LOMA LINDA UNIVERSITY
HEALTH

Relevant & Responsive to Our Community

Community Health Needs Assessment – 2019

LOMA LINDA UNIVERSITY MEDICAL CENTER
LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL
LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER
LOMA LINDA UNIVERSITY MEDICAL CENTER – MURRIETA

COMMUNITY Health Needs Assessment 2019

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For additional information on previous Community Benefit Reports and assessments, please contact our office or visit: http://medical-center.lomalindahealth.org/about-us/community-benefit

At Loma Linda University Health (LLUH), our commitment to caring for the mind, body, and spirit is part of everything we do. We're combining our educational, clinical care, and research arms to fulfill our institutional mission: to further the teaching and healing ministry of Jesus Christ to make man whole. With our community partners, we are strengthening our impact on the health and wellness of people in our region because everyone deserves the chance to enjoy a longer, healthier life. LLUH is dedicated to promoting wholeness and our Community Benefit investments are designed to address the community needs and priorities that will increase health. At LLUH, our focus on health priorities and the social determinants of health ensures our system is meeting the needs of our community as we invest in the health of tomorrow.

Our Community Benefit Objectives include implementing the 2019 Community Health Needs Assessment (CHNA) to update and inform the priority areas for the 2020-2022 Community Health Implementation Strategy (CHIS) cycle on behalf of LLUH's four licensed hospitals. The priorities of the 2016 community health needs assessment were: workforce development, education, obesity, diabetes, and mental health.

To continue the teaching and healing ministry of Jesus Christ

Past & Present - Loma Linda's Skyline, with construction of the new hospital

To Our Community Members & Community Partners,

Loma Linda University Health has been honored to serve the people of the Inland Empire for over a century as we became one of the most trusted primary health care providers and the leading specialty care providers in the Inland Empire. When LLUH began with the Sanitarium on a hill in the early 1900s, we joined a valley with rich cultural heritage as we began caring for people who had inhabited this land for generations: the many indigenous peoples from the Serrano and Cahuilla Native American tribes and the peoples of Latin American, European, African, Asian, and Middle Eastern descent. In acknowledgement to the people who built the economy, culture, and agricultural and industrial resources of this region, LLUH is grateful that today, in 2019, we serve and work alongside the people of San Bernardino and Riverside Counties.

We are proud to present the 2019 Community Health Needs Assessment in partnership with our community partners who helped us accomplish this effort. This assessment reflects a community-first approach: LLUH and our community partners talked to over 200 people and surveyed over 1,100 people in an extensive community-based assessment. While we gained a greater understanding of the challenges people face in our region, the hope and resiliency people shared with us is overwhelmingly encouraging: the rich fabric of diversity and lived experiences in our communities are a resounding strength.

It has been LLUH's privilege to listen to and understand the voice of people from the far reaches of our region. People shared with us that they want good paying jobs and their children to have access to a good education. They want to work hard and they want to help their communities become safer, more beautiful, healthier, and more connected. In unison, the community told us: People need health and they want more community. The message of this assessment is clear: we only become healthier if we work together, in community.

As LLUH's continues to fulfill the teaching and healing ministry of Jesus Christ to make man whole, we are not only building the health system of tomorrow for our community, we are partnering with resilient, hopeful community members and partners to ensure our region thrives.

Richard Hart, MD, DrP H
President
Loma Linda University Health

Kerry Heinrich, JD
Chief Executive Officer
Loma Linda University Medical Center

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www.SBCounty.gov

SAN BERNARDINO COUNTY

Public Health
Administration

Trudy Raymundo
Director

Corwin Porter
Assistant Director

Maxwell Ohikhuare, M.D.
Health Officer

June 13, 2019

Dear Community Members,

On behalf of The San Bernardino County Department of Public Health, we would like to acknowledge Loma Linda University Health's Institute for Community Partners on the extensive community-based surveying done for the 2019 Community Health Needs Assessment. The Department of Public Health congratulates LLUH and their community-based organizational partners for working in collaboration with so many community partners to listen to the health concerns, perspectives, and hope of over 1100 people from San Bernardino and Riverside Counties.

LLUH's primary goal for their assessment was to capture the perspectives of people from communities experiencing the most vulnerability. As we know is a trend across California, vulnerable populations of people come from lower income households and are often over-represented by people of color. These communities can be harder to access when health survey efforts are based on traditional methods of telephone or email surveying.

As The Department of Public Health learned about LLUH's assessment methods, we wish to acknowledge the effective approach the health system took with El Sol Neighborhood Education Center, FIND Food Bank of the Coachella Valley, and Congregations Organized for Prophetic Engagement (COPE), to survey a statistically valid population through person-to-person survey collection based on the skills of dedicated community outreach and health workers. We would also like to acknowledge the health system for conducting focus groups through community partners with over 200 people. Building trust with our communities is one of the most important aspects of the work we do. To build trust by listening is the only way forward and we acknowledge LLUH's extensive effort to listen and share their findings with their multi-sector partners. Findings from this effort will be critical as we join LLUH and other partners in developing implementation strategies that will improve the health and wellbeing of our region.

As LLUH is one of the County's many health system partners in the Community Vital Signs effort, we are working together on the County-wide vision for "healthy people in vibrant communities."

Sincerely,

Trudy Raymundo
Director
San Bernardino County
Department of Public Health

Dr. Maxwell Ohikhuare, M.D.
Health Officer
San Bernardino County
Department of Public Health

Loma Linda University Health
Licensed Hospitals

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Loma Linda University Medical Center - East Campus
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Loma Linda University Surgical Hospital
26780 Barton Rd,
Redlands, CA 92373
Phone # (909) 558-4000

Medical Center, East Campus and Surgical Hospital License # 95-3522679

Compassion | Integrity | Excellence | Teamwork | Wholeness

Loma Linda University
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Children's Hospital License # 46-3214504

Loma Linda University
Behavioral Medicine Center
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Medical Center – Murrieta License # 37-1705906

LOMA LINDA UNIVERSITY HEALTH

Institute for Community Partnerships

Mission

To ensure that Loma Linda University Health is relevant and responsive to the community.

Vision

To be the primary portal for community engagement between Loma Linda University Health and our local community.

Values

Collaboration, Respect, Equity, Compassion, and Excellence

The Institute for Community Partnerships is committed to supporting community-based research and service-learning at Loma Linda University Health (LLUH). For more than 100 years, LLUH has introduced innovative solutions aimed at improving the health and well-being of the communities we serve. Our institute is committed to strategically working with our community partners to better understand and address the needs of the community through activities such as research, teaching, and service-based learning. Community participation is at the core of our efforts, with structured learning opportunities for underrepresented minority students, training programs for community health workers, and community research projects. The Institute for Community Partnerships:

- Seeks to work "with" the community rather than "in" the community.
- Strives to better understand and address the needs of the community, while recognizing and capitalizing on its assets.
- Seeks to integrate services from research to teaching through community-based participation and service-based learning.
- Provides a supporting and coordinating role across the various schools and the Medical Center.

Our Community Benefit Objectives include:

- Improving access to health services.
- Enhancing the role of public health in health care services.
- Serving those who live in poverty or other vulnerable populations.
- Promoting and enhancing community building activities.
- Committing to community health improvement throughout the organization.

2017-2019 Community Health Implementation Strategy Priorities:

- Workforce Development, Education (*Social Determinant Priorities*)
- Mental Health, Diabetes, Obesity (*Health Priorities*)

LLUH wishes to acknowledge the following Community Partners in the 2019 CHNA:

SAC Health System (SACHS) is a non-profit community health care corporation serving the Inland Empire and a regional partner of LLUH in the care of vulnerable populations. The SACHS clinics provide affordable health care services for all, and primarily serve uninsured patients and their families. SAC Health System Leadership and LLUH work closely together in collaboration as federally qualified health center and academic health system in primary and specialty care services. In 2018, the SAC Health System had 120,695 total patient visits and LLUH had over 1.6 million outpatient visits. Together the two systems are committed to health care and service to all people, especially the underserved people of our region.

The LLUH Institute for Community Partnerships wishes to thank the following community-based organizational partners and over 10 community health and outreach workers for the completion of **1,060** surveys in the 2019 CHNA:

LLUH ICP wishes to thank the following community partners for their support in conducting focus groups for the 2019 CHNA with over **200** community members and in our ongoing community conversations to come:

CEO San Bernardino

Consulado de Mexico en San Bernardino

Community Health Systems, Inc.

Faith Advisory Council for Community Transformation

Huerta del Valle

Institute for Community Partnerships – Community Benefit Administrative Council

Loma Linda Spanish Church of Seventh-day Adventists

Loma Linda University Medical Center – Murrieta, Community Advisory Council

Loma Linda University Medical Center – Murrieta, Pediatric Advisory Council

Loma Linda University Medical Center – PossAbilities, Just for Seniors, & Sickle Cell Support Group

Loma Linda University Health – San Manuel Gateway College

La Escuelita

San Bernardino County Youth Advisory Board

San Bernardino County Superintendent of Schools

San Bernardino City Unified School District

Sanctuary of Our Lady of Guadalupe (Mecca)

Torres Martinez Desert Cahuilla Indians

Youth Hope Foundation

For a complete list of ICP Partners, see Acknowledgements

WE LIVE TO SERVE

Report Contents

Executive Summary

The 2019 Community Health Needs Assessment is about our community. It is a time capture of the strengths, resiliencies, and needs of the communities served by Loma Linda University Health. To better understand the community, the assessment was built on a community-first approach, with a total of 1,339 people from the surrounding Inland Empire participating in surveys and community conversations (focus groups).

Over and over again, the difficulties people face day-to-day in affording the essentials and in experiencing poverty were echoed as people shared the difficulties with cost of living in our region. The top social determinants of health identified were: **jobs**, **food security**, **safe green spaces**, **affordable housing**, and **access to health care**. The top health needs identified were: **behavioral health**, **asthma**, **diabetes**, and other **lifestyle-related conditions**. The most unanticipated need identified by the assessment was the prevalence of a feeling of **isolation**: 1 in 3 people shared feeling isolated.

Although the intent of a CHNA is to identify needs, the methodology of this assessment was a needs and asset-based approach to community assessment. The resiliency of the people who live and work in the Inland Empire is at the core of the assets identified. Resiliency is also the backbone to the needs the community expressed. In the many encouraging community conversations, people told us again and again that they want more community and that they were aware they needed to increase the health of our community. There was a strong sense of hope for the future. **The resounding message of the 2019 assessment is that we truly are healthier when we are together in community.**

Transforming lives through education, health care and research

About the Community We Serve

About the Community We Serve

Loma Linda University Health's primary service area can be defined, broadly, as California's San Bernardino, Riverside, and Ontario metropolitan areas. San Bernardino and Riverside counties make up the geographic area historically named "the Inland Empire" due to the region's rich diversity of native peoples and agricultural history. That identity is becoming more inclusive of the greater "Inland Region" of California as the Central and Coachella Valley's share geographic, cultural, economic, and agricultural characteristics with the Inland Empire. Situated approximately 60 miles east from the Los Angeles metropolitan area and the Pacific Ocean, the Inland Empire is home to over 4.5 million people and is the 3rd most populous metropolitan area in the State of California and the 13th most populous metropolitan area in the United States.

San Bernardino County 2.157 Million
Riverside County 2.423 Million
4.85 Million People in Region

Population Demographics

The geographic landmass of both San Bernardino and Riverside Counties total over 27,000 square miles. The two-county region has grown steadily over the last two decades with America's largest county-to-county population shift occurring between LA County and San Bernardino and Riverside Counties for the years 2007 – 2011. While the region has a mix of densely populated urban areas, almost 5% of the population of both counties is rural. The two counties are home to some of the most diverse people in California: Hispanic populations now represent the majority of the population with the region being slightly higher than the state average for people below age 18. While the population growth was experienced some of the highest rates in the nation over the past decade, a report by the United States Conference of Mayors found that this trend will continue: the Riverside-San Bernardino-Ontario metro area is expected to grow from 4.5 million to 7.2 million people in the next 30 years, making it one of the top 10 largest metro areas by 2046.

Demographics	San Bernardino County	Riverside County	State of California
Population	2,157,404	2,423,266	39,536,653
% Below 18 Years of Age	26.50%	25.40%	22.90%
% 65 and Older	11.30%	14.10%	13.90%
% Non-Hispanic African American	8.20%	6.10%	5.60%
% American Indian and Alaskan Native	2.10%	1.90%	1.60%
% Asian	7.60%	7.00%	15.20%
% Native Hawaiian/Other Pacific Islander	0.50%	0.40%	0.50%
% Hispanic	53.40%	49.10%	39.10%
% Non-Hispanic White	28.60%	35.40%	37.20%
% Not proficient in English	8%	8%	10%
% Females	50.20%	50.20%	50.30%
% Rural	4.70%	4.60%	5.00%

Data Source: County Health Rankings and Census Bureau's Population Estimates Program (PEP) - 2017

Socioeconomic Factors

At the 2019 California Economic Summit, California Governor Gavin Newsom announced the "Regions Rise Together" initiative designed to recognize the economic disparity in California. Governor Newsom stated that the "Inland parts of the state have not participated in the economic recovery to the extent the coastal areas have."[1] At the summit, leaders from the state pledged to not allow geography to limit people's opportunity to earn a livable wage and work predictable hours.

Access to livable wage jobs and predictable hours is by far one of the most important socioeconomic factors for people living in the two-county region, especially those in San Bernardino. The socioeconomic status of the region's people provide an important context to the social determinants health identified by community health assessments, as poverty remains one of the root cause factors for people in both counties.

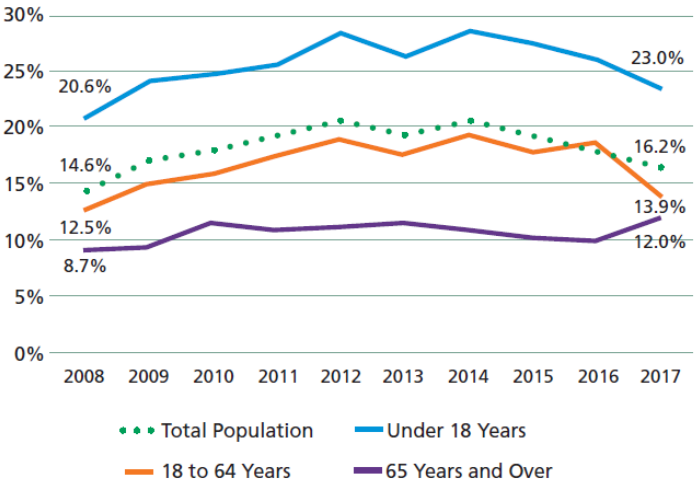
Poverty

While unemployment is trending down, not everyone has fully recovered from the Great Recession of 2008. One of the most revealing indicators of the economic health of the people living in the two-counties is the percentage of people living in poverty since the Great Recession of 2008. The California Budget & Policy Center[2] found that the two-counties in the Inland Empire have higher rates of poverty in 2017 than they had pre-recession in 2008, based on the official poverty measure that looks at people living on extremely low incomes compared to their family size. The study also identified that while the State-average for poverty rates declined overall, for many counties those rates are worse than the pre-recession rates. Riverside and San Bernardino Counties had around 11-12% poverty rate in 2007, which translates to roughly 1 in every 9-10 people. By 2015, San Bernardino County's poverty rate increased to almost 1 in every 5 people. For both counties combined, this resulted in an estimated 787,800 people living in poverty. According to the most recent county indicators, for San Bernardino County, where the poverty rates are higher, there have been gains in reducing poverty three years in a row since 2015: however, the overall rate remains higher than national averages and is still higher than 10 years ago for all age groups.[3] Those most impacted populations by poverty are youth at 23%, though this number is trending down, and seniors, the only group that have trended negatively as the poverty level has increased to 12.0% of people living in poverty.

2017 Income Thresholds for Poverty Determination

For an individual, the annual income to be considered in poverty is less than $12,140. For two people with no children, the poverty threshold is an annual income of $16,460.

Percentage of Population Living in Poverty, by Age
San Bernardino County, 2008-2017



Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates (http://factfinder2.census.gov)

Housing

[1] California Forward, "Governor Newsom to spotlight inland regional economic plan at 2019 California Economic Summit," May 2019: https://cafwd.org/reporting/entry/governor-newsom-to-spotlight-inland-regional-economic-plan-at-2019-california

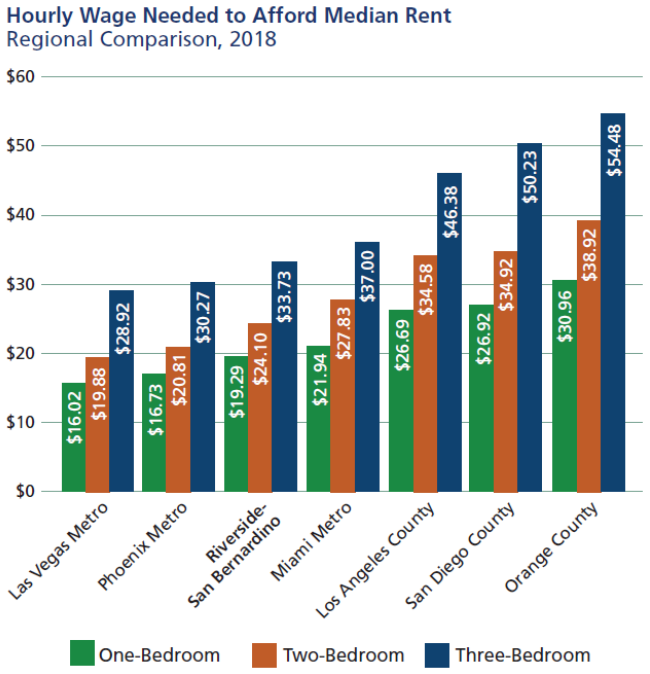
California's Official Poverty Rate Declined in 2015, but Millions of People Are Still Not Sharing in Our Recent Economic Gains. Work, Income & Poverty · September 2016 · By Alissa Anderson

[3] County Indicators Report, 2017: p. 29

According to *The Press Enterprise* report in 2018, the low housing prices are one of the main attractions for migration and population growth in the Southern California region and in particular Riverside County and San Bernardino County. As per the report, "Riverside County alone added almost 37,000 new residents – the third-biggest population growth of any county in the nation. San Bernardino County added another 20,000 new residents, coming in at number18 from 2016 to 2017." In an *LA Times* April 2019 report, the median home price was $720,000 in Orange County and $597,500 in Los Angles vs. median price of $389,500 and $336,000 in Riverside County and San Bernardino County respectively. Housing and housing affordability are generally more favorable indicators in the region when compared to State averages in California and the United States averages. Population increase is an important indicator for demand on housing availability. The issue of affordability is relative to income: while housing is more affordable for the middle-income families compared to the coastal regions, it still remains a complication for families who live at or below the federal poverty line.

Spotlight on San Bernardino – Poverty and Housing Affordability

While housing prices in San Bernardino and Riverside metro areas are seen as more affordable comparatively, the County reports that rents have increased 5% in one year from 2017 - 2018: "The minimum qualifying income needed to purchase a median-priced, entry-level single-family home ($236,720) in San Bernardino County was approximately $37,300 as of the first quarter of 2018.[4]" The average monthly rent indicators compare more favorably in San Bernardino and Riverside compared to other counties in California, "the hourly wage needed to afford a median-priced one bedroom apartment was $19.29 in 2018, compared to $18.40 in 2017.[5] This housing wage is equivalent to an annual income of $40,120." It is important to note that the poverty income thresholds are far lower than the incomes required to buy or rent a house, meaning when the price of housing or renting is considered in the region, a household needs a minimum of $37,000-$40,000 annual earnings in order to achieve housing affordability within their income. Even for people at the bottom of the housing ownership threshold of $37,000, that income translates to $17.78 an hour, which is under the average earnings needed to rent in the region. Even with favorable indicators on affordability compared to other counties in California or like-sized counties in the nation, for a significant number of households, housing affordability is a problem. As reported by the County Indicators Report in 2017, over 40,000 households were waiting for rental assistance vouchers and demand is 16 times higher than the supply. In addition to the group of people living at the edges of housing affordability in our region, there is an increase in the rise in homelessness. As reported by *The San Bernardino Sun* in April 2019, "For the second straight year, a San Bernardino County study revealed a growing homeless population in the region" with an increase of 23% based on the Point-in-Time Count. For Riverside the Point-in-Time Count increased by 21% during the same time period. As affordable housing is a problem, homelessness is on the rise in both counties.

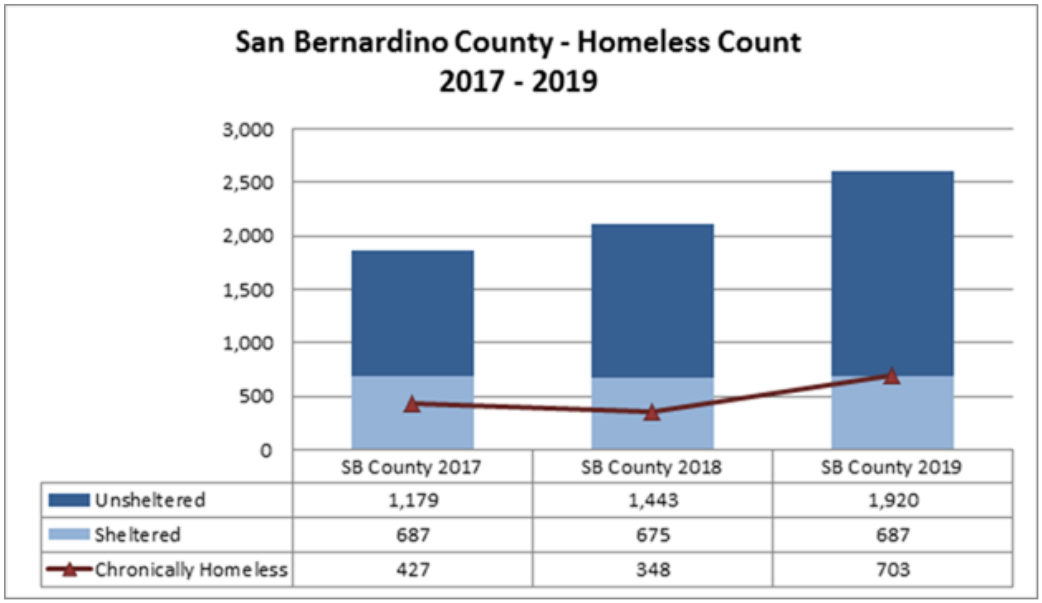


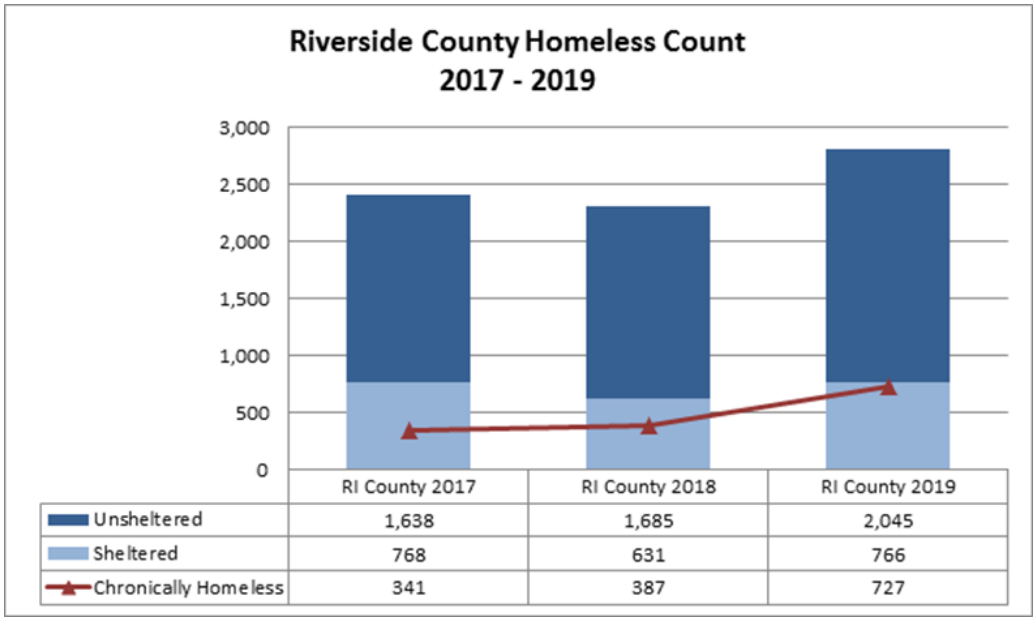
Source: Analysis of Housing and Urban Development 2018 Fair Markets Rents (www.huduser.org/portal/datasets/fmr.html) using the methodology of the National Low Income Housing Coalition (http://nlihc.org/oor)

[4] The San Bernardino *Community Indicators Report* (2017), 34.
[5] The San Bernardino *Community Indicators Report* (2017), 35.

San Bernardino County and Riverside County Homeless Point-in-Time Count[6]

Homeless Count	SB County			RI County		
	2017	2018	2019	2017	2018	2019
All Homeless Person	1,866	2,118	2,607	2,406	2,316	2,811
Sheltered	687	675	687	768	631	766
Unsheltered	1,179	1,443	1,920	1,638	1,685	2,045
Chronically Homeless	427	348	703	341	387	727





[6] SB County Source/ Full Report: http://wp.sbcounty.gov/dbh/sbchp/wp-content/uploads/sites/2/2018/04/SBC-2018-Homeless-Count-Final-Report.pdf & RI County Source/Full Report: http://dpss.co.riverside.ca.us/files/pdf/homeless/2018-rivco-pit-report-revised-6-6-18.pdf

Health Indicators

In order to assess the health of a region that represents over 4.5 million people, some macro indicators available from the extensive resources in the region contextualize the health indicators of the people living in this two-county region:

1. The degree of need experienced by people, as defined by the Community Need Index;
2. The rankings of the people here compared to other counties in California, as defined by the County Health Rankings;
3. The health indicators, as defined by multiple sources such as county health rankings, quality of life scores, health care resources available to populations, and other indicators.

Community Needs Index

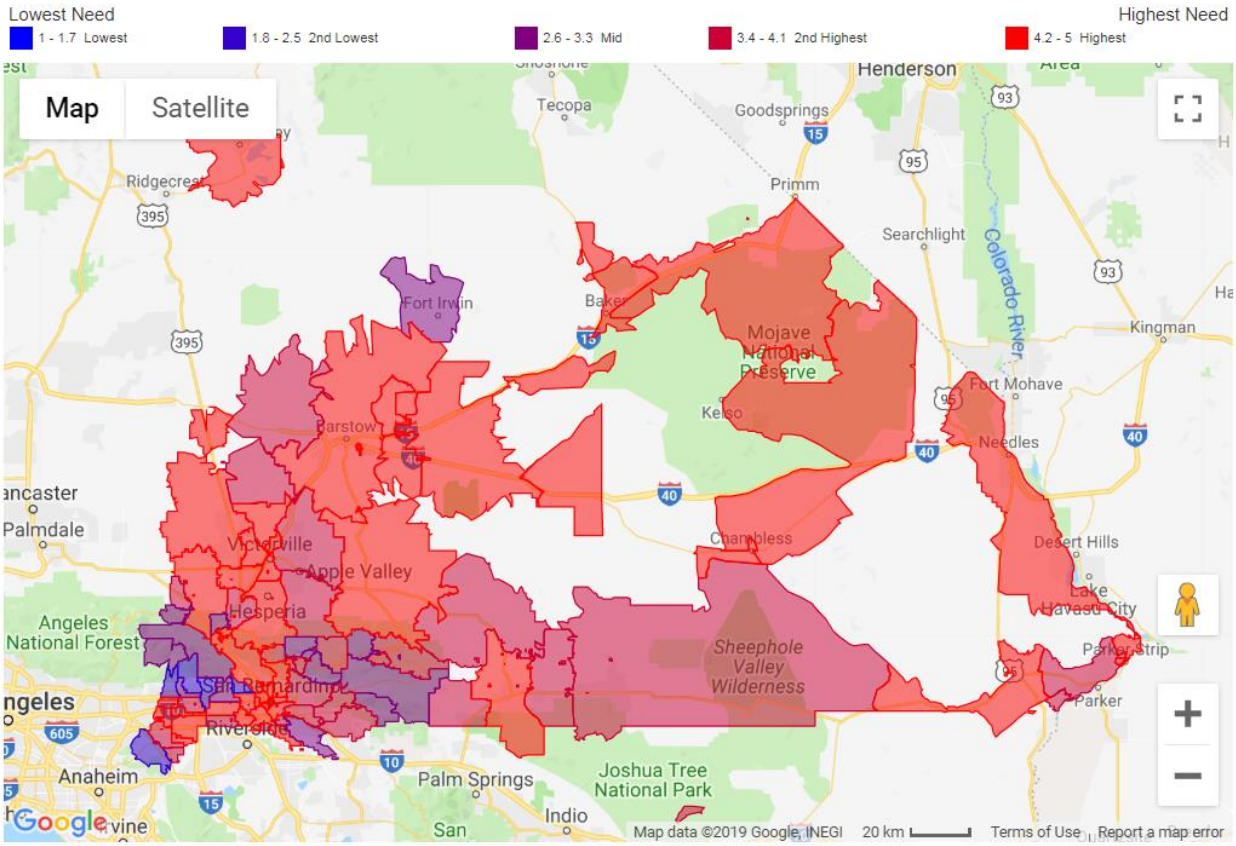
In 2004 Dignity Health and Truven Health jointly developed a Community Needs Index (CNI) to assist in the process of gathering vital socio-economic factors in the community. Based on the wide array of demographic and economic statistics, the CNI provides a score for every populated Zip Code in the United States on a scale of 1.0 (least need) to 5.0 (most need). The five barriers associated with the needs index scoring are listed below:

1. Income Barrier
    a. Percentage of households below poverty line, with head of household age 65 or more
    b. Percentage of families with children under 18 below poverty line
    c. Percentage of single female-headed families with children under 18 below poverty line
2. Cultural Barriers (*related to language or citizenship barriers*)
    a. Percentage of population that is minority (including Hispanic ethnicity): *While ethnicity is linked to cultural barriers in research, it is important to note that the association is often due to language barriers and documentation status, not the "culture" of being Hispanic.*
    b. Percentage of population over age 5 that speaks English poorly or not at all
3. Education Barrier
    a. Percentage of population over 25 without a high school diploma
4. Insurance Barrier
    a. Percentage of population in the labor force, aged 16 or more, without employment
    b. Percentage of population without health insurance
5. Housing Barrier
    a. Percentage of households renting their home

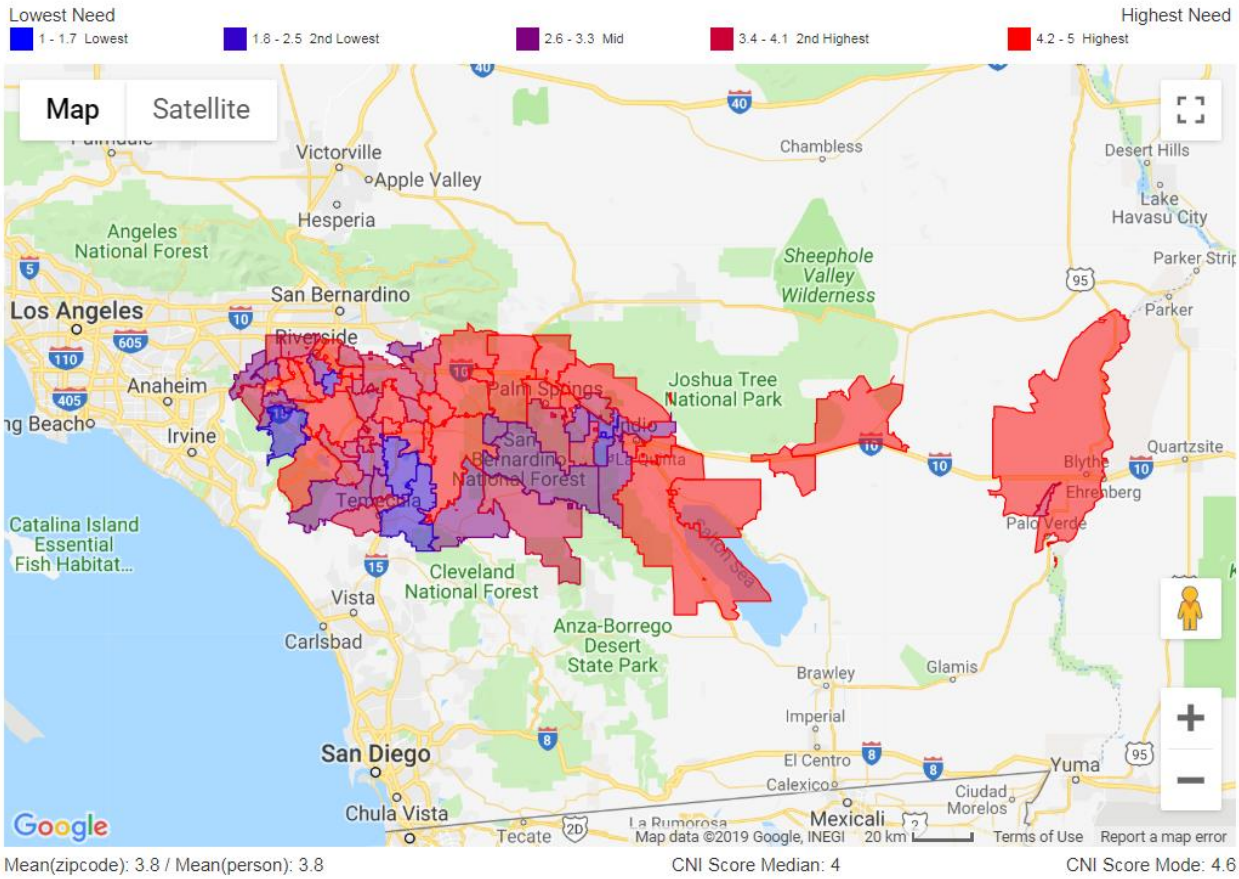
In addition to scoring the needs of community, the maps also list community resources like Schools, Parks, Hospitals, Higher Education, Community Centers, Shelters, Farmers Markets, Imaging Centers, Urgent Care Centers, Community Clinics, Primary Care Providers, Grocery Stores, and Mobile Health and Dental Clinics Stops. Based on the CNI score, San Bernardino County's average score is 4, with areas like Adelanto, Victorville, San Bernardino city, Needles, Hesperia, and Barstow with higher need scores than some other areas. Similarly, the Riverside County's average CNI score is 3.8. Areas like Mecca, Indio, Desert Hot Springs, Hemet, and Riverside city had higher need scores compared to other areas of the county.

"We need more gardens, all types, with flowers and plants. **Gardens** are freedom." - Community Member

San Bernardino County[7]



Riverside County



[7] Source: http://cni.chw-interactive.org/

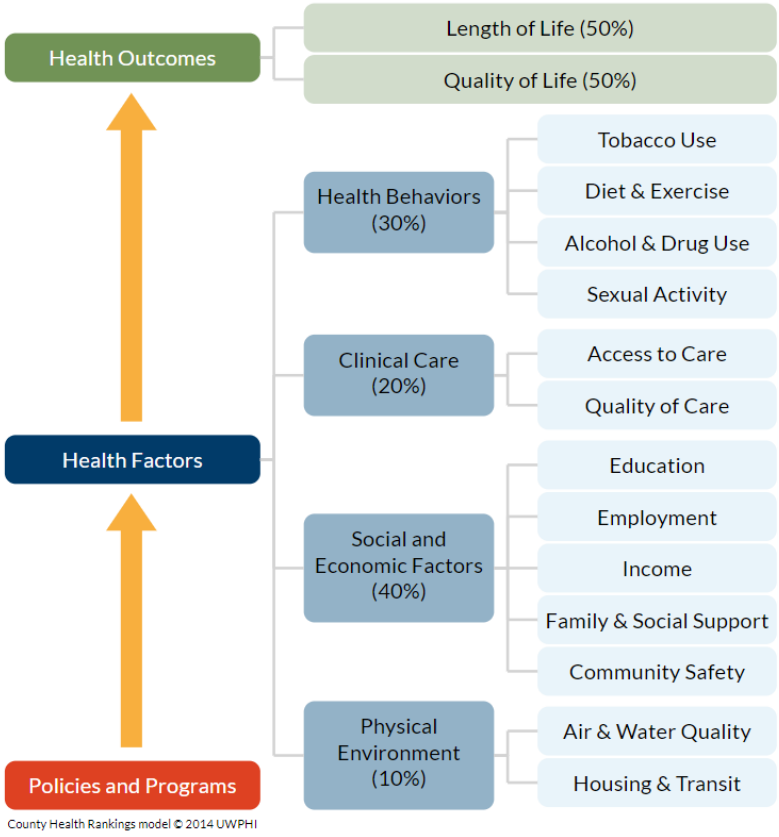
County Health Ranking (Total 58 Counties in California)	San Bernardino County					Riverside County				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Health Outcomes	**37**	**42**	**46**	**41**	**38**	**24**	**29**	**28**	**25**	**26**
Length of Life	30	32	32	33	33	23	24	23	22	24
Quality of Life	50	49	52	51	51	38	42	41	33	32
Health Factors	**47**	**47**	**45**	**44**	**47**	**39**	**39**	**40**	**39**	**35**
Health Behaviors	44	41	39	37	35	32	33	34	31	30
Clinical Care	52	52	50	50	56	48	47	47	44	47
Social and Economic Factors	36	41	34	34	32	29	32	28	26	23
Physical Environment	53	57	55	55	55	49	56	56	56	54

Source: Countyhealthrankings.org

County Health Rankings

The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).

Residents of San Bernardino rank 38 out of 58 counties for health outcomes (an improvement over the previous three years). Riverside residents rank 26 of 58 counties. For Health Factors, or the things that may negatively impact health in future, San Bernardino residents score 47 of 58, with Riverside at 35 of 58. While residents in both counties have been improving their overall health outcomes, the longer term impact of the healthcare infrastructure and social determinants of health on communities' members is more likely to decrease health without intentional efforts to improve these impacts on health.



