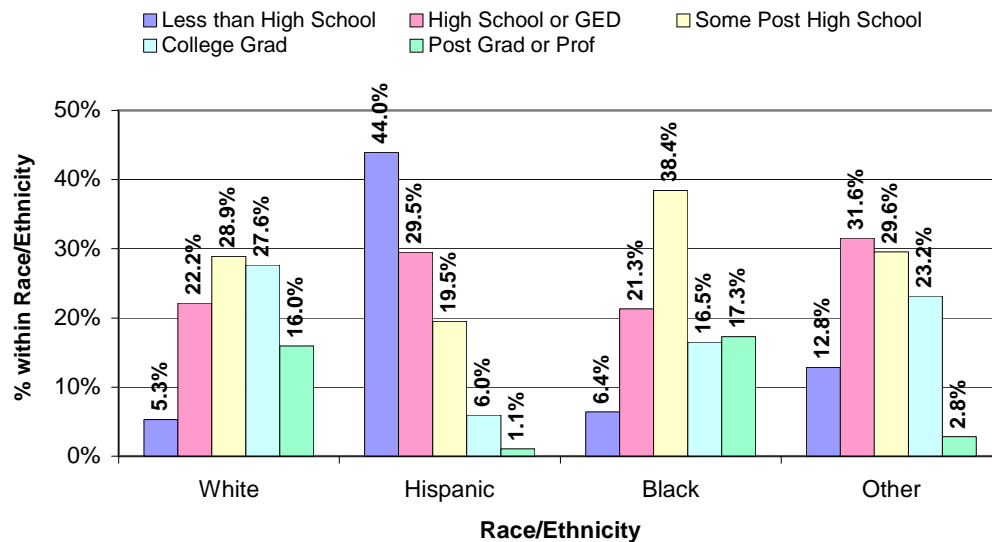
Nearly 75% of those not completing high school are Hispanic/Latino respondents. Over 90% of those having Post Graduate or Professional Degrees are White.



Forty-four percent of Hispanic/Latino respondents did not complete high school, compared to 5.3% of White respondents; likewise 43.6% of White and 7.1% of Hispanic/Latino respondents have graduated from college or have post graduate degrees.

At least 56% of respondents in all racial categories completed high school. Nearly 75% of Whites have completed education beyond high school. Slightly more than one quarter of Hispanic/Latino residents have completed education beyond high school.

Education within each Race/Ethnicity





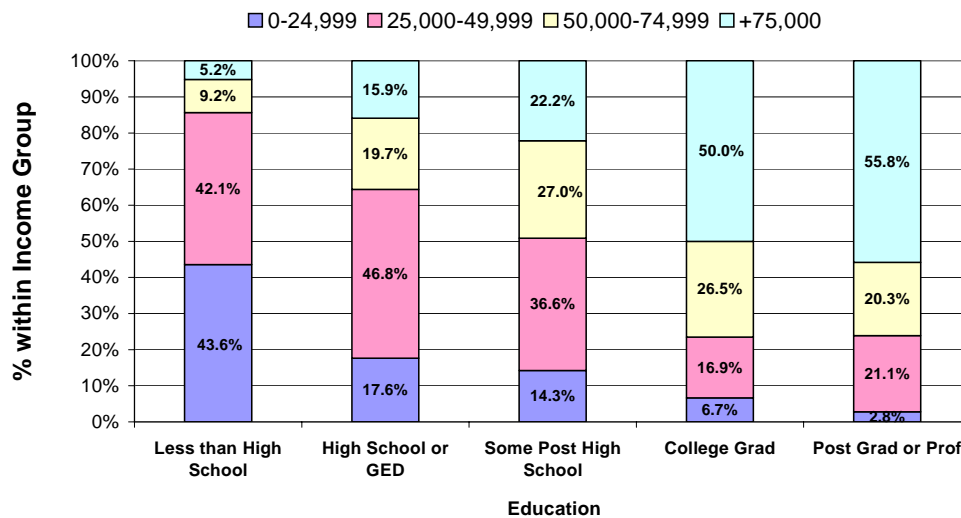
INCOME BY EDUCATION

Not surprisingly, nearly 44% of those not completing high school have a household income of less than \$25,000 per year. On the other hand, 55.8% of those with a post-graduate degree report an annual income of \$75,000 or more; 5.2% of those with less than a high school degree earn this amount annually.

As is shown, there is a positive relationship between years of education and income.

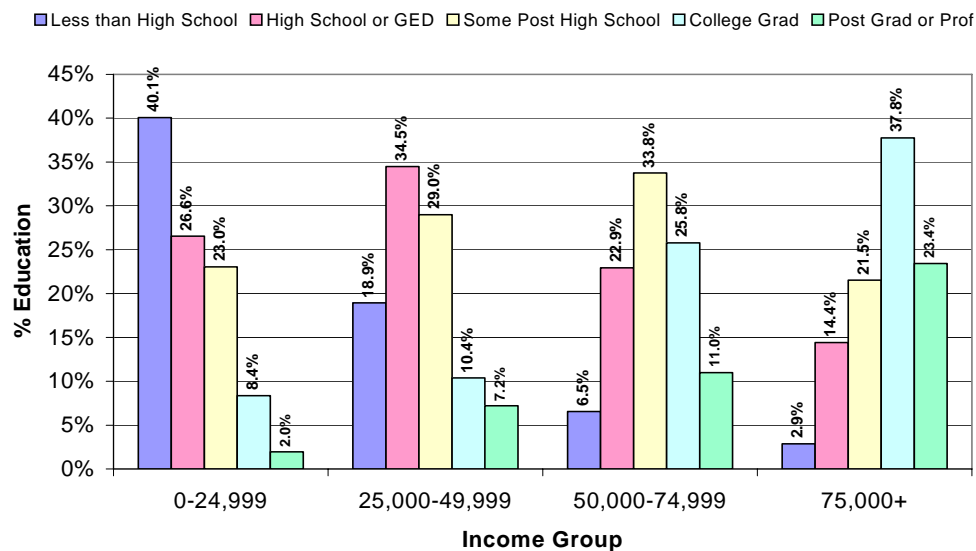
The proportion of residents in each income category with less than a high school degree decreases from 40.1% for respondents earning less than \$25,000 annually, to 18.9% for respondents with incomes between \$25,000 and \$50,000, to between 2.9 to 6.5% in the two highest income categories.

Household Income by Education



The proportion of residents reporting having some coursework beyond high school increases from 33.4% for those earning less than \$25,000 annually to 82.7% for those earning over \$75,000.

Education within each Income Group





Highlights and Key Findings

Adult Health (Age 18+)

HARC 2007 COMMUNITY HEALTH MONITOR – SURVEY RESPONDENTS (18+)

These tables show the percentage of responses for each question asked in the survey and the estimated population that those responses represent.

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS (AGE 18+)

Almost 36% of the respondents 18 and older self-report being non-White.

Demographics (18+): Race/Ethnicity (HARC, 2007)

	Weighted Percent	Population Estimates
White	64.0%	346,583
Hispanic/Latino	28.1%	152,270
Black/African American	3.6%	19,685
Other	4.2%	22,731
Total	100.0%	541,269

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

The largest group of respondents (36.9%) was 65 and older with 19.5% aged 75 or older. 14.1% were in the early retirement group of 55-64. There were slightly more female (52.7%) than male (47.3%) survey respondents.

Demographics (18+): Age, Gender (HARC, 2007)

	Weighted Percent	Population Estimates
Age		
18 to 24	8.9%	49,206
25 to 34	14.4%	79,452
35 to 44	14.6%	80,654
45 to 54	11.1%	61,230
55 to 64	14.1%	77,700
65 to 74	17.4%	96,153
75+	19.5%	107,720
Total	100.0%	552,114
Gender		
Male	47.3%	261,250
Female	52.7%	290,864
Total	100.0%	552,114

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.



The majority of respondents (55.4%) reported being married and more than 1 in 5 (22.4%) are single, never having married. Nearly 89% of respondents reported being heterosexual; 10% reported being homosexual (8.0%) or bisexual (2.0%).

Demographics (18+): Marital Status, Sexual Orientation
(HARC, 2007)

	Weighted Percent	Population Estimates
Marital Status		
Married	55.4%	302,231
Single, Never Married	22.4%	121,993
Divorced	9.4%	51,332
Widowed	8.1%	44,417
Cohabiting with Partner	3.2%	17,352
Separated	1.3%	7,082
Other	0.1%	700
Sexual Orientation		
Heterosexual	88.9%	446,680
Homosexual	8.0%	40,197
Bisexual	2.0%	10,232
Transgender	0.2%	940
Other	0.9%	4,502

More than 85% of those adults responding report being U.S. citizens. Of the 14.4% who are not citizens, 53.4% report being permanent residents. Of the 46.6% who are not citizens or permanent residents, 79.8% report not having temporary visas (these could be either seasonal residents or undocumented immigrants).

Demographics (18+): Citizenship Status
(HARC, 2007)

	Weighted Percent	Population Estimates
U.S. Citizen	85.6%	462,149
Permanent Residents with "Green Cards" (of the 14.4% who are not citizens)	53.4%	41,607
No Temporary Visa (of the 46.6% who are not citizens or permanent residents)	79.8%	28,986

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.



SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS (AGE 18+)

16.3% of respondents have not completed high school. Over half (59.1%) have completed course work beyond high school with 32.3% of those obtaining a college or postgraduate degree.

Socioeconomic Characteristics (18+): Education
(HARC, 2007)

	Weighted Percent	Population Estimates
Less than High School	16.3%	88,936
High School Grad or GED	24.7%	134,857
Some College	26.7%	145,972
College Degree	21.1%	115,136
Post-Graduate	11.2%	60,989

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

Over one-third (36.4%) of respondents reported being employed for wages and 8.8% reported being self-employed. 36% (or 197,050 residents) reported being retired. Of the 4.2% (23,278) out of work, 1.6% has been out of work for less than 1 year and 2.6% for more than 1 year. Approximately 118,000 residents (27.6%) made \$75,000 or more per year before taxes

Socioeconomic Characteristics (18+): Employment, Household Income
(HARC, 2007)

	Weighted Percent	Population Estimates
Employment Status		
Employed for Wages	36.4%	199,277
Self-employed	8.8%	48,497
Retired	36.0%	197,050
Homemaker	7.7%	42,014
Unable to Work	4.2%	22,839
Unemployed	4.2%	23,279
- Less than 1 year	1.6%	8,836
- More than 1 year	2.6%	14,443
Household Income		
Less than \$25,000	16.7%	71,479
\$25,000 - 49,999	34.3%	147,236
\$50,000 - 74,999	21.5%	92,172
\$75,000 or More	27.6%	118,242



Almost three-quarters (73.1%) of respondents reported they own their home while 26.9% rent. 60% of households surveyed consisted of 1 or 2 persons with 17.7% having a single member. Average household size of survey respondents is 1.95 people (adults and children). During the time of the survey (mid February through early April, 2007), slightly more than one quarter of respondents indicated they were “seasonal” residents in that they do not live in Eastern Riverside County full-time; they represent over 147,000 part-time residents. Over 82% live in the area 6 months or less.

Socioeconomic Characteristics (18+): Housing Characteristics, Full-time Residency, Months in Residence (HARC, 2007)

	Weighted Percent	Population Estimates
Housing Characteristics		
Own	73.1%	393,822
Rent	26.9%	144,713
1 person in Household	17.7%	95,395
2 persons in Household	42.3%	228,361
3 or more in Household	40.0%	216,217
Full-time Resident		
No	26.7%	147,150
Yes	73.3%	404,964
Number of Months in Residence (if not full-time)		
1 to 6 months	82.5%	120,877
6 to 12 months	17.5%	25,546

Note: “Population Estimate” may not reflect actual population due to non-responses and/or rounding.

ACCESS TO HEALTH CARE

Health insurance is the primary means for accessing and obtaining needed medical care and for reimbursing providers who deliver medical care. Approximately two-thirds of Californians obtain health insurance through the private market; yet, almost one in five Californians remains uninsured.

California’s uninsured population is diverse. Different segments face a variety of barriers to obtaining coverage; efforts to expand coverage must take into account the relationships among employment, income, ethnicity, citizenship status, and premium costs that influence the level of health coverage in the state.

HEALTH INSURANCE COVERAGE

According to the U.S. Census Bureau, both the number and percentage of people without health insurance increased in 2006. The number of uninsured increased from 44.8 million in 2005 to 47.0 million in 2006. The percentage of people without health insurance rose from 15.3% in 2005 to 15.8% in 2006.¹

The proportion of people covered by employment-based health insurance decreased from 60.2% in 2005 to 59.7% in 2006.² The proportion of people covered by government health programs decreased from 27.3% in 2005 to 27.0% in 2006. The percentage and the number of people covered by Medicaid were statistically unchanged at 12.9% and 38.3 million, respectively, in 2006.³

Lack of health insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than insured individuals.

¹ U.S. Census Bureau. *Health Insurance Coverage 2006: Highlights*, www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html

² *Ibid.*

³ *Ibid.*



KEY FINDING:

Over 80,000 adults (14.8%) in Eastern Riverside County report that they do not have any kind of health care coverage.

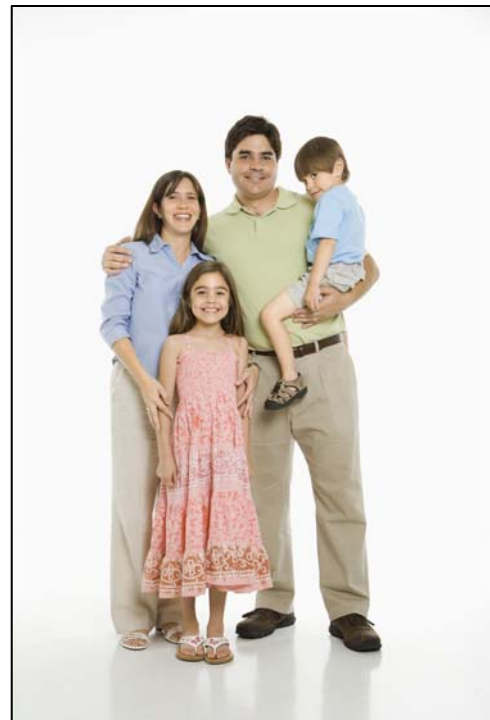
Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons. However, an estimated 80,950 Eastern Riverside County adults age 18 and older reported they did not have any kind of health care coverage. They represent 14.8% of the Eastern Riverside County adults. The CHIS for Riverside County data for 2003 for adults age 18 and older is 15.1% and CHIS California data for 2003 is 6.4%.

For those with health insurance coverage, the two major sources of payment for medical care are Medicare (34.7%, or 152,533 residents, are covered under Medicare) and employer-sponsored health plans (24.3%, or 106,796 residents, are covered under employer-sponsored health plans).

KEY FINDING:

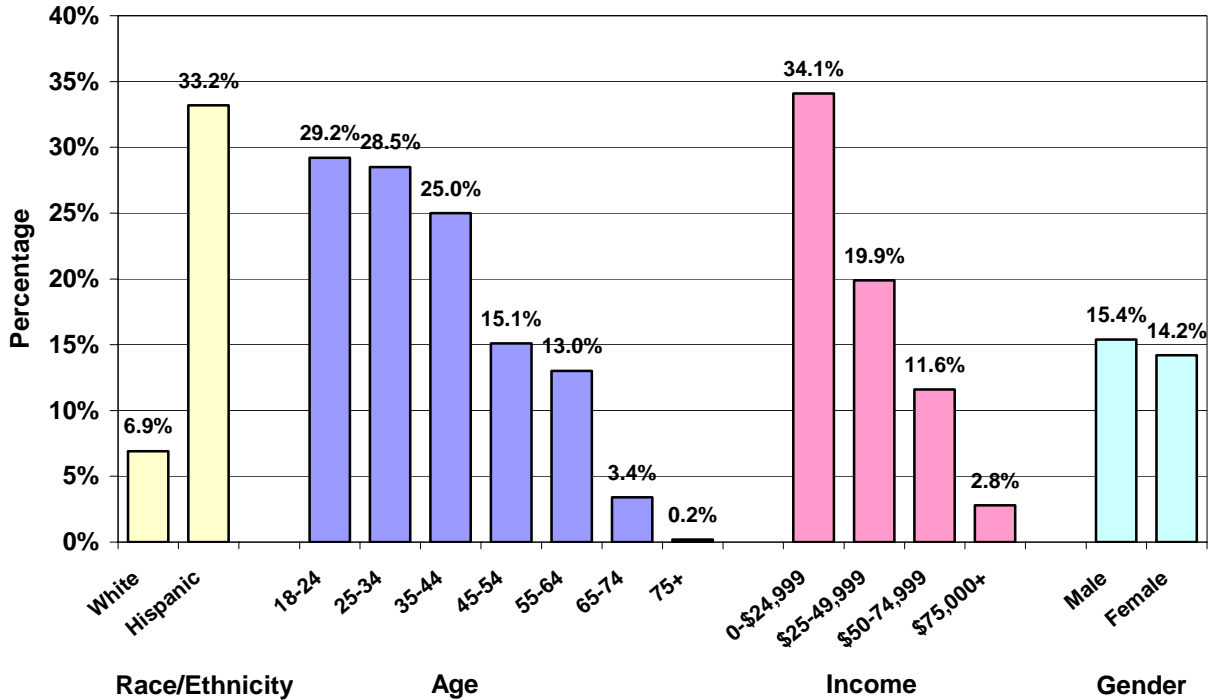
Lack of health insurance disproportionately impacts Hispanic/Latinos, younger adults, and those with lower income and education.

Hispanic/Latinos are nearly five times more likely than Whites to be uninsured (33.2% vs. 6.9%). Younger adults (18-24) are more likely to be without health care coverage than other age groups; in fact, 29.2% of younger adults are uninsured. Over 1 in 3 (34.1%) adults with incomes under \$25,000 do not have health care insurance coverage. The proportion without health insurance coverage decreases with higher incomes. The highest prevalence of those without health care insurance is among those who have not completed high school (35.7%). Approximately 73% of those without health care coverage have a high school diploma or less. They represent 58,384 adults in Eastern Riverside County.





**Percentage of Uninsured Adults in Eastern Riverside County
Within Demographic Categories
(HARC, 2007)**



KEY FINDING:

Almost 35,000 adults were without health insurance at some point in the past 12 months. They were mostly Hispanic/Latino, younger adults, less educated, and male.

During the past 12 months, 34,881 (7.4%) of Eastern Riverside County adults were uninsured. Access to health services is more limited for certain groups, namely, Hispanic/Latinos, younger adults, those with less education, and men. Hispanic/Latinos are five times more likely to be without health care coverage as Whites. The highest prevalence of those without health insurance have incomes under \$50,000, are 18-24 and 24-34 years of age, and without a high school diploma.

KEY FINDING:

The MAIN reason for lack of health insurance is the inability to pay for the coverage.

The inability to pay for the coverage is the MAIN reason (28.1%) cited for lack of health insurance by an estimated 20,000 residents. The other top reasons for lack of health insurance are that residents don't need it (12.7%) and they have lost or changed jobs (10.5%).



Reasons for Lack of Health Insurance Coverage
(HARC, 2007)

Reasons	Weighted Percent	Population Estimates
Can't Afford to Pay Premiums	28.1	20,141
Don't Need it	12.7	9,091
Lost or Changed Job	10.5	7,520
Applying for Health Care	5.9	4,231
Refused by Insurance Company	4.4	3,160
Employer Does Not Offer	4.0	2,862
Divorced or Separated	2.9	2,097
Lost Medi-Cal or Medical Assistance	2.6	1,863
Lack of Documentation to Prove Legal Status	2.5	1,790
Benefits from Former Employer Ran Out	1.3	931
Became Ineligible Because of Age	0.9	624
Spouse or Parent Lost Job	0.4	283
Spouse or Parent Died	0.2	117
Lost Temporary Assistance For Needy Families (TANF) Benefits	0.1	60
Some Other Reason	23.6	16,910
Total	100.0	71,679

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

KEY FINDING:

The MAIN types of health insurance used by Eastern Riverside County adult residents are Medicare (34.7%), employer-sponsored health plan (24.7%), and Medi-Cal (10.1%).

About one-third (34.7%) of those adults with insurance coverage indicate they have Medicare and about one-quarter (24.3%) have insurance through their employer. Medi-Cal is used by only 10% of the adult population.



Type of Health Insurance Coverage
(HARC, 2007)

Type of Coverage	Weighted Percent	Population Estimates
Medicare	34.7	152,533
Your Employer	24.3	106,796
MediCal including IEHP	10.1	44,463
A Plan that You or Someone Else Buys	8.0	35,156
Someone Else's Employer	3.4	14,986
Paying with Own Money	1.8	8,056
Military Champus or VA	1.8	7,842
MSI (Medical Services for Indigent)	0.2	903
Healthy Families	0.1	552
Access for Infants and Mothers (AIM)	0.0	111
Indian Health Service	0.0	57
Some Other Source	15.5	68,333
Total	100.0	439,788

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

PRESCRIPTION COVERAGE

Advancements in prescription drug therapy have tremendously improved longevity and the quality of life. However, the costs of prescription medications have skyrocketed and are increasing faster than any other area of health care and the annual rate of general inflation.

Access to the benefits of prescription drug therapy can be negatively affected by the lack of prescription coverage. A recent survey found that uninsured adults are twice as likely as insured adults to say that they or a family member cut pills, did not fill a prescription, or skipped medical treatment in the past year due to cost of prescription medications.¹

KEY FINDING:

Over 133,000 adults (24.6%) report that they did not have any kind of health care coverage that covers some or all of the cost of their prescription drugs.

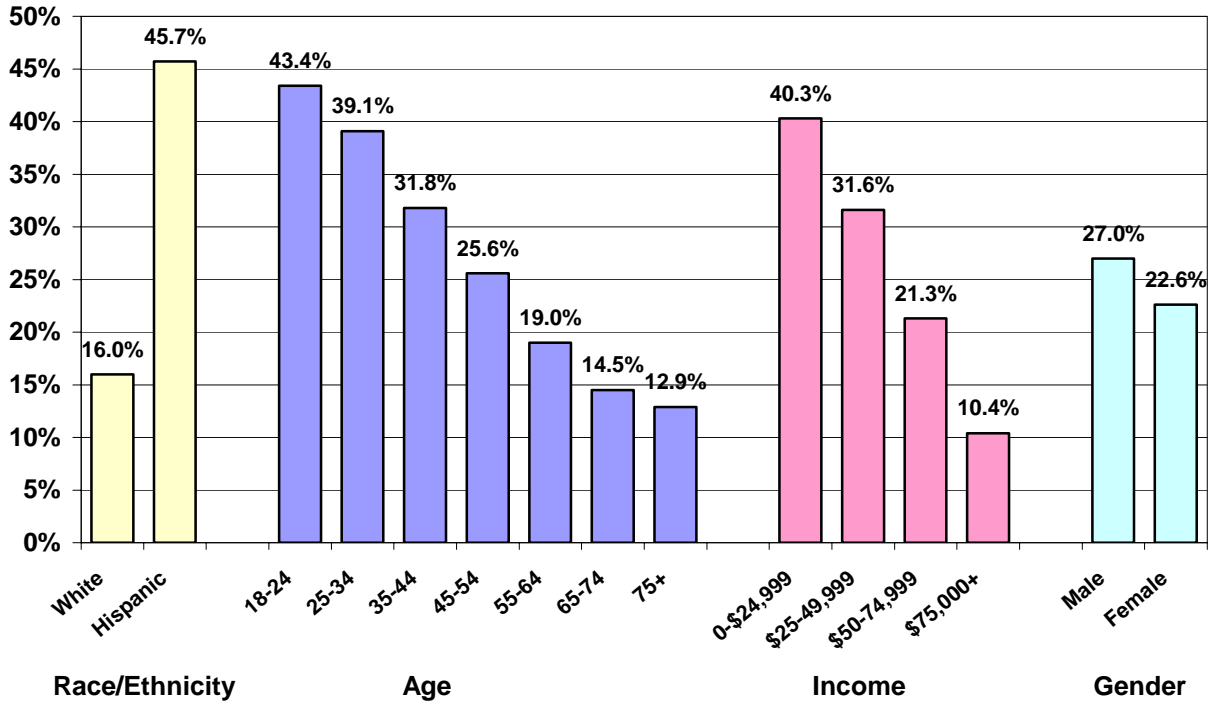
In fact, almost one quarter (24.6%) or 133,834 adults in Eastern Riverside County age 18 and older are without prescription coverage. The CHIS Riverside County data for 2005 is 8.4% and CHIS California data for 2005 is 8.5% for adults age 18 and older.

Lack of prescription coverage is more prevalent among Hispanic/Latinos, younger adults, men, and those with lower incomes and education. Almost three times as many Hispanic/Latinos do not have prescription coverage compared to Whites (45.7% vs. 16.0%). Adults under 25 years of age are more likely to be without prescription coverage than other age groups. The largest group of those without coverage for prescriptions have annual household incomes under \$25,000. Those without a high school diploma are more likely to not have health insurance coverage for prescription medications. Men are more likely not to have prescription coverage than women.

¹ Kaiser Family Foundation. Prescription Drug Trends, www.kff.org/insurance/upload/3057-04.pdf



**Percentage of Adults without Prescription Coverage
Within Demographic Categories**
(HARC, 2007)



“Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.”

-NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities, Vol. 1, Fiscal Years 2002-2006



UTILIZATION OF HEALTH CARE SERVICES

The degree to which health care services are utilized depends on a number of environmental, social, cultural, and economic factors within a community. These factors include the availability of acceptable medical services, the organizational structure of the health care delivery system, the type of health insurance coverage possessed by the individual, and individual and/or community beliefs and attitudes about accessing and utilizing health services.

Utilization of health services also depends in part on an ongoing source of care. Most people with insurance have a regular medical provider who coordinates the comprehensive health care services and oversees the patient's overall health.

KEY FINDING:

Approximately 75,900 adults have not visited a doctor or other health care provider in the past 12 months. Over 32,000 residents have never been for a routine check-up.

Overall, 75,971 or 13.9% of the residents of Eastern Riverside County have not visited a doctor or other health care provider in the last 12 months. Over 2,500 residents have never been to a doctor for treatment. Additionally, 32,119 residents have never been to a doctor for a routine check-up.

For those receiving medical care, the doctor's office is the most common source of ongoing care (56%), followed by urgent care (12.7%), the emergency room (11.4%), and a clinic (11.4%).

KEY FINDING:

The MAJOR barriers to receiving needed medical care were taking time off work and providers' hours of operation.

Nearly one in five U.S. adults – more than 40 million people – report they do not have adequate access to the health care they need, according to the annual report on the nation's health released by the Centers for Disease Control and Prevention (CDC).¹

In Eastern Riverside County, over 80,000 adults report that taking time off work and health care providers' operating hours are the two major barriers to receiving needed medical care. Other barriers include not having authorization from an HMO, finding a health care provider with whom one feels comfortable, transportation issues, language problems, and child care and/or elder care issues.

¹ Centers for Disease Control and Prevention. *Nearly One in Five Americans Say They Can't Afford Needed Health Care*. Press Release, December 3, 2007, www.cdc.gov/od/oc/media/pressrel/2007/r071203.htm



Barriers to Utilizing Medical Care
(HARC, 2007)

Barriers	Rank	Population Estimates
Taking time off work	1	84,340
Hours that the health care provider is open to see patients	2	81,308
Not having an authorization from HMO	3	53,308
Finding a doctor of the sex, age, or ethnicity that is comfortable for you	4	51,228
Transportation	5	43,534
Language barriers or problems	6	39,061
Child care	7	28,040
Elder care	8	6,411

Regarding barriers to utilizing care, adults with lower income, less education, and of Hispanic/Latino ethnicity are particularly affected. Hispanic/Latinos are over 2 times more likely than Whites to find taking time off work as a barrier to receiving medical care (25.5% vs. 8.9%). Adults who have not completed high school (20%) are more likely to find taking time off work a barrier to receiving health care. Similarly, Hispanic/Latinos are over 2 times more likely than Whites to find hours open as a barrier to receiving health care (23.2% vs. 9.3%), as do adults without a high school diploma. Hispanic/Latinos are also more likely to find not having an authorization from an HMO as a barrier to receiving care. Finding a doctor of the sex, age, or ethnicity with whom one can feel comfortable is an issue especially for women and, to a lesser extent, for adults with lower income and education. Transportation was more of a barrier for women, Hispanic/Latinos, and those with lower incomes (0-\$24,999).

KEY FINDING:	
<p>141,820 (25.7%) of Adults in Eastern Riverside County have used the emergency room for their care during the last year.</p>	<p>More than one out of four Eastern Riverside County adults (25.7%, or an estimated 141,820 adults) used the emergency room one or more times for medical care in the past year.</p> <p>These findings are similar to a recent report released by the Centers for Disease Control and Prevention that indicates that one in 10 adults ages 45-64 years did not have a usual source of health care, and more than 5 percent of adults in this age group who had diagnosed high blood pressure, serious heart conditions, or diabetes reported not having a usual source of medical care.¹</p> <p>The 2010 Healthy People Objective is to increase the proportion of adults with a source of ongoing care to 96%.</p> <p>Healthy People 2010 is a set of objectives developed for the nation to achieve over the first decade of the new century. The goals are to increase quality and years of healthy life, and to eliminate health disparities.</p>

¹ Press Release, December 3, 2007 Nearly One in Five Americans Say They Can't Afford Needed Health Care. Centers for Disease Control and Prevention, www.cdc.gov/od/oc/media/pressrel/2007/r071203.htm



GENERAL HEALTH AND PREVENTION

Preventive health, also known as preventative health, is a process of making small regular decisions and taking positive action on health, diet, exercise and lifestyle. These actions may give the body a better chance of remaining free from disease. Some research suggests that it may even be possible to reverse the damage already caused by some chronic diseases such as arthritis, asthma, cancer, diabetes, heart disease and stroke using the right methods of preventive health. These preventive health actions include mammogram screening for breast cancer, blood test and digital rectal exam for the detection of prostate cancer, regular dentist visits and professional tooth cleaning, and flu vaccinations, also called “flu shots”.

GENERAL HEALTH STATUS

Self perceived health is a powerful predictor of outcomes. Many individuals believe that we should feel healthy to live healthy.

KEY FINDING:	
<p>Over 16% or 88,961 adults in Eastern Riverside County report their health as “fair” or “poor.” Over 30% of those with the lowest annual household income (0-\$24,999) report their health as “fair” or “poor.”</p>	<p>The majority (57%) of the adults in Eastern Riverside County report their health is “excellent” or “very good,” and over one-quarter (26.8%) indicated their health is “good.” However, 11.8% report their health is “fair” and 4.4% “poor;” together, these respondents represent almost 89,000 residents.</p> <p>A higher proportion of Hispanic/Latino adults age 18 and older report to have “fair” or “poor” health than White adults (23.1% vs. 13.4%). The proportion of adults with “fair” or “poor” health decreases as income increases. Those adults 45-54 are most likely to report fair or poor health. Adults who did not complete high school are the most likely to report their health as “fair” or “poor.” Reporting health as “fair” or “poor” does not seem to be related to gender.</p>

Main Reasons for Poorer Health
(HARC, 2007)

Reason	Weighted Percent	Population Estimates
Chronic Illness	35.7	26,384
Physical Disabilities	27.0	19,940
Severe Illness	19.6	14,439
Mental or Emotional Health Problems	5.6	4,156
Old Age	4.1	3,010
Other Reasons	8.0	5,923
Total	100%	73,852

Note: “Population Estimate” may not reflect actual population due to non-responses and/or rounding.

Over 35% of those who report their health as “fair” or “poor” state the main reason is chronic illness, followed by 27% who report physical disabilities, and 19.6% who report severe illness as the main cause for their poorer health.



DISABILITY

Disabilities make it harder to take part in normal daily activities. They may limit what a person can do physically or mentally, or they can affect an individual's senses. Disability doesn't mean unable, and it isn't a sickness. Most people with disabilities can—and do—work play, learn, and enjoy full healthy lives. About one in every five people in the United States has a disability; almost all of us will have a disability at some point.¹ Some people are born with a disability; others get sick or have an accident that results in a disability; still others develop disabilities as they age.²

KEY FINDING:

Approximately 24% of adults have at least one health issue in the past 30 days that kept them from their normal daily activities.

Of the 24% of adults surveyed, at least one health issue was reported in the past 30 days that kept them from their normal daily activities. Severe headaches and joint pain are the top reasons people's lives were interrupted due to health-related problems. Severe headaches were a problem to 6.6% (36,361 adults) and joint pain was a problem to 6.5% (35,587 adults) of the residents. Other problems included trouble breathing in 2% (13,788) and dental pain in 2.3% (12,484).

Approximately 9% of respondents, representing approximately 52,900 Eastern Riverside County residents indicated they currently require special equipment such as a cane, wheelchair, a special bed, or a special telephone.

FLU SHOTS

Influenza, also called the flu, is a contagious respiratory illness caused by viruses. It can cause mild to severe illness and can even lead to death. The best way to prevent the flu is by getting a flu vaccination each year. Every year in the United States, on average, 5% to 20% of the population gets the flu, more than 200,000 people are hospitalized from flu complications, and about 36,000 people die from the flu.³

KEY FINDING:

The majority (59%), or 323,202, of Eastern Riverside County adults have not had a flu shot within the past 12 months.

During the past 12 months, the majority (59%) of Eastern Riverside County residents have not had a flu shot. CHIS Riverside County data for 2005 is 74.2% and for California 2005 is 73.6%.

Hispanic/Latinos (86.2%) are more likely than Whites (47%) to report not receiving a flu shot. Residents in the lower two income groups (0-\$24,999 and \$25,000-\$49,999) are more likely to report not receiving a flu shot in the past year; however, between 52% and 67% of respondents in each income group report not having had a flu shot. Younger adults and those with less education are more likely to report not having had a flu shot.

During the past 12 months, the great majority (98.4%) or 540,715 of Eastern Riverside County residents have not had a flu vaccine that was sprayed into the nose.

A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Approximately 30%, or 159,226 adults have received a pneumonia shot in their lifetime.

