SAN ANTONIO REGIONAL HOSPITAL

Community Health Needs Assessment 2016

Executive Summary

This report represents the Hospital Association of Southern California, Inland Counties' first coordination of the Community Health Needs Assessment (CHNA) for 11 local hospitals. HASC works with hospitals to advance quality healthcare delivery and supports the CHNA process with an Inland Area Community Benefit Stakeholder Committee representing the major hospitals in each county. This HASC Community Benefit Committee worked collectively to design the overall CHNA strategy and the coordination of primary and secondary data collection in collaboration with the Departments of Public Health in both San Bernardino and Riverside Counties. The hospitals that participated in the regional CHNA included:

- Loma Linda University Behavioral Medicine Center
- Loma Linda University Medical Center
- Loma Linda University Medical Center – Murrieta
- Loma Linda University Medical Center Children's Hospital
- Montclair Hospital Medical Center
- Parkview Community Hospital Medical Center
- Redlands Community Hospital
- Ridgecrest Regional Hospital
- San Antonio Regional Hospital
- San Bernardino Mountains Community Hospital
- San Gorgonio Memorial Hospital

Purpose of Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA) of March 23, 2010 included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The final regulations and guidance on these requirements, which are contained in section 501(r) of the Internal Revenue Code, were published on February 2, 2015 in Internal Revenue Bulletin 2015-5. Included in the new regulations is a requirement that all nonprofit hospitals conduct a community health needs assessment (CHNA) and develop an implementation strategy to address those needs every three years. Each hospital will develop its own implementation strategy using the data from this report. There may also be identified areas that the region will work on collectively, including partners outside of the healthcare system.

This report is the first regional CHNA among a large group of geographically diverse hospitals in the Inland Counties Region of Southern California. Given the rapid growth of the Inland Empire, the higher rates of poverty, significant health needs, and inadequate primary care infrastructure, this collaboration not only supports the completion of the required reporting, but fosters the opportunity for more unified and strategic thinking to address population needs in the region. This report is just the beginning of a collaborative effort to support the health of our region collectively.

The Health Needs Reviewed for the Two County Region

This regional CHNA was built on the community health improvement process initiated by the San Bernardino County Department of Public Health, Community Vital Signs. As health care continues to evolve and systems of care become more complex, the CHNA process is increasingly becoming a key component to the collective efforts of communities in addressing their most pressing health needs. The report views health with a collective lens and includes not only health outcomes and clinical care components but social determinants and health indicators from the built environment.

The process for determining community health needs requires collecting reliable public health data or metrics to measure against a benchmark (i.e. state averages) and engaging the community to solicit their input on the needs they perceive to be the most pressing in their community. The CHNA process also requires that the community participate in prioritizing health needs and that a hospital identify potential resources available to address those needs. The criteria and process used for prioritizing the health needs is not defined by the IRS, but considerations can include factors such as the severity of the health need, the number of community members impacted, or the presence of health inequities among segments of the community.

This CHNA incorporated three distinct data methodologies that, when interpreted together, provide a deeply rich picture of the health landscape of the communities. The assessment consists of a plethora of health indicators (hospitalizations, social determinants of health, maternal and child health, mortality and morbidity) gathered from multiple primary and secondary sources. This quantitative data illustrates the current snapshot of health statistics in the communities that the member hospitals serve and also how they compare across geographical boundaries. The quantitative data was stratified by common public health groupings and service areas allowing a targeted identification of unique challenges and opportunities surrounding health status, quality of life, and risk factors in the community.

The full assessment provides a detailed review of health in the Inland Empire with clear similarities and variability across the two counties and hospital service areas. Several health indicators stand out as desirable and others indicate an opportunity for additional study and outreach. The top chronic health conditions identified through data compilation include (in alphabetical order):

- Asthma
- Chronic obstructive pulmonary disease
- Diabetes
- Mental illness
- Obesity
- Substance abuse

Voices from the Community

A community health quality of life survey was administered to obtain community input regarding the strengths and areas of opportunity that exist in each community. The survey was available in English and Spanish and was disseminated through a variety of channels across hospital service areas. A total of 541 individuals completed the QOL survey. Of those who completed the survey, 50% were between the ages of 40-65, 12.6% were seniors who were 65 years or older, 30% had an annual household income of $25,000 or less, and 60% were Hispanic. Qualitative data was also garnered through the use of eight community member, health expert, and key stakeholder focus groups. The focus groups were conducted in both English and Spanish to reveal thoughts and perceptions, and to augment the quantitative data collected in the assessment process. The focus groups allowed a deep understanding of the issues respondents believe are important. The assessment displays data at the county level and when available several health indicators are provided for each hospital's service area.

The quality of life surveys and focus groups were tailored to assess the direct and indirect needs of the communities throughout the Inland Empire. The information shared gave insight into some of the concerns individuals had for their community. Experiences and community concerns varied greatly across the Inland Empire Area. Community concerns ranged from the quality of the education system, access to mental health services, pollution, economy, homelessness, climate change, and the overabundance of fast food restaurants.

The top health challenges identified for the communities involved in this CHNA are:

Health Outcomes	Social Determinants	Clinical Care	Built Environment
• Diabetes (Higher rates among Hispanics) • Behavioral Health • Heart disease and stroke • Chronic Obstructive Pulmonary Disease • Cancer o Colorectal o Lung • Obesity	• High Rates of Poverty • Lower median incomes • Lower Educational Attainment	• Shortage of primary care physicians • Lack of or failure to access preventive screenings for cancer • Inadequate prenatal care	• Affordable housing shortages • Lack of access to healthy foods

San Antonio Regional Hospital

109 Years and Growing

San Antonio Regional Hospital was founded by Dr. William Howard Craig in 1907 to meet the healthcare needs of local residents. As the community surrounding the hospital grew, it became apparent that larger, more modern facilities were needed. Community leaders rallied to raise the needed capital and the hospital moved to its current location on San Bernardino Road in 1924. Through community support, the hospital grew – from its modest beginning with 18 beds, 5 physicians, and limited staff—to a 271-bed regional medical facility with nearly 2,000 employees and a medical staff of more than 500 physicians.

The hospital's main campus in Upland is currently undergoing the largest expansion in its 109-year history. The 179,000 square foot addition, which will include a new 52-bed emergency department and 92-bed patient tower, is scheduled for completion in late 2016. The project incorporates the latest healthcare architectural design and advanced technological features with the goal of meeting the needs of the growing population in the west end of California's Inland Empire.

In addition to the main campus, the hospital has satellite locations in Rancho Cucamonga, Fontana, and Eastvale. These facilities provide outpatient care in a close, convenient setting for the region's growing population.

Leadership

San Antonio is governed by a 17-member Board of Trustees. The hospital's medical staff's President-Elect, President, and Immediate Past President are members of the board by virtue of their offices. At least two additional physicians are elected from the medical staff, and the remaining members are elected from the community at-large. The Board of Trustees, with physician leaders comprising a significant portion of its membership, sets the direction for the hospital and the Community Benefits Program.

The Executive Management Group directs the hospital's strategic planning process and allocates resources for community benefit activities. The Executive Management Group is comprised of the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Nursing Officer, Vice President of Human Resources, Vice President of Strategic Development, Vice President of Business Development and Community Outreach, and President of the Hospital Foundation.

Department directors are responsible for the operation and management of the individual departments. The directors encourage employee participation in community benefit activities, and it is this support that ensures the ultimate success of the hospital's Community Benefits Plan.

Our Commitment

The leadership at San Antonio Regional Hospital has an unwavering commitment to the hospital's mission, vision, values, and strategic plan, which focus on improving the region's overall health by providing quality patient care in a compassionate and caring environment. Our mission is to improve the overall health of our regional community by offering healthcare services that both comfort and cure, in settings that inspire confidence, and in a manner that earns the trust of our patients, our physicians, and our employees. Our vision is to use our strengths to enhance our reputation for excellence in quality care, patient experience, and an exceptional working and practice environment. Our values articulate the principles that help us to fulfill our mission and vision, and our strategic plan specifically addresses the development of programs and services in response to regional community needs.

Community Benefit

For more than a century, community benefit has been at the core of the San Antonio mission. Today, the hospital continues to demonstrate its commitment to improving health in surrounding communities and populations by providing organized and sustainable programs and services.

San Antonio Regional Hospital, through its community outreach efforts, organizes and tracks community benefit activities on an ongoing basis throughout the year. These programs and services are specifically designed to address health disparities, improve health outcomes, and empower communities to take actionable steps to improve their own health and wellness. As in most communities, the needs are great and the resources limited. The hospital understands the power of collaboration and seeks alliances with other health and social service providers to develop community-based programs with defined goals and measurable outcomes. These partnerships help to leverage the community's scarce resources to achieve the maximum benefit for its residents, which results in demonstrated improvement in their health.

Economic Valuation of Community Benefit

The Hospital's community benefit inventory was completed using software developed by the Catholic Hospital Association and VHA, Inc. in partnership with Lyon Software. The Community Benefit Inventory for Social Accountability (CBISA) software allowed San Antonio's activities to be summarized into the broad categories outlined in California's Senate Bill 697.

San Antonio Regional Hospital's primary responsibility is to provide healthcare services; however, its mission does not end there. Every effort is made to reach out into the community with additional services and programs in response to the community's needs. A summary and valuation of the 2015 program follows, along with an accounting of the financial losses sustained in providing medical care to uninsured and underinsured patients.

Definitions

Medicare

San Antonio Regional Hospital incurred a shortfall of $2,931,519 on the services it provided to Medicare patients on a fully allocated cost basis.

Medi-Cal

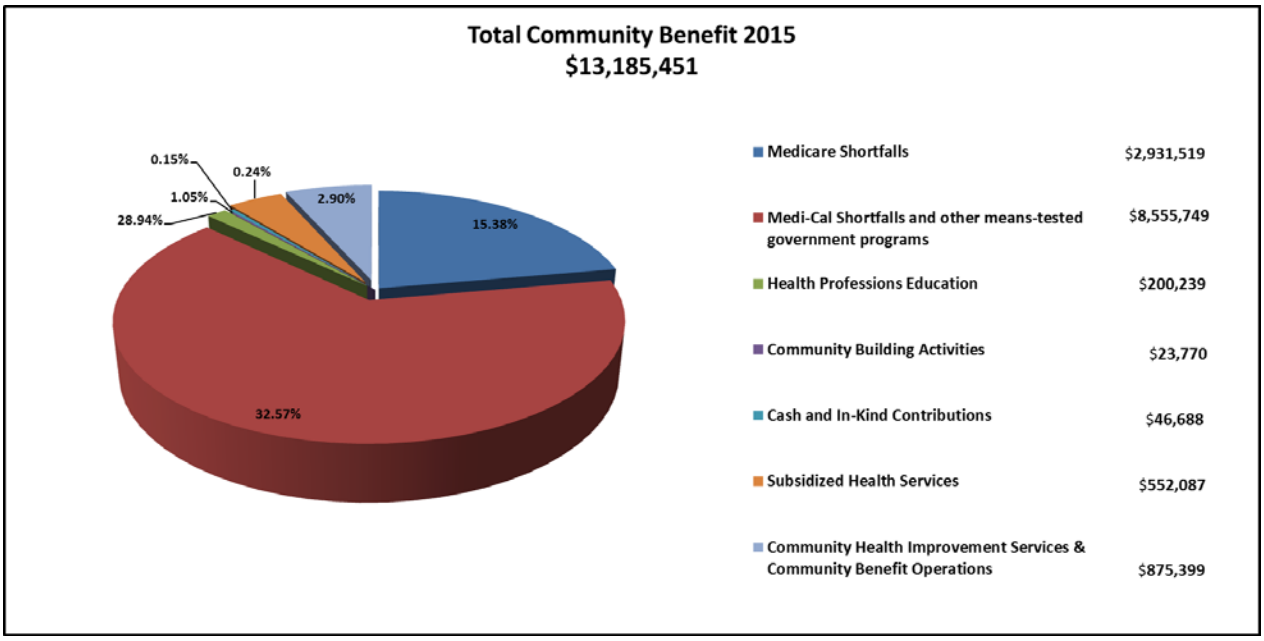
San Antonio lost $2,838,378 on the services provided to Medi-Cal patients on a fully allocated cost basis, which compares actual payments received to the total actual costs incurred by the hospital for treating these patients, during 2015.

Charity Care

The hospital makes every effort to collect payment for services rendered from the patient and/or their health insurance plan. However, when the patient is uninsured or underinsured and lacks the financial resources to pay for their medical care, the hospital makes no further to attempt to collect on these accounts, writing them off as Charity Care. The hospital provided $5,515,528 in Charity Care during 2015.

Other Uncompensated Care

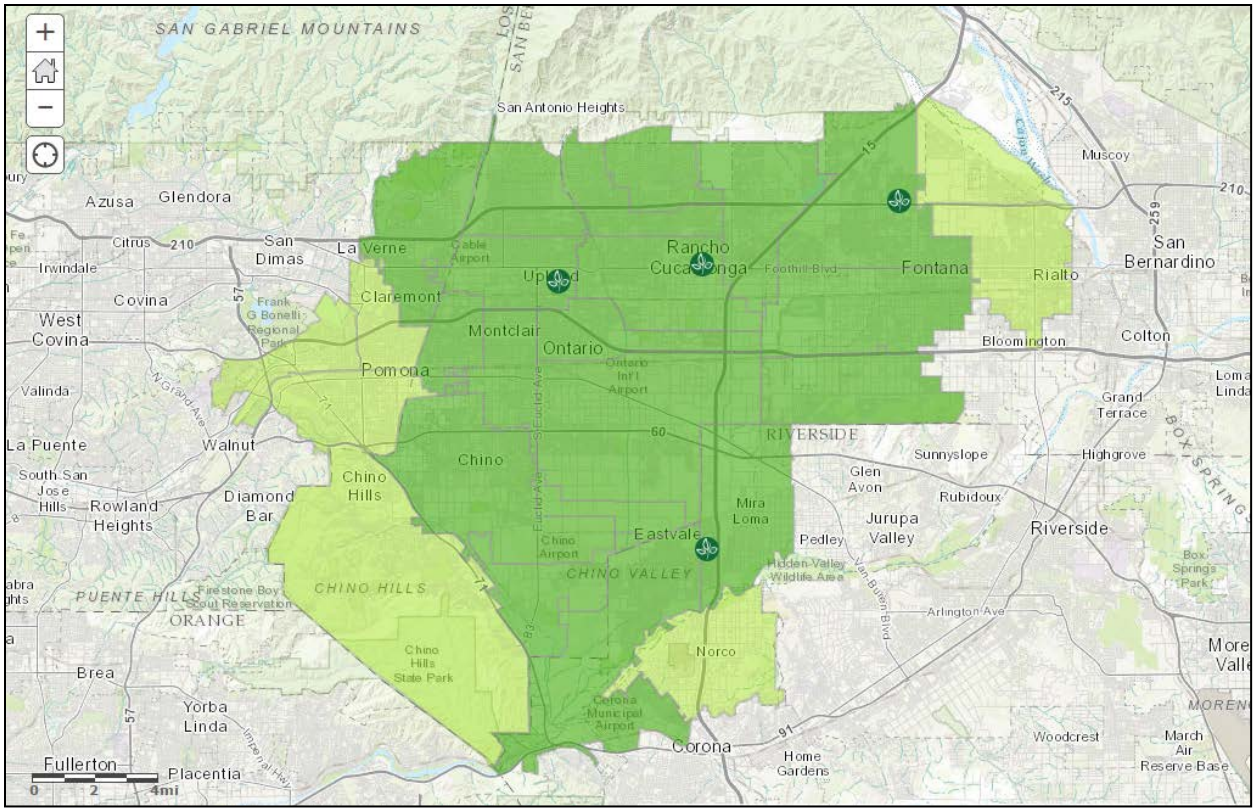
Other uncompensated care (bad debts) totaled $2,701,098 in actual cost incurred by the hospital to treat these patients. Uncompensated care is not included in the hospital's community benefit valuation; however, the costs incurred to treat these patients represent an additional direct benefit to the community.



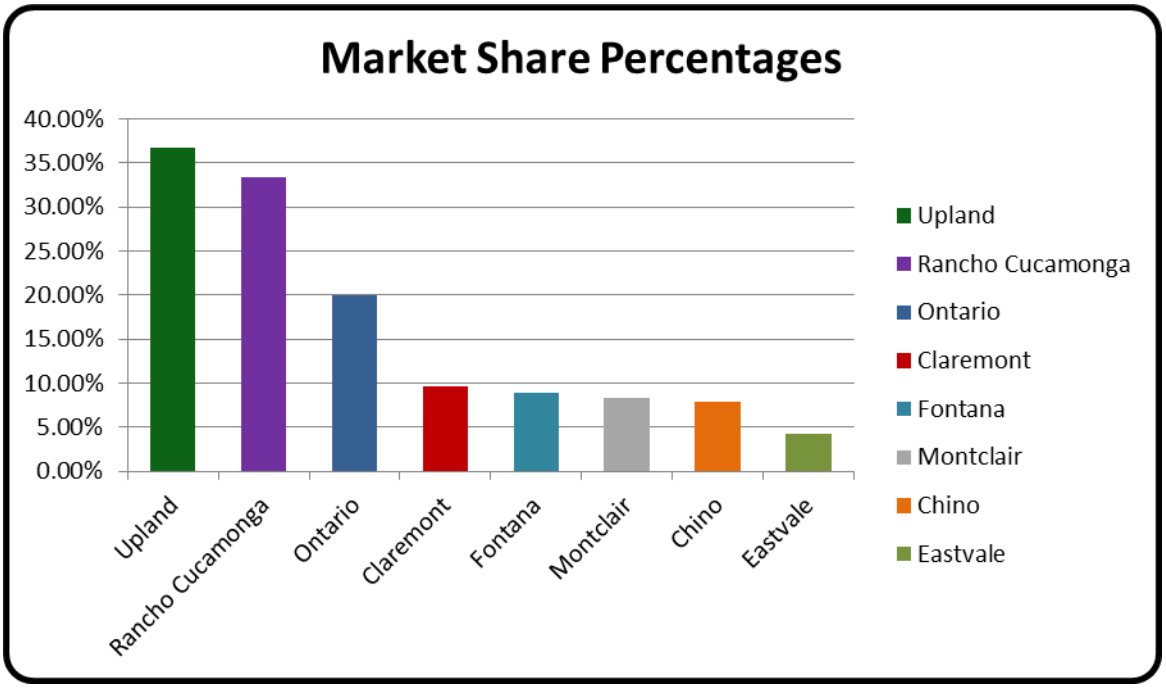
Community Profile

A community is seen as having both physical and geographic components, as well as socioeconomic and psychosocial factors that define a sense of community. Individuals can thus be part of multiple communities - geographic, virtual, and social. The current focus on community-based participatory research in public health has prompted an evaluation of what constitutes a community. In this report we defined a community as the geographic area served by specific hospital facilities and the populations they serve.

San Antonio Regional Hospital resides in the City of Upland, located in the "West End" of San Bernardino County. However, like many hospitals, San Antonio's "service area" is defined as the geographic area from which it receives the majority of its hospital admissions. The total service area is divided into "primary" and "secondary" areas, with the primary service area accounting for approximately 80% of the hospital's admissions and the majority of San Antonio's planning efforts. As illustrated on the map below, San Antonio's primary service area, denoted in dark green, is comprised of the cities of Chino, Claremont, Montclair, Eastvale, Fontana, Ontario, Rancho Cucamonga, and Upland. San Antonio's secondary service area, shaded in light green, extends to Pomona on the west, Chino Hills to the southwest, Corona and Norco on the southeast, and Rialto at the eastern edge of the service area.



San Antonio reviews population and demographic data on an annual basis, and as part of this community assessment, San Antonio's service areas are reviewed for changes in market share and each city's relative proportion of hospital discharges. Over the years, this analysis has led to minor modifications in the primary and secondary service area boundaries; however, the total service area has remained fairly constant and represents approximately 90% of San Antonio's discharges. Although acute care discharges and market share data are at best a proxy for other measures that may be more relevant to community benefits planning (e.g., outreach and outpatient activities); it is apparent that San Antonio continues to maintain its dominant role in the primary service area, particularly in the cities of Rancho Cucamonga, Ontario, and Upland where its market share is significant as shown below.



Given San Antonio's dominance in the primary service area and the fact that more than 80% of its hospitalizations are derived from this "community," the following analysis focuses on providing a more in-depth understanding of this area.

Demographic Characteristics

The following charts produced from Claritas data provide a snapshot of key demographic features in San Antonio's eight primary service area cities for the year 2016. Although these cities are geographically contiguous and share some basic similarities in terms of county and municipal governance, level of infrastructure, and general business environment, just to name a few aspects, there are some key demographic differences. For example, the median age is 30 years in Fontana, while both Claremont and Upland have a median age greater than 35 years. Although the high educational level in Claremont is not surprising given the presence of the Claremont Colleges, the low level of education, particularly in Montclair and Ontario, represents a significant concern in terms of earning capacity and the ability to purchase health insurance, which, in turn, has a direct impact on the ability to access basic healthcare. The demographic data confirms the correlation between education and earning capacity as noted by the lower median household income levels in the cities in which educational attainment is low. Average household income was positively associated with educational attainment and median home value. The demographic analysis also reveals a disparity in the number of primary care and specialty physicians between Upland and Rancho Cucamonga where physicians are plentiful and Ontario and Fontana where there are relatively few primary care physicians and specialists.

The following tables are arranged in a color-coded format for ease of comparison, city to city. The detail enables the reader to gain important insights about San Antonio's primary service area. An understanding of the disparities within the overall community can be gleaned by reviewing values within the individual tables and charts, as well as the associations between characteristics through a comparison of two or more tables or charts. This information will also serve as a foundation for the assessment's more in-depth study of health concerns at the local and regional level. For example, the lower the level of an individual's educational attainment, the greater the barriers he or she faces to accessing healthcare. Such barriers, in turn, increase the prevalence of disease and are particularly relevant to uncontrolled ambulatory-sensitive conditions such as asthma and diabetes.

The report also draws correlations between the significant number of identified health needs with lower financial status, a high number of uninsured and under-insured populations, and cost of health care as a barrier to accessing health services.

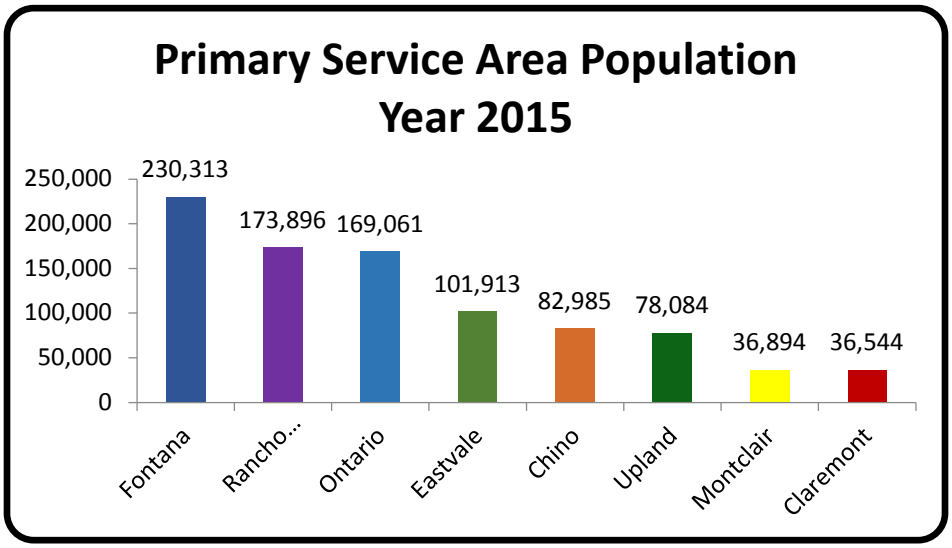
Rancho Cucamonga	
2015 Population (Estimated)	173,896
2020 Population (Projected)	182,767
Projected Growth 2015-2020	5.1%
Median Age	37.0
Educational Attainment (Age 25 & Older)	9.9% No High School Diploma
	60.3% High School Graduate
	29.8% Bachelor's Degree or Higher
Median Household Income	$94,096
Ethnicity	39.3% Caucasian
	36.2% Hispanic
	9.2% African-American
	11.6% Asian-American
	3.7% Other
Median Home Value	$454,190
Upland	
2015 Population (Estimated)	78,084
2020 Population (Projected)	79,693
Projected Growth 2015-2020	2.1%
Median Age	40.0
Educational Attainment (Age 25 & Older)	13.0% No High School Diploma
	57.8% High School Graduate
	29.2% Bachelor's Degree or Higher
Median Household Income	$89,925
Ethnicity	42.5% Caucasian
	40.0% Hispanic
	6.4% African-American
	8.3% Asian-American
	2.8% Other
Median Home Value	$486,898

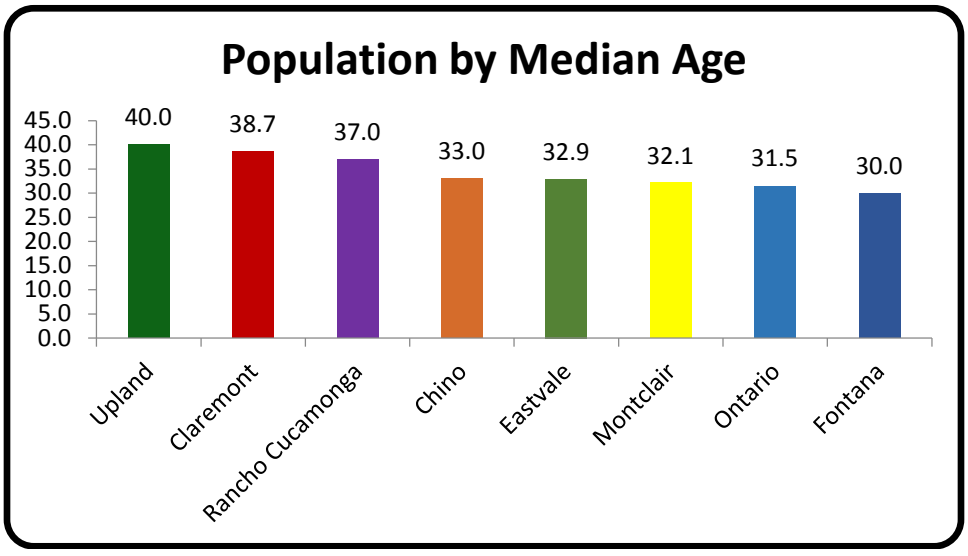
Ontario	
2015 Population (Estimated)	169,061
2020 Population (Projected)	172,069
Projected Growth 2015-2020	1.8%
Median Age	31.5
Educational Attainment (Age 25 & Older)	29.6% No High School Diploma
	56.8% High School Graduate
	13.5% Bachelor's Degree or Higher
Median Household Income	$61,971
Ethnicity	15.7% Caucasian
	71.3% Hispanic
	5.4% African-American
	5.6% Asian-American
	2.0% Other
Median Home Value	$287,835
Fontana	
2015 Population (Estimated)	230,313
2020 Population (Projected)	240,943
Projected Growth 2015-2020	4.6%
Median Age	30.0
Educational Attainment (Age 25 & Older)	30.0% No High School Diploma
	55.9% High School Graduate
	13.9% Bachelor's Degree or Higher
Median Household Income	$71,040
Ethnicity	12.2% Caucasian
	71.4% Hispanic
	7.9% African-American
	6.5% Asian-American
	2.0% Other
Median Home Value	$268,984
Montclair	
2015 Population (Estimated)	36,894
2020 Population (Projected)	37,518
Projected Growth 2015-2020	1.7%
Median Age	32.1
Educational Attainment (Age 25 & Older)	32.1% No High School Diploma
	56.1% High School Graduate
	11.8% Bachelor's Degree or Higher
Median Household Income	$55,624
Ethnicity	11.7% Caucasian
	73.8% Hispanic
	4.0% African-American
	8.7% Asian-American
	1.8% Other
Median Home Value	$293,434

Claremont	
2015 Population (Estimated)	36,554
2020 Population (Projected)	37,521
Projected Growth 2015-2020	2.6%
Median Age	38.7
Educational Attainment (Age 25 & Older)	9.1% No High School Diploma
	38.2% High School Graduate
	52.6% Bachelor's Degree or Higher
Median Household Income	$105,120
Ethnicity	55.9% Caucasian
	21.8% Hispanic
	4.7% African-American
	13.1% Asian-American
	4.5% Other
Median Home Value	$592,194
Chino	
2015 Population (Estimated)	82,985
2020 Population (Projected)	85,448
Projected Growth 2015-2020	3.0%
Median Age	33.0
Educational Attainment (Age 25 & Older)	21.3% No High School Diploma
	57.2% High School Graduate
	21.5% Bachelor's Degree or Higher
Median Household Income	$84,470
Ethnicity	24.7% Caucasian
	56.8% Hispanic
	4.5% African-American
	11.7% Asian-American
	2.3% Other
Median Home Value	$394,081
Eastvale	
2015 Population (Estimated)	101,913
2020 Population (Projected)	110,752
Projected Growth 2015-2020	8.7%
Median Age	32.9
Educational Attainment (Age 25 & Older)	18.6% No High School Diploma
	54.1% High School Graduate
	27.3% Bachelor's Degree or Higher
Median Household Income	$92,064
Ethnicity	23.4% Caucasian
	45.1% Hispanic
	8.6% African-American
	19.7% Asian-American
	3.2% Other
Median Home Value	$389,702

Source: 2015 Claritas Data within Truven's Market Expert Database

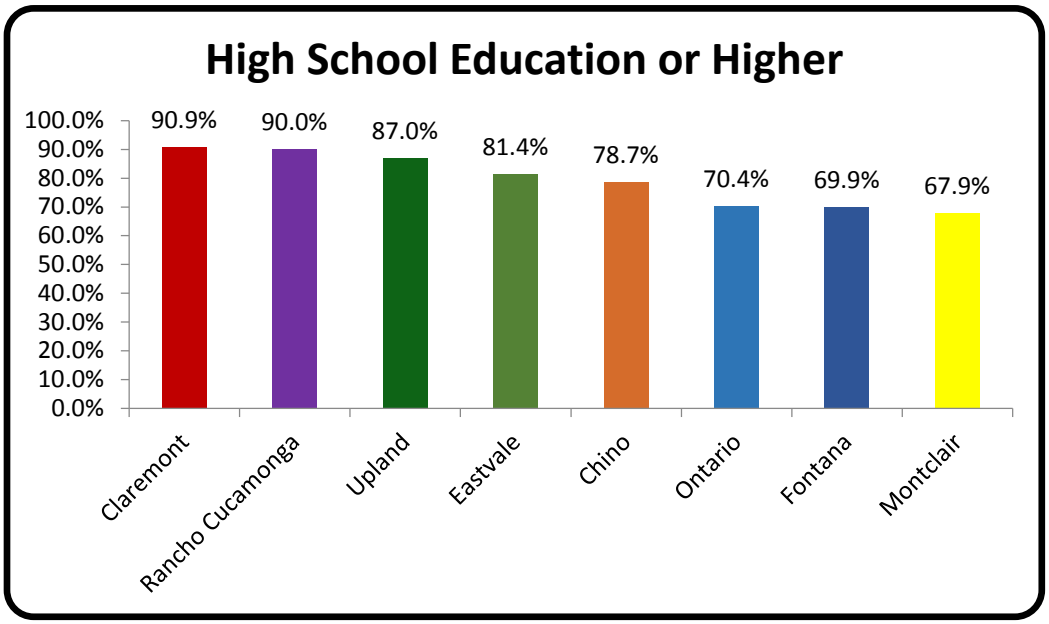
In addition to the preceding community profiles, several demographic characteristics are presented in the following charts. The intent is to provide a direct comparison among the primary service area cities with regard to key demographic indicators. This view demonstrates, for example, that Fontana continues to be the largest city in the primary service area and is one of the fastest growing areas in San Antonio's service area. The chart that follows illustrates that Fontana is also one of the youngest cities in the area based upon the median age of 30.0 years.