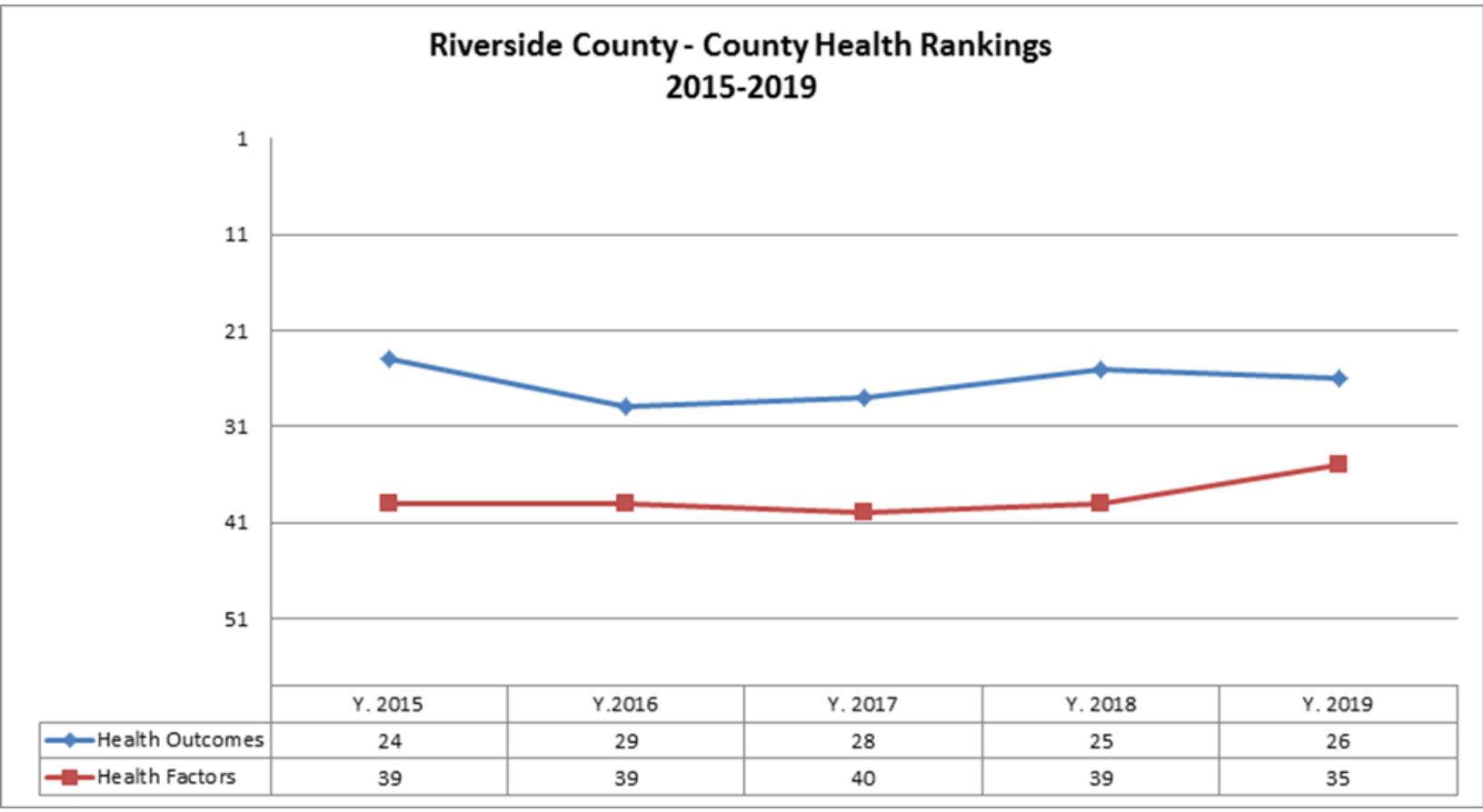
Health Outcomes represent how healthy a county is right now. They reflect the physical and mental well-being of residents within a community through measures representing not only the length of life but quality of life as well. Health Outcomes are influenced by the many factors that influence health, from the quality of medical care received to the availability of good jobs, clean water, and affordable housing. These health factors are influenced by programs and policies in place at the local, state, and federal

levels. In Health Outcomes area the County Health Rankings look at:

- Length of Life: measuring premature death and life expectancy
- Quality of Life: measuring low birth weight and those who rated their physical or mental health as poor

Health factors represent those things we can modify to improve the length and quality of life for residents. They are predictors of how healthy our communities can be in the future. The multiple health factors that affect our health can be divided into four major Health Factors:

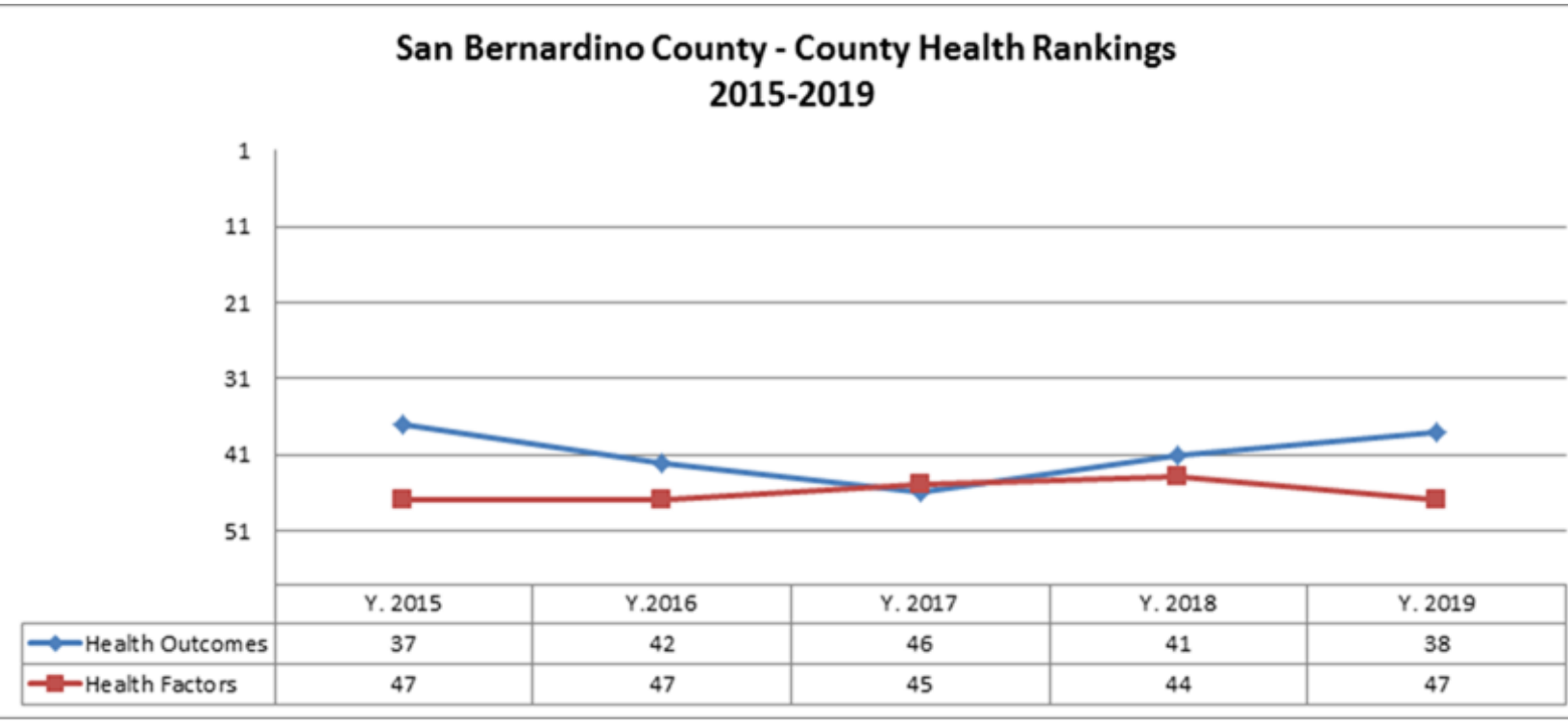
- Health Behaviors: providing rates of alcohol and drug use, diet and exercise, sexual activity, and tobacco use.
- Clinical Care: showing the details of access to and quality of health care.
- Social and Economic Factors: rating education, employment, income, family and social support, and community safety.
- Physical Environment: measuring air and water quality as well as housing and transit.



	Y. 2015	Y.2016	Y. 2017	Y. 2018	Y. 2019
Health Outcomes	24	29	28	25	26
Health Factors	39	39	40	39	35

Joy in our community is our strength. Although we may not have as much as others or we may struggle, it doesn't deter the joy.

-Community Member



Overall Riverside County fares better than San Bernardino County on Health Outcomes and Health Factors. Both San Bernardino County and Riverside County rated low on the Quality of Life, Clinical Care, and Physical Environment. The counties also had challenges addressing some of the social and economic factors that impedes health and well-being. Both counties had a higher number of premature deaths when accounting for 'Length of Life'. Additionally, the markers for 'Health Behaviors' such as adult obesity, physical inactivity, sexually transmitted infections, food insecurity, limited access to healthy foods, and higher rate of deaths due to motor vehicle crashes continue to remain areas of not only concern, but opportunity.

While the County Health Rankings provide a comparative overview of how the two counties perform to California's populations, both San Bernardino and Riverside Counties have improved their high school graduation rates and have undertaken many county-based initiatives to improve the rate of graduation in higher education. The counties are also focused on investing in the local workforce and creating competitive job opportunities for the residents of the community. Job opportunity is one of the most promising indicators as the region ranked well below state averages and now ranks above the state average. Children living in poverty, children eligible for free or reduced price lunch, disconnected youth (% of teens and young adults ages 16-19 who are neither working nor in school), and social associations continue to be a major concern for the community. Significant policy changes at state and federal levels will be required to address the key issue of how to help and protect the growth and development of future generations.

From the social and economic factors monitored by the County Health Rankings, the number of **children in poverty, violent crime, and disconnected youth** are troubling indicators for **San Bernardino County** due to above-average rankings compared to the state.

For **Riverside County**, the indicators are slightly more positive when compared to San Bernardino and the State averages. **Black and white residential segregation and unemployment** are priority areas that are problematic indicators for Riverside, when compared to state averages.

Social & Economic Factors	San Bernardino County	Riverside County	Top U.S. Performers	California
High school graduation	83%	89%	96%	83%
Some college	55%	55%	73%	64%
Unemployment	4.90%	5.20%	2.90%	4.80%
Children in poverty	23%	16%	11%	18%
Income inequality	4.6	4.7	3.7	5.3
Children in single-parent households	36%	30%	20%	31%
Social associations	4.4	4.1	21.9	5.8
Violent crime	442	291	63	421
Injury deaths	45	52	57	49
Disconnected youth	11%	9%	4%	7%
Median household income	$60,300.00	$63,800.00	$67,100	$71,800
Children eligible for free or reduced price lunch	70%	63%	32%	58%
Residential segregation - black/white	35	41	23	56
Residential segregation - non-white/white	30	30	15	38
Homicides	6	4	2	5
Firearm fatalities	9	8	7	8

Data Source: County Health Rankings 2019

Quality of Life & Access to Health Care

The community members in both counties reported greater number of poor physical and mental health days, when compared to the state of California and top national performing counties. Greater number of residents of the two counties also reported poor or fair health compared to other regions around the nation. The delay in proper clinical care and guidance may also be due to fewer primary care physicians, specialists, and other medical practitioners, like physician's assistants and nurse assistants, available to the residents of San Bernardino and Riverside County.

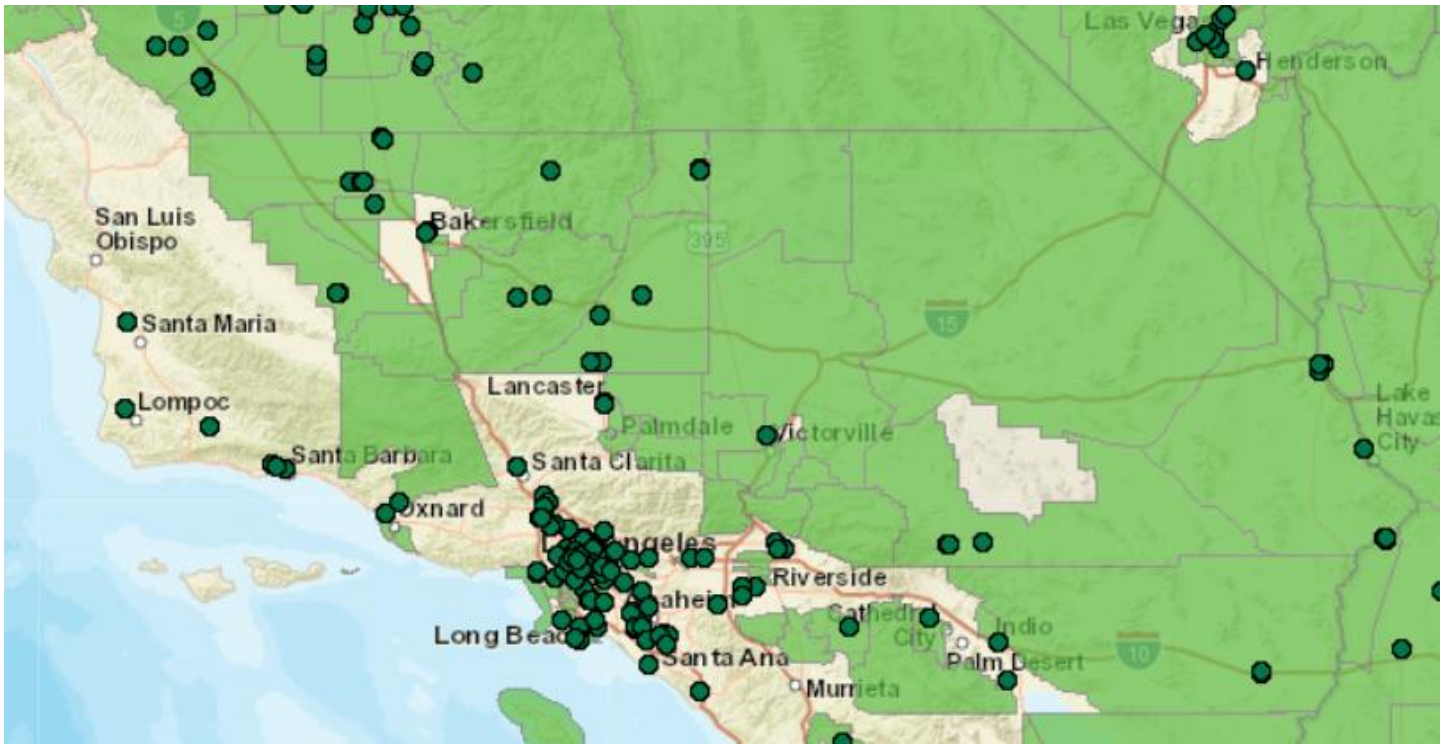
Quality of Life	San Bernardino County	Riverside County	California	Top U.S. Performers
Poor or fair health	20%	19%	18%	12%
Poor physical health days	4.1	3.8	3.5	3
Poor mental health days	3.9	3.6	3.5	3.1
Low birth weight	7%	7%	7%	6%

Data Source: County Health Rankings 2019

According to the Health Resources and Services Administration, almost all of San Bernardino's urban and rural and Riverside's rural areas fall into national professional shortage areas, meaning there are too few primary care, dental, and mental health providers based on the needs of the populations. When the ratio of health providers to population density are compared, the maps become more telling: most of San Bernardino's mountain and desert areas have a shortage of providers, while all of Riverside's desert regions lack enough primary care, dental, and mental health providers based on the populations living in those regions. Access to health care resources is not only a socioeconomic issue for many residents in the region, it is sometimes a geographic barrier that involves anywhere from 45 – 100 miles of driving.

Map of Health Professional Shortage Areas[8]

Regions in green represent shortage areas where people are required to drive 45+ miles for care.



Map of Medically Underserved Areas/Populations [9]

The areas in purple represent the region of the county with provider shortages by population density.

[8] Data.hrsa.gov
[9] Data.hrsa.gov

Clinical Care	San Bernardino County	Riverside County	California	Top U.S. Performers
Uninsured	9%	10%	8%	6%
Primary care physicians	1,750:1	2,390:1	1,270:1	1,050:1
Dentists	1,440:1	1,980:1	1,200:1	1,260:1
Mental health providers	480:1	530:1	310:1	310:1
Preventable hospital stays	4,519	3,175	3,507	2,765
Mammography screening	30%	35%	36%	49%
Flu vaccinations	30%	36%	40%	52%

Data Source: County Health Rankings 2019

The Clinical Care provider-to-patient ratio is a health factor that assesses both access and the quality of care that is available to the residents of the community. Both San Bernardino County and Riverside County have a higher rate of uninsured compared to the state and top nation performer. Access to physician, dentist, and mental health professionals continue to remain a challenge for the community members of the Inland Empire. San Bernardino County in particular, had a higher rate of preventable hospital stays, further burdening the health care system.

Community Vital Signs

Community Vital Signs is a community health improvement framework jointly developed by San Bernardino County residents, public and private sector organizations, and government. It builds upon the Countywide Vision by setting evidence-based goals and priorities for action that encompass policy, education, environment, and systems change in addition to quality, affordable, and accessible health care and prevention services. It provides the basis for aligning and leveraging resources and efforts by diverse agencies, organizations, and institutions to empower the community to make healthy choices.

One of the greatest assets in the region is the county-wide vision in implementation in San Bernardino County and the unified effort to align priorities based on four major areas. Based on the published plan, the following social determinants of health and health trends are identified in the table.

The **Social Determinant focus areas are:** education, workforce development, poverty & income, crime, and homelessness.

The **health focus areas are**: access to care, behavioral health services, alcohol and drug services, lifestyle diseases, and physical activity.

Community Vital Signs of San Bernardino County[10]			
Macro Goals based on the 2015-2020 Plan			
Education	**Economy**	**Access to Health & Wellness**	**Safety**
Increase high school **graduation** rate Increase % of students who are proficient readers by 3rd grade Increase % of adults (25+) who have a **Bachelor's** degree or higher Increase % of adults who enter or complete **college**, and/or **workforce training** with 21st century skills	Decrease % of individuals living in **poverty** Decrease the % of **children** (<18 years) living in **poverty** Increase Industry **Employment** Sector Decrease the number of **homeless** individuals Decrease the percentage of residents who spend more than 30% of their **income** on housing	Increase % of residents who have a **usual source of care** Increase the percentage of residents with **health insurance** coverage Decrease the % of residents who delayed or did not get medical care in the past year Decrease the % of 7th graders who reporting feeling sad and hopeless Increase the rate of residents accessing **behavioral health services** under the Department of Behavioral Health, safety net systems, Medi-Cal managed care (IEHP, Molina) and commercial insurance Decrease the percentage of youth (21 and under) who misused **alcohol and other drugs** in the past year Decrease the % of the adult population ever diagnosed with **diabetes and high blood pressure** Decrease the hospitalization rate for **cardiovascular** disease Decrease the percentage of **obese** adults Decrease the percentage of teens age 12-17 that are **overweight/obese** Increase the percentage of teens (12-17) who meet the CDC recommendation of 1 hour or more daily **physical activity** Increase the amount of bike trails (Class 1, 2, and 3)	Decrease the **crime rate** per capita (per 10,000) Decrease the number of gang members Increase positive relationships between residents and police/fire departments Decrease juvenile crime rate Increase the percentage of 9th grade students who reported feeling safe or very **safe at school**

[10] San Bernardino County: Community Transformation Plan, 2015-2020 (June 2015).

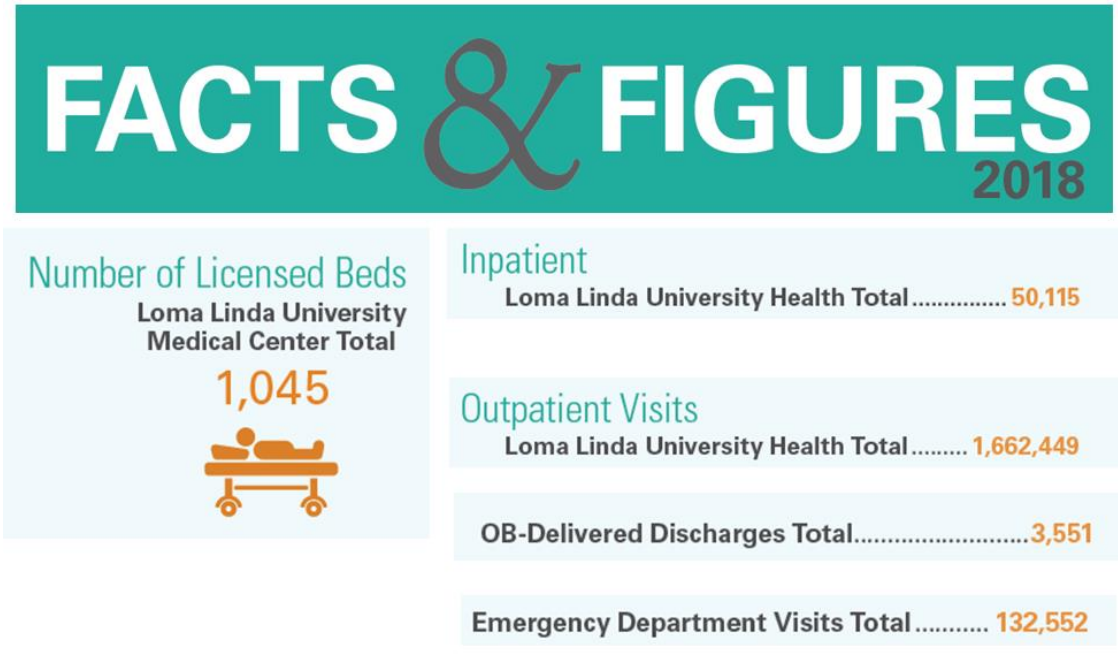
About Our Service Area

Loma Linda University Health System is a 1,045 hospital beds system and is one of the largest employers in the region, an important factor given the challenges of poverty, especially in San Bernardino. As an academic health center provider, LLUH offers primary and specialty care services and programs that are the safety-net for the people in our region. Without LLUH in the community, patients would need to travel great distances for access to the most advanced continuum of health care services, and a major gap in community-based interventions, programs, and unique community engagement activities would be created. LLUH invests in the community outside the traditional walls of our health care facilities. It is these programs and community engagement activities that extend access to the marginalized members of our community and how LLUH is able to address the root causes of illness. Consistent with our Christian mission of continuing the teaching and healing ministry of Jesus Christ, the LLUH health care system is honored to be an important part of the lives of people in our community, whether it is through community health investments, education and training, or direct health care.

The four non-profit hospitals in the LLUH System are:

1. Loma Linda University Medical Center (LLUMC) which includes two additional campuses: Loma Linda University Medical Center East Campus (LLUMCEC), and Loma Linda University Surgical Hospital (LLUSH),
2. Loma Linda University Children's Hospital (LLUCH),
3. Loma Linda University Behavioral Medicine Center (LLUBMC),
4. Loma Linda University Medical Center – Murrieta (LLUMC – M).

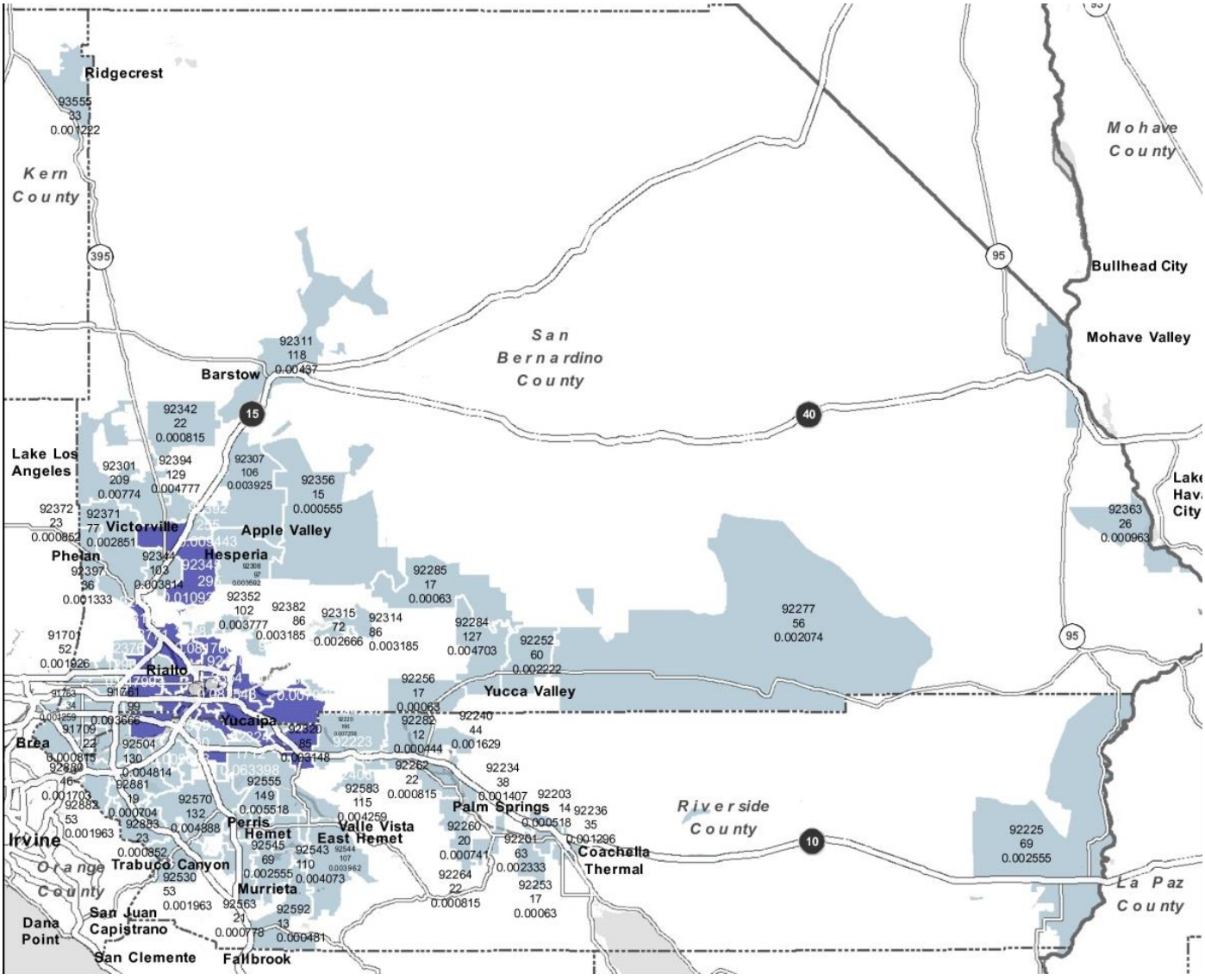
While our hospitals are the flagships of our comprehensive health system, LLUH is advancing our health care delivery system as we extend access to care in the outpatient and community settings. Our system includes a robust offering of outpatient services in primary and specialty care clinics. Additionally, for many of the hospital-based services, LLUH is the only provider of these services. This includes services like the outpatient specialty children's clinics where many of our neonatal and Children's Hospital patients receive extensive follow-up to manage their complex conditions; the outpatient rehabilitative services for children and adults that provides therapy services for many of those in our region with disabilities or developmental challenges as we maintain an institutional commitment to growing their ability to thrive; and our inpatient and outpatient behavioral medicine clinics and programs that provide behavioral health services in high-demand as California is under-resourced for behavioral health care.



SAC Health System Service Area

The SAC Health System is one of the largest federally qualified health centers (FQHC) providers of primary and specialty outpatient care in our region with over 120,695 total patient visits in 2018 representing 30,907 unique patients. The primary and secondary service regions show critical access to care from patients that come from a broad distribution of the two-county region, as SACs serves patients primarily in the East and West Valley regions of San Bernardino and the High Desert, with their secondary service region reaching patients as far as Coachella Valley (Indio Clinic) to the California State line. SACHS is an FQHC that has the most specialty services of any FQHC in the country as a patient-centered medical home for many of the residents living in vulnerable communities.

SAC Health System Service Area[11]
Federally qualified Health Center



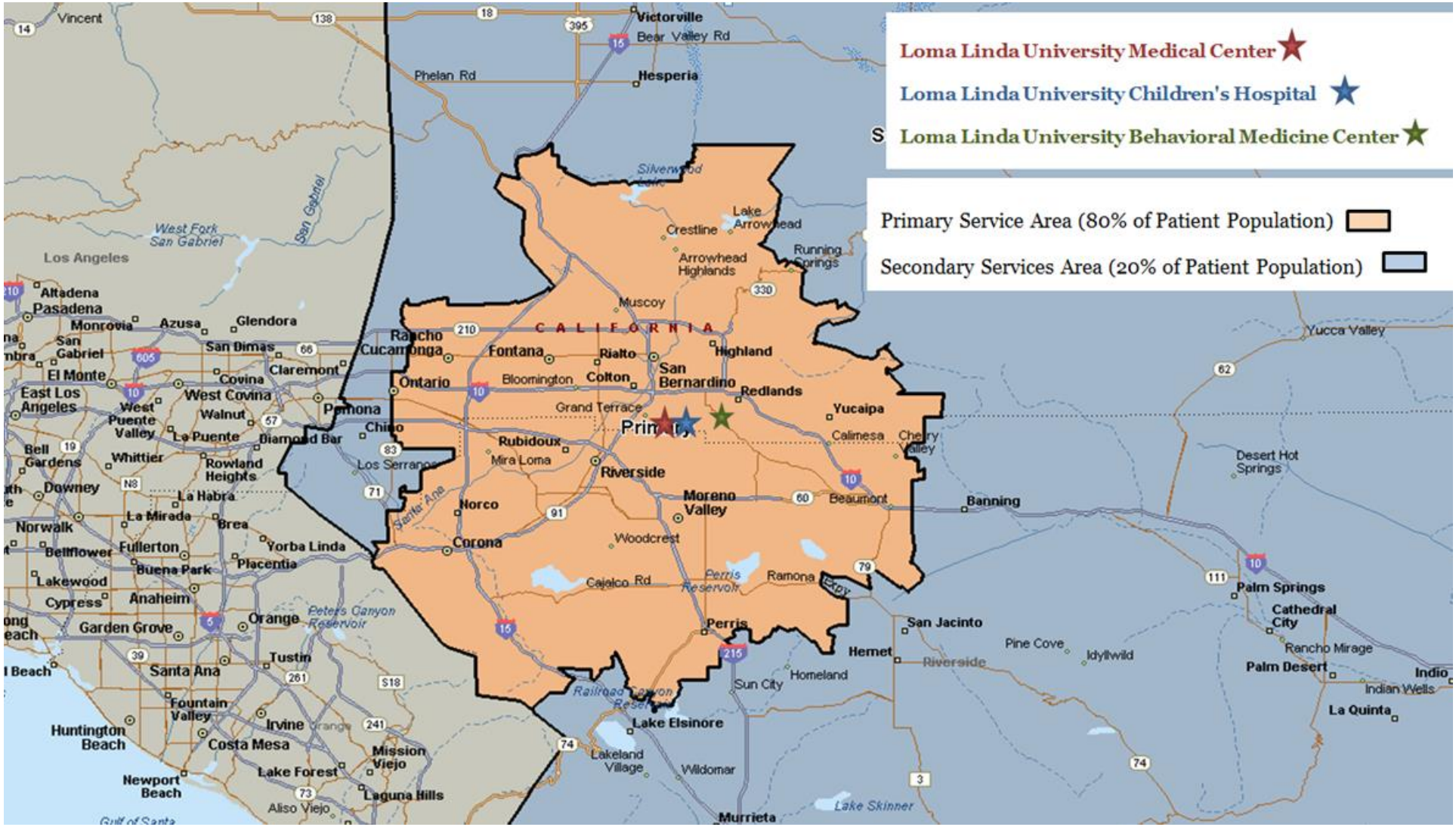
[11] https://www.wearesachs.org/

LLUH Service Area

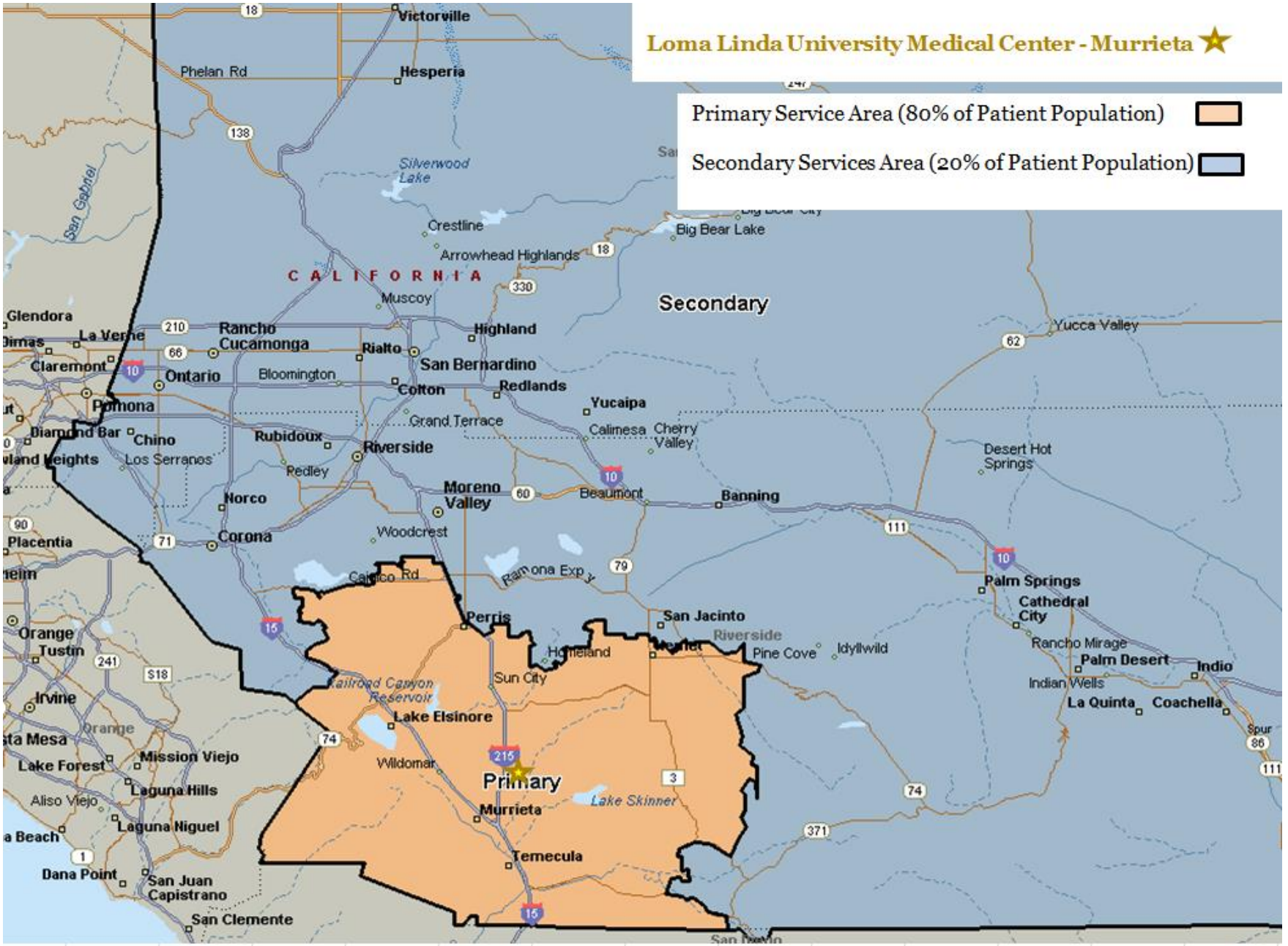
The LLUH system serves a large number of people who qualify for means-tested programs like Medi-Cal and it is core to our Christ-centered mission to serve those living near or at the poverty level, as we increase access to the full continuum of care for the most vulnerable children, families, adults, and seniors in our region with the greatest unmet health needs. People from marginalized communities or those living in difficult socioeconomic conditions account for almost 1 in every 3 patients seen at LLUH, based on patient Medi-Cal status. As an academic health center, LLUH has the ability to go beyond serving the marginalized, and actually addressing the root causes of poverty and disease through education and training, and workforce development: it is this ability that sets LLUH apart from other hospitals. As a leader in patient care we are not only investing in a comprehensive network of care, we are dedicated to offering state-of-the-art care for the most vulnerable while working with community partners to move the needle on health in our region.

What is your greatest hope for the community?
Healing. In every way spiritually, physically, mentally.
-Community Member

LLUMC, LLUCH & LLUBMC Service Area



LLUMC – Murrieta Service Area



The LLUH Economic Impact Dashboard

One important context to the service region of LLUH's hospitals is defining the economic impact LLUH has on our local economy. It is important for non-profit hospitals and health systems to quantify their total economic value for the people they serve, above and beyond the community health benefit activities they invest in fulfillment of the federal requirements.

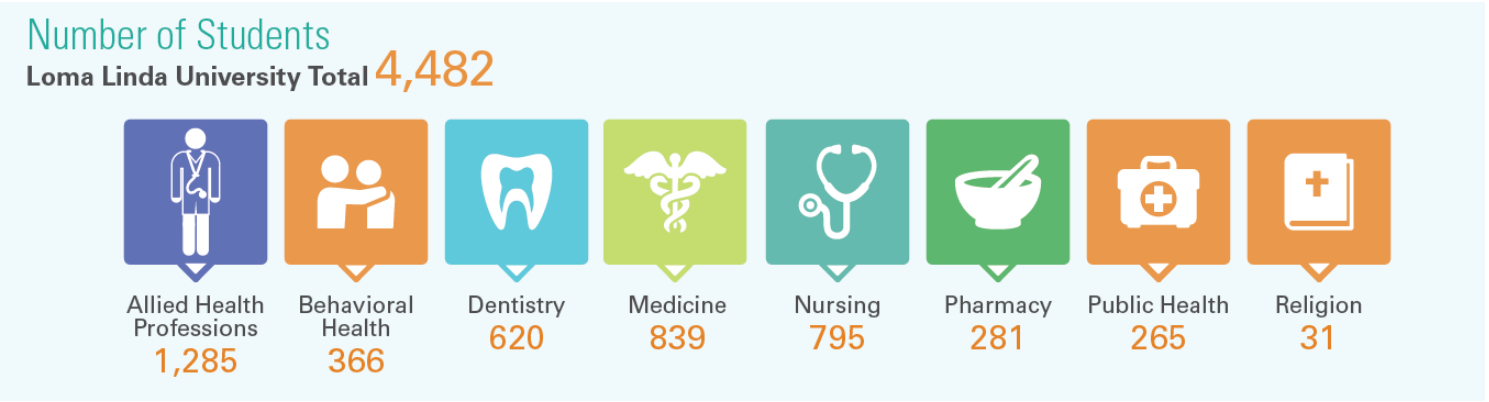
Quantifying the total economic benefit of hospitals and health systems is another way of sharing how these institutions serve the broader region. Hospitals and health systems positively impact the local economy in the form of employment, purchase of local goods and contracts for service, and other financial activities.

Experts such as John Husing, PhD and chief economist for the Inland Empire have recognized the pivotal roles in the area's turnaround. Dr. John Husing's remarks at the 2016 Research Affairs Symposium, pointed to the fact that the region has been reeling since the Great Recession of 2007 and the City of San Bernardino's 2012 bankruptcy declaration. Husing anticipates that the new ventures will make a big difference locally within the next few years. Loma Linda University Health-San Bernardino Campus, the other initiative Husing cited, will serve as a clinical and educational facility in the heart of the San Bernardino inner city. In addition to providing certificate-level training programs at San Manuel Gateway College—which was made possible through a generous gift from the San Manuel Band of Mission Indians as part of the Vision 2020 campaign—the new campus will provide health care for 200,000 people each year.

In noting that Loma Linda University Health pumps more than $1.3 billion into the Inland Empire economy each year, Husing predicted the organization's financial impact will grow far beyond that in coming years as recent graduates of the college find well-paying health care careers and begin spending their money in local communities. He also said that the new n3EIGHT center will likewise benefit the region by spawning some new companies and attracting others to the area to capitalize on research findings at the university. That in turn will create better-paying jobs that will similarly draw more highly-educated employees to the area.

> According to Husing:
> "Hospitals, ambulatory care and residential care operations had a 2018 median pay level of $62,363. They represent the only Inland Empire sector without job losses in the Great Recession. During the 2011-2018 general recovery, they added 37,858 jobs to reach a record 142,492. Importantly, the Affordable Care Act was responsible for creating health care demand as the local uninsured population fell -60.0% from 877,969 (20.5%) in 2012 to 351,398 (7.8%) in 2017, off -576,571 (-60.0%). Unfortunately, many of the newly insured are on Medicaid which is only reimbursed at 65% of costs, restraining health care job growth. That caution is heighten by the continuing attacks on the ACA yielding a low 2019 forecast of 4,800 new jobs.[12]"

[12] Inland Empire Quarterly Economic Report, April 2019 by Dr. John E. Husing



Loma Linda University (LLU) campus houses eight distinct schools built on the highest commitment to collaboration, practical training and spiritual balance. LLU is a Christ-centered Seventh-day Adventist university dedicated to mission-focused learning through the integration of health, science, and faith. The training programs, residency, and fellowship programs at LLU provide the distinct support and opportunity to the community members to attain education in a potentially higher paid job and also support the economic workforce of the inland empire by creating employment opportunities in the local regions.

The Loma Linda University Health Community Economic Impact Dashboard is currently in development and will be part of the 2020-2022 CHIS cycle as part of LLUH's efforts to quantify our total economic impact on the region. The dashboard provides a snapshot of the economic purchase power of LLUH in the region and the employment benefit provided to the people who live and work in the Inland Empire:

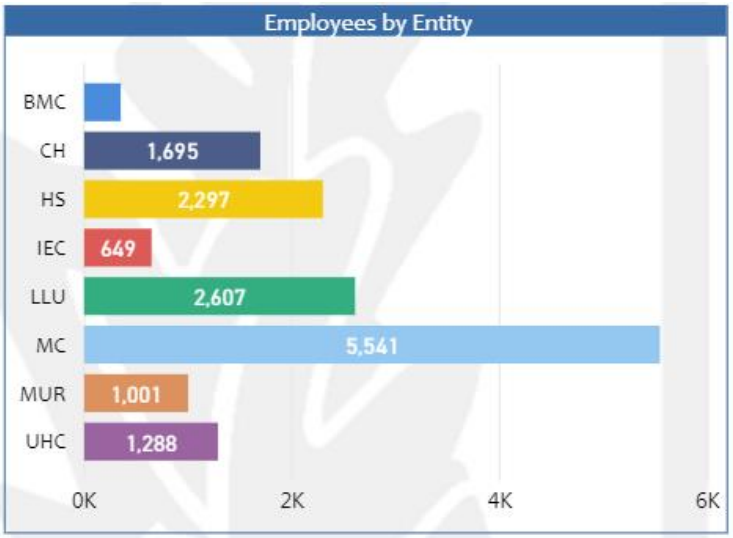
Over 3,800 local vendors with average annual purchases of over $25 million and a labor market employing over 15,000 people between San Bernardino and Riverside Counties[13].