¹ US National Library of Medicine, www.nlm.nih.gov/medlineplus/disabilities.html

² Ibid.

³ Centers for Disease Control and Prevention, <http://www.cdc.gov/flu/heyfacts.htm>



COLON CANCER SCREENING

Colorectal cancer is a term used to refer to cancer that develops in the colon or the rectum. The colon and rectum are parts of the digestive system, which is also called the gastrointestinal, or GI, system. The digestive system processes food for energy and rids the body of solid waste matter (fecal matter or stool).

Screening tests are used to look for disease in people who do not have any symptoms. In many cases, these tests can find colorectal cancers at an early stage and greatly improve the chances of successful treatment. Screening tests can also help prevent some cancers by allowing doctors to find and remove polyps that might become cancerous.

Excluding skin cancers, colorectal cancer is the third most common cancer diagnosed in men and women in the United States.¹ The American Cancer Society estimates that about 112,340 new cases of colon cancer and 41,420 new cases of rectal cancer will be diagnosed in 2007.² Colorectal cancer is the second leading cause of cancer-related death in the United States and is expected to cause about 52,180 deaths during 2007.³ Beginning at age 50, both men and women should be screened for colon cancer.⁴

KEY FINDING:

Approximately 80,000, or 28.6% of, adults 50 or older have not had a colorectal cancer screening. Compared to Whites, Hispanic/Latinos are over 2.5 times more likely to not have had a blood stool test to check for colon cancer (21.7% vs. 58.4%).

About 80,409 adults 50 or older (28.6%) have not had a blood stool test to check for colon cancer. The CHIS Riverside County data for 2005 is 27.0% and the California data for 2005 is 28.9%. The Healthy People 2010 Objective is to increase the proportion of adults 50+ years who receive the test to 50%. In Eastern Riverside County 71.4% report having the test.

Over 2.5 times the proportion of Hispanic/Latinos, compared to Whites, have not had a blood stool test to check for colon cancer (58.4% vs. 21.7%). Over 30% of the adults in the lower income groups (0-\$24,999 and \$25,000-\$49,999) are more likely to report not having had a blood stool test for cancer. Younger adults are more likely to report not having a blood stool test to check for colon cancer. Adults who did not complete high school are more likely to report they have not had a blood stool test to check for colon cancer. Not having a blood stool test is equally prevalent among men and women.

A blood stool test may involve a kit for at-home use to determine whether the stool contains blood, which can be an indicator of colorectal disease. Approximately 52% of respondents have used a home kit to check for blood in their stool, while 48% or 145,911 adults 50+ have not used a home kit. Of those who had used a home kit, 52% have done so within the past year, while over 10% have not had one in the past five years.

¹ American Cancer Society, 2007, www.cancer.org/downloads/PRO/ColorectalCancer.pdf

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*



BREAST HEALTH

A mammogram is an x-ray exam of the breast to detect and evaluate breast abnormalities. A mammogram screening that finds small breast cancers early greatly improves a woman's chance for successful treatment. The National Cancer Institute recommends that women 40 and older have mammograms every 1 to 2 years. Women who are at higher than average risk of breast cancer should talk with their health care providers about whether to have mammograms before age 40 and how often to have them.

A clinical breast examination by a health professional (such as a doctor, nurse, nurse practitioner, or physician's assistant) is an important part of routine physical checkups, an important method of early breast cancer detection, and should be performed along with mammography. A woman should have a clinical exam at least every three years starting at age 20 and every year starting at age 40. A clinical breast exam may be recommended more frequently if there is a strong family history of breast cancer.

It is estimated there will be 1,010 new breast cancer cases, and 220 deaths, in Riverside County in 2007.¹ Breast cancer is the second leading cause of death in the United States in women. It is also second only to lung cancer as a cause of cancer death in women.² Women in the United States get breast cancer more than any other type of cancer except for skin cancer.³ The lifetime chance of having breast cancer is 1 in 8. The chance of dying from breast cancer is about 1 in 35.⁴

KEY FINDING:

An estimated 12,474 or 6.4% of the adult female population 40 years of age or older report they had never had a mammogram, thus not meeting the recommendation of yearly mammograms.

HARC results show that 6.4% of the adult female population over 40 years of age report never having had a mammogram. The CHIS Riverside County data for 2005 is 9.8% and for California data for 2005 is 8.8%.

Of the women 40 years and older who report having had a mammogram sometime during their life, 74.5% (134,748) were tested within the last year. However, 46,218 women 40+ have not had a mammogram in the past year. Of women 18 years and older who report having had a clinical breast exam, about three-quarters (76%) had an exam within the last year. However, 55,808 women 18 or older have not had a clinical breast exam in the past year.

¹ American Cancer Society. *California Cancer Facts & Figures, 2007*, www.ccrca.org/PDF/ACS2007.pdf

² American Cancer Society. *Overview: Breast Cancer 2007*, www.cancer.org/docroot/CRI/content/CRI_2_2_1X_How_many_people_get_breast_cancer_5.asp?sitearea

³ *Ibid*

⁴ *Ibid*.



The Healthy People 2010 Objective is to reduce deaths to 21.3 deaths per 100,000 females. Regular mammograms and clinical breast exams are important means towards achieving this objective.

**Time Since Last Mammogram and/or Clinical Breast Exam
Among Women Who Have Ever Had These Procedures**
(HARC, 2007)

	Weighted Percent	Population Estimates
Last Mammogram		
Within Past Year (Anytime Less Than 12 Months Ago)	74.5	134,748
Within Past 2 Years (1 Year But Less Than 2 Years Ago)	15.9	28,787
Within the Past 3 Years (2 Years but Less Than 3 Years Ago)	3.0	5,513
Within The Past 5 Years (3 Years But Less Than 5 Yrs Ago)	1.6	2,917
5 Or More Years Ago	5.0	9,001
Last Clinical Breast Exam		
Within Past Year (Anytime Less Than 12 Months Ago)	76.0	176,919
Within Past 2 Years (1 Year but Less Than 2 Years Ago)	13.9	32,281
Within the Past 3 Years (2 Years but Less Than 3 Years Ago)	4.0	9,249
Within The Past 5 Years (3 Years but Less Than 5 Yrs Ago)	1.8	4,105
5 Or More Years Ago	4.4	10,173

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.





GYNECOLOGICAL HEALTH

Pap Test

The Pap test (sometimes called a Pap smear) is a way to examine [cells](#) collected from the cervix (the lower, narrow end of the uterus). The main purpose of the Pap test is to detect cancer or abnormal cells that may lead to cancer. It can also find certain non-cancerous conditions, such as infection and inflammation.

Women should have a Pap test at least once every 3 years, beginning about 3 years after they begin to have sexual intercourse, but no later than age 21.¹ Pap tests and pelvic exams may detect abnormal cells that can lead to cancer.² Women ages 65 and older should talk with their doctor about whether a Pap test is still needed.³

KEY FINDING:	
Over 90% of women surveyed have had a pap smear; approximately 9% or 26,416 women have not.	<p>HARC results for 2007 show only 9.2% of women have not had a Pap Smear test. The CHIS Riverside County data for 2005 is 11.4% and the CHIS California data for 2005 is 10.0%. The Healthy People 2010 Objective is to increase the proportion of women 18 years of age and older who have a pap test to 97%.</p> <p>Of the 90.8% of women who responded they have had a Pap test, 15.3% have not done so in the past 3 years, as recommended.</p>

Hysterectomy

A hysterectomy is the second most common surgery among women in the United States. The most common is cesarean section delivery.⁴ Over 600,000 hysterectomies are performed yearly in the United States.⁵ One in three women undergoes a hysterectomy by age 60.⁶

KEY FINDING:	
Almost 28% of female residents, representing approximately 78,600 have had a hysterectomy.	<p>The HARC results show that 27.9% of women have had a hysterectomy. The CHIS Riverside data for 2005 is 28.2% and CHIS California data for 2005 is 20.0%. Over three times as many White women compared to Hispanic/Latino women have had a hysterectomy (35.3 vs. 11.6%). Having a hysterectomy is more likely to be reported by women who completed coursework beyond high school. From 22% to 31% of women in each income group report having had a hysterectomy. As women age, the likelihood of having a hysterectomy increases.</p>

¹ National Cancer Institute, www.cancer.gov/cancertopics/factsheet/Detection/Pap-test

² Ibid.

³ National Cancer Institute, www.cancer.gov/cancertopics/pap-tests-older-women

⁴ National Women’s Health Information Center., www.4women.gov/faq/hysterectomy.htm#a

⁵ Ibid.

⁶ Ibid.



PROSTATE CANCER SCREENING

KEY FINDING:	
<p>Hispanic/Latino males are more likely than White males to have <u>not</u> had a PSA test (70.6% vs. 17.6%) and more likely than White males to have <u>not</u> had a digital rectal exam (55.7% vs. 20.9%).</p>	<p>Prostate cancer can often be found early by testing the amount of prostate-specific antigen (PSA), in the blood. PSA blood tests alone do not give doctors enough information to distinguish between benign prostate problems and cancer, but higher levels of PSA indicate a probability of cancer.</p> <p>Prostate cancer may also be found on a digital rectal exam (DRE). The DRE is less effective than the PSA blood test in finding prostate cancer, but it can sometimes find cancers in men with normal PSA levels. For this reason, American Cancer Society guidelines recommend that when prostate cancer screening is done, both the DRE and the PSA should be used.</p> <p>Health care professionals should offer the PSA blood test and digital rectal exam yearly, beginning at age 50, to men who have at least a 10-year life expectancy.¹ Men at high risk, such as Black/African Americans and men who have a first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65), should begin testing at age 45.² Men at even higher risk (because they have several first-degree relatives who had prostate cancer at an early age) should begin testing at age 40. Depending on the results of this initial test for these very high-risk men, further testing might not be needed until age 45.³ Since the use of early detection tests for prostate cancer became fairly common (about 1990), the prostate cancer death rate has dropped ⁴ (32.5% in 10 years through 2003).⁵</p> <p>HARC results for 2007 show 28.2% (47,000) of males (40+) in Eastern Riverside County have not had a PSA Test. The CHIS Riverside County data for 2005 is 50.3% and CHIS California data for 2005 is 57.4%. Additionally, 27.5% (48,123) of males (40+) have not had a Digital Rectal Exam.</p>

DENTAL HEALTH

Proper oral and dental care impact our health and well being. Regular dentist visits and professional tooth cleaning (prophylaxis) detect early signs of oral health problems. Both monitoring and treatment help deter the development of dental cavities and periodontal (gum) disease. Lack of oral and dental care can lead to tooth loss, extreme pain, systemic health problems, and even death in rare cases.

One out of 20 middle-aged adults are missing all their teeth.⁶ Severe gum disease affects about 14% of adults aged 45 to 54 years.⁷ Over 40% of poor adults (20 years and older), compared to 16% of non-poor adults, have at least one untreated decayed tooth.⁸ Employed adults lose more than 164 million hours of work each year due to oral health problems or dental visits.⁹

¹ www.cancer.org/docroot/CRI/content/CRI_2_2_3X_How_is_prostate_cancer_found_36.asp

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ www.seer.cancer.gov

⁶ Center for Disease Control, www.cdc.gov/OralHealth/factsheets/adult.htm

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.



KEY FINDING:

Among Eastern Riverside County adults, 30% or 166,592 residents have not seen a dentist or visited a dental clinic in the last year.

Approximately 30% of the adult residents of Eastern Riverside County have not seen a dentist or visited a dental clinic in the last year. Almost twice as many Hispanic/Latinos, compared to Whites, did not visit a dental professional in the last year (43% of Hispanic/Latino adults vs. 22.8% of White adults). Dental visits/visits to dental clinics within the past year are less common for respondents who report incomes below \$50,000. Adults below 45 years of age and less educated are more likely not to have visited a dental professional in the last year. A higher proportion of men than women has not seen a dental professional in the last year (35.2% vs. 26.3%).

**Time Since Last Dental Visit for Cleaning or Routine Check-up
(HARC, 2007)**

	Weighted Percent	Population Estimates
Less Than 6 Months	50.7	277,257
Six Months To Less Than One Year	18.9	103,199
One Year To Less Than 2 Years	9.5	51,976
Two Years To Less Than 5 Years	10.9	59,837
Five Or More Years Ago	8.3	45,660
Never	1.7	9,119
Total	100.0	547,049

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

CHOLESTEROL SCREENING

High blood cholesterol is a major risk factor for heart disease. Monitoring blood cholesterol can prevent or control high levels, along with consuming a diet low in saturated fat and cholesterol and high in fiber, exercising regularly, and maintaining a healthy weight. High cholesterol is often treated with lifestyle changes—a heart healthy eating plan, physical activity, and loss of excess weight—and, if those do not lower the cholesterol level enough, cholesterol-lowering medication may be prescribed.

All adults should have their cholesterol levels checked at least once every five years.¹ The desirable total cholesterol blood level measurement is less than 200mg/dL of blood [milligrams (mg) of cholesterol per deciliter (dL)].² The optimal Low Density Lipoprotein (LDL) Cholesterol level is less than 100 mg/dL.³

KEY FINDING:

Approximately 27% or an estimated 142,291 residents have never had their blood cholesterol checked.

26.9% of respondents have never had their blood cholesterol checked. This represents 142,291 residents of Eastern Riverside County. CHIS Riverside County data for 2005 reported 10.7%, and CHIS California data for 2005 reported 10.5%.

¹ Center for Disease Control, www.cdc.gov/heartdisease/prevention.htm

² National Heart Lung & Blood Institute, www.nhlbi.nih.gov/health/public/heart/chol/wyntk.pdf

³ Ibid.



Of residents who have had their blood cholesterol checked, 3% have not had it checked in more than 5 years. These residents, representing 11,644 residents, do not meet the CDC's recommendation to have the test once every five years. The HARC survey shows that 3% of adults have not had a blood cholesterol check in the past five years. The 2005 CHIS Riverside County data shows 3.1%, and CHIS California data for 2005 shows 3.9%.

Time Since Last Cholesterol Screening (In those who have ever had a screen) (HARC, 2007)

	Weighted Percent	Population Estimates
Within the past year (any time less than 1 year ago)	83.7	319,396
Within the past 2 years (1 year but less than 2 years ago)	9.2	35,088
Within the past 5 years (2 years but less than 5 years)	4.1	15,677
5 years or more years ago	3.0	11,644
Total	100.0	381,805

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.





ADULT HEALTH BEHAVIORS

ALCOHOL USE

In the United States alcohol is the most widely used psychoactive drug. Alcoholism is a disease which can cause physical dependence, loss of control, cravings, and tolerance. Alcoholism is attributed to family history as well as personal behavior.

One form of alcohol abuse is binge drinking. For men, binge drinking is the consumption of five or more drinks in a row; for women, binge drinking is consuming four or more drinks in a row. Moderate drinking is defined as no more than two drinks per day for men and no more than one drink per day for women.

It is estimated that binge drinking accounts for half of the 85,000 alcohol related deaths in the United States each year.¹ Approximately 92% of U.S. adults who drink excessively report binge drinking in the past 30 days.² 70% of binge drinking episodes involve adults over the age of 25.³ Episodes of binge drinking have increased since 1995 from 1.2 billion in 1993 to 1.5 billion in 2001.⁴

KEY FINDING:

Almost 10% of respondents report engaging in binge drinking once and 13.4% have engaged in binge drinking more than once in the past 30 days.

The 10% of respondents who indicated they participate in binge drinking more than once in the past 30 days represent over 29,000 residents of Eastern Riverside County. The 13.4% who reported they participate in binge drinking more than once represent over 40,000 residents.

Binge Drinking Behavior (Number of times in the past 30 days) (HARC 2007)

	Weighted Percent	Population Estimates
None	76.8	231,499
1	9.7	29,281
2	4.7	14,238
3 to 6	5.9	17,930
7 or more	2.8	8,462
Total	100.0	301,409

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

¹ Miller, J. W., et. al. (2004). Prevalence of adult binge drinking: A comparison of two surveys. *American Journal of Preventive Medicine*, 27(3), 197-204.

² The Centers for Disease Control and Prevention, www.cdc.gov/alcohol/quickstats/binge_drinking.htm

³ Ibid.

⁴ Nami, T. S., et. al. (2003). Binge drinking among U.S. Adults. *The Journal of the American Medical Association*, 289(1), 70-75.



KEY FINDING:

Over 7600 (2.5%) respondents reported that they have driven after having too much to drink within the past 30 days.

The Center for Disease Control reports that alcohol-related motor vehicle crashes kill someone every 31 minutes and nonfatally injure someone every two minutes (NHTSA 2006).¹ During 2005, 16,885 people in the U.S. died in alcohol-related motor vehicle crashes, representing 39% of all traffic-related deaths (NHTSA 2006).²

**Drunk Driving
(Within the past 30 days)
(HARC, 2007)**

	<i>Weighted Percent</i>	<i>Population Estimates</i>
None	97.5	299,078
1	1.0	3,162
2	1.0	3,045
3 to 6	.2	712
7 or more	.3	754
Total	100.0	306,751

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

¹Center for Disease Control, Injury Center, www.cdc.gov/ncipc/factsheets/driving.htm

² Ibid



TOBACCO USE

The most common use of tobacco is cigarette smoking. According to the Centers for Disease Control and Prevention (CDC) tobacco use kills nearly half a million Americans per year, with one in every six deaths the result of smoking. More than 4,000 toxic chemicals can be found in tobacco smoke; the most addictive is nicotine. As cigarette smoking is highly addictive, of the nearly 35 million smokers who want to quit each year, only about 6% are successful for more than a month. Though difficult to achieve, successful cessation of smoking has been linked to the nicotine patch and gum in conjunction with behavioral therapy.

It is estimated that 70.3 million Americans aged 12 and older currently use tobacco.¹ According to the National Institute on Drug Abuse, since 1964 nearly 12 million Americans have died prematurely from smoking; another 25 million U.S. smokers alive today will likely die of a smoking-related illness.² Smoking cigarettes has been linked to approximately 90% of all lung cancers, which is the number-one cancer killer of both men and women.³ Each year approximately 21% of deaths from coronary heart disease are linked to smoking.⁴

KEY FINDING:	
<p>Almost 14%, or 76,236 adults, in Eastern Riverside County, smoke cigarettes everyday or some days.</p>	<p>Almost 14% of adult respondents, or 76,236 residents, smoke cigarettes everyday or some days. Hispanic/Latinos report smoking cigarettes daily or on some days at a slightly higher rate (16.9%) than Whites (12.5%). Adults in the lower income groups are more likely to report they smoke cigarettes everyday or some days. Those in the 25-34 age group are more likely to report smoking cigarettes daily or on some days. Adults with less education are more likely to report they smoke cigarettes everyday or some days. Smoking cigarettes everyday or some days is equally prevalent among men and women.</p>

Frequency of Cigarettes Consumed
(HARC 2007)

	Weighted Percent	Population Estimates
Everyday	9.2	50,466
Some days	4.7	25,770
Not at all	86.1	473,104
Total	100.0	549,340

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

DRUG USE

Drug addiction, considered a disease, impacts the brain and causes changes in its structure and function. While the initial decision to use drugs is often voluntary, repeated use may affect one's self control and ability to make sensible decisions. While the use of drugs such as cocaine, marijuana, and heroin are widespread throughout the United States, of growing concern nationally is methamphetamine addiction. Trafficking and abuse of methamphetamines is on the rise, particularly in the Western states, and is considered a primary drug of concern in California.

In 2005, an estimated 2.9 million persons aged 12 or older used an illicit drug for the first time (within the past 12 months); averaging nearly 8,000 initiates per day.⁵ The average age of new methamphetamine users in 2005

¹ National Institute Drug Abuse. Research Report Series Tobacco Addiction,2007,

www.nida.nih.gov/researchreports/nicotine/nicotine.html

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Office of Applied Studies. National Survey on Drug Use & Health: National Results, 2005,

www.oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm#5.1



was 18.6 years. Within the adult population, methamphetamine use rose from under 2% in 1994 to approximately 5% in 2004.¹ National treatment data for the number of persons who entered treatment for methamphetamine abuse increased fivefold, from less than 1% in 1992 to over 6% in 2003.²

KEY FINDING:

Almost 11% of the respondents (59,313 adults) report using drugs in the past year.

Eight percent of respondents (43,677 residents) report they have used marijuana, 1% report using methamphetamine and 1% report using cocaine in the past 12 months.

Type of Drugs Used in Past 12 Months
(HARC 2007)

Drug	Weighted Percent	Population Estimates
Marijuana	8.0	43,677
Methamphetamine	1.0	5,574
Cocaine	1.0	5,200
Hashish	0.6	3,391
Heroin	0.1	741
PCP	0.1	730

*Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.
Note: Respondents could select more than one answer so a total percent is not provided.*

¹ Hunt, D., et. al. Methamphetamine Use. Lessons Learned, www.ncjrs.gov/pdffiles1/nij/grants/209730.pdf
² Ibid.



BIRTH CONTROL

The Centers for Disease Control and Prevention (CDC) reported in 2002 that the leading method of birth control for women under 30 is the birth control pill; female sterilization is the leading method for women 35 and older.¹ Ninety-eight percent of women between 15 and 44 years of age who have ever had sexual intercourse report using at least one method of contraception.²

KEY FINDING:	
<p>Over 1 in 3 adult residents (34.4%) report using the pill as their method of birth control.</p>	<p>Over 1 in 3 adult residents (34.4%) in Eastern Riverside County report using the pill as their method of birth control; the second largest proportion used condoms (25.7%).</p> <p>Of those adults not using birth control, 46% report they are not sexually active. For sexually active adults, the most common reasons for not using birth control are “not wanting” to use birth control and thinking they or their partner cannot get pregnant.</p> <p>Approximately 2% (2,985) of adults reported they were in need of birth control services in the past 12 months but were unable to get them. The majority (57.2%) indicated they could not obtain birth control services because the services are too expensive.</p>

**Type of Birth Control Method Used
Among All Adults Who Use Birth Control
(HARC, 2007)**

	Weighted Percent	Population Estimates
Pill	34.4	25,285
Condoms	25.7	18,946
Tubes Tied (Sterilization)	19.1	14,098
Vasectomy (Sterilization)	6.2	4,544
Shots (Depo-Provera)	7.0	5,149
Other (Specify)	6.1	4,507
Norplant	0.6	425
Rhythm Method	0.9	639
Total	100.0	73,718

Note: “Population Estimate” may not reflect actual population due to non-responses and/or rounding.

¹ Centers for Disease Control and Prevention, www.cdc.gov/nchs/data/ad/ad350FactSheet.pdf

² Ibid.



SEXUALLY TRANSMITTED DISEASES (STDs)

Sexually transmitted diseases (STDs), also known as sexually transmitted infections (STIs), are diseases which are spread through sexual contact. Sexually transmitted diseases are among the most prevalent infections found in the United States. They are often hard to diagnose because some have mild or no symptoms; even so, it is still possible for an infected person to pass on the disease to their partner. Over twenty viral or bacterial sexually transmitted diseases have been identified.

If diagnosed and treated early, most sexually transmitted diseases can be effectively treated. Health professionals recommend periodic testing or screening for those who have more than one sex partner. It is also recommended that a male or female condom be used not only to prevent the transmission of sexually transmitted diseases but also to prevent unwanted pregnancies.

More than 19 million women and men in the U.S. are infected with an STD.¹ Nearly half of all reported cases of sexually transmitted diseases occur in those between fifteen and twenty-four years of age.² Certain sexually transmitted diseases disproportionately affect women and people of color.³

KEY FINDING:	
<p><i>Of those men and women 18-45 years of age surveyed, 65.8% (101,218) do <u>not</u> use condoms for protection from sexually transmitted diseases.</i></p>	<p>Of those women and men between the ages of 18 and 45 surveyed, 65.8% (101,218) report they do not use condoms for protection from sexually transmitted diseases. Of those adults not using a condom with their partner to prevent STDs, nearly 80% (66,705) report they are in a monogamous relationship.</p>

Major Reasons for Not Using Condoms
(HARC 2007)

	<i>Weighted Percent</i>	<i>Population Estimates</i>
In a Monogamous Relationship	79.4	66,705
Do Not Like the Sensation	3.4	2,823
Do Not Like Condoms	3.3	2,801
Uncomfortable Putting On	2.6	2,166
Other Reasons	11.3	9,463
Total	100.0	83,958

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

¹ The National Institute of Allergy and Infectious Diseases, www3.niaid.nih.gov/healthscience/healthtopics/sti/default.htm

² Ibid.

³ Ibid.



AIDS/ HIV SCREENING

Acquired Immune Deficiency Syndrome (AIDS) was first reported in the United States in 1981. AIDS is caused by the Human Immunodeficiency virus (HIV) which can be transmitted in several ways, including but not limited to: having unprotected sexual intercourse with an infected person, receiving infected blood during a transfusion, receiving transplanted organs from infected donors, and by sharing or being accidentally stuck by needles or sharp objects contaminated with infected blood. It can also be transmitted from mother to child during child birth, pregnancy, or breastfeeding.

Though there is no cure for HIV/AIDS, the number of deaths from the disease has decreased as advancements in treatment have slowed the progression of HIV infection to AIDS. Treatments have also led to dramatic decreases in the rate of morbidity among persons with AIDS. Along with treatment efforts, HIV testing is important for prevention.

Since its discovery, more than 1.5 million people in the U.S. alone have been infected with HIV and 500,000 have died.¹ It is estimated that approximately 40,000 people in the United States become infected with HIV each year.² Latinos and Black/African Americans account for a disproportionate share of new HIV/AIDS diagnoses and deaths.³ Women account for a growing proportion of new AIDS diagnoses, increasing from 8% in 1985 to 27% in 2003.⁴

KEY FINDING:

About one-half of adults 18 to 64 have (49.6%) and have not (50.4%) been tested for HIV.

About one-half of adults 18 to 64 have (49.6%) and have not (50.4%) been tested for HIV. These represents 170,193 adults tested for HIV and 172,727 adults not tested for HIV. CHIS Riverside data for 2005 showed that 50% of adults have had an HIV test. CHIS California data for 2005 showed that 51.5% of Californians have had an HIV test.

Whites (52.4%) are more likely than Hispanic/Latinos (42.4%) to report they have had an HIV test. Overall, adults 18 to 64 with more education are more likely to report they have had an HIV test. Men and women are equally likely to report having had an HIV test (50.6% vs. 48.7%). Adults 25-34 are the most likely to report they have had an HIV test. No clear pattern emerges when looking at the proportion of adults in each income category that report having received an HIV test.

Approximately 7% or 25,713 adults reported that they had used intravenous drugs, been treated for a sexually transmitted or venereal disease, received money or drugs in exchange for sex, or had anal sex without a condom in the past year.

ADULT WEIGHT ISSUES

Increasing obesity is threatening the health of millions of Americans in the United States, According to the Centers for Disease Control and Prevention, obesity is an epidemic and should be taken as seriously as any infectious disease epidemic. Obesity and overweight are linked to the nation's number one killer--heart disease-- as well as diabetes and other chronic conditions.

While obese individuals need to reduce their own caloric intake and increase their physical activity, many others play a role in assisting these individuals in helping to prevent a further increase in obesity. Per the CDC health care providers should counsel their obese patients; workplaces should offer healthy food choices in their cafeterias and provide opportunities for employees to be physically active on site; schools should offer more

¹ Kaiser Family Foundation. Page 1, www.kff.org/hiv/aids/upload/Fact-Sheet-The-HIV-AIDS-Epidemic-in-the-United-States-2005-Update.pdf

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*



physical education that encourages lifelong physical activity; urban policymakers should provide more sidewalks, bike paths, and other alternatives to cars; and parents need to reduce their children's TV and computer time and encourage outdoor play. In general, restoring physical activity to our daily routines is critical. A national effort is needed to control the epidemic.¹

WEIGHT CONTROL

The United States Department of Agriculture (USDA) has developed Dietary Guidelines aimed at improving the health and well being of Americans. The Dietary Guidelines provide authoritative advice, for people two years of age or older, about how good dietary habits can promote health and reduce the risk of developing major chronic diseases.

According to the USDA, physical inactivity and poor diet are the most important factors contributing to the increase in overweight and obesity in the United States.² Regular physical activity is associated with decreased risk for obesity, heart disease, hypertension, diabetes, certain cancers, and premature mortality.³ It is recommended that adults engage in at least 30 minutes of moderate physical activity on most days—preferably on all days.⁴

KEY FINDING:

Approximately equal proportions of respondents are trying to lose weight (39.4%) and trying to maintain their weight (40.9%).

Approximately equal proportion of Whites (40.9%) and Hispanic/Latinos (37.7%) report they are trying to lose weight. The proportion reporting they are trying to lose weight increases as income increases. Between 28% and 46% of adults in all age categories report they are trying to lose weight; adults 55 to 74 are slightly more likely to report trying to lose weight. Between 38.1% and 44.9% of adults in each education category report trying to lose weight. Women are more likely than men to report they are trying to lose weight.

Of those adults trying to lose, or maintain their weight, nearly 73% are eating fewer calories and/or fat to accomplish this goal. The majority (68.8%) of respondents are using physical activity or exercise to lose weight; approximately 31% of respondents (136,583 residents) are not using physical activity or exercise to lose weight.

Hispanic/Latinos (32.7%) and Whites (29.3%) are equally likely to report they are not using physical activity or exercise to keep from gaining weight or to lose weight. Adults in the lower income groups are more likely to report they do not use exercise to control their weight. Adults 18-34 are the least likely, and adults 75 and older are the most likely, to report not using exercise to lose/maintain weight. Adults who did not complete high school are the most likely to report they do not engage in physical activity to keep from gaining or to lose weight.

¹ The Centers for Disease Control and Prevention. Obesity epidemic increases dramatically in the United States, www.cdc.gov/od/oc/media/pressrel/r991026.htm

² The United States Department of Agriculture. Dietary Guidelines for Americans, 2005, www.cnpp.usda.gov/DietaryGuidelines.htm

³ The Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, Nov. 30, 2007, 56(47), www.cdc.gov/mmwr/preview/mmwrhtml/mm5646a1.htm

⁴ Ibid.



OBESITY/BMI ANALYSIS

BODY MASS INDEX (BMI) ANALYSIS

Overweight is an excess amount of body weight which is made up of muscle, bone, fat, and water. On the other hand obesity is an excess accumulation of body fat. Adults may be measured using the Body Mass Index (BMI), the ratio of an individual's weight-to-height (weight in kilograms over the square of height in meters). Individuals with a BMI of 25-29.9 are considered "overweight" and those with a BMI of 30 or more are considered "obese."

Obesity is largely caused by two factors: poor nutrition and lack of physical activity. Poor nutrition refers to the consumption of foods high in calories and often with inadequate nutritional content. Individuals who are inactive do not burn all of these calories and unused calories are converted to fat.

According to the Mayo Clinic, two-thirds of American adults are overweight; one-third of these adults are considered obese.¹ Since the 1970's the prevalence of obesity among adults aged 20 to 74 has increased from 15% to 32.9% (as of 2004).² The estimated total cost of obesity in the United States in the year 2000 was about \$117 billion.³

The following results are from BMI estimates based on the self-reported height and weight of adult respondents to the 2007 HARC Eastern Riverside County survey.

KEY FINDING:

Based on calculated BMI, the majority (56.2%) of adults are overweight or obese; 17.9% are considered "obese" and 38.3% are considered "overweight." Together they represent over 270,000 Eastern Riverside County adult residents.

The majority (56.2%) of adults surveyed are overweight or obese; 17.9% are considered "obese" with a BMI of 30 or more. Those who are obese represent 86,110 Eastern Riverside County residents. An additional 38.3% are overweight and represent 184,066 residents. Together they total 270,176 overweight and obese adult residents.

¹ The MayoClinic.com, Tools for Healthier Lives, <http://mayoclinic.com/health/obesity/DS00314/DSECTION=1>

² The Department of Health and Human Services, www.cdc.gov/nccdphp/dnpa/obesity/index.htm

³ The Centers for Disease Control and Prevention, www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm



KEY FINDING:

Obesity disproportionately impacts Hispanic/Latinos, adults age 25-34 and 45-54, and those with lower income and lack of a high school diploma. Overweight disproportionately impacts adults age 35-54 and 65-74 and those with higher educational attainment. Overweight increases with income; obesity decreases with income.

Race/Ethnicity: Hispanic/Latino respondents were more likely than White respondents (23.1% compared to 14.5%) to have BMI scores in the obese range. Almost equal proportions of White (39.9%) and Hispanic/Latino (37.0%) respondents had BMI scores in the overweight range. Overweight is not strongly related to race/ethnicity, i.e., Whites and Hispanic/Latinos, in these data.

Age: The prevalence of having a BMI score in the overweight range is highest among respondents 35-44, and 65-74. The prevalence of having a BMI score in the obese range is greatest among respondents 25-34 and 45-54.

Income Level: Those earning less than \$25,000 annually were twice as likely as respondents earning \$75,000 or more (29.1% compared to 11.8%) to have a BMI considered “obese.” In general, the proportion of overweight respondents increases with income, while the proportion of obese respondents decreases with income.

Educational Level: Having a BMI score in the overweight range is most prevalent among those with a post graduate degree. Having a BMI score in the obese range is most prevalent among those who did not complete high school. Approximately 51% of those with a post graduate degree have a BMI score in the “overweight” category; at least one-third of respondents in the other categories are also classified as overweight. Nearly 29% of those without a high school diploma had a BMI score in the “obese” category; proportions are lower for respondents with more education.

Gender: Men are more likely than women to be overweight, while obesity does not seem to be related to gender in these data. Men (45.4%) are more likely than women (31.6%) to have BMI scores in the “overweight” range. Men (18.3%) are no more likely than women (17.6%) to have a BMI considered “obese.”

**BMI Analysis of Eastern Riverside County Residents
(HARC, 2007)**

BMI Analysis	Weighted Percent	Population Estimates
Underweight (<18.5)	1.8	8,505
Normal Weight (18.5 to 24.9)	42.0	202,229
Overweight (25.0 to 29.9)	38.3	184,066
Obese (≥30.0)	17.9	86,110
Total	100.0	480,910

Note: “Population Estimate” may not reflect actual population due to non-responses and/or rounding.