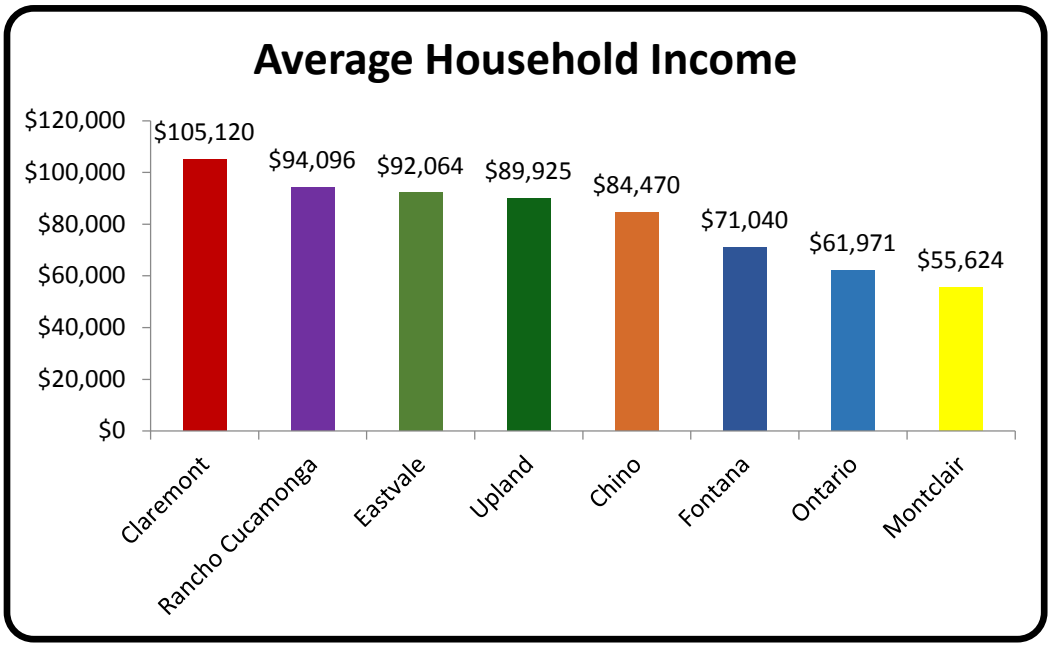




Data Source: Market Expert 2016

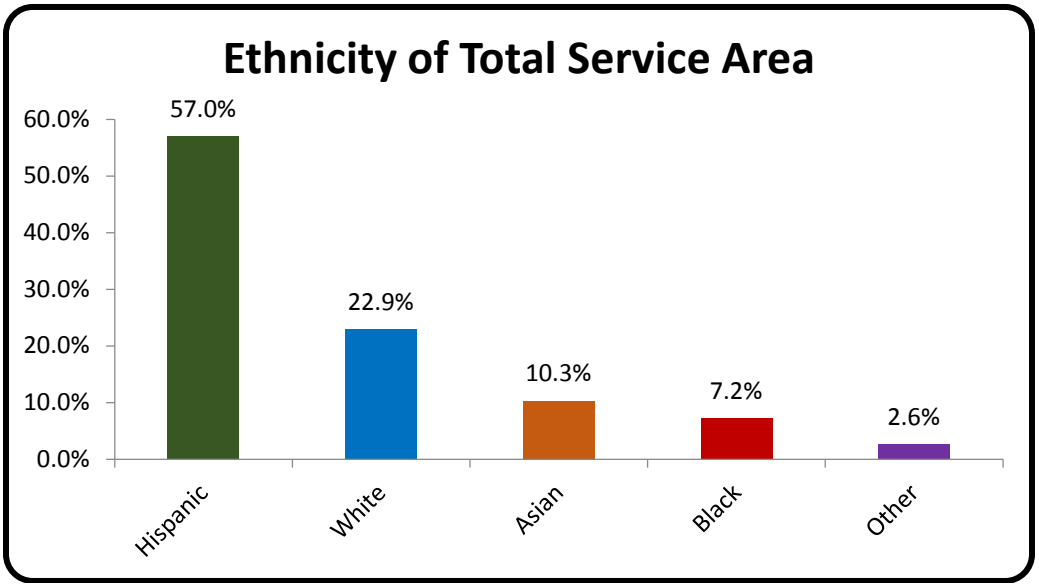
The correlation between education and income level is also readily apparent when comparing the results shown in the following two charts. The cities with the highest education level also have the largest household income.





Data Source: Market Expert 2016

The following chart illustrates the overall ethnicity of the primary service area. The Hispanic population is more than double the size of any other ethnic group, and this segment of the population is projected to continue growing over the next few years. Given this powerful dynamic, area hospitals must adapt if they are to provide culturally competent services. To remove linguistic barriers, health and medical information needs to be translated into the native language of those served. As the cultural diversity of the community is reflected in more diverse employees, hospitals will face fewer challenges in meeting the needs of the Hispanic community.



Data Source: Market Expert 2016

Regional Health Concerns

Overall Hospitalizations

The initial step in the CHNA process was to collect and analyze various sources of secondary quantitative data. The CHNA team reviewed hospital discharge data by diagnosis using Medicare Severity Diagnosis Related Group (MS-DRG) codes. MS-DRG codes, classified numerically from 001-999, are assigned to inpatient stays based on principle diagnosis and additional diagnosis, procedure, sex, and discharge status. This data is essential to understanding, comparing, and correlating health needs across the region based on hospitalizations.

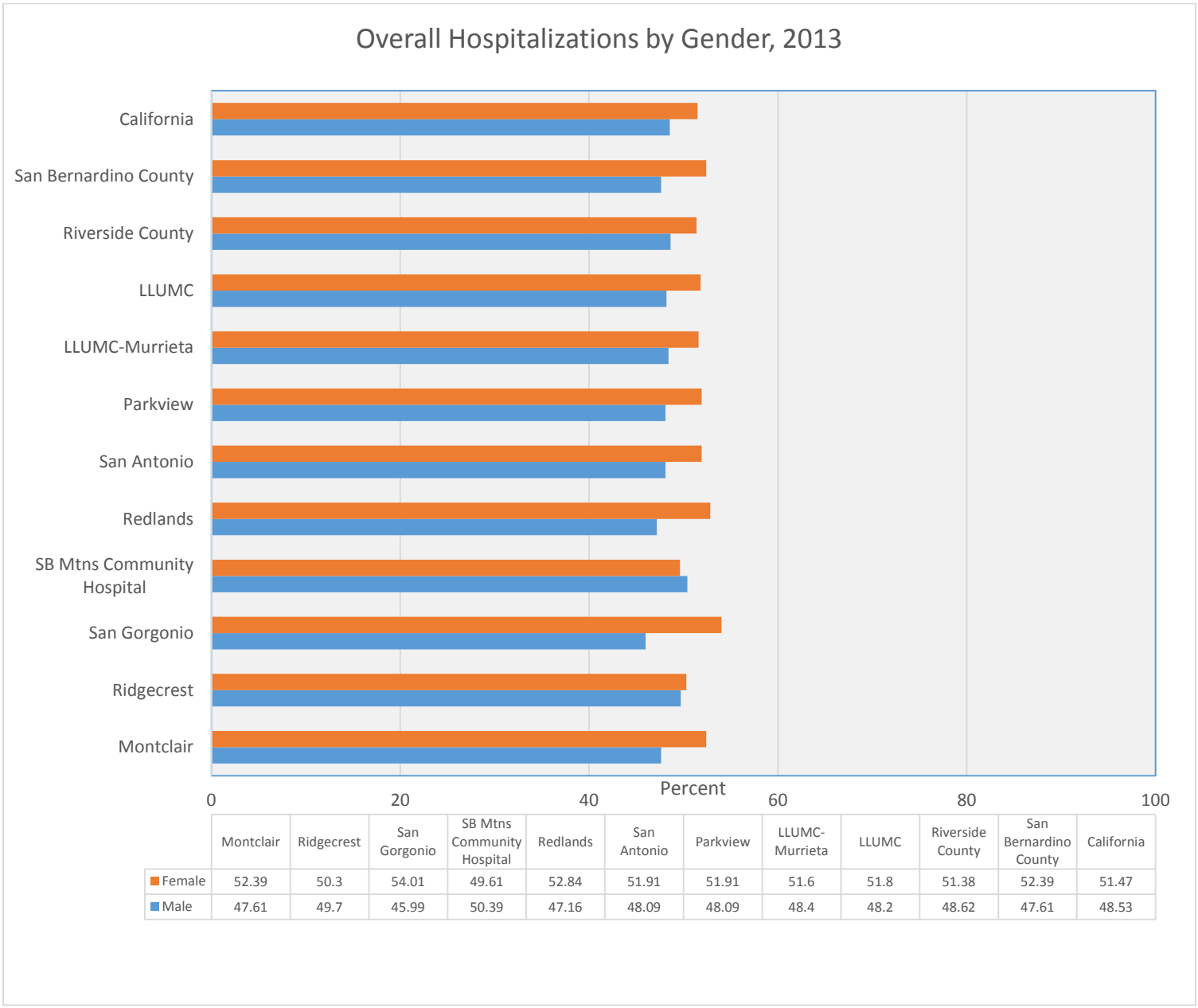
The following table includes data for the overall hospitalizations in participating hospital service areas in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center- Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, Ridgecrest, and Montclair.

Key Findings

- San Bernardino County represents 5.7% of the overall hospitalizations in California.
- San Antonio's service area represents 41% of the total hospitalizations in San Bernardino County.
- Overall hospitalizations are slightly higher among women.
- San Antonio's service area has significantly higher hospitalizations among the Hispanic population.
- There are fewer hospitalizations among the Medicare population (65+) in San Antonio's service area compared to all other hospitals, except Redlands Community.

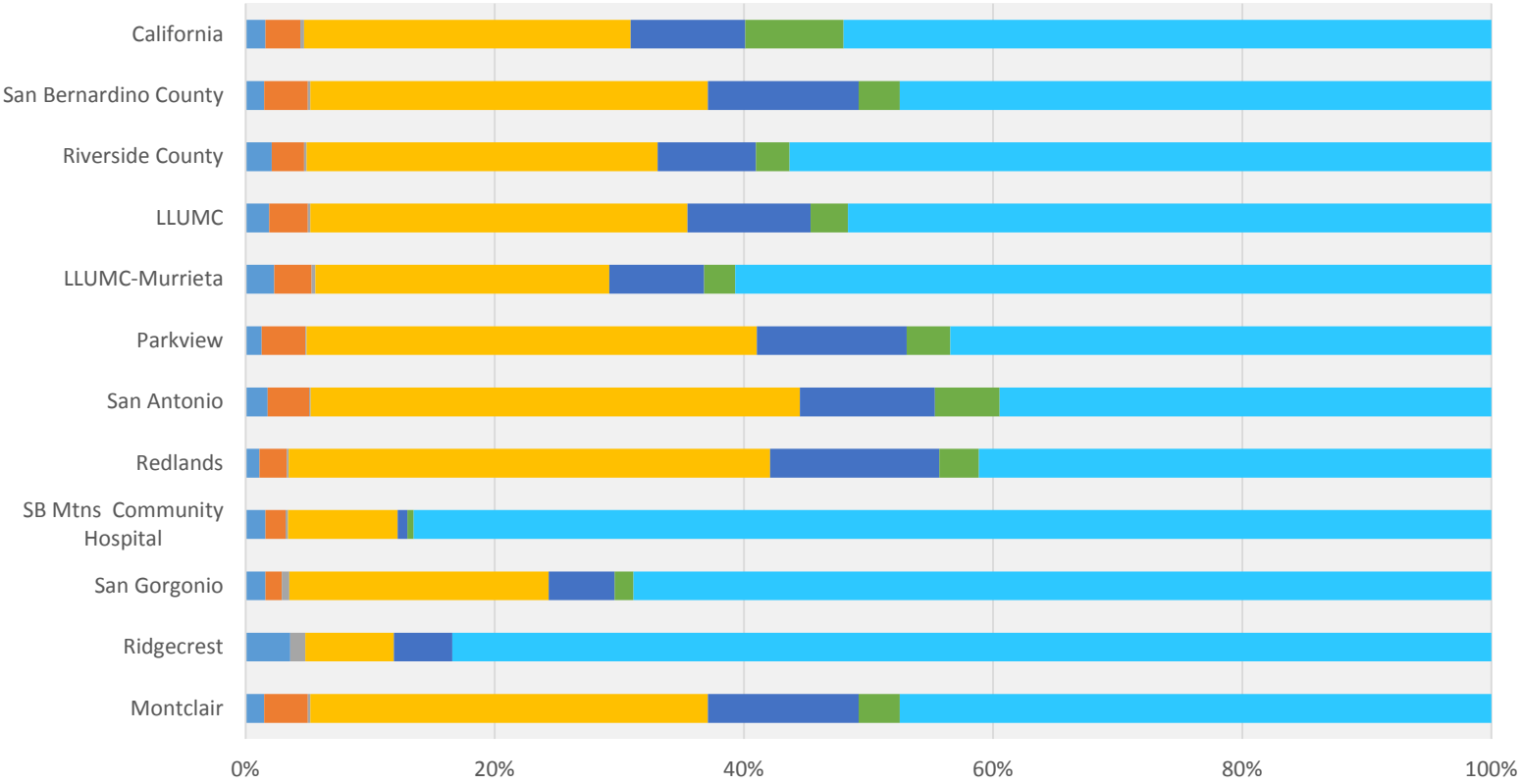
Table 1. N-Value for Total Hospitalizations per Service Area, 2013

California	SB County	Riverside County	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	SB Mtns Community	San Gorgonio	Ridgecrest	Montclair
2,440,708	140,788	147,513	275,887	152,401	55,429	58,766	39,393	2,048	25,534	169	140,788



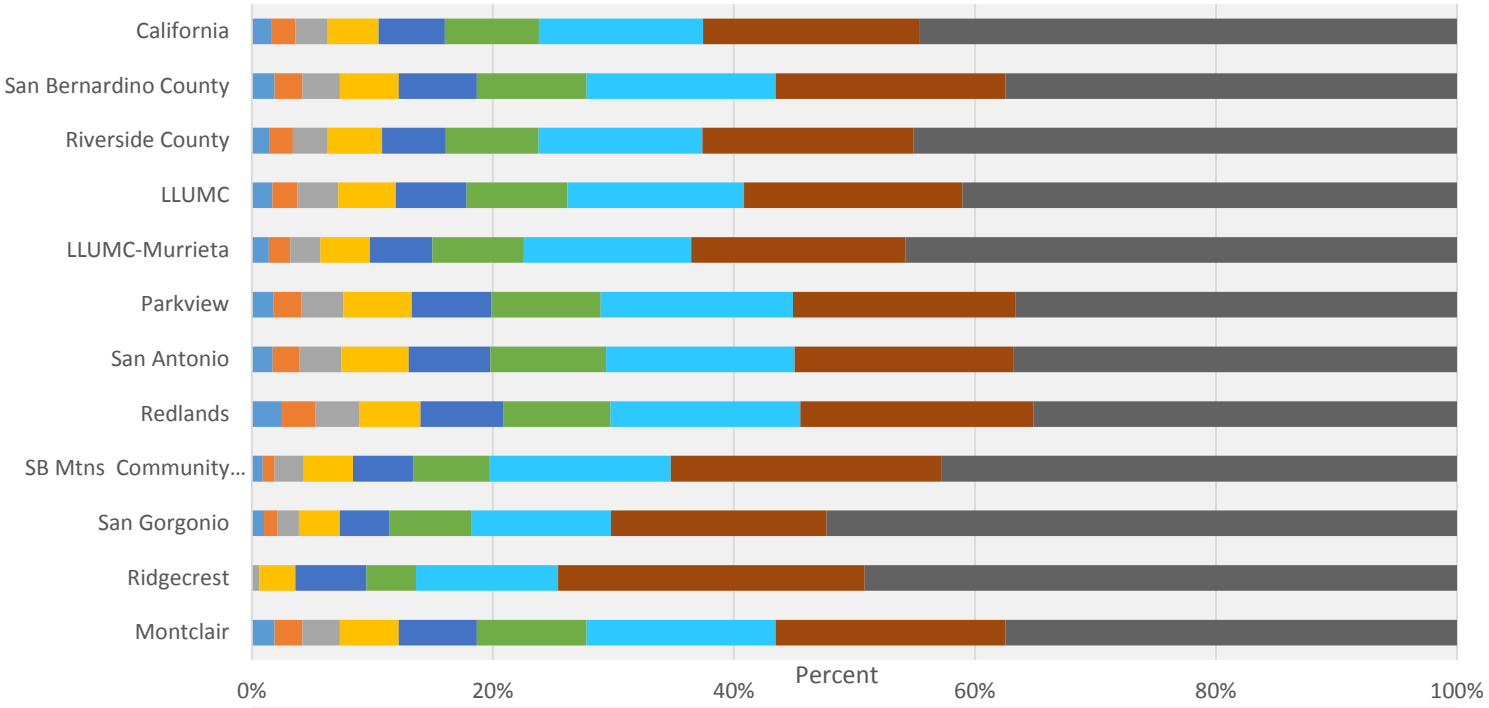
	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Female	52.39	50.3	54.01	49.61	52.84	51.91	51.91	51.6	51.8	51.38	52.39	51.47
Male	47.61	49.7	45.99	50.39	47.16	48.09	48.09	48.4	48.2	48.62	47.61	48.53

Overall Hospitalizations by Race/Ethnicity, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1.5	3.6	1.6	1.6	1.12	1.77	1.3	2.3	1.9	2.1	1.5	1.6
Other	3.5	0	1.3	1.6	2.2	3.32	3.5	3	3.1	2.6	3.5	2.8
AI/AN NH	0.2	1.2	0.6	0.2	0.15	0.13	0.1	0.3	0.21	0.2	0.2	0.3
Hispanic	31.9	7.1	20.8	8.8	38.62	39.27	36.1	23.6	30.3	28.2	31.9	26.2
Black NH	12.1	4.7	5.3	0.8	13.58	10.83	12	7.6	9.9	7.9	12.1	9.2
API NH	3.3	0	1.5	0.5	3.19	5.2	3.5	2.5	3	2.7	3.3	7.9
Whit NH	47.5	83.4	68.8	86.5	41.14	39.48	43.4	60.7	51.7	56.4	47.5	52

Overall Hospitalizations by Age Group, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	1.9	0	1	0.9	2.51	1.72	1.8	1.4	1.7	1.5	1.9	1.6
1<5 Years	2.3	0	1.1	1	2.77	2.22	2.3	1.8	2.1	1.9	2.3	2
5<15 Years	3.1	0.6	1.8	2.4	3.63	3.49	3.5	2.5	3.4	2.9	3.1	2.7
15<25 Years	4.9	3	3.4	4.1	5.1	5.59	5.7	4.1	4.8	4.5	4.9	4.2
25<35 Years	6.5	5.9	4.1	5	6.85	6.77	6.6	5.2	5.9	5.3	6.5	5.5
35<45 Years	9.1	4.1	6.8	6.3	8.91	9.61	9.1	7.6	8.4	7.7	9.1	7.8
45<55 Years	15.7	11.8	11.6	15.1	15.74	15.63	16	13.9	14.7	13.6	15.7	13.6
55<65 Years	19.1	25.4	17.9	22.5	19.34	18.2	18.5	17.8	18.2	17.5	19.1	17.9
65+ Years	37.5	49.1	52.3	42.8	35.17	36.78	36.7	45.8	41.2	45.1	37.5	44.6

All Cancers

This section includes data for all cancers in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.)

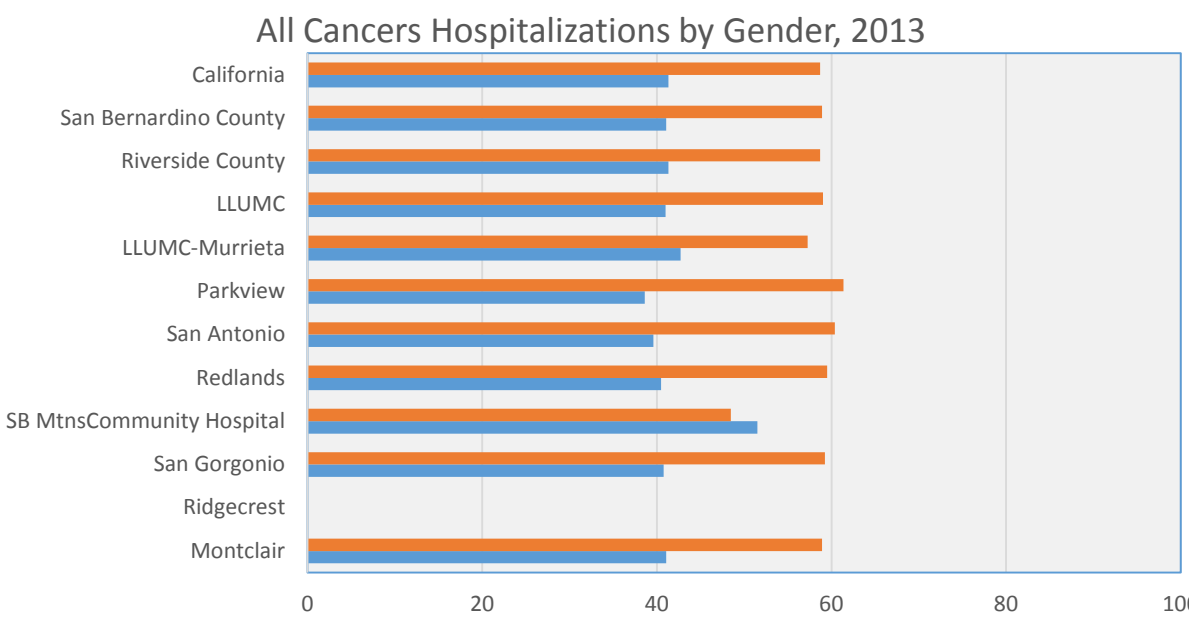
Key Findings

- Women have a significantly higher proportion of hospitalizations due to cancer at all hospitals with the exception of San Bernardino Mountains Community Hospital.

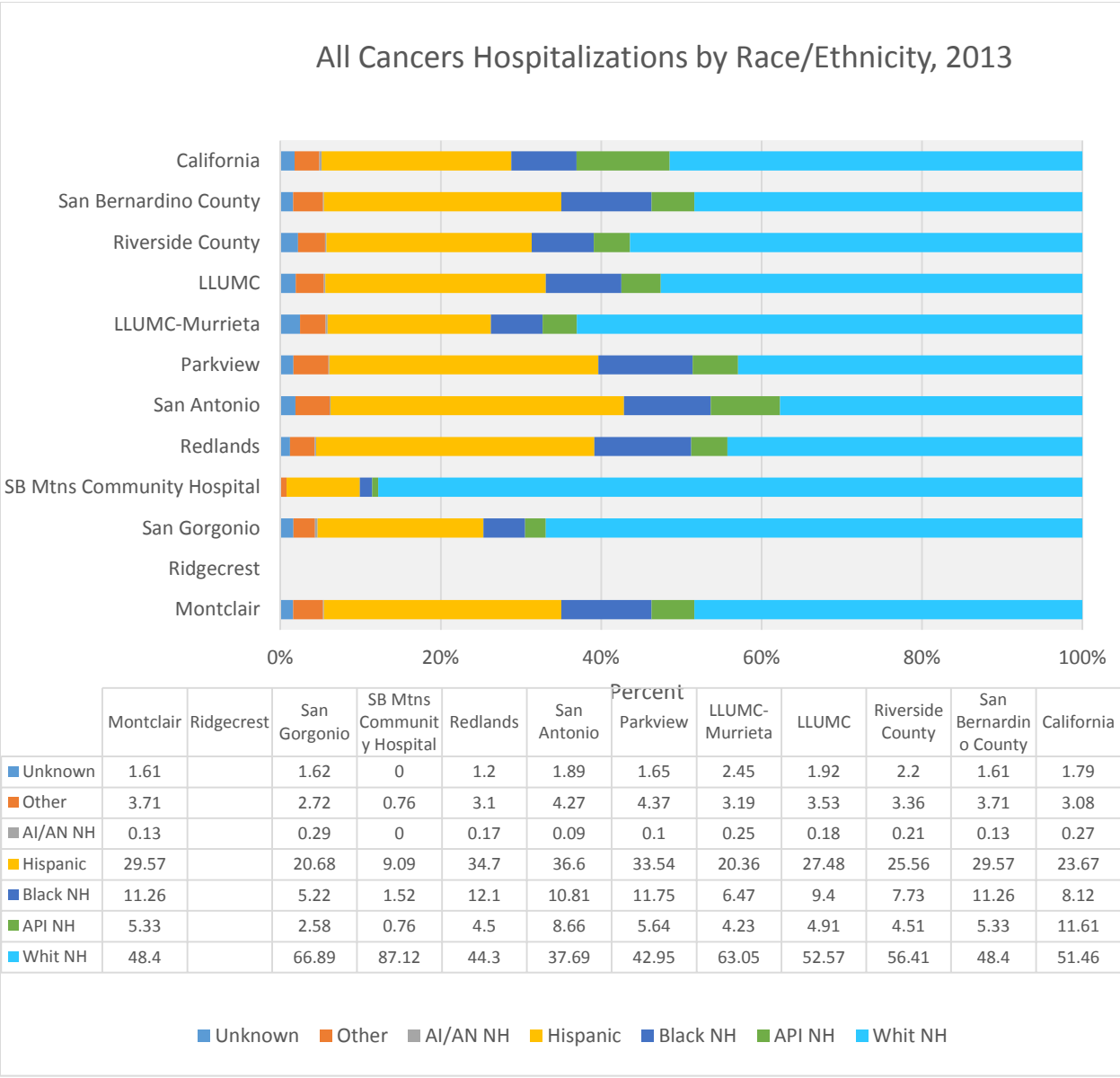
- Approximately 30% of hospitalizations due to cancer are among Hispanics at Montclair, Parkview and LLUMC; whereas they are approximately 40% at Redlands and San Antonio.

Table 2. N-Value for Total All Cancers Hospitalizations per Service Area, 2013

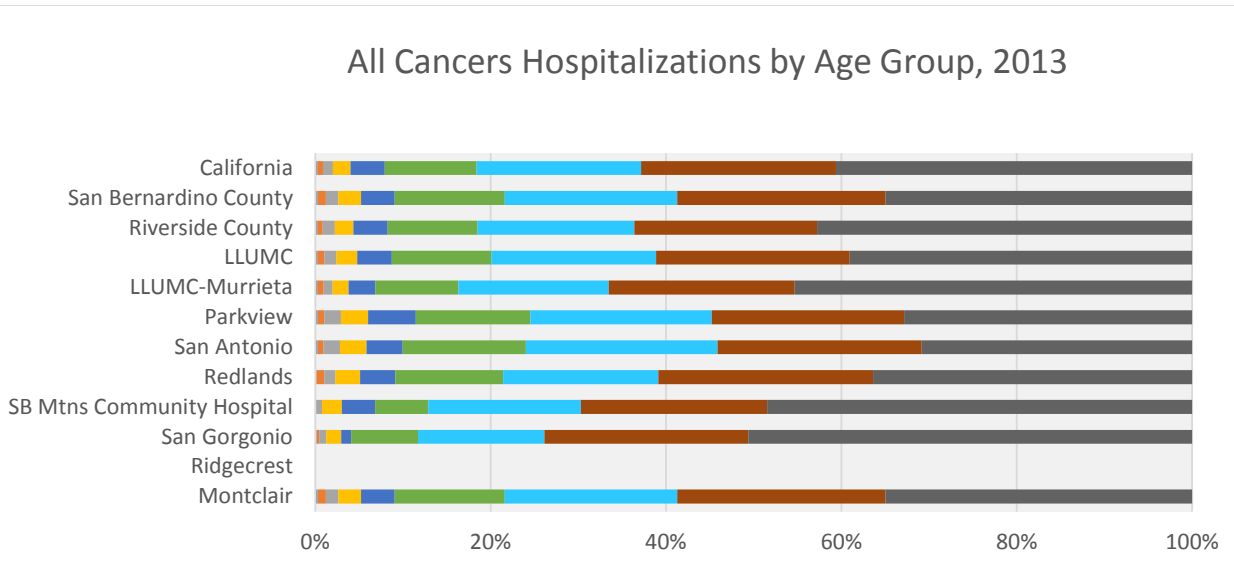
California	SB County	Riverside	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
142,376	7,529	8,443	15,485	8,518	3,157	3,489	2,415	132	1,359	*	7,529
Percent of Total Hospitalizations											
5.8	5.3	5.7	5.6	5.6	5.7	5.9	6.1	6.4	5.3	*	5.3



Percent	Montclair	Ridgecrest	San Gorgonio	SB MtnsCommunity Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Female	58.93		59.23	48.48	59.5	60.39	61.39	57.27	59.02	58.69	58.93	58.69
Male	41.07		40.77	51.52	40.5	39.61	38.61	42.73	40.98	41.31	41.07	41.31



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1.61		1.62	0	1.2	1.89	1.65	2.45	1.92	2.2	1.61	1.79
Other	3.71		2.72	0.76	3.1	4.27	4.37	3.19	3.53	3.36	3.71	3.08
AI/AN NH	0.13		0.29	0	0.17	0.09	0.1	0.25	0.18	0.21	0.13	0.27
Hispanic	29.57		20.68	9.09	34.7	36.6	33.54	20.36	27.48	25.56	29.57	23.67
Black NH	11.26		5.22	1.52	12.1	10.81	11.75	6.47	9.4	7.73	11.26	8.12
API NH	5.33		2.58	0.76	4.5	8.66	5.64	4.23	4.91	4.51	5.33	11.61
Whit NH	48.4		66.89	87.12	44.3	37.69	42.95	63.05	52.57	56.41	48.4	51.46



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0.25		0.15	0	0.12	0.26	0.25	0.21	0.24	0.21	0.25	0.22
1<5 Years	0.96		0.29	0	0.9	0.66	0.79	0.76	0.8	0.64	0.96	0.67
5<15 Years	1.41		0.81	0.76	1.3	1.89	1.9	1.02	1.39	1.37	1.41	1.14
15<25 Years	2.6		1.69	2.27	2.8	3.04	3.07	1.81	2.37	2.13	2.6	1.98
25<35 Years	3.84		1.099	3.79	4	4.13	5.45	3.08	3.91	3.92	3.84	3.91
35<45 Years	12.54		7.58	6.06	12.3	14.04	13.05	9.43	11.35	10.22	12.54	10.49
45<55 Years	19.68		14.28	17.42	17.7	21.84	20.72	17.16	18.8	17.9	19.68	18.73
55<65 Years	23.76		23.03	21.21	24.5	23.3	21.92	21.19	22.09	20.82	23.76	22.25
65+ Years	34.96		50.18	48.48	36.4	30.84	32.85	45.34	39.04	42.78	34.96	40.61

Asthma

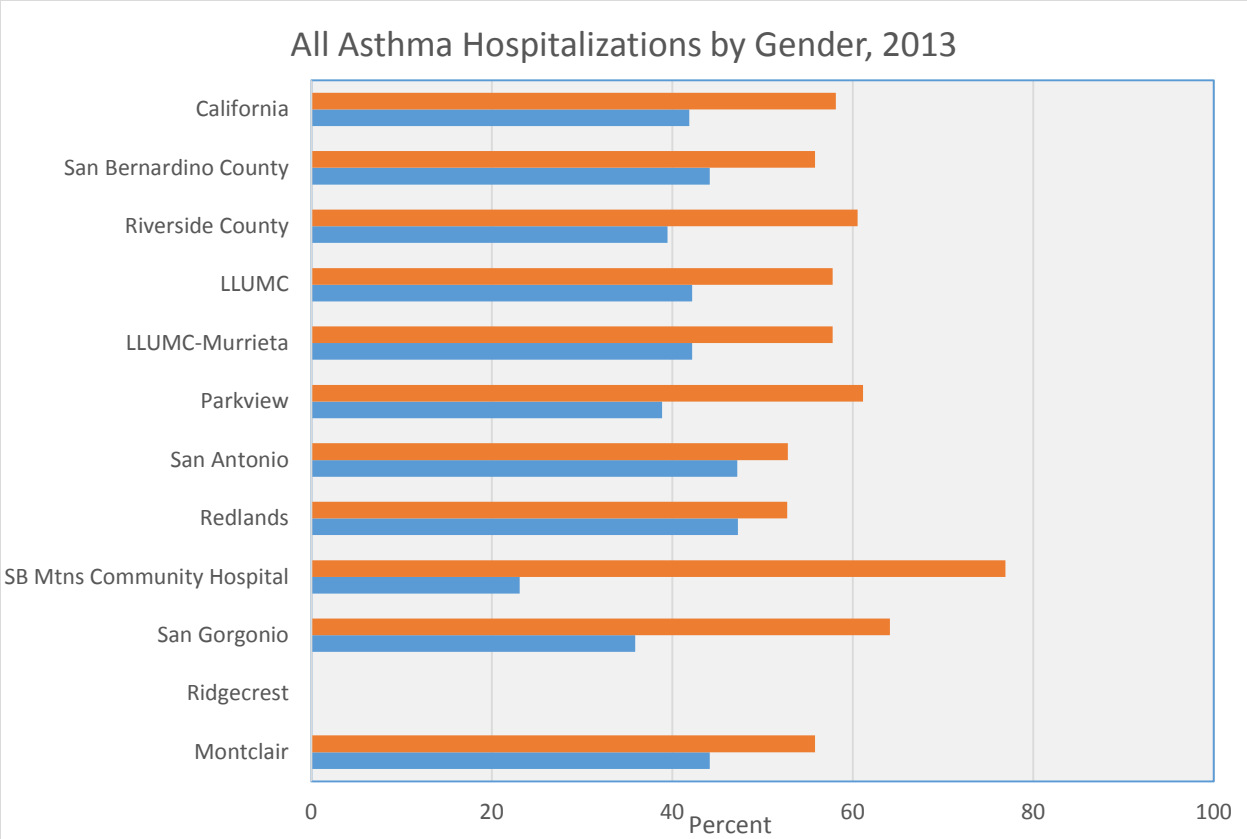
This section includes data for asthma in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.)