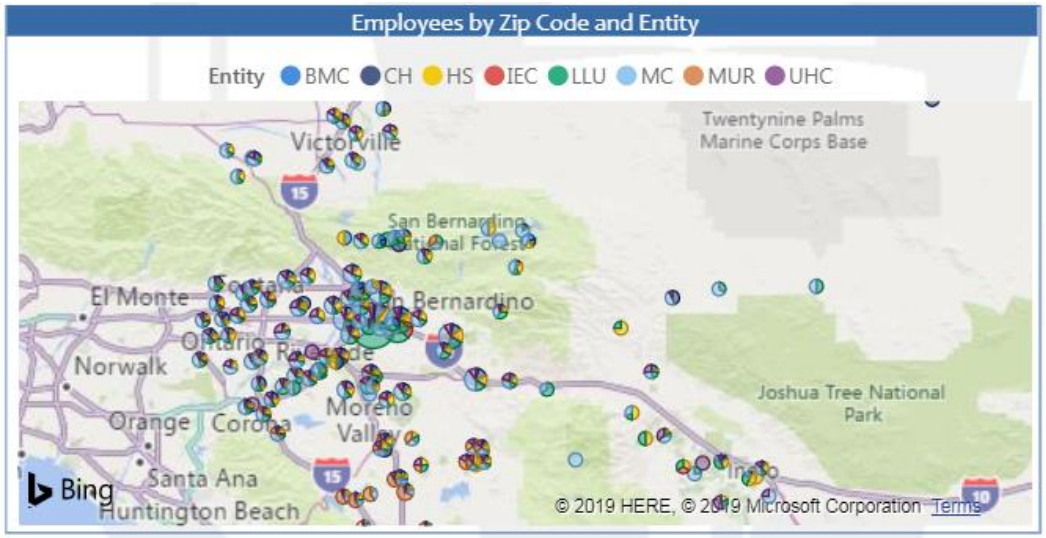
My ideal community: Everyone would have a home, everyone would have health care, everyone would be willing and able would work at a living wage, and education would be free.

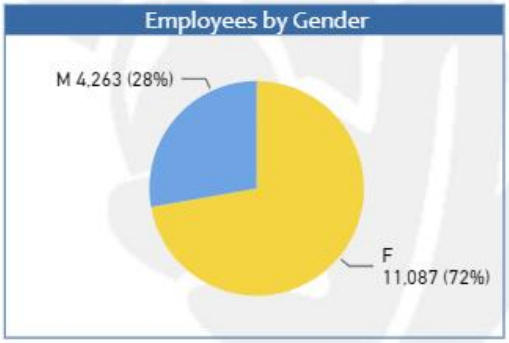
-Community Member

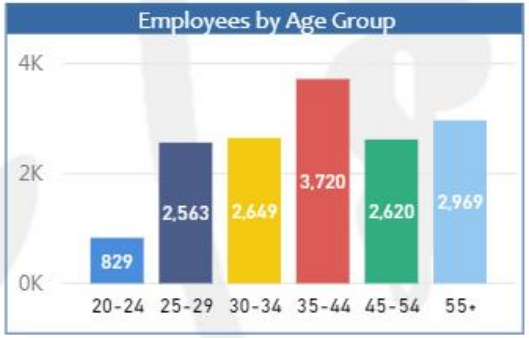
[13] Full Time, Part Time, Student jobs and Residency opportunities created in 2018

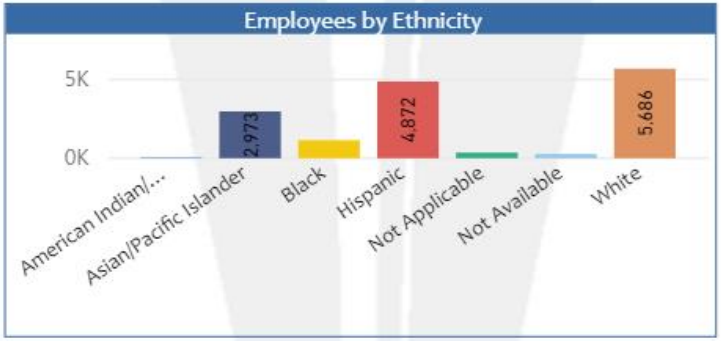
Loma Linda University Health: Community Impact Dashboard

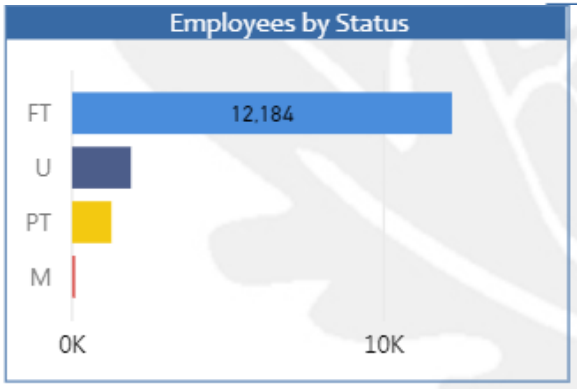


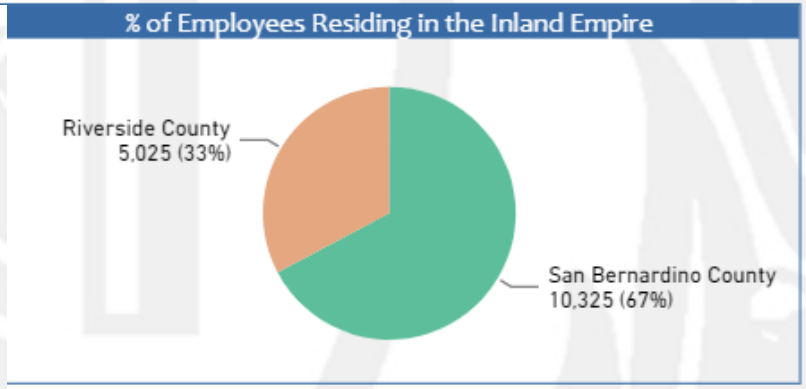












Filtered Employees

15,350

Economic Value of LLUH Local (IE) Purchases

$25,943,204

Number of Local Vendors (IE)

3,876

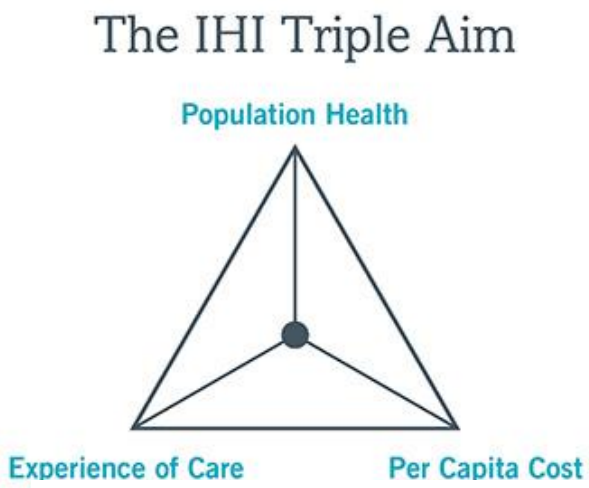
Methodology

Assessment Methodology

Why a community health needs assessment (CHNA)?

Every three years, non-profit hospitals are required to conduct a community health needs assessment (CHNA) to define the un-met health needs of people in the geographic service region of the hospital. Hospitals use these assessments to plan interventions and programs on behalf of the most vulnerable people in the communities they serve. The CHNA requirements originated from California statewide legislation in the early 1990s. Senate Bill (SB) 697 took effect in 1995 requiring non-profit hospitals to submit financial information to the Office of Statewide Health Planning and Development (OSHPD). Annual hospital Community Benefit Reports are summarized by OSHPD in a *Report to the Legislature*, which provides valuable information to the public as part of hospital's commitment to transparency: reports are made available on the hospitals websites in order to ensure access to the public. In 2010, the Internal Revenue Service (IRS) added requirements for tax exempt hospitals under the Patient Protection and Affordable Care Act of 2010. The Internal Revenue Code (IRC) Section 501(r) requires that certain tax-exempt facilities conduct a needs assessment in the community and adopt an implementation strategy for hospitals to demonstrate how they are identifying and addressing the needs of the most vulnerable people in their service regions.

One of the most significant changes to community benefit since the ACA in 2010 is that hospitals are now required to focus community benefit activities and dollars on the most vulnerable, underserved peoples in their service areas. The intent of the CHNA is to identify the health needs of uninsured persons, low-income persons, and disenfranchised populations who have the highest demonstration of un-met health needs and the highest social determinant burden given the scope of the problem at the national level. The lifelong stress and disease burden on people living on low incomes, or incomes that are at, or marginally above federal poverty limits, is measurable by indicators such as mortality rates by place. The correlation between a person's zip code and their lifelong health trajectory is well documented. Place matters and zip codes are known to be better predictors of life-long health than genetic codes.[14]

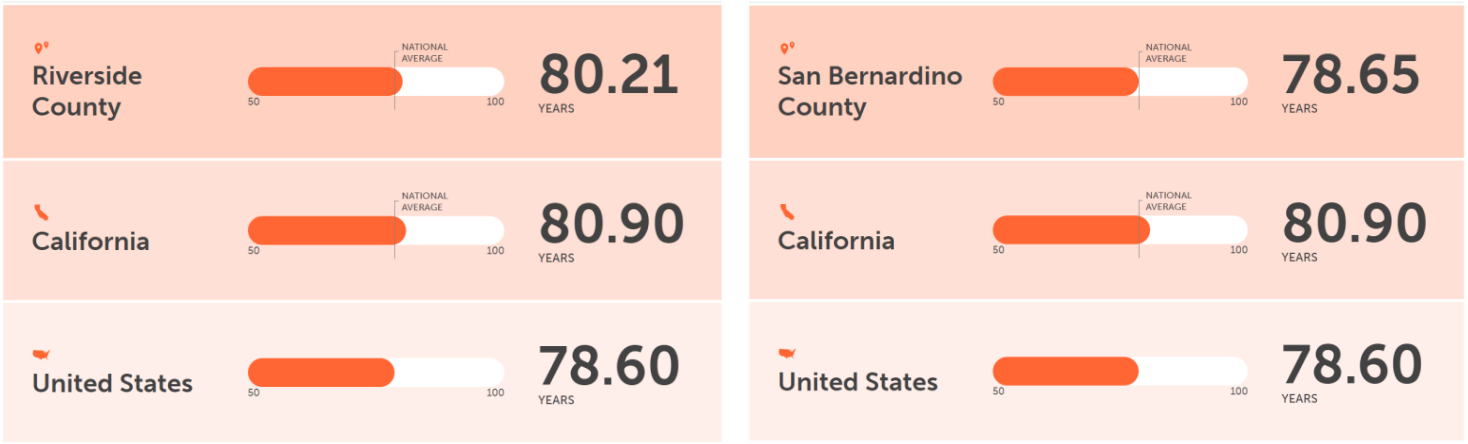


Source: Institute for Healthcare Improvement

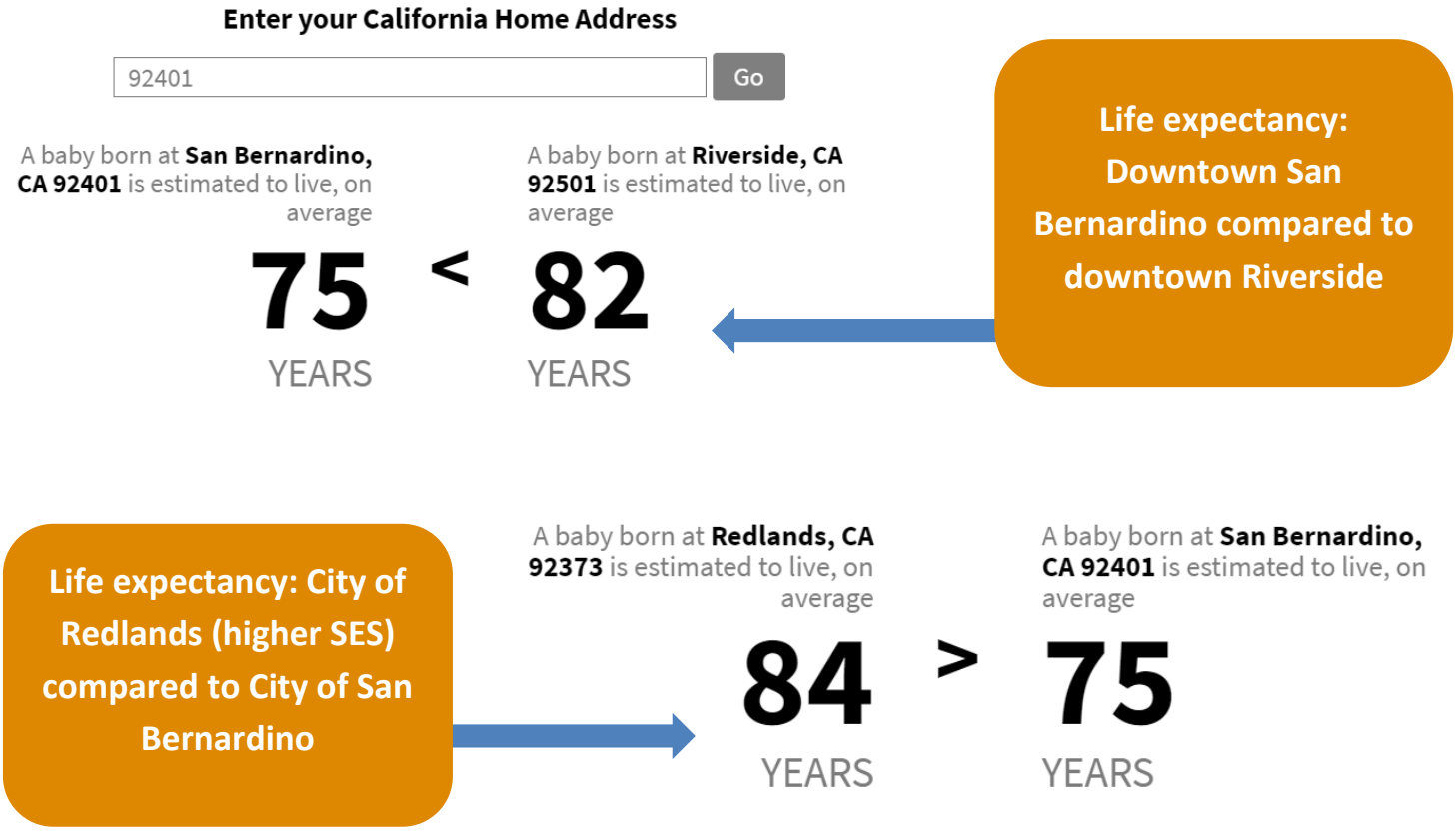
We had a healthy community at one point.
Hopefully the young ones will come back to where we were.
-Community Member

[14] Robert Wood Johnson Foundation, "Could Where you life affect how you live?" https://www.rwjf.org/en/library/interactives/whereyouliveaffectshowlongyoulive.html

Robert Wood Johnson Foundation: Could where you live affect how you live?
Life Expectancy based on Zip Code

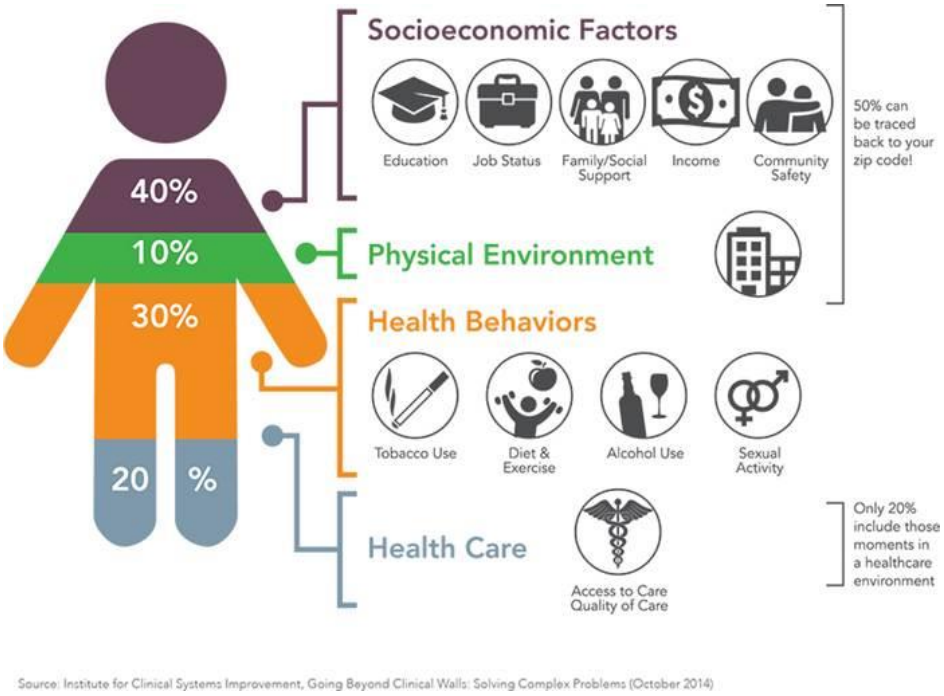


While zip-code level comparisons are valuable at the national level, looking *within* county for differences between life expectancy are vital to identifying local needs. Organizations such as The California Endowment are looking at the differences, down to the neighborhood level, between life expectancy for people in California. Within counties, neighboring cities often have dramatic differences in life expectancy. At the endowment's website, the online tool allows residents to compare based on street addresses[15]:



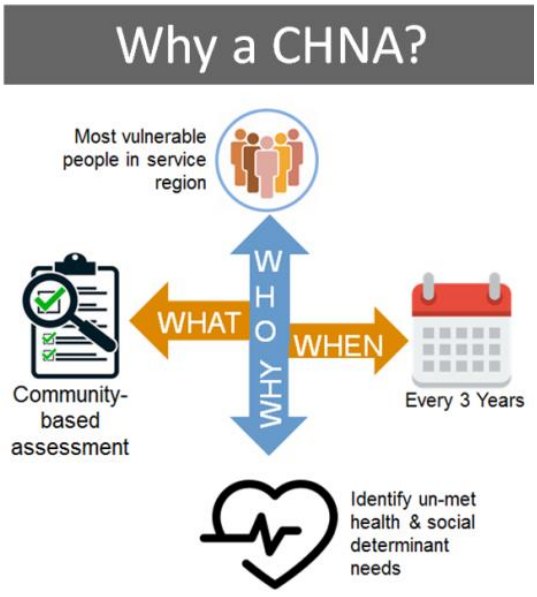
[15] California Endowment: https://www.calendow.org/news/your-zip-code-lifetime/

One reason place matters so greatly when looking at health is because of the social determinants of health (SDOH). The SDOH include factors like income insecurity, housing insecurity, and food insecurity: all essential aspects of health. Additionally, the policy environment that surrounds the communities in which people live and work are an important aspect of health and health equity. Health equity is often the hidden social determinant of health because it is dependent on a number of factors that may or may not be part of the infrastructure supporting a person and their life. These factors are often outside the control of individuals and within the control of people who are decision makers in communities. Many of the social determinants of health are either present or lacking because of health, civic, and governmental policies. When communities are well supported by policy and infrastructure in the areas housing, employment, nutritious food choices, transportation, quality education, safety and green spaces for recreation, and access to health resources access, they are able to live and work in an environment that contributes to their health. This is one major reason governments and public service organizations, such as hospitals and health systems, are working towards creating healthier communities by addressing the SDOH needs of the most disadvantaged peoples.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

To accurately identify the needs and resiliencies in the community, hospitals assess, plan, and measure outcomes to participate in the larger aims of the Affordable Care Act (ACA) to increase transparency in what they do to benefit communities they serve and more importantly, improve the overall-health of the community. More importantly, the process is a vital aspect of understanding the health challenges of the communities served by health systems. Findings support hospital decision-making on how to better support our patients and more importantly, where to focus our community-based interventions and partnerships towards building healthier communities that positively impact the health of the people across large regional areas. Ultimately, the aim of the ACA is tied to the increased health of populations at the regional level. Hospitals and health systems play a pivotal role in shaping the health of communities they serve, not only through their operations and patient-care services, but through their community benefit investments and services. The assessments and implementation strategies produced by hospitals are a valuable contribution towards the broader goals of the ACA.



What was the LLUH approach to the 2019 Community Health Needs Assessment Strategy?

In one word: partners. The LLUH partners and their relationships with the communities who carry the burden of health inequities are the backbone of the 2019 assessment. It was essential for LLUH to assess the health of the community by talking to those close to the issues with lived experience. The LLUH approach to the 2019 CHNA is not only about assessing community; it also includes moving beyond the required CHNA into ongoing community conversations that lead to demonstrable change via community empowerment. Often communities are surveyed and assessed but the people who share information are either not aware of the findings, or, they are not included in the conversations about what to do; it is LLUH's commitment to not only assess communities to better understand their needs, but through the Institute for Community Partnership's existing relationships and partners, work with the community to build healthier environments for everyone to thrive in.

Our partner provider organizations and community-based organizations were the central component the 2019 CHNA. Throughout the region, our community partners serve some of the most vulnerable populations, many of whom become patients at Loma Linda, especially due to Loma Linda's role as a quaternary and specialty care provider. For some specialty care, LLUH is the only provider in the region. In 2018, LLUH provided over 1.5 million patient care contacts in 2018[16]. Our community partners are equally working on the frontlines of healthcare service delivery and community engagement initiatives to reach the over 4.5 million people from our two counties. LLUH worked closely with partners who have the relationships, knowledge, and access to vulnerable populations they serve every day in order to reach people. By working with our partners in the field, LLUH was able to engage partner-agency experts in surveying and was able to work with partners to conduct community conversation sessions at community partner's sites to reach people where they live and work.

Goal of the Assessment – Intentional Design

One unique feature of the 2019 LLUH CHNA is that it is a distinct departure from the traditional approach of hospital CHNA work that relies on mostly secondary data and primary patient data for the bulk of the analysis and findings. **The 2019 CHNA is centered on the voice of the community.** Through the Institute for Community Partnerships, LLUH has built on strong community relationships in order to have earned the trust to have critical conversations with community members and to discuss not only their needs and concerns, but their hopes, aspirations, and assets. LLUH is committed to take the information shared by the community and through the Community Health Implementation Strategy (CHIS), work with the community to address those aspirations. One commonality of community assessment work is that the people who are surveyed are not able to participate in creating the solutions. The 2019 CHNA done by LLUH is *not* "yet another" community assessment or environmental scan that leaves communities in the same state with the same root causes of inequity left unaddressed. It is the commitment of LLUH to carry the findings and continue the conversation on solutions with the communities we serve through our CHIS implementation strategy and the 2019-2022 Community Benefit cycle.

What gives you hope?
"That we are going to live to be 100+."
-Community Member

[16] Based on FY 2018: total for inpatient, outpatient, ED and OB.

Target Population of Survey Efforts

The target population for surveying was to reach the most disenfranchised and vulnerable populations, based on socioeconomic status, in our two-county region. To ensure data collection represented the diversity of our region, surveys were conducted in areas with the highest community indexed needs due to the low socioeconomic status and included the following areas: San Bernardino County (San Bernardino Metro area and High Desert) and Riverside County (Coachella Valley). The surveys were also conducted with community partners with access to populations living at lower incomes as the primary goal, with the community partners representing outreach services to predominantly Hispanic/Latino and African American/Black community members. However, because the focus was on neighborhoods that are traditionally under-served and lower income, the surveys were not focused solely on specific ethnic groups but rather, intended to identify a range of respondents from lower-income communities. Populations and/or geographic regions that lacked representation in the quantitative survey effort were selected for focus groups, where possible to arrange. As the 2019 CHNA is the baseline study for the next three years, any populations or regions of the counties that were not surveyed in the initial assessment are part of the on-going assessment strategy and priority for the fiscal year 2019-2020. Two major indicators drove the design of this assessment:

1. The level of poverty experienced by people in our two-county region and;
2. The disproportionate burden of poverty on people of color in California.

One in five in San Bernardino County experience poverty and for Riverside, it is one in six people.[17] Additionally, from statewide studies about populations in California, 44% of California's families are headed by a working minority parent whose wages are considered low-income, compared to 16% white families.[18] Lower income households across California are over-represented by people of color. When assessing the health of populations, there are a variety of methods used to talk to people about their health experience, like surveying and focus groups. In traditional surveying methods, a large number of people are contacted in order to achieve a statistically valid sample, but the method of contact is often telephone surveys or email/internet-based surveys. For low income communities, in-person data collection has been validated as the best method for surveying because often people experiencing income insecurity lack ether the utility or technology access and the time due to low income jobs to participate in electronic survey methods.[19]

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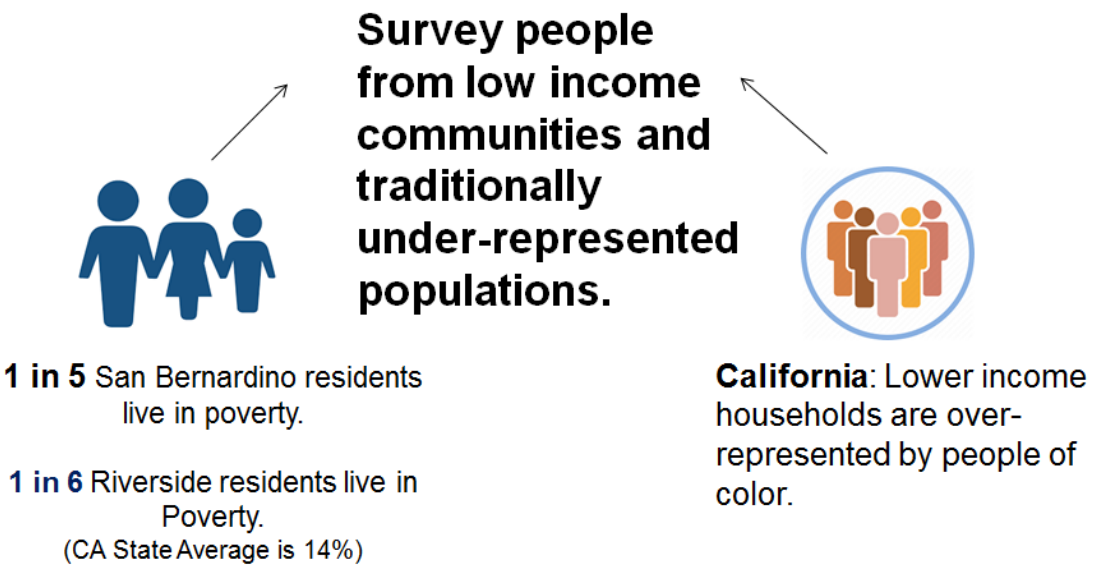
17 Depending on where federal poverty limits are set. Based on County data. Community Indicators

18 California Budget & Policy Center, "Working Poor Families Project" 2015.

19 Weiss and A. Bailar. Studies of Welfare Populations: Data Collection and Research Issues. "High Response Rates for Low-Income Population In-Person Surveys." 2002.

Assessment Design



Assessment Goals

Goal 1: Based on the best-practice approaches to surveying low-income communities, the assessment goal was defined as follows: Work with community-based partners to assess the health needs and social determinant burden of people of color living in low-income households through in-person surveying and focus groups. To assess the needs and strengths of the community served by LLUH's four licensed hospitals, the CHNA methodology prioritized the perspective of traditionally under-served, vulnerable, and/or marginalized community members in order to identify what they felt were the highest un-met health needs and most pressing social needs as well as the strengths and resiliencies of their communities. Priority was given to the community member's perceptions and expertise on their own needs with secondary data sources used to contextualize the scope of the needs identified by community members. Surveys were conducted at appropriate reading levels for the intended audience in order to achieve equity in capturing the perspectives and voice of this segment of the population.

Goal 2: Obtain a statistically valid sample, representative of population of 4.5 million people and of the diverse geography of San Bernardino and Riverside Counties in order to trend and interpret the perspectives, experience, and data provided by people from low income populations as a representative sample for the region. For a population of 4.5 million, assessing 1,044 people was required in order to achieve a 99% confidence level and 4% margin of error. Additionally, in order to ensure the data collection was not skewed towards adult health needs, ICP obtained a sampling of children's health needs through a Children's Health Survey. Because people under age 18 are not surveyed without parental involvement, it can be difficult to identify the unique and distinct needs of children apart from adults in general surveying efforts. To balance the assessment, ICP worked through the LLUH community-based programs for community children and adolescents by administering a Children's Health Survey to parents of children participating in sports and educational programs provided by LLUH community benefit investments.

Evaluation of the success of the assessment goals was dependent on the following results:

1. The demographic profile of the community served as the validation that a representative sample of people and families of color living at an income at or below <$50,000 a year with targets to speak to a racial and ethnic population that was at-least proportionate to the profile of the total county population data.
2. The geographic distribution of people at the city level, as obtained from demographic data and GIS mapping.
3. The implementation of a children's health assessment survey in order to identify the needs of children apart from adult populations picked-up in the broader survey efforts.
4. The number of people surveyed to reach a statistically valid sample size.

What data collection tools did LLUH use to assess the needs of the community?

Measurement and assessment of community was accomplished by the following:

1. Primary Data collection: Quantitative Surveying of the community members on social determinant burdens; quantitative surveying of families in a children's health study; qualitative focus groups, and quantitative hospital data.
    a. The target audience of the broader community member survey efforts was people from low-income communities and people of color who completed a questionnaire. A quantitative survey was deployed by community outreach and health workers and focus groups with diverse populations.
    b. The target audience for the children's health survey were community parents of children who participate in LLUH community benefit programs for youth completed a survey.
    c. The target audiences for community conversations[20] were conducted by the ICP team in collaboration with our community organizational partners. The conversations were held in different geographic areas from where surveying was conducted in order to capture a broader, more geographically representative sample.
        i. The target audience of the focus groups was:
            1. People from low-income communities
            2. Regional community advisors and experts at LLUH
            3. Leadership from multi-sector partners

2. Secondary data collection: A literature review of the publications produced by hospital, county, and community-based organizations on the needs and strengths of the priorities was conducted. Priority for the data summary was given to macro indicators at the county level. Office of Statewide Health Planning and Development (OSHPD), the United States Census, and other secondary data sources were consulted.
3. Data visualization of primary and secondary data collection strategies through mapping and info graphs in order to make the findings of the CHNA accessible to community members.

We need to focus on education: we need better opportunities and generational change.

-Community Member

[20] The focus groups conducted by LLUH were named "community conversations" in order to disassociate with focus groups traditionally run by hospital marketing departments and capture the spirit and intent of engagement with community members.

How did LLUH identify the needs of the community through primary data collection?

Primary Data Collection: Quantitative Community Surveying

In order to understand the social determinant burden on vulnerable populations living in our two-county region, LLUH contracted partner community based organizations to conduct at least 1,100 surveys in our two-county region (A copy of the survey is available in Appendix A).

The community-based surveys were adopted from the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. The survey was originally designed to assess health needs of patients in community-based clinic settings and to identify the social determinants of health impacting patients seeking care in lower-cost, community-based clinics. The survey assesses social determinants such as housing insecurity, safety, food insecurity, income insecurity, and other factors at play in determining the health-status of people. For the purposes of the LLUH CHNA, the survey questions were reduced to 29 questions that were most suited for the purposes of the LLUH assessment. Questions that asked about personal consumption of alcohol, drugs, and the two PHQ-2 depression screening questions were removed in order to allow the survey to be focused on community perception of social determinant burdens, not a personal questionnaire of health status. Additionally, based on feedback from community, five test questions were added to assess basic financial knowledge of respondents. In recent years, one major barrier to populations living at lower incomes is a lack of access to financial institutions that might help those with fewer resources gain the knowledge necessary to maximize the incomes they have. With the complications of poverty, sometimes those at a lower socioeconomic level are sometimes blamed for poverty based on a lack of financial literacy. In surveying, many financial literacy questions are designed around assessing knowledge that people who already have access to basic banking and lending services would need to know because often communities with a predominant population of low-income earners are subject to predatory lending and an excess of quick cash at high cost businesses.

As people living on lower incomes are more likely to rent, asking questions about home buying and mortgage lending is not an accurate assessment of the gaps or needs in financial access those who are lower-income may face. What community-based partners shared with LLUH is that people living in poverty often do not have access or understand their ability to access basic banking services and instead, become prey to predatory or high-risk lenders and credit card companies as a way to stretch their incomes; a trap that only increases poverty. The five financial knowledge questions tested in the CHNA will help determine if LLUH and community partners

A Summary of Primary Data Sources:

Health-Related Social Needs
(*Adapted from CMS* Screening Tool)

Children's Health Needs Assessment
(Adapted from Child and Adolescent Health Measurement Initiative)

Focus Group Standardized Questions & Demographics (LLUH Tool)

Hospital and Emergency Room Data –
Chronic Disease Diagnosis Codes
(All LLUH Hospitals)

Community Health Worker
Student Practicum Projet - Assessments
San Manuel Gateway College

can identify a correlation between financial knowledge and socioeconomic status and to begin to understand how this is a detriment to health.

Children's Health Survey

A 56-question children's health survey was administered to parents of children participating in the LLUH community benefit program Goal 4 Health, a soccer league aimed at integrating lower income families into recreational sports on the LLUH campus in order to increase their access to safe recreation, promoting physical activity and health education for the entire family. The program is also designed to bring together families of various socio-economic levels, families that are often segregated and have little opportunity to interact; one of the strongest and most unique aspects of the league. A significant number of families that participate in the program are from low income communities where there are no safe areas for children to play.

The 56-question health survey given to parents and adapted by the Child and Adolescent Health Measurement Initiative was a test pilot to see the efficacy of data collection using this tool through community benefit programs. The survey asked demographic questions as well as questions regarding parent's perception of their child or family's health, and questions as to frequency or access to health care resources and the prevalence of certain diseases like diabetes and asthma.

Statistical Validity of the Community-based Survey

For a region of approximately 4.5 million people, a statistically viable sample of 1,044 surveys was required, assuming a 99% confidence rate and 4% margin of error. To achieve data collection of at-least 1,044 surveys, ICP worked with community-based organizations in both counties to deploy 1,100 surveys across three community-based partners, with the organization's community-based outreach workers and community health workers administering the survey. Given the expertise of our partners in working with historically under-served and vulnerable populations, ICP felt our partners would have a better sense of where surveying would be most effective in order to reach vulnerable populations that may not be accessible through traditional telephone and email surveying. Community-based partners were also able to ensure that the survey target populations were reached in a culturally sensitive and relevant manner, as they have established relationships and trust with the communities they serve. ICP prioritized the collection of primary data from community members through our community partners' trusted relationships. The goal was for ICP to allow our partners' community health workers (CHWs) and outreach workers to go into low-income communities

where trust and relationships were already present and active. **The community health and outreach workers were vital, essential, and the basis of success for this assessment.** Outreach workers and CHWs implemented person-to-person surveying in order to talk to people with lived experience who understand first-hand what it means to live in our region without adequate access to health services and under the burden of multiple social determinants of health that impact individual's ability to meet their financial, health, and social needs. ICP also prioritized capturing the opinions of experts working directly with vulnerable populations in our region in order to better contextualize the highest needs of the communities we served.

Primary Data – Qualitative Focus Groups

For areas that were not captured through community surveys, LLUH conducted community conversations to represent the perspectives and voices of a diverse range of people from different socioeconomic backgrounds, with a special focus on people who are connected to LLUH community-based partners that routinely serve vulnerable populations in our region. Focus groups were conducted in Spanish and English based on the population participating. LLUH conducted a series of "Community Conversations," standardized focus groups with a goal of reaching at least 150 people across the two-county region in order to contextualize survey findings with community comments. Focus Groups were kept to an average size of 10-12 participants at a time. Questions were standardized to allow respondents to provide open-ended answers unprompted to questions regarding the needs and degree of social determinant burdens in their community. Of the 11 questions, 2 were strengths-based, 8 were deficit or needs focused, and the final question was a "vote by sticker" where participants were able to vote for the top two needs in their communities (based on a list of 20 social determinant and health access issues). The questions were asked to all participants, irrespective of their socioeconomic status or race and ethnicity. Demographic data (the same data as questions 1-12 of the quantitative survey) was collected from participants who were willing to fill out the anonymous forms. For focus groups, the number of people in each person's household was also asked so that responses collected could have both a number of people represented and an estimated number of people living in the same households represented. For the standardized Focus Group questions, see Appendix B for both English and Spanish. In addition to the standardized focus groups, LLUH also conducted conversations at community stakeholder meetings where themes were captured and included in the qualitative analysis as a way to validate perspectives directly heard from community members in the study.

Primary Data – LLUH Patient Chronic Disease Trends

LLUH recognizes that patient data from our system is not a full representation of the people's un-met health needs in the community we serve, though the trends seen by patients who come to LLUH for emergency and hospital care are important context to the larger picture of health in our region. As a health system, LLUH is an essential primary and specialty care provider for people in our region. As the 2019 CHNA assessment prioritized the data collection from the community in order to let the community instruct LLUH on what their needs and assets were in communities, patient data was evaluated in order to further contextualize what the community identified while also answering the following question: **What are the primary population health reasons people come to the LLUH hospitals?**

Just talk to people, younger people, older people. If you have your eyes open you can see a need and go out and help. What you give and pay forward gives you great satisfaction.
-Community Member

Hospital Data Evaluation

To study the top reasons adults come to the LLUH health system, the Institute for Community Partners reviewed the utilization trends by diagnostic codes (DRGs) and ICD-10 codes, as well as the demographic profile of LLUH patients over a two-year period. ICP focused on primary diagnosis for emergency and hospital services and also compared this to FQHC populations in our region. When reviewing the trends for adults over 18, only the diagnoses that relate to broader population health issues in chronic disease and lifestyle diseases were trended because as a Level-1 Trauma Center and quaternary care provider, LLUH hospitals see a large population of people due to trauma, cancers, or other more rare diseases. In order to identify the larger population health diagnostic trends, emergency care and specialty care factors are adjusted out and chronic disease trends were compared to known and documented trends in County and other health care partner secondary data and by what the community told ICP were the un-met health needs of our community.

For people under age 18, the review also adjusts out unique factors as LLUH has a Children's Hospital, and utilization of children with rare diseases, traumas, and cancers at Children's Hospitals are high. These reasons for visits and admissions are not always indicative of broader population health trends: therefore, when reviewing the trends for people under 18, only lifestyle or population health disease diagnoses were trended in order to identify how children's population health trends differentiates from adults.

Federally Qualified Health Center Data – SAC Health System

Data from the SAC Health System as a primary and specialty care provider for people in the region was also analyzed for population health trends. The SACHS FQHC is a major partner of LLUH in the care of people in the region and there is significant overlap in patient populations. The Health Resources and Services Administration (HRSA) data published by SACHS provides invaluable information as to the trends and needs of the total population of individuals who are living at-or-below the federal poverty line in the San Bernardino metro region, one the greatest areas of need in the LLUH service region.

Findings

Summary of Findings - What the Community Told LLUH

Through the extensive efforts in surveying, community conversations, and data analysis in partnership with community-based organizations and partners, the message of the 2019 CHNA is:

People need more health.

People want more community.

The following is an aggregation of the total quantitative and qualitative findings from the 2019 CHNA in order to capture the unified voice about how the community members who participated in the study expanded on the thematic messages above. [21]

Strengths- Resilient people in community

The strengths of the San Bernardino and Riverside County communities, according to the people who live here, are something hopeful about the region. The greatest regional asset named by community members was: **Resilient people, living in community**. When describing what was a strength or hopeful about communities in the two-county region, over and over again, the community said:

"my neighbors,"

"my community,"

"the people themselves,"

"support groups,"

"the area where we live together,"

"the small town feel and connection," and

"the partnerships between systems."

[21] For detailed findings from the data collection efforts, see the Findings Assessment by Components section of this report.

In the words of one community member: "the people here have a drive to do better, they come from nothing and do better." When community members described facing adversity, they named resiliency: "The strength of our region? Resiliency. We always bounce back on our feet." When institutions or places were named as strengths, it was always places of community: the churches, community-based organizations, and supportive organizations rooted in common cultural connections: "Our communities' strength is '*la huerta*,'" or the garden where community happens, as one community member shared.