BMI Analysis of Overweight and Obese Residents
(HARC, 2007)

Demographics	Population Estimates Overweight	Population Estimates Obese
Race/Ethnicity		
White	123,612	45,053
Hispanic/Latino	46,115	28,778
Annual Household Income		
Less than \$25,000	16,768	17,128
\$25,000.00 to \$49,999	49,385	29,522
50,000.00 to \$74,999	35,745	12,808
\$75,000.00 or more	44,110	12,971
Age		
18 – 24	8,808	5,403
25 – 34	22,599	17,026
35 – 44	32,508	10,965
45 – 54	21,647	13,136
55 – 64	24,595	11,862
65 – 74	36,699	16,019
75 and over	37,208	11,698
Educational Level		
Did Not Complete High School	25,763	19,486
Grade 12 or GED	47,974	23,219
Coursework Beyond High School	45,000	25,508
College Degree	36,940	10,972
Post Graduate Degree	28,332	6,924
Gender		
Male	105,645	42,459
Female	78,420	43,651

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

KEY FINDING:

43.3% adults with BMI scores in the obese category are not physically active.

Approximately four in ten adults with BMI scores in the obese category (43.3%) are not physically active.

Regarding physical activity, one-quarter (24.7% or 135,820) adult residents indicate that they have not participated in any physical activities or exercise such as running, calisthenics, golf, gardening, or walking for exercise during the past month.



KEY FINDING:

More than half (55.5%) of overweight adults and 31.5% of obese adults are not currently trying to lose weight.

Regarding weight control, 60.7% (333,256) of ERC adult respondents indicated they are not currently trying to lose weight.

KEY FINDING:

Of those who do not use physical activity or exercise to lose/keep from gaining weight 39.2% are obese and 30% are overweight.

Nearly two in every five adults with BMI scores in the obese range indicated they do not use physical activity or exercise to lose or keep from gaining weight. This represents 32,035 residents.

KEY FINDING:

The majority of residents with BMI scores in the overweight (86.5%) and obese range (68%) were not advised about their weight.

The majority (85.0%) or 465,320 residents have not received advice about their weight from a health care professional in the past year. Of the 15% who have been counseled by their health care provider, 10.7% have been advised to lose weight.

Concern about the obesity epidemic is evident in The Healthy People 2010 Objective to increase the percent of people who are at a healthy weight to 60%.



OVERVIEW OF MAJOR CHRONIC CONDITIONS

Chronic conditions are the major cause of illness, disability, and death in the United States. Almost 100 million Americans have chronic conditions and millions more will develop them as America ages. Projections indicate that by 2040, almost 160 million people will have chronic conditions. The cost of medical care for Americans with chronic conditions was \$470 billion in 1995. By 2040 that cost could be as high as \$864 billion.¹ According to a study done by the Milken Institute, seven chronic diseases – cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental illness – have a total impact on the economy of \$1.3 trillion annually. Of this amount, \$1.1 trillion represents the cost of lost productivity.²

KEY FINDING:

The most prevalent major chronic diseases affecting Eastern Riverside adult residents are high blood pressure (176,531 adults), high blood cholesterol (150,625 adults), arthritis (135,614 adults) and mental health disorders (148,978) as diagnosed by their health care provider.

The top four most prevalent diagnosed chronic diseases in Eastern Riverside County are high blood pressure, high blood cholesterol, arthritis and mental health disorders. These chronic conditions and other major diseases are detailed in the following sections.

Prevalence of Major Diseases in Eastern Riverside County (HARC, 2007)

	Rank	Population Estimates
High Blood Pressure	1	176,531
High Blood Cholesterol	2	150,625
Mental Health Disorders	3	148,978
Arthritis	4	135,614
Cancer	5	51,337
Diabetes	6	50,118
Asthma	7	47,760
Heart Disease	8	41,195
Obesity	9	39,932
Bone Disease	10	36,040
Respiratory Disease or Emphysema	11	19,661
Stroke	12	14,576
Liver Disease	13	7,987
Tuberculosis	14	4,360

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

¹ National Academy on an Aging Society. *Chronic Conditions: A Challenge for the 21st Century*, www.agingsociety.org/agingsociety/pdf/chronic.pdf

² Milken Institute. *Annual Economic Impact of Chronic Disease On U.S. Economy Is \$1 Trillion*, www.milkeninstitute.org/newsroom/newsroom.taf?cat=press&level1=new&function=detail&ID=129



OBESITY/OVERWEIGHT

The Centers for Disease and Prevention (CDC) ranks obesity, after smoking, as the second leading cause of preventable death in the United States. Obesity accounts for approximately 112,000 excess deaths per year in the US relative to healthy weight individuals.¹ Obesity accounts for \$22.2 billion, or 19 percent, of the total cost of heart disease.²

Obesity has serious medical consequences. It can lead to increased risk for type 2 diabetes, hypertension, coronary heart disease, ischemic stroke, colon cancer, gall bladder disease, osteoarthritis, and obstructive sleep apnea.

KEY FINDING:

In Eastern Riverside County, 7.3% (39,932) residents have been diagnosed by their health care provider as being obese.

In Eastern Riverside County, 7.3% or 39,932 adults age 18 and older have been diagnosed as obese or overweight by their health care provider.

In general, an obesity diagnosis is as likely for Whites as it is for Hispanic/Latino (8.1% compared to 5.3%). Income and educational level does not seem to be related to an obesity diagnosis. Overall, obesity diagnoses increases with age and then declines for older adults aged 75 and over. Almost equal proportions of men and women are affected by diagnosed obesity (6% vs. 8.4%).

The Healthy People 2010 Objective is to reduce obesity to 15% of the population.



¹ National Institute of Health. *Weight Control Information Network, 2001*, <http://win.niddk.nih.gov/statistics/index.htm>

² Colditz, G.A. (1999). *Economic costs of obesity*. *Medicine & Science in Sports & Exercise*, S663-S667.



HIGH BLOOD PRESSURE

High blood pressure is often referred to as a “silent killer” because it usually has no symptoms until the individual is diagnosed with associated medical conditions or complications.



These medical conditions or complications include stroke, heart attacks, congestive heart failure, blood vessel damage (arteriosclerosis), kidney failure, brain damage, and/or loss of vision. Over 95% of high blood pressure is associated with no identifiable causes and may be related to genetic and environmental factors such as salt intake and stress. Sometimes high blood pressure is caused by another disorder.

Nearly one in three U.S. adults has high blood pressure, but because there are no symptoms, nearly one-third of these people do not know they have high blood pressure.¹ High blood pressure killed 54,186 Americans in 2004.

KEY FINDING:

Over 32% of Adults in Eastern Riverside County (176,500) have been diagnosed with high blood pressure.

More than 32% of the residents in Eastern Riverside County have been told by a doctor, nurse, or other health care professional that they have high blood pressure. This translates to an estimated 176,531 residents who have hypertension. The CHIS Riverside County data for 2005 is 30.4% and CHIS California data for 2005 is 24.8%.

Whites are more likely than Hispanic/Latinos to be diagnosed with high blood pressure (40.2% vs. 15%). Approximately 138,392 White adults are diagnosed with high blood pressure compared to 22,602 Hispanic/Latino residents. Older adults are more likely to have high blood pressure than those under 65. Over half of those 65-74 and those 75 and older have been diagnosed with high blood pressure. Adults with higher annual household incomes of \$75,000 or more are more likely to have high blood pressure than those with lower incomes. Women are somewhat more likely to be diagnosed with high blood pressure than men (52% vs. 48%).

¹ American Heart Association, 2002, www.americanheart.org/presenter.jhtml?identifier=2114



HIGH BLOOD CHOLESTEROL

High blood cholesterol contributes to high blood pressure, which is a major risk factor for heart disease. Risk factors for high cholesterol include age, gender, heredity, eating foods high in saturated fats and cholesterol, being overweight or obese, and/or lack of physical activity.

One in three (37.1%) or an estimated 101 million Americans have high blood cholesterol.¹ Everyone age 20 and older should have their cholesterol checked at least once every five years.²

KEY FINDING:	
One out of four adults (over 150,000 adults) report having been diagnosed with high blood cholesterol.	More than 27% of the adults who reside in Eastern Riverside County have been told by a doctor, nurse, or other health care professional they have high blood cholesterol. This translates to 150,625 residents. The CHIS Riverside County data for 2005 is 23.8% and CHIS California data for 2005 is 22.1%. The Healthy People 2010 Objective is to reduce the number of people with high blood cholesterol to 17%.

KEY FINDING:	
Twice as many Whites, compared to Hispanic/Latinos, have been diagnosed with high blood cholesterol (34.7% vs. 15.5%).	Age is a major factor affecting the likelihood of developing high blood cholesterol, with proportions ranging from a low of 1.2% of adults 18-24 years old to a high of 49.8% for adults 65-74 years old. In addition, twice as many Whites, compared to Hispanic/Latino adults, have been diagnosed with high blood cholesterol. Between 23% and 31% of adults in each income group report a diagnosis of high blood cholesterol. A diagnosis of high blood cholesterol is more likely to be reported by adults in the higher education categories. High blood cholesterol is equally as prevalent among men and women.

MENTAL HEALTH DISORDERS

Mental health disorders are common in the United States, and internationally. Mental health disorders include mood disorders (such as depression with or without suicidal thoughts, bipolar disorder, and schizophrenia), anxiety disorders (such as panic disorder, obsessive compulsive disorder, and post-traumatic stress), eating disorders, attention deficit hyperactivity disorder (ADHD), autism, and Alzheimer’s disease.

An estimated 26.2% of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year. They represent 57.7 million people in the United States.³ Even though mental illness is widespread in the population, the main burden of illness is concentrated in a much smaller population—about 6 percent, or 1 in 17, who suffer from a serious mental illness.⁴ The burden of mental illness on health and productivity in the United States and throughout the world has been underestimated.⁵

¹ American Health Association. *Update-At-a-Glance, 2007*, www.americanheart.org/downloadable/heart/1166712318459HS_StatsInsideText.pdf
² Heart Health – Check Your Cholesterol, http://findarticles.com/p/articles/mi_m1608/is_8_18/ai_89389710
³ National Institute of Mental Health, www.nimh.nih.gov/health/statistics/index.shtml
⁴ *Ibid.*
⁵ *Ibid.*



KEY FINDING:

Of all surveyed adults, the two most common diagnoses are: depressive disorders, 8.3% (45,276) and generalized anxiety disorders, 4.4% (24,101).

Survey respondents were asked in separate questions whether or not they had each of the following mental health disorders: depressive disorder, generalized anxiety disorder (GAD), panic disorder, phobia, post-traumatic stress disorder (PTSD), bipolar disorder, obsessive-compulsive disorder (OCD), schizophrenia or other. Respondents could select more than one answer.

KEY FINDING:

Approximately 22% of adults (121,752 people) have had an emotional, mental, or behavioral problem such as stress, anxiety, or depression that concerned them during the past 12 months.

Almost 122,000 adults in Eastern Riverside County have been concerned about an emotional, mental, or behavioral problem in the past year. Of these adults, Hispanic/Latinos are almost 1.5 times more likely than Whites to report having a mental health concern (26.2% vs. 17.9%). Those with annual household incomes under \$25,000 are the most likely to report mental health concerns (32.8%), followed by those with incomes of \$25,000 to \$49,999 (27.7%). Those with more education are less likely to report being concerned about their mental health. Women are slightly more likely than men to report concern for their mental health (24% vs. 20%). The prevalence of mental health concerns decreases with age.



KEY FINDING:

Of those who report being concerned about emotional, mental, or behavioral problems, approximately half did (49.2% or 60,226 adults) and half did not (50.8% or 62,105 adults) believe their problems were severe enough to need professional help.

Of those who report being concerned about emotional, mental, or behavioral problems, approximately half did (49.2%) believed their problems were severe enough to need professional help. Whites are more likely than Hispanic/Latino respondents to report needing professional help for their emotional, mental, or behavioral problem. Adults with annual household incomes of \$75,000 or more are more likely to report mental health concerns severe enough to need professional help. Adults 35-54 are more likely than older or younger respondents to report needing professional help. Those with a college degree are the most likely to report needing professional help. Women are somewhat more likely than men to report needing professional help for their mental health problem.

Of those with mental health concerns, approximately 28% (34,609 Eastern Riverside County residents) visited a mental health professional during the past 12 months.

Of those adults who did not receive treatment, the main reason provided by 56.8% or an estimated 10,343 adults was that the problem corrected itself. Almost one in five respondents (19.1%) reported they could not afford treatment.

Of those diagnosed with a mental health condition, approximately 35%, or 26,623 Eastern Riverside County residents, reported they are still bothered or concerned about their emotional, mental or behavioral problem. Of those still bothered by their problems, nearly 76% are currently receiving treatment and 24.4% are not receiving treatment.

**Main Reason Did Not Receive Mental Health Treatment
(HARC, 2007)**

	Weighted Percent	Population Estimates
Problem corrected itself	56.8	10,343
Could not afford it	19.0	3,455
No further Improvement expected	2.4	429
Could not find help	1.3	243
Shame, embarrassment	0.8	144
No services available	0.6	101
Other	19.1	3,479
Total	100.0	18,194

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.



ARTHRITIS

According to the Centers for Disease Control and Prevention (CDC), as many as 46 million, or nearly 1 in 5 adults in the United States, suffers from arthritis.¹ Arthritis is the leading cause of disability among Americans over age 15. It is second only to heart disease as a cause of work disability.² Arthritis limits everyday activities such as walking, dressing, and bathing for more than 7 million Americans. Arthritis-attributable activity limitation is expected to increase in the future with the aging of the population.³

KEY FINDING:

One out of four adults (over 135,000 adults) report having been diagnosed with arthritis.

One out of four (24.8%, or 135,614 adults) report having been told by a doctor, nurse, or other health care professional that they have arthritis. The CHIS Riverside County data for 2001 is 24.2% and CHIS California data for 2001 is 20% for adults 18 and older.

Over three times as many Whites as Hispanic/Latinos report an arthritis diagnosis. Arthritis is more likely to be reported by those adults earning less than \$25,000 per year and by those adults earning between \$50,000 and \$74,999. Older adults, especially those 75 years and over, are more likely to have arthritis. Likewise, a higher proportion of women report an arthritis diagnosis.

About 21% (28,644 adults) of those with arthritis indicate that their doctor or other health professional suggested an educational course or class to teach them how to manage problems related to their arthritis or joint symptoms. Slightly more residents (29.8% or 39,747) reported their doctor or other health professional suggested losing weight to help their arthritis or joint symptoms. Over 38% of those with arthritis indicated their doctor or other health professional suggested over-the-counter supplements such as glucosamine. The largest proportion (59%, or 79,424 residents) reported their doctor or another health professional suggested physical exercise to help their arthritis or joint symptoms.



¹ Centers for Disease Control and Prevention. *Arthritis - Data and Statistics*, 2005, www.cdc.gov/arthritis/datastatistics/index.htm

² Arthritis Foundation. *Learn about Arthritis*, www.arthritis.org/learn-about-arthritis.php

³ *Ibid*



CANCER

In 2004, cancer was the number two cause of death in the United States, comprising 23.1% or 553,888 deaths.¹ Nearly one out of every two Californians born today will develop cancer in their lifetime; it is likely one in five will die from the disease.²

Family history has been shown to be associated with a slightly higher risk of cancer. Other factors include life-style and health behaviors and exposure to carcinogens. Since cancer is best treated early before it spreads to other parts of the body, screening for cancer is highly recommended.

KEY FINDING:

Over 51,000 adults, or almost 9% of the adult Eastern Riverside County population, have been told they have cancer.

Approximately 9.3% or 51,337 adults have been told by a doctor, nurse, or other health care professional they have cancer. The CHIS Riverside County data for 2005 is 11.5% and CHIS California data for 2005 is 8.7% for adults 18 and older.

More than five times as many White residents as Hispanic/Latino residents report being diagnosed with cancer (13.3% vs. 2.6%). Adults with higher levels of education are more likely to report being diagnosed with cancer than those with lower levels of education. Adults 55 and older are more likely to have cancer than those under 55. Comparing residents of different incomes reveals no clear pattern. Likewise, cancer was not related to gender in these survey data.

The Healthy People 2010 Objective is to reduce the incidence of cancer deaths to 159.9 per 100,000.

DIABETES

Diabetes is a group of diseases marked by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. Diabetes can lead to serious health complications such as heart disease, blindness, kidney failure, lower extremity amputations, and premature death.

There are three main types of diabetes: Type I, Type II and gestational diabetes. Type I diabetes is an autoimmune disease in which the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin a hormone that regulates the metabolism of sugars and other nutrients. This type of diabetes usually strikes children and young adults and has been referred to as "juvenile diabetes." Type I diabetes accounts for 5-10% of all diagnosed cases of diabetes. Individuals with Type I diabetes, previously called insulin-dependent diabetes mellitus, must take insulin daily to live.

In 2002, 54 million American adults 20 and older had pre-diabetes, as measured by impaired fasting glucose levels, a blood test that measures the rate of glucose metabolism.³ In 2005, approximately 20.8 million people, or 7.0% of the United States population, had diabetes. This prevalence estimate includes 6.2 million not yet diagnosed.⁴ In 2005, 1.5 million new cases of diabetes were diagnosed in people aged 20 years or older.⁵

¹ Centers for Disease Control and Prevention. *National Vital Statistics Reports, 55, (19)*, www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_19.pdf

² California Cancer Registry, www.ccrca.org/PDF/ACS2007.pdf

³ The Centers for Disease Control and Prevention. National Diabetes Fact Sheet: Information and National Estimates on Diabetes in the United States, Atlanta, GA, 2005.

⁴ *Ibid.*

⁵ *Ibid.*



KEY FINDING:

Almost 1 in 10 Eastern Riverside County adults (50,118 adults) have been diagnosed with diabetes.

Nearly 10% or 50,118 adults were told by a doctor or other health practitioner they have diabetes. This total does not include those diagnosed with gestational diabetes, pre-diabetes, and borderline diabetes, (which indicates a probability of developing diabetes). The CHIS Riverside County data for 2005 is 8.5% and CHIS California data for 2005 is 7.0% for adults 18 and older.

KEY FINDING:

Diabetes disproportionately impacts less educated (16.2%) and lower income adults (14.2%) than those that are better educated and have higher annual household incomes.

Those adults with lower annual household incomes (under \$25,000) are more likely to be diagnosed with diabetes than are those with higher incomes. Diabetes is also most prevalent among those who have not completed high school. Whites are only slightly more likely than Hispanics/Latinos to report being diagnosed with diabetes (10.2% vs. 8.6%). The prevalence of diabetes is highest among adults 45-54, 65-74, and 75+.

Over 24,000 or half of the adults currently receiving treatment for diabetes were diagnosed when they were 55 or older. Another 18,425 or 38.6% were first diagnosed between the ages of 35 and 54.

KEY FINDING:

Of those currently receiving treatment for diabetes, 10% (3,893 adults) have never had their hemoglobin A1C blood test to measure long-term glucose levels; 44.3% (21,199 adults) have never had their feet examined for sores or irritations, and 3.4% (1,645 adults) have never had an eye exam with pupil dilatation.

Since diabetes can lead to serious health complications such as heart disease, blindness, kidney failure, lower extremity amputations, and premature death, preventive exams and treatment are especially important for those diagnosed with diabetes.

Almost 58%, or 23,493 adults, currently receiving treatment for diabetes had been checked one to three times for hemoglobin A1C in the past year. However, nearly 10%, or 3,893 adults, have never been checked for hemoglobin A1C. To watch overall glucose control, the A1C level should be measured at least twice a year, according to the American Diabetes Association.¹

About 44%, or 21,199 adults, currently receiving treatment for diabetes indicated their health professional had never, in the past year, checked their feet for sores or irritations. Over 33% or 16,139 indicate they had been checked one to three times in the past year.

Almost 42%, or 20,292 adults, currently receiving treatment for diabetes have had an eye exam with pupil dilatation within the last year. Approximately 3%, or 1,645 residents, have never had this procedure performed. About 14% of adults with diabetes indicate the disease is affecting their eyes or they have retinopathy, a serious eye abnormality that can lead to blindness. This translates to 7,044 adults who reside in Eastern Riverside County.

¹ www.diabetes.org/type-1-diabetes/a1c-test.jsp



Types and Frequency of Education for Diabetes
(HARC, 2007)

Reasons	Weighted Percent	Population Estimates
Hemoglobin A1C Checked		
Never	9.6	3,893
1 to 3 Times in the Past Year	57.9	23,493
4 to 6 Times in the Past Year	24.2	9,817
7 or More Times in the Past Year	8.3	3,350
Feet Checked		
Never	44.3	21,199
1 to 3 Times in the Past Year	33.7	16,139
4 to 6 Times in the Past Year	19.2	9,171
7 or More Times in the Past Year	2.7	1,291
No Feet	0.2	77
Eyes Examined		
Never	3.4	1,645
Within the Past Month	33.7	16,512
Within the Past Year	41.5	20,292
Within the Past 2 Years	11.1	5,418
2 or More Years Ago	10.3	5,018

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

KEY FINDING:

Although two-thirds of adults (33,190) being treated for diabetes have taken a course or class in how to self-manage their diabetes, one-third (16,928) have not taken a diabetes self-care management class.

Two-thirds of those surveyed and being treated for diabetes have taken a diabetes self-care management course or class. However, one-third (33,190 residents) have not taken any course or class to help them better manage their diabetes and minimize diabetes-related complications.

ASTHMA

Asthma is a chronic inflammatory lung disease characterized by recurrent episodes of breathlessness, wheezing, coughing, chest tightness or shortness of breath. Asthma is a disease with a genetic predisposition and a strong allergic component. Approximately 75-80% of those with asthma have significant allergies. Another factor contributing to the development of asthma is being overweight or obese.

Although asthma is a disease of all age groups, the largest recent increases in asthma cases have been among the young. Asthma attacks tend to decrease with age. If not properly managed, asthma can be a life-threatening disease.



KEY FINDING:

Over 47,000 adults or almost 9% of the adult population have been diagnosed with asthma.

More than 8% of adults have been told by a doctor, nurse, or other health care professional they have asthma. This translates to 47,760 Eastern Riverside County residents. The CHIS Riverside County data for 2007 is 13.3% and CHIS California data for 2007 is 12.7% for adults 18 and older.

In Eastern Riverside County, adults in the lowest income category (0-\$24,999) are twice as likely to report an asthma diagnosis as are residents in the higher income categories. Those adults 18-24 years old are the most likely to be diagnosed with asthma (16.7%), followed by adults 35-44 years old (12.7%). Less educated respondents report slightly higher levels of asthma diagnoses than those with more education. Asthma does not seem to be related to race/ethnicity or gender.

In the past 12 months, approximately 11% of adults (representing 5,318 residents) had an episode of asthma or an asthma attack that required them to visit an emergency room or urgent care center.

HEART DISEASE

Heart, or cardiovascular disease, refers to a variety of abnormal conditions of the heart. The most common type of heart disease is coronary artery disease (CAD) which is a result of a condition called atherosclerosis. Complications of coronary artery disease include angina, which is chest pain when part of the heart is not getting enough blood, or heart attack, which occurs when all or most of the blood supply to part of the heart is suddenly cut off. Risk factors for CAD include age, family history of heart disease, high blood cholesterol, high blood pressure, smoking, diabetes, being overweight, poor diet, and/or lack of physical activity.

Heart disease is the leading cause of death in the United States. In 2004, 27.2% of all deaths, or 652,486 deaths, were attributed to heart disease.¹ According to the National Institute of Health (NIH), there are 79.4 million individuals in the United States with cardiovascular disease (CVD).²

KEY FINDING:

Over 41,000 adults or 7.5% of the adult population have been diagnosed with heart disease.

Nearly 8%, or 41,195, of the adults of Eastern Riverside County indicate they had been told by a doctor, nurse, or other health care professional that they had heart disease. The CHIS Riverside County data for 2005 is 9.9% and CHIS California data for 2005 is 6.2% for adults 18 and older.

¹ Centers for Disease Control and Prevention. *Cause of Death, 2004*, www.cdc.gov/nchs/data/dvs/LCWK2_2004.pdf

² National Heart, Lung, and Blood Institute. *Chartbook, 2007*, www.nhlbi.nih.gov/resources/docs/07-ctbk.pdf



KEY FINDING:

Whites are over three times as likely as Hispanic/Latinos to be diagnosed with heart disease (9.8% vs. 3.1%).

Whites are much more likely to be diagnosed with heart disease than Hispanic/Latinos. Heart disease strikes men almost twice as often as women (10.1% vs. 5.3%). Those with a higher education (coursework after high school and beyond) are more likely to be diagnosed with heart disease.

Approximately 10.9% of those in the lowest income category (0-\$24,999) are likely to be diagnosed with heart disease compared to 5.8-7.9% in the other income categories. Heart disease increases with age, affecting 17.2% of adults 75 and older.

KEY FINDING:

Approximately 4.6% or 26,272 adults have had a heart attack or myocardial infarction.

Almost 5% of the adults who reside in Eastern Riverside County been told by a doctor, nurse, or other health care professional that they have had a heart attack, or myocardial infarction.

Again, Whites are more likely than Hispanic/Latinos to report a heart attack (6.2% vs. 2.9). Of those having a heart attack, 68.5% are men and 31.5% are women. Approximately 4% to 6% of adults in each educational attainment category report having had a heart attack. Heart attacks or myocardial infarctions increase with age. Having a heart attack does not seem to be related to income.

Approximately 35%, or 8,839 adults, who had a heart attack went to outpatient rehabilitation after leaving the hospital, while over half (52.3%) did not. The rest (12.6%) indicated they were not hospitalized.

BONE DISEASE

The most common type of bone disease is osteoporosis, which is a skeletal disorder characterized by decreased bone density, often leading to an increased risk of fracture.

According to the National Institutes of Health (NIH), 10 million individuals have osteoporosis and another 34 million have low bone mass placing them at risk for osteoporosis.¹

KEY FINDING:

Over 6,000 adults or almost 6% of the adult population have been diagnosed with bone disease.

Over 6% of adults, representing 36,040 Eastern Riverside County residents, have been told by a doctor, nurse, or other health care professional they have bone disease or osteoporosis.

More White residents, compared to Hispanic/Latino residents, report a diagnosis of bone disease (28,684 Whites vs. 5,336 Hispanic/Latinos). Those with annual household incomes under \$25,000 are more likely to be diagnosed with bone disease or osteoporosis. The prevalence of bone disease increases with age. Females are three times more likely than males to report being diagnosed with bone disease or osteoporosis (9.6% vs. 3.2%). A diagnosis of bone disease or osteoporosis does not seem to be highly related to educational attainment.

¹ National Institute of Health Osteoporosis and Related Bone Diseases. *National Resource Center, 2006*, www.niams.nih.gov/Health_Info/Bone/Osteoporosis/overview.pdf



RESPIRATORY DISEASE/EMPHYSEMA

Respiratory diseases primarily affect the lungs, causing difficulty breathing and a decreased supply of oxygen to the body through the bloodstream. Chronic obstructive pulmonary disease (COPD), a category of lung diseases, refers to two related diseases: chronic bronchitis and emphysema.

Emphysema, characterized by loss of elasticity of the air spaces in the lungs, is a major cause of death and disability. It is the fourth leading cause of death in the United States, accounting for over 100,000 annual deaths, yet it is not a highly publicized disease. Smoking is a major risk factor and cause of emphysema.¹ Approximately 16-30 million people are currently affected by emphysema in the United States.²

KEY FINDING:

While the prevalence is lower than other chronic diseases, over 19,000 adults have been told they have respiratory disease or emphysema.

3.6% of respondents have been told by a doctor, nurse, or other health care professional they have emphysema.

STROKE

Stroke is the third leading cause of death in the United States and a leading cause of serious long-term disability. Over 160,000 people die each year from a stroke in the United States.³ According to the Centers for Disease Control and Prevention (CDC), about 700,000 strokes occur in the United States each year. About 500,000 of these are first or new strokes. Nearly three-quarters of all strokes occur in people over the age of 55.⁴ According to American Stroke Association figures, someone in the United States has a stroke every 53 seconds and someone dies of one every 3.1 minutes. The direct and indirect costs for stroke in the United States in 2002 approached \$50 billion.⁵

KEY FINDING:

There are approximately 14,500 adults in Eastern Riverside County who have had a stroke.

Almost 3%, or 14,576 residents, have been told by a doctor, nurse, or other health care professional that they have had a stroke. The CHIS Riverside County data for 2005 is 3.9% and CHIS California data for 2005 is 2.3%.

¹ National Emphysema Foundation, www.aemphysemafoundation.org:9001/nefusa/

² Ibid.

³ Centers for Disease Control and Prevention. *Stroke facts and statistics, 2005*, www.cdc.gov/stroke/stroke_facts.htm

⁴ Ibid.

⁵ American Heart Association. *Stroke - America's No. 3 killer, 2002*, www.americanheart.org/presenter.jhtml?identifier=3002566



Highlights and Key Findings

Senior Health (Age 55+)

Older adults represent the fastest growing segment of society. A century ago, one in every 100 Americans was over the age of 65. In 2000, the number of older adults totaled 35 million or one in every 8 Americans. By 2030, when the youngest Baby Boomers will be 65, the number of older adults is expected to double.

DEMOGRAPHICS OF RIVERSIDE COUNTY SENIORS (AGE 55+)

Based on U.S. Census and California Department of Finance estimates, seniors aged 55 and older make up slightly more than 27% of the population of Eastern Riverside County. The population is almost equally divided among the 55 to 64, 65 to 74, and 75+ age groups with the 75+ age group being slightly less than the other two (34.5%, 34.8%, and 30.7% respectively).

Within Riverside County as a whole, the percentage of White seniors increases as the age group increases while the percentage of Hispanic/Latino seniors decreases. Therefore, the younger population has more Hispanic/Latinos. Almost one quarter of the 55 to 64 age group is Hispanic/Latino.

Senior Age Distribution by Ethnicity/Race

	White	Hispanic/ Latino	Black/ African American	Other	Total
Age 55-64	63.5%	23.6%	6.1%	6.7%	100.0%
Age 65-74	68.7%	19.8%	5.5%	6.0%	100.0%
Age 75+	79.9%	12.5%	3.4%	4.2%	100.0%

HARC 2007 COMMUNITY HEALTH MONITOR – SURVEY RESPONDENTS

The tables below show the percentage of responses for each question and the estimated population that those responses represent. Population estimates are derived using the most recent population numbers available for the region. They are calculated using a statistical weighting method that allows the survey data to more accurately reflect the entire population of Eastern Riverside County.

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS (AGE 55+)

Almost 90% of the respondents 55 and older self-report being White.

Demographics (55+): Race (HARC, 2007)

	Weighted Percent	Population Estimates
White	89.2%	245,578
Hispanic/Latino	7.6%	20,824
Black/African American	1.7%	4,581
Other	1.5%	4,266
Total	100.0%	275,249

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.



The majority (61.7%) report being married with the second largest group (14.7%) being widowed. More than 93% of those seniors responding report being U.S. citizens. Of the 6.5% who are not citizens, 66.2% report being permanent residents. Of the 33.8% who are not citizens or permanent residents, a small number report having temporary visas.

Demographics (55+): Marital Status, Citizenship Status
(HARC, 2007)

	<i>Weighted Percent</i>	<i>Population Estimates</i>
Marital Status		
Married	61.7%	172,222
Single, Never Married	9.8%	27,319
Divorced	11.2%	31,129
Widowed	14.7%	40,997
Separated	1.1%	3,020
Cohabiting	1.5%	4,267
Total	100.0%	278,954
Citizenship Status		
U.S. Citizen	93.5%	260,273
Permanent Resident (of the 6.5% who are not citizens)	66.2%	7,590
No Temporary Visa (of the 33.8% who are not permanent residents)	90.9%	9,802

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS (AGE 55+)

Over 90% of seniors 55 and older report having graduated from high school. Over 70% report having some college or being college graduates.

Socioeconomic Characteristics (55+): Education
(HARC, 2007)

	<i>Weighted Percent</i>	<i>Population Estimates</i>
Less than high School	9.1%	25,393
High School Grad or GED	19.3%	54,059
Some College	28.3%	79,305
College Degree	28.4%	79,451
Postgraduate Degree	14.8%	41,534

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.



Nearly 70% of the seniors report being retired while an additional 21% are employed for wages or self-employed. About 41% of senior households have an income of less than \$50,000. Nearly one quarter have incomes between \$50,000 and \$75,000. Over 1/3 have incomes greater than \$75,000. Most (88.3%) of senior households report owning their homes. Over one quarter (27.1%) report having only one person in the household. Nearly 2/3 report being 2 person households.



Socioeconomic Characteristics (55+): Employment, Household Income, Housing
(HARC, 2007)

	Weighted Percent	Population Estimates
Employment Status		
Retired	69.2%	192,715
Employed for Wages / Self - employed	21.0%	58,604
Homemaker	5.3%	14,769
Unable to Work	2.8%	7,735
Unemployed	1.7%	4,827
Household Income		
Less than \$25,000	13.5%	27,553
\$25,000 - 49,999	27.6%	56,389
\$50,000 - 74,999	24.9%	50,821
\$75,000 or More	34.0%	69,551
Housing Characteristics		
Own	88.3%	244,272
Rent	11.7%	32,425
1 person in Household	27.1%	74,384
2 persons in Household	64.4%	177,022
3 or more in Household	8.5%	23,427

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

HEALTH COVERAGE (65+)

Lack of health insurance coverage is of major concern to seniors, especially those 65 and older (of whom, many qualify for Medicare at age 65). Lack of health insurance coverage prevents many seniors from accessing needed health care.

About 354,000 uninsured adults 65 years and older in the United States—approximately 1.1% of the country's seniors—had no health insurance in 2000. Almost three quarter (72.3%) of the uninsured seniors were aged 65 to 74; 24.3% were 75 to 84; and 3.4% were 85 or older.¹

Although, the vast majority of seniors 65 and older in Eastern Riverside County have health care coverage; 2.8% or 5,607 do not have any health insurance coverage at all. CHIS Riverside County data for 2005 is 1.1 % and CHIS California for 2005 is 0.7% for adults age 65 and older.