Key Findings

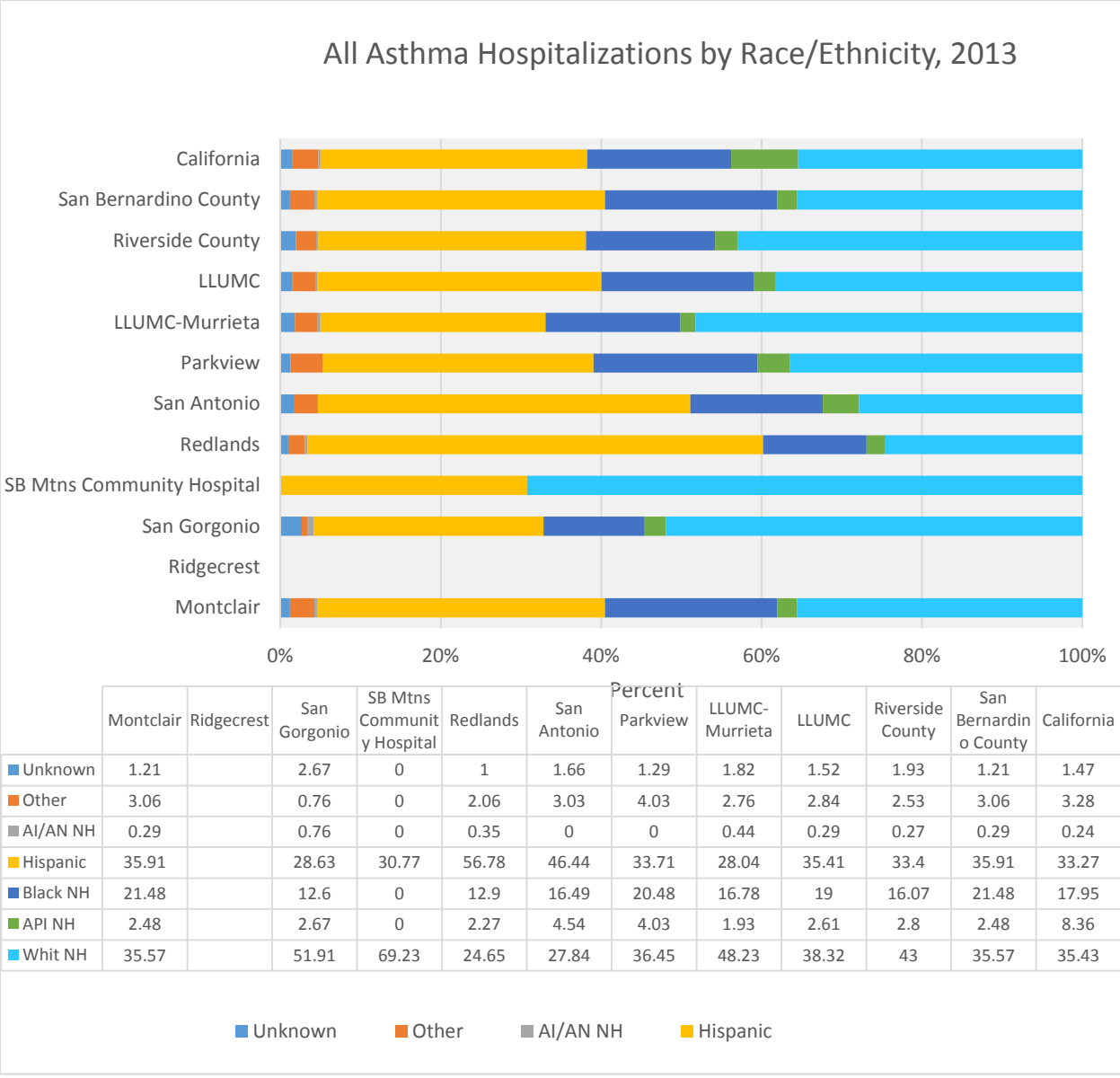
- Women have a significantly higher proportion of hospitalizations due to asthma compared to men at all hospitals.
- Hispanics have a significantly higher proportion of hospitalizations due to asthma compared to any other racial/ethnic group at Redlands and San Antonio.
- Hospitalizations for asthma are significantly higher for those under the age of 15 and over the age of 45 years.

Table 3. N-Value for Total Asthma Hospitalizations per Service Area, 2013

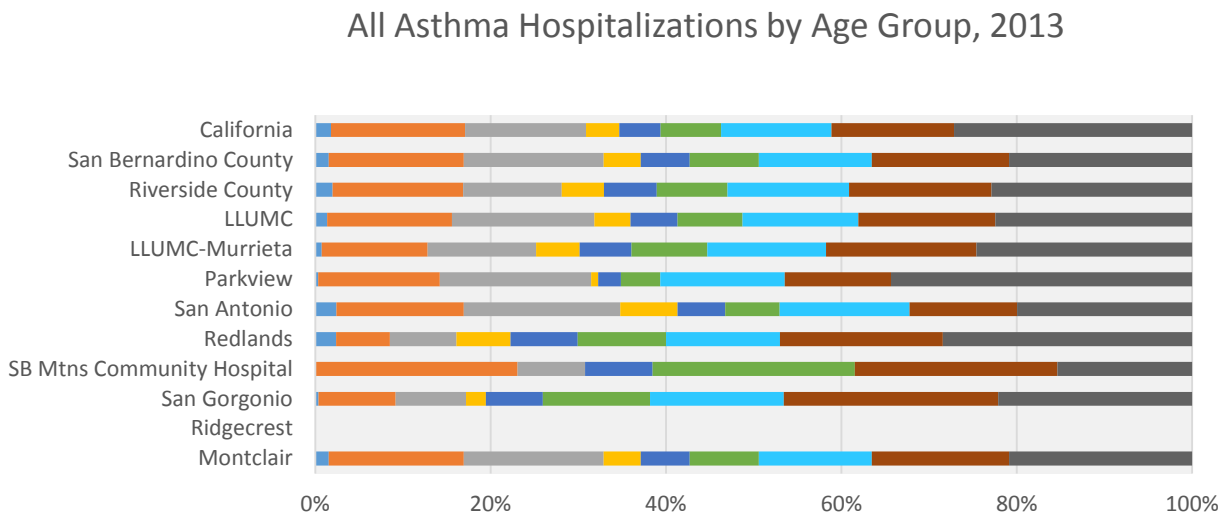
California	SB County	Riverside County	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
30,483	2,058	1,500	3,411	1,812	620	661	4,317	13	262	*	2,058
Percent of Total Hospitalizations											
1.2	1.5	1.0	1.2	1.2	1.1	1.1	11.0	.06	1.0	*	1.5



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Female	55.83		64.12	76.92	52.72	52.8	61.13	57.78	57.78	60.53	55.83	58.12
Male	44.17		35.88	23.08	47.28	47.2	38.87	42.22	42.22	39.47	44.17	41.88



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1.21		2.67	0	1	1.66	1.29	1.82	1.52	1.93	1.21	1.47
Other	3.06		0.76	0	2.06	3.03	4.03	2.76	2.84	2.53	3.06	3.28
AI/AN NH	0.29		0.76	0	0.35	0	0	0.44	0.29	0.27	0.29	0.24
Hispanic	35.91		28.63	30.77	56.78	46.44	33.71	28.04	35.41	33.4	35.91	33.27
Black NH	21.48		12.6	0	12.9	16.49	20.48	16.78	19	16.07	21.48	17.95
API NH	2.48		2.67	0	2.27	4.54	4.03	1.93	2.61	2.8	2.48	8.36
Whit NH	35.57		51.91	69.23	24.65	27.84	36.45	48.23	38.32	43	35.57	35.43



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	1.55		0.38	0	2.36	2.42	0.32	0.72	1.35	1.99	1.55	1.79
1<5 Years	15.4		8.78	23.08	6.16	14.52	13.87	12.09	14.25	14.89	15.4	15.3
5<15 Years	15.94		8.02	7.69	7.57	17.85	17.26	12.36	16.21	11.23	15.94	13.79
15<25 Years	4.23		2.29	0	6.18	6.51	0.81	4.97	4.13	4.81	4.23	3.79
25<35 Years	5.59		6.49	7.69	7.64	5.45	2.58	5.91	5.36	6.01	5.59	4.72
35<45 Years	7.87		12.21	23.08	10.08	6.2	4.52	8.66	7.42	8.06	7.87	6.88
45<55 Years	12.88		15.27	0	13	14.83	14.19	13.52	13.22	13.87	12.88	12.6
55<65 Years	15.65		24.43	23.08	18.58	12.25	12.1	17.16	15.6	16.24	15.65	13.98
65+ Years	20.89		22.14	15.38	28.42	19.97	34.35	24.61	22.46	22.9	20.89	27.14

Breast Cancer

This section includes data for breast cancer in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.)

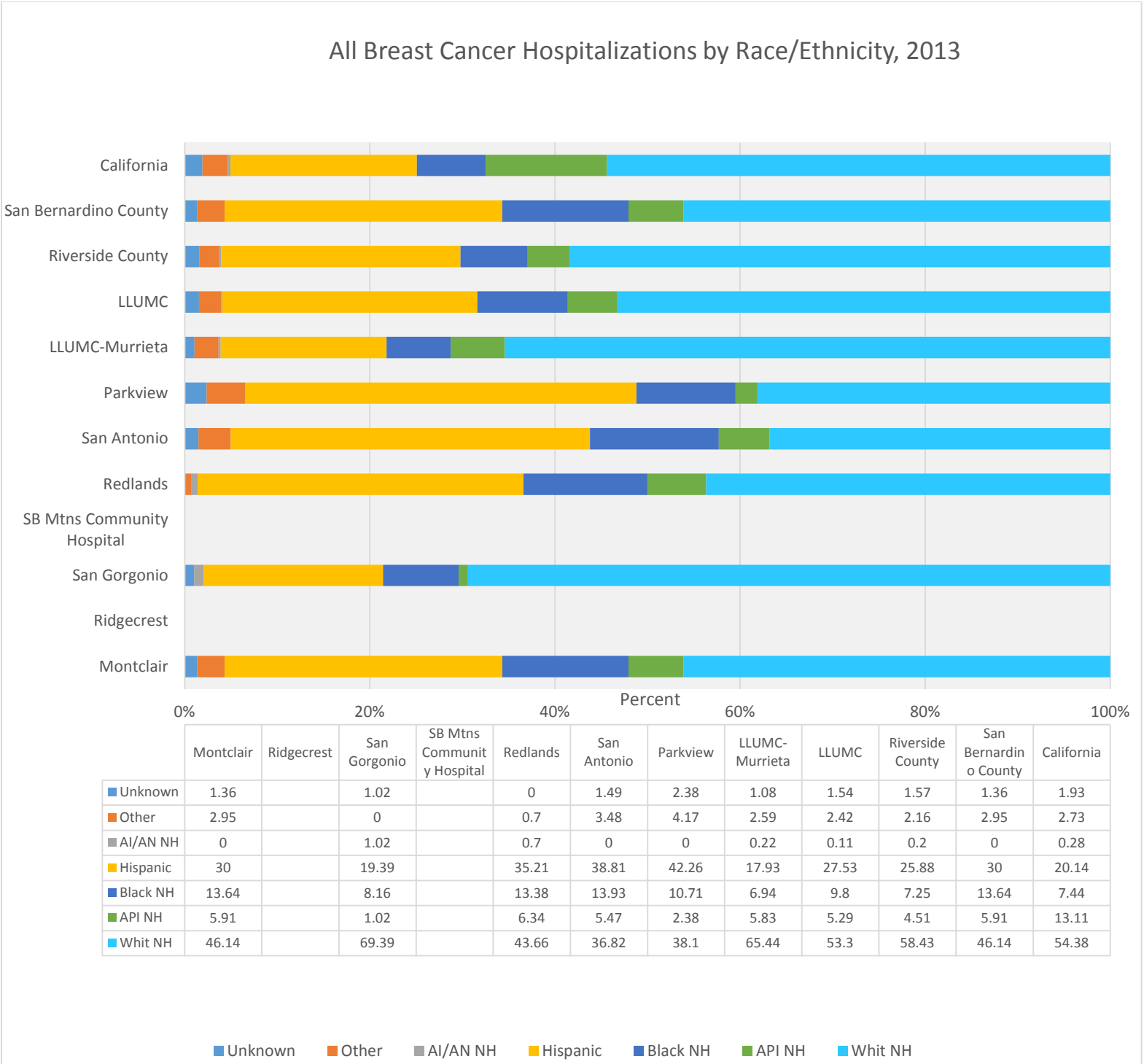
Key Findings

- Approximately 40% of hospitalizations due to breast cancer are among Hispanic women at San Antonio and Parkview.

- San Antonio hospitalizations for women 35-45 years of age are significantly higher at 21%.

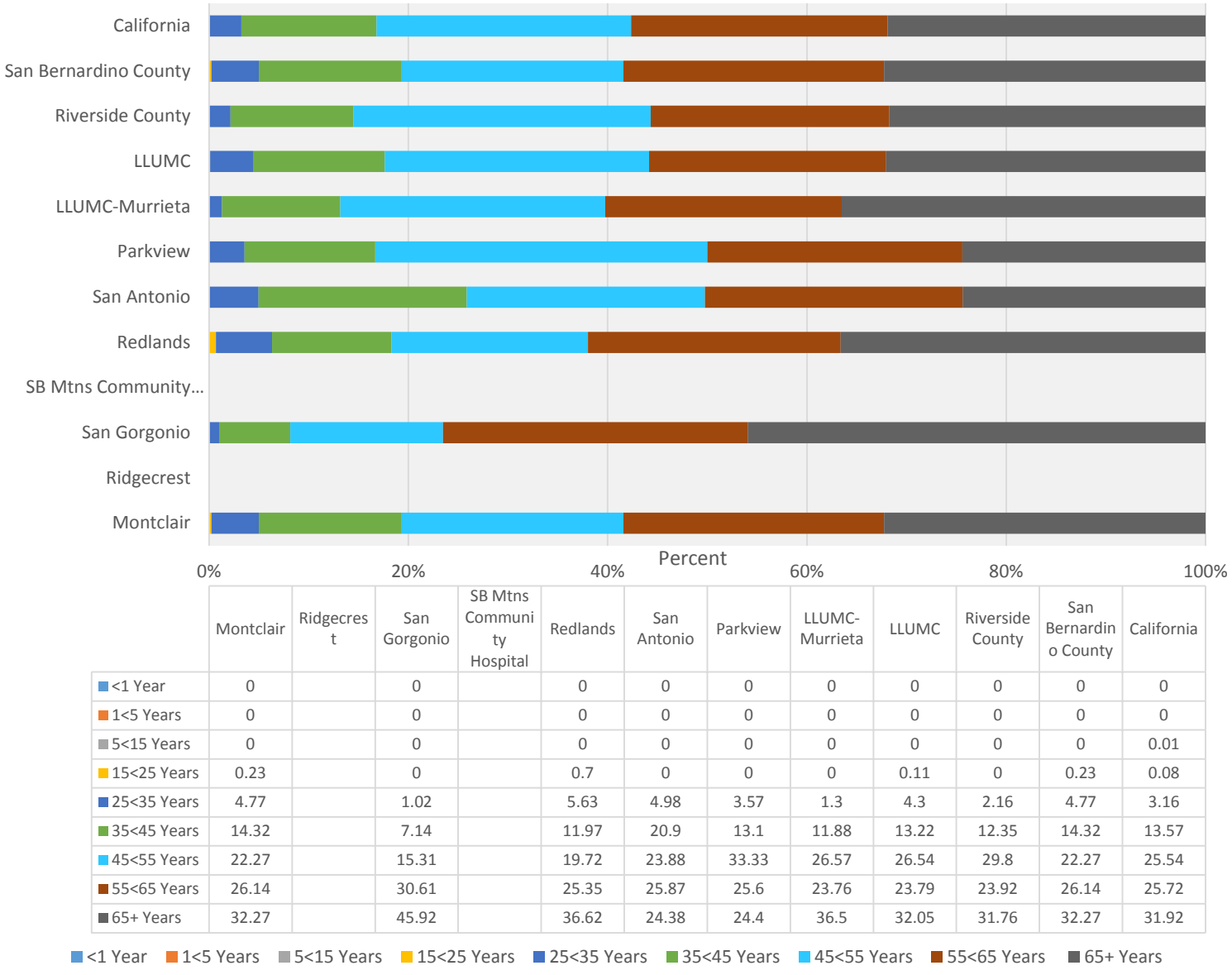
Table 4. N-Value for Total Breast Cancer Hospitalizations per Service Area, 2013

California	SB County	Riverside County	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
7,920	440	510	908	463	168	201	142	*	98	*	440
Percent of Total Hospitalizations											
.32	.31	.35	.33	.30	.30	.34	.36	*	.38	*	.31



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1.36		1.02		0	1.49	2.38	1.08	1.54	1.57	1.36	1.93
Other	2.95		0		0.7	3.48	4.17	2.59	2.42	2.16	2.95	2.73
AI/AN NH	0		1.02		0.7	0	0	0.22	0.11	0.2	0	0.28
Hispanic	30		19.39		35.21	38.81	42.26	17.93	27.53	25.88	30	20.14
Black NH	13.64		8.16		13.38	13.93	10.71	6.94	9.8	7.25	13.64	7.44
API NH	5.91		1.02		6.34	5.47	2.38	5.83	5.29	4.51	5.91	13.11
Whit NH	46.14		69.39		43.66	36.82	38.1	65.44	53.3	58.43	46.14	54.38

All Breast Cancer Hospitalizations by Age Group, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0		0		0	0	0	0	0	0	0	0
1<5 Years	0		0		0	0	0	0	0	0	0	0
5<15 Years	0		0		0	0	0	0	0	0	0	0.01
15<25 Years	0.23		0		0.7	0	0	0	0.11	0	0.23	0.08
25<35 Years	4.77		1.02		5.63	4.98	3.57	1.3	4.3	2.16	4.77	3.16
35<45 Years	14.32		7.14		11.97	20.9	13.1	11.88	13.22	12.35	14.32	13.57
45<55 Years	22.27		15.31		19.72	23.88	33.33	26.57	26.54	29.8	22.27	25.54
55<65 Years	26.14		30.61		25.35	25.87	25.6	23.76	23.79	23.92	26.14	25.72
65+ Years	32.27		45.92		36.62	24.38	24.4	36.5	32.05	31.76	32.27	31.92

Cardiovascular Disease

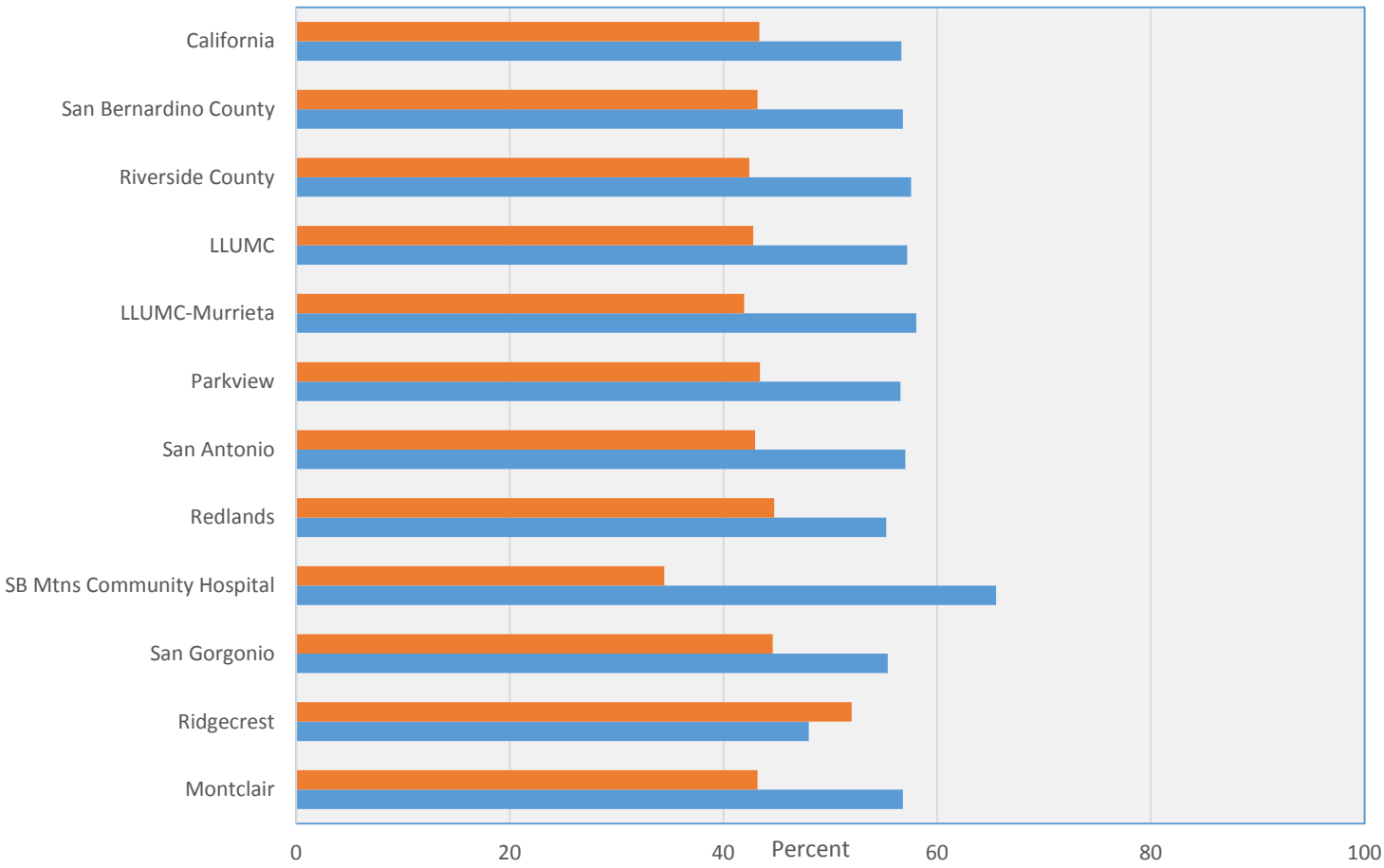
This section includes data for cardiovascular disease in in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, Ridgecrest, and Montclair.

Key Findings

- Hospitalizations due to cardiovascular disease are significantly higher among men compared to women at all hospitals with the exception of Ridgecrest.
- Approximately 30% of hospitalizations due to cardiovascular disease are among Hispanics at Redlands and San Antonio.
- Although total hospitalizations among Caucasians and Hispanics are just under 40% at San Antonio, hospitalizations for cardiovascular disease are significantly higher for Caucasians at 44% versus 32% for Hispanics.

Table 5. N-Value for Total Cardiovascular Disease Hospitalizations per Service Area, 2013

California	SB County	Riverside County	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
274,435	16,729	18,344	33,844	19,149	6,145	6,693	5,529	261	3,989	25	16,729
Percent of Total Hospitalizations											
11.2	11.9	12.4	12.3	12.6	11.1	11.4	14.0	12.7	15.6	14.8	11.9

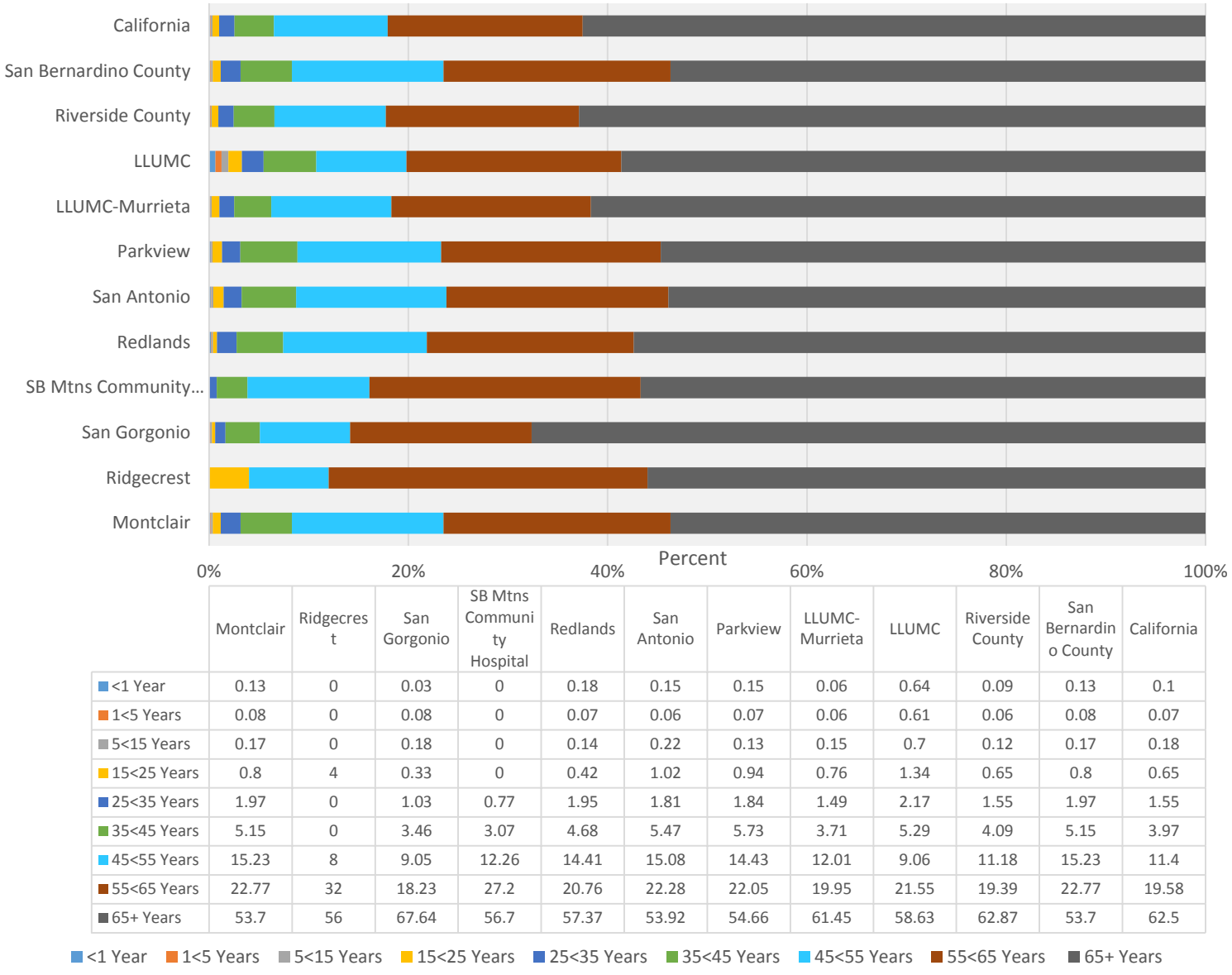


	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Female	43.19	52	44.62	34.48	44.76	42.96	43.43	41.94	42.8	42.43	43.19	43.35
Male	56.81	48	55.38	65.52	55.24	57.04	56.57	58.06	57.2	57.57	56.81	56.65

All Cardiovascular Disease Hospitalizations by Race/Ethnicity, 2013

	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1.61	4	2.01	2.3	1.05	1.55	1.29	2.4	1.94	2.18	0	1.57
Other	4.04	0	1.63	0.38	2.28	4.39	4.05	3.23	3.39	2.77	3.07	3.04
AI/AN NH	0.19	0	0.43	0	0.4	0.15	0.15	0.19	0.19	0.19	0.16	0.26
Hispanic	24.91	4	16.29	8.43	27.08	31.94	31.03	18.34	23.49	21.88	22.86	20.56
Black NH	12.74	16	4.99	0	12.06	12.13	13.13	7.72	10.05	7.69	11.49	9.78
API NH	3.71	0	1.88	1.53	3.58	5.53	3.89	2.52	3.29	2.87	3.04	8.64
Whit NH	52.78	76	72.78	87.36	53.55	44.3	46.46	65.61	57.66	62.43	59.39	56.16

All Cardiovascular Disease Hospitalizations by Age Group, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0.13	0	0.03	0	0.18	0.15	0.15	0.06	0.64	0.09	0.13	0.1
1<5 Years	0.08	0	0.08	0	0.07	0.06	0.07	0.06	0.61	0.06	0.08	0.07
5<15 Years	0.17	0	0.18	0	0.14	0.22	0.13	0.15	0.7	0.12	0.17	0.18
15<25 Years	0.8	4	0.33	0	0.42	1.02	0.94	0.76	1.34	0.65	0.8	0.65
25<35 Years	1.97	0	1.03	0.77	1.95	1.81	1.84	1.49	2.17	1.55	1.97	1.55
35<45 Years	5.15	0	3.46	3.07	4.68	5.47	5.73	3.71	5.29	4.09	5.15	3.97
45<55 Years	15.23	8	9.05	12.26	14.41	15.08	14.43	12.01	9.06	11.18	15.23	11.4
55<65 Years	22.77	32	18.23	27.2	20.76	22.28	22.05	19.95	21.55	19.39	22.77	19.58
65+ Years	53.7	56	67.64	56.7	57.37	53.92	54.66	61.45	58.63	62.87	53.7	62.5

Colon Cancer

This section includes data for colon cancer in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.)

Key Findings

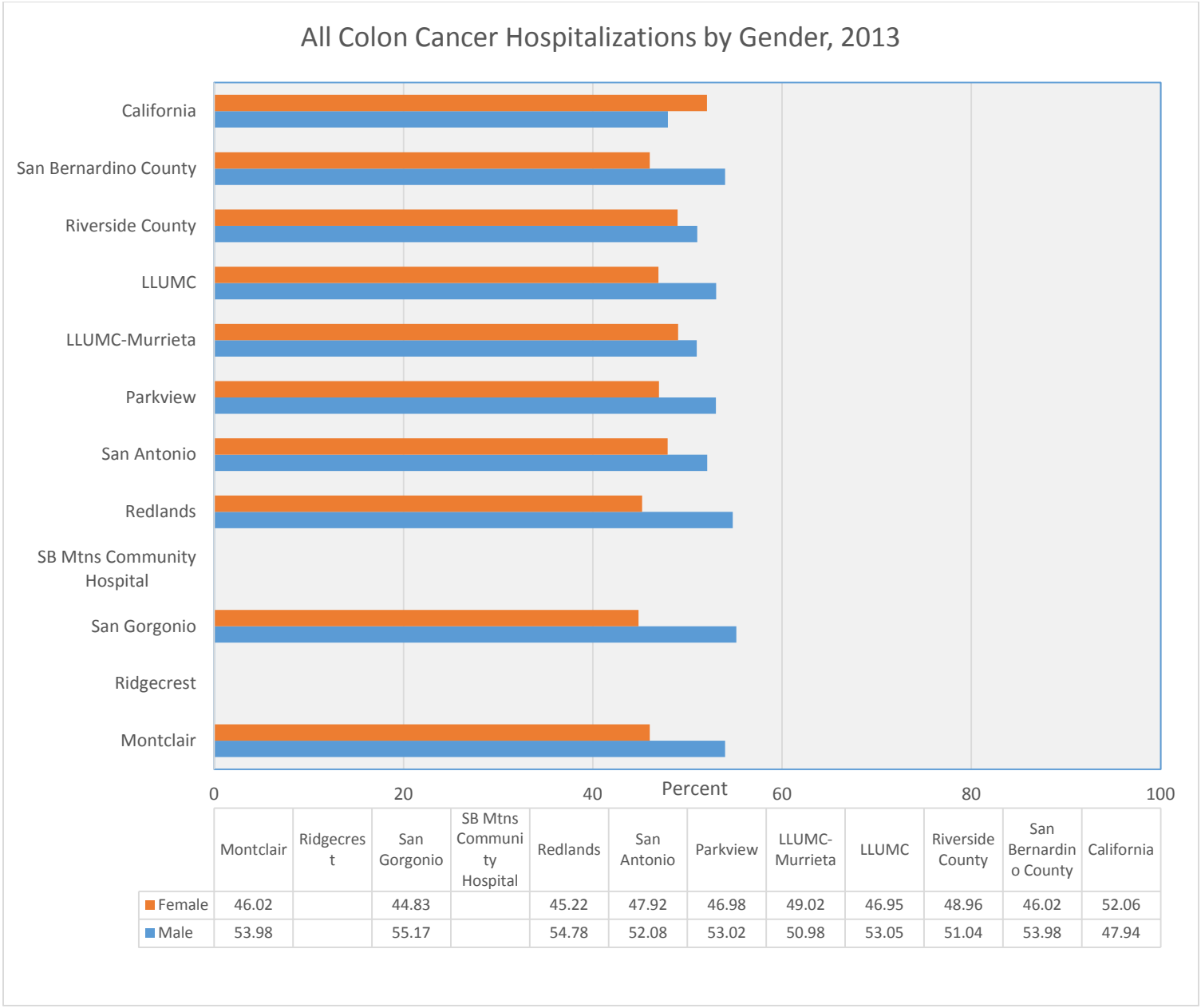
- Men have a significantly higher proportion of hospitalizations due to colon cancer compared to women at LLUMC, Parkview, Redlands, San Gorgonio, and Montclair.

- Hospitalizations among Caucasians are significantly higher in all areas except San Antonio, where Caucasians and Hispanics are similar at 38%, and 32% respectively.

- Hospitalizations among those 45 to 55 years of age are significantly higher at San Antonio.