Resiliency in community defines the spirit of the people here: a sentiment that is more important than ever despite economic issues and the terrorist incident of the last decade. In the words of one community member: "When we are in crisis we come together as a community …" as she went on to share about the December 2nd, 2015 mass shooting in our region. The region is still recovering from the terrorist incident that brought the world's attention to San Bernardino and placed San Bernardino on an exclusive list of cities like Paris, London, Boston, and New York: places where the people have had to re-establish normalcy after terrorist attacks. Despite a terrorist incident and economic hardship due to the Great Recession of 2008, the identity and attitudes of the people here do not reflect defeat: there was no sense of brokenness or hopelessness in the voice of the 200+ people who participated in the LLUH focus groups. What the community told LLUH was that a spirit of hope persists due to the resiliency of the people in our region, even in spite of their deep awareness and knowledge as to the challenges their communities face: **resilient people living in community. San Bernardino Strong.**

Summary of Assessment Components

Total Community Members Surveyed (All Methods): 1339

Population Health Data	**LLUH & SACHS**
Community-based Survey for SDOH:	**N = 1060 People**
99% Confidence Interval	English: 542 (51%)
4% Margin of Error	Spanish: 518 (49%)
Community Conversation/Focus Groups 18 Groups: 11 English, 7 Spanish	**N = 205 People**
Children's Health Survey	**N = 74 People**

Summary of Findings

The table below summarizes the findings from the four primary methods of the LLUH CHNA:

- Community based survey — N = 1060 People
- Community-based focus groups — N = 205 People
- Children's Health Survey — N = 74 People
- Population-level data (LLUH & SACHS) — Patient Population Trends

Loma Linda University Health - Community Health Needs Assessment 2019

Shortlisted Areas of Needs

Community-Based Survey (Languages: English and Spanish) ≤ 25% 26% to 45% 46% ≥	
Challenge Paying for Essentials (Food, Medical, Housing, Utilities)	57%
Food Insecurity	49%
Stress Related to Immigration	45%
Community Crime Perception: Neighborhood Safety	43%
Community Crime Perception: Level of Crime and Issue	35%
Problems-related to Current Housing	35%
Isolation and Lonely	33%
Assistance with Employment	27%
Basic Financial Literacy: Leading Risk of Predatory Lending	26%
Need Help with School or Training	23%
Reliable Transportation	21%
Housing Insecurity	10%

Community-Based Focus Group (Languages: English and Spanish) ≤ 10% 11% to 15% 16% ≥	
Cost of Housing & Homelessness	21%
Work/Jobs	14%
Access to Care	11%
Mental/Behavioral Health	11%
Alcohol and Substance Abuse	9%
Food, Transportation and Other Resources	7%
Parks/Built Environment/Green Spaces	7%
Immigration, Discrimination and Isolation	6%
School/Education	5%
Disability	4%

Children's Health Survey ≤ 15% 16% to 20% 21% ≥	
Built Environment, Green Spaces and Need Playground/Parks	23%
Difficulties Affording Essentials (Food, Medical, Housing, Utilities)	22%
Access to Health Care	20%
Parent/Guardian Needed Emotional Support	20%
Mental Health Counseling (Received or Needed)	18%
Child Experienced Racism/Discrimination	16%
Need Extra Support of Help Coordinating Child's Care	15%
Asthma	14%
Neighborhood Safety	14%

LLUH Hospital Patient Data & SACH Health System Population Health Data: Chronic Health Condition or Conditions due to Lifestyle Only Based on ICD-10 and DRGs *(Listed in Alphabetical Order)*
Asthma
Behavioral Health
Cardiovascular Disease (CVD)
Diabetes
Hypertension
Obesity

Findings by Assessment Component: LLUH Population Health Data

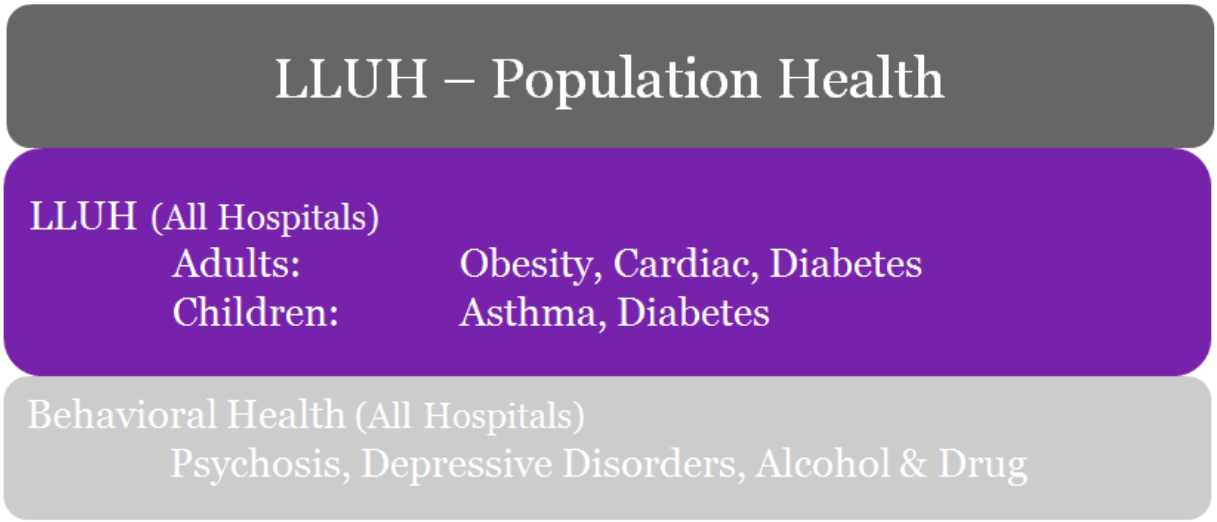
Tool: LLUH Hospital Patient Data – Chronic Disease Trends

Purpose: To answer the question: What are the primary population health reasons people come to the LLUH hospitals?

Key Facts: Diagnostic data (DRB and ICD-10 codes) was trended for adults >18 and children/youth <18 years to determine the highest prevalence of chronic disease rates among patients presenting at LLUH's emergency rooms and hospital admissions.

Data was trended over a two-year period, from January 2017-December 2018, based on data available for all four hospitals (LLUMC, LLUCH, LLUBMC, LLUMC-Murrieta)

Highlight Findings:



Findings by Assessment Component: SACHS Population Health

Tool: SAC Health System (SACHS) – Public Data

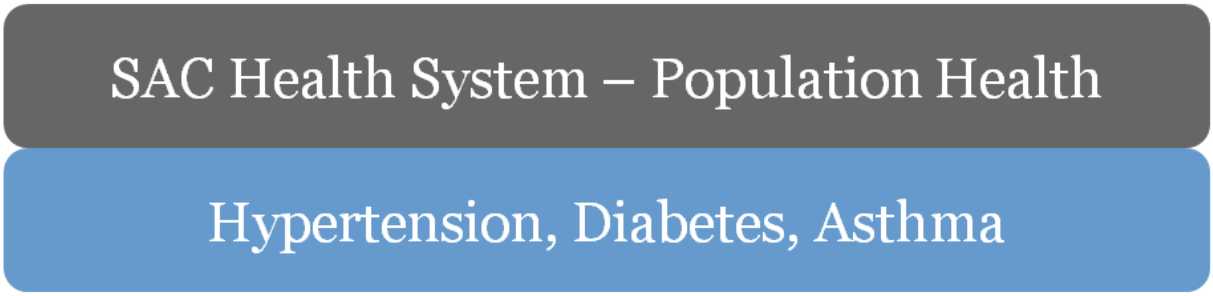
Purpose: As an LLUH partner in the care of the medically underserved and at-risk populations in our region, the SACHS population health data is an important data set for the evaluation of population health trends due to the degree of overlap of patients seen by both health systems. The aggregate, public population health data published by SACHS provides important context to the chronic disease trends experienced by the people in the service regions of both institutions. See Appendix D for data.

Key Facts: SACHS saw 30,907 unique patients in 2018.

97% of the SACHS patient population was below 200% of poverty.

78% were at or below 100% of poverty.

Highlight Findings:



Findings by Assessment Component: Community Survey

Tool: Community-based Survey conducted by ICP & Community Partners

Purpose: A 33-question survey, adapted from the CMS Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool, was conducted with 1060 people. The survey was designed to identify the social determinant burden experienced by people in lower income communities. The aggregate findings from the survey are summarized in the following pages. See Appendix A for the survey and findings by question.

The goal of the assessment was to deploy community health workers through the LLUH partner organizations and survey community members who represent the strengths, needs, and perspectives of under-served communities and to identify their social determinant needs:

> 67% of the survey respondents had an average household income of $50,000 or less. 62% reported a race other than white, with 8% reporting African American and 4% American Indian/Native American. For ethnicity, 74% reported Hispanic, Latino, Spanish ethnicity.

The top social determinant needs reported by 1060 people in surveys were:

1. **Income Insecurity** *(Difficulty paying for essentials)*
2. **Food Insecurity**
3. **Stress related to immigration**

Community-based Survey for SDOH

N = 1060 People

Representative of 4.5 million people at:

99% Confidence Interval

4% Margin of Error

English Surveys: 542 (51%)
Spanish Surveys: 518 (49%)

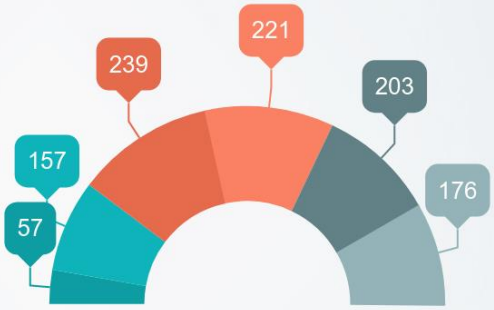
LLUH CHNA 2019 Community-Based Survey

Key Demographics

Total Number of Community-based Surveys (N) = 1,060

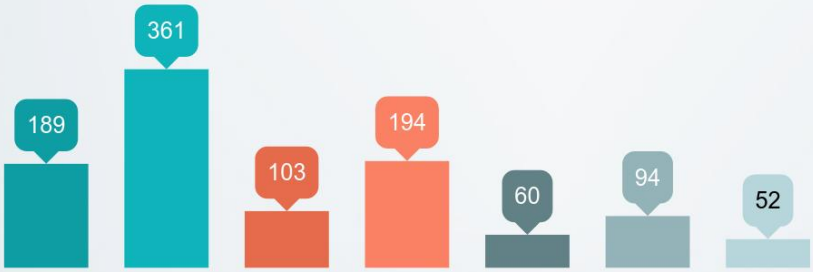
Male (33.62%) Female (66.38%)

Age Distribution



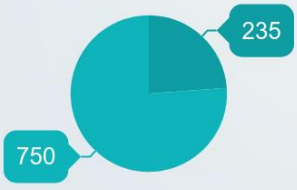
18-20 (5.41%) 21-29 (14.91%) 30-39 (22.70%) 40-49 (20.99%) 50-59 (19.28%)
60 or older (16.71%)

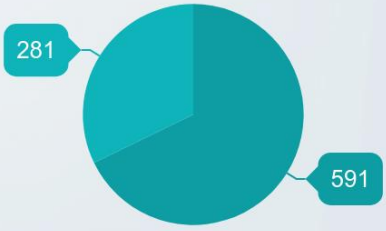
Education Level



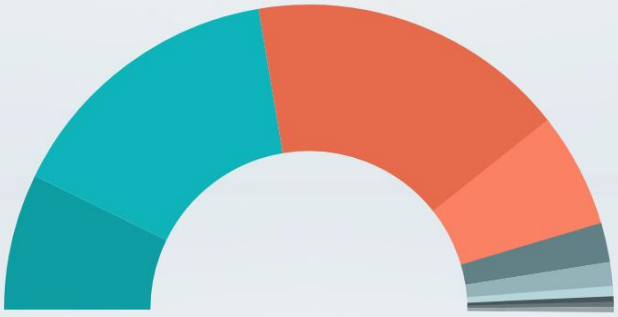
Less than high school
High school or equiv..
Vocational education..
Some college but not..
Associate degree
Undergraduate degree
Graduate degree

Household Income





Health Insurance - No (23.86%)
Health Insurance - Yes (76.14%)



Employed (FT or PT) (67.78%)
Not Employed (32.22%)

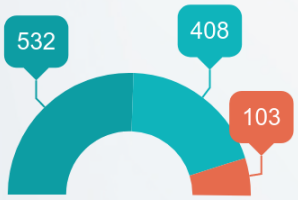
$0 to $9,999 (14.36%) $10,000 to $24,999 (30.12%) $25,000 to $49,999 (33.98%) $50,000 to $74,999 (12.33%)
$75,000 to $99,999 (3.97%) $100,000 to $124,999 (2.57%) $125,000 to $149,999 (1.18%) $150,000 to $174,999 (0.64%)
$175,000 to $199,999 (0.32%) $200,000 and up (0.54%)

LLUH CHNA 2019 Community-Based Survey

Key Focus Areas To Improve Community Health

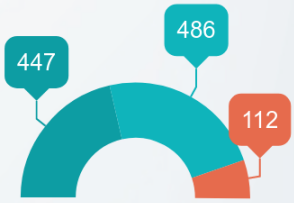
Last 12 months worried that food would run out

Never true (51.01%) Sometimes true (39.12%)
Often true (9.88%)



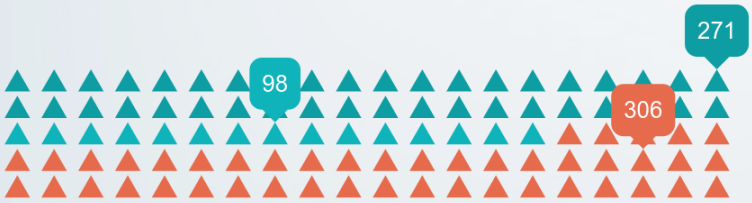
Difficulty paying for food, housing, medical care and utilities

Not at all (42.78%) Somewhat hard (46.51%)
It is very hard (10.72%)



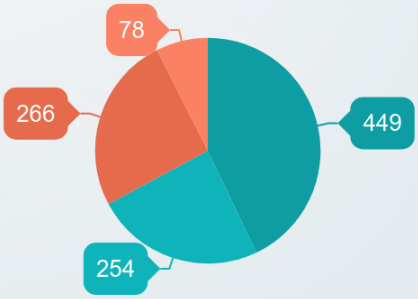
Problem related to current Housing

At least 1 problem from.. (40.15%) 2 problems or more (14.52%)
None (45.33%)



Feel lonely or isolated

Never (42.88%) Rarely (24.26%) Sometimes (25.41%)
Frequently (7.45%)



Help finding or keeping a job

I don't need help (72.05%) Yes, help finding work (18.38%)
Yes, help keeping work (9.57%)

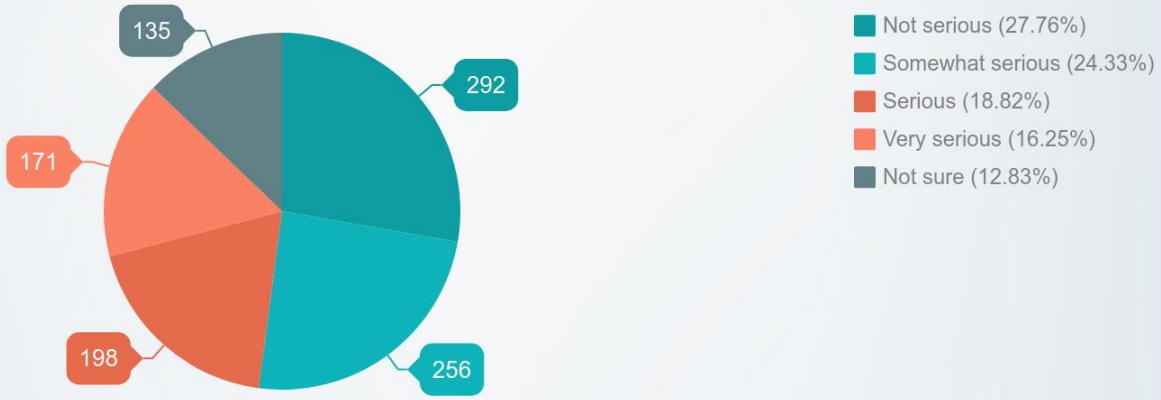
Help with school or training

No (76.15%) Yes (23.85%)

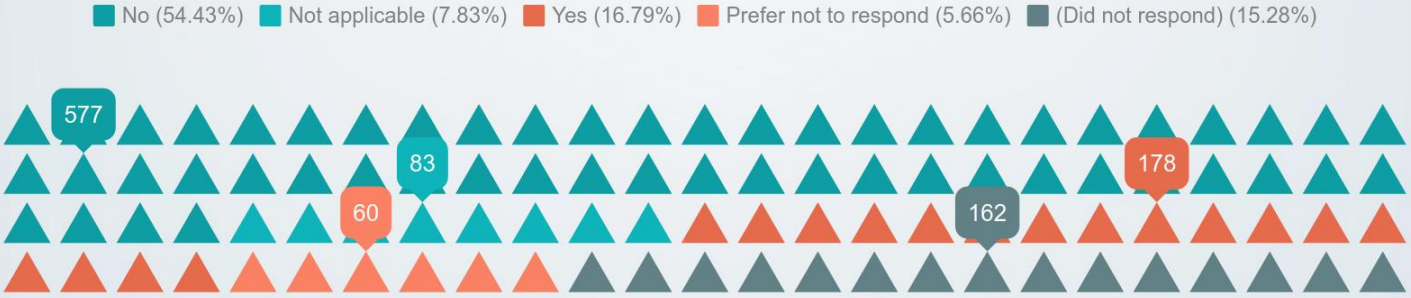
LLUH CHNA 2019 Community-Based Survey

Key Focus Areas To Improve Community Health

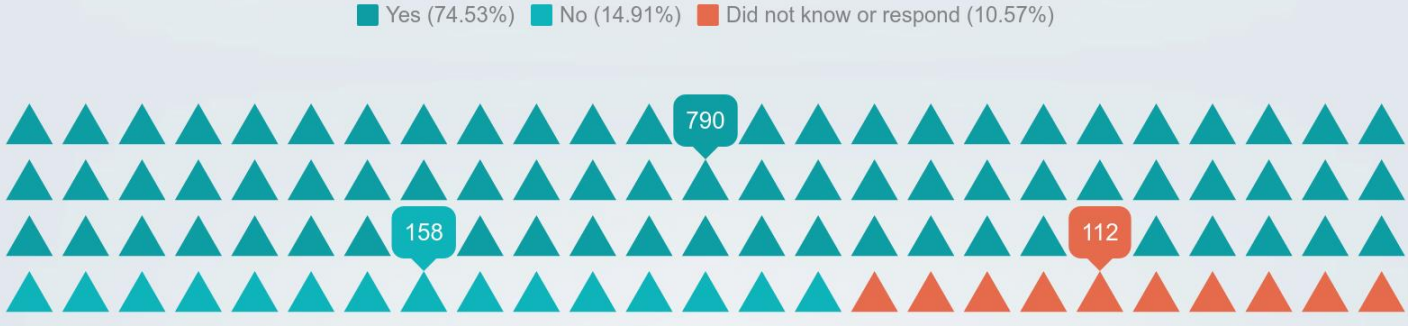
Feel the level of crime is a serious issue in your community



Immigration status a cause of stress to families and children



Basic financial literacy/knowledge to avoid predatory lending



Findings by Assessment Component

Tool: Children's Health Survey

Purpose: A 56-question survey, adapted from the Child and Adolescent Health Measurement Initiative. The survey was designed to identify parent's perception of their children's health and health needs and was administered through ICP community benefit programs. See Appendix C for findings.

Findings: 74 Parents/Legal Guardians completed the adopted version on Child and Adolescent Health Measurement Initiative (CAHMI) survey. The mean household size for survey respondents was 4.5.

The goal of the assessment was to listen to people who represent the strengths, needs, and perspectives of under-served communities and to identify the needs of children across the socioeconomic spectrum: 26% of the survey respondents had an average household income of $50,000 or less.

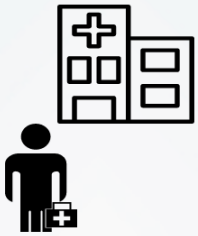
The top determinants named were: **Built environment** (need for safe green spaces), **income insecurity** (difficulties affording the essentials), and **access to care**.

Children's Health Study:

N = 74 People

LLUH CHNA 2019
Children's Health Survey

Key Focus Areas To Improve Community Health

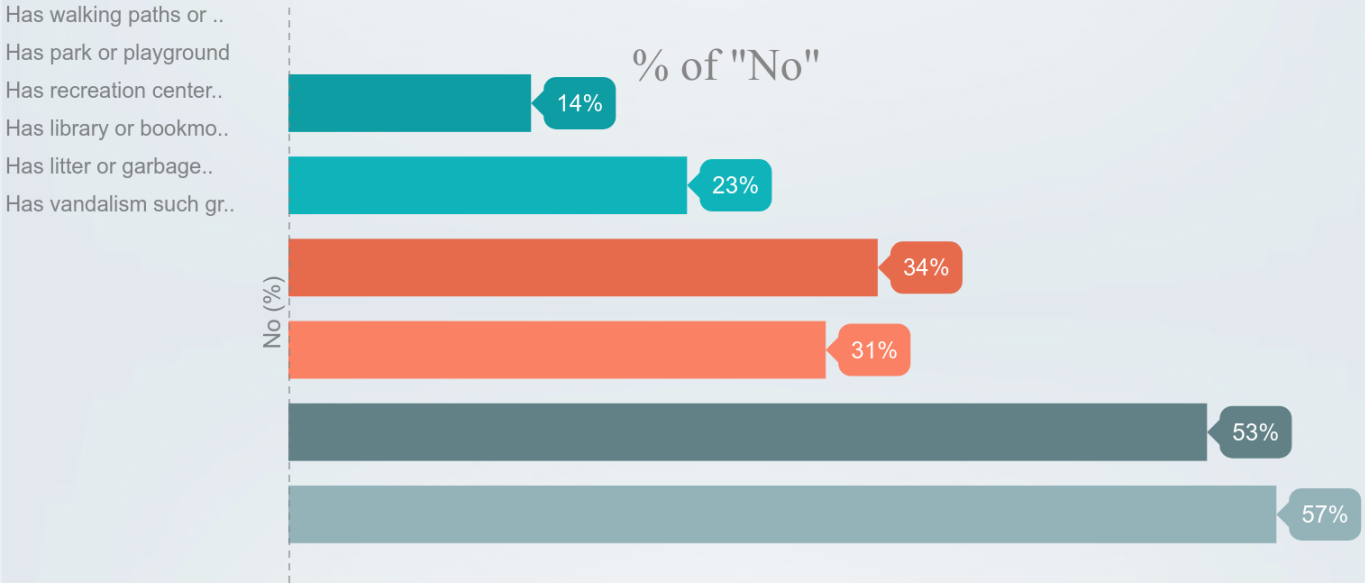


Child needed or saw a health care professional for Mental Health

Child has Asthma

Hard to get by on family's income -hard to cover basics like food or housing

Built Environment and Neighborhood



Findings by Assessment Component

Tool:	ICP & Community Partner Focus Groups: “Community Conversations”
Purpose:	To capture the voice of the community and their perspective on the un-met health needs of their communities.
Key Facts:	18 focus groups were conducted with community partner organizations representing 205 people comprised of community members and the LLUH system community advisory councils. Standardized questions were used with all groups. Seven of the focus groups were conducted in Spanish; 11 were conducted in English. See Appendix B for focus group questions and findings.

The goal of the assessment was to listen to people who represent the strengths, needs, and perspectives of under-served communities and to trend their key words into unified themes. More than 50% of participants represented households of less than $50,000 per year.

From the voice of community members they told us:

People need health.

People want more community.

Community members named the social determinants of health:

1. **Cost of housing/affordability**
2. **Work/Jobs**
3. **Access to care**

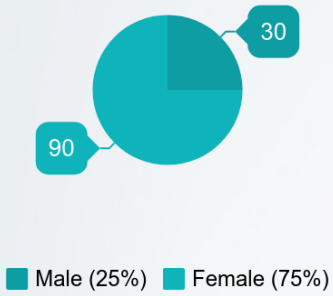
Community Conversations:

N = 205 People **11 in English; 7 in Spanish**

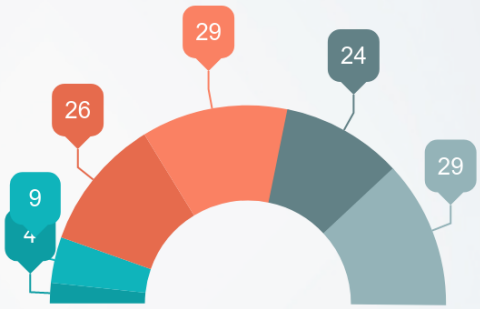
LLUH CHNA 2019
Community-Based Focus Group

Key Demographics

Total Number of Community-based Focus Group (N) = 121

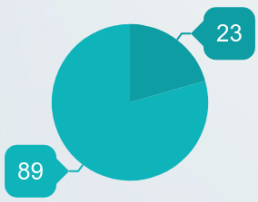


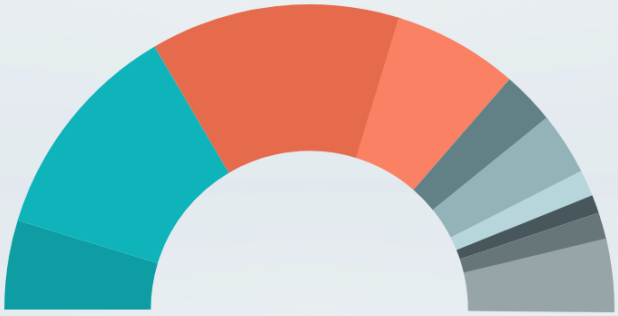
Age Distribution

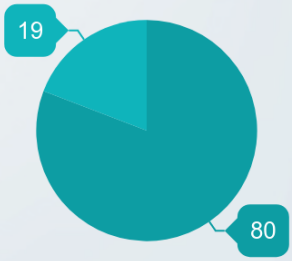


Education Level

Household Income



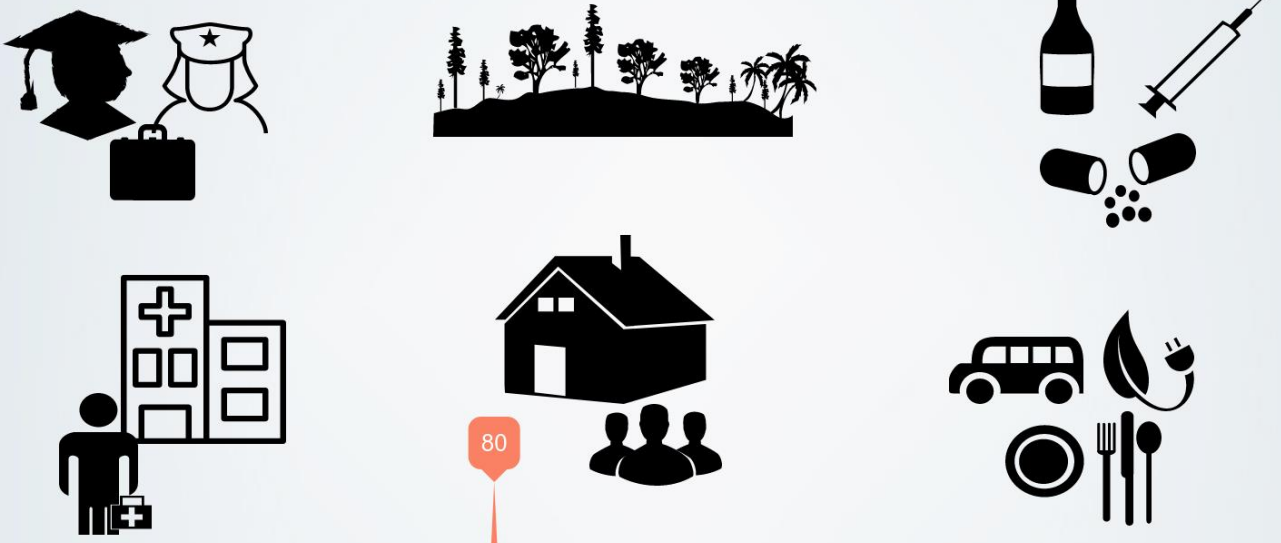


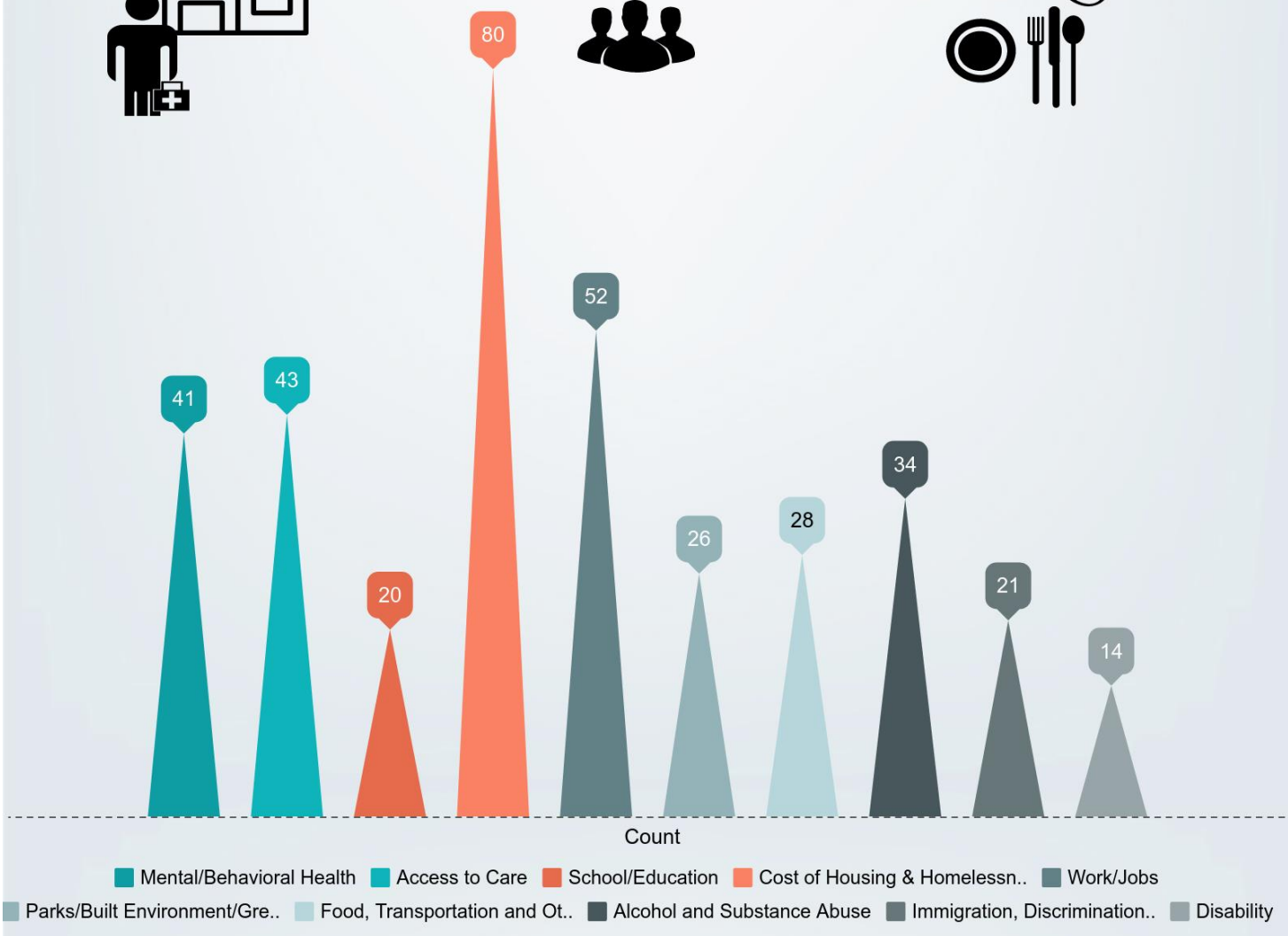


$0 to $9,999 (9.43%) | $10,000 to $24,999 (23.58%) | $25,000 to $49,999 (26.42%) | $50,000 to $74,999 (13.21%)
$75,000 to $99,999 (5.66%) | $100,000 to $124,999 (6.60%) | $125,000 to $149,999 (2.83%) | $150,000 to $174,999 (1.89%)
$175,000 to $199,999 (2.83%) | $200,000 and up (7.55%)

LLUH CHNA 2019
Community-Based Focus Group

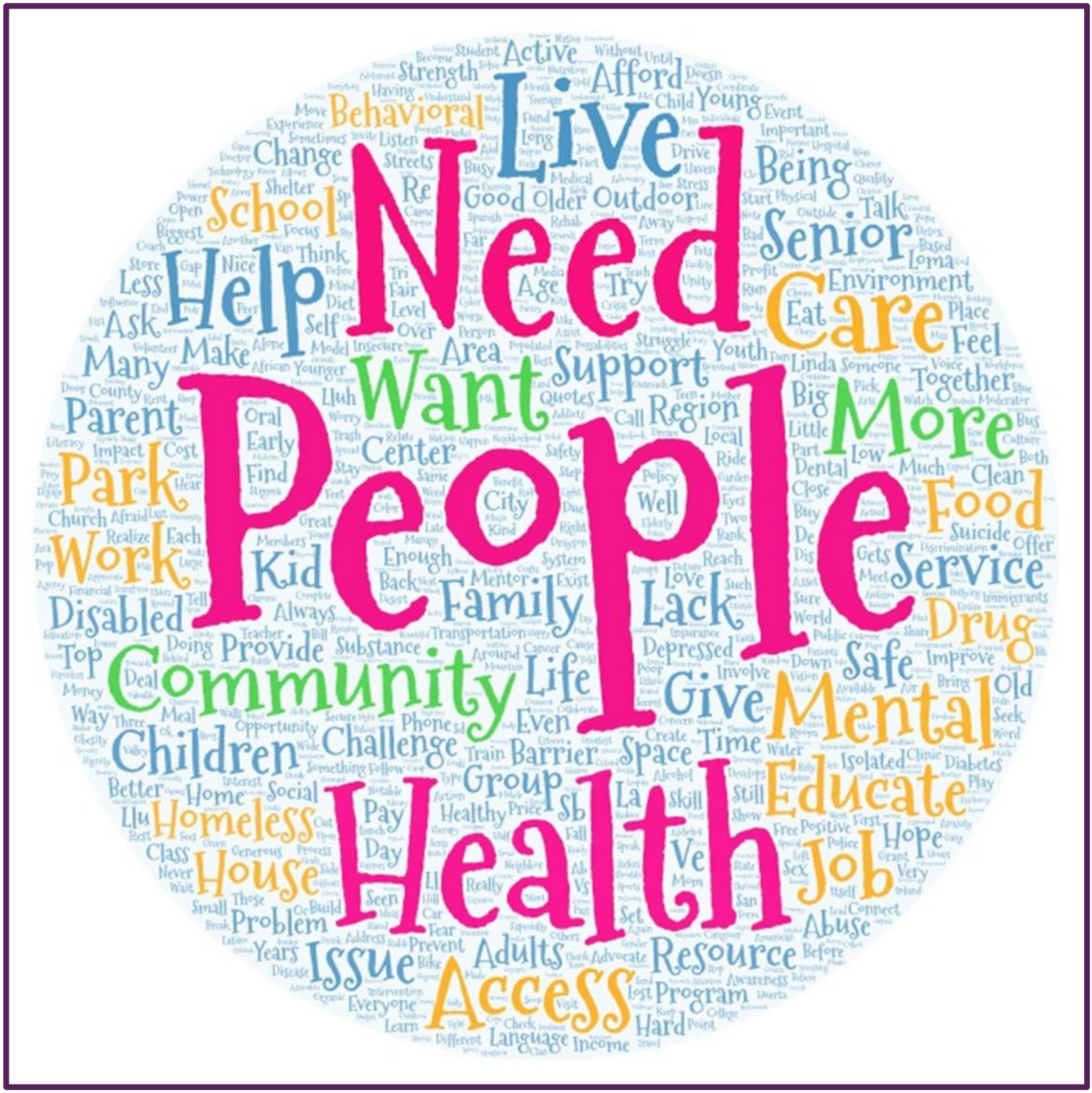
Key Focus Areas To Improve Community Health



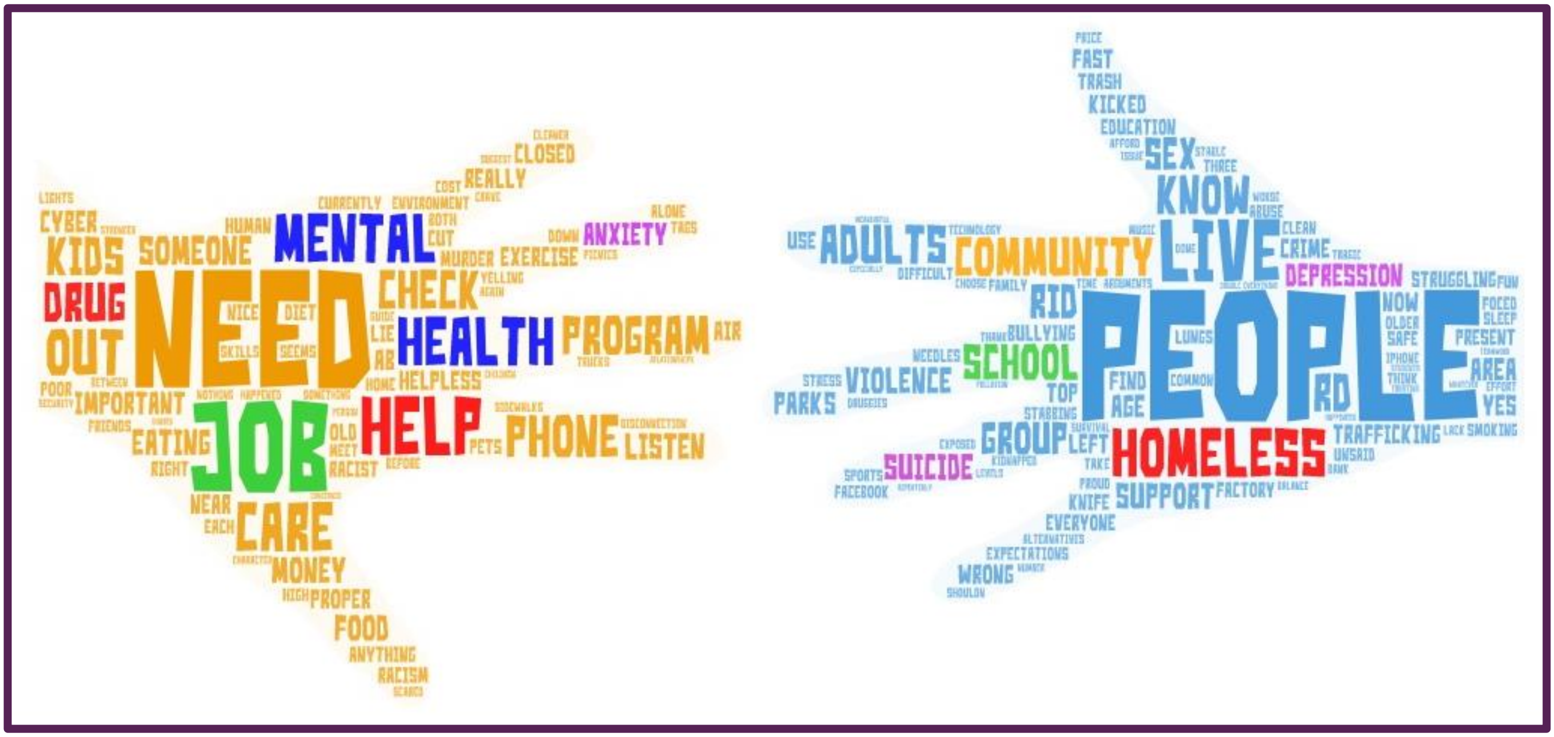


Focus Groups – Thematic Findings by Frequency of Key Words –

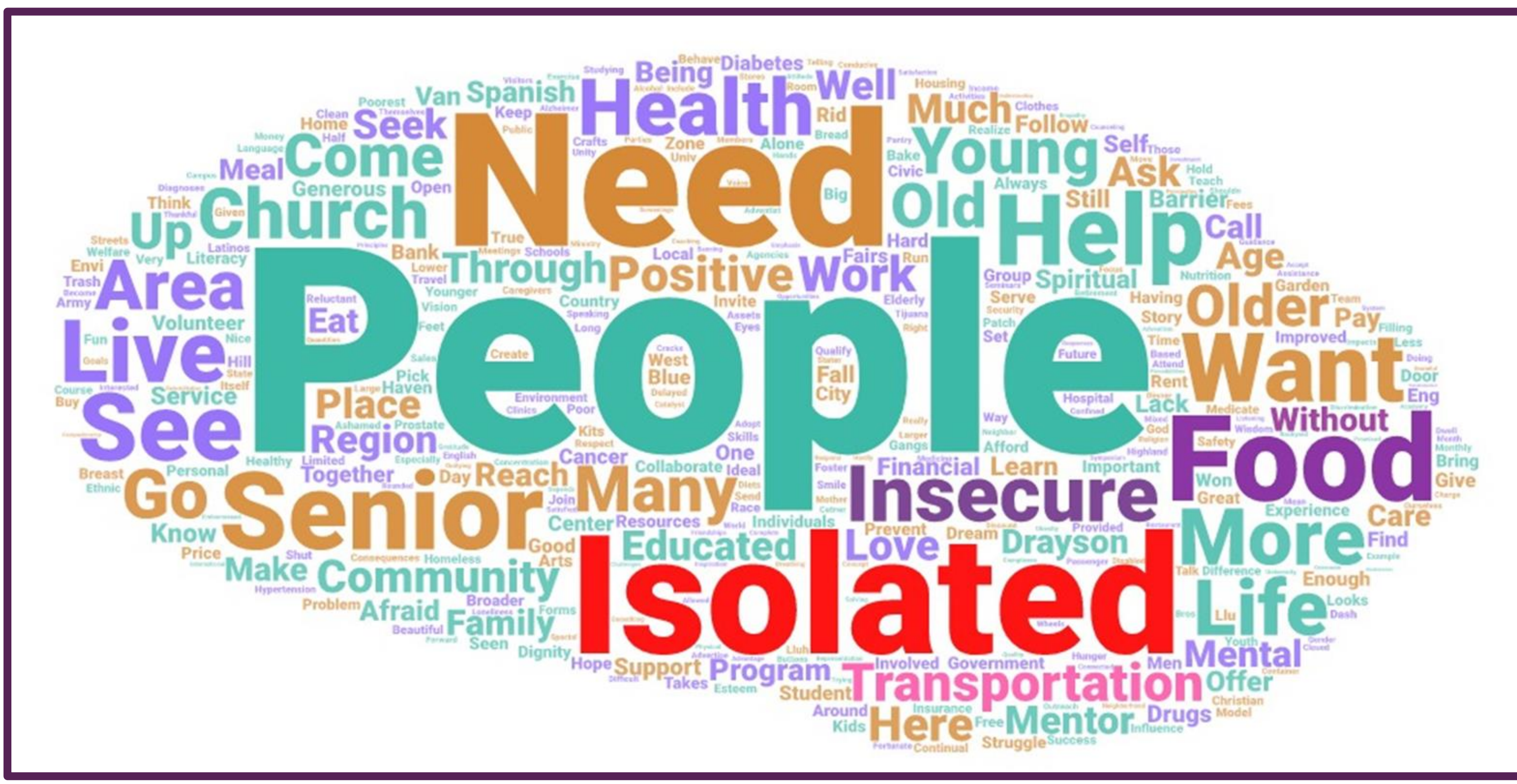
All Groups



Focus Groups – Thematic Findings by Frequency of Key Words – Youth



Focus Groups – Thematic Findings by Frequency of Key Words – Seniors



LOMA LINDA UNIVERSITY HEALTH

San Manuel Gateway College

The Power of Community Health Workers (CHWs) in Assessing the Needs of Under-served Communities

As part of the training of community health workers at the LLUH San Manuel Gateway College, CHWs learn to assess the communities they serve for the social determinants of health. Every cohort of students produces practicum projects where they perform assessments in underserved regions. For the 2019 CHNA and 2020-2022 CHIS, LLUH will work with SMGC's CHWs to continuously assess the needs of communities with preliminary findings below. The Data Visualization section includes a map of CHW projects across the region.