¹ American Academy of Family Physicians. *Surprising Number of U.S. Elders Do Not Have Health Insurance Coverage - Not Even Medicare*, www.aafp.org/online/en/home/press/aafpnewsreleases/april/seniorsinsurance.html



KEY FINDING:

Over 28,000 Eastern Riverside County seniors 65 and older lack Medicare Part B coverage and over 41,000 lack Medicare Supplemental Insurance.

A large number of Eastern Riverside County seniors have Medicare Part A coverage but do not have Medicare Part B and/or Medicare Supplemental Insurance. While Medicare Part A helps pay for in-patient hospital stays, skilled nursing facilities, limited home health, and hospice care, Medicare Part B helps pay for doctors' services and outpatient hospital services and requires a monthly premium. Over 16%, or an estimated 28,192 senior residents, report that they do not have Medicare Part B. Lack of Medicare Part B is higher among Hispanic/Latinos than Whites, adults age 75 and older, and those without a high school diploma.

Medicare supplemental insurance, also referred to as Medigap, provides supplemental coverage for many of the medical expenses not covered by Medicare. Although more than 3 out of 4 senior respondents 65+ indicate they have supplemental insurance; 22.3%, or an estimated 41,118 residents, do not have supplemental insurance. Hispanic/Latinos are almost three times more likely than Whites to be without supplemental insurance coverage. In general, lack of supplemental insurance coverage is more prevalent for senior residents with less education and incomes under \$50,000. Seniors 65-74 are no more likely than seniors 75+ to report they are without supplemental insurance coverage. Men and women are equally likely not to have supplemental insurance coverage.

HEALTH STATUS (55+)

Older adults are living longer, developing more chronic conditions, and experiencing a higher prevalence of functional limitations as they age. Maintaining good health enables older adults to remain independent, stay socially engaged, and enjoy a good quality of life.

KEY FINDING:

While most older residents enjoy "good", "very good", or "excellent" physical health, over 43,000 older residents say their health is only "fair" or "poor."

To measure general health, Eastern Riverside County residents age 55 or older were asked to assess their own health status as "excellent," "very good," "good," "fair," or "poor." Approximately one in six older adults age 55 or older rate their overall health status as "fair" or "poor." This represents 16% of the residents. The result reported by CHIS for Riverside County 2005 is 33.1% and CHIS California 2005 is 28.1% for adults aged 55 or older.

Of those residents rating their health as "fair" or "poor," the largest proportion (36.6%) cite chronic illness as the main reason for their poorer health, followed by physical disabilities (24.1%), and severe illnesses (23.4%). Only 7% thought their health was "fair" or "poor" because of old age.



NUTRITION (55+)

Nutrition is a fundamental element of healthy human development and a vital contributor to the overall health of seniors. The survey found that almost 7,000 or 3% of seniors age 55 or older are not getting enough to eat on a daily basis.

KEY FINDING:

Almost 7,000 seniors report they are not getting adequate nutrition on a daily basis.

Nutrition is a fundamental element of healthy development and a vital contributor to the overall health of seniors. Healthy eating provides essential energy and nutrients for general well being, maintenance of health and functional autonomy, and prevention of chronic diseases at older ages. Combined with physical activity, good nutritional status is a key element for seniors to remain independent, maintain their quality of life, and avoid progression of chronic conditions.

Seniors over 60 years of age who meet the eligibility requirements may receive a meal subsidized by the federal government under the Older Americans Act. The meals are provided at the community level for those who are homebound. Local providers that deliver meals to the homebound elderly are oversubscribed; 40% nationwide and 30% in California have waiting lists. At the same time, senior centers are struggling to entice 60 and 70-year-olds to come in and dine.¹

BODY MASS INDEX (55+)

KEY FINDING:

Based on computed Body Mass Index, over half of older adults in Eastern Riverside County (an estimated 138,082 seniors) are overweight or obese.

Based on self-reported height and weight, the computed Body Mass Index indicates that over half (54.8%) of the seniors in Eastern Riverside County are overweight (39.1%) or obese (15.7%). This translates into 98,503 seniors who are overweight and 39,579 seniors who are obese. Almost 40%, or an estimated 110,211, of all Eastern Riverside County seniors are trying to lose weight and an additional 43.2%, or an estimated 120,790, seniors are trying to maintain their current weight. Of the senior residents who are trying to lose or maintain their weight, 72.4% or an estimated 158,287 seniors are eating fewer calories and/or less fat and almost 67% or an estimated 153,016 are using physical activity or exercise. In the past 12 months, only 14% of seniors 55 and over have been given advice about their weight from a doctor, nurse, or other health professional.

DAILY CARE (55+)

Seniors who live alone sometimes need assistance with the activities of daily living (ADLs). Activities of daily living, sometimes referred to as personal care needs, are the basic tasks of everyday life such as eating, bathing, dressing, toileting, and transferring oneself from place to place. Inability to perform the ADLs are significant predictors of increased use of home health and inpatient hospital services; changes in living arrangements; admissions to a nursing home; and increased mortality for seniors.

¹ Meals on Wheels Association of America, *Meals and Wheels, Articles*, www.mowaa.org/displayContent.asp?MemberNo=5E5C58&type=&CurrentNo=5E5C57

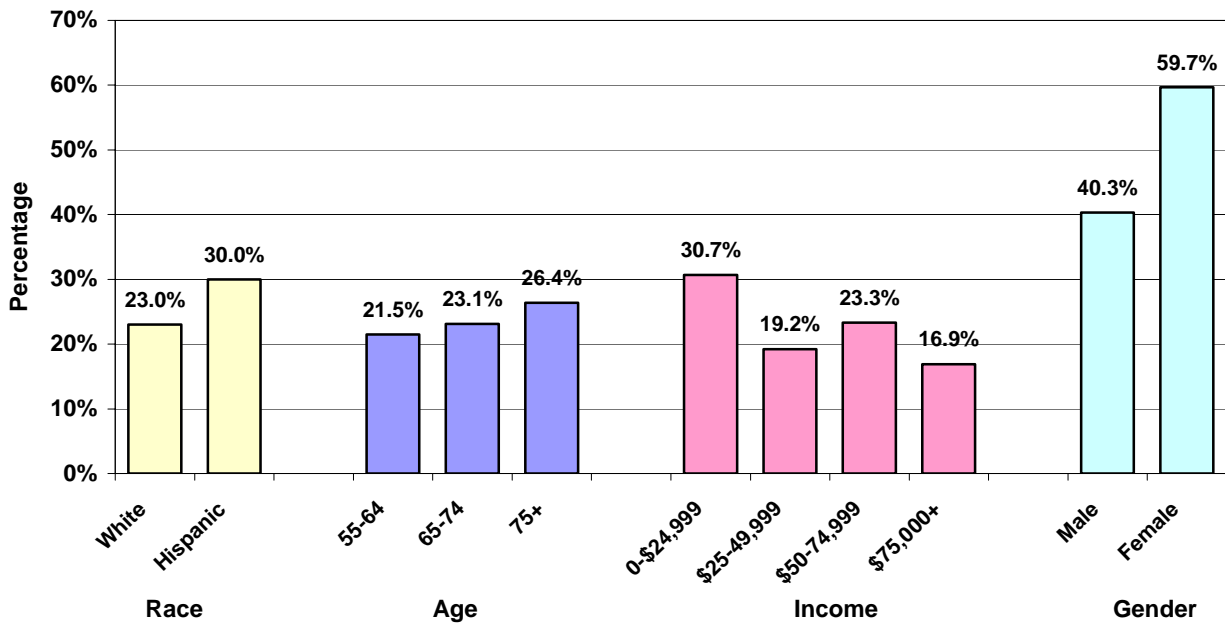


KEY FINDING:

Nearly one quarter, or an estimated 62,800, of the older adults who need assistance do not have someone to assist them.

An estimated 62,800 (23.8%) of the older adults in Eastern Riverside County who need assistance do not have someone to assist them. In particular, Hispanic/Latino older adults are more likely than White older adults to report not having someone to assist them when they needed help (30% vs. 23%). In addition, seniors with the lowest annual household income (0-\$24,999) have the highest prevalence (30.7%) of not having someone available to assist them. Women, compared to men, are more likely not to have someone to assist them (59.7% vs. 40.3%). Not surprisingly, the proportion of seniors without someone to assist them increases with age.

Percentage of Seniors Who Do Not Have Someone to Assist Them Within Demographic Categories
(HARC, 2007)





FALLS/MOBILITY (55+)

Among older adults, falls are the leading cause of deaths due to injury and the most common cause of nonfatal injuries and hospital admissions from trauma. The risk of being seriously injured in a fall increases with age. Many seniors choose to avoid activities because they fear falling. By stopping activities, the physical condition of seniors may deteriorate making them even more prone to falling.

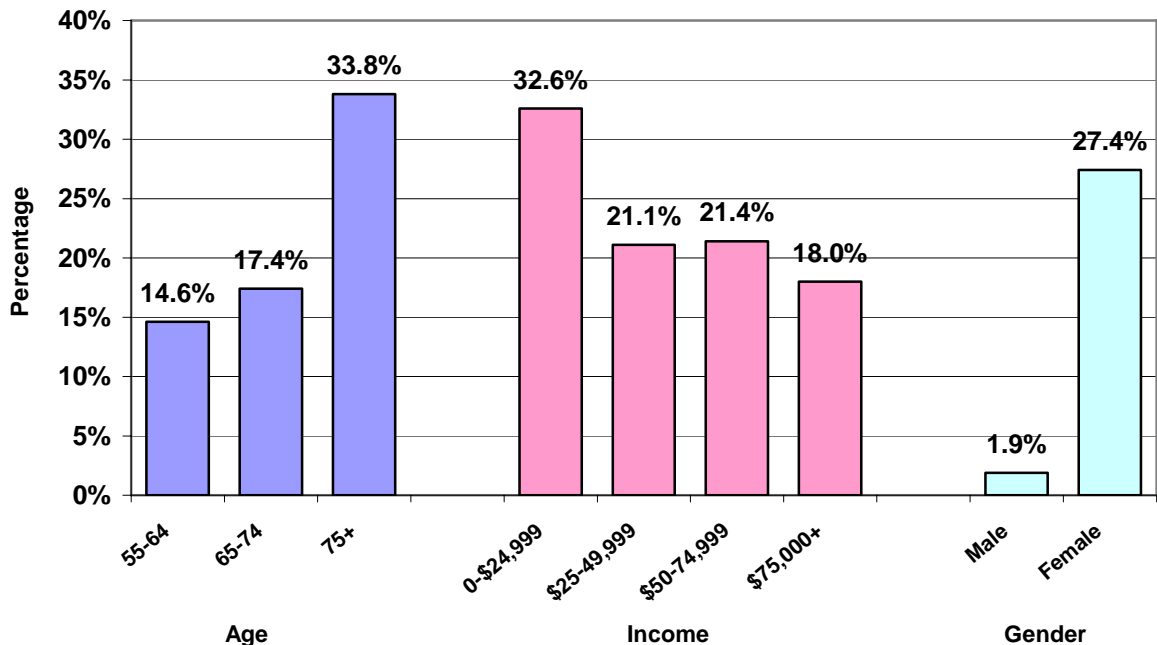
KEY FINDING:

32,700 older adults report having fallen in the past three months; 53,659 of older adults (22%) are concerned about or afraid of falling.

An estimated 32,700 or 12.1% of Eastern Riverside County adults age 55 and older report they have fallen one or more times in the past three months. Of those who have fallen, an estimated 12,140 or 37.2% older adults report experiencing an injury resulting from their fall.

In general, a high proportion of older adults (22.5% or an estimated 53,659 older adults) are concerned about or afraid of falling. Concern about or fear of falling is highest among adults 75 years and older (33.8%), those with annual household incomes of 0-\$24,999 (32.6%), and women (27.4%).

Percentage of Seniors Concerned About or Afraid of Falling Within Demographic Categories (HARC, 2007)





TRANSPORTATION (55+)

Being able to travel, whether by driving or using some alternative transportation, is essential if older adults are to maintain their independence and lead vital lives. Unfortunately, age-related changes in vision, and physical and cognitive skill declines, can challenge lifelong patterns of driving, walking, or transit use. Alternative forms of transportation such as paratransit, public transportation, senior van services, taxi vouchers, medical vans, and ride share programs will be needed for individuals who no longer drive.

KEY FINDING:

Approximately 10,000 Eastern Riverside County older residents report difficulty in obtaining transportation when they need it.

An estimated 10,005 Eastern Riverside County older residents report they have difficulty obtaining transportation when they need it to accomplish the activities they want and need to do. This translates to 3.7% of Eastern Riverside County older residents.

ELDER ABUSE (55+)

Elder abuse, also called elder mistreatment, refers to acts of commission or omission that result in harm, or threats to harm, the health or welfare of an older adult, occurring within any relationship in which there is an expectation of trust. Elder abuse includes psychological or physical abuse; neglect by a family member, relatives, or strangers; taking financial advantage of seniors; and self-neglect (the most common form of abuse).

KEY FINDING:

21,795 older adults reported they have been abused. Older adults are more likely to experience financial abuse (14,684) than being mistreated or neglected physically or mentally (7,111).

During the past year, 21,795 seniors age 55 and older reported that they have been abused. Over 7,100 seniors indicated they were mistreated or neglected physically or mentally during the past 12 months. They represent almost 3% of the seniors in Eastern Riverside County. By comparison, over 14,600 residents, or nearly 6% of seniors, report they were taken advantage of financially by someone such as a merchant, neighbor or family member.

These numbers may understate the prevalence of elder abuse. It is estimated that for every one case of elder abuse, neglect, exploitation, or self-neglect reported to authorities, about five more go unreported.¹

¹ National Center on Elder Abuse. *Statistics at a Glance*, www.ncea.aoa.gov/ncearoot/Main_Site/Library/Statistics_Research/Abuse_Statistics/Statistics_At_Glance.aspx





Highlights and Key Findings

Child Health (Age 0-17)

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The tables below show the percentage of responses for each question and the estimated population that those responses represent. Population estimates are derived using the most recent population numbers available for the region. They are calculated using a statistical weighting method that allows the survey data to more accurately reflect the entire population of Eastern Riverside County.

CHILDREN (AGES 0 TO 5)

Based on Census and California Department of Finance estimates, children in the 0 to 5 year age group represent 7.8% of the total population of Eastern Riverside County.

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS (AGES 0 TO 5)

Over 75% of the respondents self-reported their children's race to be non-white, with the majority being Hispanic/Latino (73.4%).

Demographic Characteristics (0 to 5): Race/ Ethnicity (HARC, 2007)

	Weighted Percent	Population Estimates
White	22.5%	6,334
Hispanic/Latino	73.4%	20,640
Black/African American	3.4%	964
Other	0.6%	170
Total	100.0%	28,108

The majority (57.1%) of the responding adults reported being married. Although the number of responses was small, the second largest group reported being single parents who were never married.

Demographic Characteristics (0 to 5):

Responding Adult's Marital Status (HARC, 2007)

	Weighted Percent	Population Estimates
Married	57.1%	16,190
Single, never married	16.2%	4,583
Divorced	4.2%	1,205
Widowed	0.8%	229
Separated	9.3%	2,631
Cohabiting	12.4%	3,522
Total	100.0%	28,360



More than 2/3 of the respondents were the birth mothers of the children. Over 16% were birth fathers. More than 62% of those responding reported being U.S. citizens. 60.1% of those who were not citizens reported being permanent residents. A small sample who were not citizens or permanent residents reported having temporary visas.



**Demographics (0 to 5): Responding Adults
Relationship to Child, Citizenship Status**
(HARC, 2007)

	Weighted Percent	Population Estimates
Responding Adult's Relationship to Child		
Birth Mother	69.3%	19,660
Birth Father	16.7%	4,750
Grandparents	10.3%	2,929
Other	3.6%	1,021
Total	100.0%	28,360
Citizenship Status of Responding Adult		
U.S. Citizen	62.3%	17,244
Permanent Resident (of the 37.7% who are not citizens)	60.1%	6,259
No temporary visa (of the 39.9% who are not permanent residents)	81.3%	3,377

SOCIOECONOMIC CHARACTERISTICS OF SURVEY RESPONDENTS (AGES 0 TO 5)

Over 1/3 of the respondents reporting on children 0 to 5 indicated that they had not completed High School.

**Socioeconomic Characteristics (0 to 5):
Responding Adult's Education**
(HARC, 2007)

	Weighted Percent	Population Estimates
Less than High School	34.5%	9,716
High School Grad or GED	27.3%	7,700
Some College	24.7%	6,960
College Degree	11.7%	3,292
Post-Graduate	1.8%	502



Over one half of responding adults reported being employed for wages or self-employed. Almost one quarter reported being stay at home mothers or fathers (homemakers).

Slightly more than 1/3 of the households had incomes less than \$25,000. Almost 1/2 indicated having incomes between \$25,000 and \$50,000. Therefore, more than 3/4 of the households with children 0 to 5 had incomes less than \$50,000.

Socioeconomic Characteristics (0 to 5): Responding Adult's Employment Status, Household Income
(HARC, 2007)

	Weighted Percent	Population Estimates
Employment Status of Responding Adult		
Employed for Wages / Self - employed	55.6%	15,483
Homemaker	23.9%	6,664
Unemployed	14.3%	3,976
Student	3.7%	1,044
Retired	1.7%	467
Unable to Work	0.8%	218
Household Income		
Less than \$25,000	33.8%	8,125
\$25,000 - 49,999	45.8%	11,000
\$50,000 - 74,999	7.6%	1,815
\$75,000 or more	12.8%	3,065

Housing ownership is almost equally divided between owning and renting with slightly more (53%) renting their homes. The majority (82.7%) of families have 4 or more persons in their household. Over 1/3 have 5 persons in their household. Average household size for child survey respondents is 4.4 (adults and children).

Housing Characteristics (0 to 5)
(HARC, 2007)

	Weighted Percent	Population Estimates
Own	47.0%	13,186
Rent	53.0%	14,869
2 persons in household	2.3%	666
3 persons in household	15.0%	4,242
4 persons in household	24.7%	7,009
5 persons in household	34.6%	9,803
6 or more in household	23.4%	6,641



CHILDREN (AGES 6 TO 17)

Based on Census and California Department of Finance estimates, children in the 6 to 17 year age group represent 18.4% of the total population of Eastern Riverside County.

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS (AGES 6 TO 17)

Slightly less than 75% of the respondents self-reported their children’s race to be non-white, with the majority being Hispanic/Latino (65%).

Demographic Characteristics (6 to 17): Race/ Ethnicity
(HARC, 2007)

	Weighted Percent	Population Estimates
White	26.6%	26,264
Hispanic/Latino	65.0%	64,182
Black/African American	5.5%	5,472
Other	2.8%	2,789
Total	100.0%	98,707

The majority (68.2%) of the responding parents or guardians reported being married. About 2/3 of the respondents were the birth mothers of the children. Almost 25% were birth fathers.

Demographics (6 to 17): Responding Parent’s/Guardian’s Marital Status, Relationship to Child
(HARC, 2007)

	Weighted Percent	Population Estimates
<i>Marital Status of Child's Parents or Guardians</i>		
Married	68.2%	67,869
Separated	12.7%	12,674
Divorced	10.0%	9,976
Single, never married	5.4%	5,376
Cohabiting	2.9%	2,905
Widowed	0.7%	740
Total	100.0%	99,540
<i>Relationship to Child</i>		
Birth Mother	66.4%	65,288
Birth Father	24.9%	24,481
Grandparents	2.9%	2,812
Other	5.8%	5,721
Total	100.0%	98,302



More than 70% of those responding reported being U.S. citizens. 64.5% of those who were not citizens reported being permanent residents. A small sample who were not citizens or permanent residents reported not having temporary visas.

Demographics (6 to 17): Citizenship Status
(HARC, 2007)

	Weighted Percent	Population Estimates
U.S. Citizen	70.3%	69,216
Permanent Resident (of the 29.7% who are not citizens)	64.5%	18,844
No temporary visa (of the 35.5% who are not permanent residents)	87.5%	9,212

SOCIOECONOMIC CHARACTERISTICS OF SURVEY RESPONDENTS (AGES 6 TO 17)

Almost 1/3 of the respondents reporting on children 6 to 17 indicated that they had not completed High School. Over 2/3 reported being employed for wages or self-employed. Almost 19% reported being stay at home mothers or fathers (homemakers). Nearly 1/4 of the households had incomes less than \$25,000. Almost 1/2 indicated having incomes between \$25,000 and \$50,000. Therefore, more than 3/4 of the households with children 6 to 17 had incomes less than \$50,000.

Socioeconomic Characteristics (6 to 17): Parent's Education, Employment Status
(HARC, 2007)

	Weighted Percent	Population Estimates
Education of Parent or Guardian		
Less than High School	32.8%	32,364
High School Grad or GED	26.9%	26,505
Some College	21.9%	21,544
College Degree	14.2%	14,009
Post-Graduate	4.2%	4,125
Employment Status of Parent or Guardian		
Employed for Wages / Self - employed	67.8%	66,695
Homemaker	18.9%	18,605
Unemployed	7.2%	7,123
Unable to Work	4.4%	4,305
Retired	1.2%	1,147
Student	0.4%	429
Household Income		
Less than \$25,000	24.8%	22,083
\$25,000 - 49,999	45.4%	40,435
\$50,000 - 74,999	11.3%	10,040
\$75,000 or more	18.5%	16,518



The majority (56.5%) of households reporting on children 6 to 17 reported owning their homes. The majority (88.3%) of families have 4 or more persons in their household. Over 1/3 have 6 or more persons in their household.

Housing Characteristics (6 to 17) (HARC, 2007)

	Weighted Percent	Population Estimates
Own	56.5%	55,695
Rent	43.5%	42,871
2 persons in household	2.1%	2,125
3 persons in household	9.6%	9,576
4 persons in household	25.4%	25,247
5 persons in household	25.2%	25,041
6 or more in household	37.7%	37,553





HEALTH CARE COVERAGE

Growing Up Healthy: Having access to health care is a foundation for optimal health. “Health insurance is the primary financial vehicle for obtaining access to quality medical care and for reimbursing providers who deliver care.



Unfortunately, for a number of children, access to health care has become increasingly difficult to obtain. Approximately one in five Californians remains uninsured.”¹

Children with health insurance are more likely to receive regular checkups, immunizations, vision screenings, routine dental care, and have overall better health. Healthier children exhibit better school performance, gain more out of their education and have a greater chance of strengthening California’s economy. Children without health care coverage are at a greater risk for health problems. Without health insurance coverage, children may be unable to see a health-care provider when needed.

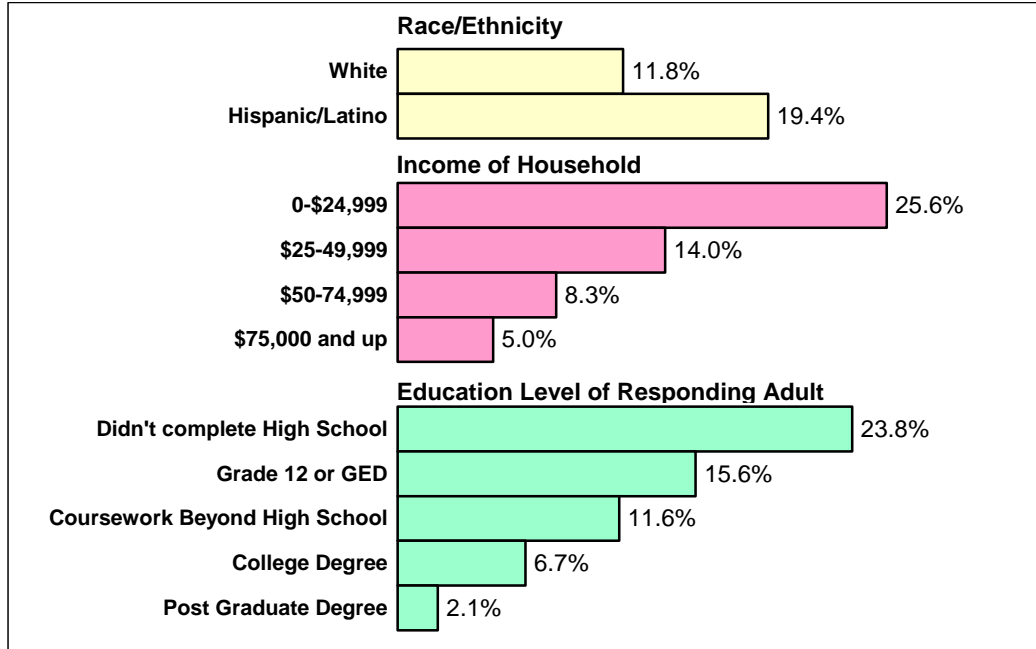
Children who had any type of health care coverage for a portion, or for the entire past year are considered “insured”. Those who did not have any type of health care coverage at any time during the past year are considered “uninsured.”

KEY FINDING:	
<p>Over 23,000 Eastern Riverside County children ages 0-17 lack any source of primary health care coverage. Of those, 4,822 are children ages 0-5 and 18,247 are children ages 6-17.</p>	<p>Nearly 16% of survey respondents indicated their child does not have health care coverage. CHIS 2005 Riverside County data showed that the rate for children under 18 years of age without health insurance is 9%. The CHIS 2005 California rate for uninsured children under 18 years of age is 6.4%.</p> <p>The likelihood of being covered by health insurance varied among children by race, household income, age, and parental education level. The uninsured rate for Hispanic/Latino children (19.4%) was higher than the uninsured rate for White children (11.8%). Health insurance coverage rates decreased with decreasing consecutive household income groups. 1 in 4 children living in households with annual income of \$0-\$24,999 did not have primary health coverage. The proportion of children without health care coverage is highest for those living with adult respondents who did not complete high school (23.8%) then declines as respondent level of education increases.</p> <p>When parents were asked why their child was not insured, the most common reason given was inability to pay the cost of premiums; 17.2% of respondents indicated they were in the process of applying for coverage and 1 in 10 indicated they were refused coverage by an insurance company.</p>

¹ California Health Care Foundation. 2007, www.chcf.org/topics/healthinsurance



Percentage of Children who Lack Primary Health Coverage Within Demographic Categories (HARC 2007)



KEY FINDING:

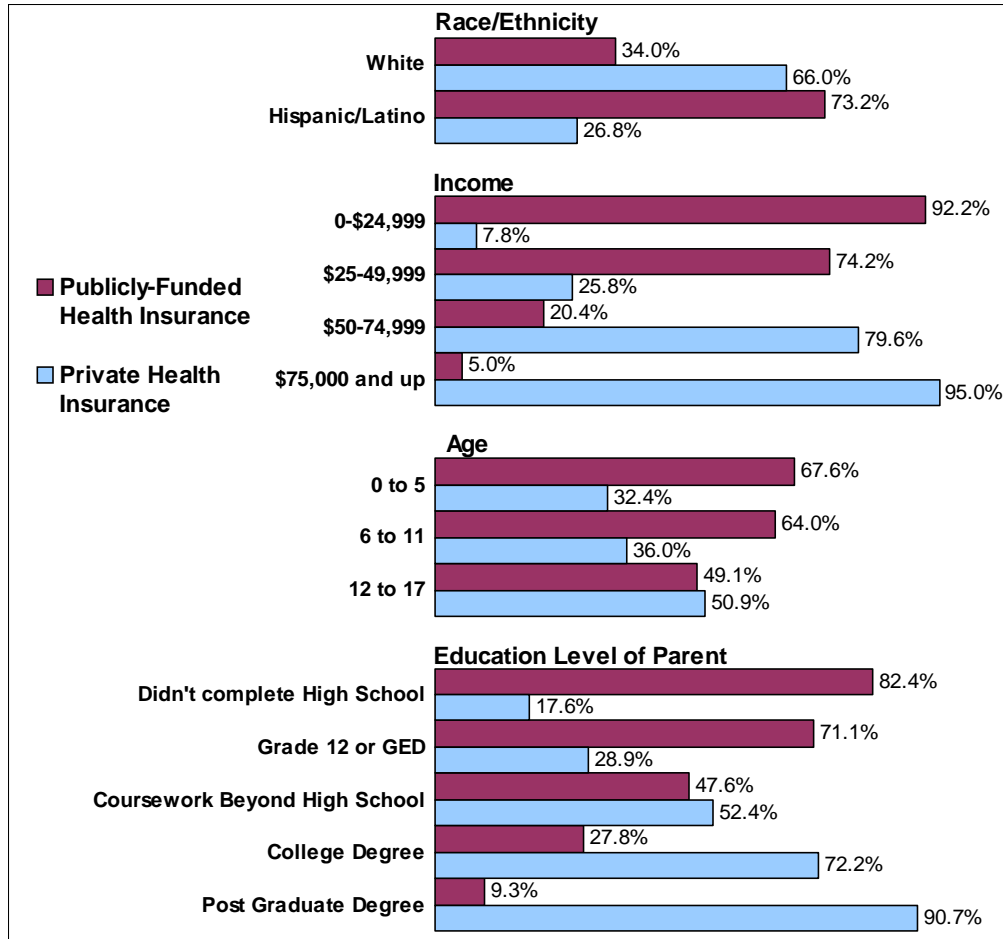
Eastern Riverside County has approximately 65,630 children under 18 years of age who have publicly-funded health insurance; 25,866 children ages 0 through 5, and 39,591 children ages 6 through 17.

For reporting purposes, HARC broadly classifies health care coverage as publicly-funded (government) or private health care coverage. Private health coverage refers to health insurance plans provided through an employer, a union, or purchased individually through a private company. Government health coverage includes federal programs (like Medicare and Medi-Cal) and programs administered by state and local governments (like the State Children’s Health Insurance Program –SCHIP and Healthy Families).

Results from the HARC survey show approximately 59.4% of children under 18 years of age were enrolled in publicly-funded health insurance programs. Hispanic/Latino children (73.2%) are more likely to have health insurance through a publicly-funded source than White children (34%). The proportion of children with publicly-funded insurance decreases with each categorical increase in respondent income. The vast majority of children living in households with annual incomes below \$25,000 (92.2%) have publicly-funded insurance, followed by 74.2% of children in households with annual incomes between \$25,000 and \$49,999. Similarly, the proportion of children with publicly-funded insurance decreases with each categorical increase in respondent education—moving from a high of 82.4% (respondents with less than a high school education) to 9.3% (respondents with a post graduate degree). Children 12 to 17 years old (50.9%) were more likely to be insured by private health coverage than those under 6 years old (32.4%) and 6 to 11 years old (36%).



Percentage of Children (0-17) with Health Care Coverage Within Demographic Categories and Type of Health Insurance (HARC 2007)



KEY FINDING:

Over 6,100 children 0-5 years old and over 8,670 children 6-17 years old were not covered for a portion of the previous year.

Among children who were reported as having some type of health care coverage, nearly 14,780 children (12%) were without health care coverage at some time during the past year, 6,102 (14.6%) children ages 0-5, and 8,677 (10.7%) children ages 6-17.

Of those who had been without healthcare coverage, approximately 19.4% (2,579) were without coverage for the entire year. An estimated 10.3% (1,377) of children were without health care coverage for 11 out of 12 months.



PRESCRIPTION COVERAGE

KEY FINDING:

In Eastern Riverside County there are 33,035 children who do not have prescription drug coverage.

An estimated 22.8% of Eastern Riverside County children ages 0 to 17 do not have any kind of health care coverage that pays some or all of the cost of prescription drugs. CHIS 2005 Riverside County data showed that 3.8% of children ages 0 to 17 had no prescription coverage. CHIS 2005 California results showed that 6.3% had no prescription coverage.

Hispanic/Latino children (30%) are about 2 ½ times more likely than White children (11.9%) to lack prescription coverage. Children living in households with annual incomes of less than \$25,000 (39.6%), as well as older children (27.7% and 26.2% for children ages 6 to 11 and 12 to 17, respectively) are also more likely to be without prescription coverage. Survey respondents without a high school degree (37.5%) are more likely to report their child had no prescription coverage. An equal portion 22.9% of female and male children lack prescription coverage.

Of those children with some kind of health care coverage that covers some or all of the cost of their prescription drugs, over one-tenth (15,503) were reported by parents as having not obtained a needed prescription because of cost.

DENTAL COVERAGE

KEY FINDING:

In Eastern Riverside County there are 42,242 children who do not have dental coverage.

An estimated 29.3% of children ages 0-17 in Eastern Riverside County do not have any kind of health care coverage that pays for some or all of the cost of routine dental care. CHIS 2005 Riverside County results showed that 19.4% of children ages 0-17 had no dental coverage. CHIS 2005 California showed that 21.3% of children ages 0-17 were without coverage.

Approximately equal proportions of Hispanic/Latino children (32.9%) and White children (29.6%) were reported to lack dental coverage. Respondents in the lowest income category (43.3%) are the most likely to report their child does not have dental coverage. The proportion of children without dental coverage slightly increases as children age (25.7%, 29.9%, and 31.7% for children 0-5, 6-11, and 12-17, respectively). Respondents without a high school degree are the most likely (44.0%) to report their child does not have dental coverage. Lack of dental coverage is not related to child gender in these data.



VISION COVERAGE

KEY FINDING:

In Eastern Riverside County there are 46,271 children who do not have vision coverage,

Approximately 32.9% of children ages 0-17 in Eastern Riverside County lack vision coverage. CHIS 2005 Riverside County results showed 13% of children lacked vision coverage. Results for CHIS 2005 California showed 12.7% of children lacked vision coverage.

Lack of vision coverage is unrelated to child race/ethnicity in these data (34.5% White, and 35.2% Hispanic/Latino). While at least one-quarter of children in household income groups from \$25,000 and over lack coverage, it is highest for children who live in households with an annual income of less than \$25,000 (48.2%). The proportion of children in each age group who lack vision coverage increases with age; however differences are not large (29.5%, 33.7%, and 35.1% for children ages 0-5, 6-11, and 12-17, respectively). Respondents without a high school diploma (44.4%), as well as respondents with a post graduate degree (42.2%), are the most likely to report their child does not have vision coverage. 33.2% of both male and female children do not have vision coverage.