Table 6. N-Value for Total Colon Cancer Hospitalizations per Service Area, 2013

California	SB County	Riverside	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
8,561	465	482	901	461	149	192	157	*	87	*	465
Percent of Total Hospitalizations											
.35	.33	.33	.33	.30	.27	.33	.40	*	.34	*	.33

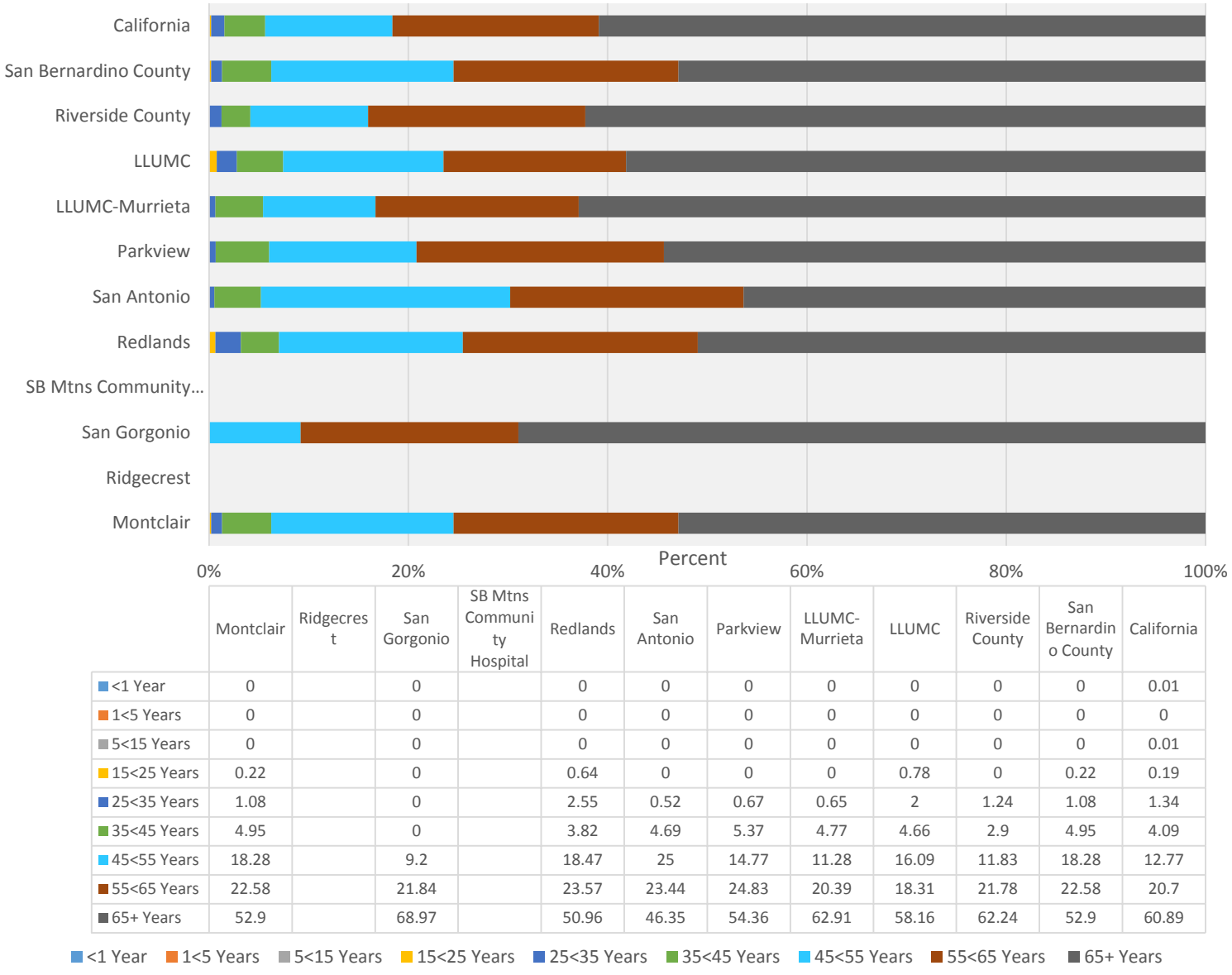


	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Female	46.02		44.83		45.22	47.92	46.98	49.02	46.95	48.96	46.02	52.06
Male	53.98		55.17		54.78	52.08	53.02	50.98	53.05	51.04	53.98	47.94

All Colon Cancer Hospitalizations by Race/Ethnicity, 2013

	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1.94		2.3		2.55	0	2.01	2.39	1.89	2.49	1.94	1.72
Other	4.73		3.45		5.1	5.73	4.7	3.69	4.11	3.32	4.73	2.78
AI/AN NH	0		0		0	0	0	0	0	0	0	0.14
Hispanic	26.02		13.79		24.2	32.29	24.83	16.92	21.42	17.63	26.02	18.06
Black NH	11.18		5.75		11.46	17.71	12.08	6.72	9.43	7.88	11.18	7.88
API NH	4.52		1.15		2.55	6.25	5.37	3.9	4.44	4.15	4.52	12.63
Whit NH	51.61		73.56		54.14	38.02	51.01	66.38	58.71	64.52	51.61	56.79

All Colon Cancer Hospitalizations by Age Group, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0		0		0	0	0	0	0	0	0	0.01
1<5 Years	0		0		0	0	0	0	0	0	0	0
5<15 Years	0		0		0	0	0	0	0	0	0	0.01
15<25 Years	0.22		0		0.64	0	0	0	0.78	0	0.22	0.19
25<35 Years	1.08		0		2.55	0.52	0.67	0.65	2	1.24	1.08	1.34
35<45 Years	4.95		0		3.82	4.69	5.37	4.77	4.66	2.9	4.95	4.09
45<55 Years	18.28		9.2		18.47	25	14.77	11.28	16.09	11.83	18.28	12.77
55<65 Years	22.58		21.84		23.57	23.44	24.83	20.39	18.31	21.78	22.58	20.7
65+ Years	52.9		68.97		50.96	46.35	54.36	62.91	58.16	62.24	52.9	60.89

Colorectal Cancer

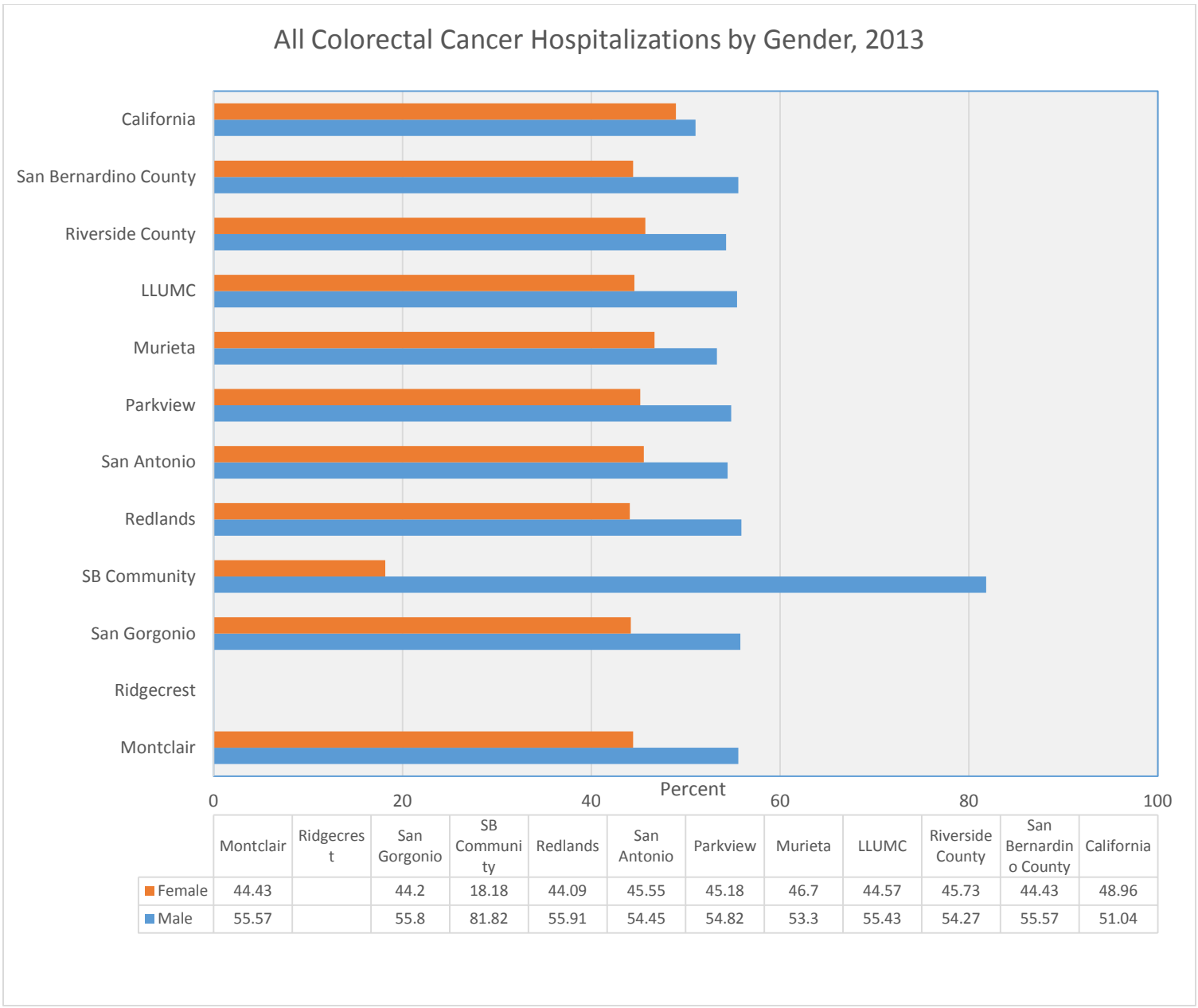
This section includes data for colorectal cancer in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.)

Key Findings

- Colorectal cancer hospitalizations are higher among men, especially at San Bernardino Community.
- There is a significantly higher rate of hospitalizations among Caucasians.
- Hospitalizations are higher among Caucasians at San Antonio, but not to the significant degree as all other hospital service areas.

Table 7. N-Value for Total Colorectal Cancer Hospitalizations per Service Area, 2013

California	SB County	Riverside	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
12,222	673	737	1,344	773	228	292	220	11	138	*	673
Percent of Total Hospitalizations											
.50	.48	.50	.49	.51	.41	.50	.56	.56	.54	*	.48

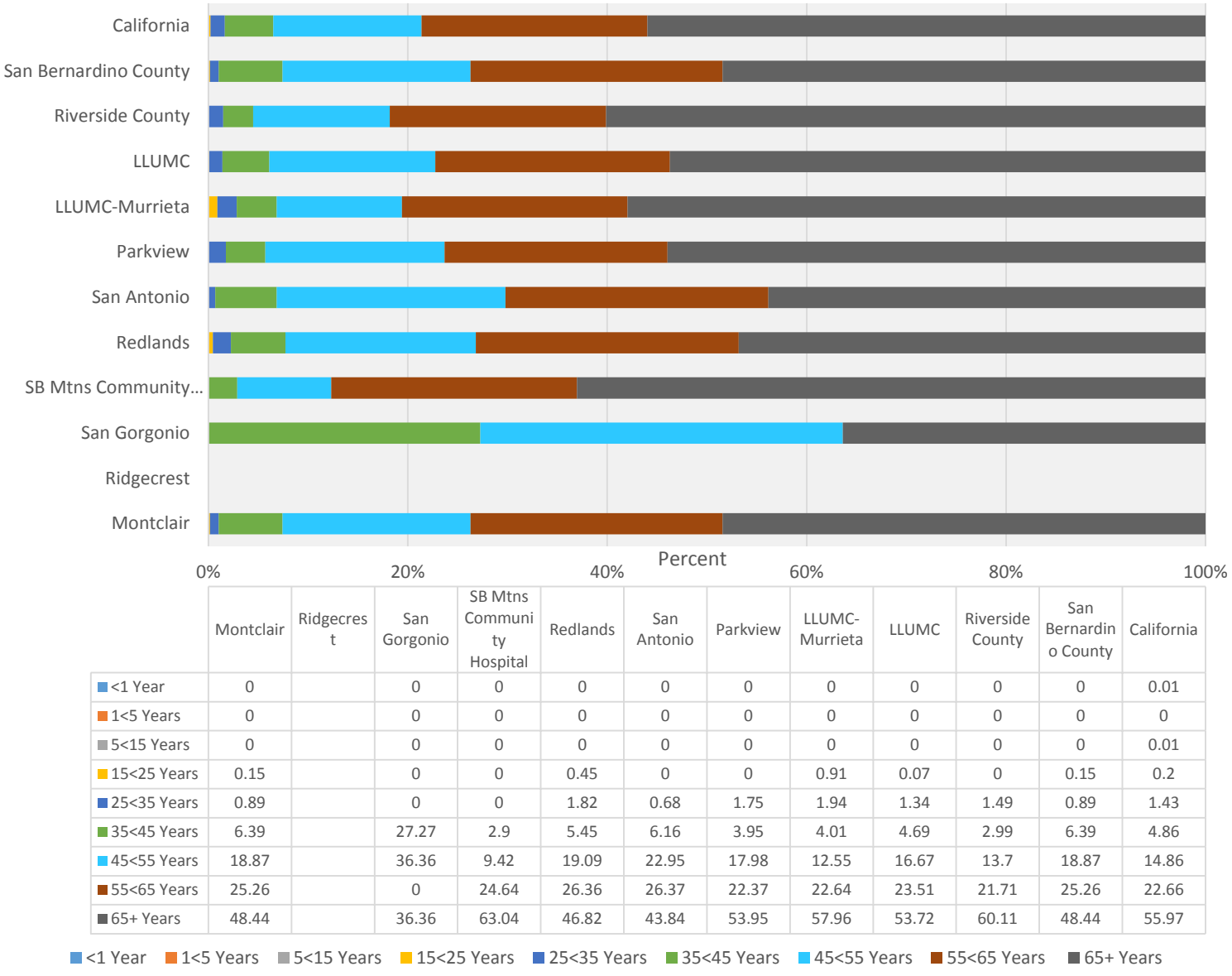


	Montclair	Ridgecrest	San Gorgonio	SB Community	Redlands	San Antonio	Parkview	Murieta	LLUMC	Riverside County	San Bernardino County	California
Female	44.43		44.2	18.18	44.09	45.55	45.18	46.7	44.57	45.73	44.43	48.96
Male	55.57		55.8	81.82	55.91	54.45	54.82	53.3	55.43	54.27	55.57	51.04

All Colorectal Cancer Hospitalizations by Race/Ethnicity, 2013

	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1.93		2.17	0	1.82	1.37	1.32	2.72	1.79	2.04	1.93	1.64
Other	3.42		2.17	0	3.64	3.77	4.39	2.72	3.05	2.85	3.42	2.79
AI/AN NH	0.15		0	0	0	0.34	0	0.13	0.07	0	0.15	0.2
Hispanic	28.08		15.22	0	27.27	34.25	26.75	19.15	24.33	21.17	28.08	19.36
Black NH	10.4		6.52	9.09	14.55	13.7	10.96	5.82	8.41	6.78	10.4	7.27
API NH	5.05		1.45	0	3.64	7.88	7.02	3.88	4.76	4.34	5.05	13.22
Whit NH	50.97		72.46	90.91	49.09	38.7	49.56	65.59	57.59	62.82	50.97	55.51

All Colorectal Cancer Hospitalizations by Age Group, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0		0	0	0	0	0	0	0	0	0	0.01
1<5 Years	0		0	0	0	0	0	0	0	0	0	0
5<15 Years	0		0	0	0	0	0	0	0	0	0	0.01
15<25 Years	0.15		0	0	0.45	0	0	0.91	0.07	0	0.15	0.2
25<35 Years	0.89		0	0	1.82	0.68	1.75	1.94	1.34	1.49	0.89	1.43
35<45 Years	6.39		27.27	2.9	5.45	6.16	3.95	4.01	4.69	2.99	6.39	4.86
45<55 Years	18.87		36.36	9.42	19.09	22.95	17.98	12.55	16.67	13.7	18.87	14.86
55<65 Years	25.26		0	24.64	26.36	26.37	22.37	22.64	23.51	21.71	25.26	22.66
65+ Years	48.44		36.36	63.04	46.82	43.84	53.95	57.96	53.72	60.11	48.44	55.97

Chronic Obstructive Pulmonary Disease (COPD)

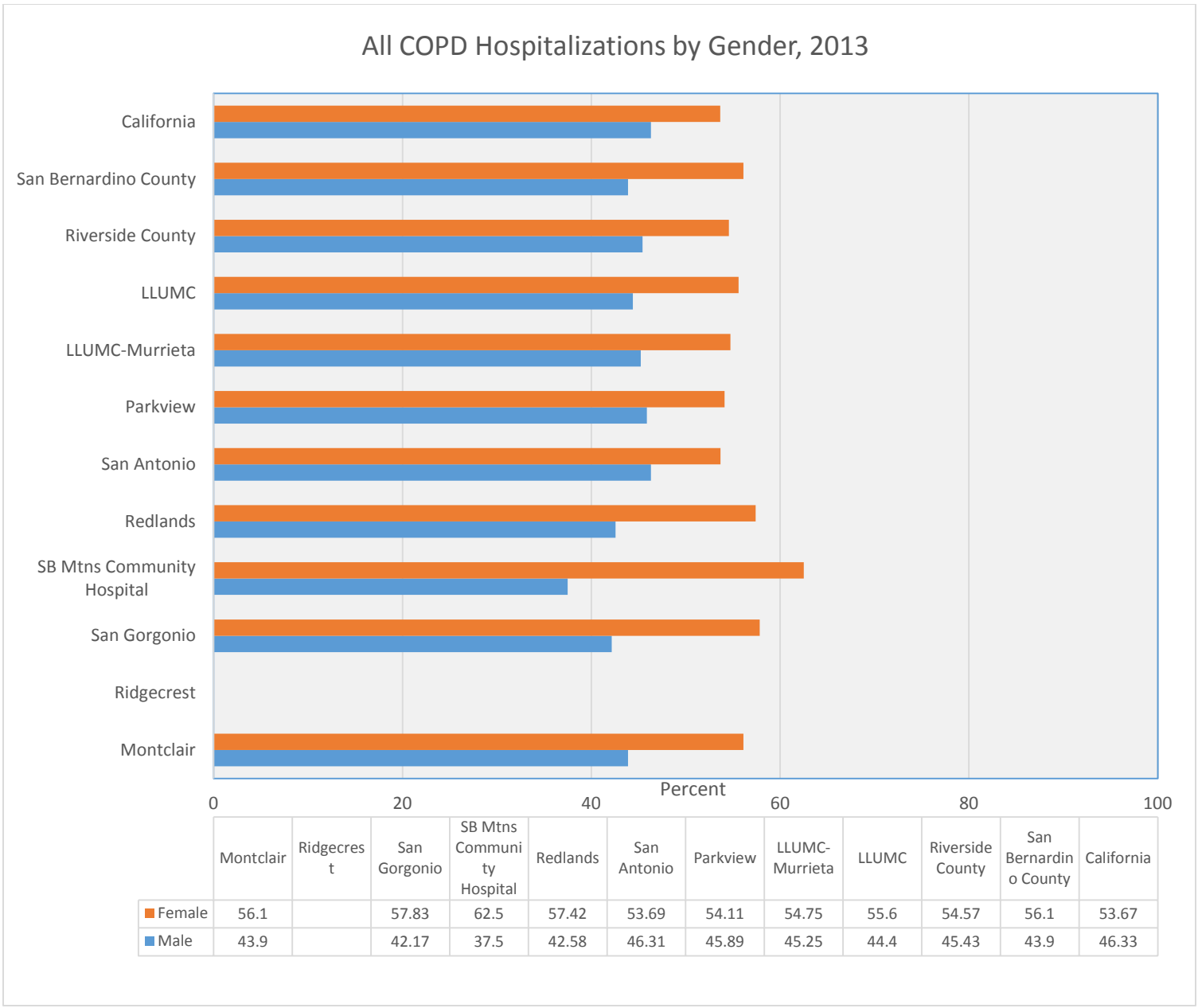
This section includes data for chronic obstructive pulmonary disease in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.)

Key Findings

- Women have a significantly higher proportion of hospitalizations due to COPD compared to men.
- There is a significantly higher rate of hospitalizations among Caucasians.
- Hospitalizations due to COPD are predominantly higher in those 55 years of age and older.

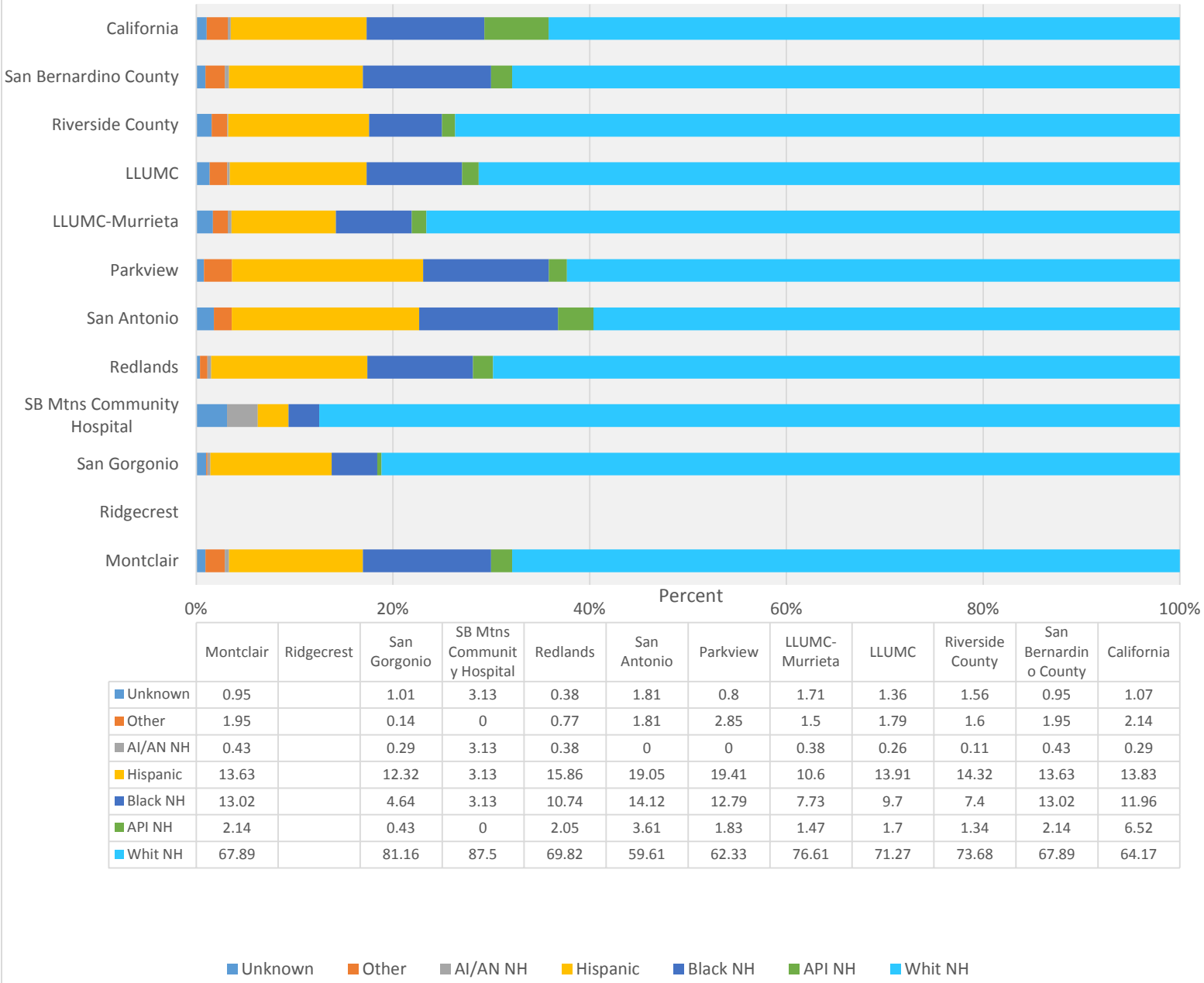
Table 8. N-Value for Total COPD Hospitalizations per Service Area, 2013

California	SB County	Riverside County	LLUMC	Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
40,357	2,105	2,758	4,637	2,924	876	609	782	32	690	*	2,105
Percent of Total Hospitalizations											
1.7	1.5	1.9	1.7	1.9	1.6	1.0	2.0	1.6	2.7	*	1.5

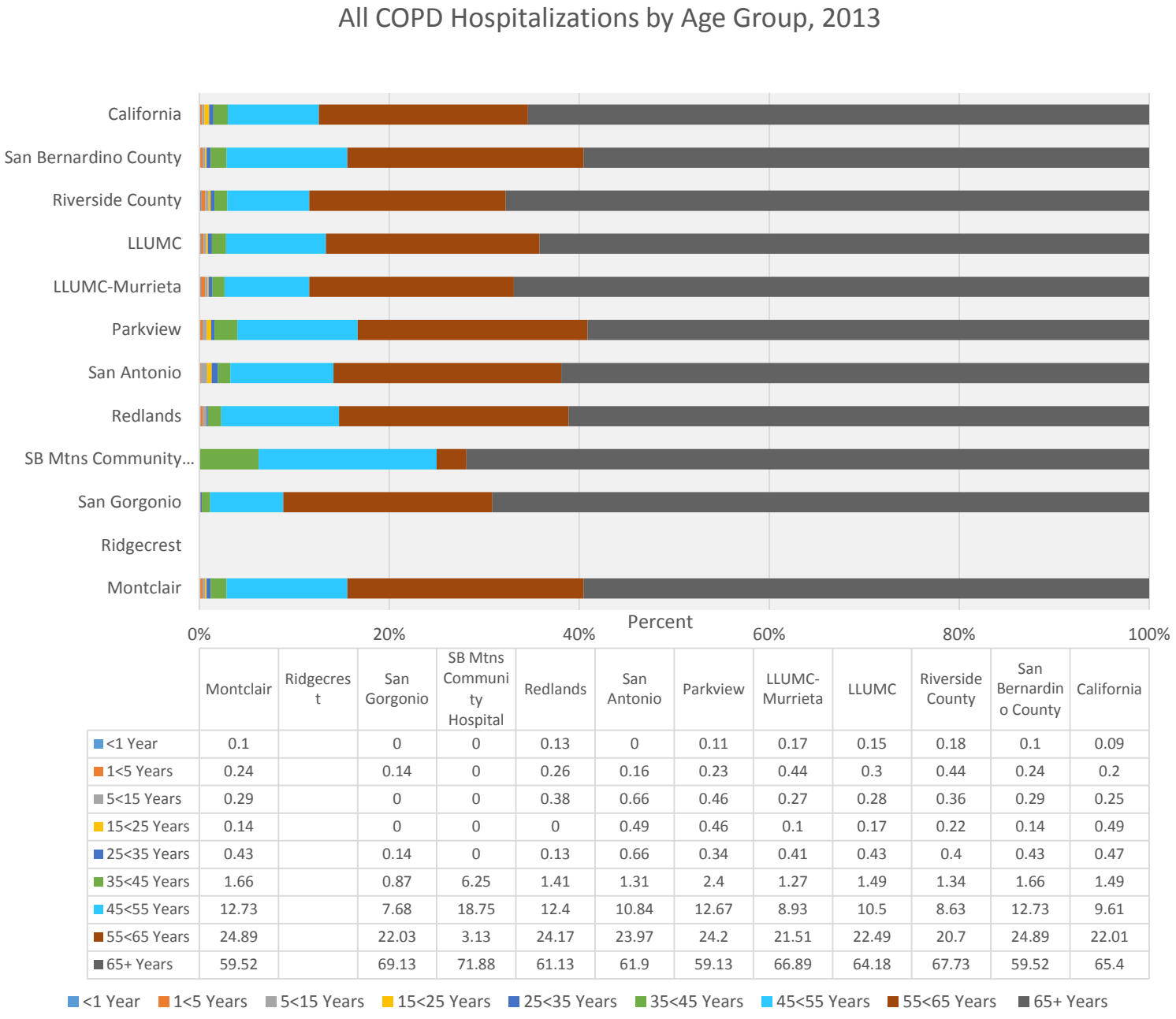


	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Female	56.1		57.83	62.5	57.42	53.69	54.11	54.75	55.6	54.57	56.1	53.67
Male	43.9		42.17	37.5	42.58	46.31	45.89	45.25	44.4	45.43	43.9	46.33

All COPD Hospitalizations by Race/Ethnicity, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	0.95		1.01	3.13	0.38	1.81	0.8	1.71	1.36	1.56	0.95	1.07
Other	1.95		0.14	0	0.77	1.81	2.85	1.5	1.79	1.6	1.95	2.14
AI/AN NH	0.43		0.29	3.13	0.38	0	0	0.38	0.26	0.11	0.43	0.29
Hispanic	13.63		12.32	3.13	15.86	19.05	19.41	10.6	13.91	14.32	13.63	13.83
Black NH	13.02		4.64	3.13	10.74	14.12	12.79	7.73	9.7	7.4	13.02	11.96
API NH	2.14		0.43	0	2.05	3.61	1.83	1.47	1.7	1.34	2.14	6.52
Whit NH	67.89		81.16	87.5	69.82	59.61	62.33	76.61	71.27	73.68	67.89	64.17



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0.1		0	0	0.13	0	0.11	0.17	0.15	0.18	0.1	0.09
1<5 Years	0.24		0.14	0	0.26	0.16	0.23	0.44	0.3	0.44	0.24	0.2
5<15 Years	0.29		0	0	0.38	0.66	0.46	0.27	0.28	0.36	0.29	0.25
15<25 Years	0.14		0	0	0	0.49	0.46	0.1	0.17	0.22	0.14	0.49
25<35 Years	0.43		0.14	0	0.13	0.66	0.34	0.41	0.43	0.4	0.43	0.47
35<45 Years	1.66		0.87	6.25	1.41	1.31	2.4	1.27	1.49	1.34	1.66	1.49
45<55 Years	12.73		7.68	18.75	12.4	10.84	12.67	8.93	10.5	8.63	12.73	9.61
55<65 Years	24.89		22.03	3.13	24.17	23.97	24.2	21.51	22.49	20.7	24.89	22.01
65+ Years	59.52		69.13	71.88	61.13	61.9	59.13	66.89	64.18	67.73	59.52	65.4

Diabetes

This section includes data for diabetes in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.)

Key Findings

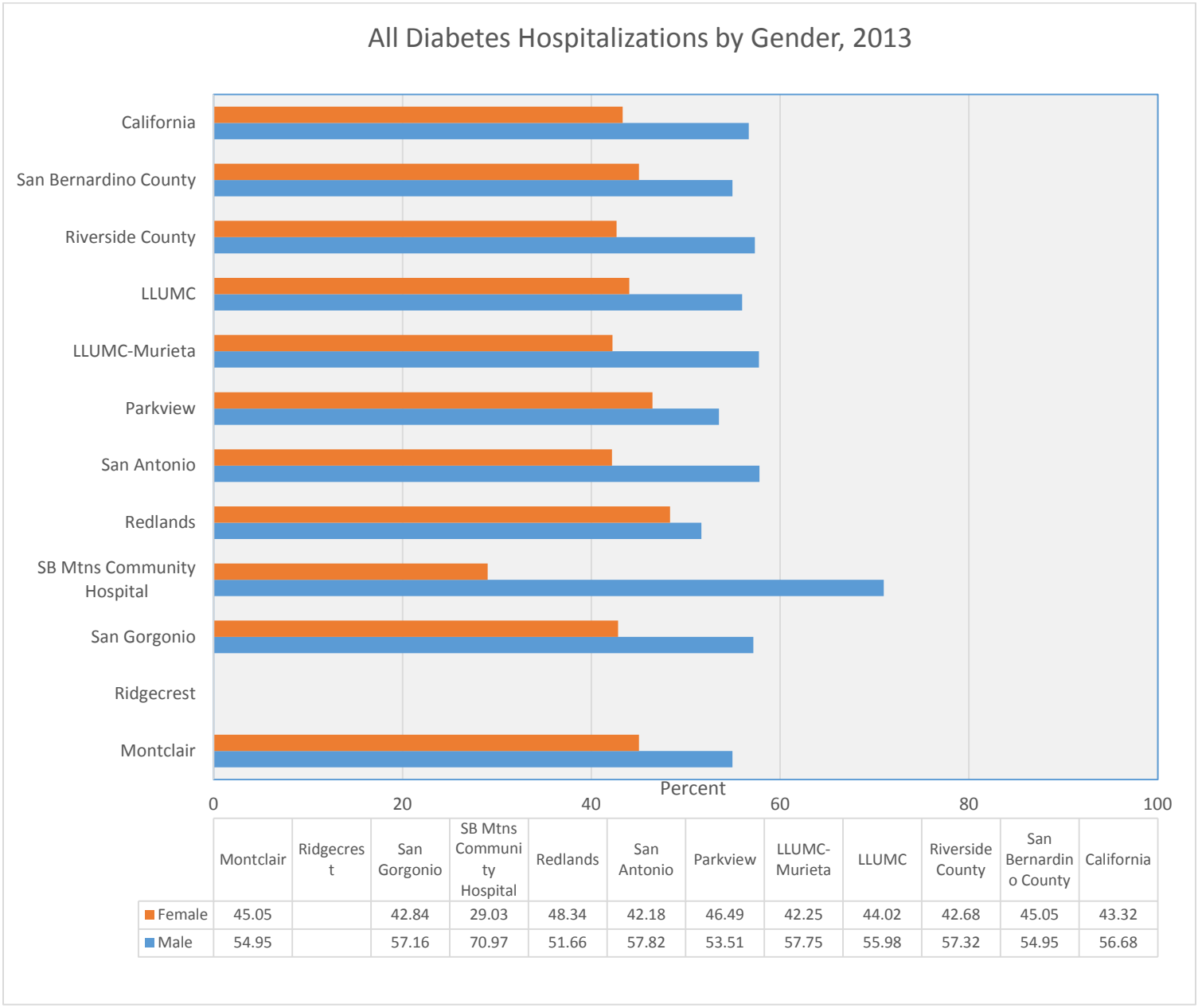
- Men have a significantly higher proportion of hospitalizations due to diabetes compared to women at all hospitals with the exception of Ridgecrest.

- Hispanics have a higher proportion of hospitalizations due to diabetes compared to any other racial/ethnic group at Redlands, San Antonio, Parkview, and LLUMC. (52% at San Antonio).

- Sixteen percent of the hospitalizations at San Antonio were among those under 25 years of age.