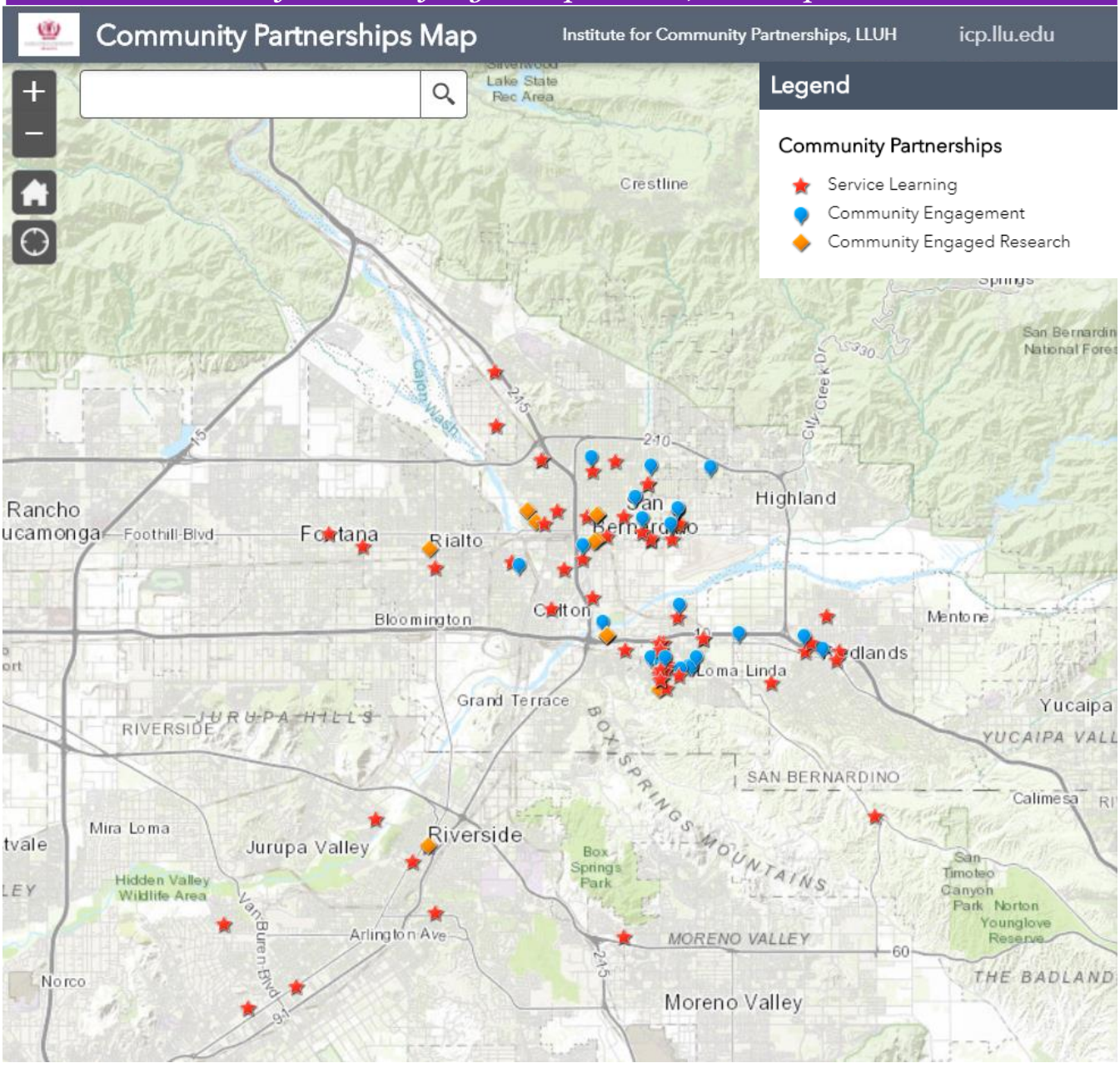
46 Community Health Worker Student Projects have been analyzed to-date.

Data Visualization & Mapping

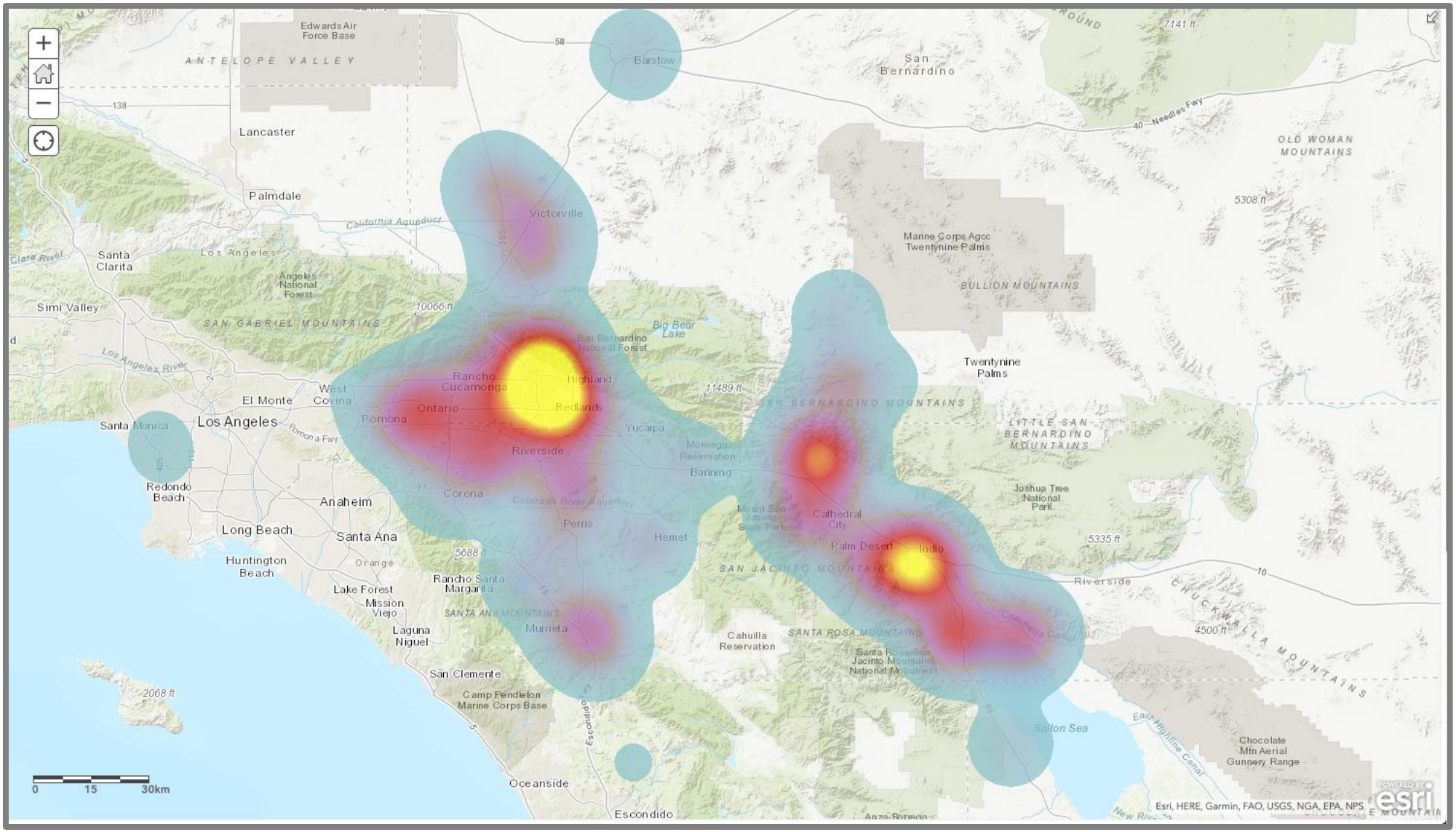
Data Visualization - GIS Mapping

LLUH's work with ESRI's ArcGIS® mapping system is allowing for enhanced data collection and analysis as to the geographic profile of certain disease or even social determinant needs experienced in our region. LLUH is working on developing the capability to link chronic population health trends to social determinant burdens through data visualization in order to refine our approach to community benefit and improvement of health outcomes, a major goal for the 2020-2022 implementation cycle. For the 2019 CHNA, the LLUH team was able to visualize diabetes, asthma, and behavioral health diagnoses. The maps on the following pages illustrate the geographic profile of the disease burden and complicating factors. The ICP Partners Maps, below, is an illustration of the distribution of resources and assets across the same region and the geographic representation of the 2019 CHNA community-based data collection efforts.

Mapping our Collaborations – ICP Partners Map
For a full view of regional partners, visit: icp.llu.edu

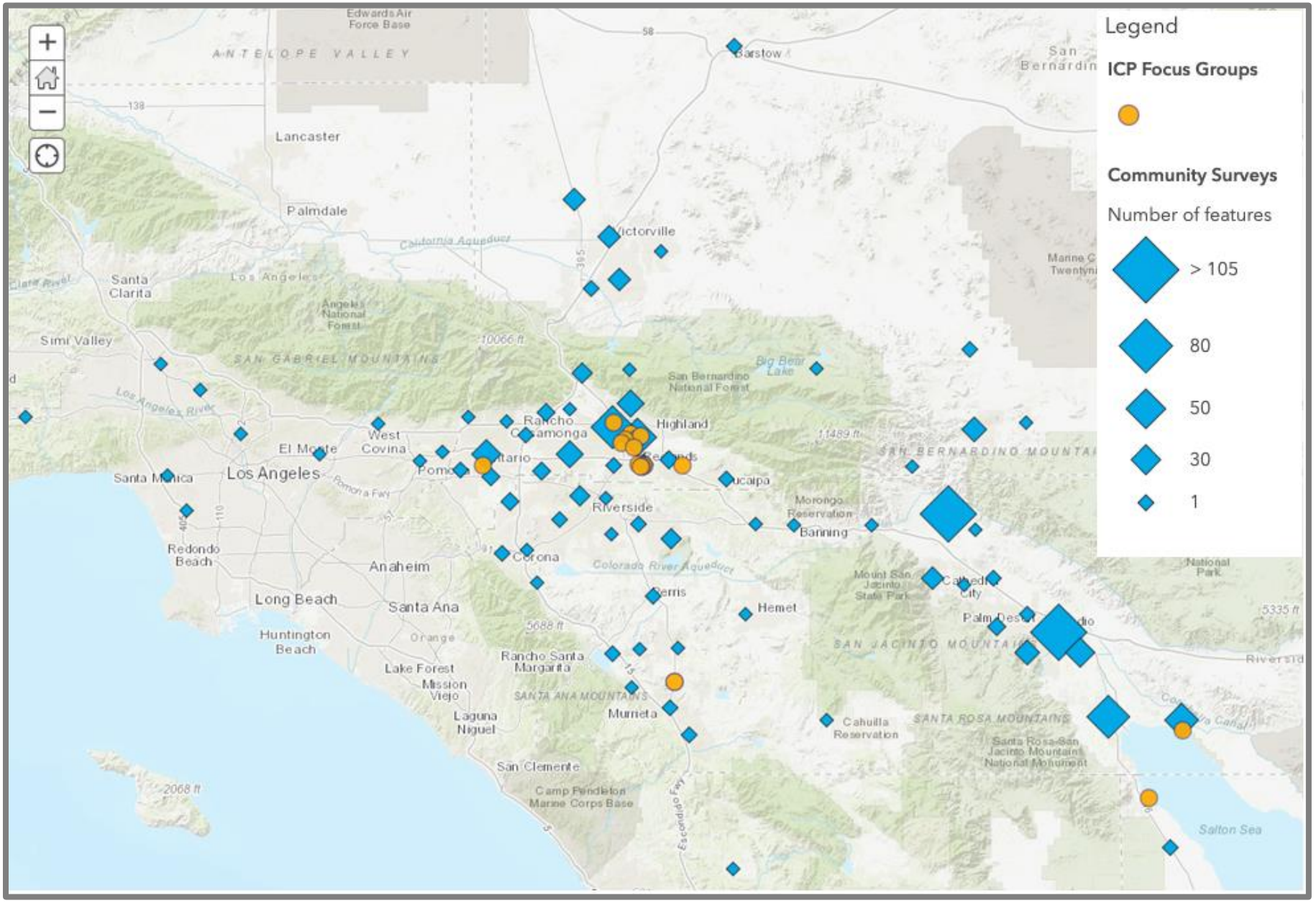


LLUH Community-based Survey and Focus Group[22]



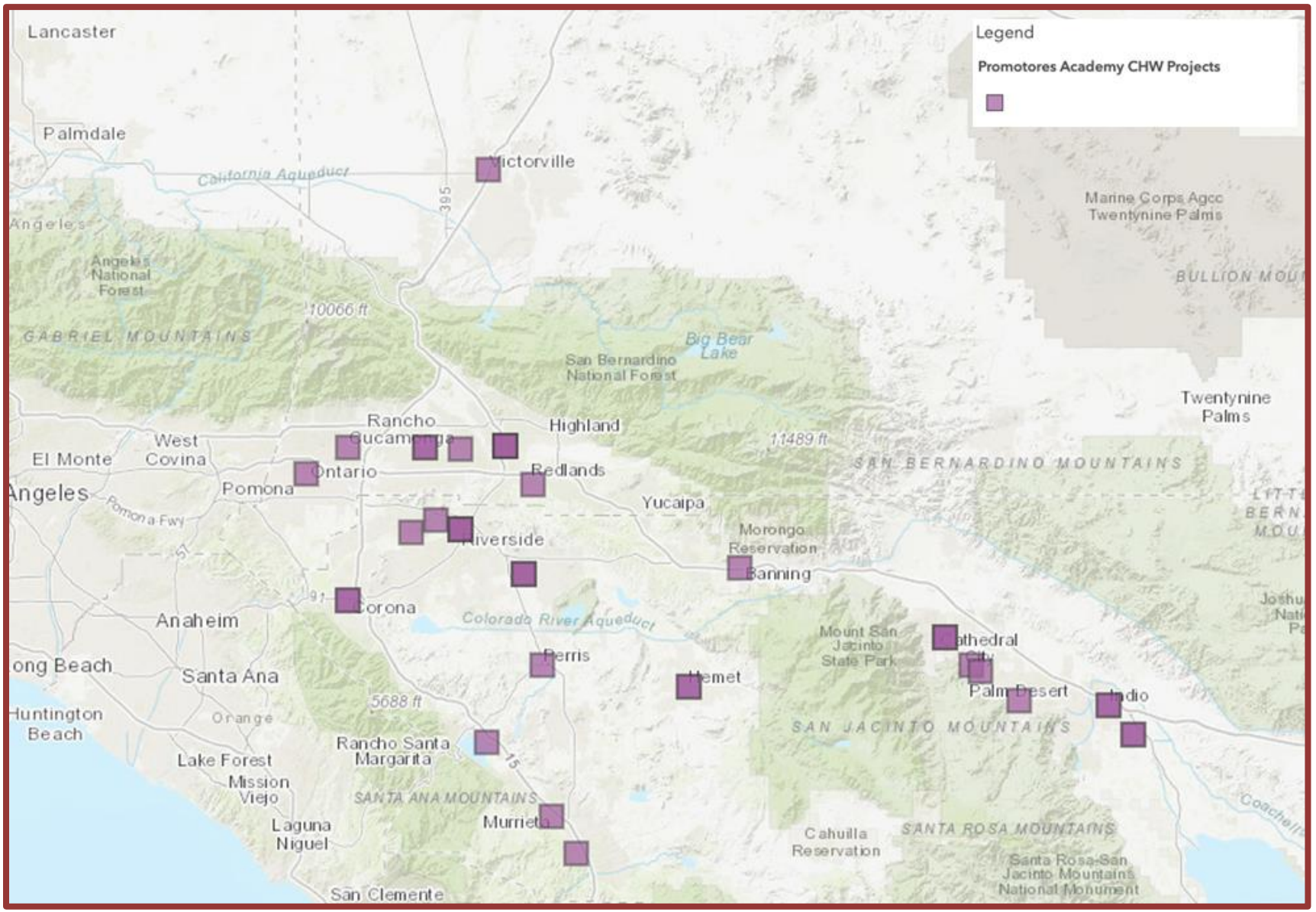
[22] Data based on Zip Codes listed by Survey and Focus Group participants

LLUH Community-based Survey and Focus Group[23]



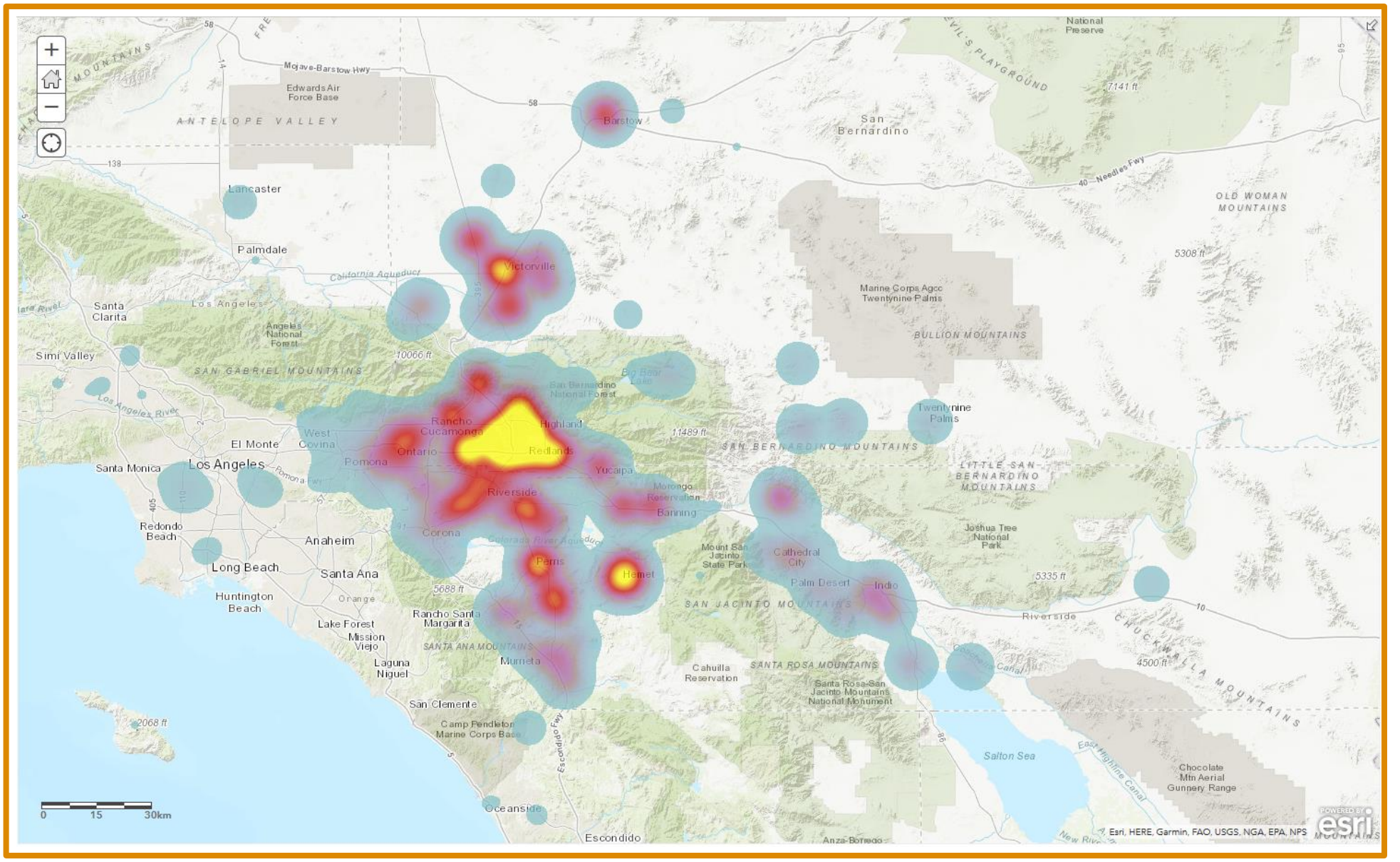
[23] Data based on Zip Codes listed by Survey and Focus Group participants.

Loma Linda University San Manuel Gateway College: *Promotores* Academy CHWs Assessments[24]



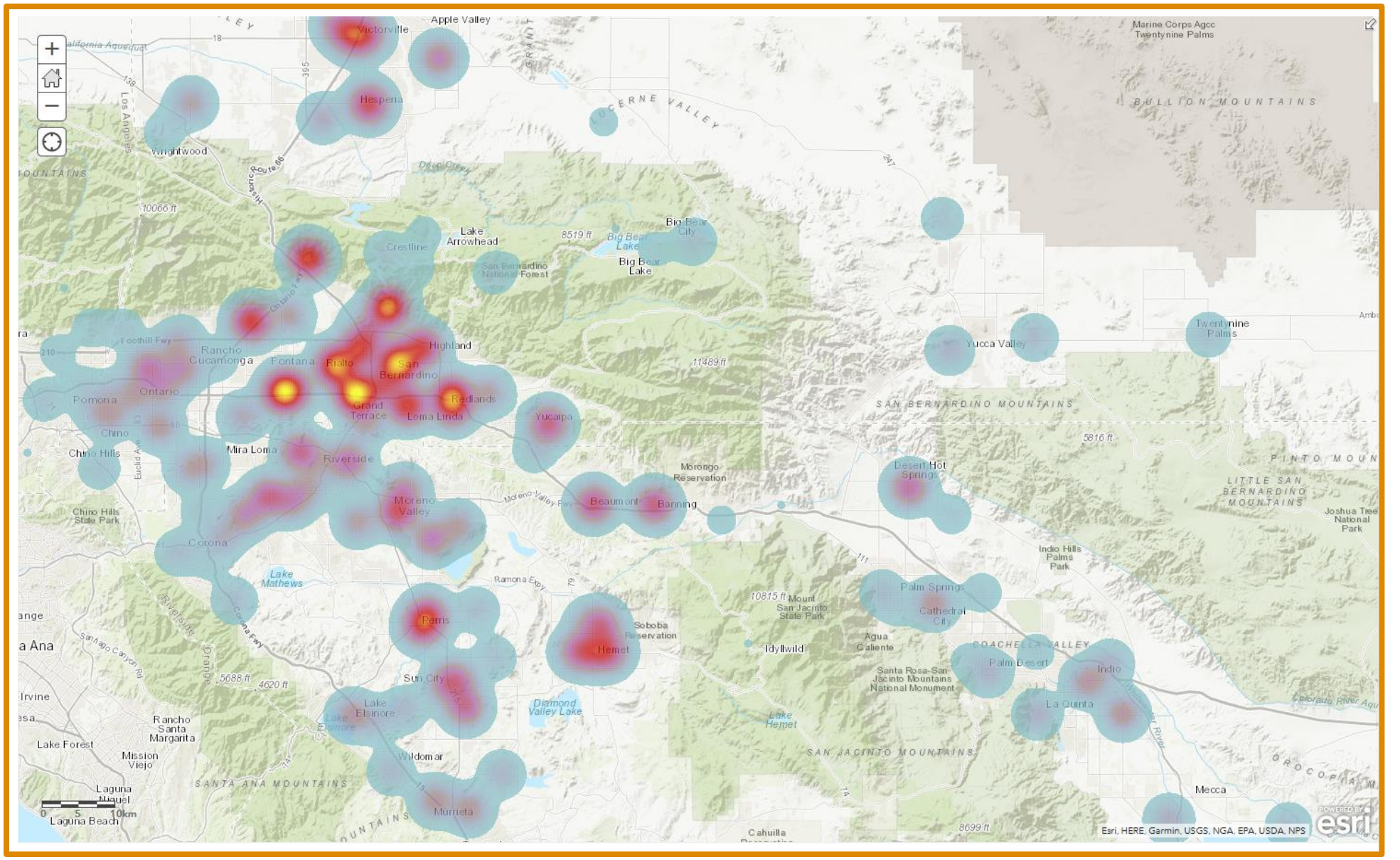
[24] Data based on Community Health Workers (Practicum Projects) Community Needs Assessments.

Diabetes Concentrations from a Regional Perspective[25]



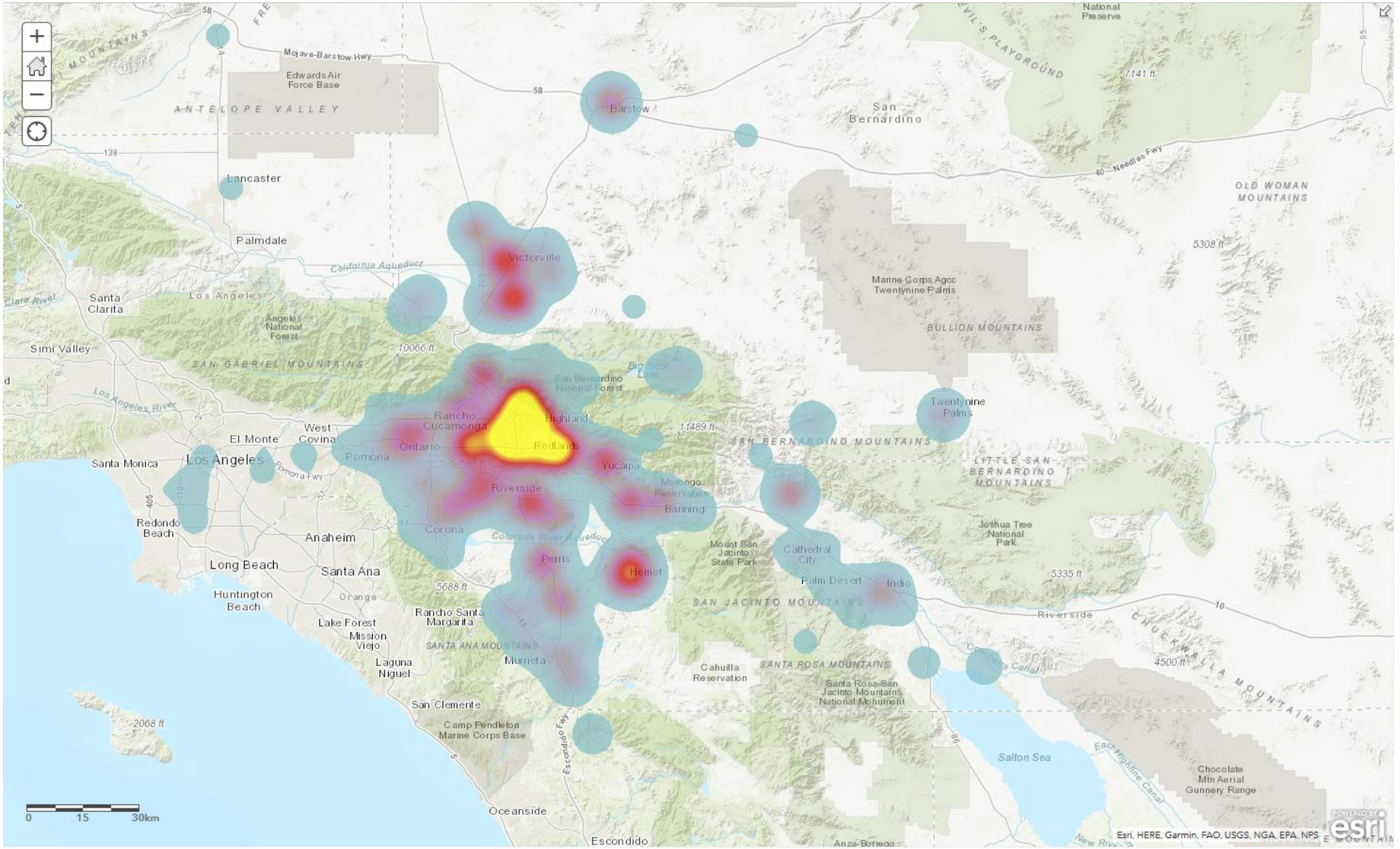
[25] Based on LLUH System Data (2017 – 2018). Patients (all age groups) who presented to emergency departments and for inpatient admissions due to Diabetes as the primary reason for visit.

Diabetes Hot Spot Concentrations[26]



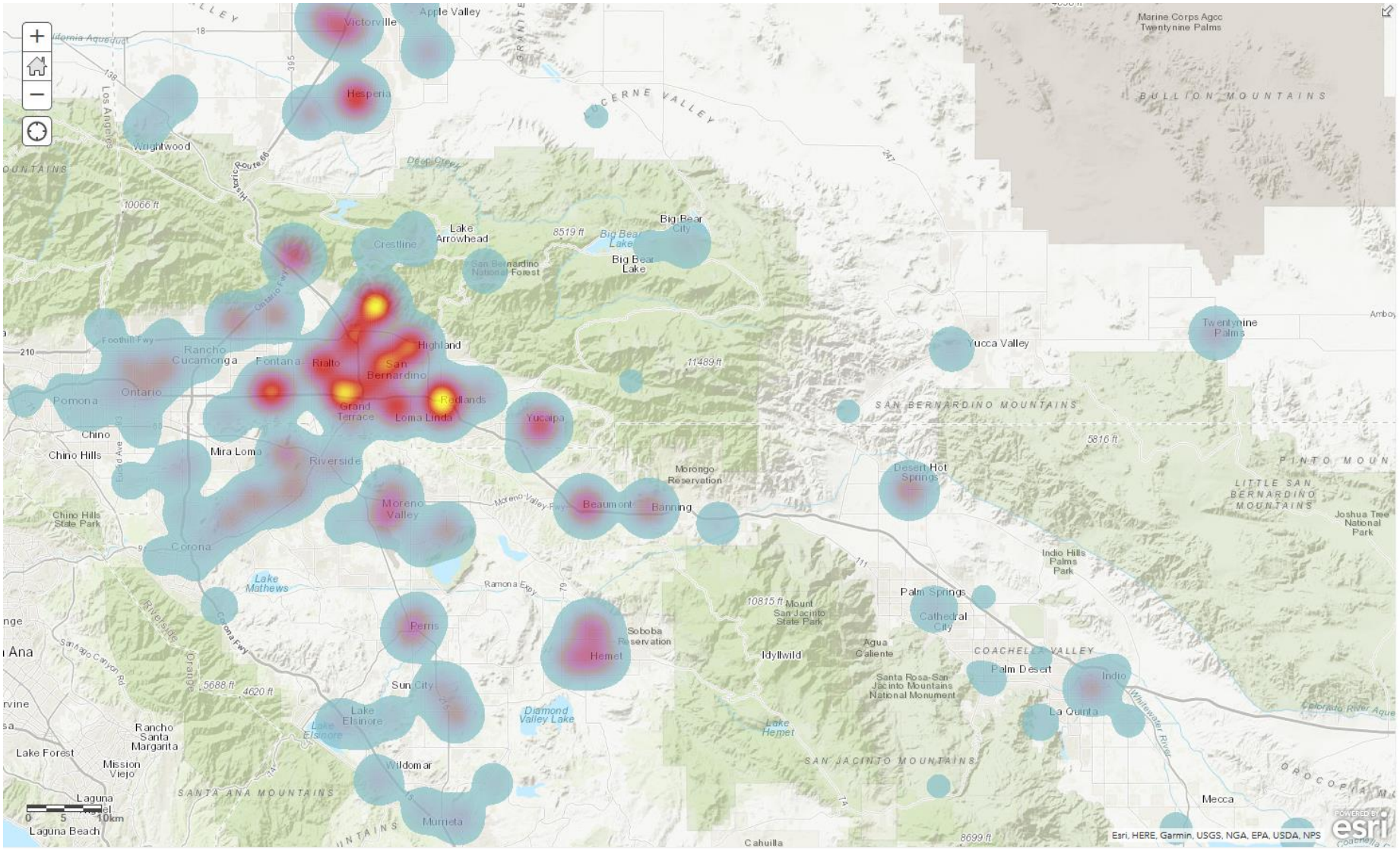
[26] Based on LLUH System Data (2017 – 2018). Patients (all age groups) who presented to emergency departments and for inpatient admissions due to Diabetes as the primary reason for visit.

Asthma Concentrations from a Regional Perspective[27]



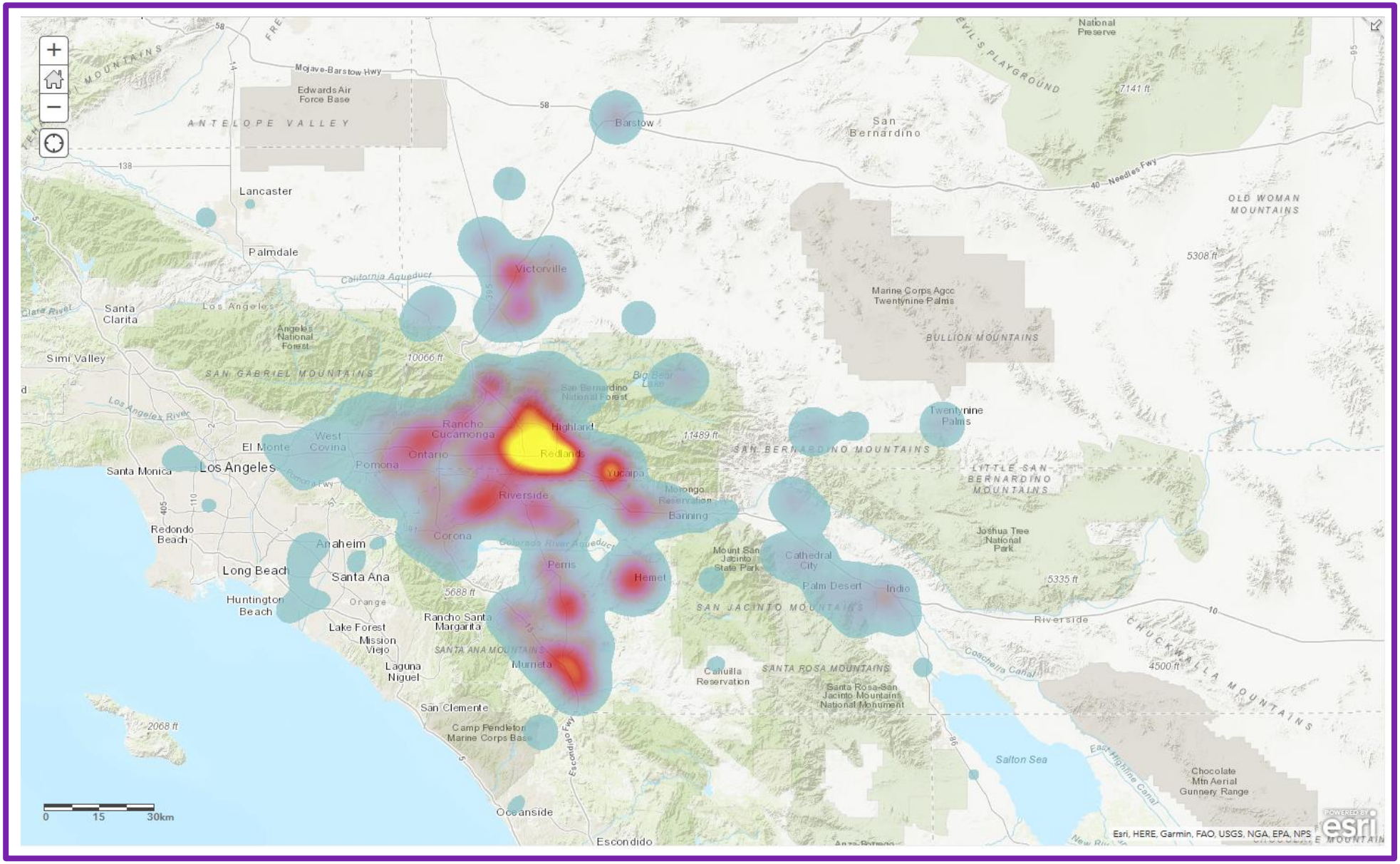
[27] Based on LLUH System Data (2017 – 2018). Patients (all age groups) who presented to emergency departments and for inpatient admissions due to Asthma as the primary reason for visit.

Asthma Hot Spot Concentrations[28]



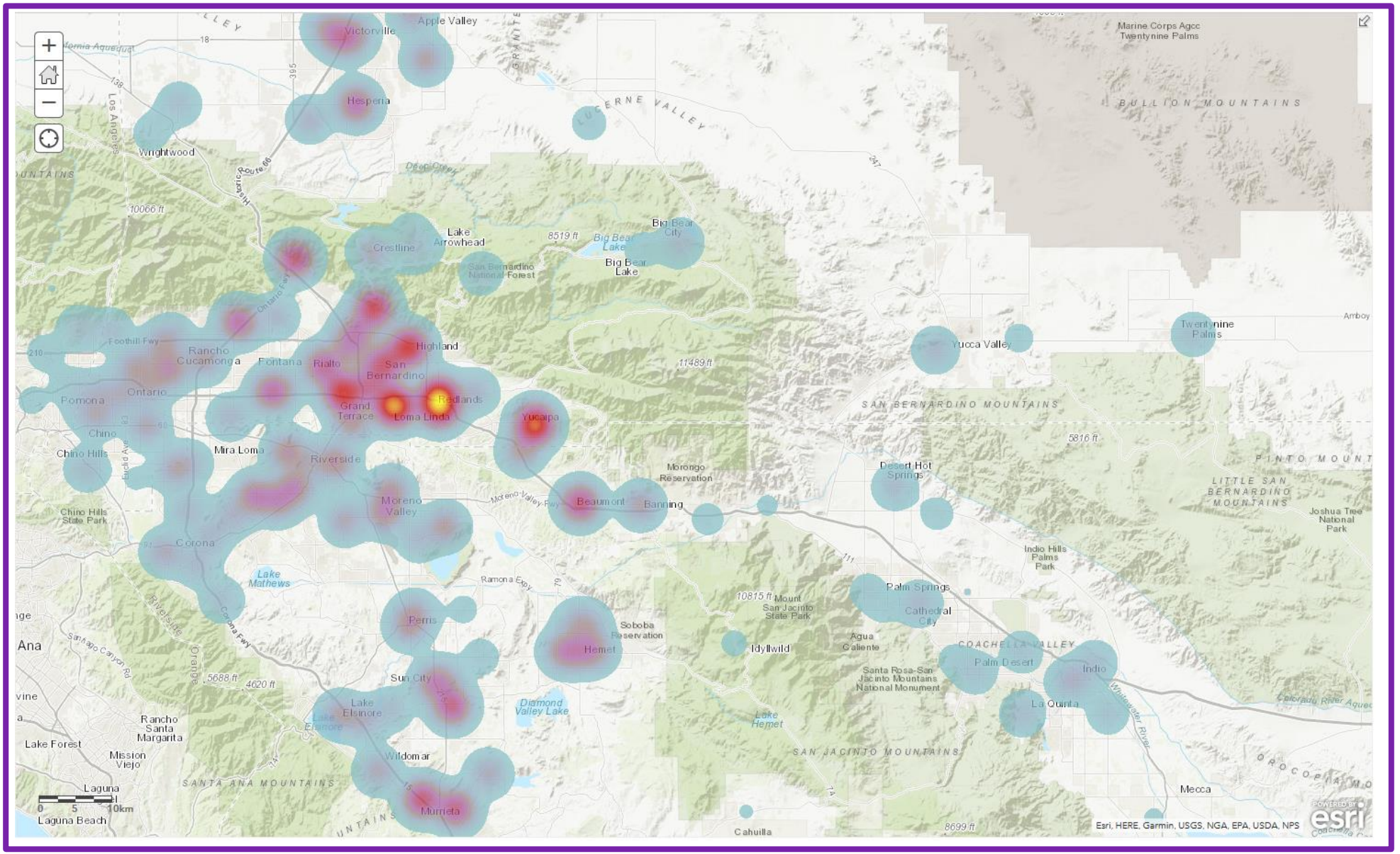
[28] Based on LLUH System Data (2017 – 2018). Patients (all age groups) who presented to emergency departments and for inpatient admissions due to Asthma as the primary reason for visit.