MENTAL HEALTH COVERAGE

KEY FINDING:

In Eastern Riverside County there are 37,993 children who do not have mental health coverage.

More than one-third (35.6%) of children ages 0-17 in Eastern Riverside County lack health coverage that pays for their mental health care services.

Hispanic/Latino children (45.9%) are over 2 ½ times more likely than White children (17.5%) to lack mental health coverage. Children living in households with annual incomes below \$25,000 are the most likely (55%) to lack mental health coverage; proportions are lower for children in households with higher incomes. As children age they are less likely to have any kind of health coverage that pays for some or all of the cost of mental health care services (28.1%, 35.9%, and 37.9% for children ages 0-5, 6-11, and 12-17, respectively). Over half (53.9%) of the children who live with parents/guardians without a high school diploma are without mental health coverage. Approximately 36% of both male and female children are without mental health coverage.



ERC CHILD UTILIZATION OF HEALTH CARE SERVICES

“People use health care services for many reasons: to cure illnesses and health conditions, to mend breaks and tears, to prevent or delay future health care problems, to reduce pain and increase quality of life, and sometimes merely to obtain information about their health status and prognosis. Health care utilization can be appropriate or inappropriate, of high or low quality, expensive or inexpensive. The study of trends in health care utilization provides important information on these phenomena and may spotlight areas that may warrant future in depth studies because of potential disparities in access to, or quality of, care. Trends in utilization may also be used as the basis for projecting future health care needs, and to forecast future health care expenditures...”¹

Results from the 2007 HARC survey show the latest trends of how Eastern Riverside County children utilize health services.

KEY FINDING:

8576 children ages 0-5, and 40,693 children ages 6-17 have not seen a health care provider in six or more months.

In Eastern Riverside County, 49,267 (34.3%) children ages 0-17, and 40,693 (41%) children ages 6-17 are reported as not having seen a health care provider during the past 6 months. Of those who have visited a health care provider during the past 6 months, over half of the visits (64.7%) for ages 0-5, and nearly (59%) for ages 6-17 are for routine care.

KEY FINDING:

Over 11,170 of survey respondents reported being either “neutral,” “dissatisfied,” or “very dissatisfied” with the quality of care their child received on their last visit.

While the majority of survey respondents reported being either “satisfied” or “very satisfied” with the quality of care their child received on their last visit, over 11,170 survey respondents (9.3%) reported being either “neutral,” “dissatisfied,” or “very dissatisfied” with the quality of care their child received at their last visit.

KEY FINDING:

Over half of survey respondents indicated that their child’s health care provider did not have services available evenings and weekends.

Over half of survey respondents (56.7% or 64,748) indicated that their child’s health care provider did not have services available evenings and weekends.

¹ National Center for Health Statistics. 2003 *Health care in America: Trends in utilization*. Available at, www.cdc.gov/nchs/data/misc/healthcare.pdf



KEY FINDING:

Nearly one in four children ages 0-5 used the emergency room in the last 12 months.

Results from the 2007 HARC survey show that (23.9 percent) of children age five or under used the emergency room in the last 12 months. This translates to 11,232 children ages 0-5 who used the emergency room in the last 12 months.

KEY FINDING:

Fever is the leading cause of visits to the emergency room among children ages 0-5, whereas injury is the leading cause for children 6-17.

1,661 (15.7%) of children 0-5 visited the emergency room due to a fever, and 2,473 (23.5%) of children 6-17 visited due to injury.





Utilization of Child Health Care Services
(HARC 2007)

	0 - 17 Years Old		0 - 5 Years Old		6 - 17 Years Old	
	Weighted Percent	Population Estimates	Weighted Percent	Population Estimates	Weighted Percent	Population Estimates
LAST DOCTOR VISIT						
Less than 6 months ago	65.7	94,394	81.4	37,592	58.3	56,802
6 or more months ago	34.3	49,267	18.6	8,576	41.7	40,693
REASON FOR DOCTOR VISIT						
Routine	61.0	73,286	64.7	27,798	58.9	45,488
Acute illness	24.0	28,813	28.1	12,053	21.7	16,760
Chronic illness	7.0	8,406	5.6	2,427*	7.7	5,979
Injury	7.5	8,969	0.9	377*	11.1	8,592
Other	0.6	693	0.7	307*	0.5	386
SATISFACTION WITH QUALITY OF CARE AT LAST DOCTOR VISIT						
Very Satisfied	48.6	58,679	53.8	23,322	45.8	35,357
Satisfied	42.1	50,764	36.1	15,650	45.4	35,114
Neutral, dissatisfied, or very dissatisfied	9.3	11,174	10.1	4,378	8.8	6,796
DIFFICULTIES WITH ANY OF THE FOLLOWING ON LAST DOCTOR VISIT						
Time waiting for doctor	17.4	20,820	23.1	9,938	14.1	10,882
Time to get appointment	11.9	14,363	15.3	6,579	10.0	7,784
Attitude of staff	12.8	15,332	9.4	4,010*	14.7	11,322
Attitude of doctor	8.7	10,423	8.3	3,537*	8.9	6,887
ARE SERVICES AVAILABLE EVENINGS AND WEEKENDS						
Yes	43.3	49,381	44.3	17,310	42.7	32,071
No	56.7	64,748	55.7	21,764	57.3	43,037
VISIT TO ER IN THE LAST 12 MONTHS						
Yes	14.9	21,929	23.9	11,232	10.7	10,696
No	85.1	125,059	76.1	35,764	89.3	89,267
TOP FIVE REASONS						
Fever	9.1	1,913	15.7	1,661	2.4	252*
Flu	6.3	1,337	12.1	1,285	0.5	52*
Injury	17.4	3,669	11.3	1,196*	23.5	2,473
Earache	9.0	1,899	6.6	697*	11.4	1,202*
Difficulty breathing/ Asthma	6.5	1,374				

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.
*Use with caution, small numbers.



ERC CHILD GENERAL HEALTH AND PREVENTION

The general health of a child is influenced by many factors, including a broad category that encompasses the overall well-being of children. A look at the general health of a child is a powerful predictor of their future health outcomes, and the health of the community as a whole.

General health status is a powerful predictor of future rates/incidences of whether a child is likely or unlikely to have a disease. It can also serve to indicate any underlying conditions that a child might have.

KEY FINDING:	
Approximately 7,888 children ages 0-17 were rated as having “fair” or “poor” health.	<p>To measure general health, Eastern Riverside County survey respondents with children 0-17 years old were asked to assess their child’s health status as “excellent,” “very good,” “good,” “fair,” or “poor.” Approximately 7,888 or 5.3% of children 0-17 years old were rated as “fair” or “poor”.</p> <p>Over 2,390 or 5.1% of children ages 0-5 were rated as having either “fair” or “poor” health, compared with nearly 5,500 or 5.5% of children ages 6-17.</p>

DENTAL HEALTH

Good dental and oral health contributes to children’s overall well-being. Dental caries, or tooth decay, is the single most common health-related problem for children-- five times more common than asthma.¹ Untreated dental problems can cause pain, dysfunction, absence from school, low weight, and poor appearance—problems that can greatly reduce a child’s capacity to succeed in life.

Children should have a dental check-up at least twice a year. Regular dental visits can help children stay cavity free.² In addition to regular dental check-ups, brushing teeth twice a day, flossing once a day, eliminating frequent snacking and drinking plenty of fluoridated water are also important to good oral hygiene.

KEY FINDING:	
Nearly 36,000 children ages 0-17 have never been to a dentist	<p>Nearly 25% of children ages 0-17 in Eastern Riverside County have never been to a dentist; this represents over 36,000 children. More than 23,000 children, 21.2%, had not been to the dentist in the past 12 months.</p> <p>Over 10,000 Eastern Riverside County children between 6 to 17 years old, about 1 in 10 in the sample, missed school due to dental problems.</p>

VISION TEST

Proper eye care is very important. Vision problems can begin at an early age, and without treatment, can worsen and lead to permanent vision loss and/or delayed development. Because a child can have a serious vision problem without parents being aware of it, infants should be screened for common eye problems during their regular pediatric appointments. Children should begin to receive screening for eye disease by an ophthalmologist, pediatrician or other trained screener by age three.³

¹ U.S. Department of Health and Human Services, 2000

² American Academy of Pediatric Dentistry, 2007

³ American Academy of Ophthalmology, 2007

www.medem.com/medlb/article_detailb_for_printer.cfm?article_ID=ZZZKHI7C15D&sub_cat=117



KEY FINDING:

Nearly 52% (50,441) of children 6-17 had not had a vision exam within the past year.

When asked about their children, nearly 52% of their children age 6-17 had not had a vision exam within the past year. This represents 50,441 children age 6-17 in Eastern Riverside County.

Hispanic/Latino children (56.4%) were more likely than White children (43.3%) not to have had an eye exam in the past year. Families in the lowest income group (0-\$24,999) were the most likely (64.2%) to report that their child has not had a vision exam within the past 12 months, followed by families in the highest income group (50.2%) of \$75,000 or more. Parents who did not complete high school are the most likely to report their child has not had a vision exam in the past year. Boys were slightly more likely than girls not to have had a vision exam in the past year (53.7% vs. 48.3%).

KEY FINDING:

26,410 children 0-5 have not had their eyes checked by an eye doctor.

Eastern Riverside County survey respondents with children 0-5 years old were asked if their child has had their eyes checked by an eye doctor or an optometrist. The majority (57.2%) of children 0-5 years old had not had their eyes checked by an eye doctor. This translates to more than 26,410 children ages 0-5 who had not had their eyes checked by an eye doctor.

HEARING TEST

Babies learn through hearing; and according to the American Academy of Pediatrics, language development can be normalized if hearing is corrected by 6 months old. Therefore, infants should have their hearing tested before 6 months of age. Even if hearing is not corrected at 6 months, the earlier a problem is detected, the better the child’s chance of learning.¹

KEY FINDING:

Nearly 12,640 children 0-5 years old (27.3%) had never had their hearing tested.

Eastern Riverside County survey respondents with children 0-5 years old were asked if their child had ever had their hearing checked by a doctor (health care provider). Survey results show that nearly 12,640 children 0-5 years old (27.3%) had never been tested for hearing abnormalities.

IMMUNIZATIONS

Before immunizations (vaccines), over 50,000 children per year in the United States were killed or disabled by currently preventable diseases. These diseases include Polio, Rubella (German measles), Measles, Diphtheria, and Influenza B and Pertussis (whooping cough).

Health care providers should educate caregivers about immunizations and vaccines. It is recommended that a “reminder system” be in place to help caregivers with the proper schedule for immunizations.²

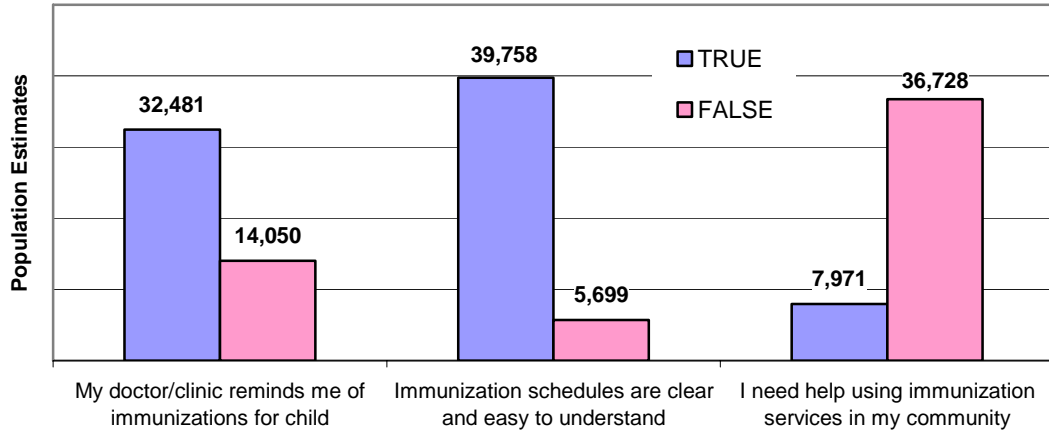


¹ American Academy of Pediatrics. *Parenting corner Q&A*, www.aap.org/PUBLICED/BR_HearingScreen.htm

² American Academy of Pediatrics. *Parent Education Sheets*, 2007, www.aap.org



Immunizations for Child (HARC, 2007)



KEY FINDING:

Eastern Riverside County has 14,050 children 0-5 years old whose doctors do not remind the child's caregivers about immunizations.

Over 30% of caregivers of children 0-5 years old report that their child's doctor (or clinic) does not remind them about immunizations for their child. This represents approximately 14,050 children 0-5 years old whose doctors do not remind the child's caregivers about immunizations.

Approximately 5,700 caregivers (12.5%) said that immunization schedules are unclear and hard to understand. Approximately 7,980 caregivers (17.8%) indicated that they need help using the immunization services in their community.

INJURY PREVENTION

Unintentional injuries kill more children in the U.S. each year than anything else. Ranked among the top causes of injury death of children are drowning and head injuries resulting from biking accidents. The good news is that measures can be taken to avoid these tragedies.

Swimming Pools

While swimming can be a fun pastime, ignoring the necessity for taking precautions can result in serious injury or drowning. A child underwater can lose consciousness in two minutes and suffer brain damage after five. Residents with pools or spas are encouraged to use a pool/spa cover, to install fencing around the pool that is at least four feet high on all sides, and to secure any gates with a lock or a latch in order to make access to the water difficult for children.¹

¹ International Association of Certified Home Inspectors. *Safety Guidelines for Home Pools*, www.nachi.org/poolsafety.htm



KEY FINDING:

Nearly 13,120 children ages 0-17, live in homes where there is no latch, lock, or pool/spa cover used to prevent entry to the pool or spa.

In Eastern Riverside County, it is estimated that approximately three in ten children ages 0-17 (29.2% or 42,929) live in a house or apartment with a pool or spa on the premises. Of those, over one-quarter (26.0% or 11,167) do not have fencing that separates their house or apartment from the pool. In addition, over one-third (30.6% or 13,116) live in a house or apartment where there is no latch, lock, or pool/spa cover used to prevent entry to the pool or spa.

Head Injuries

Head injuries can be devastating for children and their families. An estimated 140,000 children end up in emergency rooms each year due to head injuries resulting from biking accidents, and the time it can take to recuperate from a head injury can be very long.¹

One way to reduce a child's risk of sustaining an accidental head injury is to have them wear bicycle helmets when riding their bikes. When used properly, a bicycle helmet can reduce the risk of brain injury by 88%.²

KEY FINDING:

45,630 kids ages 0-17 "sometimes, seldom, or never" use a helmet when on their bike, scooter, skateboard or skates.

The largest proportions of children in both age groups (48.6% and 50.4%) are reported to use a helmet "sometimes, seldom, or never" when on their bike, scooter, skateboard or skates. This translates to 9,620 children ages 0-5, and 36,010 children ages 6-17.

¹ Centers for Disease Control and Prevention. *Head Injuries and Bicycle Safety*, 2003, www.cdc.gov/healthmarketing/entertainment_education/tips/headinjury.htm

² *Ibid.*



MENTAL AND BEHAVIORAL HEALTH STATUS (4-17)

Good emotional and behavioral health enhances a child’s sense of well-being, leads to satisfying social relationships at home and with peers, and leads to achievement of full academic potential. Children with emotional or behavioral difficulties may have problems managing their emotions, focusing on tasks, and/or controlling their behavior. These difficulties, which may persist throughout a child’s development and can lead to lifelong disability, are usually noticed first by parents. Parents’ reports are crucial to alerting doctors about their child’s emotional and behavioral difficulties and to obtaining mental health services.¹

KEY FINDING:	
<p>Approximately 5.4% of children have been diagnosed with a developmental delay, and 4.1% with ADHD/ADD</p>	<p>Approximately 5.4% of the parents report their child had been diagnosed with a developmental delay, followed by ADHD/ADD (4.1%), an eating disorder (3.2%) and anxiety disorder (2.6%), such as panic disorders, obsessive-compulsive disorder or a phobia.</p>

Type of Mental Health Diagnoses in Children 0-17 (HARC, 2007)

	Weighted Percent	Population Estimates
Developmental Delay	5.4	6,519
ADHD or ADD	4.1	4,971
Eating Disorders	3.2	3,341
Anxiety disorder	2.6	3,126

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding

KEY FINDING:	
<p>Nearly 21% (24,740) of children 4-17 years old were reported to have difficulties with emotions, concentration, behavior, or getting along with others.</p>	<p>White children (25%) are more likely than Hispanic/Latino children (18.4%) to be reported as having difficulties. Between 20% and 24% of children living in households with incomes below \$75,000 were more likely to be reported as having emotional or behavioral difficulties. The parents of children ages 6-11 years (28.5%) were more likely to report that their child has difficulties with emotions, concentration, behavior, or being able to get along with other people.</p>

¹ America’s Children. *Key National Indicators of Well-Being, 2007*, www.childstats.gov/pdf/ac2007/ac_07.pdf



KEY FINDING:

During the past 12 months, 20,571 Eastern Riverside County parents contacted school staff about their child's emotional or behavioral difficulties (ages 5-17).

Survey results show that during the past 12 months, 18.1% reported contacting school staff about their child's emotional or behavioral difficulties. This represents 20,571 children ages 5-17.

Parents with White children (21.7%) were more likely than parents of Hispanic/Latino children (16.1%) to report contacting staff at the child's school about their emotional or behavioral difficulties. Parents in the two lower income groups, \$0-\$24,000 (18.4%) and \$25,000-\$49,000 (23%) were more likely to report contacting school staff about their child's difficulties. Parents with a child ages 6-11 years (26%) were more likely to report that their child has difficulties with emotions, concentration, behavior, or being able to get along with other people. Parents with post graduate degrees were the least likely (9.4%) to contact school staff/personnel about their child's emotional or behavioral difficulties. Parents who completed coursework beyond high school were the most likely (27.7%) to contact school staff/personnel. The parents of boys were slightly more likely to report contacting school staff about their child's difficulties than parents of girls (19.6% vs. 15%).





ERC CHILD SOCIAL HEALTH

PARENTAL CONCERNS

Parents of children 0-17 were asked about their greatest concern for their child. Of the respondents that expressed a concern for their child, the highest reported concern was the quality of education. For parents, making sure children receive a quality education has always been a top priority. They understand that the more education their children receive, the more options they will have in life. In many areas, parents can choose from neighborhood, charter, public or private schools (religious or secular), or they can opt to teach their children at home.

KEY FINDING:

While education was the most frequently identified parental concern, the next four listed concerns were health related.

Survey results show the highest reported concern parents had for their child, mentioned by 26.3% of respondents (representing approximately 28,000 Eastern Riverside County residents), was the quality of education. The second most self-identified concern was their child's weight and/or physical fitness, followed by their child's development (physical or mental), physical safety, and emotional well-being.

Top Five Parental Concerns for Child (HARC, 2007)

Concerns for Child	Weighted Percent	Population Estimates
Quality of education	26.3	27,781
Child's weight and/or physical fitness	13.0	13,696
Child's development (physical or mental)	9.7	10,245
Physical safety	8.0	8,406
Emotional well-being	7.6	8,001

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

KEY FINDING:

Parents with children 12-17 are more likely to have concerns about their child's quality of education.

Considering only the top parental concern, a higher proportion of parents of children 12-17 (82%) are concerned for their child's quality of education; proportions in the other two age categories are lower, but still 50% or higher.



KEY FINDING:

Respondents without a high school diploma (43.2%) and respondents in the lower income categories, \$0-\$24,999 (63.9%), and \$25,000-\$29,999 (53.8%) are least likely to be concerned about their child's quality of education.

Furthermore, respondents without a high school degree were less likely (43.2%) to be concerned about their child's quality of education, compared with respondents in all the higher education levels, ranging from 76.2% for respondents with a high school diploma to 97.6% for respondents with a post graduate degree.

Although over half of the respondents in each income category expressed concern about the quality of their child's education, respondents in the two lower income categories are less likely than respondents in the two upper income categories to be concerned about their child's quality of education \$0-\$24,999 (63.9%) and \$25,000-\$49,000 (53.8%), compared to \$50,000-\$74,999(85.8%) and \$75,000+ (82.2%).

PARENTAL DISCUSSIONS (6-17)

One of the most important actions an adult can do for a child or adolescent is to listen well and talk about difficult subjects. Talking about issues like drugs, sex, and depression helps the child understand the subject, but even more importantly, those discussions lead to solid and trusting relationships between adults and children. These relationships directly influence the child's self esteem and ability to make wise choices. When a parent is willing to talk about these subjects, their children are more likely to come to them first when confronted by tough choices. When the relationship is strong, the child will also be able to trust the parent when problems arise as a result of unwise choices.¹

Some adults may be hesitant to talk with younger children about some of these subjects. However, there are at least two reasons they should talk to kids early. First, kids are often already hearing about these topics from other places, notably television, and getting a message that may not help the child make wise decisions. Secondly, younger children tend to talk with their parents first about tough issues; as children grow older, they tend to talk first with their peers. If a parent wants to significantly influence a child in these areas, early is the best time.²



¹ www.talkingwithkids.org/index.htm

² Reese, E., Bird, A., and Tripp, G. (2007). Children's self-esteem and moral self: Links to parent-child conversations regarding emotion. *Social Development*, 16(3), 460-478.



**Parents Who Indicated They Had Not Spoken
To Their Child About The Following Topics:**
(HARC, 2007)

Discussion Topic	Weighted Percent	Population Estimates
Suicide	70.5	70,513
Depression or isolation	67.7	67,395
Eating disorders	64.1	63,785
Interpersonal (domestic) violence	63.2	62,754
Sexual issues or pregnancy	44.5	44,198
Gangs or violence	36.8	36,774
Smoking	33.5	33,488
Alcohol	32.2	32,240
Dealing with anger	31.1	30,830
Drugs	29.6	29,662

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

PARENTAL DISCUSSIONS – SUICIDE

Suicide is the third leading cause of death for 15- to 19- year olds in the United States; even more adolescents attempt suicide each year. The exact number of attempted suicides is unknown because many may not be treated in a hospital and/or may not be recorded as self-inflicted injury.

A survey conducted in 2001 showed that 19% of high school students had seriously thought about suicide, 14.8% had made plans to attempt suicide, and 8.8% had made a suicide attempt during the year before the survey.¹ Teens with an increased risk for suicide include those who are depressed and experience feelings of worthless, rejection, helplessness, or isolation. Other risk factors for adolescent suicide are: previous suicidal behavior, history of psychiatric disorder or substance abuse, family history of suicide, loss of a parent through any means, a history of abuse, violence or neglect, social isolation/alienation because of being gay, and being bullied.²

KEY FINDING:	
<p>Nearly 71% (70,513) of respondents reported they have <u>not</u> talked with their child about suicide in the past year.</p>	<p>Nearly 71% of respondents reported they have not talked with their child about suicide in the past year. This represents an estimated 70,513 children.</p> <p>White children (83.2%) were more likely than Hispanic/Latino children (63.3%) <u>not</u> to have been talked to about suicide. The proportion of parents who have not talked to their child about suicide increases as annual income increases. Parents with a child 12-17 were more likely than parents with a child 6-11 to report talking to their child about suicide. Parents who did not complete high school were the most likely to report they have talked with their child about suicide. The parents of boys are less likely than parents of girls to talk with their child about suicide (74.6% vs. 66.4%).</p>

¹ SAMHSA Children and Suicide Warning Signs. *You are Not Alone*, 2006.

² American Psychiatric Association, 1996.



PARENTAL DISCUSSIONS – DEPRESSION OR ISOLATION

Clinical depression is a mental, emotional, and behavioral disorder that can appear during childhood and adolescence. Depression in children can lead to school failure, alcohol or other drug use, and even suicide.

Children under stress, who experience loss, or who have attention, learning or conduct disorders are at a higher risk for depression. It can be difficult to diagnose depression among adolescents, particularly because normal teenage behaviors and attitudes are often troubling to parents as well.¹

KEY FINDING:	
<p>Nearly 68% (67,395) of respondents report <u>not</u> having talked with their child during the past year about depression or isolation.</p>	<p>Nearly 68% of respondents reported not having talked with their child during the past year about depression or isolation. This represents an estimated 67,395 children.</p> <p>White children (74.1%) were more likely than Hispanic/Latino children (64.2%) <u>not</u> to have been talked to about depression or isolation. Parents in the highest income group were the most likely (81.4%) to report they have not talked to their child about depression or isolation; at least 50% of adults in each income category have not talked with their child about this topic. Parents of children 6 to 11 are more likely not to have talked, or had someone else talk, to their child about depression or isolation. The majority of respondents in all educational groups reported not talking to their child about depression or isolation in the past year. The parents of boys and girls are about equally likely not to have talked to their child about depression or isolation.</p>

PARENTAL DISCUSSIONS – EATING DISORDERS

Eating disorders are medical illnesses marked by severe disturbances in eating behavior. The two main types of eating disorders are anorexia nervosa and bulimia nervosa. A third category, which includes several variations of eating behaviors, is eating disorders not otherwise specified.²

Forty percent of newly identified cases of anorexia are in girls 15-19 years old.³ Although eating disorders are typically considered a “female” disorder, more and more males are being affected; one in four preadolescent cases of anorexia occurs in boys. The prevalence of eating disorders among younger age groups, as young as 7 years of age, is increasing.⁴ Many people who suffer from eating disorders also have coexisting psychiatric illnesses. While researchers are unsure of the underlying causes and nature of eating disorders, there are psychological and medicinal treatments available to help treat these illnesses.

¹ National Mental Health Association, 2005.

² National Institute of Mental Health, 2007, menanddepression.nimh.nih.gov/health/publications/eating-disorders/summary.shtml

³ National Eating Disorders Association. *Anorexia Nervosa*, 2006, www.edap.org/p.asp?WebPage_ID=286&Profile_ID=41142>

⁴ Eating Disorders Coalition for Research. Sources: Susan Ice, M.D., Medical Director, The Renfrew Center, and the *Journal of the American Academy of Child and Adolescent Psychiatry*, 2007.



KEY FINDING:

Over 64% (63,785) of respondents report not having talked with their child about eating disorders in the past 12 months.

Over 64% of respondents reported not having talked with their child about eating disorders in the past 12 months. This represents approximately 63,785 children who had not talked to an adult in the household about eating disorders in the past year.

White children (80.2%) were more likely than Hispanic/Latino children (56.5%) not to have talked to an adult in the household about eating disorders. Talking to a child about eating disorders is less common as respondent's level of income increases. Parents with a child 12-17 were more likely than parents with a child 6-11 to talk with him/her about eating disorders. In general, talking to a child about eating disorders is less common as respondent's level of education increases. The parents of boys are less likely than the parents of girls to talk with them about eating disorders.

PARENTAL DISCUSSIONS – INTERPERSONAL OR DOMESTIC VIOLENCE

Domestic violence is a serious problem encountered by many young people living in the United States. It is estimated that each year 3.3 million children are exposed to violence by family members.

Data show that slightly more than half of females in violent relationships live in households with children under age 12. Children who are exposed to violence and maltreatment often suffer increased depression, anxiety, post traumatic stress, anger, alcohol and drug abuse, and lower academic achievement.¹

KEY FINDING:

Over 63% (62,754) of respondents reported not having talked with their child, during the past 12 months, about interpersonal (domestic) violence.

Over 63% of respondents reported not having talked with their child, during the past 12 months, about interpersonal (domestic) violence. This represents approximately 62,754 children who had not talked to an adult in the household about interpersonal (domestic) violence.

White children (76.7%) were more likely than Hispanic/Latino children (58.1%) not to have been talked to about interpersonal violence. Parents in the highest income group are most likely not to have talked with their child about interpersonal violence. The majority of children in both age groups have not been talked to about interpersonal violence. Parents with an education at or beyond high school were more likely not to have talked with their child about interpersonal violence. Talking to a child about interpersonal violence is not related to child gender in these data.

¹ California Attorney General's Crime and Violence Prevention Center. *Facts: Domestic Violence and Children, 2007*, www.safestate.org/index.cfm?navid=214



PARENTAL DISCUSSIONS – SEXUAL ISSUES OR PREGNANCY

Despite achievements made in reducing teenage pregnancy rates, the United States still ranks-highest among the western industrialized world for teen pregnancies and births. More than 30% of girls will become pregnant at least once by the age of 20.¹

According to the Youth Risk Behavior Survey developed by the Centers for Disease Control and Prevention, roughly half (47%) of all U.S. high school students report having sex at least once, (this behavior puts them at risk of both pregnancy and infection with a sexually transmitted disease, or STD). The estimated number of HIV/AIDS cases among teens rose between 2001 and 2005. By the end of 2005, 6,324 new AIDS cases had been reported among 13- to 19-year olds. Studies have shown that teenage pregnancy rates are lowered when parents provide guidance and maintain open communication with their children about sexuality, contraception, STDs, and the responsibilities of intimate relationships and pregnancy.²

KEY FINDING:

Nearly 45% (44,198) of respondents report not having talked with their child about sexual issues or pregnancy.

Nearly 45% of respondents report not having talked with their child about sexual issues or pregnancy. This represents an estimated 44,198 children.

White children (48.8%) were slightly more likely than Hispanic/Latino children (42.9%) not to have had a conversation with an adult in the household about sexual issues or pregnancy. At least 39% of respondents in each income category have not talked with their child about sexuality or pregnancy during the past year. Children 12-17 are more likely to have had someone talk with them about sexual issues or pregnancy. The parents of boys are less likely than the parents of girls to talk with them about sexual issues or pregnancy (48.7% vs. 39.8%).

PARENTAL DISCUSSIONS – GANGS AND VIOLENCE

Gang violence is a serious problem in California, and no one is immune from the impact that gangs and youth violence can have on a community. Today, gangs, and the violence they attract, draw young people from all walks of life, socioeconomic backgrounds, races, and ethnic groups. Youth violence is a problem not only for law enforcement, but also for the community.

Street gangs recruit members at young ages. These children become part of dangerous crimes such as drug distribution, drive-by shootings, carjackings, home invasions and even taking innocent lives. Early interventions by school programs and community involvement do show positive results in helping lead these kids down a different path.³

¹ The National Campaign to Prevent Teen and Unplanned Pregnancy. *Emerging Answers 2007: Research Findings on Programs to Reduce the Problems of Teen Pregnancy and Sexually Transmitted Disease*, 2007, www.thenationalcampaign.org/EA2007/default.aspx

² *Ibid.*

³ *California Attorney General's Crime and Violence Prevention Center*, 2007, www.safestate.org/index.cfm?navID=12



KEY FINDING:

Nearly 37% (36,774) of respondents reported not having talked with their child about gangs or violence in the past year.

Approximately 37% of respondents reported not having talked with their child about gangs or violence in the past year. This represents approximately 36,774 children who have not had a talk with a parent or guardian about gangs or violence.

White children (52.2%) were more likely than Hispanic/Latino children (30.7%) not to have talked with an adult in the household about gangs or violence. Respondents with greater household incomes are less likely to have talked to their child about gangs or violence. Children 6 to 11 years of age (43.2%) were more likely not to have had someone talk with them about gangs or violence than were children 12 to 17 years of age (32.5%). Respondents with more education are more likely than respondents with less education not to have talked with their child about gangs or violence. Parents of boys were more likely than parents of girls to report having talked with their child about gangs or violence.

PARENTAL DISCUSSIONS - SMOKING

Smoking cigarettes has very harmful effects on the bodies of young kids and adolescents, especially at a time when they are still growing and developing. Tobacco use in adolescents exposes them to the many dangers that come as a result of using tobacco: cancer, heart disease, lung disease, nicotine addiction, oral cancer, gum disease, emphysema, and an increased risk of cardiovascular disease, including heart attacks.

Because tobacco is such an addictive substance (due to the nicotine), a person who starts smoking at an early age is more likely to develop a strong addiction.¹ Youth who currently smoke are more likely than youth who do not smoke to use tobacco products other than cigarettes, illicit drugs, and alcohol.² Data from the 2006 National Survey on Drug Use and Health show the number of girls who smoke cigarettes slightly outnumber the boys who smoke.³

KEY FINDING:

Nearly 34% (66,550) of respondents report that no adult in the household has talked with their child about smoking.

Nearly 34% of respondents report that no adult in the household has talked with their child about smoking, representing 66,550 children.

Hispanic/Latino children were more likely than White children to have had a conversation about smoking. Parents in the higher income groups are more likely not to have talked with their child about smoking. Although no clear pattern emerges, respondents with a college degree are the most likely to report not talking with their child about smoking. Talking to children about smoking is not related to child age or child gender.