Table 9. N-Value for Total Diabetes Hospitalizations per Service Area, 2013

California	SB County	Riverside	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
54,249	3,734	3,414	6,738	3557	1,398	1,567	1,322	31	684	*	3,734
Percent of Total Hospitalizations											
2.1	2.7	2.3	2.4	2.3	2.5	2.8	3.4	1.5	2.7	*	2.7



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murieta	LLUMC	Riverside County	San Bernardino County	California
Female	45.05		42.84	29.03	48.34	42.18	46.49	42.25	44.02	42.68	45.05	43.32
Male	54.95		57.16	70.97	51.66	57.82	53.51	57.75	55.98	57.32	54.95	56.68

All Diabetes Hospitalizations by Race/Ethnicity, 2013

	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	1		0.88	6.45	0.76	1.34	0.86	1.52	1.25	1.35	1.04	1.31
Other	3.2		1.32	6.45	1.97	2.74	2.5	2.81	2.75	2.02	3.24	2.29
AI/AN NH	0.2		1.17	0	0.38	0.06	0.07	0.48	0.28	0.4	0.16	0.4
Hispanic	41.7		27.92	6.45	45.76	52.33	42.92	34.05	40.5	38.64	41.67	37.56
Black NH	15.8		9.5	0	14.9	14.1	19.03	12.71	14.84	14	15.83	14.85
API NH	2.3		1.46	0	2.87	2.87	2.5	1.6	2.14	1.82	2.3	5.38
Whit NH	35.8		57.75	80.65	33.36	26.55	32.12	46.84	38.25	41.77	35.75	38.2

	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0		0	0	0	0	0	0	0	0	0	0.01
1<5 Years	0.48		0.44	0	0.83	0.45	0.43	0.3	0.4	0.47	0.5	0.44
5<15 Years	5.3		3.65	3.23	5.22	5.36	3.36	3.2	4.41	3.54	5.3	3.35
15<25 Years	10.58		13.74	12.9	12.63	9.83	12.09	8.2	11.8	11.42	10.6	8.5
25<35 Years	11.06		7.31	16.13	11.42	12.89	12.73	8.1	10.54	10.98	11.1	9.98
35<45 Years	11.73		10.38	3.22	10.74	12.38	10.94	11.2	11.35	11.1	11.7	12.03
45<55 Years	18.93		17.98	16.13	18.15	17.42	19.89	15.5	18.42	17.49	18.9	18.86
55<65 Years	18.18		21.64	38.71	18.68	16.85	19.24	18.1	18.58	19.51	18.2	19.99
65+ Years	23.73		24.85	9.68	22.31	24.82	21.32	35.4	24.5	25.51	23.7	26.83

Lung Cancer

This section includes data for lung cancer in in California, San Bernardino County, Riverside County, Loma Linda University Medical Center (LLUMC), Loma Linda University Medical Center – Murrieta (LLUMC-Murrieta), Parkview, San Antonio, Redlands, Mountains Community, San Gorgonio, and Montclair. (Data was unavailable for Ridgecrest due to small numbers.).

Key Findings

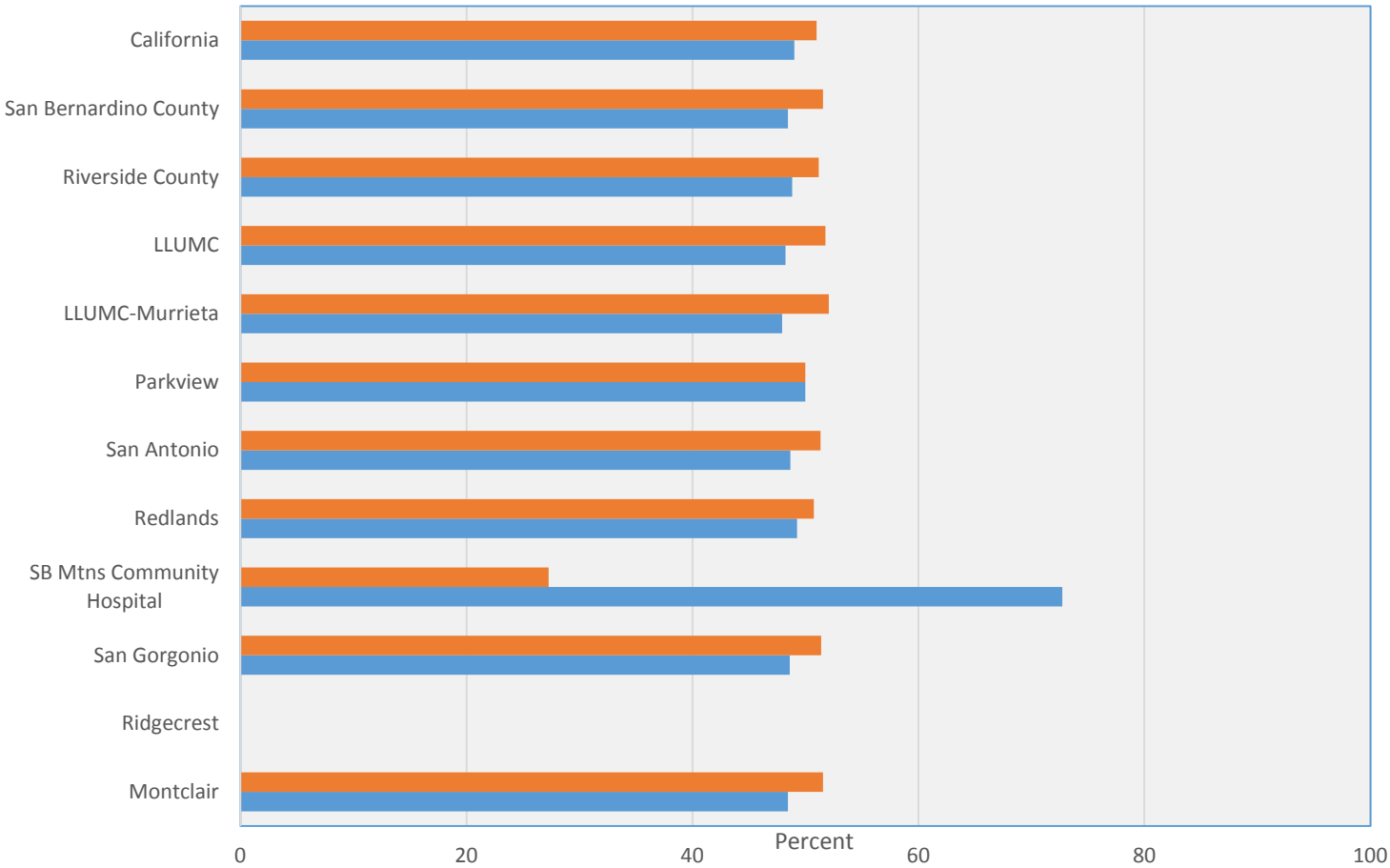
- Caucasians represent the large majority of lung cancer hospitalizations from all service areas.

- Caucasians double that of the Hispanic population in hospitalizations in San Antonio service area.

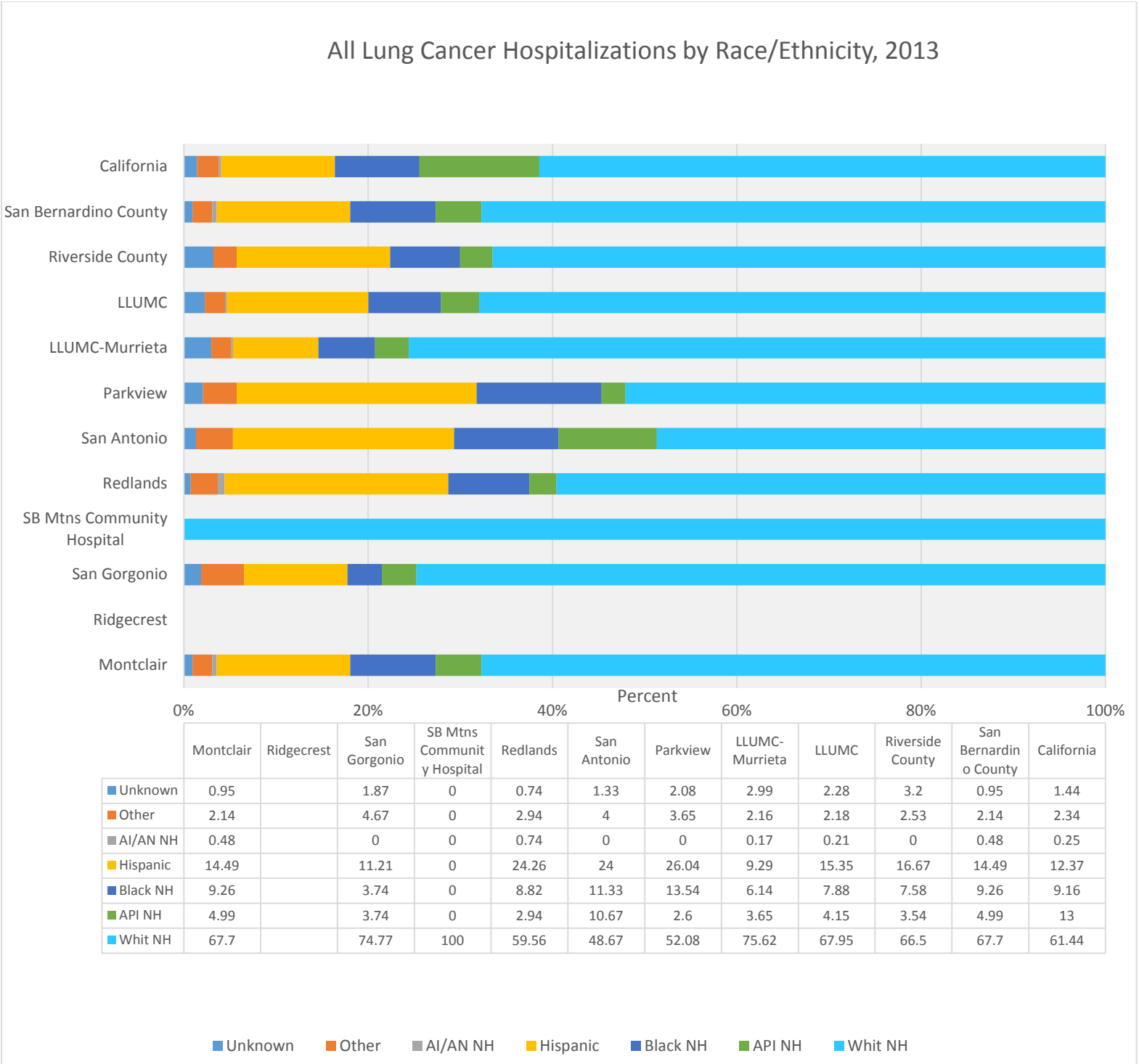
Table 10. N-Value for Total Lung Cancer Hospitalizations per Service Area, 2013

California	SB County	Riverside County	LLUMC	LLUMC-Murrieta	Parkview	San Antonio	Redlands	Mtns Community	San Gorgonio	Ridgecrest	Montclair
9,188	421	594	964	603	192	150	136	11	107	*	421
Percent of Total Hospitalizations											
.38	.30	.40	.35	.40	.35	.26	.35	.54	.42	*	.30

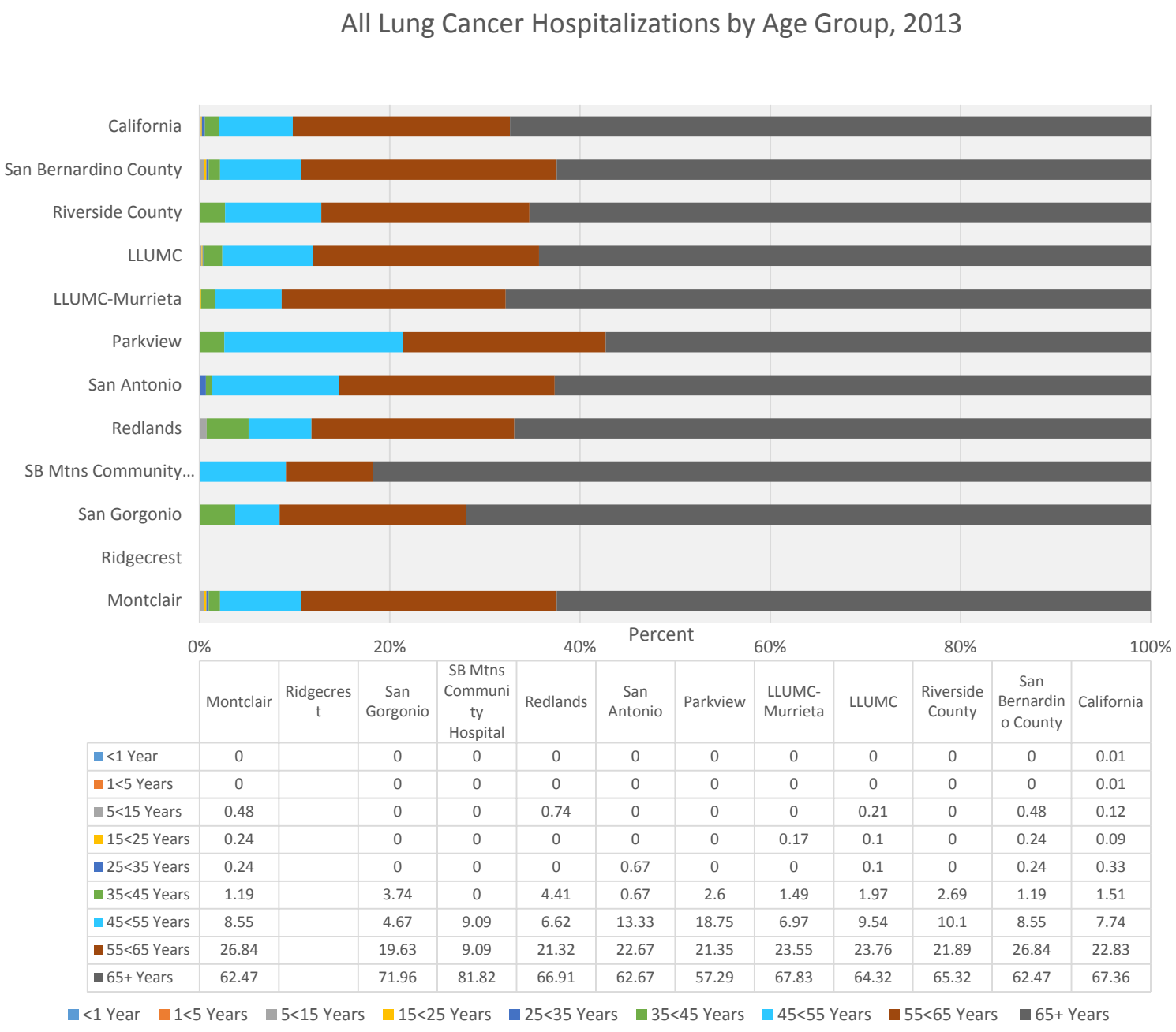
All Lung Cancer Hospitalizations by Gender, 2013



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Female	51.54		51.4	27.27	50.74	51.33	50	52.07	51.76	51.18	51.54	50.98
Male	48.46		48.6	72.73	49.26	48.67	50	47.93	48.24	48.82	48.46	49.02



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
Unknown	0.95		1.87	0	0.74	1.33	2.08	2.99	2.28	3.2	0.95	1.44
Other	2.14		4.67	0	2.94	4	3.65	2.16	2.18	2.53	2.14	2.34
AI/AN NH	0.48		0	0	0.74	0	0	0.17	0.21	0	0.48	0.25
Hispanic	14.49		11.21	0	24.26	24	26.04	9.29	15.35	16.67	14.49	12.37
Black NH	9.26		3.74	0	8.82	11.33	13.54	6.14	7.88	7.58	9.26	9.16
API NH	4.99		3.74	0	2.94	10.67	2.6	3.65	4.15	3.54	4.99	13
Whit NH	67.7		74.77	100	59.56	48.67	52.08	75.62	67.95	66.5	67.7	61.44



	Montclair	Ridgecrest	San Gorgonio	SB Mtns Community Hospital	Redlands	San Antonio	Parkview	LLUMC-Murrieta	LLUMC	Riverside County	San Bernardino County	California
<1 Year	0		0	0	0	0	0	0	0	0	0	0.01
1<5 Years	0		0	0	0	0	0	0	0	0	0	0.01
5<15 Years	0.48		0	0	0.74	0	0	0	0.21	0	0.48	0.12
15<25 Years	0.24		0	0	0	0	0	0.17	0.1	0	0.24	0.09
25<35 Years	0.24		0	0	0	0.67	0	0	0.1	0	0.24	0.33
35<45 Years	1.19		3.74	0	4.41	0.67	2.6	1.49	1.97	2.69	1.19	1.51
45<55 Years	8.55		4.67	9.09	6.62	13.33	18.75	6.97	9.54	10.1	8.55	7.74
55<65 Years	26.84		19.63	9.09	21.32	22.67	21.35	23.55	23.76	21.89	26.84	22.83
65+ Years	62.47		71.96	81.82	66.91	62.67	57.29	67.83	64.32	65.32	62.47	67.36

Social Determinants of Health

Social determinants of health are defined as the condition in which people are born, grow, live, work, and age. Essentially, where we live, work, and play impacts our health. Understanding these conditions can help identify where gaps may lie. Circumstances are most often shaped by resources at varying geographical locations. This section explores five determinants of health including:

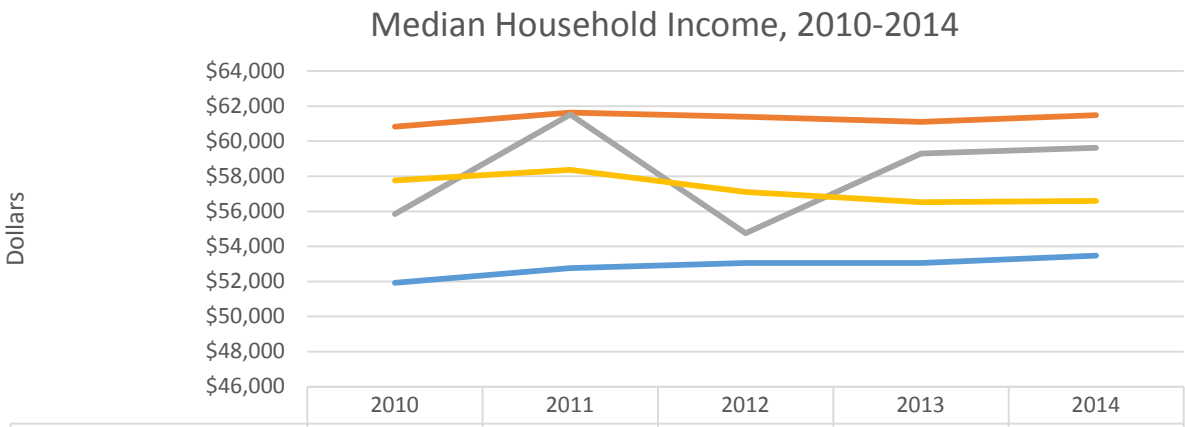
- Economic Stability
- Education
- Health and Healthcare
- Neighborhood and Built Environment
- Social and Community Context

Income

The association and relationship between higher levels of economic wealth and optimal health, and lower levels of economic wealth and poor health, have been well documented. It has been illustrated that different levels of income have significant differences in health outcomes. Income is the indicator that most directly measures material resources and can influence health by its direct effect on living standards; specifically, access to better quality food, housing, and healthcare services. In addition, income is used to measure an individual's socioeconomic status (SES). As a result, SES is closely tied to health outcomes as it provides access to a wide range of advantages. Such advantages include higher education, access and availability of professional occupations that offer benefits, and a better living environment. This directly influences an individual's power, prestige, and is beneficial to their social connections – all of which may provide greater protection against high risk behaviors that ultimately affect a person's health.

Median household income refers to the income level earned by a given household where half of the homes in the area earn more and half earn less. In other words, it is the amount that divides the income distribution into two equal groups. This indicator is used instead of the average or mean household income because it can give a more accurate picture of an area's actual economic status. Median household incomes are frequently used to determine housing affordability.

From 2010 to 2014, the median income significantly increased for the United States by $1,568, significantly increased for California by $656, significantly increased for San Bernardino County by $3,781, and significantly decreased for Riverside County by $1,176. The median household income is significantly higher for San Bernardino and Riverside Counties compared to the United States but is significantly lower compared to California. In 2014, the median household income was significantly higher in San Bernardino County compared to Riverside County by $3,034.

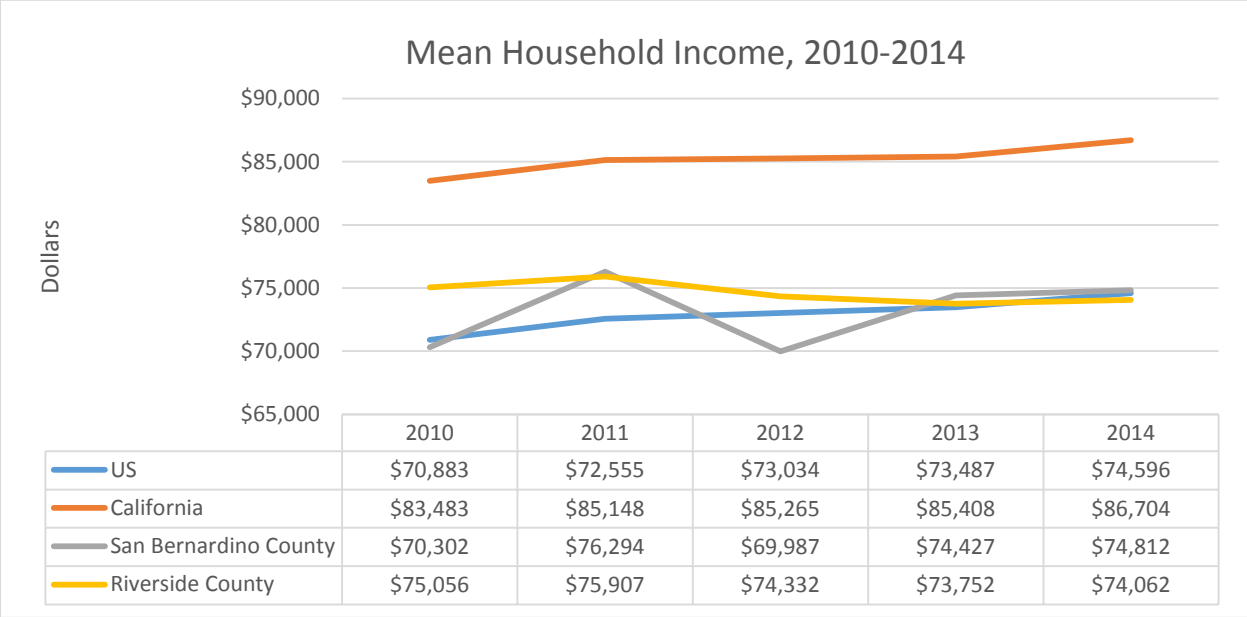


	2010	2011	2012	2013	2014
US	$51,914	$52,762	$53,046	$53,046	$53,482
California	$60,833	$61,632	$61,400	$61,094	$61,489
San Bernardino County	$55,845	$61,525	$54,750	$59,294	$59,626
Riverside County	$57,768	$58,356	$57,096	$56,529	$56,592

Data Source: American Community Survey, 2009-2014

Mean income (average) is the amount obtained by dividing the total aggregate income of a population by the number in the population.

From 2010 to 2014, the mean income significantly increased for the United States by $3,713, significantly increased for California by $3,221, significantly increased for San Bernardino County by $4,510, and decreased for Riverside County by $994. There is no statistically significant difference in the mean household income for San Bernardino and Riverside Counties compared to the United States, but both are significantly lower compared to California. In 2014, the mean household income was similar between San Bernardino County and Riverside County.

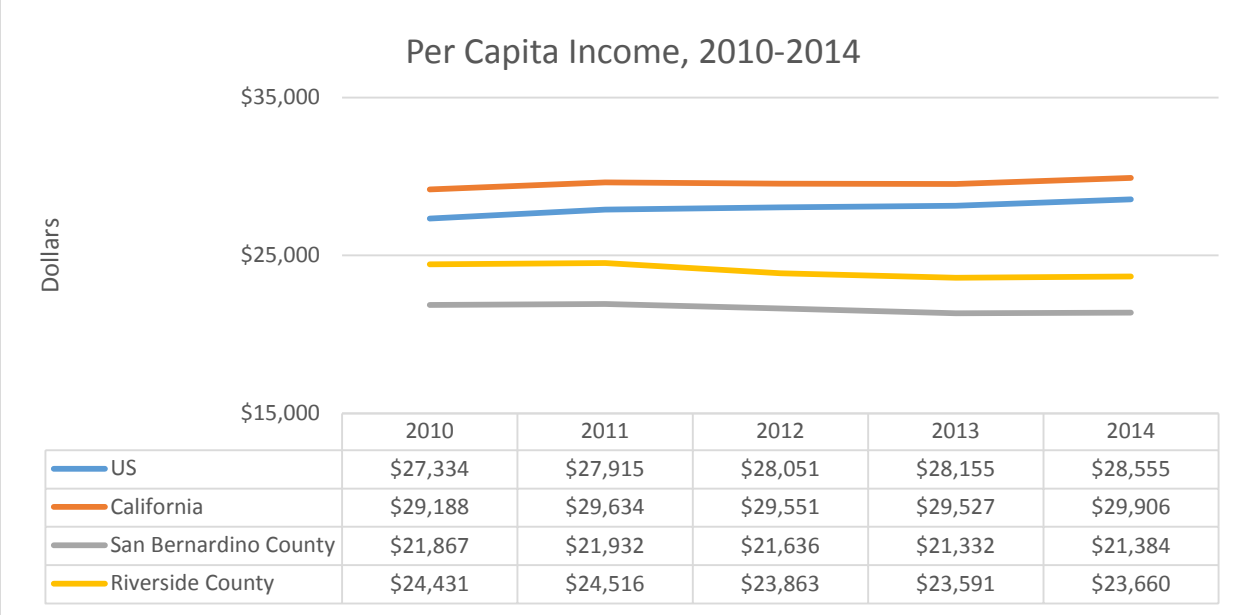


	2010	2011	2012	2013	2014
US	$70,883	$72,555	$73,034	$73,487	$74,596
California	$83,483	$85,148	$85,265	$85,408	$86,704
San Bernardino County	$70,302	$76,294	$69,987	$74,427	$74,812
Riverside County	$75,056	$75,907	$74,332	$73,752	$74,062

Data Source: American Community Survey, 2009-2014

Per capita income is defined as the total national income (GDP) divided by the total population. Per capita income includes children and the non-working population in its calculations and serves as an indicator to measure a population's standard of living.

Per capita income is significantly lower in San Bernardino and Riverside Counties compared to the United States and California. From 2010 to 2014 the per capita income increased significantly in the United States by $1,221, an increase of four percent, and increased by $718 in California, an increase of two percent. Between 2010 and 2014 in San Bernardino County, the per capita income decreased by $483, a 2.2% decrease, and for Riverside County it decreased by $771, a 3.2% decrease. The per capita income for San Bernardino County remained significantly below the per capita income for Riverside County from 2010 to 2014. On average the per capita income for San Bernardino County has been approximately $2,382 (11%) less than Riverside County.

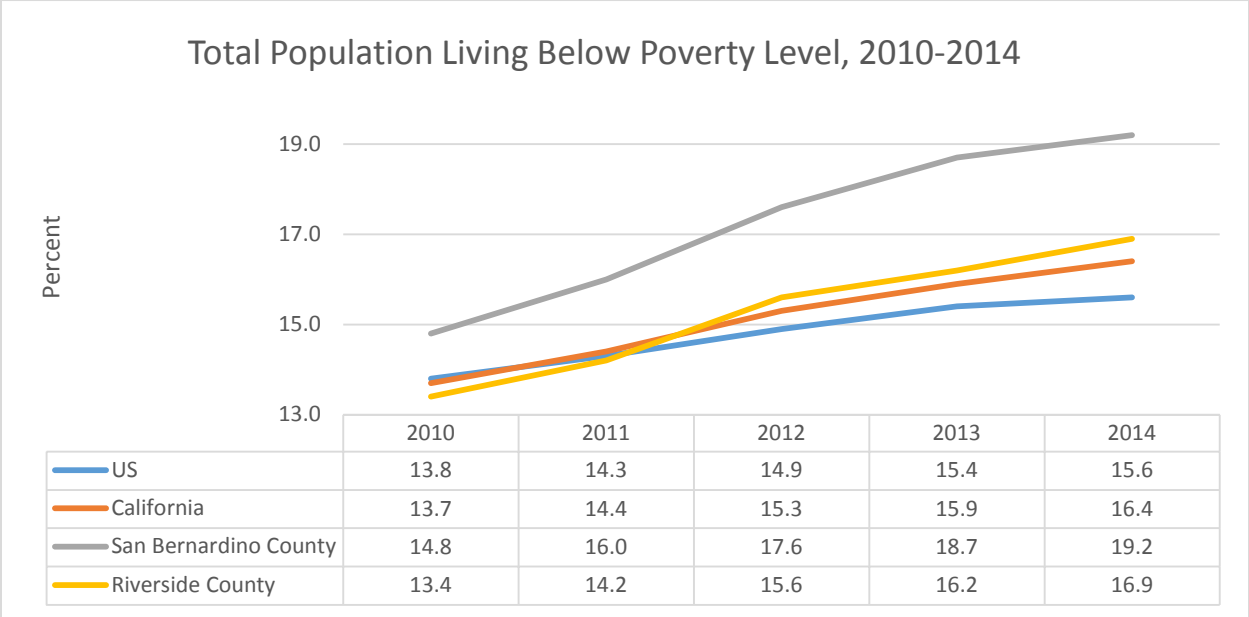


	2010	2011	2012	2013	2014
US	$27,334	$27,915	$28,051	$28,155	$28,555
California	$29,188	$29,634	$29,551	$29,527	$29,906
San Bernardino County	$21,867	$21,932	$21,636	$21,332	$21,384
Riverside County	$24,431	$24,516	$23,863	$23,591	$23,660

Data Source: American Community Survey, 2009-2014

Poverty

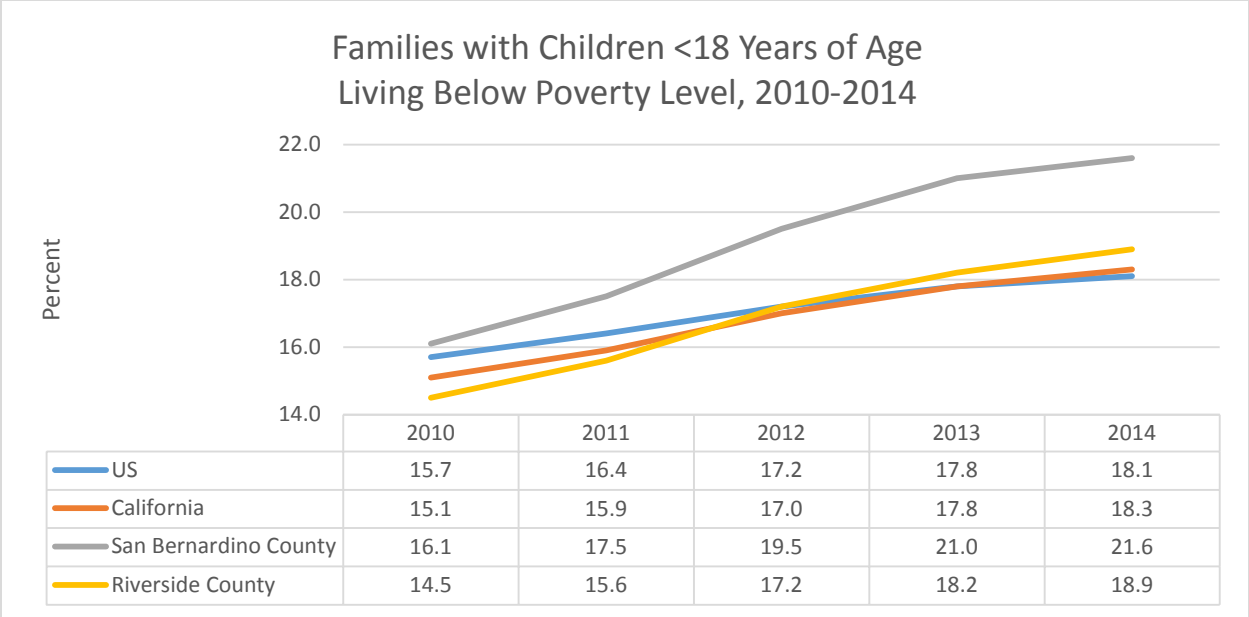
Poverty was defined as 100% of the federal poverty level (FPL). The FPL is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services (HHS). FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. In 2014, the HHS guideline for 100% FPL annual household income for a family of four was $23,850.