Behavioral Health Concentrations from a Regional Perspective[29]



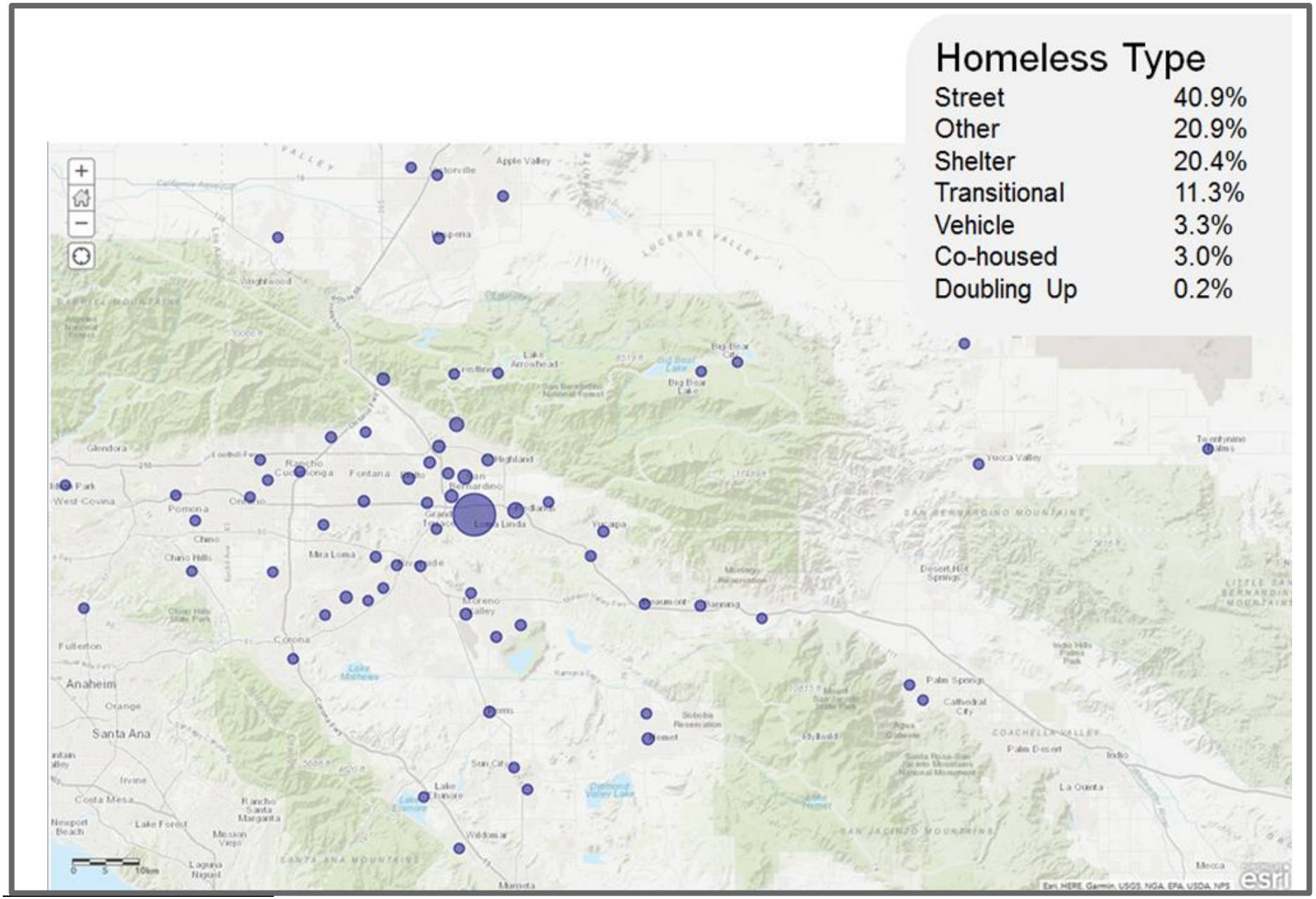
[29] Based on LLUH System Data (2017 – 2018). Patients (all age groups) who presented to emergency departments and for inpatient admissions due to a behavioral health diagnosis or issue. Representative of behavioral health DRG and ICD-10 related codes such as psychosis, anxiety, depression, alcohol and drug abuse or overdose, and suicidal ideation, intentional self-harm.

Behavioral Health Hot Spot Concentrations[30]



[30] Based on LLUH System Data (2017 – 2018). Patients (all age groups) who presented to emergency departments and for inpatient admissions due to a behavioral health diagnosis or issue. Representative of behavioral health DRG and ICD-10 related codes such as psychosis, anxiety, depression, alcohol and drug abuse or overdose, and suicidal ideation, intentional self-harm.

LLUH Patients Experiencing Homelessness[31]



[31] Data based on tracking of homeless patients in the LLUH system by zip code and type of homelessness experienced when presenting to emergency departments and inpatient settings. Homeless patients sometimes report the city of the hospital where they are being seen if they have no address, which can hyper-concentrate zip code frequency.

Evaluation of the Last CHIS: 2017-2019

Evaluation of the Last LLUH Community Health Implementation Strategy: 2017-2019 Program Years) [32]

Through the Institute for Community Partners and other health and wellness programs on the LLUH Campus, LLUH has invested time, resources, and dollars in improving the health and well-being of the communities we serve. The 2016 Community Health Needs Assessment identified five primary areas of focus along with access to health care (a common goal among all non-profit providers for community benefit) to inform the 2017-2019 fiscal years as part of the three-year community benefit cycle:

Priorities of last three years:

Workforce Development
Education
→ Social Determinant Priorities

Mental Health
Obesity
Diabetes
Access to health care
→ Population Health Priorities

Based on data collected by ICP, the following macro statistics provide insight as to the total extent of the LLUH community-based partnerships, contacts, and interventions:

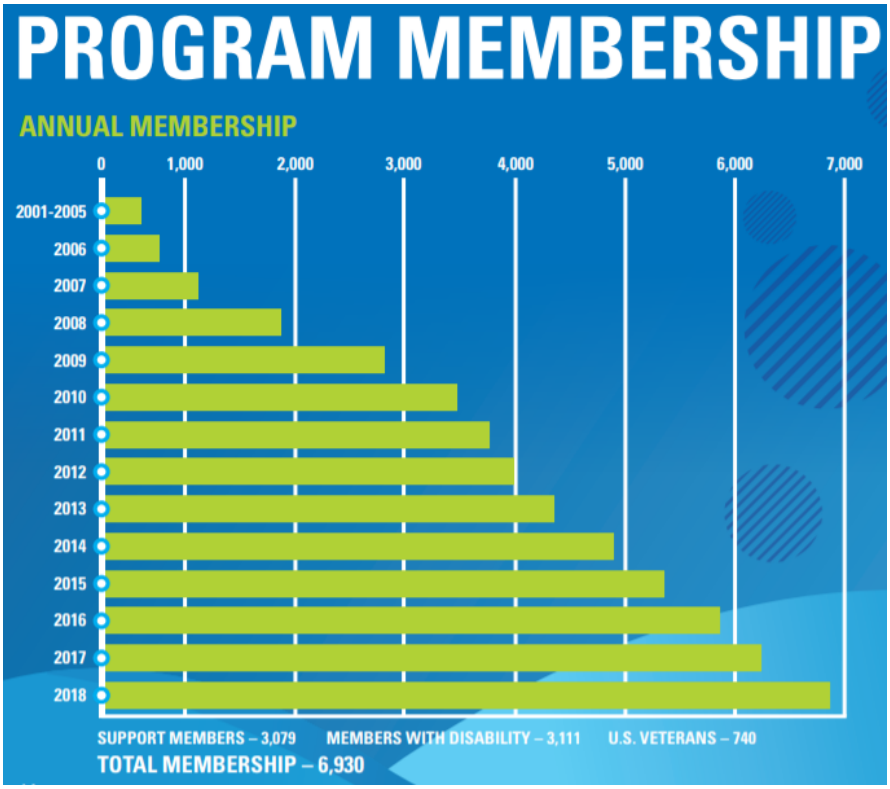
[32] 2019 fiscal year financial information is reported in 2020, in keeping with IRS guidelines for tax reporting. Any information presented in this report on 2019 is only programmatic. Financial data for FY19 will be available in Spring of 2020.

LLUH Health System – Health Education, Outreach, and Special Populations

As a major academic medical provider, LLUH is privileged to serve people living, thriving, and healing from health conditions that represent a range of special populations. Every year, LLUH hospitals provide supportive resources and services above and beyond the standards of patient care in order to encourage the health, wellness, and in order to address the whole-person need of the people we serve. For some populations, LLUH is the only provider in the region for specialty services. These are cash and in-kind services provided to community members as part of our community benefit.

LLUH System Health System
Amyotrophic Lateral Sclerosis (ALS) Support Group
Chemical Dependency Support Group and Educational Forms
Cancer Outreach Events
Cancer Health Fairs
Cancer Screenings
Cancer Support Groups
Cancer Walk
Cancer Support Services
Children Breastfeeding Education for Community Members
Children and Family Health Fair
Children Prevention Programs: OK KIDS, Health4Life, Safe Kids
Youth Alternative Solutions
Heart Health Education
Heart Health Prevention Education
Heart Health Screening
Heart Health Wellness Fairs
Sickle Cell Education Series
Sickle Cell Fair
Clergy Collaboration and Appreciation
Faith and Health Initiatives and Counseling
Children's Day
Family Health Fair
Baby Conference
Charity Medications
Community Support/Watch Groups

Outcomes Spotlight - PossAbilities



The PossAbilities program is one of LLUH's longstanding community benefit programs. PossAbilities is a free community outreach program developed by Loma Linda University Health. Its goal is to offer disabled individuals who were born with, or have suffered a permanent physical injury, a sense of community and a healthy social network. The mission of PossAbilities is to provide new direction and hope through physical, social, and educational interaction with peers and their community. This free membership program is tailored to persons with physical disabilities such as limb amputation, stroke, spinal cord injury, traumatic brain injury, multiple sclerosis, muscular dystrophy, spina bifida, and sickle cell disease.

In 2018 the program reached a milestone of **6,930** members. Membership is open to both disabled and able-bodied peoples: with support groups and activities representing a truly community-based approach. While the program costs are off-set by sponsorships, Loma Linda University Medical Center is the primary funder of the program with **over $500,000 in community benefit dollars** invested in FY 2018.

PossAbilities Highlight Programs

For a complete report on PossAbilities, please see their website and annual reports at: www.teampossabilities.org

Annual PossAbilities Triathlon

The Annual PossAbilities Triathlon, 5K & Kids' Triathlon, features events for adults and children and it is held at the Loma Linda University Drayson Center. What makes this triathlon special is that challenged and able-bodied athletes as well as U.S. veterans compete on the same stage. This is perhaps the largest event on the PossAbilities calendar. The triathlon is a collaboration between Loma Linda University Health, San Bernardino Sheriff's Department, City of Loma Linda, and dozens of local businesses and vendors. Each year, nearly 1,000 athletes participate in this family-oriented, non-competitive event.

Annual reach: 1,500 at the regional and local levels.

Sickle Cell Disease Support Group and Educational Series

The adult and family Sickle Cell Disease Support Group and Educational Series offers support, educational material, and wellness resources to help those with sickle cell manage their disease and to achieve the highest quality of life. The group meets once a month to share information, motivation, education, connections, recreation, relationships, and encouragement. This support group is only one of four such groups in California and the ONLY group in Inland Empire!

Annual reach: 300 at the national and local levels.

Limb Loss Running Clinic

The limb loss running clinic is a new addition to the program offerings. This free clinic is offered to members with limb loss who want to learn how to improve running whether for a competition, for fitness, or engagement with their family. Through careful instruction by physical therapists and prosthetists, participants can achieve higher ambulation function through one-on–one instruction.

Annual reach: 100 at the local level.

Outcomes Spotlight –
ICP & Community Engagement

Through the Institute for Community Partnerships, LLUH is able to partner with organizations on community-based participatory research initiatives and is able to provide community partner organizations assessment, implementation, and evaluation and research expertise. ICP, funded by the LLUH hospitals, increases access to the resources of the academic medical, graduate institution, including graduate student researchers, in order to support the region through assessment, implementation on projects, and research. Additionally, ICP manages the service learning projects for LLUH students to go out and serve the broader community in volunteer hours and time spent in service working with community members.

For the 2017-2019, three-year cycle of community benefit, LLUH implemented the following community programs, a representation of efforts across the institution towards the community benefit priority areas and as part of the commitment to increasing access to health resources and care.

Comprehensive Programs based on 2016 CHNA & 2017-2019 Program Years

LLUH Community Benefit	Workforce	Education	Mental Health	Obesity	Diabetes
Summer Gateway Program*	X	X			
My Campus*	X	X			
Goal 4 Health*		X		X	
Community Health Worker Pilot at LLUH	X		X	X	X
Reach out and Read		X			
Just for Seniors			X	X	
PossAbilities			X		
Mental/Behavioral Health Education and Awareness			X		
Senior Behavioral Health Services			X		
Behavioral Health Fairs			X		
Chemical Dependency & Educational Forms			X		
Children Camp Good Grief			X		
Behavioral Health Screenings			X		
Stand up to Stigma 5k			X		
Operation Fit				X	X
Help Me Grow				X	
Diabetes Monthly Support Group					X
Diabetes Blood Screenings					X
Diabetes Treatment and Prevention					X

*Pipeline Programs for Communtiy Youth to increase access to healthy lifestyles and health care career opportunities.

Outcomes Spotlight: ICP Pipeline Programs

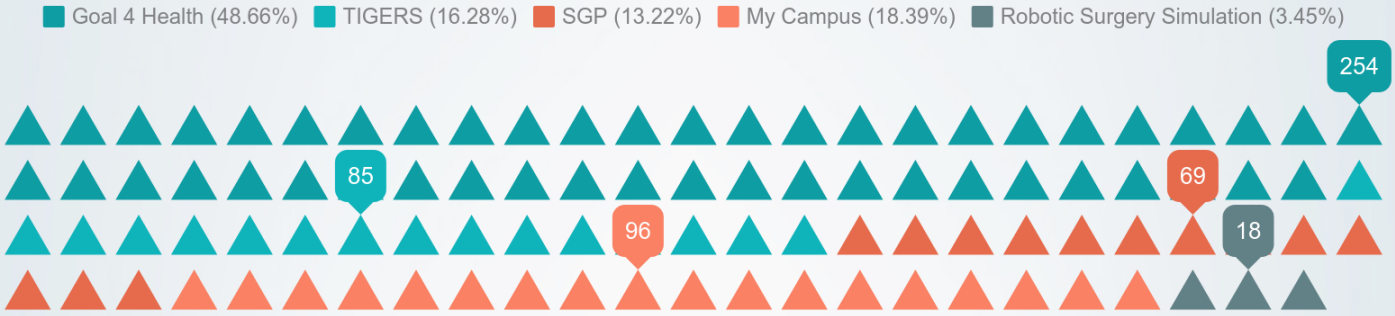
The pipeline programs run by the Institute for Community Partnerships are intended to provide disadvantaged youth exposure and access to exercise, healthy lifestyle education, and career options in health care in order to increase access to education, as part of the community benefit investments made by the LLUH hospitals. The pipeline programs Goal 4 Health, My Campus, and Summer Gateway are run by the Community-Academic Partners in Service (CAPS) office and funded by hospital community benefit.

In 2018, CAPS served 522 youth from the surrounding areas, and predominantly from disadvantaged and low income neighborhoods, by providing a safe place for children to play in a community soccer league; quarterly My Campus events, where local high school students attend informative sessions on healthcare careers and tours of the campus; and the Summer Gateway summer-camp, a three-week intensive for local underrepresented minority high school students to spend time on the LLUH campus and learn about the potential for healthcare graduate school and career options to increase their likelihood of pursuing a 4-year bachelor's degree upon graduating from college.

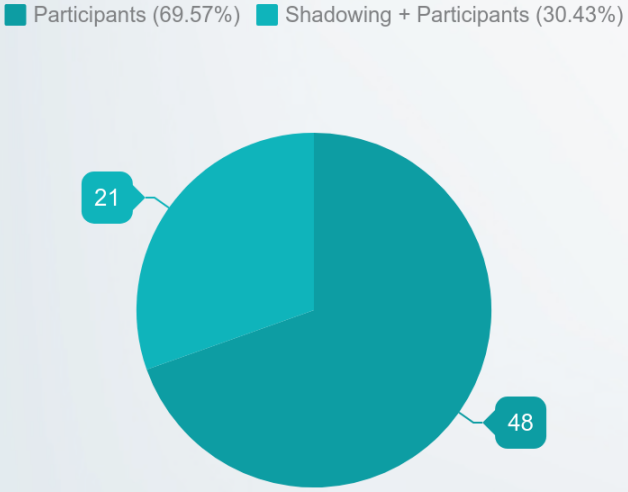
LLUH CHNA 2019
Institute for Community Partnerships

CAPS Program Evaluation

CAPS Program Participants

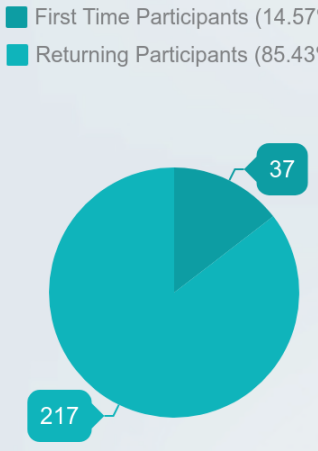


Summer Gateway Program

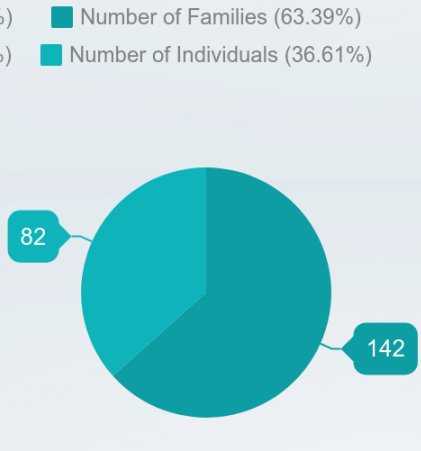


My Campus

Goal 4 Health



Goal 4 Health



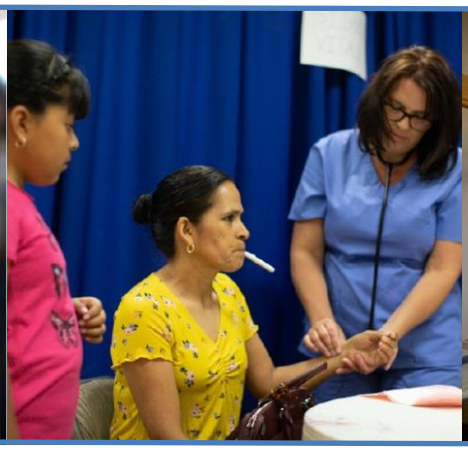
Robotic Surgery Simulation Tour

Outcomes Spotlight: Operation Fit

Operation Fit Children Served: 360 Children 2017 - 2019

Over the 2017-2019 cycle, LLUH community benefit has sponsored the program Operation Fit, a summer camp for children who are underrepresented minority youth from low-income households. The program recruits children to enroll from families seen at the SACHS clinic. The program, Directed by Dr. Marti Baum, Medical Director for Community Health Development at LLUH, provides a week-long program, led by medical students and residents on exercise and nutrition to encourage healthy lifestyles among youth and to provide early-intervention for childhood obesity. Since 2017, Operation Fit has run four camps with 30 children served per camp, per year, or an average of 120 children served annually.

Outcomes Spotlight: Coachella Connect


ICP, local community partners, and local partner health systems organized a community health services fair in order to bring basic medical and dental services to under-served populations out in the East Coachella Valley; populations that often lack access to services due to socioeconomic, and geographic realities. Services provided by the LLU team focused on vision, and comprehensive dental services. **Community Partners Involved:** Our Lady of Guadalupe Church (Mecca), the San Bernardino Diocese, Consulate of Mexico in San Bernardino, Galilee Center, Riverside University Health System, Loma Linda University Health: Eye Institute, School of Dentistry, Children's Hospital, Department of Psychiatry, School of Medicine

120 Vision Screenings

Glasses & Referrals

175 Basic Health Screenings & Vitals Taken

100 Dental Services

Fillings, extractions, cleanings, sealants

50+ Consultations performed by Mexican Consulate



Outcomes Spotlight: Dream Homes Community Health Assessment 2018

LLUH partnered with Desert Healthcare District (DHCD), El Sol Neighborhood Education Center, and many other partners including Cathedral City to implement a community health needs assessment for the Dream Homes neighborhood. The project was funded by DHCD and centered on CHWs working with residents of Cathedral City to assess their health status. The CHWs were provided by the El Sol Neighborhood Educational Center and exemplified the reality that when CHWs can build trust in communities, they do what external evaluators and assessors of community needs cannot: they collect the data but more importantly, simultaneously empower community members to act on community priorities. Through the assessment, the CHWs worked with the community, ICP, and local organizations to host a health fair and to host community forums to support the civic empowerment of residents of the neighborhood. In community forum meetings, CHWs facilitated conversations with the city and county in relation to policing, public works and neighborhood beautification, and conversations about the need for a safe green space for residents to walk and exercise. Among the top health priorities identified for residents **were high blood pressure, cholesterol, diabetes, depression, and anxiety; with access to parks and green spaces and food insecurity** as some of the top social determinants of health needs identified. As part of the sustaining work in the community, LLUH is partnering with other local non-profits to continue to deploy CHWs into under-resourced neighborhoods.

LLUH is deploying community health works through community partners to reach under-resourced neighborhoods and peoples.

Community-based Partner Investments

LLUH has made significant investments in our partner organizations over the 2017-2019 funding cycle through grants, investments in capacity-building of local partners, and in-kind contributions of resources to support the operations of local partners who serve our primary community benefit populations, by community benefit priority areas:

LLUH Community-based Partner Investments based on 2016 CHNA & 2017-2019 Program Years

LLUH Community Benefit	Workforce	Education	Mental Health	Obesity	Diabetes
Youth Hope	X	X			
Community Health Workers / *Promotores de Salud*	X	X			
Scholarships for San Manuel Gateway College	X	X			
San Bernardino Unified School District Bing Wong Elementary	X	X			
CEO San Bernardino	X	X			
FIND Food Bank Community Health Workers	X	X			
Making Hope Happen - *Scholarships*	X	X			
Youth Hope Foundation	X		X		
SAC Health System *(FQHC - San Bernardino, CA)*			X	X	X
Path of Life Ministries			X		
Restaurando Vidas			X		
Voice in the Desert Community Agency			X		
National Alliance on Mental Illness			X		
Alcoholics Anonymous			X		
Community Health Systems, Inc. *(FQHC - Riverside, CA)*					X

Outcomes Spotlight - Scholarships to Support Workforce Development & Education

Over the past three years, LLUH has invested in over **$100,000 in scholarships** to local youth to increase their access to a college education through support of community partners whose mission is to increase access to underserved, under-represented, and minority youth in our region.

San Manuel Gateway College, scholarships to subsidize the cost of a professional certificate program and/or technical training programs:

- Medical Assistant
- Certified Nursing Assistant
- Pharmacy Tech
- Surgical Tech
- *Promotores* Academy

San Bernardino City Unified School District, through the Making Hope Happen Foundation scholarships for students from financially challenged households and situations so they can attend the college of their choice. The scholarships provide $3,000 per student awarded with a mentor to help support them to ensure the success of their transition into a college education. LLUH awarded **22 scholarships** in 2019.

Impact

Impact on the Community - LLUH Community Benefit

Total Community Benefit & Investment by LLUH Health

Fiscal Years January 1, 2016 – June 30, 2018[33]

In a three-year fiscal period, LLUH reported over $500 million in benefit to the community, based on the reporting categories. Within a five-year period (2014-2018) LLUH contributed over $1 billion in benefits to the community.

Of the over $7 million in community health investment in the last three years, LLUH has impacted the lives of over 600,000+ community members in our two-county service region.

$515.72 Million Total
Inland Empire Service Region

$361.59 Million
Shortfalls in Medicaid

$25.16 Million
Free, Low-Cost care & Subsidized Health Services

$7.16 Million
Community Health Services

$121.80 Million
Education & Research

This report is prepared based on audited financial statements and Hospital's 990-Schedule H

[33] The 2019 fiscal information will be available Spring of 2020, in keeping with IRS guidelines for reporting.

What LLUH can do to Enhance Implementation Strategy

Like many academic medical providers, LLUH implements a number of community-based programs and services as well as outreach activities that impact the lives of many people in our region. LLUH is fortunate with the blessing of having many system activities we can identify that benefit the community. While LLUH has a good financial accounting and tracking of these community benefit activities, the collection of standardized data remains the primary focus of the 2020-2022 CHIS cycles to increase our ability to tell the story of the impact we have on the community. The following initiatives will be primary strategies for the 2020-2022 community health implementation strategy:

Better measure the social determinant of health burden on low-income populations:

Strategy 1: Through the Institute for Community Partnerships, LLUH will conduct **continuous assessments and evaluations** through community-based surveying and community conversations, in order to assess the needs and strengths of communities as they evolve, and in order to have comparison data to the baseline data collected in the CHNA.

Strategy 2: LLUH is committed to implementing a **social determinants screening** through the electronic health record system for our patients to improve data collection and enhance physician decision-making on how to better care for populations of people who experience health barriers due to the burden of the social determinants of health.

Standardize data collection across community benefit initiatives, programs, and outreach for improved outcomes tracking:

Strategy 1: ICP will create **standardized data collection required of all ICP projects and studies** in order to capture the same data across all efforts. While the project-specific outcomes will differ, the primary data collection will allow for enhanced data capture of number of people served and any changes in health status across programs.

Strategy 2: Working with hospital leadership, ICP will create **standardized data collection for community benefit activities** in order to begin to increase data collection and reporting on the wide variety of activities and services provided across our health system.

Acknowledgements

LLUH COMMUNITY PARTNERS 2016-2019

- Air Quality Management District (AQMD)
- Alsad Seventh-day Adventist Church
- American Cancer Society
- American College of Cardiology
- American Heart Association
- American Lung Association
- American Red Cross
- AmeriCorps
- Bing Wong Elementary School
- Boys and Girls Club
- C.E.R.T. - Community ER Response Team
- California Association of Marriage & Family Therapists
- California Bicycle Coalition
- California Safe Program
- California Thoracic Society
- Catholic Diocese of San Bernardino
- Central City Lutheran Mission
- CEO San Bernardino
- Chamber of Commerce – Inland Empire
- Childhood Cancer Foundation of Southern California, Inc.
- Community Advisory Council, LLUMC-Murrieta
- Community Clinic Association of San Bernardino County
- Community Health Development, LLUMC-East Campus
- Community Health Systems, Inc.
- Consulado de Mexico en San Bernardino
- CVEP Career Pathways Initiative
- Desert Healthcare District & Foundation
- El Sol Neighborhood Educational Center
- First 5 of San Bernardino and Riverside
- FIND Food Bank, Indio
- Faith Advisory Council for Community Transformation (FACCT)
- Faith Based Communities
- Hospital Association of Southern California
- Huerta del Valle
- Inland Coalition for Health Professions
- Inland Empire Children's Health Initiative
- Inland Empire United Way
- Inland Empire Women Fighting Cancer
- Latino Health Collaborative
- Jefferson Transitional Program
- La Escuelita
- NAMI Alliance on Mental Illness
- Nu Voice Society Inland Empire
- Omni Trans
- Path Live Ministries
- Partners for Better Health
- Pediatric Advisory Council, LLUMC-Murrieta
- Reach Out
- Restarundo Vidas
- Riverside County Emergency Medical Services (RCEMS)
- Riverside County Department of Public Health
- Ronald McDonald House
- Riverside County Department of Public Health
- SAC Health System
- Sanctuary of Our Lady of Guadalupe (Mecca)
- Safe Kids Inland Empire Coalition
- San Bernardino Associated Governments (SANBAG)
- San Bernardino City Schools Wellness Committee
- San Bernardino City Unified School District
- San Bernardino Diocese
- San Bernardino County Department of Public Health
- San Bernardino County Healthy Communities 2020
- San Bernardino County Medical Society
- San Bernardino County Youth Advisory Board
- San Manuel Gateway College
- San Manuel Band of Mission Indians
- Think Together
- Torres Martinez Desert Cahuilla Indians
- Voice in the Desert
- Youth Hope Foundation

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Community Editor: Lydia Daly, Retired Teacher

To Make Man Whole


Chan Shun Pavilion
Cancer Institute
Coleman Pavilion
School of Medicine

Appendix

Appendix A

Community-based Survey & Findings

LOMA LINDA UNIVERSITY
HEALTH

Community Health Needs Assessment 2019

Loma Linda University Health
Institute for Community Partnerships: Community Benefit
Office Address:
11175 Mountain View Avenue, Suite M
Loma Linda, California 92354
Phone # (909) 558 – 3841

Loma Linda University Health: Community Health Needs Assessment 2019

You are invited to participate in the Loma Linda University Health – Community Health Needs Assessment 2019 quantitative questionnaire, designed to analyze the needs of our community. Your responses to this questionnaire will assist in developing the institution's tri-annual Community Health Implementation Strategy and help our leadership in prioritizing the Community Benefit investments, to address the needs of our community.

This survey is comprised of 33 questions related to demographic information, health-related social needs, community crime perception, stress related to immigration status and basic financial literacy.

Your replies will be anonymous, so do not put your name anywhere on the form. Participation is completely voluntary. You may choose to not answer any question by simply leaving it blank. Returning the completed survey indicates your consent for use of the answers you supply. If you have any questions concerning your rights as a participant, you may contact:

Loma Linda University Health

Institute for Community Partnerships: Community Benefit

Office Address:

11175 Mountain View Avenue, Suite M

Loma Linda, California 92354

Phone (909) 558 – 3841

By completing this survey and returning it you are also confirming that you are **18** years of age or older.

Demographic Questionnaire

1. What is your gender?
    a. Male
    b. Female
    c. Other: _____
    d. Prefer not to answer

2. What Category below includes your age?
    a. 18-20
    b. 21-29
    c. 30-39
    d. 40-49
    e. 50-59
    f. 60 or older

3. What is the highest level of school you have completed or the highest degree you have received?
    a. Less than high school
    b. High school or equivalent (e.g. GED)
    c. Vocational education or Certificate program
    d. Some college but not degree
    e. Associate degree
    f. Undergraduate degree
    g. Graduate degree

4. Which of the following categories best describes your employment status?
    a. Employed, working full-time
    b. Employed, working part-time
    c. Not Employed, looking for work
    d. Not employed, Not looking for work
    e. Retired
    f. Disabled, not able to work

5. How much total combined money did all members of your HOUSEHOLD earn last year?
    a. $0 to $9,999
    b. $10,000 to $24,999
    c. $25,000 to $49,999
    d. $50,000 to $74,999
    e. $75,000 to $99,999
    f. $100,000 to $124,999
    g. $125,000 to 149,999
    h. $150,000 to $174,999
    i. $175,000 to $199,999
    j. $200,000 and up
    k. Don’t know
    l. Prefer not to answer

6. Which of the following best describes your race?
    a. African American/Black
    b. American Indian/Native American
    c. Asian
    d. Caucasian/White
    e. Native Hawaiian/ Other Pacific Islander
    f. 2+ Races
    g. Other:_____
    h. Prefer not to respond

7. Are you Hispanic/Latino/Spanish decent?
    a. Yes
    b. No

8. Were you without health insurance anytime within the past 12 months?
    a. Yes
    b. No

9. Do you currently have health insurance?
    a. Yes
    b. No

10. What type of Health Insurance do you have?
    a. Private Health Insurance (HMO/PPO)
    b. MediCal (IEHP, Molina or other)
    c. Medicare
    d. Other: _____
    e. Not Sure
    f. Not Applicable

11. What City do you currently reside in :
    a. City: _____
    b. Zip Code (5 digit): _____

The Accountable Health Communities Health-Related Social Needs Screening Tool

12. What is your living situation today?
    a. I have a steady place to live
    b. I have a place to live today, but I am worried about losing it in the future
    c. I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park.)

13. Think about the place you live. Do you have problems with any of the following?
    CHOOSE ALL THAT APPLY
    a. Pests such as bugs, ants, or mice
    b. Mold
    c. Lead paint or pipes
    d. Lack of heat
    e. Oven or stove not working
    f. Smoke detectors missing or not working
    g. Water leaks
    h. None of the above

14. Within the past 12 months, have you worried that your food would run out before you got money to buy more?
    a. Often true
    b. Sometimes true
    c. Never true

15. Within the past 12 months, have you worried the food you bought just didn't last and you didn't have money to get more?
    a. Often true
    b. Sometimes true
    c. Never true

16. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
    a. Yes
    b. No

17. In the past 12 months has the electric, gas, oil, or Water Company threatened to shut off services in your home?
    a. Yes
    b. No
    c. Already shut off

18. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is
    a. It is very hard
    b. Somewhat hard
    c. Not at all

19. Do you want help finding or keeping work or a job?
    a. Yes, help finding work
    b. Yes, help keeping work
    c. I don't need help

20. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?
    a. I don't need any help
    b. I get all the help I need
    c. I could use a little more help
    d. I need a lot more help

21. How often do you feel lonely or isolated from those around you?
    a. Never
    b. Rarely
    c. Sometimes
    d. Fairly often
    e. Frequently

22. Do you speak a language other than English at home?
    a. Yes
    b. No

23. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent?
    a. Yes
    b. No

Community Crime Perception

24. Please rate how serious you feel the level of crime is in your community.
    a. Very Serious
    b. Serious
    c. Somewhat Serious
    d. Not Serious
    e. Note Sure

25. In the past three years would you say the level of crime in your community?
    a. Increased
    b. Decreased
    c. Stayed about the same
    d. Not Sure

26. How safe do you feel in your community?
    a. Very Safe
    b. Generally Safe
    c. Somewhat Safe
    d. Not Safe at all
    e. Not Sure

Stress Related to Immigration Status

27. Are you or someone in your family worried about being detained or deported due to your or their immigration status?
    a. Yes
    b. No
    c. Not Applicable
    d. Prefer not to Respond

28. Is your OR Your family's immigration status a cause of stress to your child or children in your family?
    a. Yes
    b. No
    c. Not Applicable
    d. Prefer not to Respond

Financial Literacy Questionnaire

29. Did you know you could use a Bank in the United States even if you are not a U.S. citizen?
    a. Yes
    b. No
    c. I don't Know

30. If I deposit money in a bank, I can trust that I will be able to easily access the money again, without problems.
    a. Yes
    b. No
    c. I don't Know

31. I can use a bank to cash my paycheck without being charged a fee.
    a. Yes
    b. No
    c. I don't Know

32. I have the skills I need to plan how to use my money each month to cover my expenses.
    a. Yes
    b. No
    c. I don't Know

33. If I need to purchase a car, furniture, or electronics and I take a loan or use a credit card, I understand how much extra the fees and interest rate will cost me.
    a. Yes
    b. No
    c. I don't Know

LOMA LINDA UNIVERSITY HEALTH

Evaluación de las Necesidades de Salud de la Comunidad 2019

Loma Linda University Health
Instituto de Alianzas Comunitarias: Beneficio Comunitario
Dirección de la oficina:
11175 Mountain View Avenue, Suite M
Loma Linda, California 92354
Teléfono # (909) 558 – 3841

Loma Linda University Health: Evaluación de las Necesidades de Salud de la Comunidad 2019

Usted está invitado a participar en el cuestionario cuantitativo de Salud, Evaluación de Necesidades de Salud Comunitaria 2019 de Loma Linda Universidad, diseñado para analizar las necesidades de nuestra comunidad. Sus respuestas ayudarán a desarrollar la Estrategia de Implementación de Salud Comunitaria trianual de la institución y ayudarán a nuestro liderazgo a priorizar las inversiones de Beneficios Comunitarios, para atender las necesidades de nuestra comunidad.

El cuestionario se compone de 33 preguntas relacionadas a la información demográfica, las necesidades sociales relacionadas con la salud, la percepción del crimen en la comunidad, el estrés relacionado con el estatus migratorio y financiera básica.

Sus respuestas serán anónimas, así que no pongas tu nombre en ningún lugar en el cuestionario. La participación es totalmente voluntaria. Puede optar por no contestar ninguna pregunta simplemente dejándola en blanco. Devolver el cuestionario completo indica su consentimiento para el uso de las respuestas que suministra. Si tiene alguna pregunta sobre sus derechos como participante, puede ponerse en contacto con:

Loma Linda University Health
Instituto de Alianzas Comunitarias: Beneficio Comunitario
Dirección de la oficina:
11175 Mountain View Avenue, Suite M
Loma Linda, California 92354
Teléfono (909) 558 – 3841

Al completar este cuestionario y devolverla, también confirma que tiene **18 años** de edad o más.

Cuestionario Demográfico

1. ¿Cuál es tu género?
    a. Varon
    b. Mujer
    c. Otro: _____
    d. Prefiero no contestar

2. ¿Qué categoría incluye tu edad?
    a. 18-20
    b. 21-29
    c. 30-39
    d. 40-49
    e. 50-59
    f. 60 años o más

3. ¿Cuál es el nivel más alto de la escuela que usted ha completado o el grado más alto que usted ha recibido?
    a. Menos que escuela secundaria
    b. Escuela secundaria o equivalente (por ejemplo, GED)
    c. Programa de educación vocacional o certificado
    d. Alguna universidad pero no grado
    e. Título universitario de preparación básica
    f. Título universitario
    g. Título de posgrado

4. ¿Cuál de las siguientes categorías describe mejor su situación de empleo?
    a. Empleado, trabajando tiempo completo
    b. Empleado, trabajando a tiempo parcial
    c. No empleado, buscando trabajo
    d. No empleado, no buscando trabajo
    e. Jubilado/retirado
    f. Discapacitado, no puedo trabajar

5. ¿Cuánto dinero total combinado ganaron todos los miembros de su HOGAR el año pasado?
    a. $0 a $9,999
    b. $10,000 a $24,999
    c. $25,000 a $49,999
    d. $50,000 a $74,999
    e. $75,000 a $99,999
    f. $100,000 a $124,999
    g. $125,000 a $149,999
    h. $150,000 a $174,999
    i. $175,000 a $199,999
    j. $200,000 y arriba
    k. No se
    l. Prefiero no contestar

6. ¿Cuál de los siguientes describe mejor su raza?
    a. Afroamericano / negro
    b. Indio americano / nativo americano
    c. Asiático
    d. Caucásico/blanco
    e. Nativo de Hawai / otras islas del Pacífico
    f. 2+ Razas
    g. Otro:_____
    h. Prefiero no contestar

7. ¿Eres de origen hispano / latino / español?
    a. Sí
    b. No

8. ¿Estuvo sin seguro médico en los últimos 12 meses?
    a. Sí
    b. No

9. ¿Tiene seguro médico?
    a. Sí
    b. No

10. ¿Qué tipo de Seguro de Salud tiene?
    a. Seguro de salud privado (HMO/PPO)
    b. MediCal (IEHP, Molina o otro)
    c. Medicare
    d. Otro: _____
    e. No se
    f. No aplica

11. ¿En qué Ciudad reside actualmente?

a. Ciudad: _____

b. Código postal (5 números): _____

La Herramienta De Evaluación De Las Necesidades Sociales Relacionadas Con La Salud De Las Comunidades Sanitarias Responsables

12. ¿Cuál es su situación de hogar actual?
    a. Tengo un lugar fijo para vivir
    b. Tengo un lugar para vivir hoy, pero me preocupa perderlo en el futuro
    c. No tengo un lugar fijo para vivir (estoy temporalmente con otros, en un hotel, en un refugio, viviendo fuera en la calle, en una playa, en un coche, en un edificio abandonado, en una estación de autobús o tren, o en un parque.)