¹ Kids Health-The Nemours Foundation,

www.kidshealth.org/parent/positive/talk/smoking.html

² U.S. Department of Health and Human Services and SAMSHA's National Clearinghouse for Alcohol and Drug Information, 2005, <http://oas.samhsa.gov/nsduh/2k5nsduh/2k5results.htm#Ch4>

³ U.S. Department of Health and Human Services and SAMSHA's National Clearinghouse for Alcohol and Drug Information, *Tips for Teens: The Truth About Tobacco*, 2007, <http://ncadi.samhsa.gov/govpubs/sma4280/default.aspx>



PARENTAL DISCUSSIONS - ALCOHOL

Alcohol is the number one choice of drug among young people, making underage drinking a leading public health problem in the United States. Young people who drink heavily may be putting themselves at risk for a range of potential health problems such as brain damage, liver damage, and reproductive system damage. The younger children and adolescents are at an age when they start to drink, the more likely they will be to engage in risky behaviors that harm themselves and others, such as using other drugs(including marijuana and cocaine), having sex with multiple partners, drinking and driving, and earning poor grades in school.¹

Three-fourths of 12th graders, more than two-thirds of 10th graders, and about two in every five 8th graders have consumed alcohol.² Youth tend to drink intensively when they drink, often consuming four to five drinks at one time, referred to as binge drinking.³ Identifying youth at risk, and early intervention, are very helpful at preventing underage drinking.⁴

KEY FINDING:	
<p>Over 32% (32,240) of respondents reported no adult in the household has talked with their child about alcohol in the past year.</p>	<p>Over 32% of respondents reported no adult in the household has talked with their child about alcohol in the past year. This represents approximately 32,240 children.</p> <p>White children (43.8%) are more likely than Hispanic/Latino children (26.9%) not to have had a conversation with an adult in the household about alcohol. Parents in the \$50,000 to \$74,999 income group are the most likely not to have talked with their children about alcohol. As with other drugs, parents of children 6 to 11 years of age were more likely (45.5%) than parents of children 12-17 (23.1%) not to have talked with their child about alcohol. Respondents without a high school education are the most likely to indicate they have talked with their child about alcohol in the past year. The parents of boys were slightly more likely (34.2%) than the parents of girls (29.8%) not to talk with them about alcohol.</p>

PARENTAL DISCUSSIONS – DEALING WITH ANGER

Anger is a normal reaction and part of growing up. Feeling angry is not always bad; when properly dealt with, it can be a productive emotion. However if a child does not learn to control anger, it can lead to difficulties ranging from mild peer relationship interruption to a psychiatric disorder called Oppositional/Defiance Disorder—which can, in turn, lead to full- scale social aggression.⁵

While professional help is available for these disorders, talking with children about their behaviors (both the positive and negative aspects) and actively listening to how they feel can do a lot to help them learn to control their anger.⁶

¹ National Institute on Alcohol Abuse and Alcoholism. *Alcohol Alert*, 2006, <http://pubs.niaaa.nih.gov/publications/AA67/AA67.htm>

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*

⁵ NYU Child Study Center. *Anger: Helping children cope with this complex emotion*, 2004, www.mayoclinic.com/health/oppositional-defiant-disorder/DS00630

⁶ Borba, M. (1999). *Parents Do Make a difference*, www.parentingbookmark.com/pages/articleMB01.htm



KEY FINDING:

About 31.1% (30,830) of respondents report not having talked with their child in the past year about dealing with anger.

About 31.1% of respondents reported not having talked with their child in the past year about dealing with anger. This represents an estimated 30,830 children.

White children (32.4%) and Hispanic/Latino children (30.8%) were about equally likely to have the adult respondent report not talking with them about dealing with anger. Parents of children in both age groups were equally likely (31.2% and 31.0% for younger and older children, respectively) not to have talked with their child about controlling anger. Parents without a high school degree are the most likely to report talking with their child about dealing with anger (differences between categories are not very large). The parents of girls were less likely than the parents of boys to talk with them about dealing with anger.

PARENTAL DISCUSSIONS - DRUGS

Some teens experiment with drugs out of boredom as a way to fill their time, while others turn to drugs to help them deal with uncomfortable emotions or problems they may have. In addition to the commonly-known illicit drugs, there is a new array of substances that kids today use to get high. Research shows that more teenagers are getting high through the intentional abuse of prescription and over-the-counter medications. Teens today are more likely to have abused prescription pain medicines to get high than they are to have tried other drugs like ecstasy, cocaine, crack or LSD.¹

Many teens think these drugs are safe because they have legitimate uses, but taking them without a prescription to get high or “self-medicate” can be as dangerous and addictive as using street narcotics and other illicit drugs.²

KEY FINDING:

Nearly 30% (29,662) of respondents reported they have not talked with their child about drugs during the past 12 months.

Nearly 30% of respondents reported they have not talked with their child about drugs during the past 12 months. This represents approximately 29,662 children.

White children (42.5%) are more likely than Hispanic/Latino children (24.7%) not to have talked with their parents/guardians about drugs. At least 25% of parents in each income category have not talked with their children about drugs. Parents/guardians are more likely to report talking to children 12-17 about drugs than children 6-11. Parents earning less income annually are more likely to report they have talked with their children in the past year about drugs. The parents of boys are less likely than the parents of girls to talk with them about drugs (33.0% vs. 25.7%).

¹ www.drugfree.org/Portal/About/NewsReleases/Generation_Rx_Teens_Abusing_Rx_and_OTC_Medications

² www.drugfree.org/Parent/Resources/Prescription_Medicine_Misuse



ERC CHILD WEIGHT ISSUES

In 2005 the American Medical Association in collaboration with the Health Resources and Service Administration and the Centers for Disease Control and Prevention formed an expert committee to review previous recommendations on the evaluation and treatment of child and youth obesity. The December 2007 issue of *Pediatrics*, the official Journal of the American Academy of Pediatrics, included a Supplement entitled Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. Some highlights of that report are presented below.¹

PREVENTION

Obesity prevention should be targeted at all children, since they are establishing eating and activity behaviors. The following are healthy habits which may prevent excessive weight gain:

- ❖ limiting consumption of sugar-sweetened beverages
- ❖ consuming adequate fruits and vegetables, approximately 9 age appropriate servings daily
- ❖ eating breakfast daily
- ❖ limiting the number of meals eaten out in restaurants, particularly fast food restaurants
- ❖ eating meals together with the family
- ❖ limiting portions
- ❖ eating a diet rich in calcium
- ❖ consuming a diet high in fiber
- ❖ eating a diet with the right balance of carbohydrate, protein and fat
- ❖ limiting consumption of energy-dense foods
- ❖ limiting television and other screen time
- ❖ engaging in moderate to vigorous physical activity for at least 60 minutes each day

According to the Expert Committee, the incidence of childhood obesity is increasing at an alarming rate. Between 1963 and 1970 approximately 5% of US children were considered to be obese. The number jumped to a staggering 17% between 2003 and 2004.²

Obesity in children, as in adults, puts them at risk for developing other medical conditions such as diabetes, hypertension, cardiovascular disease and hyperlipidemia. Until recently, Type 2 diabetes, formerly called adult onset diabetes never occurred in children. Today we are witnessing an epidemic of type 2 diabetes in children. Physicians treating these patients are being challenged as they are mapping uncharted territory.

¹ *Pediatrics*, 2007, http://pediatrics.aappublications.org/cgi/reprint/120/Supplement_4/S164

² *Ibid*



BMI ANALYSIS

KEY FINDING:	
<p>Nearly 50% (47,441) of children in Eastern Riverside County are either overweight or obese as determined by BMI criteria.</p>	<p>Parents/guardians of children 2-17 reported that 33.6% are obese as measured by HARC calculated BMI. The US incidence of obesity (via calculated BMI) between 2003 and 2004 is 17%.</p> <p>Over 15,900 or 16.8% of children age 2-17 in Eastern Riverside County are overweight. In combination, overweight and obese children make up 49.8% of the child population in ERC. This is higher than the rate of 33.6% for overweight or obese children reported by The Institute of Medicine of the National Academies.¹</p> <p>In comparing overweight and obese children, White children are more likely to be overweight, while Hispanic/Latino children are more likely to be obese. Children ages 2-5 and 6-11 are more likely to be obese while children ages 2-5 and 12-17 are more likely to be overweight. When comparing genders, a higher proportion of male than female children are considered overweight, while approximately equal proportions of boys and girls are obese.</p>

BMI Analysis, Children 2 to 17
(HARC, 2007)

	<i>Weighted Percent</i>	<i>Population Estimates</i>
Underweight (<5 th percentile)	5.6	5,332
Healthy Weight (5 th to 84 th percentile)	44.6	42,553
Overweight (85 th to 94 th percentile)	16.8	15,984
Obese (≥95 th Percentile)	33.0	31,457
Total	100.0	95,325

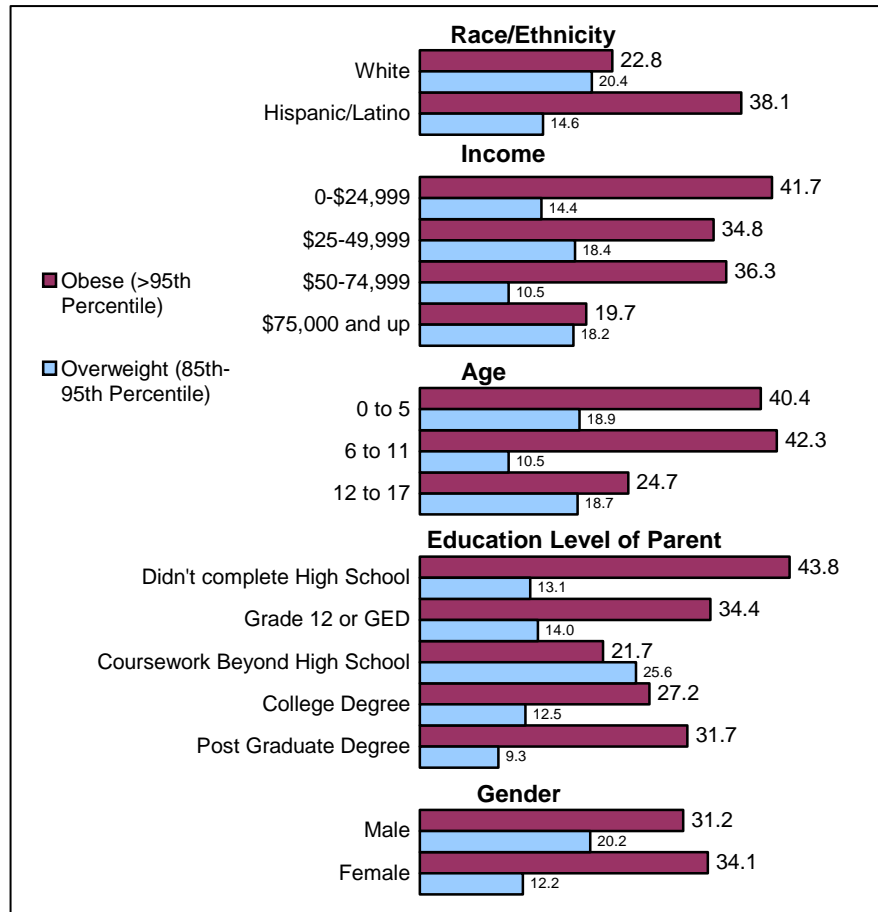
“This may be the first generation of children who do not outlive their parents.”

*-Deborah Taylor-Tate
Commissioner, FCC*

¹ Institute of Medicine. *What Government Can Do To Respond To Childhood Obesity, Fact Sheet September 2006, www.iom.edu/Object.File/Master/36/987/11722_govt_factsheet.pdf*



Comparison of Overweight and Obese Children within Demographic Categories (HARC, 2007)



KEY FINDING:

While parents in Eastern Riverside County perceive their children ages 0-17 to be “about the right weight” (75.3%), BMI results show that a larger percentage, nearly 50% are overweight or obese.

Lack of recognition of their child’s weight problem is consistent for children ages 0-5 and 6-17. 85.7% of parents with children ages 0-5 stated their children were “about the right weight”, but BMI results ages 2-5, show that 59.3% are overweight or obese. 70.4% of parents with children ages 6-17 stated their children were “about the right weight”, with BMI results showing 43.4% are overweight or obese.

A recent study conducted by the C.S. Mott Children’s Hospital indicates that parents do not recognize that their child is overweight. Modification of a child’s diet or physical activity will not occur if a parent is in denial of a child’s obesity.¹

¹ CS Mott Children’s Hospital National Poll on Children’s Health, December 2007, www.med.umich.edu/mott/research/CBH%20Poll/NPCH%20vol%202%20issue%203%20BMI.pdf



FAMILY MEAL TIME

Family meal times are more than just eating together. This important interaction can lead to better physical and mental health for children. Frequent meals together are related to better nutritional intake, and a decreased risk for unhealthy weight control practices.

In an article published in the Journal of the American Dietetic Association, frequency of family meals was associated with increased intake of fruits, vegetables, grains, and calcium-rich foods and negatively associated with soft drink consumption.¹

KEY FINDING:

Over 41% or 41,162 children ages 6-17 do not eat meals with their family every day.

Results from the HARC survey show that almost 39% of children ages 0-5 do not eat meals with their family every day. This represents 18,207 children.

Family Eats Meals Together (HARC 2007)

	0 - 5 Years Old		6 - 17 Years Old	
	Weighted Percent	Population Estimates	Weighted Percent	Population Estimates
1-2 times per week	8.6	4,037	9.3	9,297
3-4 times per week	11.4	5,334	14.3	14,273
5-6 times per week	15.6	7,318	14.7	14,674
Every Day	61.2	28,710	58.8	58,668
None	3.2	1,518	2.8	2,918

EATING FRUITS AND VEGETABLES

Fruits and Vegetables contain essential vitamins, minerals and fiber that protect against chronic diseases and at the same time help combat obesity.

KEY FINDING:

Approximately 30% of children ages 1-17 in Eastern Riverside County do not eat 5 servings of fruits and vegetables in their daily diet.

Over 39,600 children in Eastern Riverside County do not eat the recommended 5 servings of fruits and vegetables daily.

37.4% (48,728) of parents believe their child eats “enough” fruits and vegetables, although it is unknown how much they actually eat.

¹ Spear, B. A. (2006). The Need for Family Meals. *J Am*, 106, 218-219.



FAST FOOD

Eating fast foods which are high in fat often replaces the healthy foods that children should be consuming. Eating the right balance of carbohydrate, protein and fat will reduce the potential consequences of the child developing adult diseases such as high blood pressure and Type 2 diabetes. The average American family spends about 40% of their food budget on fast food.¹

KEY FINDING:	
Over 58,000 children ages 6-17 (60.9%), according to the HARC 2007 survey, eat fast food one to two times a week.	Over 21% of survey respondents indicated that their child ate fast food 3-7 times per week. This represents over 20,000 children. 17.9% (17,130) indicated that their children did not eat any fast food.

Times Child Ate Fast Food in the Past Week
(HARC, 2007)

	Weighted Percent	Population Estimates
None	17.9	17,130
1	38.8	37,134
2	22.1	21,101
3	10.4	9,904
4	3.4	3,237
5	3.0	2,906
6	0.2	149
7	4.2	4,035
Total	100.0	95,595

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

¹ Joint Informational Hearing of the California Health and Human Services Committee. *Childhood Obesity and the Role of California's Schools, 2001.*



EXTRACURRICULAR ACTIVITIES

With obesity on the rise, it is has become more important that children participate in physical activities that will build stronger muscles and bones and a leaner body. It is recommended that all children 2 years and older should get 60 minutes of moderate to vigorous exercise on most, preferably all, days of the week.¹

KEY FINDING:	
Parents/guardians report that 59.5% of children ages 7-17 engaged in more sedentary activities than physical activity in the week prior to the HARC 2007 survey.	Hispanic/Latino children were only slightly more likely than White children to engage in predominantly sedentary activities. Parents/guardians of children ages 12-17 (65.3%) compared to children ages 7-17 (51.2%) were more likely to report their child spent most of their time during the past week engaged in sedentary activities, while females were over 1 ½ times more likely than males to have spent most of the previous week engaged in sedentary activities. The majority of children in all BMI categories spent more of the previous week engaged in sedentary activities than in physical activity which validates the need for all children to increase their physical activity.

Main Child Physical and Sedentary Activity
(HARC, 2007)

	Weighted Percent	Population Estimates
Physical activity	40.5	40,202
Sedentary activity	59.5	59,131
Total	100.0	99,332



¹ U.S. Department of Agriculture (USDA) and the Department of Health and Human Services (HHS). Dietary Guidelines for Americans, 2005, www.oznet.ksu.edu/humannutrition/dgaexecsummary.pdf



Community Health Monitor Highlights

Community Health

LIVABLE COMMUNITY

A livable community is one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life.¹ The livability of a community is improved by promoting quality of life, economic development, and social equity.

KEY FINDING:	
<p>11.2% of adults reported that crime was their greatest concern about their community, while 10.0% reported that their greatest concern was safety and security.</p>	<p>Crime (11.2%) or neighborhood safety and security (10.0%) were the top two major concerns of Eastern Riverside County residents about their community. Healthcare, affordable housing, drug trafficking, gang activity, and overcrowding / population growth were selected by between 4% and 6% of adult respondents.</p> <p>The largest proportion of respondents (22.7%) indicated they had no concerns about their community; they represent 110,880 Eastern Riverside County residents.</p>

Major Concerns in Your Community (HARC 2007)

Issue	Weighted Percent	Population Estimates
I do not have any concerns	22.7	110,880
Crime	11.2	54,595
Neighborhood Safety and Security	10.0	48,649
Healthcare	5.8	28,272
Affordable Housing	5.0	24,421
Drug Trafficking	4.9	23,775
Gang Activity	4.7	22,956
Overcrowding/ Population Growth	4.4	21,661
Cost of Living	3.1	15,246
Vandalism	2.8	13,793
Weather, Earthquake, Natural Disasters, or Fire	2.2	10,934
Senior Issues/ Aging	1.7	8,135
Lack of After School Programs	1.6	7,735
Lack of Transportation	1.4	6,950
Air Quality	1.4	6,785
Schools/ Education	1.2	6,004
Political/ Government Issues	1.1	5,160

¹ AARP. *Livable Communities: An Evaluation Guide*, 2005, www.aarp.org/research/housing-mobility/indliving/d18311_communities.html



Issue	Weighted Percent	Population Estimates
Illegal Immigration	1.0	5,013
Growing Diversity	1.0	4,994
Poverty	1.0	4,823
Other	11.6	56,706
Total	100.0	487,487

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.

COMMUNITY SOCIAL AND ECONOMIC NEEDS

Community residents age 18 and older sometimes need assistance with many of their social and economic needs such as financial assistance, assistance with transportation and food, and child care assistance. Government programs and community-based organizations often provide some assistance in these areas.

KEY FINDING:

Over 210,000 residents (37.9%) of Eastern Riverside County required some form of economic or social assistance.

Adult respondents in Eastern Riverside County were more likely to report needing financial assistance (7.6%), followed by assistance for utilities (5.2%), transportation (5.0%), food (4.6%), housing (4.4%), and home health care (4.1%) in the past 12 months. Population estimates of these needs by Eastern Riverside County residents are provided in the next graph.

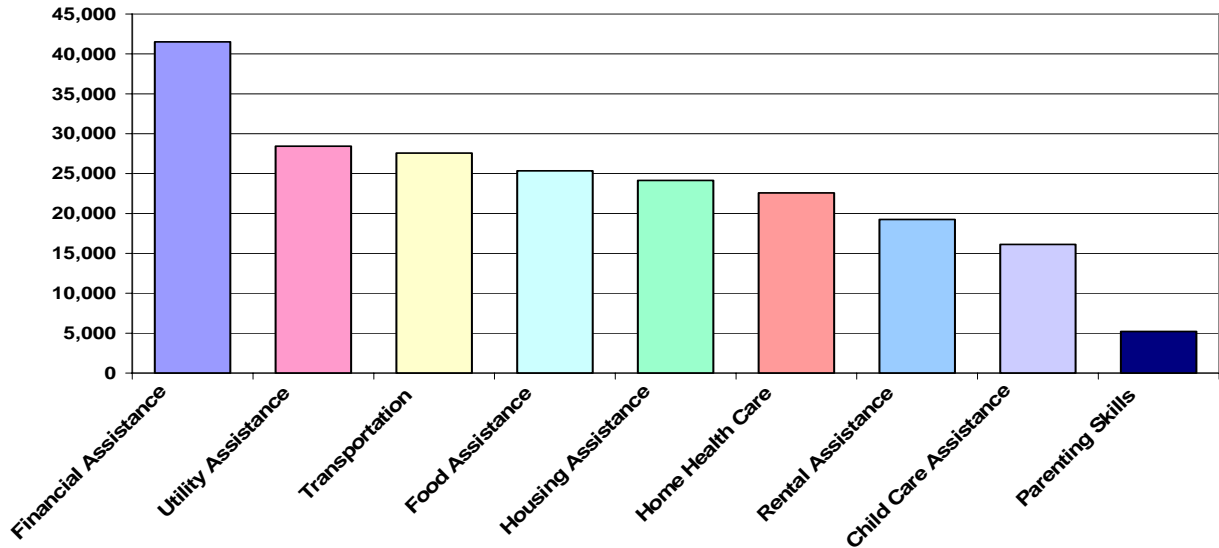
Major Social and Economic Needs in Past 12 Months (HARC 2007)

Need	Weighted Percent	Population Estimates
Financial Assistance	7.6	41,520
Utility Assistance	5.2	28,449
Transportation	5.0	27,562
Food Assistance	4.6	25,364
Housing Assistance	4.4	24,148
Home Health Care	4.1	22,577
Rental Assistance	3.5	19,259
Child Care Assistance	2.9	16,116
Parenting Skills	0.9	5,209

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding
 Note: Respondents could select more than one answer so a total percent is not included.



Population Estimates for Residents Requiring Assistance in Last 12 Months
(HARC, 2007)



KEY FINDING:

Almost one out of four adult residents (24.8 %) report not being able to receive services they require.

Over 24% report that they are not able to receive the services they require. They represent 23,252 residents.

Of the 24.8% of those not receiving needed services, 38% indicated they did not meet the requirements of the program they applied for. Over 29% indicated they did not ask for the service or decided they did not need it and 23.8% did not know where to go to obtain the service they needed.

Reasons Not Able to Receive Services
(HARC 2007)

	Weighted Percent	Population Estimates
Did not meet the requirements	38.0	7,484
Did not need it or Did not ask for it	29.4	5,785
Did not know where to go	23.8	4,690
Lack of documentation to prove legal residency	1.4	285
Other	7.4	1,455
Total	100.0	19,700

Note: "Population Estimate" may not reflect actual population due to non-responses and/or rounding.



County Health Status Indicators

Health Status Indicators Summary – Riverside County

The State of California Department of Health Statistics collects and reports on 24 health status indicators for each of the 58 counties. Most of these indicators can be compared to national rates and Healthy People 2010 (HP2010) objectives. While not an all-inclusive list, these indicators provide a broad assessment of health status in key areas, Mortality, Morbidity, Infant Mortality, Prenatal Care, Natality, Breastfeeding, and Child Poverty. The full report follows this discussion of the results. Definitions of terms used in this indicator section can be found at www.dhs.ca.gov/hisp/chs/OHIR/reports/healthstatusprofiles/2006/profiles.pdf.

Mortality

Age-adjusted mortality rates are collected for All Causes, Coronary Heart Disease, All Cancers, Cerebrovascular Disease, Lung Cancer, Unintentional Injuries, Female Breast Cancer, Motor Vehicle Accidents, Diabetes, Drug-Induced Deaths, Suicide, Firearm Injuries, and Homicides. Riverside County age-adjusted mortality rates are generally higher than California except for Diabetes and Homicide. Rates for Coronary Heart Disease rates in Riverside County are 20% higher than the rate for the State. All the Riverside mortality rates are higher than the Healthy People 2010 objectives.

Morbidity

Morbidity rates for the incidence of Chlamydia, AIDS, TB, Syphilis, Hepatitis C, and Measles are collected. Morbidity rates for Riverside County are lower than those for California, except for Syphilis, which is 18% higher. All of the county rates are higher than the HP 2010 objectives, except for Measles where the county rate and objective is 0.00, and for Hepatitis C where the county rate of 0.04 is lower than the HP2010 objective of 1.00.

Infant Mortality

Infant Mortality is reported by race. All of the infant mortality rates for Riverside County are higher than the state rate, except for Blacks. However, all of these rates are higher than the HP2010 objective of 4.5.

Prenatal Care

Data are reported on Adequate and Adequate Plus Care, Late or No Prenatal Care, and Low Birth Weight Infants. Riverside County reports a lower percentage of mothers having Adequate or Adequate Plus prenatal care and a higher percentage of Late or No Prenatal Care that does the State. However, the county has a lower rate (6.2%) of Low Birth Weight Infants that does the State (6.6%).

Natality

Rates for Births to Mothers Aged 15-19 are reported. Riverside County has a higher rate (44.2) than the State (39.2). There is no HP2010 objective established for this metric.

Breastfeeding

Pertaining to breastfeeding, Riverside County reports a slightly smaller percentage (79.3%) of breastfeeding initiation compared to the State (83.7%). Since the HP2010 objective is 75%, the county has exceeded the HP2010 goal.

Child Poverty

With information gathered from the Census, it can be determined that a lower percentage (18%) of persons under the age of 18 is living in poverty in Riverside County in comparison to the State (19.6%). There is no HP2010 objective for this metric.



RIVERSIDE COUNTY'S HEALTH STATUS PROFILE FOR 2006

<i>Health Status Indicator: Mortality</i>	<i>Age-Adjusted Death Rate</i>	<i>HP2010</i>	<i>Age-Adjusted Death Rate</i>	<i>Age-Adjusted Death Rate</i>
	<i>Riverside</i>	<i>Objective</i>	<i>Statewide</i>	<i>National¹</i>
All Causes (2002-2004 Average)	757.8	N/E	704.5	832.7
Coronary Heart Disease	200.9	162.0	164.7	172.0
All Cancers	170.3	158.6	164.1	190.1
Cerebrovascular Disease	55.1	50.0	52.4	53.5
Lung Cancer	46.4	43.3	41.8	54.1
Unintentional Injuries	36.0	17.1	29.3	37.3
Female Breast Cancer	23.7	21.3	22.8	25.3
Motor Vehicle Accidents	17.4	8.0	12.1	14.8
Diabetes	16.2	N/A ¹	21.3	25.3
Drug-Induced Deaths	10.4	1.2	10.0	9.9
Suicide	9.8	4.8	9.4	10.8
Firearm Injuries	9.5	3.6	9.4	10.3
Homicide	6.0	2.8	6.7	6.0
<i>Morbidity</i>	<i>Crude Case Rate</i>	<i>HP2010</i>	<i>Crude Case Rate</i>	<i>Crude Case Rate</i>
	<i>Riverside</i>	<i>Objective</i>	<i>Statewide</i>	<i>National¹</i>
Chlamydia Incidence	213.24	N/A ²	324.31	A
AIDS Incidence (Age 13 And Over)	13.69	1.00	13.72	17.6
Tuberculosis Incidence	4.13	1.00	8.71	5.1
Syphilis Incidence	4.04	0.20	3.43	2.5
Hepatitis C Incidence	0.04	1.00	0.13	1.6
Measles Incidence	0.00	0.00	0.01	A
<i>Infant Mortality</i>	<i>Birth Cohort</i>		<i>Birth Cohort</i>	<i>Birth Cohort</i>
	<i>Infant Death Rate</i>	<i>HP2010</i>	<i>Infant Death Rate</i>	<i>Infant Death Rate</i>
	<i>Riverside</i>	<i>Objective</i>	<i>Statewide</i>	<i>National²</i>
Infant Mortality: Black	9.8	4.5	11.2	13.8
Infant Mortality: Asian/P.I.	6.2	4.5	4.1	4.8
Infant Mortality: All Races	5.9	4.5	5.3	7.0
Infant Mortality: Hispanic	5.5	4.5	5.1	5.6
Infant Mortality: White	5.4	4.5	4.7	5.8



<i>Prenatal Care</i>	<i>Percentage</i>	<i>HP2010</i>	<i>Percentage</i>	<i>Percentage</i>
	<i>Riverside</i>	<i>Objective</i>	<i>Statewide</i>	<i>National¹</i>
Adequate/Adequate Plus Care	75.3	90.0	78.3	75.4
Late Or No Prenatal Care	15.5	10.0	13.0	16.0
Low Birth Weight Infants	6.2	5.0	6.6	7.9
<i>Nativity</i>	<i>Age-Specific Birth Rate</i>	<i>HP2010</i>	<i>Age-Specific Birth Rate</i>	<i>Age-Specific Birth Rate</i>
	<i>Riverside</i>	<i>Objective</i>	<i>Statewide</i>	<i>National¹</i>
Births To Mothers Aged 15-19	44.2	N/E	39.2	41.6
<i>Breastfeeding</i>	<i>Percentage</i>	<i>HP2010</i>	<i>Percentage</i>	<i>Percentage</i>
	<i>Riverside</i>	<i>Objective</i>	<i>Statewide</i>	<i>National¹</i>
Breastfeeding Initiation	79.3	75.0	83.7	68.0
<i>Child Poverty</i>	<i>Percentage</i>	<i>HP2010</i>	<i>Percentage</i>	<i>Percentage</i>
	<i>Riverside</i>	<i>Objective</i>	<i>Statewide</i>	<i>National³</i>
Persons Under 18 In Poverty	18.0	N/E	19.6	17.6

National¹: 2003 mortality, morbidity, and teenage birth rates. 2003 breastfeeding and natality percentages.

National²: 2002 infant mortality.

National³: U.S. Census Bureau: Small Area Income and Poverty Estimates (www.census.gov/hhes/www/saie/)

N/A¹: National Objective is based on both underlying and contributing cause of death which requires use of multiple cause of death data files. California's data exclude multiple/contributing causes of death.

N/A²: Prevalence data is not available in California to evaluate Healthy People 2010 National Objective of no more than 3 percent testing positive in the population aged 15 to 24 years.

N/E: National Objective for the HP2010 has not been established.

A: National rate is not comparable to California due to rate calculation methods.

Note: Crude death rates, crude case rates, and age-adjusted death rates are per 100,000 population. Birth cohort infant death rates are per 1,000 live births. Age-specific birth rates are per 1,000 population.

Sources: Department of Health Services: Center for Health Statistics, Birth and Death Statistical Master Files, 2002-2004, and Birth Cohort Files, 2001-2003; Division of Communicable Disease Control, Office of Statistics and Surveillance; Office of AIDS, AIDS Case Registry; Genetic Disease Branch, Newborn Screening Program.

Department of Finance: 2003 Population Estimates with Age, Sex, and Race/Ethnic Detail, May 2004.

National Center for Health Statistics; Births: Final Data for 2003, National Vital Statistics Reports, Vol 54 No. 2, September 2005.

National Center for Health Statistics; Deaths: Final Data for 2003, Tables 1-4, Released January 2006.

U.S. Centers for Disease Control and Prevention (CDC), Healthy People 2010, CDC Wonder website at URL:

<http://wonder.cdc.gov/data2010/obj.htm>

The 2006 County Health Status Profiles are produced by the California Department of Health Services and the California Conference of Local Health Officers. The full report is available on-line at

www.dhs.ca.gov/hisp/chs/OHIR/reports/healthstatusprofiles/2006/profiles.pdf



Eastern Riverside County Profile

INTRODUCTION

A profile of a study area is essential to understanding the health status and needs of a community. This section includes a demographic profile with data obtained from secondary (not primary survey) sources, an economic profile of Eastern Riverside County, a socioeconomic profile, and an environmental profile that discusses air pollution, the Salton Sea, and water use.

DEMOGRAPHIC PROFILE

A demographic profile of a study area is essential to understanding the health status and needs of that community. Historical and projected population growth within the area, and the extent of seasonal populations, provide a background upon which to report detailed characteristics such as race, age, gender, and income.

POPULATION GROWTH

Significant diversity and contrast exist in the region. However, growth is a constant throughout the eastern county—showing a 26% population increase in the total (permanent plus seasonal) population from 2000 to 2006.

The permanent population in Eastern Riverside County went from slightly more than 395,000 to nearly 512,000 during the six year period from 2000 to 2006.

Because much of the area is considered a resort destination, the seasonal population adds significant numbers during the September to May winter season.

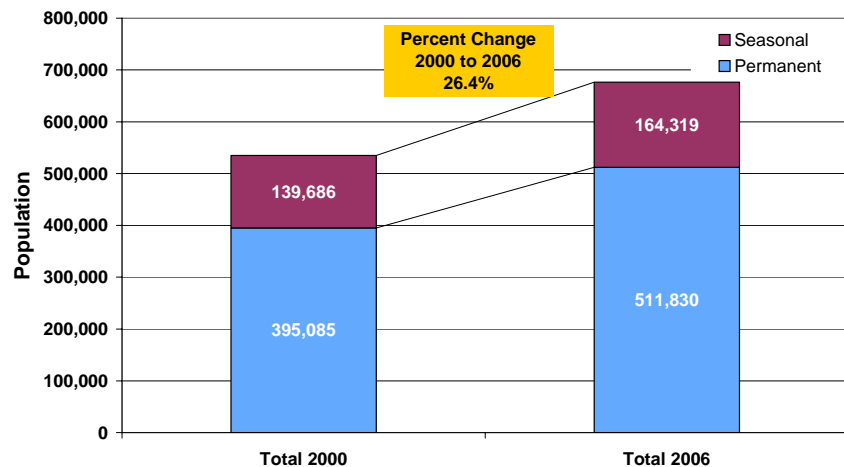
Seasonal residents increased from nearly 140,000 in 2000 to more than 164,000 in 2006. This includes a rough estimate of seasonal residents on the eastern edge of the county around the city

of Blythe. However many more seasonal residents in that area reside 20

miles away in Quartzsite, Arizona where as many as 250,000 people spend the winter. Many of these people come to Blythe for social and health services.

The Desert Resorts Convention and Visitors Bureau estimates there are over 3.5 million overnight visitors, in addition to those who stay for more extended periods, in the nine cities in the center of Coachella Valley. There are various estimates ranging from 500,000 to two million overnight visitors spending time in the

Eastern Riverside County Population Change 2000 to 2006
Permanent + Seasonal



Source: Riverside County Progress Report, TLMA 2006
Wheeler Report, 2006



Blythe/Quartzsite area during the winter.¹

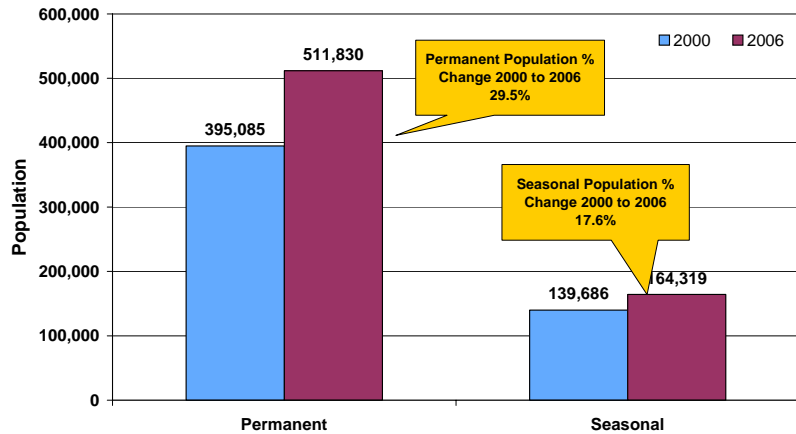
Because of seasonal residents and transient visitors, demand for health and social services increases significantly during the winter season. However, the continuing increase in permanent residents results in an increased demand for year-round services as well.