	2010	2011	2012	2013	2014
US	13.8	14.3	14.9	15.4	15.6
California	13.7	14.4	15.3	15.9	16.4
San Bernardino County	14.8	16.0	17.6	18.7	19.2
Riverside County	13.4	14.2	15.6	16.2	16.9

Data Source: American Community Survey, 2009-2014

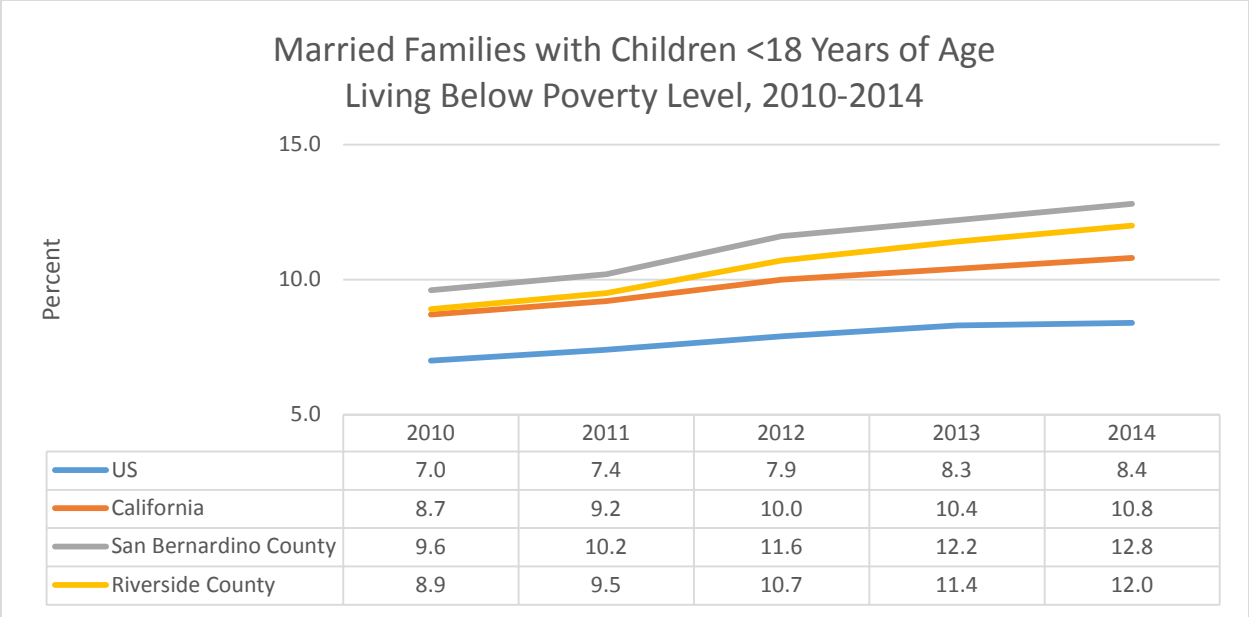
From 2010 to 2014, the proportion of the population that lived in poverty significantly increased in the United States, California, San Bernardino County, and Riverside County. The proportion was significantly higher in San Bernardino County compared to the other three populations. In 2014, approximately one in five people lived in poverty in San Bernardino County. From 2010 to 2014, the rate of poverty increased by 13% in the United States, by 20% in California, by 30% in San Bernardino County, and by 26% in Riverside County. The increase in the rate of poverty was approximately 2.3 higher in San Bernardino County compared to the United States and 1.5 times higher compared to California. The increase in the rate of poverty was approximately two times higher in Riverside County compared to the United States and 1.3 times higher compared to California.



	2010	2011	2012	2013	2014
US	15.7	16.4	17.2	17.8	18.1
California	15.1	15.9	17.0	17.8	18.3
San Bernardino County	16.1	17.5	19.5	21.0	21.6
Riverside County	14.5	15.6	17.2	18.2	18.9

Data Source: American Community Survey, 2009-2014

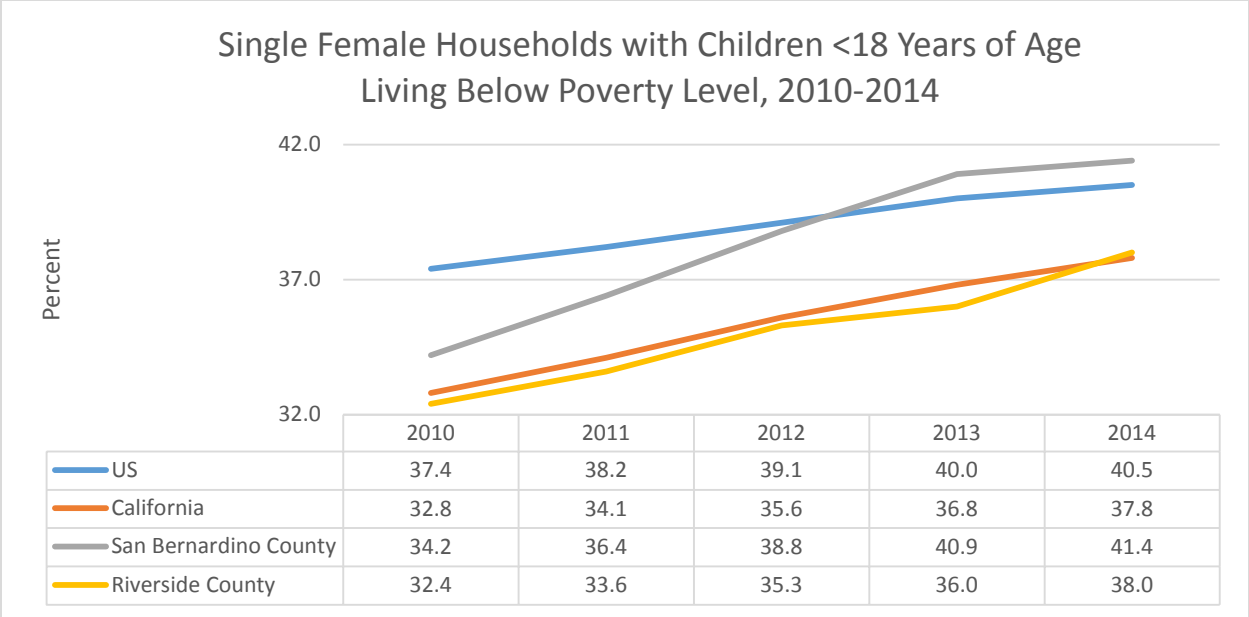
From 2010 to 2014, the proportion of families with children 18 years or younger that lived in poverty significantly increased in the United States, California, San Bernardino County, and Riverside County. The proportion was significantly higher in San Bernardino County compared to the other three populations. In 2014, approximately 22% of families with children 18 years or younger lived in poverty in San Bernardino County compared to 19% in Riverside County. Approximately 18% of families with children 18 years and younger lived in poverty in the United States and California. From 2010 to 2014, the rate of poverty among families with children 18 years and younger increased by 15% in the United States, by 21% in California, by 34% in San Bernardino County, and by 30% in Riverside County. The increase in the rate of poverty among families with children 18 years and younger was approximately 2.3 times higher in San Bernardino County compared to the United States and 1.6 times higher compared to California. The increase in the rate of poverty among families with children 18 years and younger was approximately two times higher in Riverside County compared to the United States and 1.4 times higher compared to California.



	2010	2011	2012	2013	2014
US	7.0	7.4	7.9	8.3	8.4
California	8.7	9.2	10.0	10.4	10.8
San Bernardino County	9.6	10.2	11.6	12.2	12.8
Riverside County	8.9	9.5	10.7	11.4	12.0

Data Source: American Community Survey, 2009-2014

From 2010 to 2014, the proportion of married families with children 18 years or younger that lived in poverty significantly increased in the United States, California, San Bernardino County, and Riverside County. The proportion was significantly higher in San Bernardino County and Riverside County compared to the United States and California. In 2014, approximately 13% of married families with children less than 18 years of age lived in poverty in San Bernardino County and 12% in Riverside County. From 2010 to 2014, the rate of poverty increased among married families with children 18 years or younger by 20% in the United States, by 24% in California, by 33% in San Bernardino County, and by 35% in Riverside County. The increase in the rate of poverty was approximately 1.7 higher in San Bernardino County compared to the United States and 1.4 times higher compared to California. The increase in the rate of poverty was approximately 1.8 higher in Riverside County compared to the United States and 1.4 times higher compared to California.

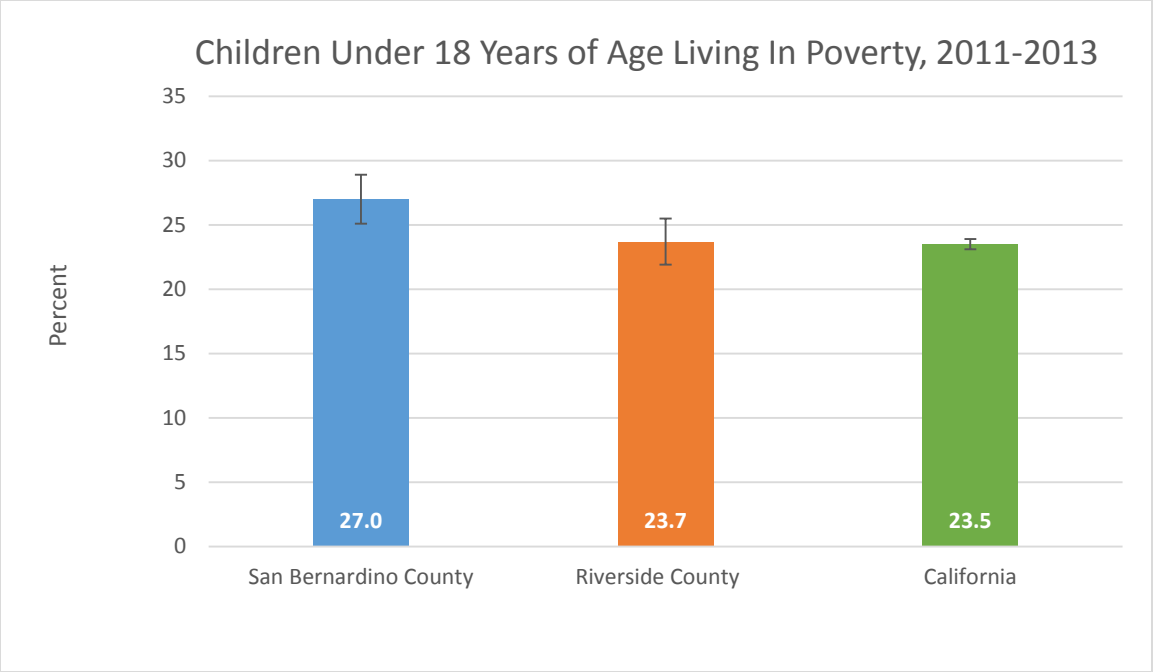


	2010	2011	2012	2013	2014
US	37.4	38.2	39.1	40.0	40.5
California	32.8	34.1	35.6	36.8	37.8
San Bernardino County	34.2	36.4	38.8	40.9	41.4
Riverside County	32.4	33.6	35.3	36.0	38.0

Data Source: American Community Survey, 2009-2014

From 2010 to 2014, the proportion of single female households with children 18 years or younger that lived in poverty significantly increased in the United States, California, San Bernardino County, and Riverside County. In 2014, the proportion was significantly higher in San Bernardino County and the United States compared to California and Riverside County. In 2014, approximately 40% of single female households with children less than 18 years of age lived in poverty in San Bernardino County and the United States. In Riverside County and California, the proportion was 38%.

From 2010 to 2014, the rate of poverty increased among single female households with children 18 years or younger by 8% in the United States, by 15% in California, by 21% in San Bernardino County, and by 17% in Riverside County. The increase in the rate of poverty was approximately 2.6 times higher in San Bernardino County compared to the United States and 1.4 times higher compared to California. The increase in the rate of poverty was approximately 2.1 times higher in Riverside County compared to the United States, but no different compared to California.



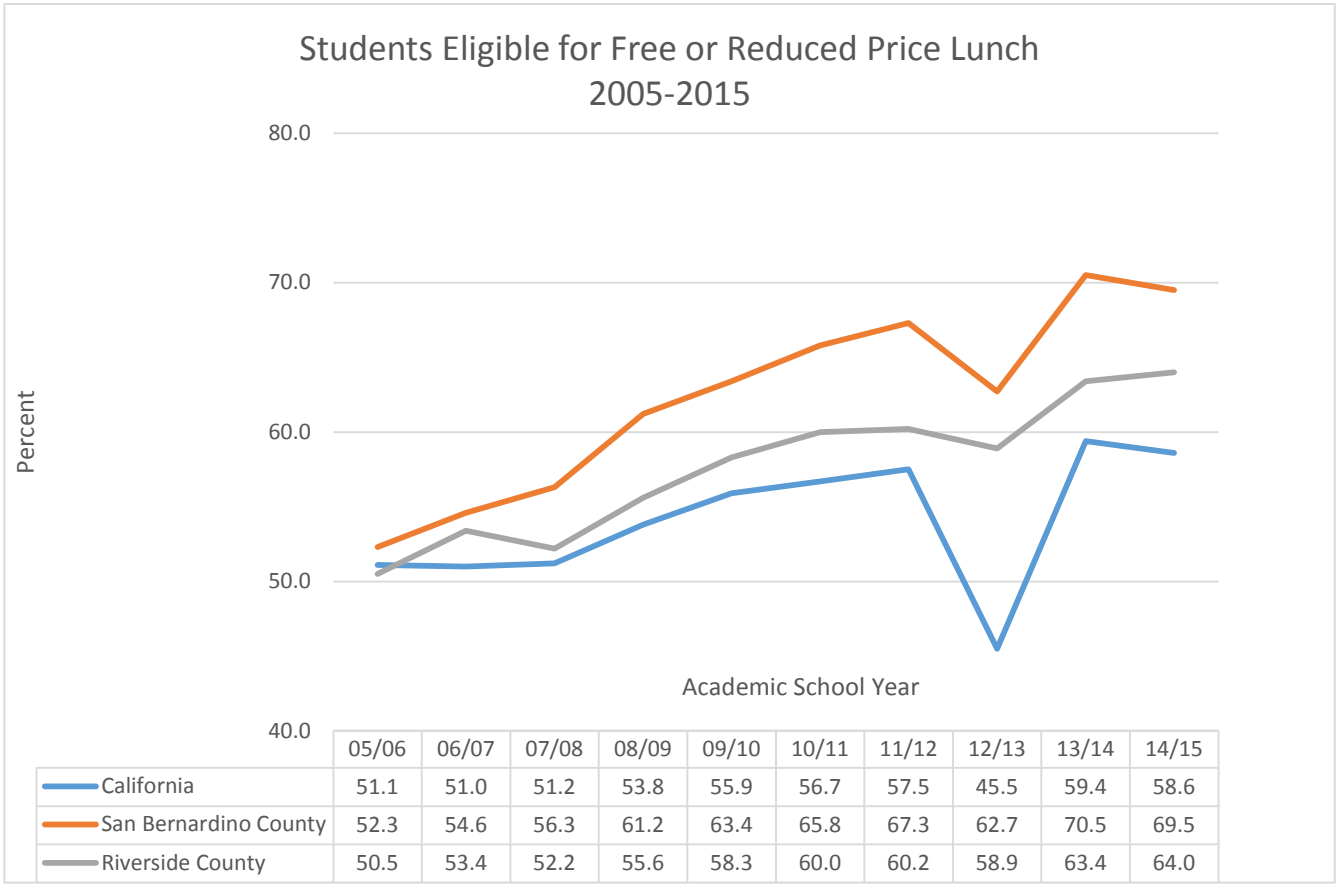
Data Source: American Community Survey, 2011-2013

A significantly higher proportion of children 18 years and younger live in poverty in San Bernardino County (27%) compared to approximately 25% in California. There was no statistically significant difference in the proportion of children 18 years and younger living in poverty between San Bernardino County and Riverside County. The proportion of children living in poverty in San Bernardino County is approximately 15% higher than in California. There was no statistically significant difference in the proportion of children 18 years and younger living in poverty between California and Riverside County.

Free and Reduced Lunch

The free and reduced price meal program is a federal program offering assistance to students whose families meet the definition of being a low-income family. Every public school in the United States offers a free and reduced meal program for their students. Students who are eligible for free or reduced breakfasts and lunches at school, as defined by the National School Lunch Act, may eat school meals for free or at a reduced cost.

Eligibility is determined via an application process that parents must complete and submit each year. Children from families at or below 130 percent of the federal poverty level (FPL) are eligible for free meals. Children from families between 130-185 percent of the FPL are eligible for reduced-priced meals.



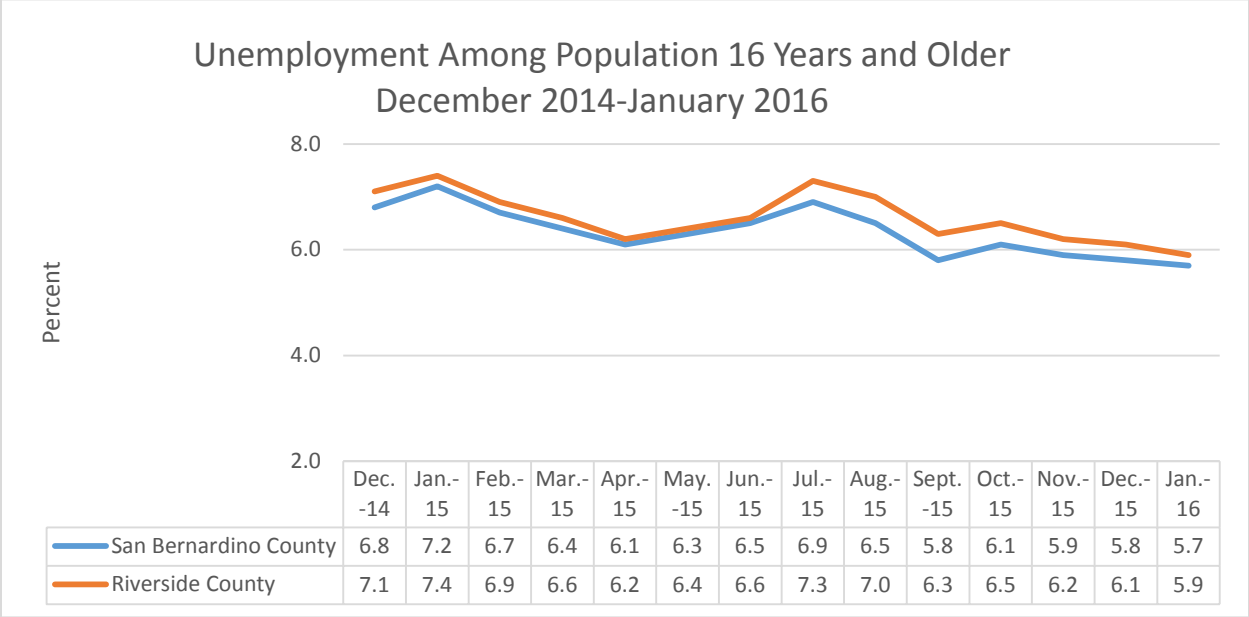
	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
California	51.1	51.0	51.2	53.8	55.9	56.7	57.5	45.5	59.4	58.6
San Bernardino County	52.3	54.6	56.3	61.2	63.4	65.8	67.3	62.7	70.5	69.5
Riverside County	50.5	53.4	52.2	55.6	58.3	60.0	60.2	58.9	63.4	64.0

Data Source: California Department of Education, 2005/2006 Academic School Year through 2014/2015 Academic School Year

Approximately 70% of students in primary education at public institutions in San Bernardino County are eligible for free and reduced price meals compared to 64% in Riverside County and 60% in California. The proportion in San Bernardino and Riverside Counties is significantly higher compared to California. Compared to each other, San Bernardino County has a significantly higher proportion of students eligible for free and reduced price meals compared to Riverside County. From the 2005/2006 academic school year to the 2014/2015 academic school year, the proportion of students eligible for free and reduced price meals has increased by approximately 15% for California, by approximately 33% for San Bernardino County, and by approximately 27% for Riverside County. In the 2014/2015 academic school year, the proportion of eligible students for free and reduced price meals was 19% higher in San Bernardino County compared to California and 9% higher in Riverside County compared to California.

Unemployment

Unemployment is associated with higher mortality rates, especially from cardiovascular disease and suicide. The stress of joblessness can lead to anxiety, depression, substance abuse, and poor mental health. Unemployment can also affect a neighborhood's well-being. As the levels of joblessness increase, sociability and collective participation and commitment in solving neighborhood problems are weakened. When people cannot find work, they are more likely to turn to crime and street economy (e.g. selling drugs, working in commercial sex) to make money.



	Dec.-14	Jan.-15	Feb.-15	Mar.-15	Apr.-15	May.-15	Jun.-15	Jul.-15	Aug.-15	Sept.-15	Oct.-15	Nov.-15	Dec.-15	Jan.-16
San Bernardino County	6.8	7.2	6.7	6.4	6.1	6.3	6.5	6.9	6.5	5.8	6.1	5.9	5.8	5.7
Riverside County	7.1	7.4	6.9	6.6	6.2	6.4	6.6	7.3	7.0	6.3	6.5	6.2	6.1	5.9

Data Source: Bureau of Labor of Statistics, December 2014-January 2016

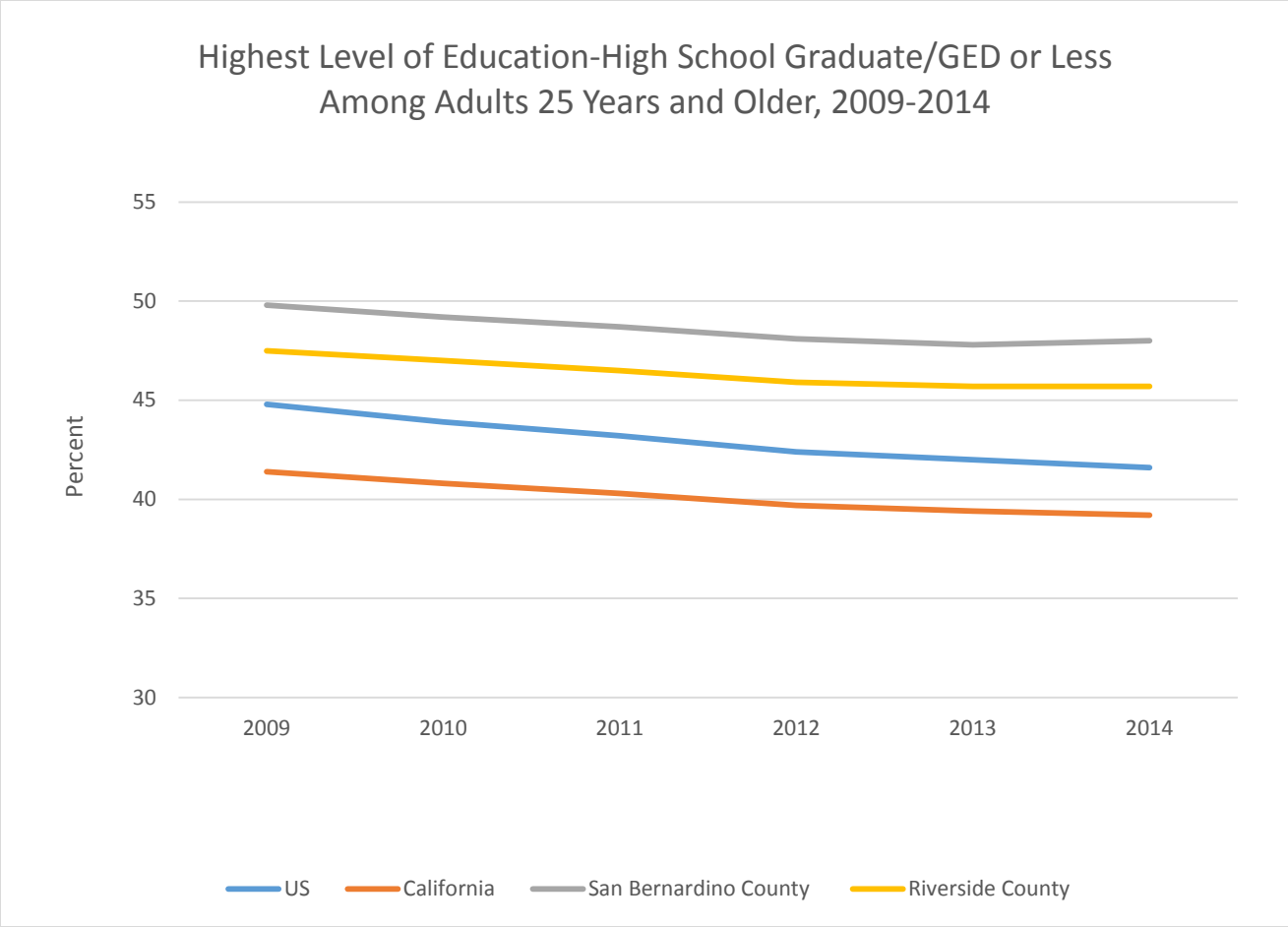
Unemployment occurs when a person who is actively searching for employment is unable to find work. Unemployment is often used as a measure of the health of the economy. The most frequently cited measure of unemployment is the unemployment rate. This is the number of unemployed persons divided by the number of people in the labor force. Note that the unemployment rate above was not adjusted for seasonal employment. There was no significant difference in the unemployment rate between San Bernardino County and Riverside County for the period of December 2014 to January 2016.

Education

Educational attainment is commonly used to assess the influence of socioeconomic circumstances on health and is a strong determinant of current and future employment and income. An individual's overall physical and mental health and life expectancy are directly correlated to their income, and research has shown that educational attainment is one of the strongest predictors of income. For most people, educational attainment reflects material and other resources of the family and the knowledge and skills attained by young adulthood. Therefore, education captures both the long-term influence of early life circumstances and the influence of adult circumstances on adult health.

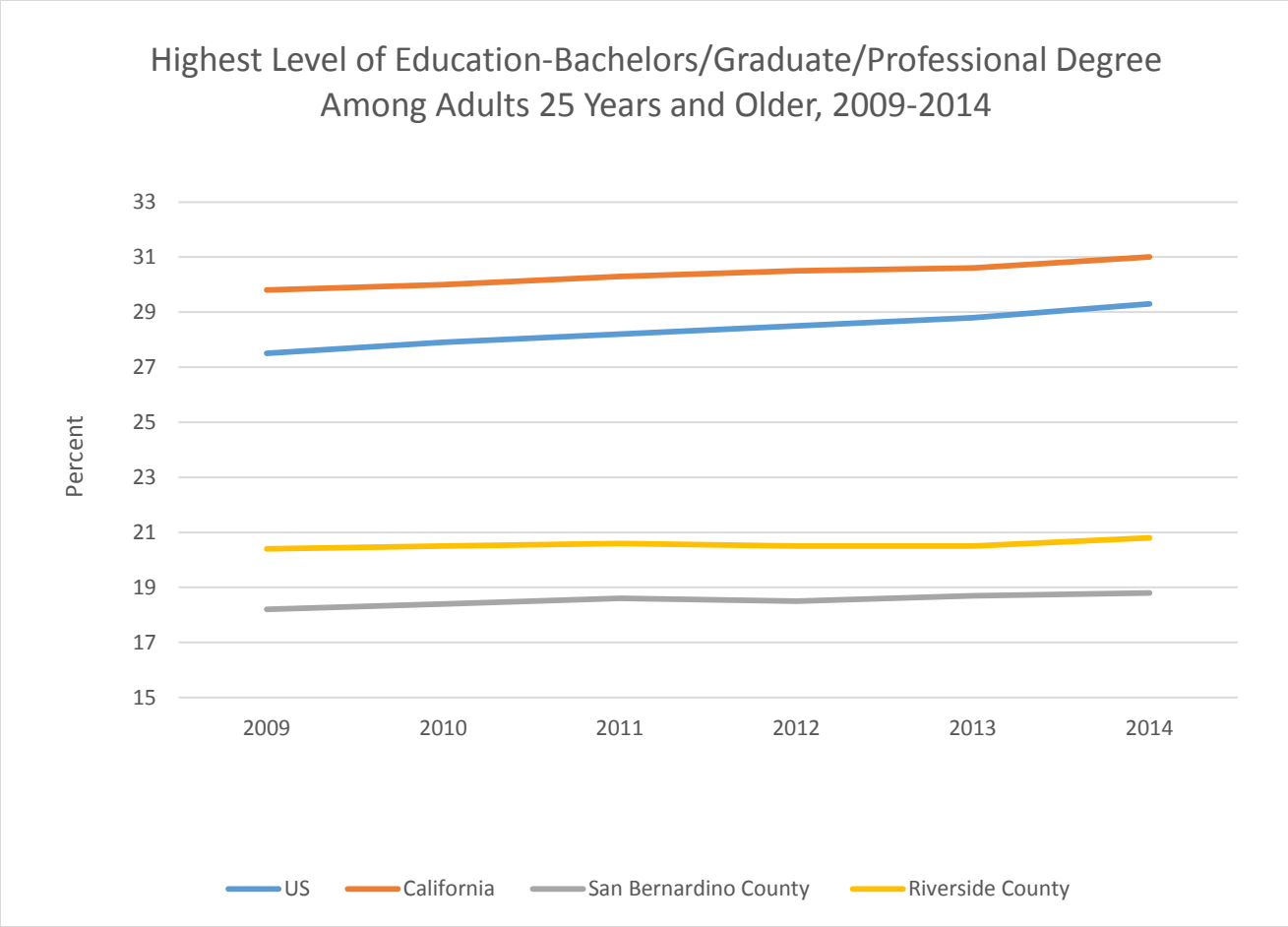
The gradient of educational attainment illustrates that people with a higher level of education are more likely to have higher paying jobs and are more likely to be employed than people with a lower level of education. Studies have shown that each additional year in school is associated with increased life expectancy and better health. Research also suggests that people who complete higher levels of education have better cognitive and psychological resources, such as problem solving, practice with teamwork, dependability, structure, and routine. What's more, research demonstrates less educated individuals are more likely to be employed in jobs that are low-wage and require less skill, working in conditions that are more dangerous, stressful, and offer the worker less control than that enjoyed by more highly educated individuals. Furthermore, low-wage and low-skill jobs more often do not provide health insurance, making it more difficult to access preventive and immediate healthcare.

Conversely a person's health also affects their education. Health conditions are a common contributor to the decision to leave school. For instance, pregnancy, parental or sibling illness, and chronic conditions such as asthma can all lead to excessive absenteeism and ultimately to dropout. As a result, individuals are less educated and in the course of their life are more likely to resign to low paying jobs.



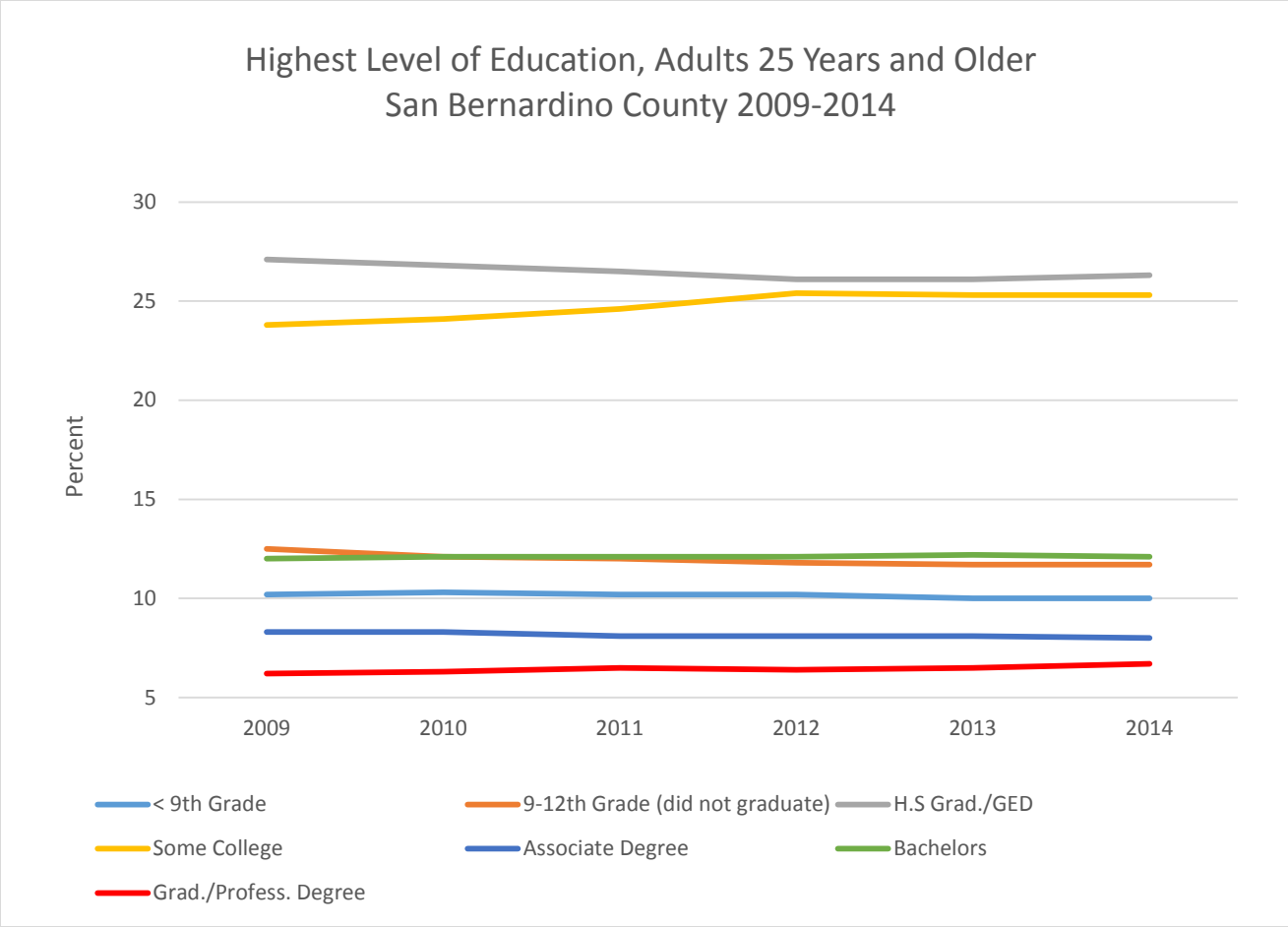
Data Source: American Community Survey, 2009-2014

The proportion of adults 25 years and older whose highest level of education was high school graduate/GED or lower was significantly higher in San Bernardino and Riverside Counties compared to the proportion in the United States and in the State of California; thus it is observed that San Bernardino and Riverside Counties have a higher proportion of adults who are less educated. For approximately 50% of adults 25 years and older in San Bernardino County, the highest level of education achieved is high school graduate/GED or lower compared to approximately 45% for Riverside County; a significant difference between the two counties. In the United States and in California, the proportion of adults 25 years and older whose high level of education is high school graduate/GED or lower is approximately 40%. From 2009 to 2014, the proportion of adults 25 years and older whose highest level of education is high school graduate/GED or lower has remained stable for San Bernardino County and Riverside Counties, whereas in the United States and in California the proportion has decreased. This proportion has dropped 3.2% in the United States and 2.2% in the State of California.