13. Piense en el lugar donde usted vive. ¿Tiene problemas con alguno de los siguientes?

    ELIJA TODOS LOS QUE APLIQUEN

    a. Plagas como insectos, hormigas o ratones
    b. Molde
    c. Pintura de plomo o tuberías
    d. Falta de calor
    e. El horno o la estufa no funcionan
    f. Detectores de humo faltan o no funcionan
    g. Fugas de agua
    h. Ninguno de los anteriore

14. En los últimos 12 meses, ¿te preocupó que tu comida se acabara antes de tener dinero para comprar más?
    a. Muchas veces cierto
    b. A veces cierto
    c. Nunca es cierto

15. En los últimos 12 meses, ¿te preocupó que la comida que compraste no durara y que no tuvieras dinero para comprar más?
    a. Muchas veces cierto
    b. A veces cierto
    c. Nunca es cierto

16. ¿En los últimos 12 meses, falta de transporte confiable te mantuvo de citas médicas, reuniones, trabajo o de conseguir las cosas necesarias para la vida diaria?
    a. Sí
    b. No

17. En los últimos 12 meses, ¿la compañía de electricidad, gas, petróleo o agua ha amenazado con cerrar los servicios en su hogar?
    a. Sí
    b. No
    c. Ya cerrado

18. ¿Qué tan difícil es para ti pagar lo básico como comida, alojamiento, atención médica y Calefacción? ¿Dirías que es:
    a. Muy difícil
    b. Algo difícil
    c. No es difícil

19. ¿Quieres ayuda para encontrar o mantener un trabajo o empleo?
    a. Sí, ayudar a encontrar trabajo
    b. Sí, ayuda a mantener el trabajo
    c. No necesito ayuda

20. Si por alguna razón necesita ayuda con actividades diarias como bañarse, preparar comidas, ir de compras, administrar finanzas, etc., ¿obtiene la ayuda que necesita?
    a. No necesito ayuda
    b. Consigo toda la ayuda que necesito
    c. Yo podría utilizar un poco más de ayuda
    d. Necesito mucho más ayuda

21. ¿Con qué frecuencia te sientes solo o aislado de los que te rodean?

a. Nunca
b. Raramente
c. Algunas veces
d. Con bastante frecuencia
e. Frecuentemente

22. ¿Hablas otro idioma que no sea inglés en casa?

a. Sí
b. No

23. ¿Quieres ayuda con la escuela o el entrenamiento? Por ejemplo, ¿empezar o completar un entrenamiento laboral o obtener un diploma de secundaria, GED o equivalente?

a. Sí
b. No

<u>Percepción De La Delincuencia En La Comunidad</u>

24. Por favor, dime qué tan serio crees que es el nivel de crimen en tu comunidad.

a. Muy serio
b. Serio
c. Algo serio
d. No es grave
e. No estoy seguro

25. ¿En los últimos tres años dirías que el nivel de delincuencia en tu comunidad a:

a. Aumentado
b. Decrecido
c. Se mantuvo igual
d. No estoy seguro

26. ¿Qué tan seguro se siente en su comunidad?

a. Muy seguro
b. Generalmente seguro
c. Algo seguro
d. No me siento seguro
e. No estoy seguro

Estrés Relacionado con el Estado de Inmigración

27. ¿Está usted o alguien en su familia preocupado por ser detenido o deportado debido a su estatus de inmigración?
    a. Sí
    b. No
    c. No aplica
    d. Prefiero no contestar

28. ¿El estatus de inmigración de su familia o de usted es causa de estrés para su hijo o hijos en su familia?
    a. Sí
    b. No
    c. No aplica
    d. Prefiero no contestar

Cuestionario de Educación Financiera

29. Sabía que podría usar un banco en los Estados Unidos aunque no sea ciudadano?.
    a. Sí
    b. No
    c. No se

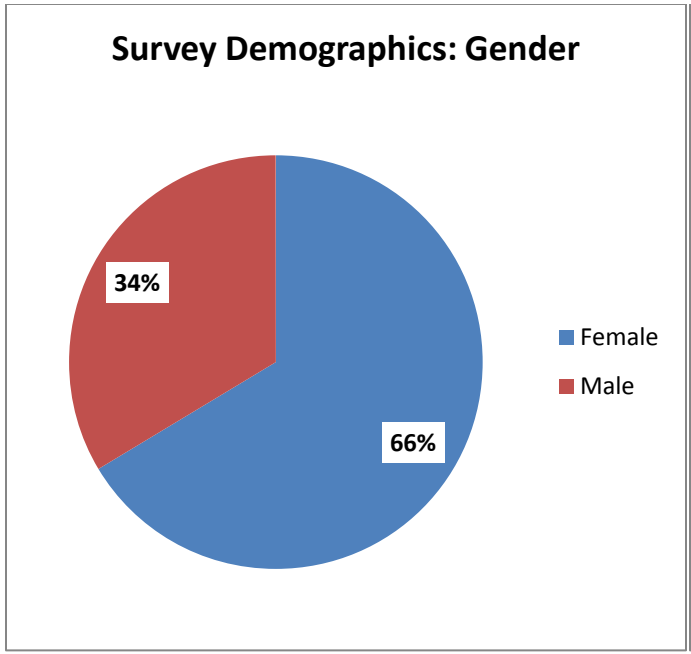
30. Si deposito dinero en un banco, confió en que puedo acceder fácilmente el dinero de nuevo, sin problemas.
    a. Sí
    b. No
    c. No se

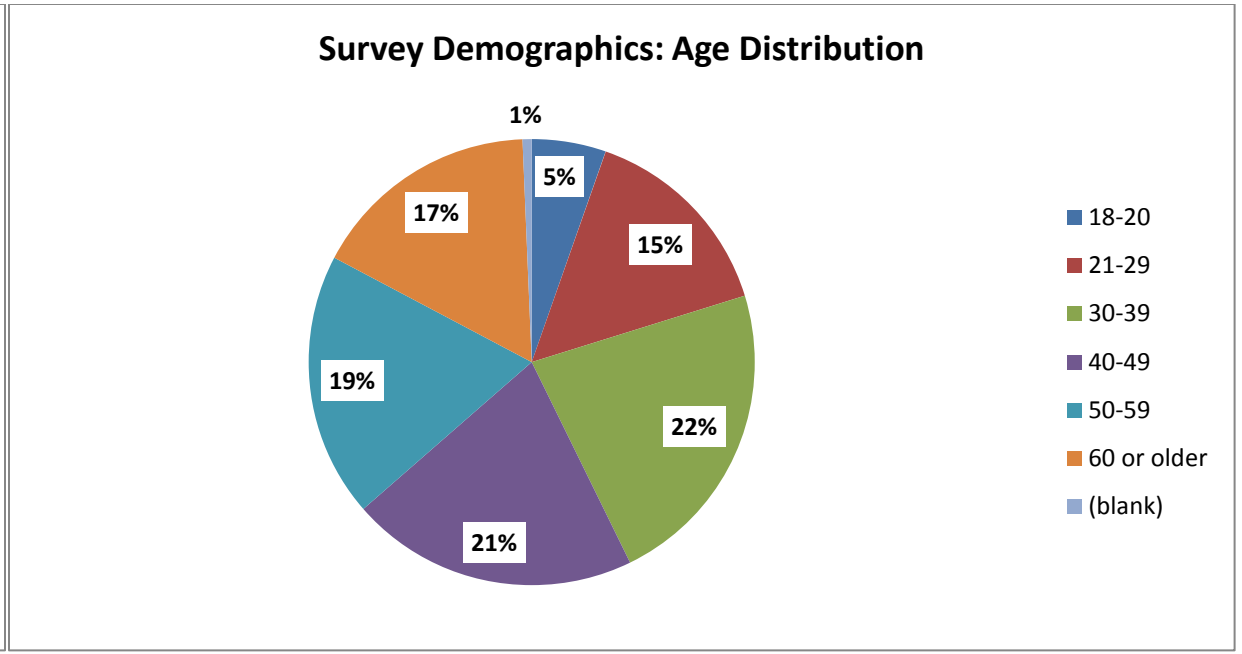
31. Puedo usar un banco para cobrar mi cheque sin cobrar una tarifa.
    a. Sí
    b. No
    c. No se

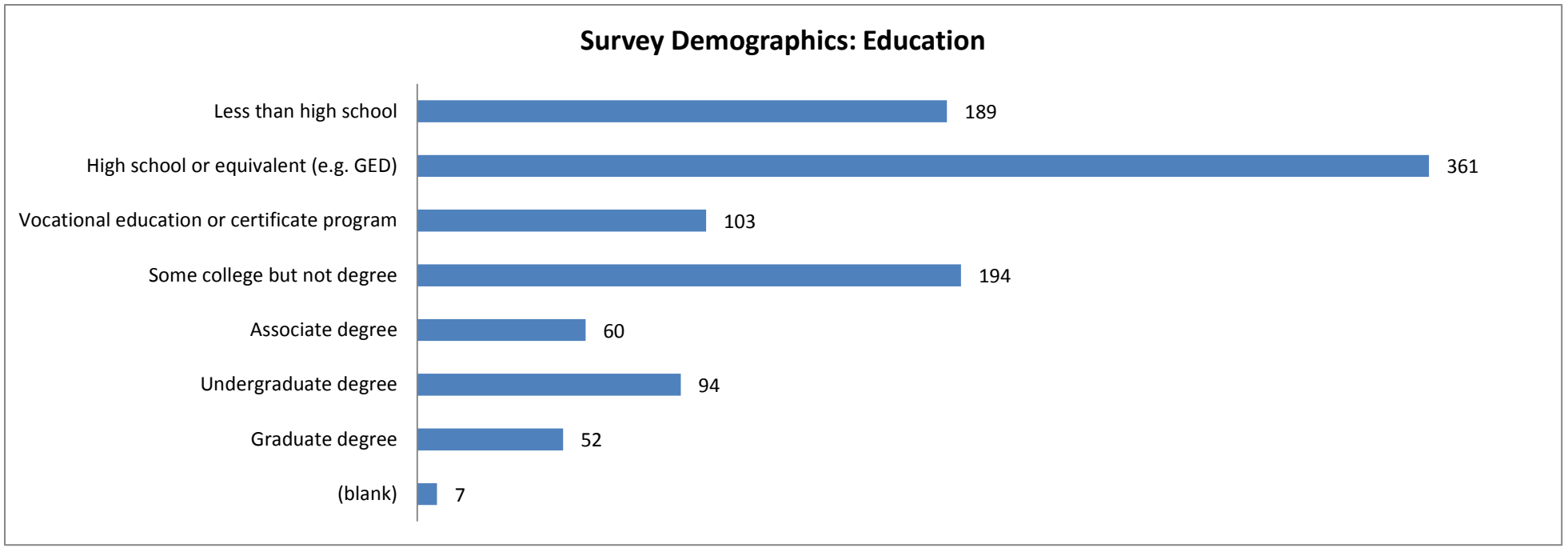
32. Tengo las habilidades que necesito para planear cómo usar mi dinero cada mes para cubrir mis gastos.
    a. Sí
    b. No
    c. No se

33. Si necesito comprar un automóvil, un mueble o un equipo electrónico y solicito un préstamo o uso una tarjeta de crédito, entiendo cuánto me costarán las tarifas y la tasa de interés.
    a. Sí
    b. No
    c. No se

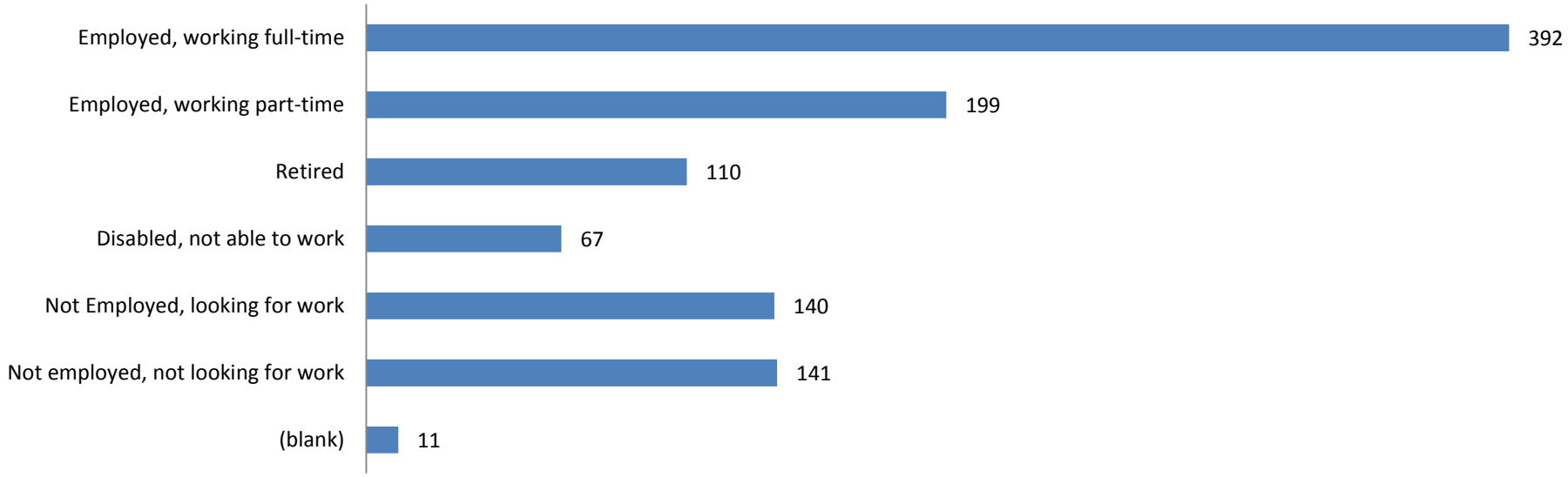
APPENDIX A - LLUH Community-Based Survey FINDINGS



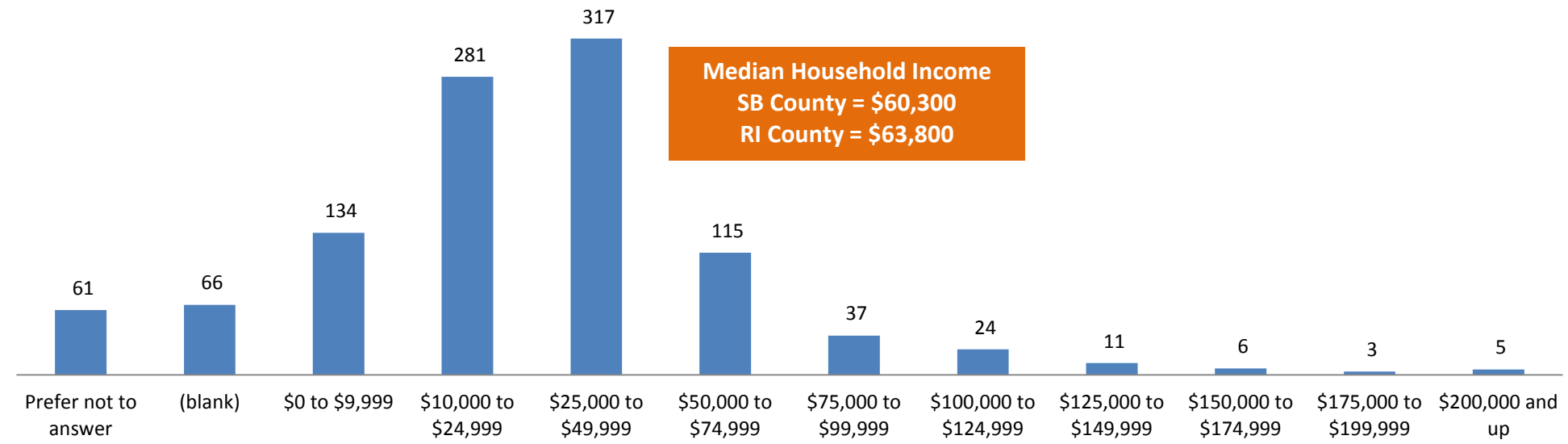


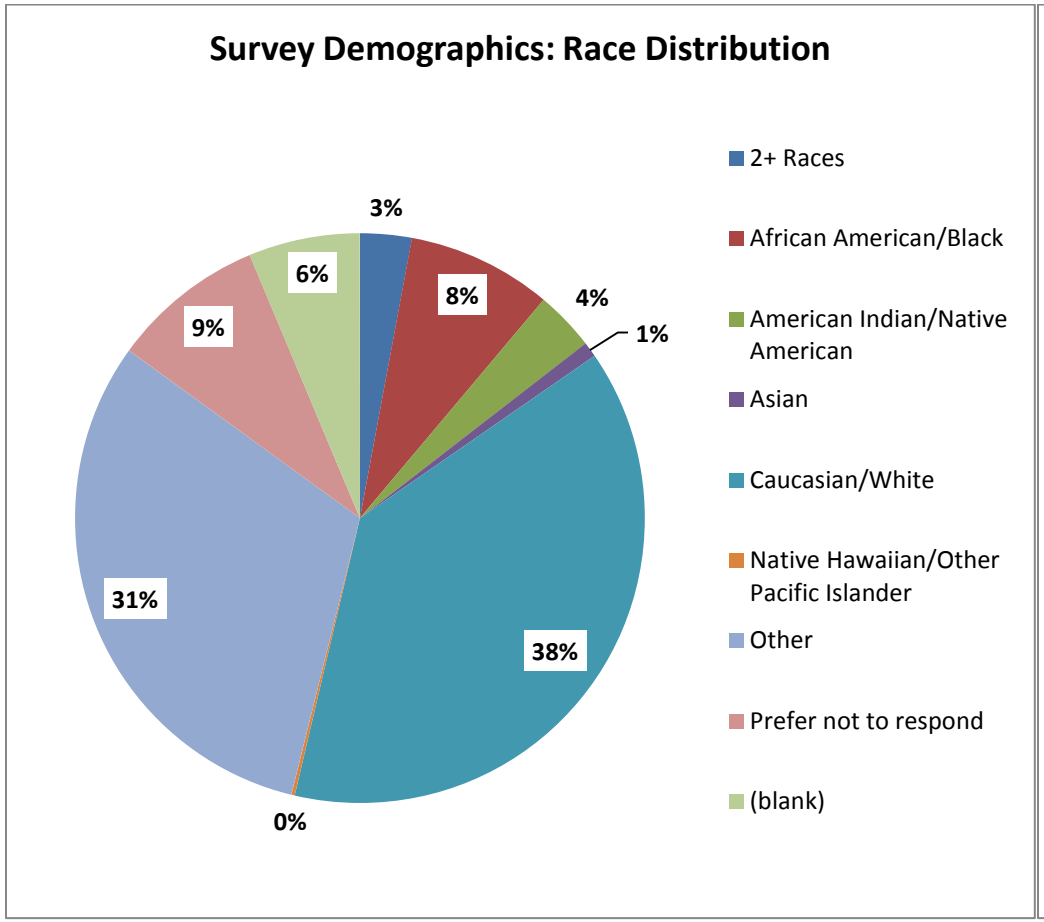


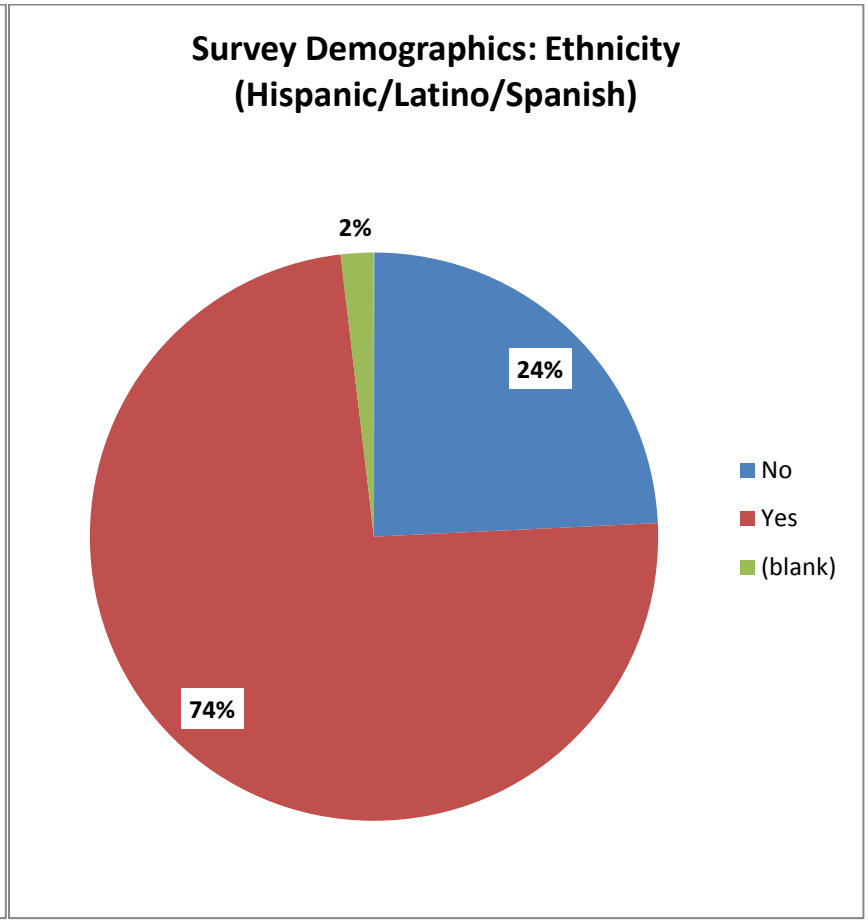
Survey Demographics: Employment Status

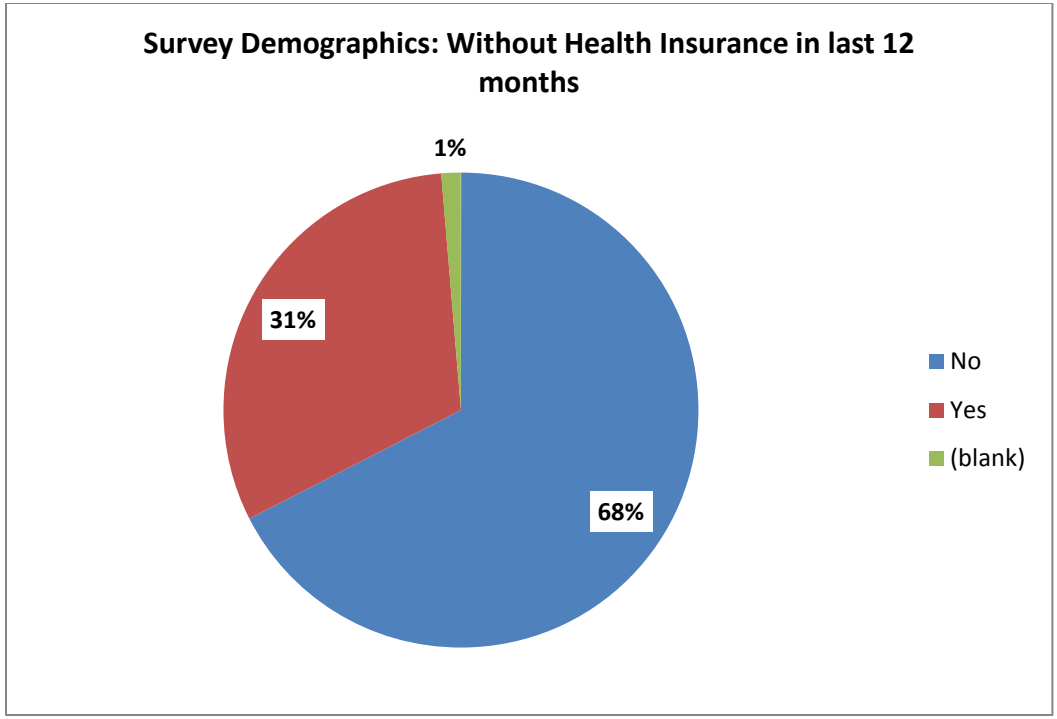


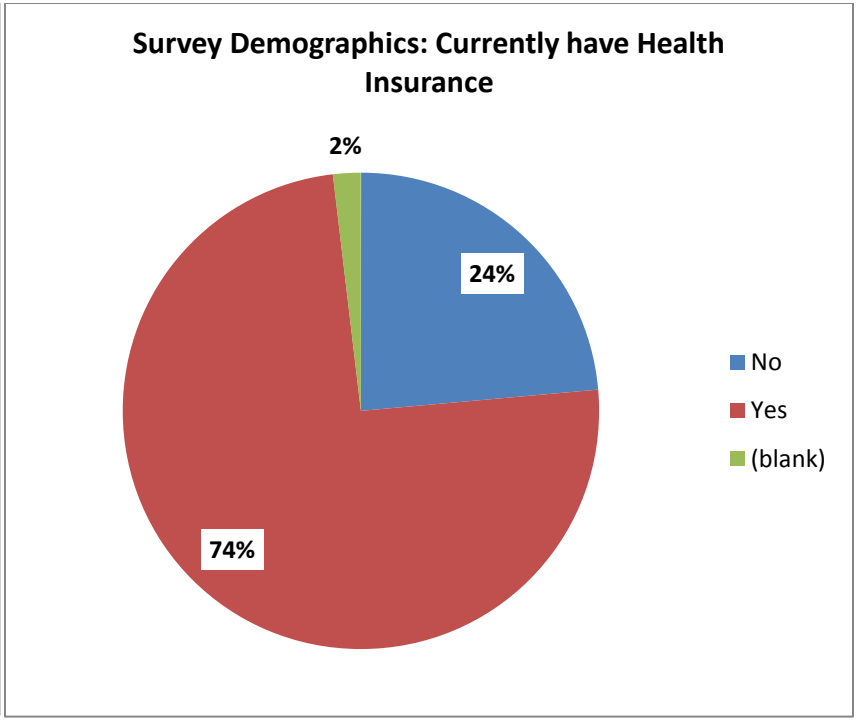
Survey & Focus Group Demographics: Average Household Income

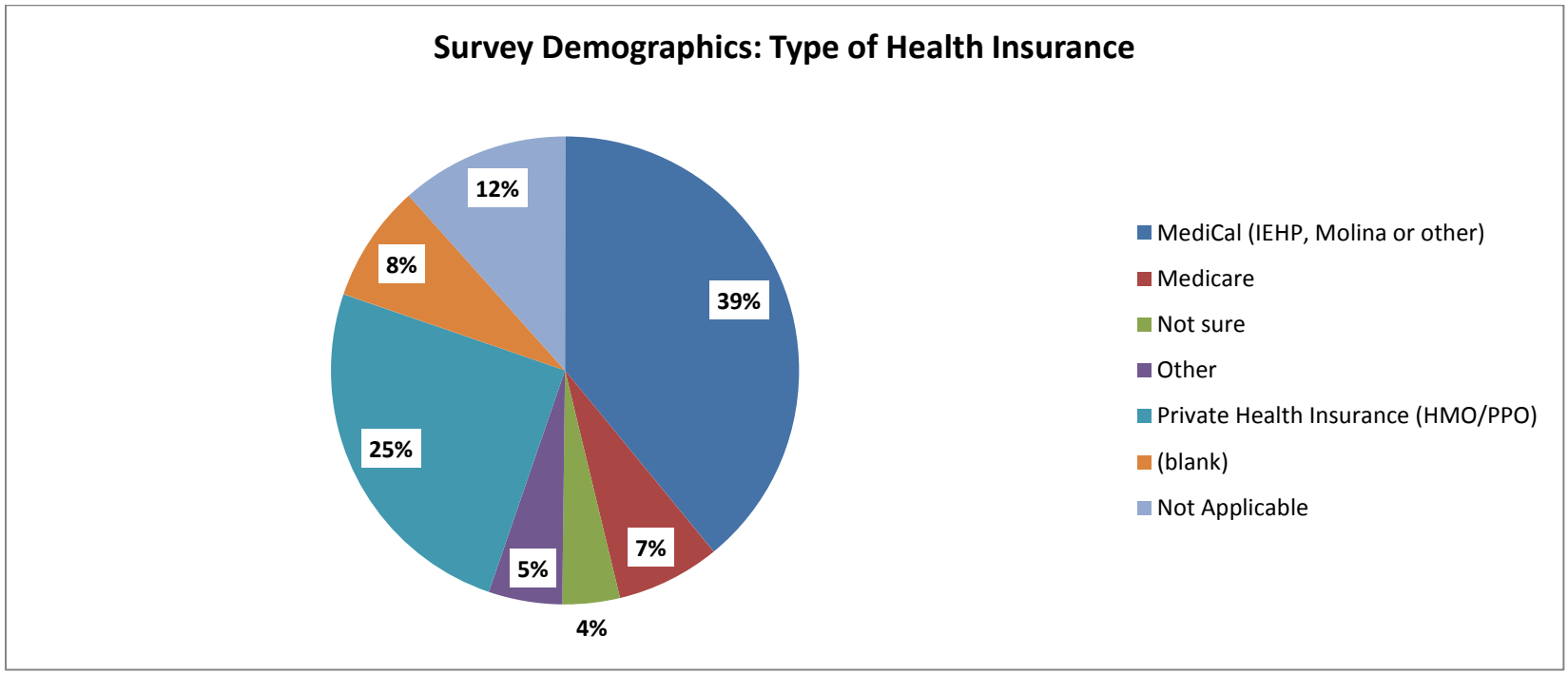



Survey Demographics: Race Distribution
3%
8%
4%
1%
9%
6%
31%
38%
0%
2+ Races
African American/Black
American Indian/Native American
Asian
Caucasian/White
Native Hawaiian/Other Pacific Islander
Other
Prefer not to respond
(blank)

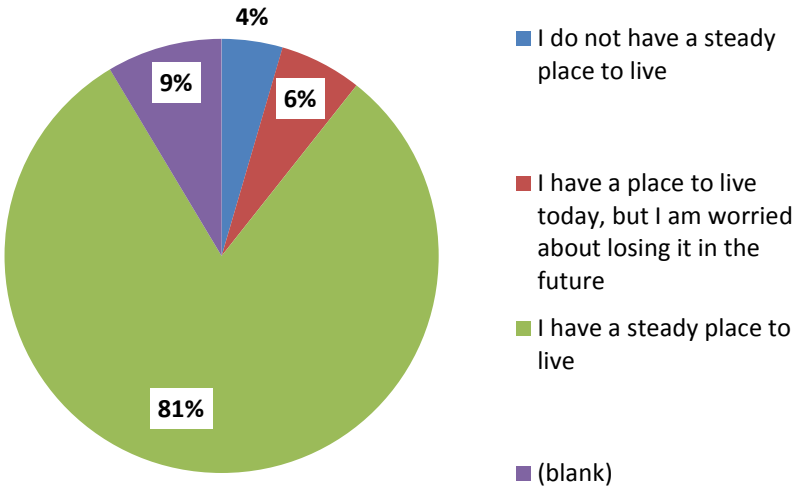

Survey Demographics: Ethnicity (Hispanic/Latino/Spanish)
2%
24%
74%
No
Yes
(blank)


Survey Demographics: Without Health Insurance in last 12 months
1%
31%
68%
No
Yes
(blank)

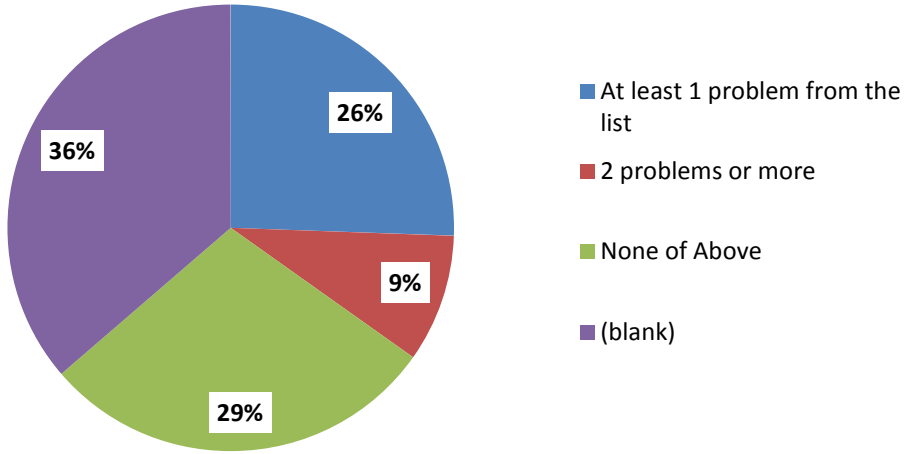

Survey Demographics: Currently have Health Insurance
2%
24%
74%
No
Yes
(blank)


Survey Demographics: Type of Health Insurance
12%
8%
39%
25%
7%
5%
4%
MediCal (IEHP, Molina or other)
Medicare
Not sure
Other
Private Health Insurance (HMO/PPO)
(blank)
Not Applicable

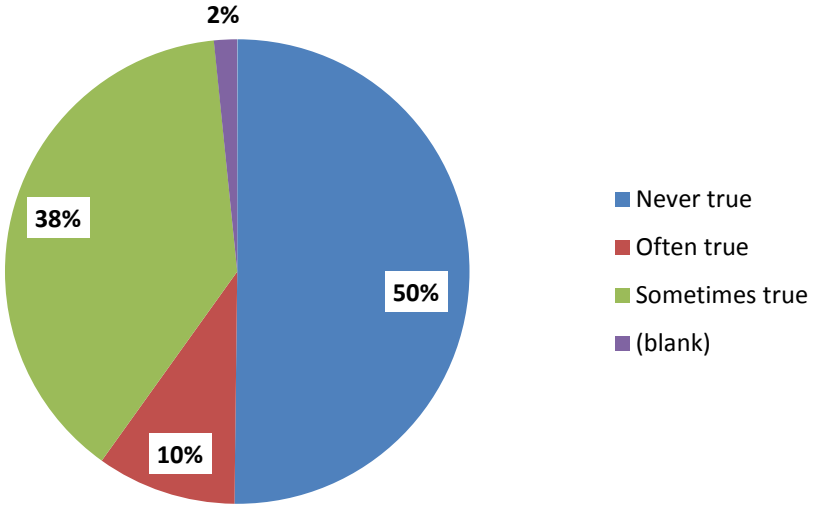
SODH: Housing Insecurity



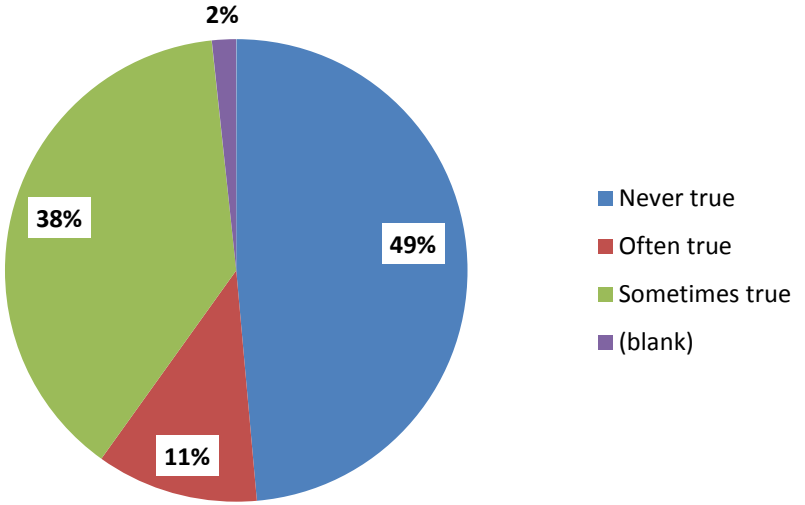
SODH: Housing-related Problem (Pests, mold, lead paint or pipes, lack of heat, etc.)