An increase of nearly 30% in the permanent population between 2000 and 2006 is indicative of a change in perception about Eastern Riverside County as a year-round place to live rather than just a resort destination.

Economic growth has also created new employment opportunities to support a larger permanent population (see Economic Profile).

Seasonal residents increased by almost 18% between 2000 and 2006. Although not as great an increase as in the permanent population, this increase shows a continuing interest in Eastern Riverside County for wintertime or “snowbird” accommodations.

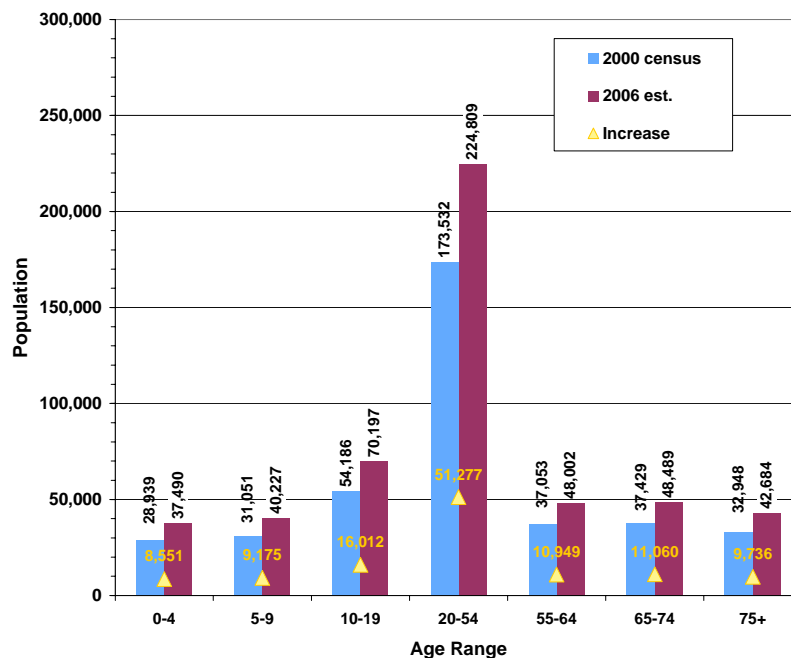
Eastern Riverside County Population Change 2000 to 2006
Permanent and Seasonal



AGE ANALYSIS

The largest population increase occurred in the 20-54 group, with a change of over 51,000. The next largest increase was in the pre-retirement and retired group of 55+, where there was a change of nearly 32,000. Children under 10 increased by almost 18,000, and teenagers increased by more than 16,000.

Eastern Riverside County Permanent Population by Age



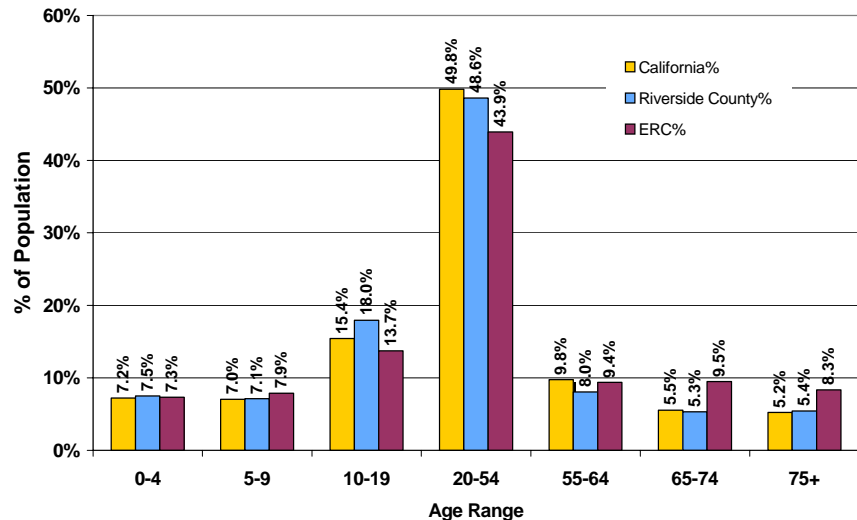
¹ U.S. Health and Human Services. *Impact of Seasonal Population Variations on Frontier Communities: Maintenance of The Healthcare Infrastructure, Rural Health Policy, April 2006*, <http://ruralhealth.hrsa.gov/pub/SeasonalPopulation.asp#AppB>



Based on [California Department of Finance Data](#) the age profile of Eastern Riverside County (ERC) differs from that of both Riverside County and the State of California. Note that both the Riverside County and California data are not independent of the ERC data.

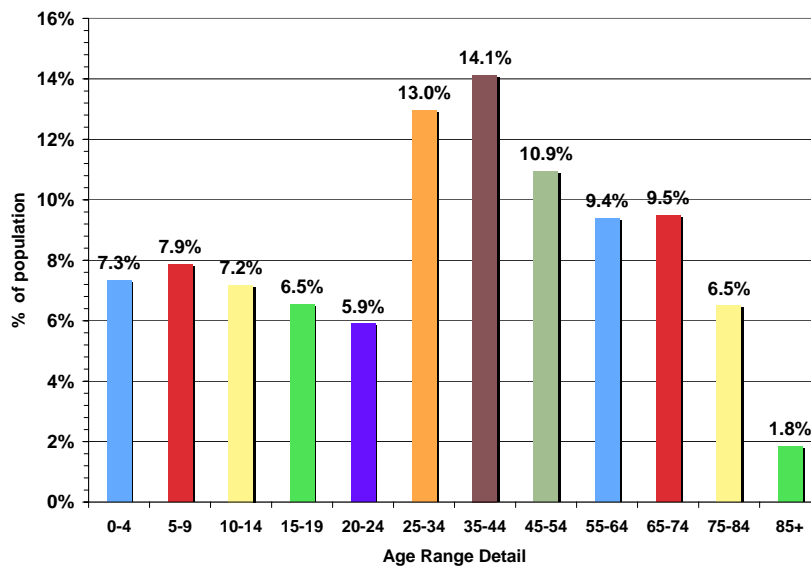
ERC had nearly the same proportion of children under 10 as Riverside County and California. Riverside County and California have a higher proportion of teenagers and adults aged 20 to 54. As would be expected in a region thought of as a retirement destination, ERC had a higher proportion of those over 55 than Riverside County and California.

Eastern Riverside County Age Compared to Riverside County and State, 2006



Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Eastern Riverside County Permanent Population % by Age



Looking at age in more detail shows that the 35 to 44 age group constitutes the largest percent of the population at 14.1%, followed by the 25 to 34 age group at 13%, and the 45 to 54 age group at 10.9%



RACE ANALYSIS

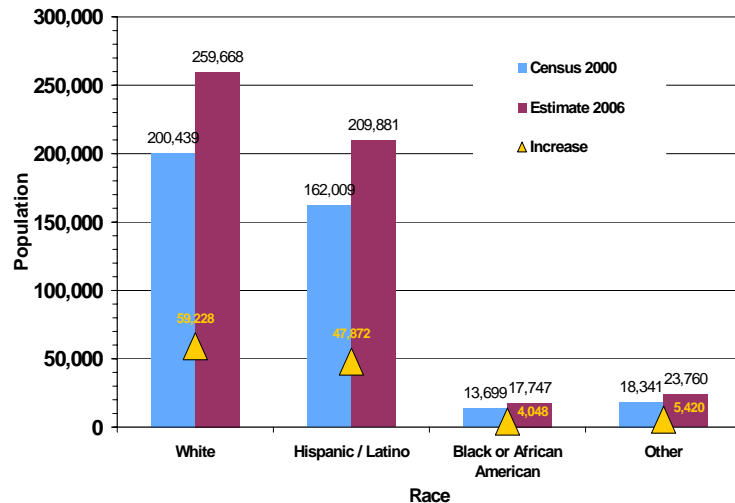
Those of White and Hispanic/Latino race made up the two largest and, by far, the majority of people residing in Eastern Riverside County (ERC). Whites were the largest group with nearly 260,000 people in 2006. The Hispanic/Latino population grew to almost 210,000 in 2006.

Between 2000 and 2006, the White population increased by over 59,000, while the Hispanic/Latino population increased by nearly 48,000.

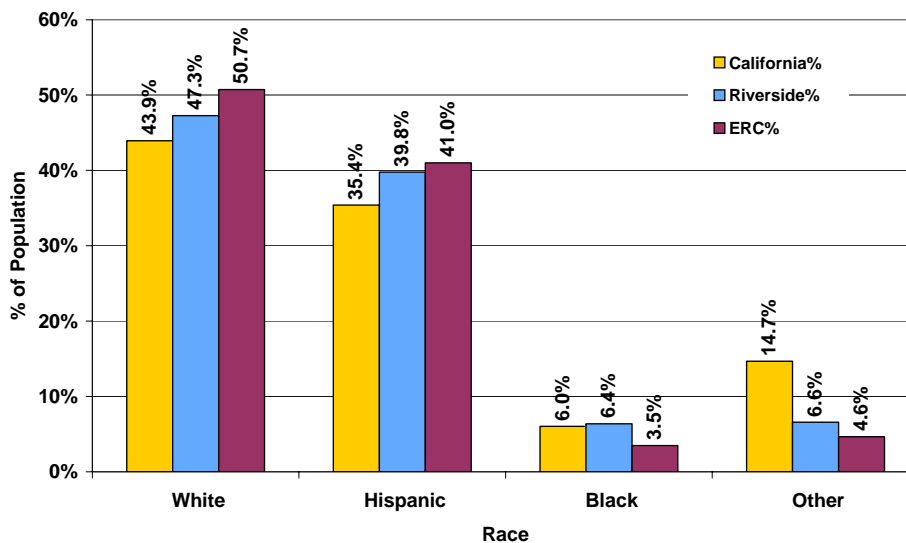
Black/African Americans increased by slightly over 4,000 to nearly 18,000 people in 2006.

The “other” group represents Asians, American Indians and Alaska Natives, Native Hawaiians or other Pacific Islanders, and Multi-racial people. This group increased by 5,420 people to nearly 24,000 in 2006.

Eastern Riverside County Permanent Population by Race



Eastern Riverside County Race Compared to Riverside County and State, 2006



When compared to all of Riverside County and the State of California, Eastern Riverside County has a higher proportion of White and Hispanic/ Latino residents. As a result, there is a lower proportion of Black/African American and other racial groups.

Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.



ECONOMIC PROFILE

EMPLOYMENT

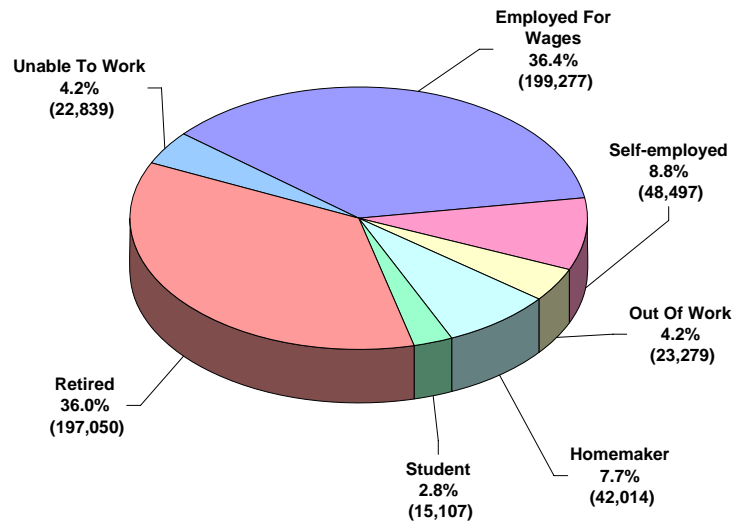
Eastern Riverside County (ERC) tends to under-perform the Inland Empire’s (Riverside and San Bernardino counties) economy in bad times, but out-perform in good times. Job growth has been slower in 2006 due to a slowdown in construction, which resulted in a job growth of 2.5% in ERC versus 3.9% for the larger region based on California Employment Development Department statistics.¹

The Chapman University Inland Empire Economic Forecast 2007² reports that the Inland Empire’s growth in construction activity, trade (wholesale and retail), transportation and utilities, and financial activity has resulted in the region’s job growth consistently outpacing California’s.

However, the Chapman Economic Forecast predicts a slowing of job growth through 2007 with an annual growth rate of approximately 2.2%. Such job growth is the weakest in the Inland Empire since 1994. The greatest growth will be in the trade and transportation and utilities sectors, whereas the financial and construction sectors will see a decline in employment.

Within Riverside County, the industries with the greatest employment are government, retail trade, construction, leisure and hospitality, professional and business services, educational and health services, and manufacturing.³

Since 4.2% of survey respondents reported being out of work, job growth is important to the economic future and health of the community. While 45.2% reported being employed for wages or self-employed, there is a significant retiree population (36.0%) that will not be competing for existing or new jobs.



EDUCATIONAL OPPORTUNITIES

Those with a college education earn, on average, 75% more than those with a high school education. College graduates also have much lower unemployment rates, crime rates, and a decreased dependence on government assistance programs. Those with less than a high school education are more likely to earn minimum wage and to be employed in the service industry (e.g., janitorial and cleaning staff, food counter and preparation workers, cashiers, salespeople, and teachers’ aides).

College campuses create opportunities for advancement within the community while providing employment opportunities for many local residents. The economic strength of the region is enhanced by these factors.

There are five institutions of higher education within the bounds of Eastern Riverside County.

- ❖ Two community colleges offer two-year transfer programs as well as two-year technical degrees and certificated skill programs. College of the Desert is located in Palm Desert and Palo Verde College is located in Blythe.

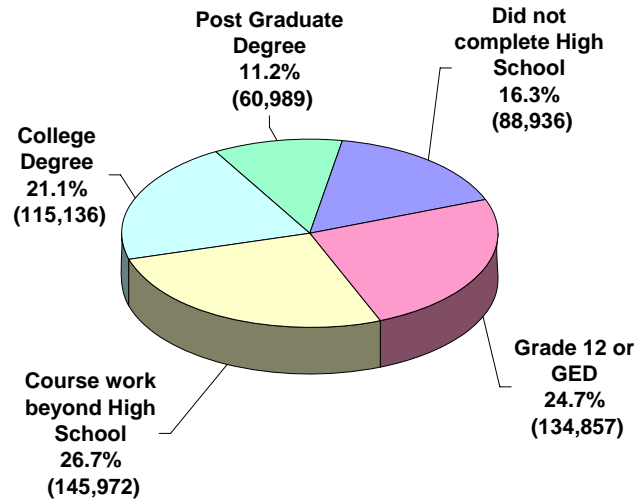
¹ Coachella Valley Economic Report. *Coachella Valley Economic Partnership, 2007.*

² The Inland Empire Economic Forecast. *Chapman University Gary Anderson Center for Economic Research, 2007.*

³ Riverside County Progress Report. *Riverside County Center for Demographic Research/TLMA, 2007.*



- ❖ The University of California, Riverside has a satellite campus in Palm Desert. UCR Palm Desert offers graduate education programs focused on entrepreneurial management, the arts, and the physical and cultural environment.
- ❖ California State University, San Bernardino has a satellite campus in Palm Desert offering undergraduate degrees in accounting, communications, criminal justice, English, finance, human development, management, nursing, liberal studies, and psychology. Masters degrees are offered in public administration and education, as well as education credentials.
- ❖ Chapman University College has a Coachella Valley campus offering credential programs in Education, and Masters degrees in Education, Criminal Justice and Gerontology.
- ❖ Additional higher education resources are available within commuting distance in Western Riverside County.



While 16.3% of residents within Eastern Riverside County have not completed high school, over 59% reported having completed course work beyond high school and 32.3% have attained at least a college degree.

HOUSING

From 2001 to 2006, there were been five years of double-digit home price appreciation in the Inland Empire (Riverside and San Bernardino Counties),¹ which is mirrored in Eastern Riverside County. As a result, housing affordability reached an all-time low. It now takes 46.2% of a median family income to make an annual mortgage payment on a median-priced home in the Inland Empire.² Housing affordability might not be a problem if there were healthy job and income growth, and low mortgage rates. However, in the current environment of weak job and income growth, the affordability issue has a greater negative impact on economic growth.

The current low affordability coupled with a high unsold inventory of homes contributed to a decrease in home prices during 2007, thereby improving the affordability index. Forecasts range from a home prices staying level³ to a decrease of 5.7%.⁴

¹ The Inland Empire Economic Forecast. Chapman University Gary Anderson Center for Economic Research, 2007.

² Ibid

³ The Desert Real Estate Report, <http://desertrealestate.com/newsa.htm>

⁴ The Inland Empire Economic Forecast. Chapman University Gary Anderson Center for Economic Research, 2007.

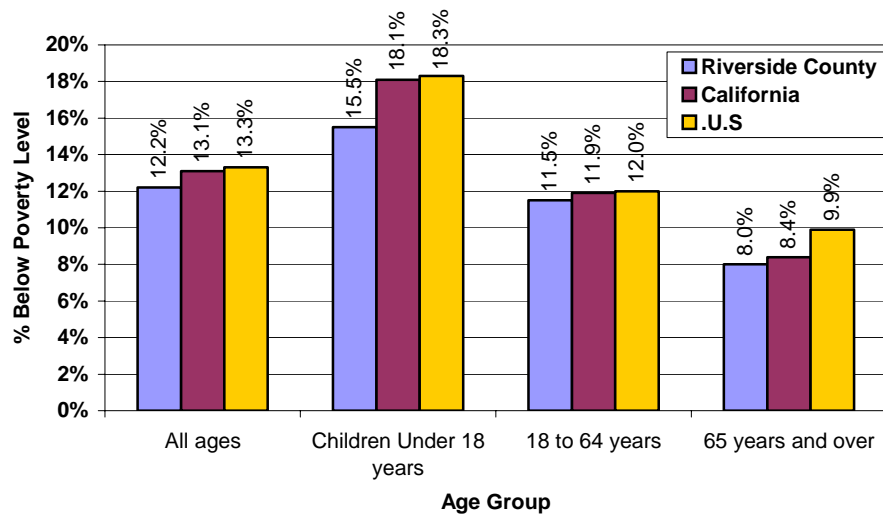


SOCIOECONOMIC PROFILE

A socioeconomic profile of the community helps to provide a context for evaluating health status and needs. These data can help to establish barriers to and disparities in health care access, coverage, and utilization. Some of the socioeconomic indicators are collected regularly to meet the requirements of federal and state health and human services programs. Other indicators are provided through census or survey collection. At this time, the 2000 Census American Community Surveys are the most complete and officially recognized sources of these indicators.

POPULATION BELOW POVERTY LEVEL

The U.S. Census American Community Survey (ACS) is completed each year. For 2006 the survey reported that 15.5% of the children under 18 in Riverside County were below the poverty level during the previous 12 months. In California and the U.S. the survey reported that 18.1% and 18.3%, respectively, of children were below the poverty level. The ACS results for all age groups are shown in the chart below.



ACS results are also tabulated for other groups which are summarized in the following table.

Percentage Of Families And People Whose Income In The Past 12 Months Is Below the Poverty Level

	Riverside County	California	U.S.
All families	9.1%	9.7%	9.8%
With related children under 18 years	12.6%	14.3%	15.0%
With related children under 5 years only	10.5%	12.8%	15.9%
Married couple families	5.8%	5.8%	4.7%
With related children under 18 years	7.7%	8.3%	6.5%
With related children under 5 years only	8.4%	6.6%	6.1%
Families with female householder, no husband present	23.9%	24.0%	28.6%
With related children under 18 years	30.7%	31.7%	36.9%
With related children under 5 years only	19.2%	35.2%	45.2%
All people	12.2%	13.1%	13.3%
Under 18 years	15.5%	18.1%	18.3%
Related children under 18 years	15.0%	17.7%	17.9%
Related children under 5 years	17.0%	19.2%	21.0%
Related children 5 to 17 years	14.3%	17.2%	16.7%



	Riverside County	California	U.S.
18 years and over	11.0%	11.4%	11.6%
18 to 64 years	11.5%	11.9%	12.0%
65 years and over	8.0%	8.4%	9.9%
People in families	10.0%	11.0%	10.8%
Unrelated individuals 15 years and over	25.1%	23.0%	24.4%

The Federal Poverty Guidelines are revised each year based on cost of living changes in the United States. Below are the guidelines for 2007 based on 2006 cost of living data.

2007 Health and Human Services Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.
1	\$10,210
2	13,690
3	17,170
4	20,650
5	24,130
6	27,610
7	31,090
8	34,570
For each additional person, add	3,480

SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148

SCHOOL MEAL PROGRAMS

One measure of how many families are living close to the poverty level in Eastern Riverside County is the number of children eligible for free or reduced price meals at school. Eligibility is determined at 185% of the Federal Poverty Guidelines.

There is significant variation among school districts in the percentage of children eligible for the two programs. Coachella Valley Joint Unified district has the highest eligibility at over 89%. The largest district, Desert Sands Unified, has a rate of 50%.

Percentage of Children Eligible for Free or Reduced Price School Meals for Eastern Riverside County School Districts

	Public Enrollment	Free Meals	Reduced Price Meals	Free/Reduced Price Meals	% Free/Reduced Price Meals
Coachella Valley Joint Unified	16,531	12,710	2,040	14,750	89.2%
Banning Unified	4,953	2,934	854	3,788	76.5%
Palm Springs Unified	23,689	13,200	4,009	17,209	72.6%
Palo Verde Unified	3,704	1,868	241	2,109	56.9%



	Public Enrollment	Free Meals	Reduced Price Meals	Free/Reduced Price Meals	% Free/Reduced Price Meals
Beaumont Unified	5,913	2,268	1,024	3,292	55.7%
Desert Sand Unified	25,304	9,909	2,734	12,643	50.0%
Desert Center Unified ^a	25	6	5	11	44.0%
Eastern Riverside County	80,119	42,895	10,907	53,802	67.2%
Riverside County	393,227	146,038	51,609	197,647	50.3%
California	6,156,300	2,532,029	595,641	3,127,670	50.8%

Source: State of California Department of Education
 2005-2006 Free/Reduced-Price Meal Data
www.cde.ca.gov/ds/sh/sn/freereduced0506.asp Accessed 11/07/07
^a Comprised of only one elementary school

FOOD STAMP & CALWORKS PROGRAMS

Another measure of poverty in Eastern Riverside County is the enrollment in Food Stamp and California Work Opportunity and Responsibility to Kids (CalWORKS) programs.

Food Stamp programs assist low-income households to obtain sufficient and healthier foods for their families.¹ Benefits are determined by income, expenses, and number of persons in the household. Only essential food items can be purchased with food stamps. Alcoholic beverages, paper products, pet food, tobacco products, prepared hot foods, and cleaning products are excluded. Eligibility requirements include residence in the county, U.S. citizenship, income and resources below the allowable limit, and provision of social security numbers for all members of the household.

Total Food Stamp Enrollment Eastern Riverside County as of September 2006

	All Food Stamp Programs	Non-Assistance Food Stamps	Public Assistance Food Stamps	Transitional Food Stamps
ERC Total	7,975	3,789	3,170	1,016

Source: September 2006 Caseload Summary data set.
 Planning and Evaluation, County of Riverside, Department of Public Social Services

CalWORKs provides temporary cash assistance, employment focused services and other supportive services to needy families with children.² Limits on income, property, and resources determine eligibility for the program. Most able-bodied parents are also required to participate in the CalWORKs Greater Avenues for Independence (GAIN) employment services program. There is also a time limit as to how long adults can receive CalWORKs. CalWORKs supportive services include child care, counseling, mental health services, bus fare, substance abuse treatment, and job retention services in addition to cash grants. Many families receiving CalWORKs also receive Food Stamp benefits.

Homeless persons may be eligible to receive CalWORKs and/or food stamps.

¹ www.fns.usda.gov/fsp/
² www.cdss.ca.gov/cdssweb/PG85.htm



Total CalWORKs Enrollment Eastern Riverside County as of September 2006

	Adoption Assist.	Child Care	Cash Assist. Program for Immigrants	CalWORKs	Diversion	Foster Care	Food Stamps (All)	Gen Relief/ Assist.	Cal WORKs Homeless Perm.	CalWORKs Homeless Temp.	In-Home Supportive Services	Immediate Need	Welfare To Work (GAIN)
ERC Total	652	858	22	5,323	57	763	7,975	23	17	31	3,751	49	2,048

Source: September 2006 Caseload Summary data set.
 Planning and Evaluation, County of Riverside, Department of Public Social Services

MEDI-CAL & INDIGENT PROGRAMS

Medi-Cal is California's Medicaid program. It is a public health insurance program that provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care children, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal is financed equally by the State and Federal Governments.¹

Total Medi-Cal Enrollment by Age Category Eastern Riverside County 2005

	Total Enrolled	Total < Age 6 Enrolled	Total Age 6 - 17 Enrolled
Region Total	79,398	19,213	24,147

Source: State of California Medical Care Statistics Section: Medi-Cal Beneficiaries by Zip Code, 2005
 Compiled: Epidemiology and Program Evaluation Branch, Department of Public Health
 Community Health Agency, County of Riverside

MEDICALLY INDIGENT SERVICES PROGRAM (MISP)

The Medically Indigent Services Program (MISP), developed in Riverside County in 1983, was designed to provide assistance for the health needs of adults between the ages of 21 and 64; specifically, it was designed to cover acute illnesses and medical care to prevent disability. The goal of the program is to reduce costly hospitalization and increase the ability to work. County of Riverside residents, who may not otherwise qualify for Medi-Cal, might be able to qualify for the County of Riverside MISP program. The MISP program provides primary care (outpatient) through the county network of clinics.

¹ www.dhcs.ca.gov/services/medi-cal/Pages/Default.aspx



ENVIRONMENTAL PROFILE

The environment of Eastern Riverside County has a significant effect on the health status of the community. Following is an environmental profile of the region and a summary of the important environmental issues facing the regional communities.

A number of environmental factors in Eastern Riverside County affect the health of our residents. Exposure to harmful elements in the environment, such as air and land pollutants, water contamination, and/or food contamination, can have both short and long term impacts on the health of communities.



- ❖ The climate of Eastern Riverside County is a continental, desert-type with hot summers, mild winters and very little annual rainfall. Precipitation is less than six inches annually and occurs mostly in the winter months from active frontal systems and in the late summer months from thunderstorms.
- ❖ Temperatures exceed 100 degrees Fahrenheit on the average for four months each year, with daily highs near 110 degrees Fahrenheit during July and August. Summer nights are very mild with minimum temperatures in the mid-70's. During the winter season daytime highs are quite mild with early morning lows around 40 degrees.
- ❖ The region is exposed to frequent gusty winds. The strongest and most persistent winds typically occur immediately to the east of the Banning Pass, which is noted as a wind power generation resource area. Aside from this locale, the wind conditions in the remainder of the valley are geographically distinct. Stronger winds tend to occur in the open mid-portion of the valley, while lighter winds tend to occur closer to the foothills. Less frequently, widespread gusty winds occur over all areas of the valley.

AIR POLLUTION

The Clean Air Act requires the U.S. Environmental Protection Agency (EPA) to set national outdoor air quality standards for six "criteria pollutants" considered harmful to public health and the environment: carbon monoxide, nitrogen dioxide, particulate matter, ozone, sulfur dioxide, and lead. It also permits states to adopt additional or more protective air quality standards, if needed. California has set additional and more stringent standards for some pollutants identified above, such as particulate matter and ozone, and for some pollutants not addressed by federal standards.

- ❖ The [South Coast Air Quality Management District \(AQMD\)](#) is the agency responsible for attaining state and federal clean air standards in the South Coast Air Basin (SCAB). The SCAB includes portions of Los Angeles, San Bernardino, and Riverside counties and all of Orange County.
- ❖ Eastern Riverside County (ERC) is in three different air basins as defined by the California Air Resources Board.¹ The San Gorgonio Pass area and the Coachella Valley are in the South Coast Air Basin (SCAB). Part of the Coachella Valley is located in the Salton Sea Air Basin. The eastern section of ERC is in the Mojave Desert Air Basin.

¹ www.arb.ca.gov/knowzone/basin/basin.swf



- ❖ While the topography and climate of Southern California combine to make the SCAB an area of high air pollution potential, the demographics of the Coachella Valley, as it is bounded by the San Jacinto Mountains, serves as a buffer to many of the pollutants generated in Western Riverside County and the remainder of the SCAB. High and Low air pressure zones throughout the Coachella Valley also contribute to buffering transported pollutants. Protected by majestic mountains, the Coachella Valley is impacted by pollutant transport from the Basin, e.g., ozone, but to a much lesser degree than other areas in the region.
- ❖ The Coachella Valley's central pollutant is particulate matter known as PM. PM comes in a range of sizes. The Coachella Valley's most significant pollutant is known as PM-10—particles less than 10 micrometers in diameter or about 1/7 the diameter of a human hair. The San Gorgonio Pass and Palo Verde Valley are less affected by PM-10 pollution because of their geography. PM-10 measurements are collected at a number of sites within the Coachella Valley.

BLOWSAND

In the Coachella Valley, a natural sand migration process has direct and indirect effects on air quality.

“Blowsand” produces PM-10 by direct particle erosion (natural PM-10). When the sand lands on road surfaces it is ground into PM-10 by moving vehicles and re-suspended in the air (man-made PM-10). There are several blowsand areas throughout the Coachella Valley.

- ❖ The national PM-10 ambient air standard is 50 mgs/cubic meter of air on an annual average. A Coachella Valley State Implementation Plan (CVSIP) implemented in 1990 resulted in compliance until 1999. For the next three years, the Coachella Valley fell out of compliance.
- ❖ Because the Coachella Valley failed to maintain its federal PM-10 standard, the new CVSIP, initiated in 2002 and approved by the state and federal agencies, moved from best available control measures to more stringent control measures to bring the desert into federal compliance. These stronger measures include dust control ordinances adopted by the cities and the county and dust certification classes for developers and their subcontractors instructed by AQMD staff both in English and in Spanish. Federal air quality funds were also allocated and managed by the Coachella Valley Association of Governments (CVAG) for PM-10 projects and used by cities and CVAG to bring the area into federal compliance. The deadline for compliance of the above plan was December 2006.¹



- ❖ The chart below shows the progress of the Coachella Valley thus far in meeting the federal PM-10 standard. In order to determine compliance, the EPA reviews the last three years of the CVSIP's results. While the 2006 figure of 53.0 is over the federal standard, the Coachella Valley remains in compliance because the annual average is determined by the last three years. Given this, the annual average (using 2004 and 2005 figures) is 46.4 which is well under the 50.0 federal standard. For more information, please go to www.aqmd.gov or www.cvag.org.

¹ www.aqmd.gov/aqmp/PM10Plans.htm



PM-10 ATTAINMENT FIGURES*		
Year	Coachella Valley	Federal PM-10 standard
2002	50.6	50.0
2003	51.8	50.0
2004	40.6	50.0
2005	45.7	50.0
2006	53.0	50.0

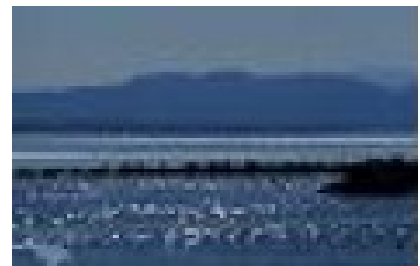
* The federal PM-10 standard is 50 mgs/cubic meter of air on an annual average.

- ❖ Failure to meet the federal PM-10 air quality standard may result in the EPA reassigning any and all federal transportation funds awarded to the Coachella Valley cities and county designated for roads, bridges, and/or freeways in the Coachella Valley to cover the expense of any and all air quality control measures initiated by EPA to bring the Coachella Valley into federal attainment.
- ❖ While our air quality has improved significantly overall in the SCAB, Southern California is still far from meeting all federal and state air quality standards and, in fact, is among the worst in the nation. The AQMD is currently drafting its Air Quality Management Plan (AQMP) for 2007. The draft plan employs up-to-date science and analytical tools to create a comprehensive strategy aimed at controlling pollution from all sources including stationary sources, on-road and off-road mobile sources, and area sources. More importantly, the AQMP calls upon the state air quality agency and the EPA to accelerate emission reduction programs particularly from mobile sources by implementing the AQMP measures that are within their respective authorities. For more information, please go to www.aqmd.gov or www.cvag.org for the CVSIP.

THE SALTON SEA - ECOSYSTEM RESTORATION

The Salton Sea is located in a closed desert basin in Riverside and Imperial Counties, south of Indio and north of El Centro. It has been the focus of international water quality and ecosystem restoration efforts in Southern California.

- ❖ An important stop along the Pacific Flyway, the saline and eutrophic sea supports a productive fishery and more than 400 species of resident and migratory birds, of which more than 50 have status as threatened, endangered, or species of concern.
- ❖ The largest sources of the sea’s inflow are
 1. The New River, which originates in, and conveys industrial and agricultural wastes from, Mexico into the United States;
 2. The Alamo River, which also originates south of the border and consists mainly of agricultural return flows from the Imperial Valley; and
 3. The Imperial Valley agricultural drains, which transmit pesticides, nutrients, selenium, and silt to the sea. Nutrient input to the sea can contribute to algal blooms and odors and lead to low dissolved oxygen conditions that are dangerous to fisheries.
- ❖ The basin is more than 200 feet below sea level and has no natural outlet. Although lakes have existed in this basin in the past, the current body of water formed in 1905 when a levee break along the Colorado River caused water to enter the basin for about 18 months into an area with an elevation second only to Death Valley as the lowest in the United States.





- ❖ Scientists predicted that the desert's intense heat would completely evaporate the sea in 8 to 14 years. But agricultural drainage of more than one million acre feet per year, mostly from Imperial County farms and to a lesser extent from the Coachella and Mexicali valleys, has sustained the Salton Sea.
- ❖ Since 1905, the Sea has fluctuated in size with varying inflow and today is 34 miles long and between 9 and 10 miles wide with a surface area of about 365 square miles.
- ❖ A balance between inflowing water and evaporation sustains the Sea. With no outlet, any salts that are dissolved in the inflow are trapped. Salt concentrations in the Sea are currently about 48,000 milligrams per liter (mg/L) or about 30% higher than ocean water. Salinity will continue to rise under current conditions. However, under a recently approved Quantification Settlement Agreement inflow to the Sea will be significantly reduced. The reduction in inflow will cause the Sea to shrink and cause salinity to rise faster than it would have without a reduction in inflow.