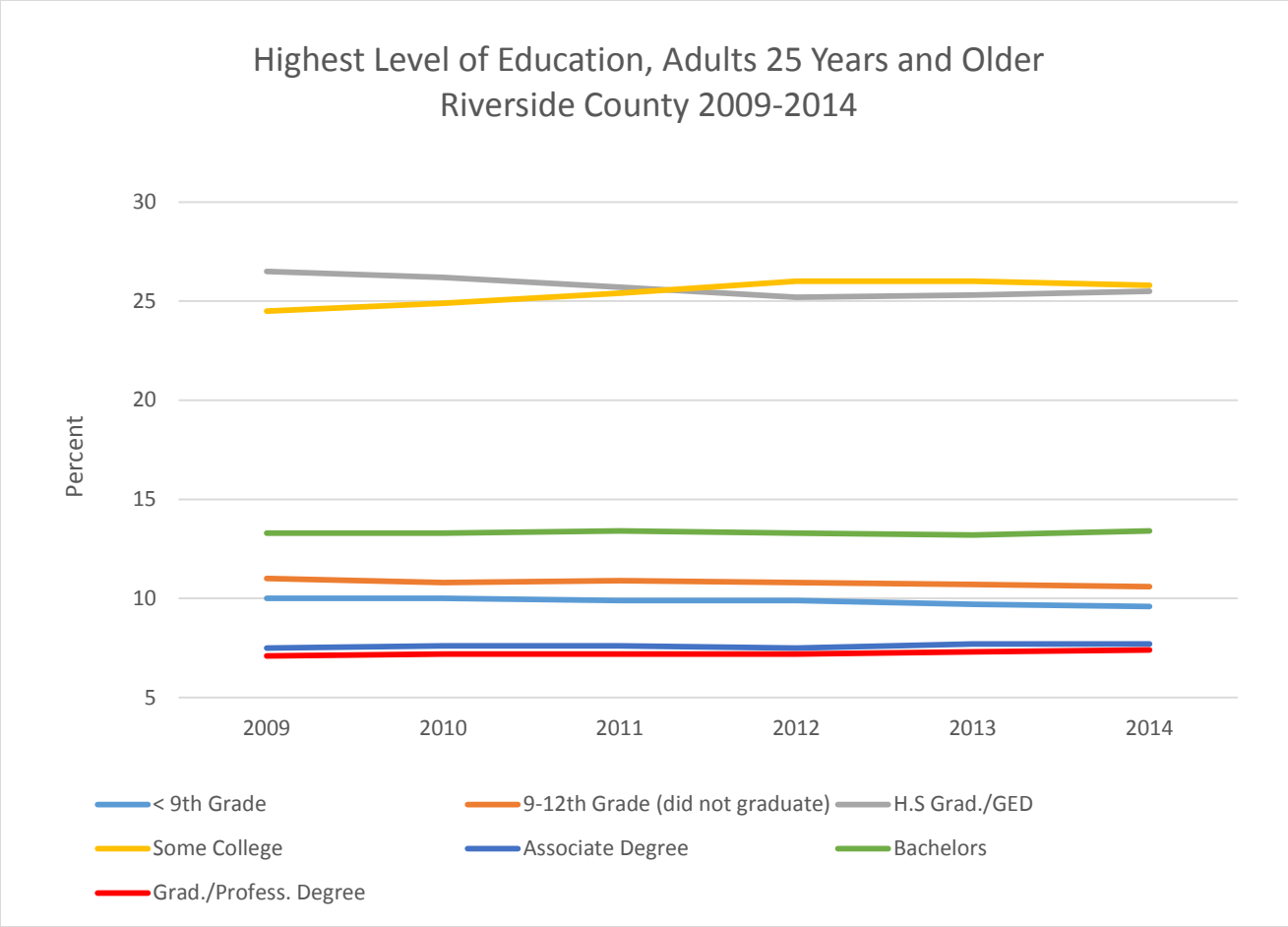
Data Source: American Community Survey, 2009-2014

The proportion of adults 25 years and older whose highest level of education is bachelors/graduate/professional degree is significantly lower in San Bernardino and Riverside Counties compared to the United States and the State of California. In San Bernardino and Riverside Counties, approximately 20% of adults have received a bachelors/graduate/professional degree compared to approximately 30% for the United States and the State of California. From 2009 to 2014, the proportion of adults 25 years and older whose highest level of education is a bachelors/graduate/professional degree has remained stable for San Bernardino and Riverside Counties, and has significantly increased for the United States and the State of California.



Data Source: American Community Survey, 2009-2014

For approximately 26% of the adult population in San Bernardino County, the highest level of education is a high school diploma or GED. Approximately 25% have had some college but did not acquire a degree and about 12% received a bachelor's degree. In addition, the highest level of education for about one in 10 adults is ninth grade or less. For each of the educational groups identified in the above graph, the proportions each year have remained stable from 2009 to 2014.



Data Source: American Community Survey, 2009-2014

For approximately 26% of the adult population in Riverside County, the highest level of education is a high school diploma or GED. Approximately 25% have had some college but did not acquire a degree and about 12% received a bachelor's degree. In addition, the highest level of education for about one in 10 adults is ninth grade or less. For each of the educational groups identified in the above graph, the proportions each year have remained stable from 2009 to 2014.

Healthcare Access

The lack of access to adequate healthcare can pose barriers to one's physical and psychological well-being. Identification of risk factors complemented by early intervention can help to prevent or minimize the debilitating effects of chronic disease and its associated co-morbidities. The rates of mortality, morbidity, and visits to emergency departments can be reduced when the population has appropriate access to healthcare services.

The follow table includes key indicators that form a picture of healthcare access in the Inland Empire region.

Health Care Access Indicators				
Report Area	Percent of Uninsured[1]	Ratio of Population to Primary Care Physicians[2]	Ratio of Population to Dentists[3]	Ratio of Population to Mental Health Providers[4]
Riverside County, CA	22%	2,420:1	2,070:1	670:1
San Bernardino County, CA	20%	1,740:1	1,540:1	560:1
California	19%	1,270:1	1,260:1	360:1

1. Percentage of population under age 65 without health insurance, US Census Bureau's Small Area Health Insurance Estimates (SAHIE), 2013
2. Area Health Resource File/American Medical Association, 2013
3. Area Health Resource File/National Provider Identification file, 2014
4. CMS, National Provider Identification, 2015

Riverside and San Bernardino County lag behind the State of California with more of their population uninsured and with less access to healthcare providers. Sufficient availability of essential healthcare professionals is necessary to improve health outcomes and prevent morbidity and mortality.

Neighborhood and Built Environment

Food Access

Access to healthy food has been proven to be important in maintaining good health, psychological well-being, and preventing premature death. The following tables and graphs provide snapshots of food security indicators for the Inland Empire area compared to California.

Fast Food Restaurants

Fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

Fast Food Restaurant Concentration, 2013

Report Area	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Riverside County, CA	2,189,641	1,420	64.85
San Bernardino County, CA	2,035,210	1,435	70.51
California	37,253,956	27,912	74.9

Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2013.

Grocery Stores

Supermarkets and smaller grocery stores primarily engage in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included in the grocery store category. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

Grocery Store Concentration, 2013			
Report Area	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Riverside County, CA	2,189,641	349	15.94
San Bernardino County, CA	2,035,210	315	15.48
California	37,253,956	8,085	21.7

Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2013.

Food Deserts

This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Feeding America's Map the Meal Gap initiative developed methodology for mapping food insecurity by generating two types of community-level data: food insecurity and child food insecurity estimates by income, and estimates of food budget shortfalls reported by food insecure individuals. Feeding America analyzed the relationship between food insecurity and indicators of food insecurity and child food insecurity (poverty, unemployment, homeownership) at the state level. Using coefficient estimates based on this information in addition to similar variables at the county level, estimated food insecurity rates are generated for individuals and children at the county level.

Population Living in Food Deserts, 2010			
Report Area	Total Population	Population with Low Food Access	Percent Population with Low Food Access
Riverside County, CA	2,189,641	262,830	11.6%
San Bernardino County, CA	2,035,210	254,220	12.2%
California	37,253,956	5,401,770	13.9%

Data Source: Feeding America, Map the Meal Gap. 2014.

Qualitative Assessment Findings

San Antonio Regional Hospital's Community Health Specialist worked in collaboration with the Regional CHNA research team, consisting of the Hospital Association of Southern California's (HASC) Community Benefit Stakeholders Committee and Scientific Technologies Corporation (STC), in the collection of primary data for the development of the quantitative analysis. The team conducted a community resident focus group and 541 quality of life surveys with a completion rate of 60%. Coupled with validated secondary research data, the analyzed information collected by the CHNA team, with the addition of a *Healthy Communities* key informant focus group, will be used to develop San Antonio Regional Hospital's Community Benefit Implementation Strategy. This strategy will address the community's health needs, which have been stratified into major health priorities, by establishing initiatives designed to improve the overall health and well-being of the community. San Antonio will use the implementation strategy as a framework for the work to be accomplished over the next three years.

Community Focus Groups

Individuals commissioned to participate in the focus groups were selected based on their ability to provide dynamic, multi-disciplinary perspectives on health. The topics discussed in these focus groups include time spent in the Inland Empire, projects in the community, desired changes in the community, prevalent health problems, and barriers to or facilitators of health.

One focus group held at San Antonio Regional Hospital was comprised of community residents representing the cities of Ontario, Upland, and Chino. STC conducted this focus group in Spanish and the discussion lasted 90 minutes.

A second focus group targeted key informants across the Healthy City programs in the region. The session was conducted in English at San Antonio Regional Hospital, and leaders from the cities of Chino Hills, Eastvale, Fontana, Montclair, Ontario, Rancho Cucamonga, and Upland participated in the 120 minute session. The discussion was facilitated by the Executive Director of the Lewis-San Antonio Healthy Communities Institute in an effort to enhance dialogue and communication among participants in these groups, in addition to capturing responses related to the focus group discussion points within the CHNA framework.

Participants gave verbal and written consent to have the focus group meeting sessions recorded in addition to providing their name and contact information on a sign-in sheet. These focus groups were confidential, anonymous sessions.

An exit survey was given at the end of each session to tabulate participants' responses and to provide additional quantitative and qualitative information. The report that follows includes the results from these exit surveys.

The discussion guide utilized during both focus group sessions addressed the following issues:

- Community strengths and improvements
- Prevalent health problems within the communities
- Healthcare access and barriers to care
- Communication and community involvement

Key Focus Group Findings

The focus groups began with broader questions to assess participants' views on how the community has improved and what changes are needed. Access to healthcare, health status of the community, resources in the community that facilitate good health, and barriers to health were discussed. When the focus group participants were asked to describe the health of their communities, the following terms were repeatedly mentioned by both groups: healthier food options, physical activity, language barriers, grocery costs, and barriers to healthcare access.

Major Health Issues

The following are major health issues identified by participants from both focus groups, individually and collectively:

Mental Health

Mental health, paired with the well-adopted social stigma surrounding it, is perhaps the single most challenging and prevalent issue to be addressed in these communities. Focus group participants voiced that there is a pressing need for mental health providers and resources, in addition to a reduction in the reluctance to seek assistance among people who are in need of such services. Furthermore, the community lacks education for parents with children who suffer from behavioral problems and special needs. Awareness of the stigma associated with mental health illness and a growing shortage of providers in the region have long been identified as a barrier to accessing these critically needed services.

Smoking

Another identified concern was the effects of smoking and other controllable factors that contribute to poor air quality. In particular, the high proliferation of vape and smoke shops, combined with pesticides introduced into the environment, perpetuate air pollution and the inhalation of carcinogens. Robust smoking education targeting the youth would help prevent lung disease and promote a healthy environment. Additionally, participants suggested that they would like to see the elimination of smoking in public parks.

Unhealthy Eating

High prices of groceries from either farmers' markets or grocery stores exacerbate unhealthy eating patterns in the community. Additionally, there is a great disparity between the prices of inorganic and organic produce. Participants stated that the community is too heavily saturated with fast food restaurants and that an increase in healthier food options is needed. Offering healthier, nutrient filled food options in schools and educating the community on the availability of community garden resources would play a key role in creating a healthier built environment and advocating lifestyle behaviors that impact chronic disease prevention.

Sedentary Lifestyles

The availability of safe walkways, school routes, and bike paths lays the foundation for youth and adults alike to lead active and healthy lifestyles. This begs the question of whether or not community members live in an environment conducive to participate in healthy activities that are often encouraged. Participants stated that the need for resources such as increasing recreational exercise classes, enhancing park maintenance, increasing the number of bike routes, and investing in complete streets were offered as suggestions for countering the communities' sedentary way of life.

Chronic Diseases

Diabetes and high blood pressure are among the top chronic diseases within these communities. Community members described that there was a need for more education and support groups surrounding these topics.

Quality of Life Survey Results

Background

A paper and electronic format survey was conducted among community members in San Antonio's primary service area. During the five-week survey period, community members submitted opinions and personal perceptions about the healthcare needs of the region, barriers faced by people attempting to access care, challenges in navigating the healthcare system, areas of improvement within the community, and ways the hospital may enhance the services it provides in order to address the needs of the community.

The survey was distributed online via Survey Monkey, and paper copies were provided at local participating hospitals and key community locations. Translated versions of the survey were provided for individuals whose primary language was Spanish. The empirical information collected from the survey is a reliable supplement to the foregoing summaries of the focus groups, as well as the synthesis of secondary data representing the community's current health status. Survey participants included community members from various constituencies and geographic areas within San Antonio's primary service area. For certain questions, survey participants had the option of

selecting from more than one factor. After the results of the survey were compiled, a number of themes emerged and will be explored in the following analysis.

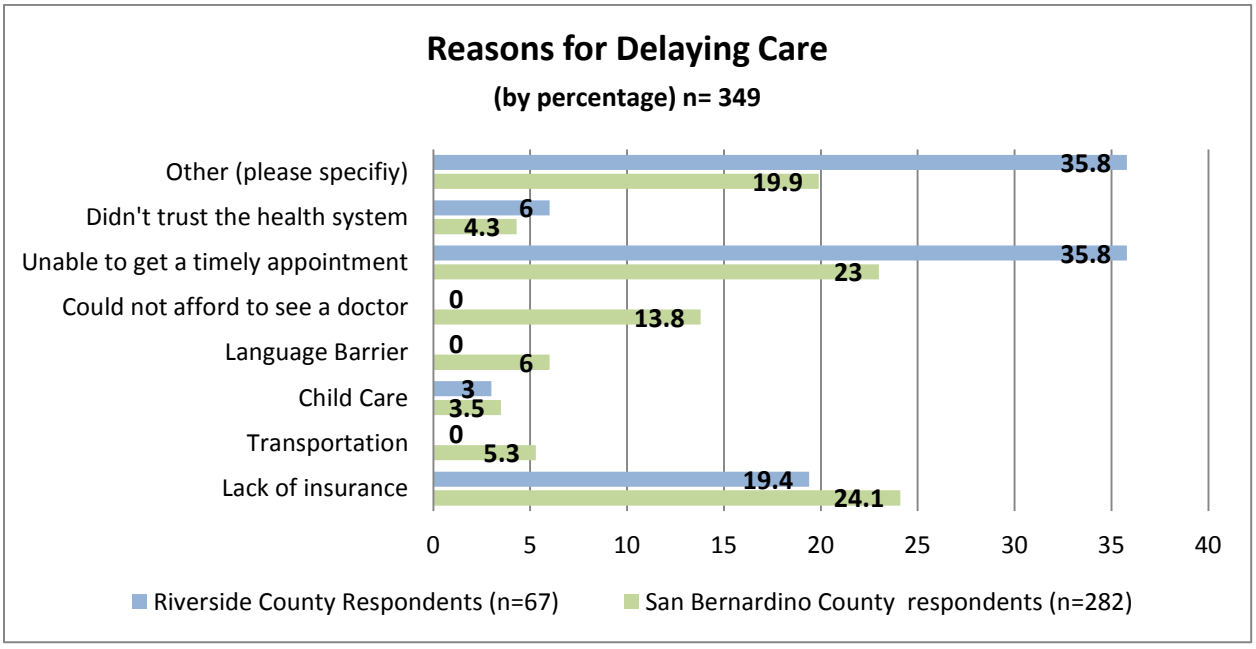
Demographics

Of the 541 respondents, 80% were female, 20% were male, 50% were between the ages of 40 – 65, and 12.6% were 65 years and older. Among individuals who completed the survey, 54.8% were married, 50% had a high school education or less, and 30% had an annual household income of $25,000 or less. Hispanics accounted for 60% of the survey participants and about 26% were Caucasian. Respondents represented San Antonio's service area along with those of other partner hospitals across the region.

Healthcare Access

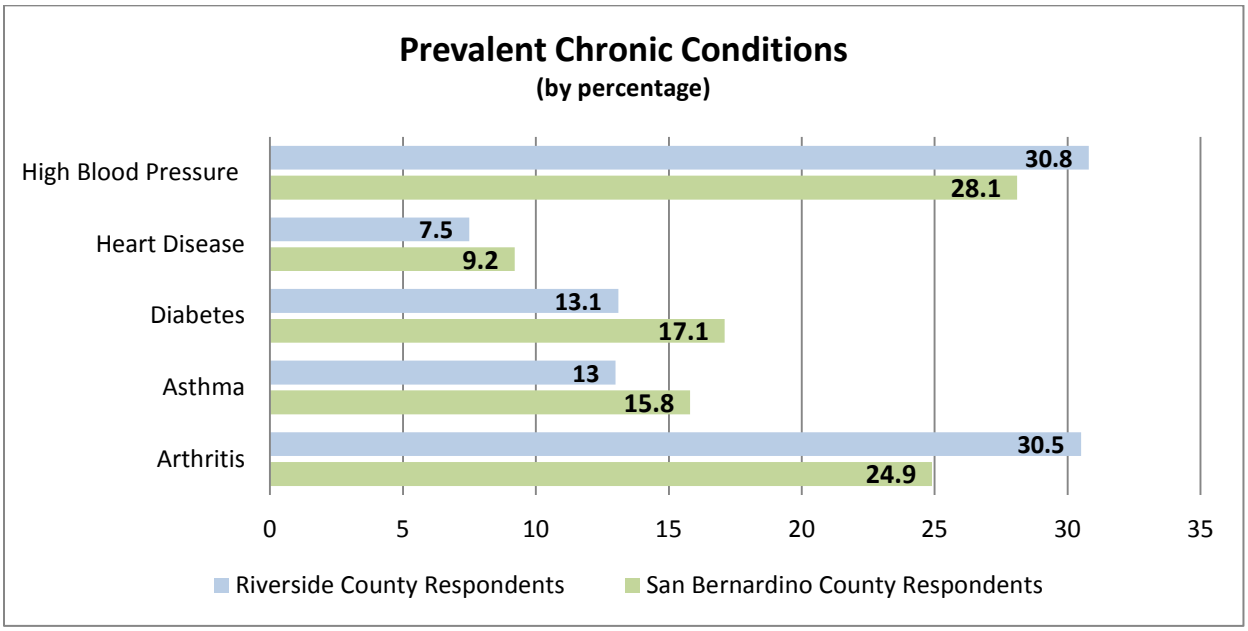
Many survey respondents (over 65%) indicated that they have a primary care provider that clearly explains what is needed to care for their health. Yet 15% of the survey participants stated having difficulty in understanding their doctor. Some respondents do not have someone to help them understand their provider, but others stated they received help from the medical office staff or an adult family member. Roughly 10% of respondents reported not having a primary care provider as a barrier to or a delay in accessing care.

Despite the expanded coverage of healthcare to previously uninsured populations under the Affordable Care Act (ACA), disparities in access to health services still exist. The chart below shows that the inability to receive a timely appointment, lack of insurance, and health care costs still pose significant barriers to accessing care.



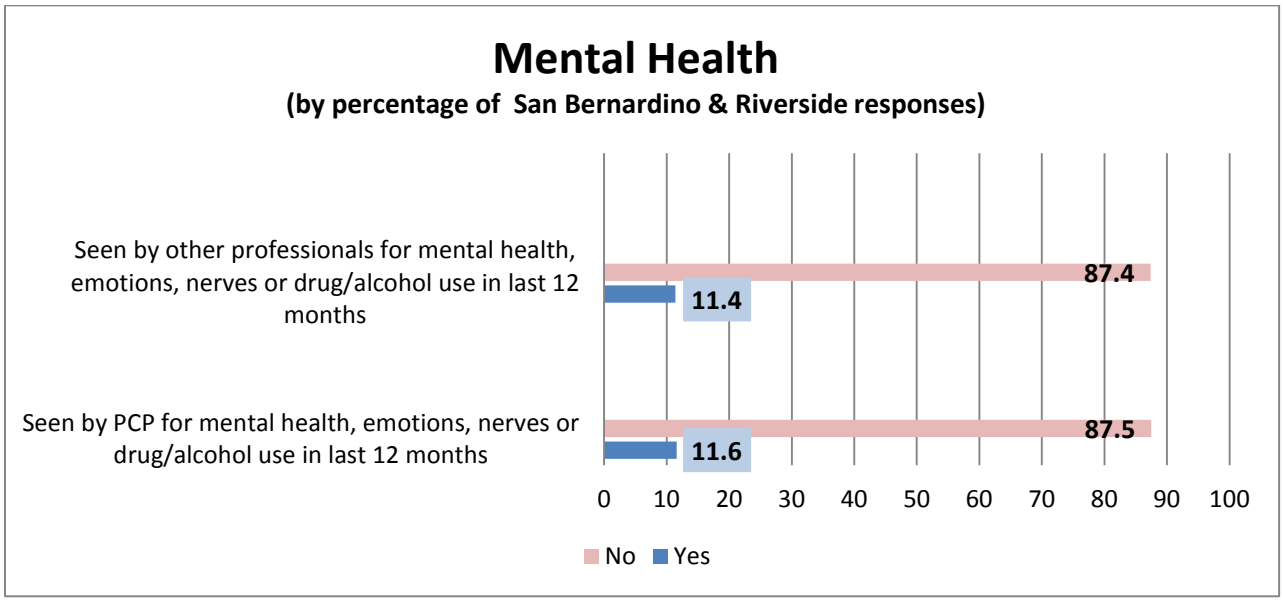
Chronic Conditions (Personal Health)

Over 70% of the individuals who participated in the survey rated their general health as good, very good, or excellent. Despite these responses, specific concerns emerged regarding health conditions including high blood pressure, heart disease, diabetes, asthma, and arthritis as shown in the chart below. Respondents indicated that their medical providers have asked about these conditions. In addition, there were community health educational events, health screenings, and school-based health educational programs offered several times throughout of the year to help target these specific conditions.



Mental Health

Of the total number of survey participants from San Bernardino and Riverside counties, 12% reported they had seen their primary care physician for issues pertaining to mental health including emotions, nerves, and use of alcohol or drugs. Nearly the same number of participants also reported they had seen a mental or behavioral health professional such as a counselor, psychiatrist, or social worker in the previous 12 months. Additionally, more than 25% stated they had felt hopeless or so depressed that nothing could cheer them up either some of the time, or a little of the time.



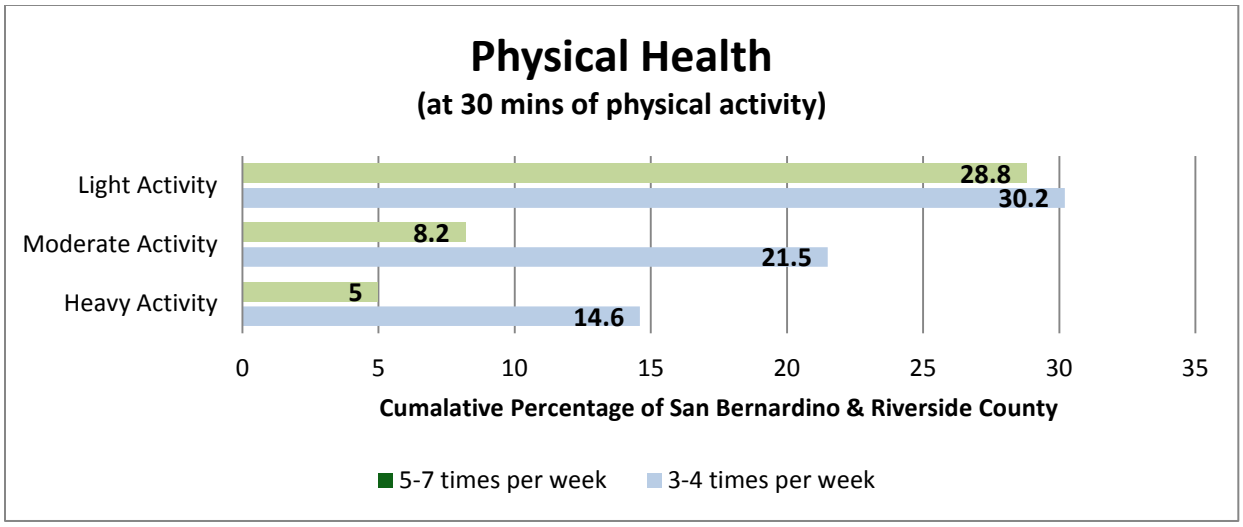
Substance Use

Survey participants were asked to enter the number of times per week they consumed alcoholic beverages or used tobacco products, including cigarettes, cigars, or vape. Among the respondents, 91% stated they do not smoke cigarettes. The majority of the participants do not drink alcoholic beverages. There were minimal responses that indicated high use of cigarettes or consumption of alcoholic beverages.

Prevention and Wellness (Physical Health)

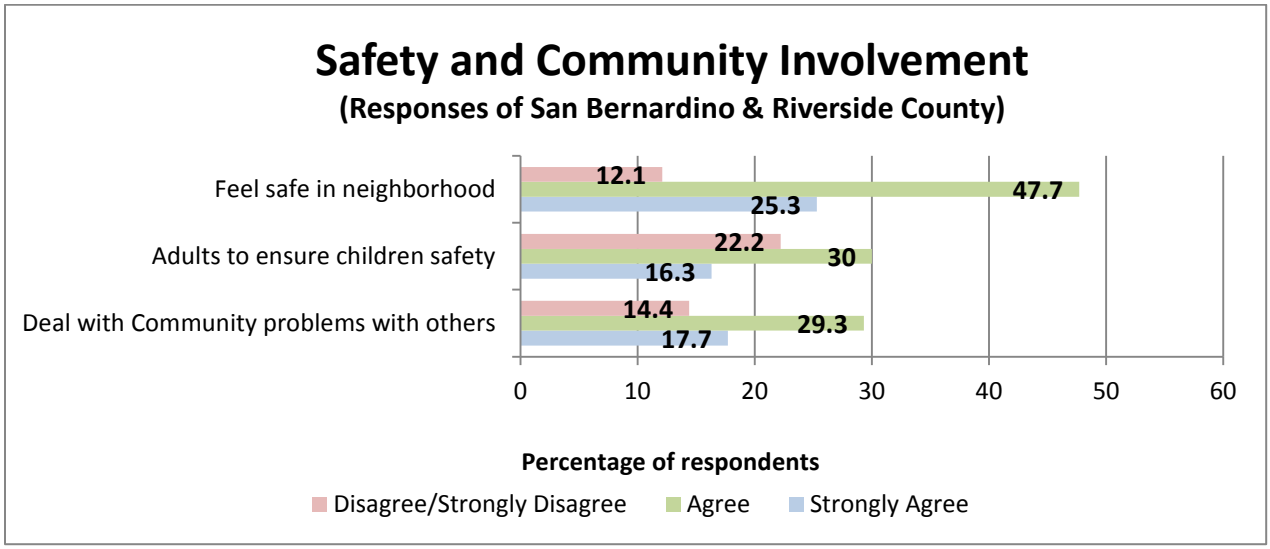
Optimal physical wellness is developed through a combination of physical activity and good nutrition. Remaining physically active improves quality of life by boosting mental wellness, lowering risk factors for cardiovascular disease, and boosting energy levels. The three levels of physical active are, light activities (walking, household chores, gardening, etc.), moderate activities (jogging, playing baseball, resistance training, etc.) and heavy activities (running, playing soccer/basketball, uphill biking, weight training,

etc.). Many of the survey participants (59%) reported spending 30 minutes doing light physical activity between 3-7 times per week. Only 20% reported spending 30 minutes doing heavy physical activity between 3-7 times weekly.



Healthy Environment (Safety)

The safety of the environment where one resides has an impact on his or her health. This survey included questions related to safety in the community and the level of community involvement. Many of the survey respondents (73%) agreed that they feel safe in their residential area. Within these communities, nearly half of the adults look out for the safety of the children. Moreover, nearly half of the participants feel at ease in addressing community issues with their neighbors.



Identified Health Needs

The following section outlines the key areas identified as major health concerns during the review, analysis, and consolidation of the assessment findings. This process included a thorough understanding of the qualitative data captured through primary research in the form of surveys and focus groups, as well as the analysis of quantitative data gathered by researching a variety of secondary data sources. Before embarking on the details of the identified priority areas, a brief overview of basic health indicators will set the stage for the more in-depth discussion to follow.

Based on findings from the California Department of Health Services, San Bernardino County fails to meet nearly all of the Healthy People 2020 national objectives for diseases seen in high incidence in the area as shown in the following table. The national objective refers to the Healthy People 2020 goals established by the U.S. Public Health Service. Unless otherwise shown, the rates presented below describe the number of age-adjusted deaths or cases from a particular cause per 100,000 residents.

Disease	Riverside	San Bernardino	California	Healthy People 2020 National Objective
All Cause Cancers	**152**	**164.7**	146.5	161.4
Cerebrovascular Disease (Stroke)	**33.1**	**39**	34.4	34.8
Chronic Lower Respiratory Disease	**43.2**	**54.9**	33.7	-
Colorectal Cancer	**14.5**	**16.6**	13.3	14.5
Coronary Heart Disease	**113.9**	**113.4**	96.6	103.4
Diabetes	**19.1**	**32.4**	20.4	-
Female Breast Cancer	**20.5**	**24.1**	20.3	20.7
Lung Cancer	**35.4**	**36.4**	31.7	45.5
Prostate Cancer	**19.7**	**24**	19.3	21.8
Substance Abuse	**14.2**	**10.3**	11.3	11.3

Source: 2016 County Health Status Profiles

Asthma and Other Respiratory Diseases (including Chronic Obstructive Pulmonary Disease)

The prevalence of respiratory problems experienced in San Bernardino County is approaching epidemic proportions, similar to cardiovascular disease, due to the area's high rates of smoking and air pollution. San Bernardino County ranks among the worst in the state in both of these factors that contribute to poor respiratory health among residents. In fact, the air quality ratings for San Bernardino County are among the worst

in the country. Poor air quality continues to be cited as a factor in the negative health effects of the area, particularly when considering the environmental impact on lung-related problems like asthma.

Along with asthma, other high risk conditions affected by air quality are: chronic bronchitis, emphysema, cardiovascular disease, and diabetes. Most people aren't aware that air quality affects those with cardiovascular disease and diabetes. The particle pollution is especially threatening to those with cardiovascular disease, as breathing it can potentially cause death and increase the risk of heart attacks and strokes. People with diabetes face a higher risk of cardiovascular disease which also puts them at risk.

There is higher prevalence of these diseases in populations living in poverty as this group has been shown to be at higher risk for developing respiratory diseases. According to data from the American Lung Association, individuals with lower incomes face greater risk from air pollution because they often live closer to sources of pollution, which includes major highways or factories. This population also is more likely have diseases that put them at higher risk.

Arthritis

An estimated 52 million people in America have been diagnosed with some form of arthritis, rheumatoid arthritis, lupus, gout, or fibromyalgia. The Arthritis Foundation reports that 1 in 5 adults and nearly 300,000 babies and children have arthritis or a rheumatic condition. Arthritis has become leading cause of disability in the United States causing significant employment and economic impacts in the nation. It has been reported that people with arthritis or a rheumatic condition miss more work days each year due to illness or injury than any other medical condition. In fact, one-third of workers diagnosed with arthritis have limitations in their ability to work, the type of work they can perform, or whether they are able to work full-time or part-time. Arthritis is among the most costly non-traumatic joint disorder among adults accounting for $156 billion annually in lost wages and medical expenses, 44 million outpatient visits, and more than 1 million hospitalizations across the United States.

Among adults diagnosed with arthritis, 47% have at least one other medical disorder or condition including heart disease (57%), diabetes (52%), hypertension (44%), and obesity (36%) and one-third have either anxiety or depression. Getting regular physical activity is a strategy that relieves pain and improves function for people living with arthritis; however, 38% of adults with arthritis report no leisure-time aerobic activity. Arthritis has a higher incidence rate in white non-Hispanic populations, however, minority populations including African-American, Asian-American, and Hispanic, experience greater severity of pain and more limitations from work and physical activity.

With more than 100 different types of arthritis and related conditions, each with their own risk factors, there is no sure way to prevent the disease. Lowering risk factors for developing arthritis includes maintaining healthy joints through modifiable risk factors

such as maintaining a healthy diet low in sugar, not smoking, minimizing alcohol consumption, and preventing injuries through proper safety equipment, proper training, and safe play.

Cancer

Cancer is the second leading cause of death in the United States. In San Bernardino County there are five primary types: breast, cervical, lung, prostate, and colorectal. Cancer is a major concern not only in this region, but in the nation as a whole; however, cancer incidence rates continue to decline in California and across the country. San Bernardino County has one of the highest age-adjusted death rates due to all cancers in the state. It ranks 40th out of California's 58 counties and is substantially higher than the state and national goals as shown in the following chart.

Obesity has also been linked as a contributing factor for many cancers. As obesity increases at an alarming rate, higher cancer incidence rates are expected in San Bernardino County. The hospital is being proactive in addressing issues that prevent or cause cancer. Prevention activities are designed to increase cancer awareness, help participants develop healthy habits through diet and exercise, and encourage regular screening and physicals.

Equipping the body with the best resistance is the most reliable safeguard against cancer of all types. The American Cancer Society recommends refraining from any tobacco use. Weight control, healthy dietary intake, and regular exercise are essential. Healthy eating habits: five or more servings of fruit or vegetables a day, whole grains as opposed to refined grains and sugars, and limiting red and processed meats. The optimal exercise level is defined as 30 minutes of exercise for adults and 60 minutes for children and teens on five or more days per week. Alcohol intake should be limited to no more than one drink per day for women and no more than two drinks per day for men. Communicating with one's physician regarding exams and screenings is essential to ensure early stage detection and treatment.

Breast Cancer

Breast cancer is defined as cancerous growths that develop in breast tissue, and like all cancers, occur as a result of abnormal changes in the genes that regulate the growth and health of cells. In the United States, breast cancer, while it does affect a small percentage of men, is most prevalent in women; however, the largest mortality rate from breast cancer is among Hispanic women. Approximately 40% of all hospitalizations due to breast cancer are among women at San Antonio Regional Hospital. Emphasis on regular screenings has increased early detection, effectively improving prognosis. In California, breast cancer mortality has declined by 30% because of these awareness efforts.

Colorectal Cancer

Colorectal cancer is cancerous growths that form in the tissue of the colon or the rectum. Of the cancers that affect both men and women alike, colorectal cancer is the second leading cause of cancer-related deaths in the United States, and one of the most commonly diagnosed. Risk factors associated with colorectal cancer include inflammatory bowel disorder (IBD), lack of physical activity, low consumption of fruits and vegetables, low fiber and high fat diets, increased alcohol consumption, tobacco use, and being overweight or obese. A family history of colorectal cancer or colorectal polyps and certain genetic syndromes increase the risk of developing colorectal cancer.

Lung Cancer

Lung cancer is the second most common cancer among men and women, and the leading cause of death in both men and women with 1 in 4 cancer deaths as a result of lung cancer. Tobacco use is the cause for 80% of all cases. The American Cancer Society estimates that there will be 18,140 new lung cancer cases in California in 2016. Abstaining from smoking and avoiding secondhand smoke is the best prevention against lung cancer. In California, lung cancer incidence rates have improved tremendously as a result of the state's tobacco control initiative.

The risk for smokers is much higher than that of non-smokers and the risk factor increases the longer one smokes or the more packs per day are smoked. Additionally, smoking cigars and pipes are almost as likely to cause lung cancer as cigarettes. "Light cigarettes, low-tar, and menthol cigarettes have shown to increase the risk even more since smokers tend to inhale more deeply. Second-hand smoke can also increase the risk of developing lung cancer and is thought to cause more than 7000 deaths from lung cancer per year. Other contributing risk factors include exposure to radon, asbestos, or other cancer-causing materials in the workplace. The risk of developing lung cancer can be lowered significantly by not smoking and through early detection screenings.

Prostate Cancer

Prostate cancer is the most common cancer among men, and the American Cancer Society estimates there will be 17,240 new cases of prostate cancer in California in 2016. Prostate cancer develops primarily in older men with 6 cases out of 10 in men aged 65 years of age or older. While prostate cancer can be a serious disease, most men that are diagnosed do not die from it. In fact, more than 2.9 million men in America that have been diagnosed with prostate cancer at some point in their lives are still alive today. Prostate cancer is rare in men younger than 40, however, the chance of developing the disease rises rapidly after the age of 50. Prostate cancer occurs more frequently in African-American men than in men of other races. African-American men are also twice more likely to die from the disease than are white men. Prostate cancer occurs less likely in Asian-American and Hispanic-American men than non-Hispanic men, however, the reason for these racial and ethnic variances are unknown. Men who have a family history of prostate cancer, particularly in a father or brother, double the risk factor of developing the disease.

Lifestyle choices that can lower risk factors of developing prostate cancer include diet, physical activity, and not smoking. Men who tend to eat a diet high in red meat or high-fat dairy products have a slightly higher chance of getting prostate cancer. There are also some correlations between obesity and more advanced or aggressive forms of prostate cancer. Minimizing consumption of red meat and high-fat dairy products, consuming more fruits and vegetables and lean meats combined with physical activity and weight control can have significant impacts on lowering risk factors of developing prostate cancer.

Cardiovascular Disease

San Bernardino County is brimming with cardiac disease cases and the resulting mortality rate is exorbitant and will be shown in the charts that follow. While numerous factors affect cardiac health, increasing awareness of the potential risk factors is the first step in improving cardiac health within the community. Cardiovascular disease (CVD) is an umbrella term that is used in generic reference to a number of diseases of the heart and blood vessels. As shown in the following chart, CVD is the nation's number one cause of death.

Cardiovascular disease, like most diseases, is a composite of uncontrollable and controllable risk factors. Some of the uncontrollable risk factors include age, gender, and genetics. Risk increases with age as blood vessels lose elasticity and durability, and certain families lack the enzymes necessary to digest cholesterol. Women are less likely to have cardiovascular disease than men before menopause, but risk increases significantly post-menopause. However, aside from these components, most risk factors are manageable. Smoking, diabetes, obesity, lack of exercise, high blood pressure and cholesterol, and excessive stress all negatively affect cardiac function. Healthy diet, frequent aerobic activity, regular health screenings, and an active avoidance of all tobacco-related products helps to mitigate these tractable risk factors.

Cerebrovascular Disease (Stroke)

Cerebrovascular disease, also known as stroke, is the leading cause of serious long-term disability in the United States and the third leading cause of death. Approximately 795,000 people in the United States suffer from stroke each year and more than 140,000 die from the disease. While three-quarters of all strokes occur in people 65 or older, the risk of stroke more than doubles after the age of 55. Stroke deaths have a higher incidence rate in African-Americans than in whites, at any age.

Up to 80% of strokes can be prevented through understanding and controlling existing medical conditions and adopting healthy behaviors. Diets high in saturated fats, trans fats, and cholesterol have been linked to stroke and heart disease, and high sodium can raise blood pressure levels. Increasing physical activity can lower risk factors of developing obesity, high blood pressure, high cholesterol, and diabetes, lowering the risk of stroke. Tobacco use also increases the risk of stroke by damaging the heart and

blood vessels. Additionally, nicotine from cigarettes raises blood pressure and the carbon monoxide in smoke displaces the amount of oxygen in blood. Making healthy lifestyle changes to eat a healthier diet, be physically active, and effectively control medical issues such as high blood pressure, high cholesterol, and diabetes can significantly lower risk factors associated with stroke.

Diabetes

Obesity and lack of physical activity are leading causes of diabetes, which has become an increasing health risk across the nation for both adults and children. Due to the high correlation between childhood and adult obesity, indicators of increased risk for diabetes begin with childhood obesity. However, there is a significant difference: people in their youth have a greater opportunity to decrease their risk factors and lessen the likelihood they will develop diabetes. A new study by the CDC reports that people with pre-diabetes who lose weight and increase their physical activity can prevent or delay type 2 diabetes and in some cases return their blood glucose levels to normal.[i]

The current nationwide high rates of pre-diagnosed diabetes show the major effect that health changes could have for this population and their future costs of care. The alarming current rates of pre-diabetes are 35% for those over the age of 20 and 50% for people age 65 and older. In terms of medical costs, this is an epidemic of major financial proportions with an estimated cost of $116 billion nationwide.[ii] This is especially concerning from the hospital care perspective because the hospitalization and emergency room visit rates due to diabetes are among the worst percentiles in the nation[iii]. Moreover, diabetes is a leading cause of other major health concerns including kidney failure, blindness, nervous system disease, limb amputations, hypertension, heart disease, and stroke. For these reasons, communities need to work together to fight the diabetes epidemic at the local level through awareness and prevention, treatment, and ongoing disease management.

Hypertension

Hypertension, also known as high blood pressure, is the measure of how much force is exerted on the blood vessels and arteries as blood passes through the body. Factors that contribute to the risk of developing hypertension include comorbidities from other health conditions, lifestyle, and family history. Normal blood pressure is recognized as being less 120/80 mmHg, while prehypertension is between 120/80 mmHg and 139/89 mmHg. Lifestyle changes that can prevent or control hypertension include eating a diet low in sodium, total and saturated fats, and cholesterol, and high in fruits and vegetables. Additionally, increasing physical activity, refraining from use of tobacco products and alcohol consumption, and controlling weight can improve blood pressure and lower the risks associated with comorbidities of hypertension.

Obesity

Obesity is defined as having an unhealthy proportion of body fat, and being overweight or obese increases the risk of type 2 diabetes, heart disease, hypertension, osteoarthritis, sleep apnea, respiratory disease, and certain types of cancer including breast, prostate, and colon cancers. Additionally, higher body weights increase the likelihood of developing complications from other illnesses or diseases. In clinical terms, being overweight means having a body mass index (BMI) of 25 to 29.9, and obese as having a BMI greater than 30. Generally speaking, a BMI of 30 is the same as being 30 pounds overweight and is seen at higher incidence within some minority groups, as well as those with lower household income and less education. The development of obesity is multifactorial that has roots in the environment and evidence has shown that causes involve the integration of social, behavioral, cultural, physiological, metabolic, and genetic factors.

Lifestyle changes have proven to show significant results in reducing weight and lowering the risk factors of developing comorbidities of obesity. Adopting healthier habits such as following a nutritious diet, increasing physical activity, and reducing the amount of time being inactive can help to control weight, improve mood, and increase energy levels. The surrounding built environment play a critical role in the health of communities and the spread of the obesity epidemic through the existence and availability of sidewalks and walking paths, safe streets, bicycle lanes, and green spaces and parks for recreational activity. Creating environments that are safe and accessible make it easier to engage in physical activity and consume healthy diets.

Behavioral Health

Behavioral health, for the purposes of this report, encompasses mental health and substance abuse, and the behavioral manifestations of those conditions.

Mental Health

Mental health itself has commonly been used interchangeably with mental illness; however, knowledge in the field has progressed to a level that differentiates the two. Mental health has been defined by the World Health Organization (WHO) as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” It is estimated that only 17% of adults in the United States are considered to be in an optimal state of mental health. Positive mental health is also associated with improved health outcomes. The U.S. Department of Health and Human Services has defined mental illness as “collectively all diagnosable mental disorders” and includes conditions that affect mood, thinking, and behavior associated with distress or impaired function. Depression is the most common form of mental illness, affecting more than 26% of adults in the United States and is estimated that by the year 2020, mental illness will be the second leading cause of disability throughout the world behind heart disease.

Evidence has shown that mental illnesses, particularly depressive disorders, are strongly correlated to many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity. Additionally, improvements in mental health from physical activity, not smoking, minimal consumption of alcohol, and adequate sleep have shown to lower risk factors for many chronic diseases. Another attribute of mental health is the discrediting stigma associated with the illness. Stigma surrounding mental illness separates the bearer apart from the rest of society, often presenting with perceptions of shame and isolation. Stigma often results in a delay in seeking care, causing needless suffering self-denial of symptoms, and refrain from daily activities. These effects can preclude access to appropriate medical care, housing, employment, and insurance, thus creating barriers to prevention efforts and effectively addressing the issue as a public health priority. This highlights the need to identify and connect to resources in the community, educate the public on how to accept and support persons with mental illness, and break down barriers to those seeking treatment for mental illness.

Substance Abuse

Abuse of tobacco, alcohol, and illicit drugs has significant economic impacts to the United States, costing more than $700 billion annually related to crime, lost worker productivity, and healthcare. In addition to health concerns, drug abuse and its related problems have deep social impacts within society. Causes of drug-induced deaths include dependent and non-dependent use of drugs and medically prescribed drugs. People struggling with addiction often engage in other self-destructive and criminal behavior, which often result in injury or death. Recreational use of drugs can, and often does, lead to unintentional overdose ad death. In San Bernardino County, the drug-induced death rate is 10.3, which has increased since 2013.

Substance abuse has major impacts on individuals, families, and communities with direct ties to teenage pregnancy, sexually transmitted diseases (STDs), domestic violence, child abuse, motor vehicle accidents, physical altercations, crime, homicide, and suicide. Adolescent abuse of prescription drugs have been trending upwards for the last several years, particularly in the use of prescription pain medications Vicodin and OxyContin. Reasons for the increase are attributed to the expanded availability of prescription drugs from various multiple sources, and the perception that prescription medications are safer than street drugs.

A comprehensive approach to behavioral health means including prevention an integral part of the continuum of care. The Behavioral Health Continuum of Care model, first introduced by an Institute of Medicine report, places promotion and prevention as the first two key components of developing strategies and interventions aimed at addressing problems associated with mental health and substance abuse. These strategies are anchored in addressing root causes of behaviors in the communities by creating environments that foster and inhibit healthy behaviors, limit opportunities for risky behaviors, and shift individual attitudes and community norms for sustainable change.

San Antonio Regional Hospital's Prioritized Health Needs

Prioritization is a key step in the community health improvement process and serves as the point of transition from identifying and analyzing the health needs of the community to developing strategies and initiatives to address the identified needs. The prioritization process brings together the hospital CHNA team alongside stakeholders from the community to determine health priorities. Including community representatives ensures the likelihood of making measurable impacts on health improvement outcomes and quality of life within the community. Throughout the process of gathering secondary data, facilitating focus groups, and conducting quality of life surveys, the following health needs emerged as priority areas of concern:

Health Conditions

- Arthritis
- Asthma
- Cancer
- COPD
- Diabetes
- Heart Disease
- Mental Illness
- Stroke

Health Risk Factors

- High Blood Pressure
- Obesity

Environment

- Insufficient access to healthy foods
- Limited options for physical activity
- Housing issues (affordability/unsafe conditions)
- Safe, secure community spaces

Social Determinants of Health

- Low educational attainment
- Low income
- High poverty rates

Unhealthy Behaviors

- Unhealthy eating habits
- Sedentary lifestyle
- Smoking
- Substance abuse

Healthcare Access

- Health insurance (inability to access; affordability)
- Physician/workforce shortages
- Preventative screening (inability/failure to access)
- Inadequate prenatal care

Using the foregoing master list of identified community needs, the CHNA research team was asked to score each need based on the following criteria:

- Size, severity, and importance of the need to the community
- Alignment with the hospital's mission, scope, and strategic plan
- Resources required and available to address the community need
- Hospital's ability to impact the community need

To determine the relative importance of each criterion, a weight was assigned to measure the health need from one (low priority) to three (high priority) and the scores were averaged. The following table illustrates the scoring instrument used to prioritize each need.

Priority Level	Importance	Alignment	Resources	Impact
High Priority - 3	High	Consistent with mission, scope, and two or more San Antonio strategies	No additional resources needed, or services are currently in place	Can provide a service likely to measurably improve the community's health status
Moderate Priority - 2	Moderate	Consistent with mission, scope, and one of the San Antonio strategies	Minimal resources needed to initiate new or extend a current service	Can provide a service likely to improve the community's health status; may involve collaboration with other community organizations
Low Priority - 1	Low	Outside hospital scope/ not addressed in San Antonio strategies	Requires significant new resources	Inability to measurably improve this need (may be outside hospital scope)

This prioritization process ranked the individual needs, but more importantly, common themes emerged around the identified health needs which revealed significant correlations to four general priority areas: 1) access to healthcare services, particularly in terms of barriers preventing access to appropriate levels of care; 2) health education and literacy, which drives prevention and wellness; 3) a significant number of health indicators depend upon chronic disease management initiatives; and 4) major controllable factors exist within the physical environment that support healthy communities. These categories are described in detail below.

Access to Healthcare

Access to Healthcare encompasses the pressing need to collaborate with community organizations and governmental agencies to improve accessibility for individuals who are uninsured or underinsured and lack the ability to acquire routine medical care. Factors contributing to this significantly unmet need in San Antonio's community include the region's low educational attainment, which leads to lower wages and higher unemployment; a high blue collar work force with limited access to affordable employer-sponsored health insurance plans; and limited to non-existent options for disenfranchised segments of the population, particularly families with one or more undocumented members. A primary goal would be to enhance the community's economic stability by creating a pipeline that would serve as a platform for low-skilled or under-educated workers to overcome barriers preventing them from entering the labor force. Creative solutions are necessary to develop and implement programs that target those who are currently slipping or projected to slip through the cracks of the diminishing healthcare safety net, as the result of increasing local, state, and federal financial pressures and the associated reductions in health and human services programs.

Prevention and Wellness

Prevention and wellness hinges upon active promotion of health education. Knowledge of personal health status through screenings and health fairs empowers the community to take a more direct role in managing and improving their own health and well-being. Health literacy is a component of wellness promotion and concentrates on the community's expressed concern regarding the inability to understand and navigate the health system to access services and information. A further extending and more expansive approach to health education is needed to increase the general population's awareness of prevention and wellness, in addition to the health benefits of behavioral and lifestyle changes. Advocating these concepts will garner support for a healthy environment, improve the overall health status of residents, and address significant controllable factors contributing to chronic diseases.

Chronic Disease Management

The chronic disease management category represents a significant area of need to effectively manage existing conditions and diseases such as cancer, diabetes, asthma,

and cardiovascular disease. A number of health indicators, such as obesity, high blood pressure, high cholesterol, inadequate or inappropriate nutrition, and physical inactivity, have revealed critical ongoing health risks that will continue to exacerbate the high incidence of chronic diseases and their associated mortality rates. Case management and follow-up care will allow individuals with chronic diseases to access routine health status checks and self-management classes to prevent further progression of co-morbidities. Raising awareness of these factors and the correlated risks they represent, as well as providing education on appropriate management techniques for those suffering from a chronic disease, will improve health outcomes for people in San Antonio Regional Hospital's community.

Diabetes and high blood pressure were among the most prevalent health problems in these communities. More health education for parents and children about disease management, treatment, and the importance of medication adherence is needed to help individuals control their health status and to prevent progression of their illness. However, behavior change on an individual basis is not sufficient. Concerted efforts are also needed to enhance knowledge about available resources and screenings, improve access to healthcare providers and services, and increase affordability of medications so that people are able to properly monitor, manage, and promote their own wellness.

Healthy Environment

Finally, creating a healthy environment addresses the need to encourage and support healthy communities by improving the overall health status of residents and addressing the major controllable factors contributing to chronic diseases. Improving the physical environment of the community includes ensuring access to safe water and clean air, healthy workplaces, safe houses and neighborhoods, and complete streets and sidewalks. Partnering with local cities, governmental agencies, community-based organizations, and public health departments to affect change in the environment can have a positive influence on the health of our communities. San Antonio Regional Hospital is an active member of the Healthy Cities collaborations and seeks to increase its partnership with primary and secondary service area cities by introducing opportunities to bring the exceptional services provided at the hospital into community settings. This is evident in the HELP program, which engages community members in advocating for healthier lifestyles for their children, their families, and their community.

2014 - 2016 Implementation Plan
Status and Evaluation of Impact

San Antonio Regional Hospital has responded to the health needs of the surrounding communities for over 100 years, expanding its scope over the years from traditional hospital care to developing broader community benefit programming to address the needs of the vulnerable populations it serves.

Following the completion of the 2013 Community Health Needs Assessment, San Antonio Regional Hospital developed an Implementation Plan to design and implement community benefit programs that addressed the identified needs of the community. This process included developing goals, objectives, and initiatives using the primary and secondary data collected during the CHNA as the framework to identify opportunities, realize potential challenges, provide insight into established programming, and create community partnerships for addressing the health priorities.

The 2014-2016 Implementation Plan focused on community members noted to be most at risk due to existing or impending health conditions, often compounded by one or more social determinants of health, that were likely to result in adverse health outcomes. From 2014 through 2016, hospital staff continued to engage partners and leverage resources to implement the identified strategies and develop measurable outcomes.

The programs and initiatives from the 2014-2016 Implementation Plan were organized into categories recommended by the Catholic Health Association (CHA) in their A Guide for Planning & Reporting Community Benefit. Below is a description of each program or activity, the current state of the initiative, as well as the realized impact of major strategies implemented or expanded in the 2014-2016 Implementation Plan to further delineate the positive impact the hospital's strategies are having on the community.

Community Health Education

Survive and Thrive

The *Survive and Thrive* program was a strategy to address the need identified from the 2013 CHNA for increased cancer programming for patients and their families. The program was intended to be a support group network led by cancer survivors focusing on recovery and survivorship by providing support and resources for cancer patients and their families. San Antonio explored the development of a cancer support program that would enable cancer survivors to facilitate support groups and programs for cancer patients, their caretakers, and other cancer survivors by identifying the number of survivor-led programs and the number of program participants. It was determined that the success of the program requires the appointment of a cancer survivor to serve as

the “champion” to engage volunteers and program participants. This key individual is yet to be identified.

Seniors Helping Seniors

Seniors Helping Seniors is a peer-to-peer health education and social support program based on a train-the-trainer model using lay health educators. Through focus groups and key informant interviews, it was identified that seniors in the community were faced with limited access to transportation; however, local senior centers, where transportation was readily available, are a natural place for seniors to congregate and an ideal location to expand the *Generations Ahead* program as a prelude to developing the *Seniors Helping Seniors* program. San Antonio explored the feasibility of expanding its senior outreach program to local senior centers to include identifying possible sites, developing education and support programs led by *Generations Ahead* members, and increasing *Generations Ahead* membership. The hospital will continue to expand its partnerships with area senior centers through the *Generations Ahead* program.

Communication Plan

The 2014 CHNA findings indicated that some members of the community were unaware of the services available to assist them their health. The hospital planned to address this need by developing a communication plan to promote current health services available to community members to raise awareness of the hospital’s existing community benefit program and to enhance community access to important health services. Additionally, by enhancing consumer awareness of available resources, the hospital would be better equipped to assist patients navigate the healthcare system and increase access to healthcare providers. Following the CHNA in 2013, the hospital developed an informal communication plan to guide community benefit and marketing staff on promoting programs, initiatives, and services internally, and to the greater community to improve and expand access to community benefit and health services.

Grant Opportunities

Accessing healthcare services was a consistent theme mentioned throughout the 2013 CHNA. To increase access to healthcare services, the hospital committed to leveraging grant funding to expand current community benefit offerings or develop new initiatives with an overarching aim of improving health and reducing risk factors associated with chronic diseases and illnesses. San Antonio began identified potential grants and other funding sources to support health and wellness and disease prevention and management activities for vulnerable populations. Grants were applied for and awarded from Susan G. Komen and Avon to support the Women Caring for Women program and to support the San Antonio Women’s Breast and Imaging Center’s Nurse Navigator position. Additionally, the BUILD Health Challenge was a grant opportunity that San

Antonio became involved with in 2015 in partnership with the City of Ontario and Partners for Better Health that ultimately supported the expansion of the Know Your Numbers program aimed at obesity reduction and prevention in Ontario.

Bilingual Educational Materials

Several focus group participants in the 2013 CHNA process revealed that the hospital is viewed as the primary source of health information within the community and identified a lack of health education materials available in the Spanish language. The hospital understood that providing materials in other languages at community events would increase health literacy and understanding of health issues. Beginning in 2014, a number of bilingual materials were produced and distributed at health screenings and events. Additionally, bilingual staff and volunteers began to and continue to supported health screenings and community outreach events.

Self-Help Programs

Generations Ahead Stepping Out Program

Survey respondents in 2013 indicated the most important resources that aided in a healthy lifestyle were activities or amenities that encourage physical activity. Efforts to improve the built environment would have positive effects on many existing chronic conditions and would empower community members to manage their own health, the health of their families, and the health of the community as a whole. The hospital began to explore the built spaces in the surrounding communities and discovered that only a few of the cities in the hospital's service area have dedicated hiking, biking, and walking trails. Some residents voiced concerns regarding their personal safety on streets in the neighborhoods where they live, work, grow, and play.

Cancer Fit for Life

The Cancer Fit for Life is an exercise program for cancer survivors that were identified based on data showing a five-year survival rate of 68% for all cancers that were diagnosed from 1999-2005. Exercise was identified as an important healing method to reduce the side effects of treatment while improving the quality of life for patients. The hospital, in coordination with the Women's Breast and Imaging Center Nurse Navigator, explored the expansion of San Antonio's Cancer Resource Center exercise program to alleviate symptoms, improve functional capacity, and restore muscle function for cancer patients. Several community gyms and fitness instructors were approached, however, there was little interest expressed in the program and the decision was made to postpone the implementation to a future date.

Community Fit for Life

With the unprecedented obesity rates in San Bernardino County identified in the 2013 CHNA, especially among children, focus group participants suggested exercise programs at the hospital or opportunities to participate in recreational programming in their cities as a means to address the obesity epidemic, increase physical activity, and improve overall health. San Antonio, alongside the hospital's facilities and engineering department, and Healthy Cities' partners explored the development of a community exercise program using the hospital walking path to encourage physical activity for the family unit. Implementation, originally planned to launch in 2015, has been postponed due to construction delays with the hospital's new Emergency Department and Patient Tower. Following completion of all construction activity on the hospital campus, plans to complete the walking path will continue.

Community-Based Healthcare Services

Community Health Improvement Program

The escalating number of patients with chronic conditions and the implementation of the Affordable Care Act are two principal reasons San Antonio developed and implemented the Community Health Improvement Program (CHIP). The Centers for Disease Control has reported that as a nation, 86% of our healthcare dollars goes to treatment of chronic diseases. To address these persistent conditions and the associated burgeoning healthcare costs, The Affordable Care Act, among other things, encourages the development of new approaches, such as the formation of "medical homes" and "accountable care organizations" (ACOs), in the belief that they will improve healthcare quality and slow the growth of healthcare spending in America.

The Community Health Improvement Program is one of the initiatives San Antonio Regional Hospital developed to: 1) diminish healthcare gaps, 2) promote the delivery of evidence-based care, and 3) reduce unnecessary emergency room visits and hospitalizations. Coordinated by a dedicated interdisciplinary healthcare team employing a series of individualized continuous care algorithms, this program focuses on appropriate patient identification, prevention, evidence-based disease management, and exemplary treatment of individuals with chronic conditions.

Each participating CHIP member is closely monitored in accordance with an individualized Comprehensive Health Profile (CHP), Quality Care Plan (QCP), and longitudinal patient scorecard. A novel stratification scale that assesses socioeconomic status, education/assimilation capacity, mental health history, adherence potential, psychological stress factors, and support is utilized along with data mining and standardized clinical assessments to individualize evidence-based clinical strategies based upon each person's respective needs and capabilities.

A unique aspect of CHIP is the training and utilization of student health coaches. In addition to the CHIP interdisciplinary clinical team, members are monitored by health coaches trained through an innovative credit based collaborative educational seminar and internship program with California State University San Bernardino (Schools of Public Health, Nursing, Biology, and Kinesiology) and Western University of Health Sciences, College of Graduate Nursing. After appropriate screening, selected students participate in a seminar taught by our interdisciplinary team of healthcare professionals including physicians, nurses, nutritionists, social workers, and hospital administrators. The work of the student health coaches is overseen by licensed professionals (RN and MD) as needed and their scope of activities are consistent with their competence and the training and demonstrated skills provided through the program.

Once trained, Student Health Coaches are assigned to provide in-home visits and phone interactions. Students engage in the process of educating and motivating at-risk members to take an active and meaningful role in their health and well-being. The primary objectives of the health coach are to foster meaningful interactions for boosting cooperation and adherence, while helping to resolve non-medical issues that impede effective risk factor management and patient care.

In 2015, CHIP successfully recruited 31 student health coaches, of which 10 students left the program before the end of the year to pursue employment opportunities or enroll in medical school. These health coaches cared for a total of 44 patients in 2015, which increased significantly from 7 patients in 2014.

Know Your Numbers

San Antonio, in collaboration with Loma Linda University Masters of Public Health students, initiated the Know Your Numbers (KYN) program in Ontario, California with the goal of reducing chronic disease incidence in the poor, uninsured, and underinsured populations through screening and education. KYN is a free screening program which provides blood pressure, body mass index, blood glucose, and blood cholesterol checks among the low-income population living in surrounding communities.

The KYN program is a health education and self-management program that is designed around the health belief model that assumes that health-related actions depend on whether participants believe they are susceptible to significant health issues and following a prescribed health recommendation would either reduce, or eliminate further risk. Participants consult with a registered nurse (RN) following the screening to learn about their own numbers and what impacts they have on their health. Following the consultation, participants are connected with additional resources through referrals, educational materials, and community programs to aid in improving their health.

The initial screening program included 50 participants, of which 72% were Hispanic, 22% were uninsured, 48% did not have a primary care physician, and 36% had never visited a hospital. Thirty four percent of the participants had high blood pressure and 20% displayed numbers indicative of a hypertensive crisis. Fifty percent of the participants were clinically obese and 34% were overweight as indicated by their BMI metrics.

Due to the success of the initial pilot program, KYN was expanded under the BUILD (Bold, Upstream, Innovative, Local, Data-driven) Health Challenge grant opportunity in collaboration with Partners for Better Health (PBH), the City of Ontario-Healthy Ontario Initiative (HOI), San Bernardino County Department of Public Health (SBCoDPH), and the Ontario-Montclair School District (OMSD). The BUILD Ontario collaborative is anchored in a health hub model, with screening sites located conveniently in and around the Healthy Eating and Active Living (HEAL) zone of Ontario. The current initiative has attracted 304 participants from the community, of which 45% are uninsured, 59% have no medical home, 60% have a combined household income of less than $20,000, and 55% are unemployed. Additionally, participants are referred to additional health and social services, receive preventative education and support resources, and are connected with Clinical Community Health Workers (CCHW) that provides personalized one-on-one case management services.

HELP Expansion 12+

CHNA participants recognized that there were numerous programs available for younger children, but health education is vital as a child continues to age. While the HELP program has improved health within families, many feel that older children are missing out on important health information that can affect the health of the overall family. With the goal of improving the health and wellbeing for all people that live, work, grow, and play within the hospital's community, San Antonio explored the expansion of the HELP program to older children by integrating the "Body Works" curriculum with HELP as a means to increase participation for children 12 and older. In 2015, with the assistance of a Randall Lewis Health Policy Fellow, San Antonio developed and delivered the new expanded curriculum to 17 local high school students. With the coordination and partnership of the Upland Unified School District, the high school HELP instructors implemented the six-week HELP program to local middle school students as a part of the physical education course. In 2016, the expanded HELP program has become incorporated into elective curriculum at Upland High School and will be taught to 108 high school students.

Healthcare Support Services

Spanish Community Presentations

Throughout the 2013 CHNA process, participants noted language barriers as a challenge in accessing or understanding health information. There are not enough opportunities to increase their knowledge or health because of the limited number of presentations or workshops offered in their primary language (Spanish). In 2014, San Antonio explored the feasibility of offering community education programs in Spanish, however, due to low participation and limited resources, further development was discontinued.

Community Building Activities

Community Garden

Access to healthy food was mentioned frequently throughout the CHNA process in 2013. Many participants acknowledged farmer's markets and community gardens as sources for healthy foods. A community garden would address concerns regarding access to healthy food while enriching the neighborhood by bringing community members together in a healthy learning environment. In 2014, San Antonio prepared a feasibility study to develop a community garden as a method to increase healthy food options, engage community members, and promote wellness. After extensive community canvasing, no suitable land area with adequate resources could be identified to serve as a community garden asset. Interest from the hospital to plant a community garden still exists and plans have been postponed upon the identification of appropriate land area and resources.

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A special thank you for the input from community members, hospital executives and staff on the front lines of the healthcare system, and the public health officers who shared their perspectives. Their voices and endorsement of greater coordination are important as the community reflects upon, reforms, and renews the commitment to meeting the region's healthcare needs.

Hospital Association of Southern California

The Hospital Association of Southern California (HASC), working in partnership with the California Hospital Association (CHA), provides leadership at the local, state, and federal levels on legislation, budget concerns, and regulatory issues. Their mission is to lead, represent, and serve hospitals, and to work collaboratively with other stakeholders to enhance community health.

Consultants Involved and Qualifications

In January 2016, the Hospital Association of Southern California (HASC) contracted with Scientific Technologies Corporation (STC) to complete the first regional Community Health Needs Assessment (CHNA) for several of its member hospitals representing the greater Inland Empire including San Bernardino and Riverside Counties. STC has worked with public health agencies around the world to provide technology and data to empower consumers, healthcare providers, and public health professionals with appropriate information and decision support to improve the health of the communities they serve. STC and HASC worked in strong collaboration with both San Bernardino and Riverside Counties Departments of Public Health.

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