The [Salton Sea Authority](#) (SSA) is the Joint Powers Agency formed in 1993 by the State as the regional agency for identifying and implementing corrective measures to preserve the beneficial uses of the Sea. It is comprised of cooperating agencies that work with State agencies, federal agencies and the Republic of Mexico to develop programs that would continue beneficial use of the Salton Sea. The SSA has made a concerted effort to collect all known suggestions for remediation of the Salton Sea and has subjected these proposals to formal review against specified criteria.

- ❖ In 2003 the California Legislature passed the Salton Sea Restoration Act which directed the State to undertake the restoration of the Salton Sea ecosystem and to come up with a Restoration Study to be submitted to the Legislature by the end of 2006. This Restoration Study, called the "State's Preferred Alternative," has not yet been approved by the California Legislature. The Restoration Act also established the Advisory Committee to provide balanced representation of interests in the Salton Sea.
- ❖ The State is preparing a Programmatic Environmental Impact Report (PEIR) which includes 8 action alternatives or plans to be considered to restore the Salton Sea. Numerous public meetings have taken place to get feedback from the public on the alternatives. A preliminary recommendation released March 27, 2007 from California Secretary for Resources, Mike Chrisman, calls for a \$6 billion hybrid plan partially based on elements from the Salton Sea Authority's restoration plan (as listed below).¹ The California Legislature has not yet approved final recommendations.
- ❖ The SSA has developed "A Salton Sea Authority Plan for Multi-Purpose Project" that will provide wild-life habitats, improve water quality, and protect air quality in the Coachella Valley as well as meet the needs of those living and working in the local communities.
- ❖ The Salton Sea Authority and the Coachella Valley communities support and believe that this Multi-Purpose Project Plan incorporates a number of important elements including:
 1. In-sea barrier and circulation channels to separate the current Sea into two separate bodies;
 2. Water treatment facilities to improve existing water and inflow water;
 3. Habitat enhancement features to meet the needs of fish and bird populations;
 4. A Colorado River water storage reservoir to enable water storage to balance supply and demand of water use;
 5. Preservation of park, open space, and wildlife areas;
 6. Cost estimate, financing plan and implementation; and,
 7. Dust control and air quality mitigation efforts.
- ❖ Under the other suggested alternatives, the Salton Sea would recede and some of the area that is currently underwater would be exposed. Over time, these areas may contribute to increased dust emissions from disturbance and wind erosion and result in negative impacts similar to the extensive long-term water di-

¹ www.saltonsea.water.ca.gov/PEIR/



versions at the Mono Lake and basins of the Owens River which is currently undergoing an ecosystem restoration.

- ❖ If a solution is not developed and implemented soon, the Salton Sea is likely to become too saline to support many of the current fish and bird populations. Also, PM-10 levels will likely increase impacting the health of residents throughout the communities. For more information, go to www.saltonsea.ca.gov.

WATER

A number of agencies manage the water resources for Eastern Riverside County. Much of the water comes from locally replenished groundwater sources with additional water imported from the Colorado River through the Coachella Canal.

- ❖ The San Gorgonio Pass area has multiple water districts. [The Yucaipa Valley Water District](#) and the [South Mesa Water Company](#) provide water to Calimesa. Water for Beaumont is supplied by the [Beaumont-Cherry Valley Water District](#). [City of Banning Water Division](#) supplies water to Banning.
- ❖ Moving towards the Coachella Valley, water is supplied to the Cabazon area by the [Cabazon Water District](#).
- ❖ In the Coachella Valley, water is managed by the [Desert Water Agency](#) for Palm Springs, Desert Hot Springs, and Cathedral City. The [Coachella Valley Water District](#) manages water resources for the remainder of the Valley.
- ❖ Blythe and the surrounding area are served by the [City of Blythe Public Works Department](#).

All drinking and other domestic water comes from a vast underground aquifer, a source usually referred to as groundwater. The snowcapped mountain ranges surrounding the Coachella Valley continually replenish water in the Coachella Valleys' natural groundwater basins.

- ❖ Were it not for the aquifer, much of Eastern Riverside County would have stayed raw desert, suitable only for a few drought-tolerant animals and plants.
- ❖ Our water is naturally pure and healthy and requires little treatment to meet state and federal water quality standards.

THE COACHELLA CANAL

Initially constructed in the 1930s, the Coachella Canal carries water that has traveled several hundred miles, diverted from the Colorado River into the All-American Canal at Imperial Dam north of Yuma, Arizona.

- ❖ The use of canal water for non-potable purposes helps to conserve the valley's groundwater supply for domestic use.
- ❖ The Coachella Valley would look much different today had the 122 mile canal not been built. Without imported water, the aquifer would have been over-drafted to a point that it could no longer supply agriculture with irrigation. The canal is an engineering marvel where water travels through the canal entirely by gravity flow, thus eliminating electricity costs normally associated with pumping.





LAKE CAHULLA

Construction of this man-made lake was completed in 1969. It is located between Avenues 56 and 58, west of Jefferson Street. It's three-quarters of a mile long, up to half that in width and 11-12 feet deep.

- ❖ The Lake has gained popularity as a spot for fishing, camping and day-use recreation and gives the Coachella Valley Water District greater control over the flow of canal water into the valley.



Water conservation is key for Eastern Riverside County. As one of the fastest growing areas in California, local government and the water districts within the region promote and have implemented plans to conserve and manage our water.

- ❖ For example, most Coachella Valley golf courses are irrigated using groundwater but increasing numbers are using recycled water to help preserve and extend the life of our aquifer. Additionally, the desert cities and local water districts promote drought tolerant landscaping.
- ❖ Relative to water supply reliability in the Coachella Valley, according to the 2005 California Water Update from the California Department of Water Resources:

“One of the most significant challenges of this region will be adapting to requirements of the new Quantification Settlement Agreement (QSA) for distribution and use of California’s legal entitlement of Colorado River water. Under this 2003 agreement California agencies must reduce total consumptive use of Colorado River water to 4.4 million acre-feet per year; whereas, past usage often exceeded 5.0 maf/year. The QSA also assists the transfer of water to meet urban needs in the South Coast region and provides water for the Salton Sea. Other regional issues include the potential impacts of Colorado River fish restoration programs on the availability of water for diversions and the development of solutions to groundwater overdraft problems in the upper (urbanized) and lower (agricultural) part of the Coachella Valley.”¹

- ❖ In 2002, one local district, the Coachella Valley Water District ([CVWD](#)) developed a 35 year blueprint for meeting water needs in the Coachella Valley. It involves a three point solution including conserving water, finding new sources, and converting groundwater to other uses. In existence since 1918, and with a territory of approximately 1,000 square miles, CVWD is considered one of the most “diverse and innovative” water agencies in California.

WATER CONTAMINANTS

The Riverside County Community Health Agency’s Environmental Health Division is responsible for regulating the water quality of pools and spas and selected drinking water systems. These are accomplished through a system of water quality monitoring inspections, postings, advisories, and closures.

- ❖ While the Eastern Riverside County domestic water supply meets current requirements, there are some areas—particularly in the Eastern Coachella Valley—where there are high naturally occurring minerals or elements that may pose some health risks. This includes low levels of arsenic, which is a mineral known to cause cancer in humans at high concentrations. Arsenic removal facilities have been established in several sites in this area.
- ❖ Nitrate plumes are also present in the Cove Communities. Nitrate in drinking water at levels above 45 milligrams per liter (mg/L) is a health risk for infants younger than six months old.
- ❖ However, these naturally occurring minerals or elements (including fluoride) are closely monitored for change by local water districts.

¹ www.crss.water.ca.gov/crqs/index.cfm



Other Recent Community Surveys

COACHELLA VALLEY HEALTH COLLABORATIVE (CVHC) REPORT

The Coachella Valley Health Collaborative (CVHC) is a newly formed collaborative whose individual partners have a long history of organizing and working together to create systems change. In 2006, the Coachella Valley Health Collaborative was awarded a grant from The California Endowment (TCE) to support infrastructure development of a regional health collaborative that will utilize a primary prevention approach to address the public health needs of Coachella Valley residents. One component of the grant was to perform a community strengths/ needs assessment. Consultants were hired to accomplish these three major activities:

Review public health community indicator statistics and 21 existing local needs assessment documents from 2000-2006 including TCE funded projects in the Coachella Valley.

Perform a community strengths and needs assessment using 10 focus groups of 157 community leaders, service providers, grassroots organizations, and area leaders.

Distribute a written survey to 350 service providers to assess the health-related needs of various target populations and community strengths and resources.

REVIEW OF EXISTING COMMUNITY HEALTH NEEDS ASSESSMENTS

A review of existing community health needs assessments revealed that diabetes, obesity, and nutrition were the major healthcare needs identified across all community needs documents. Other findings included:

- ❖ Affordable and accessible recreation, adult education and childcare are the most needed child and family services.
- ❖ Poor nutrition and senior hunger can negatively affect senior health and independence.
- ❖ Homeless individuals report persistent health care needs, symptoms of mental illness, and use of alcohol and/ or other drugs.
- ❖ Among agricultural workers, incidences of high cholesterol, obesity, hypertension, and iron deficiency anemia are higher than among all U.S. adults.
- ❖ Students in 5th, 7th, and 9th grades in Coachella, Indio, and Palm Springs have a greater percentage of students who are overweight than in Riverside County and California.
- ❖ Diabetes, alcohol drugs, obesity, cancer, and teen pregnancy were the top five health concerns among Latinos.
- ❖ The need for affordable care and health insurance, greater and easier access to care, and lack of transportation were consistent themes.
- ❖ Building capacity, engaging the community, and informing the community about available resources and opportunities are three strategic areas identified for social change.

FOCUS GROUPS

Diabetes/ obesity/ nutrition was the top priority health need for adults, children, and seniors identified by the 157 community leaders, service providers, grassroots organizations, and area leaders who participated in the 10 focus groups. More specifically,

- ❖ For **adults**, the priority health needs are diabetes/ obesity/ nutrition, access to health care, and mental health services.



- ❖ For **children**, the priority health needs are diabetes/ obesity/ nutrition, health education, and access to health care.
- ❖ For **seniors**, the priority health needs are diabetes/ obesity/ nutrition, affordable health care, and mental health services.
- ❖ The major strengths and assets in the Coachella Valley in addressing health needs identified are (1) three hospitals and lower cost public health clinics, (2) number of health, social service, and faith-based organizations, (3) collaborative efforts of organizations, (4) work of promotoras in the Latino community, (5) wealth and level of volunteerism, and (6) existence of regional collaboratives and organizational networks.
- ❖ Weaknesses of the healthcare delivery system include (1) lack of adequate mental health services, (2) lack of affordable care and health insurance, (3) insufficient number of specialists and geriatricians, and (4) inadequate funding; and (5) complexity of the system.

SERVICE PROVIDER SURVEY

The Service Provider Survey found that the major health needs and issues that need to be addressed in the next 3-5 years by the community to improve the overall health of Coachella Valley residents are: (1) Alcohol and drug abuse, (2) Diabetes, nutrition and obesity, and (3) Mental health.

- ❖ The most critical health needs of adults in the Coachella Valley are (1) Diabetes, obesity and nutrition, (2) Drug and substance abuse, and (3) Mental health. The most critical health needs of children in the Coachella Valley are (1) Diabetes, obesity and nutrition, (2) Drug and substance abuse, and (3) Health education. The most critical health needs of seniors in the Coachella Valley are (1) Diabetes, obesity, and nutrition, (2) Heart disease, and (3) Mental health.
- ❖ The major community strengths and resources in addressing the health needs are (1) the number and quality of medical facilities, (2) availability of community clinics, (3) commitment to improving health and (4) good dissemination of information was also seen as important. Lack of affordable healthcare, lack of mental health services, and shortage of medical staff was seen as major weaknesses of the healthcare system.

RECOMMENDATIONS

Based on the findings from the review of public health statistics and existing needs assessment documents, and the results from the Focus Groups and Service Provider Survey, the consultants identified a number of key recommendations.¹

¹ Copies of the complete report, Branin, J. & Martinez, R., *Coachella Valley Health Needs Assessments, 2000-2006, 2007*, www.regionalaccessproject.org

Comparative Analysis of Coachella Valley Needs Assessments Documents (2000-2006)

	Asthma Allergies	Alcohol & Drug Abuse	Cancer	Child-hood Diseases	Dental Care	Diabetes Nutrition Obesity	Domestic Violence Abuse	Family Planning	Heart Disease	HIV/AIDS Hepatitis C	Home-lessness	Lung Disease	Mental Health	Prenatal & Baby Care	Teen Pregnancy
Alzheimer's Assn. Latino Outreach		X	X		X	X							X		X
An Epidemic: Overweight Children						X									
Blue Ribbon Senior Nutrition						X									
Coachella Child and Family Assessment														X	
Coachella Valley Hunger Report						X									
Community Profile 2002 Riverside Cty		X			X	X	X	X	X			X	X	X	X
County Health Status Profiles 2002		X	X						X			X			
County of Riverside 2006 Coachella Valley Farm Worker Survey															
County of Riverside Homeless Assessment		X				X	X				X	X			
Desert Hot Springs Health Plan		X		X								X	X		
Diabetes in Two Cahuilla Communities						X									
Eastern Riverside Cty Needs Assessment	X	X	X		X	X	X		X	X			X	X	X
Eastern Riverside Cty Health Needs	X					X	X			X					X
Evaluation Agric Worker Health	X		X											X	
Growing Epidemic: Child Overweight						X									
In Their Own Words: Farmworker Access			X	X	X			X	X				X		
Pathways to Farmworker Health													X	X	
Preparing for Boom Demographics						X									
Providing Assistance to Older Adults															
Suffering in Silence: Agric Workers					X	X							X		
Summary Discussion of Mental Illness															
Total	3	6	5	2	5	12	4	2	3	3	1	1	9	6	4

(Copies of the complete report, Branin, J. & Martinez, R. (2007) *Coachella Valley Health Needs Assessments, 2000-2006*, can be downloaded from www.regionalaccessproject.org)



Two groups that require different survey methods are the homeless and farm worker populations. Since these groups are not readily available by telephone, studies of these populations relied upon direct field interview techniques to gather their data. Surveys of these two groups were completed recently and their results are summarized here to complete the profile of Eastern Riverside County.

2007 COUNTY OF RIVERSIDE HOMELESS COUNT¹

A survey of homeless people was completed in January 2007 for all of Riverside County, which provided a picture of how many people are homeless on a particular day. Although the study does not address health care needs of this population, having an idea of the number of people can be helpful in determining the extent of the need. The study presents a summary for all of Riverside County, but city-based numbers are provided as well. Here is the Executive Summary from the report. The jurisdictions that represent Eastern Riverside County are highlighted in the summary table.

EXECUTIVE SUMMARY

*How many homeless people are there in the County of Riverside who live on the streets, shelters, or transitional housing programs on any give day? The answer is **4,508 adults and children** according to the 2007 County of Riverside Homeless Count.*

Background Information

The 2007 County of Riverside Homeless Count was a street-based and service-based enumeration of all homeless individuals in the cities, communities, and unincorporated areas of Riverside County during the designated day-of-the-count which was January 24, 2007.

The street-based enumeration included homeless encampments and other places that homeless people use as part of their daily activities. Homeless encampments are those places that homeless people use primarily for sleeping. Other places (non-encampments) include streets and sidewalks where homeless people are usually en route and locations where homeless people gather such as vacant lots, parks, municipal service or business centers, parked cars, abandoned buildings, and other locations that are not homeless encampments.

The service-based enumeration included both residential and non-residential locations where homeless persons receive temporary housing and other essential services. Such places included emergency shelters, transitional housing programs, substance abuse treatment facilities, mental health service facilities, public social service agencies, public schools, food and clothing programs, etc.

The count included a methodology that relied on a simple count instrument for recording a small amount of identifier information from each homeless adult encountered during the process. The identifier prevented a person from being included in the final tally of the count more than once. During the enumeration, counters recorded the initials, gender, ethnicity, year of birth, and state born of each individual homeless person. If the same person was encountered again counters would establish the same code.

Afterwards, the information for every person every time was loaded into a data base. The information was then used to code each person. For example, a homeless person may have the following code of "WTMW1957CA. This meant that this person's first name began with "W", his last name began with "T", he was male "M", he was White "W", born in 1957, and born in California. If the code appeared more than once, however, this person would only be counted once in the final tally.

Identifier information for the count was generally not collected from children under the age of 18 unless they were emancipated or otherwise homeless and unaccompanied. The number of children under 18 years of age in homeless families during the designated day-of-the-count was captured by asking the adults encountered "how many children under 8 years old are living with you today?"

¹ The County of Riverside Department of Public Social Services Homeless Programs Unit, *The 2007 County of Riverside Homeless Count*, <http://dpsr.co.riverside.ca.us/dpsr/PDFs/Homeless/HomelessCount0907.pdf>



Count Results

While the primary purpose of the count was to find out how many people were homeless on a given day, some demographic questions can be answered as well. The homeless count gathered limited information about adults only (see Appendix A Count Instrument). Such information included location (whether a person was counted on the streets or in a residential facility that serves homeless people) age, gender, ethnicity, and state of birth. Adults were also asked if their “spouse or partner were homeless and living with them” and “how many of their children were homeless and living with them.” Results are as follows:

A. Location:

2,775 (or 61.6%) of adults and children were counted on the streets; 1,733 (or 38.4%) were counted in facilities for a total of 4,508 persons.

B. Age:

Seniors (Age 62 or Older)

- 149 (or 4.0%) of the 3,714 adults counted were seniors age 62 or older;
- 93 (or 2.5%) of the 3,714 adults counted were seniors age 65 or older;
- 22 (or 0.6%) of the 3,714 adults counted were seniors age 75 or older.

Youth (Ages 18 – 24)

- 264 (or 7.1%) of the 3,714 adults counted were youth between the ages of 18 – 24.

Unaccompanied Children (Ages 1 – 17)

- 15 (or 0.4%) were unaccompanied (without parents) children between the ages of 13 – 17.

C. Gender:

- Of the 3,714 adults counted, 2,525 (or 67.9%) were men and 1,189 (or 32.%) were women.

D. Ethnicity:

- Of the 3,714 adults counted, 1,689 (or 45.5%) were White; 1,258 (or 33.9%) were Hispanic or Latino; 565 (or 15.3%) were African American or Black; 82 (or 2.2%) stated other; 81 (or 2.2%) stated American Indian or Alaskan Native; and 39 (or 1.1%) stated Asian or Pacific Islander.

E. State Born:

- Of the 3,714 adults counted, 1,690 (or 45.5%) were born in California.

F. Children:

- Of the 4,508 persons who were counted, 794 or 17.7% were children under the age of 18 living with a homeless parent(s) who was included in the count.

G. Household Composition:

Two-Parent Families

- There were 31 two-parent families that consisted of 62 adults and 23 children.

Single-Parent Families

- There were 309 single-parent families that consisted of 309 adults and 671 children.

Couples

- There were 143 homeless adults who stated they were living with a spouse or partner but had no children living with them.

H. Findings By Jurisdiction:

The table below identifies the cities and communities in which homeless adults and their children were encountered during the homeless count as reported by the volunteers participating in the enumeration process.



JURISDICTION	PERSONS COUNTED	
	#	%
Banning	102	2.3
Beaumont	36	0.8
Bermuda Dunes	2	0.0
Blythe	106	2.4
Cabazon	7	0.2
Cathedral City	99	2.2
Coachella	33	0.7
Corona	274	6.1
Desert Hot Springs	75	1.7
Glen Avon	1	0.0
Hemet	480	10.6
Highgrove	5	0.1
Homeland	8	0.2
Indio Hills	15	0.3
Indio	684	15.2
Jurupa	12	0.3
La Quinta	0	0.0
Lake Elsinore	115	2.6
Lake Mathews	1	0.0
Lakeland Village	13	0.3
March Air Force Base	131	2.9
Mead Valley	1	0.0
Mecca	71	1.6
Mesa Verde	10	0.2
Mira Loma	8	0.2
Moreno Valley	45	1.0
Murrieta	8	0.2
Norco	6	0.1
Palm Desert	12	0.3
Palm Springs	260	5.8
Pedley	1	0.0
Perris	379	8.4
Quail Valley	3	0.1
Ripley	4	0.1
Riverside	1,174	26.0
Rubidoux	32	0.7
School Districts	97	2.2
Sun City	20	0.4
Temecula	105	2.3
Thousand Palms	9	0.2
Valle Vista	20	0.4
Wildomar	5	0.1
Winchester	1	0.0
Domestic Violence Locations (Confidential)	38	0.8
TOTALS	4,508	100.0

The jurisdictions highlighted in the table above are those for Eastern Riverside County. Combined they account for 1,521 homeless persons which is about one-third (33.7%) of the county's homeless.



COACHELLA VALLEY FARM WORKERS SURVEY 2006¹

A comprehensive survey of farm workers was completed in late 2006. To complete the picture of the population in Eastern Riverside County, here is an extract from the Executive Summary of that report showing its major findings.

“In 2005, the Agricultural Industry generated over \$4 billion dollars in financial impact on the Riverside County economy including over \$1.7 billion in the Coachella Valley region. Critical to this significant economic impact on the local economy is a thriving and productive work force that tends the agricultural crops and livestock of the region. To gain a better understanding of the living conditions and daily service needs of the farm worker population in the eastern Coachella Valley, the office of County Supervisor Roy Wilson and the County of Riverside Department of Public Social Services commissioned the 2006 Coachella Valley Farm Worker Survey Project.

This report provides a profile of farm workers living and working in the Coachella Valley year-round and seasonally. The profile is based on a comprehensive survey in Spanish that contained more than 100 questions prepared by local community stakeholders. The survey was administered to 525 year-round and seasonal farm workers. The responses to the questions were analyzed and serve as the basis of the findings within this report. These findings relate to many aspects of the lives of farm workers and their families including housing, employment, income, health status, education, residency, social services, and transportation.

FARM WORKERS WHO LIVE IN THE COACHELLA VALLEY YEAR-ROUND

The first set of findings concern farm workers who stated they live in the Coachella Valley year-round. Seventy-two percent (72%) of survey respondents stated they lived in the valley year-round, whereas 28% lived in the Coachella Valley seasonally.

Social Services

FINDING: Farm workers identified medical services as the first service that would be most helpful for them and their families.

Transportation

FINDING: Farm workers identified transportation as the second service that would be most helpful for them and their families.

Education

FINDING: 71% of farm workers stated they could not communicate in English and nearly two-thirds (65%) of them were interested in learning English.

Housing

FINDING: 88% of farm workers who live year-round in the Coachella Valley live in conventional housing situations including apartments, houses and mobile homes.

Employment

FINDING: 24% of farm workers reported they worked 12 months out of the year doing farm labor in the Coachella Valley.

Income

FINDING: 78% of farm workers stated their annual household income was less than \$15,000.

¹ The County of Riverside Department of Public Social Services Homeless Programs Unit. *Coachella Valley Farm Workers Survey, Final Report, 2006*, <http://dpss.co.riverside.ca.us/dpss/PDFs/Homeless/FarmWorkerSurvey.pdf>



FARM WORKERS WHO LIVE IN THE COACHELLA VALLEY SEASONALLY

Social Services

FINDING: Seasonal farm workers identified medical services as the first service that would be most helpful for them and their families.

Transportation

FINDING: Seasonal farm workers identified transportation as the second service that would be most helpful for them and their families.

Education

FINDING: 80% of seasonal farm workers stated that they could not communicate in English and nearly two-thirds (63%) of them were interested in learning English.

Housing

FINDING: 30% of seasonal farm workers live in situations not meant for human habitation such as outdoors or other locations not meant for sleeping, cars/truck/vans/trailers on streets or in parking lots, trailers or recreational vehicles on private residential property or in converted garages.

Employment

FINDING: 45% of seasonal farm workers reported they work six (6) days a week doing farm labor in the Coachella Valley.

Income

FINDING: 97% of seasonal farm workers stated their annual household income was less than \$15,000.







Health Care Resources and Utilization

When assessing health care access, the availability of healthcare facilities is an important consideration. However, there are other factors which may also play a significant part as well. These include cost of service, cultural barriers, hours of service, and language proficiency at provider locations. Measurement of these factors is very difficult and complicates the process of assessing access, but describing the resources available will provide a basis for evaluating access needs.

ACUTE HEALTHCARE FACILITIES

ERC SHORT-STAY HOSPITALS

Eastern Riverside County has five acute care hospitals and one chemical dependency recovery hospital. Two of the acute care hospitals are for-profit and three are not-for-profit. All of the acute care hospitals have Emergency Rooms. Desert Regional Medical Center has a regional trauma center.

DISCHARGE DATA ANALYSIS

The California Office of Statewide Health Planning and Development (OSHPD) collects data for all people discharged from hospitals in the state. This data is publicly available in an aggregated form to be used for analysis purposes. The tables in this section are summarized from the 2005 OSHPD Inpatient Hospital Discharge Data Pivot Profiles¹. The public dataset is comprised of one record for each inpatient discharged from a California licensed hospital. These hospitals include: General Acute Care, Acute Psychiatric, Chemical Dependency Recovery, and Psychiatric Health. Definitions of other terms included in these tables can be found on the OSHPD website.

The aggregate data can be looked at in two ways:

1. The services provided to people who go to Eastern Riverside County (ERC) hospitals, or
2. The services provided to those living in ERC by hospitals within or outside of ERC.

1. SERVICES PROVIDED TO THOSE DISCHARGED FROM ERC HOSPITALS

DISCHARGES/ DAYS	ERC	Riverside	California
Number of Hospitals	6	17	457
Number of Discharges	58,835	195,275	3,990,255
Number of Discharge Days	260,798	823,430	20,622,391
Average Length of Stay	4.4	4.2	5.2

Hospital discharges (D/Cs) from the 6 facilities in Eastern Riverside County account for 30% of the discharges from the 17 facilities in Riverside County and almost 32% of the discharge days.

The average length of stay in ERC at 4.4 days is slightly longer than in the county but substantially shorter than for the state at 5.2 days.

OSHPD data includes the principal diagnosis for each patient encounter. For ease of reporting, these diagnoses are grouped into Diagnosis Related Groups or DRGs.

Following is a summary of the Top 10 DRGs for different age groups for discharges from Eastern Riverside County hospitals.

¹ Office of Statewide Health Planning and Development. *Inpatient Hospital Discharge Data Pivot Profiles*, www.oshpd.ca.gov/HID/Products/PatDischargeData/PivotTables/PatOrginMkt/default.asp



Top 10 DRGs by Age Group for Discharges from ERC Hospitals

DRG	DRG	Encounters
Top 10 DRGs: All Ages, Excluding Normal Newborns & Deliveries		
209	Major Joint & Limb Reattachment Procedures (HIP or KNEE REPLACEMENT)	1,742
143	Chest Pain	1,588
89	Simple Pneumonia & Pleurisy Age >17 w CC	1,376
127	Heart Failure & Shock	1,353
462	Rehabilitation	1,018
14	Intracranial Hemorrhage or Cerebral Infarction (STROKE)	941
88	Chronic Obstructive Pulmonary Disease (COPD)	878
527	Percutaneous Cardiovascular Proc W Drug-Eluting Stent W/O AMI (PTCA)	835
430	Psychoses	788
390	Neonate w Other Significant Problems	754
Ages 0 to 5, Excluding Normal Newborns		
390	Neonate w Other Significant Problems	736
98	Bronchitis & Asthma Age 0-17	345
389	Full Term Neonate w Major Problems	267
388	Prematurity wo Major Problems	260
91	Simple Pneumonia & Pleurisy Age 0-17	220
184	Esophagitis, Gastroent & Misc Digest Disorders Age Age 0-17	197
385	Neonates, Died or Transferred to Another Acute Care	166
386	Extreme Immaturity or Respiratory Distress Syndrome	108
298	Nutritional & Misc Metabolic Disorders Age 0-17	101
387	Prematurity w Major Problems	91
Ages 6 to 17		
167	Appendectomy wo Complicated Principal Diagnosis wo CC	70
184	Esophagitis, Gastroent & Misc Digest Disorders Age Age 0-17	66
98	Bronchitis & Asthma Age 0-17	59
91	Simple Pneumonia & Pleurisy Age 0-17	52
298	Nutritional & Misc Metabolic Disorders Age 0-17	34
165	Appendectomy w Complicated Principal Diagnosis wo CC	31
279	Cellulitis Age 0-17	24
322	Kidney & Urinary Tract Infections Age 0-17	19
383	Other Antepartum Diagnoses w Medical Complications	16
220	Lower Extrem & Humer Proc Exp Hip, Foot, Femur Age 0 -17 w/o CC	15
Ages 55 to 64		
143	Chest Pain	259
209	Major Joint & Limb Reattachment Procedures Of Lower Extremity	240
88	Chronic Obstructive Pulmonary Disease	150
527	Percutaneous Cardiovascular Proc W Drug-Eluting Stent W/O Ami	142
127	Heart Failure & Shock	129
89	Simple Pneumonia & Pleurisy Age >17 w CC	129
462	Rehabilitation	125
14	Intracranial Hemorrhage or Cerebral Infarction	94
125	Circulatory Disorders Excp Ami, w Card Cath wo Complex Dx	84
174	G.I. Hemorrhage w CC	82
Ages 65+		
209	Major Joint & Limb Reattachment Procedures Of Lower Extremity	1,180
127	Heart Failure & Shock	966
89	Simple Pneumonia & Pleurisy Age >17 w CC	964
143	Chest Pain	741
462	Rehabilitation	717
14	Intracranial Hemorrhage or Cerebral Infarction	667
88	Chronic Obstructive Pulmonary Disease	570
527	Percutaneous Cardiovascular Proc W Drug-Eluting Stent W/O Ami	553
174	G.I. Hemorrhage w CC	449
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC	412

Source: State Inpatient PivotTable - Hospital Share, ERC Hospitals, 2005, Courtesy of Desert Regional Medical Center



2. WHERE ERC RESIDENTS GO FOR HOSPITALIZATION

The other way to look at hospital discharge data is by tracking the hospitals used by residents of Eastern Riverside County for their hospitalizations. Based on the Zip code recorded for each encounter, this is a summary of the hospitals used by ERC residents.¹

Hospital Location	Patient Encounters	% Encounters	Total Days	ALOS
ERC Hospitals	49,761	80.6%	196,077	3.9
San Bernardino County Hospitals	6,163	10.0%	32,835	5.3
Western Riverside County Hospitals	3,340	5.4%	18,800	5.6
Los Angeles County Hospitals	1,426	2.3%	8,853	6.2
San Diego County Hospitals	453	0.7%	3,073	6.8
Orange County Hospitals	405	0.7%	2,455	6.1
Out of Area Hospitals	228	0.4%	1,051	4.6
Grand Total	61,776	100.0%	263,144	4.3

In 2005, ERC residents utilized ERC hospitals for service 80.6% of the time. An additional 10% of the time, they went to San Bernardino County hospitals and 5.4% of the time they went to hospitals in Western Riverside County. Those going to San Bernardino and Western Riverside County hospitals most likely live closer to the western border of our survey area.

OTHER HEALTHCARE FACILITIES

Additional healthcare resources are provided by Community Clinics, Specialty Clinics, Long-term Care Facilities, and Counseling and Mental Health Facilities.

¹ Source: State Inpatient PivotTable Report - Market Share by Hospital, 2005, Courtesy of Desert Regional Medical Center



Where Do We Go From Here?

This Executive Report of the HARC Community Health Monitor – 2007 for the Coachella Valley and Eastern Riverside County has provided selected highlights from the full data report which is available on the CD attached to this document or through the HARC website, www.harcddata.org.

This first ever, community-based, scientific study of the health needs in our region highlights many of the disparities and issues that should be the focus of interventions to improve the health and quality of life in Eastern Riverside County. An analysis of the data has resulted in identifying multiple gaps and areas of concern that need to be addressed in order to improve our overall health as a community. HARC's job is to maintain objectivity and be the provider of the data but not participate in advocacy or setting community priorities. Rather, HARC supports the concept that the community and its organizations and individuals will use HARC's reports and data to set priorities, strengthen existing programs and, when necessary, develop new ones to improve the health and quality of life in our area.

When asking "Where do we go from here", the response can be considered within the context of four groups. First, the community as a whole such as public agencies including the county and cities, foundations, chambers of commerce, media and other broad-based, umbrella organizations can play a major role in terms of focusing funding, community infrastructure and design, communication and advocacy on issues that will improve the health of the community. The Coachella Valley Health Collaborative (CVHC) may be an appropriate focus for discussions about priorities, advocacy and fostering change based on the data generated by the HARC Community Health Monitor.

A second group includes the many nonprofit and proprietary organizations that have a role in providing healthcare and quality of life services. Using scientific data such as that provided by HARC has the potential to help shape changes in the delivery of service by strengthening existing or adding new services. For nonprofit organizations, data from HARC together with other documentation can be used to support funding requests from foundations, government agencies and philanthropists.

Individual residents in our community comprise a third group who should take note of many of the findings in the HARC data and make proactive changes in taking responsibility for their own health care and that of their families. Where individual responsibility is not enough and major health system changes are needed, individual residents may need to get involved with advocacy to make such changes.

Finally, the fourth group, the HARC collaborative, needs to fulfill its pledge to keep pace with the growing, diverse and ever-changing health-related needs of Coachella Valley and Eastern Riverside County by partnering with the community to provide periodic, scientifically conducted studies in addition to its triennial Community Health Monitor survey. In doing so, the community will be able to see change, improvement, trends and remaining challenges that will emerge over a period of time.

HARC is but a first step to increasing community awareness and improving the health and quality of life status in our region.

"Health and intellect are the two blessings of life."

Menander (c. 342-292 B.C.)

-Monostikoi