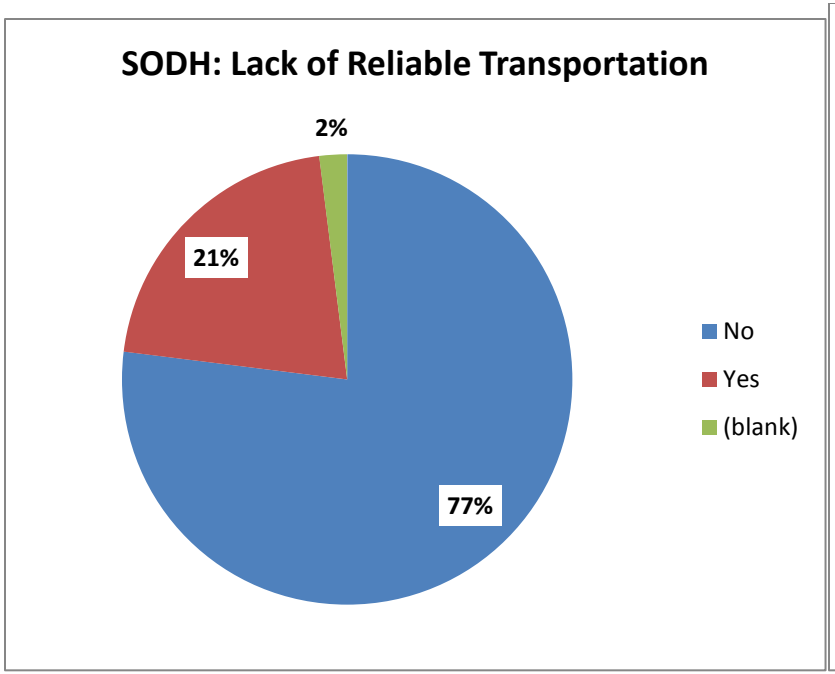


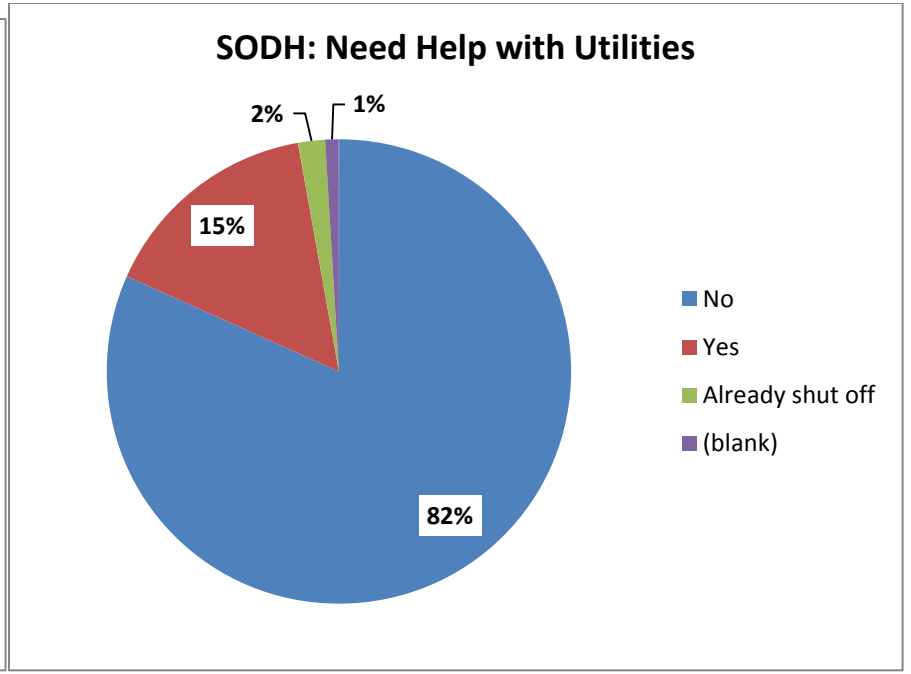
SODH: Last 12 months worried about food running out

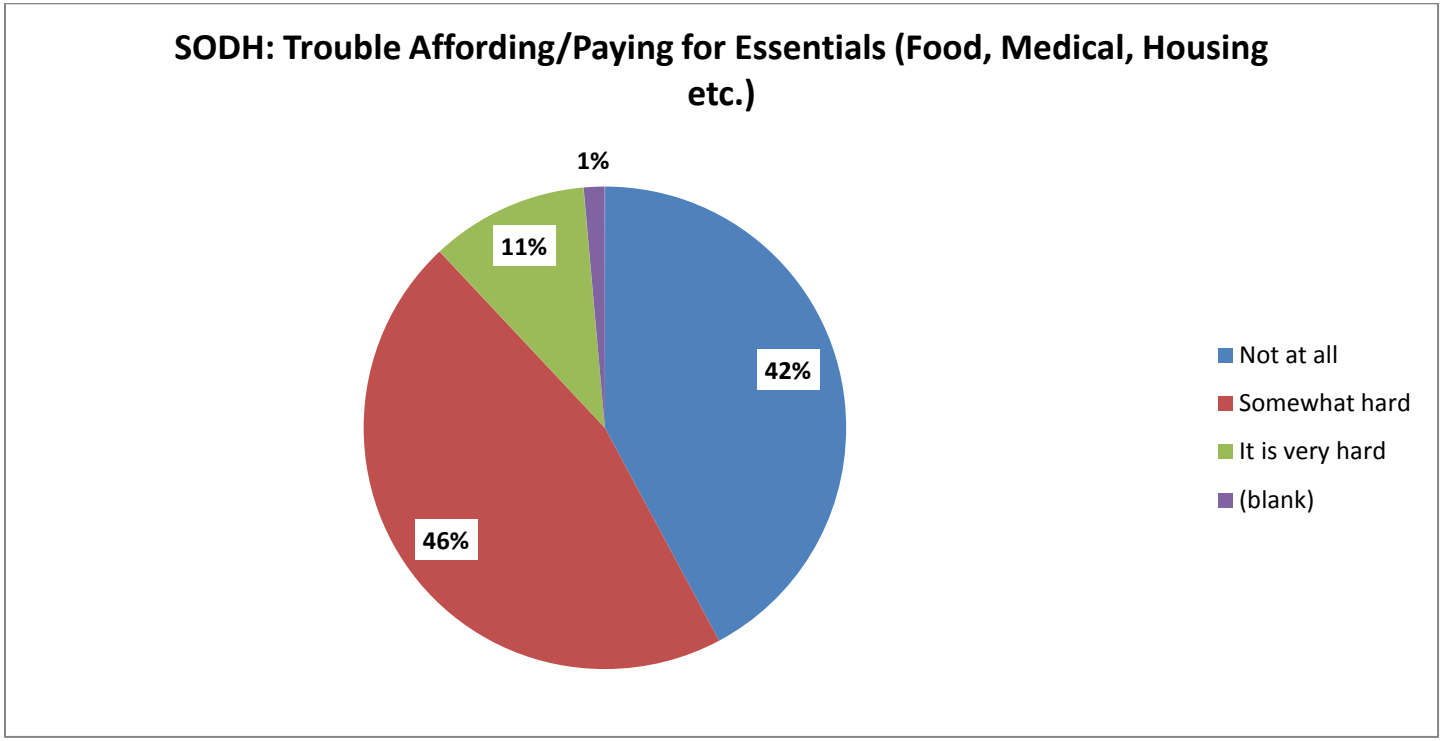


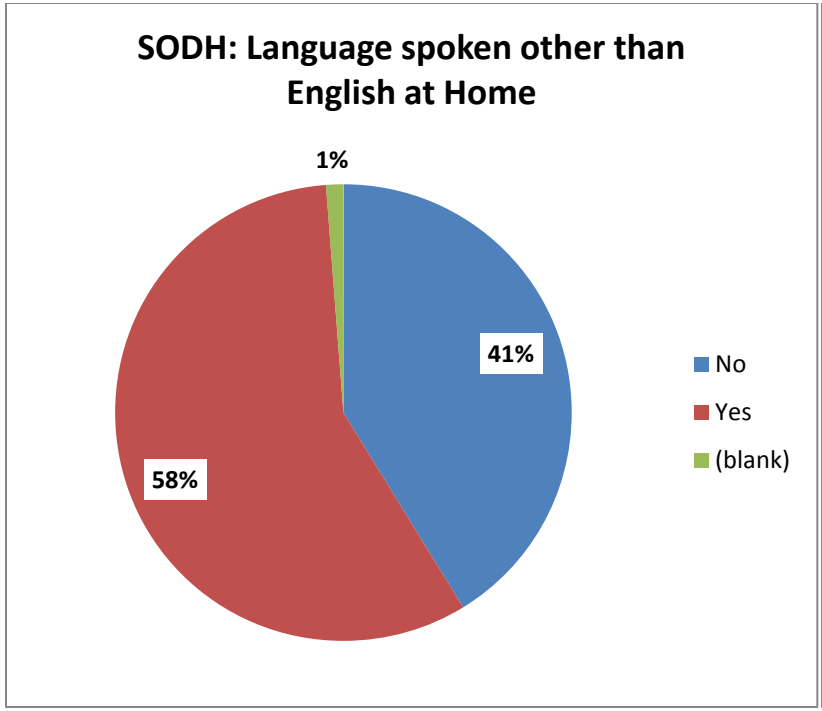
SODH: Last 12 months worried food wouldn't last and not enough money to buy more




SODH: Lack of Reliable Transportation
2%
21%
77%
No
Yes
(blank)


SODH: Need Help with Utilities
2%
1%
15%
82%
No
Yes
Already shut off
(blank)


SODH: Trouble Affording/Paying for Essentials (Food, Medical, Housing etc.)
1%
11%
42%
46%
Not at all
Somewhat hard
It is very hard
(blank)


SODH: Language spoken other than English at Home
1%
41%
58%
No
Yes
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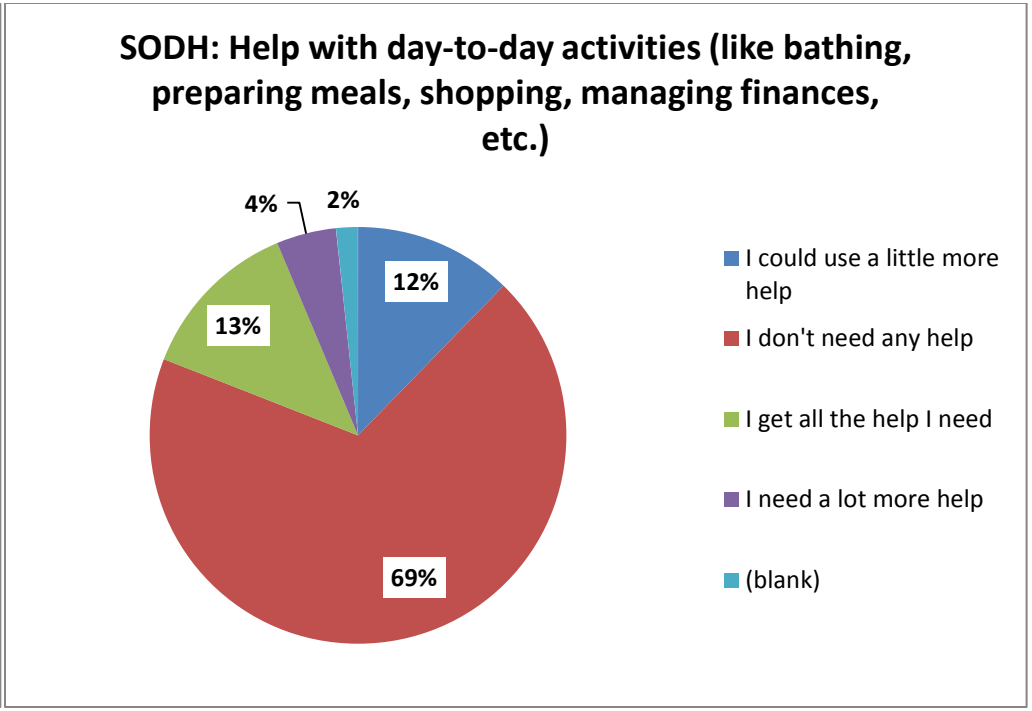
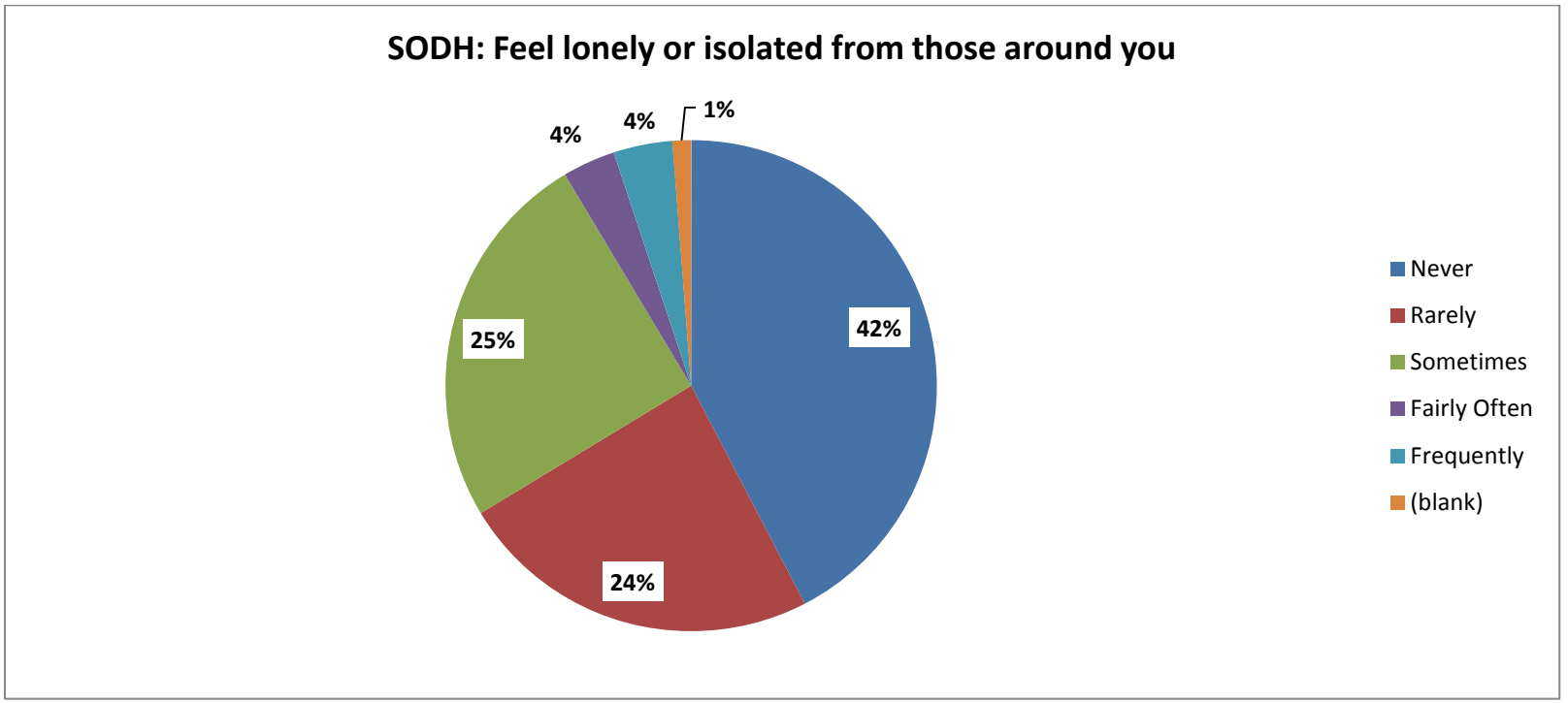
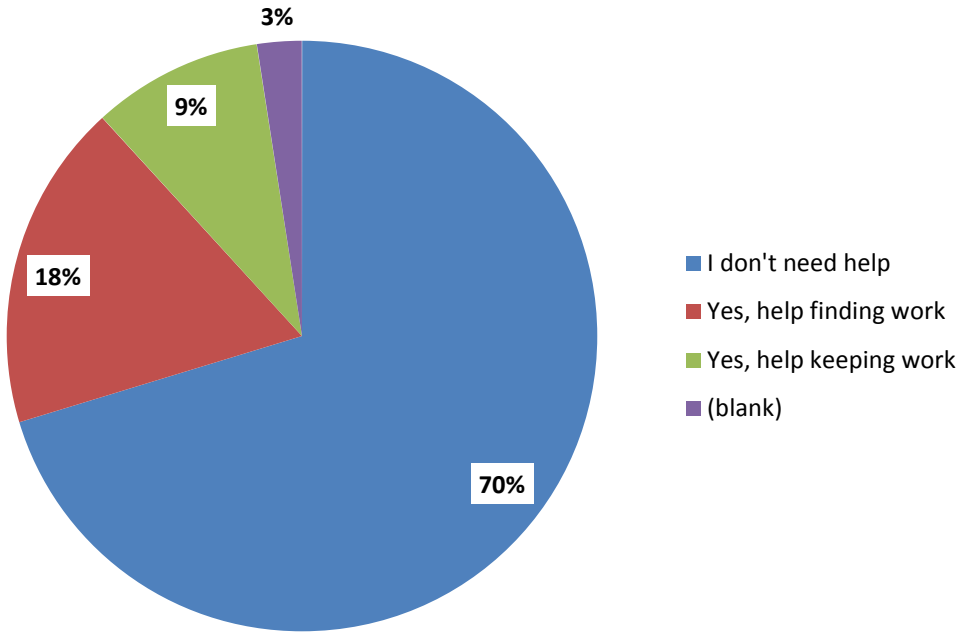
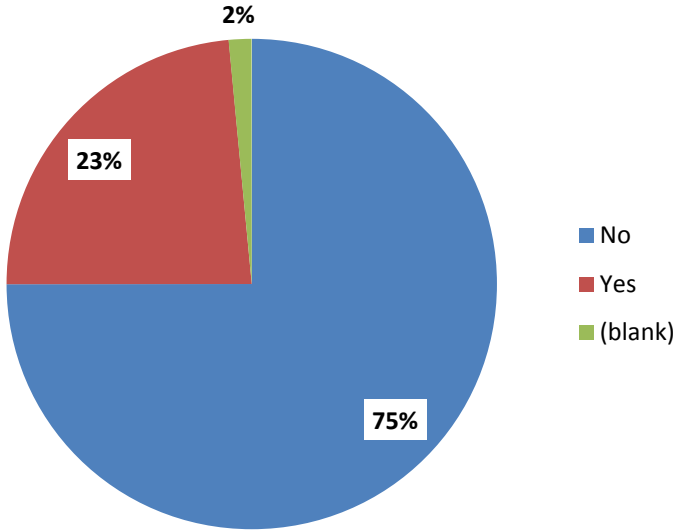

SODH: Help with day-to-day activities (like bathing, preparing meals, shopping, managing finances, etc.)
4%
2%
12%
13%
69%
I could use a little more help
I don't need any help
I get all the help I need
I need a lot more help
(blank)

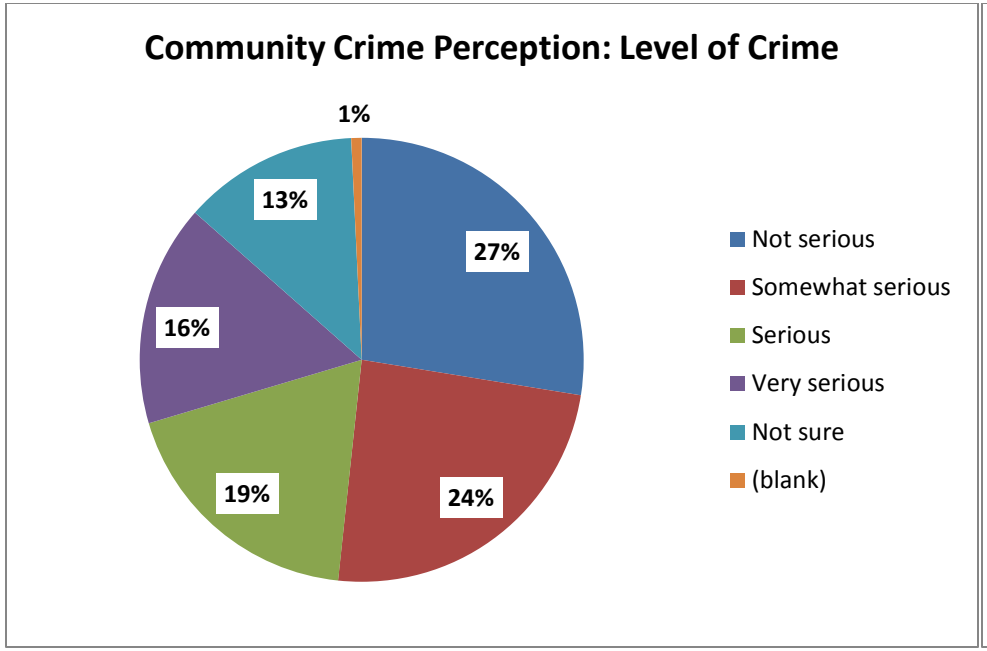

SODH: Feel lonely or isolated from those around you
4%
4%
1%
42%
25%
24%
Never
Rarely
Sometimes
Fairly Often
Frequently
(blank)

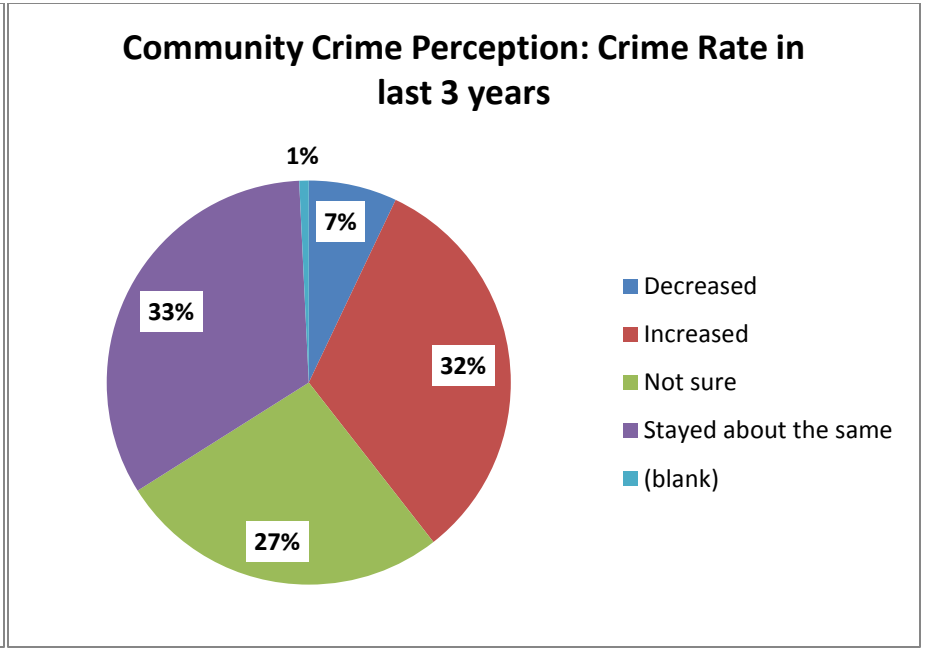
Assistance with Employment

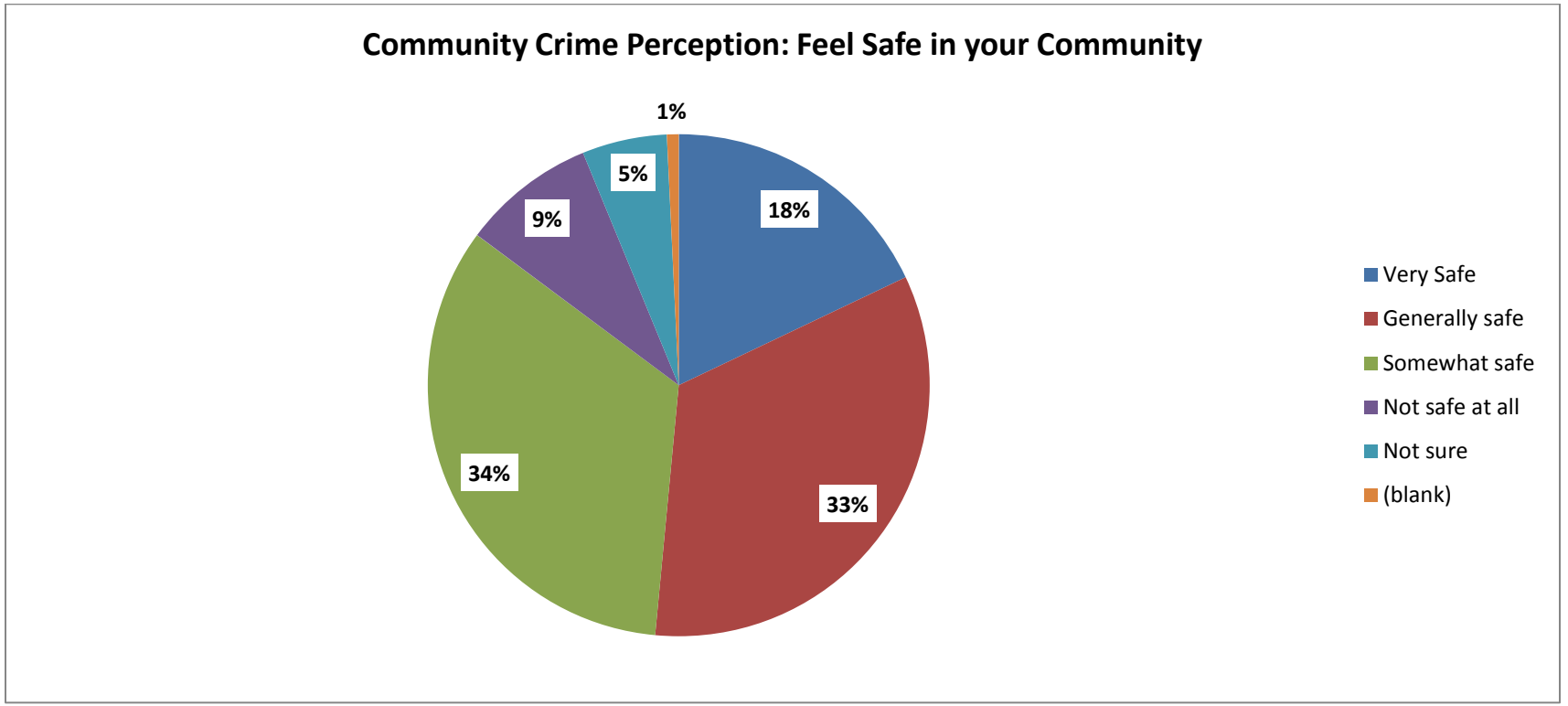


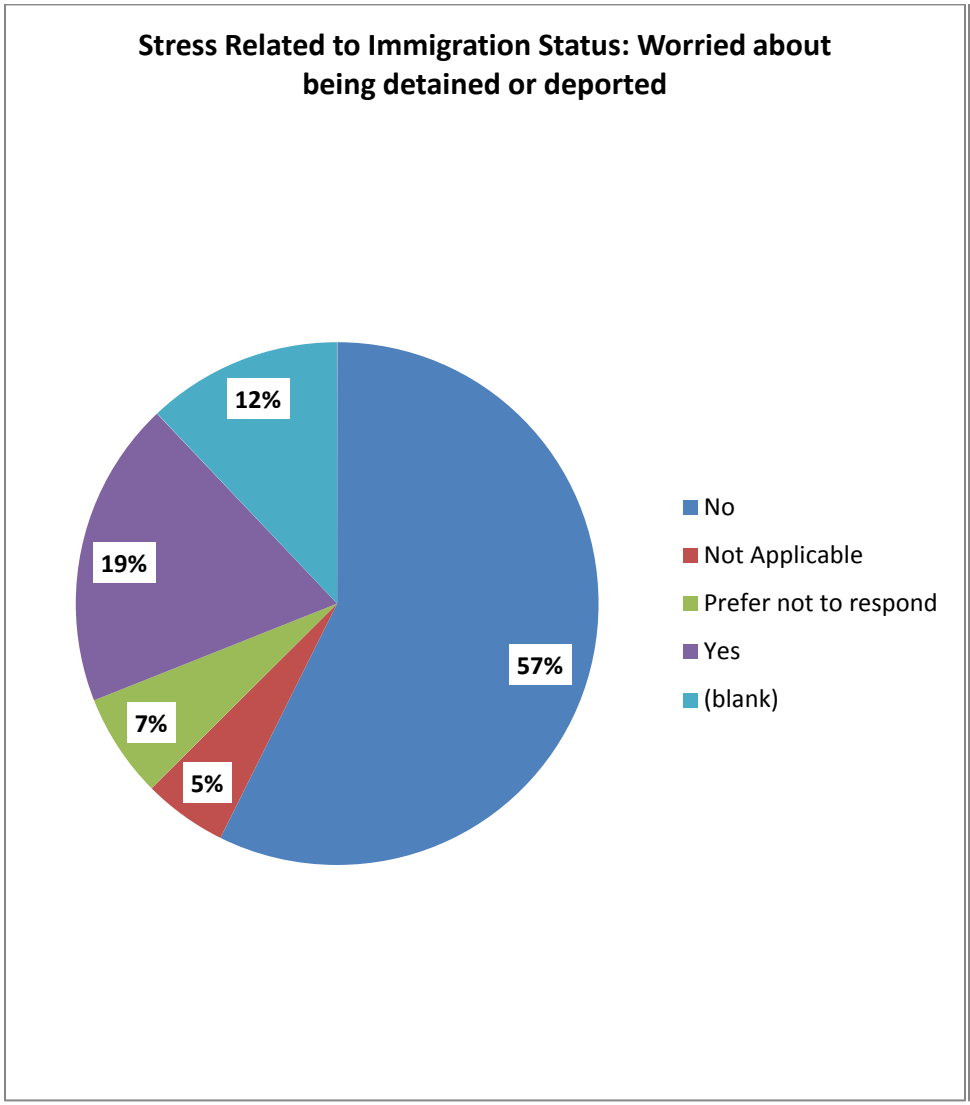
Help with School or Training

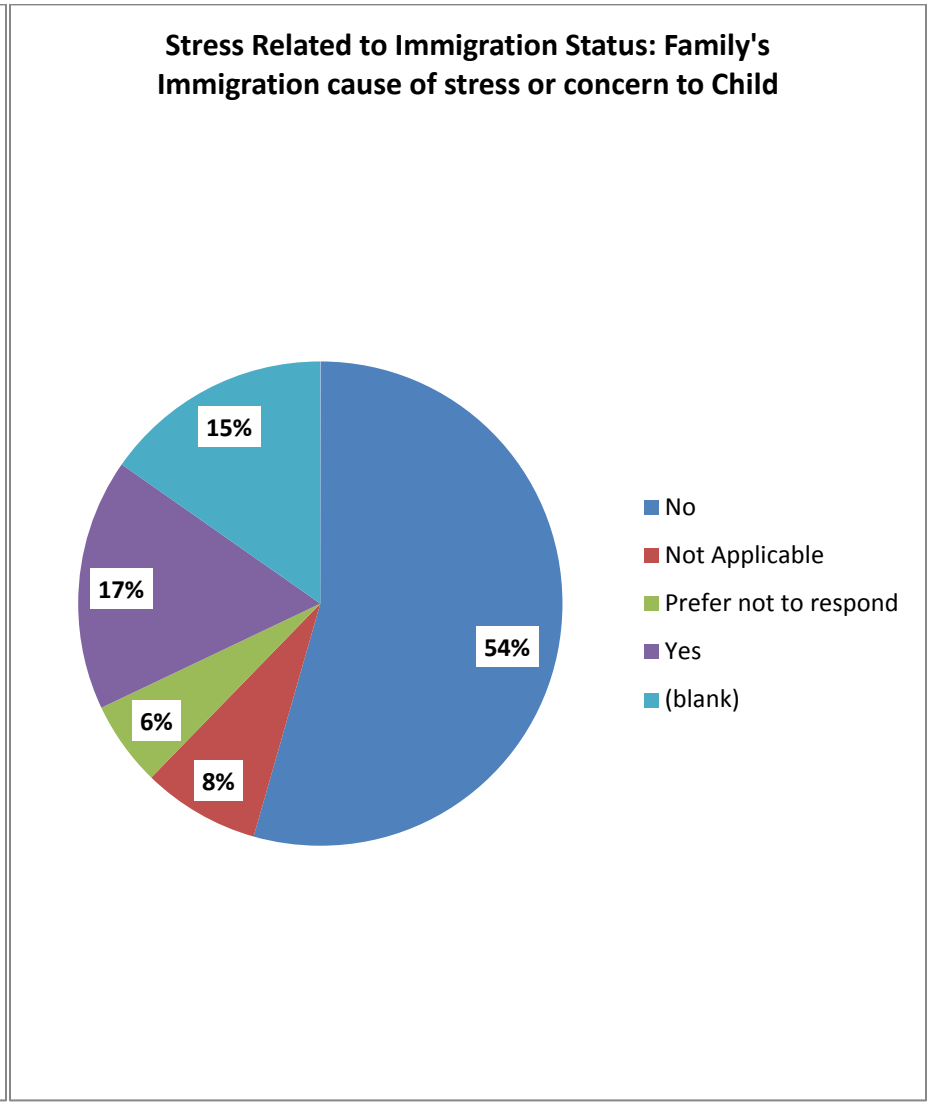


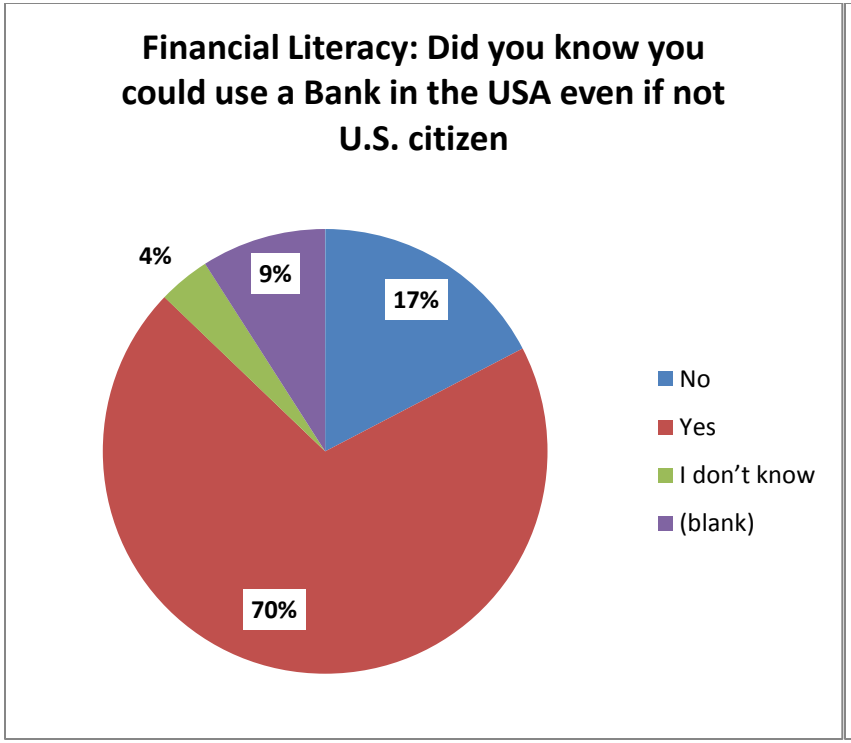

Community Crime Perception: Level of Crime
1%
13%
27%
16%
19%
24%
Not serious
Somewhat serious
Serious
Very serious
Not sure
(blank)

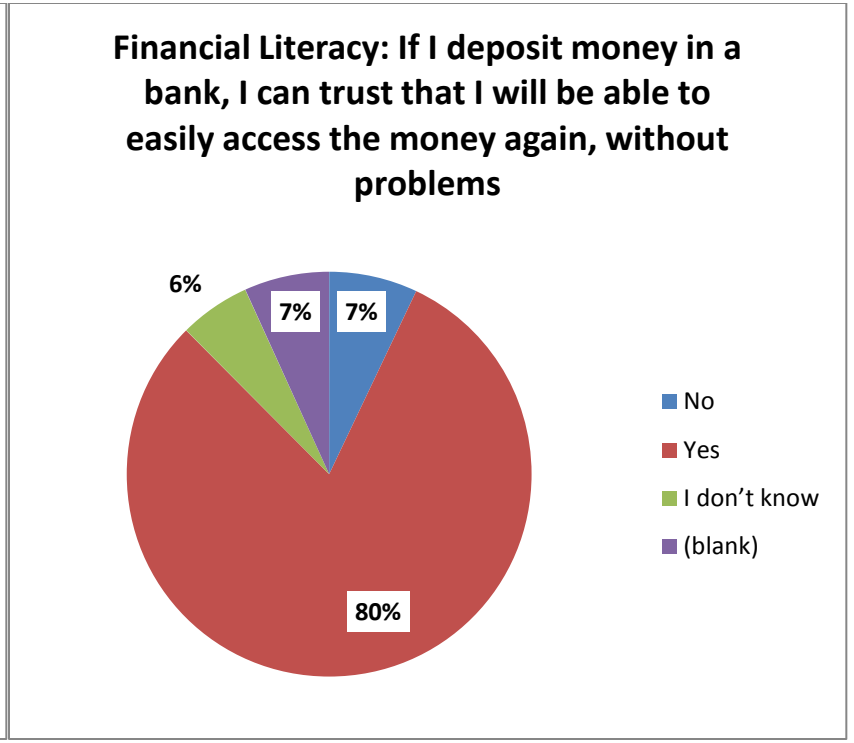

Community Crime Perception: Crime Rate in last 3 years
1%
7%
33%
32%
27%
Decreased
Increased
Not sure
Stayed about the same
(blank)

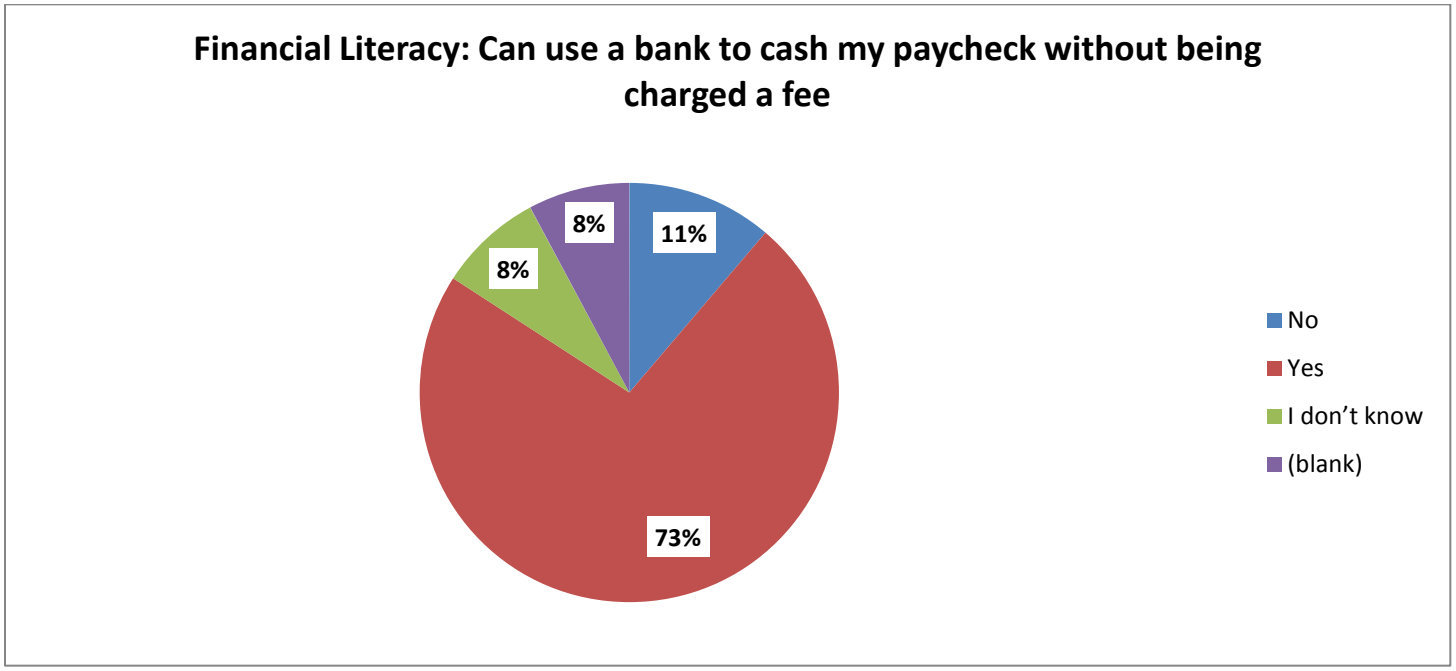

Community Crime Perception: Feel Safe in your Community
1%
5%
18%
9%
34%
33%
Very Safe
Generally safe
Somewhat safe
Not safe at all
Not sure
(blank)


Stress Related to Immigration Status: Worried about being detained or deported
12%
19%
57%
7%
5%
No
Not Applicable
Prefer not to respond
Yes
(blank)

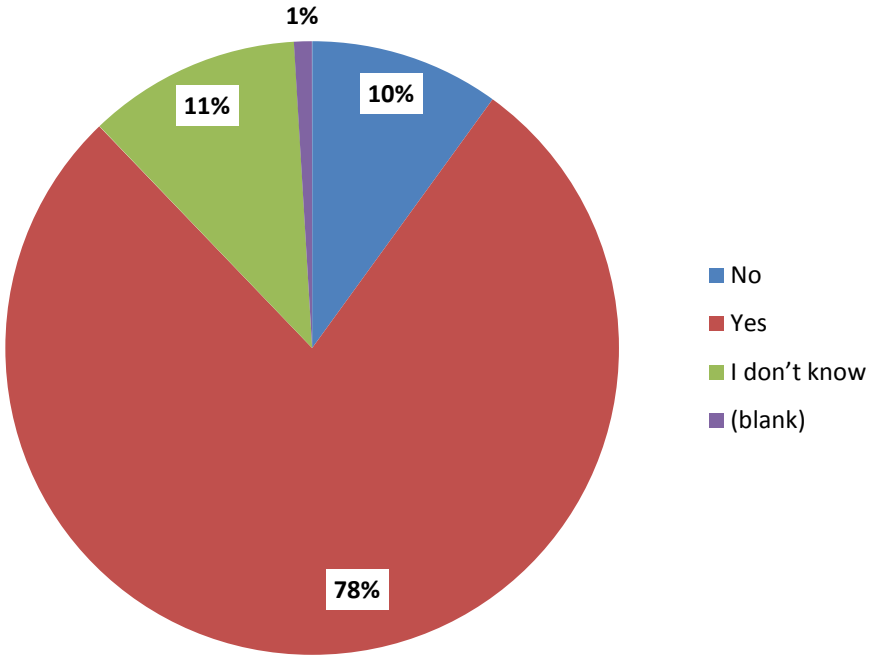

Stress Related to Immigration Status: Family's Immigration cause of stress or concern to Child
15%
17%
54%
6%
8%
No
Not Applicable
Prefer not to respond
Yes
(blank)


Financial Literacy: Did you know you could use a Bank in the USA even if not U.S. citizen
4%
9%
17%
70%
No
Yes
I don't know
(blank)

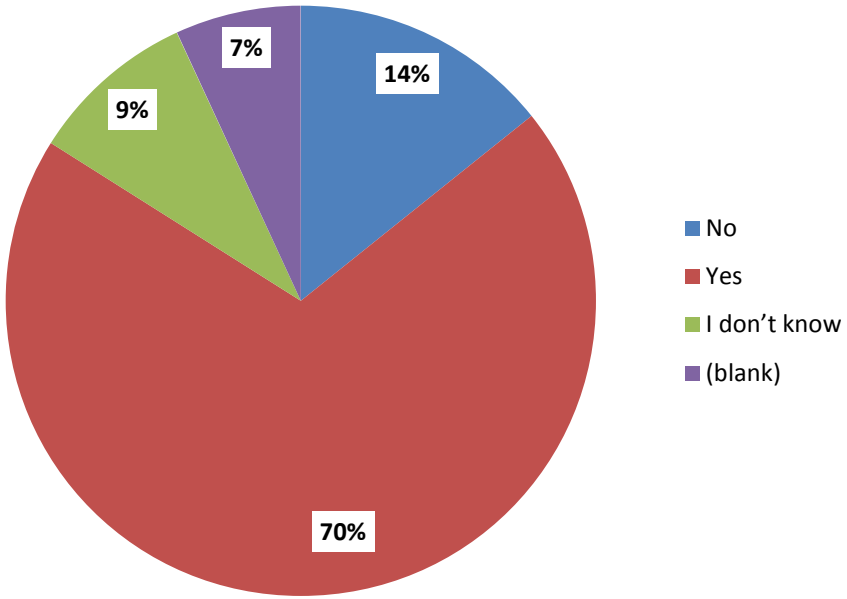

Financial Literacy: If I deposit money in a bank, I can trust that I will be able to easily access the money again, without problems
6%
7%
7%
80%
No
Yes
I don't know
(blank)


Financial Literacy: Can use a bank to cash my paycheck without being charged a fee
8%
11%
8%
73%
No
Yes
I don't know
(blank)

Financial Literacy: I have skills I need to plan how to use my money each month to cover my expenses



Financial Literacy: If I need to purchase a car, furniture, or electronics and I take a loan or use credit card, I understand how much extra the fees and interest rate will cost me



Appendix B

Community Conversation (Focus Group) Findings

2019 CHNA Community Conversations - Outline
English

1. What are your communities' greatest strengths?

2. If you could do one thing to improve the quality of life in your community what would it be?

3. What are the top 3 health challenges in your community? Circle the most important?

4. What are the biggest challenges for (choose your age group):
   a. children in our region? (parents respond)
   b. adolescents/teenagers in our region?
   c. adults (26-59)
   d. older adults (60+)?

5. What behavioral health or mental health problems are impacting people in your community?

6. If you could only pick two problems to focus on, which would you pick to improve the health of your community? (Each participant votes with dots)

Access to education or school
Access to health care
Behavioral Health (Mental Health)
Cost of housing/affordability
Dental/Oral health
Disability
Discrimination
Environment
Homelessness
Immigration
Incarceration/Prison/Jail
Isolation
Jobs/Employment
Lack of food/hunger
Language barriers
Mental Health Services (Access)
Parks and safe outdoor spaces
Safety
Smoking
Substance Abuse (Alcohol or drugs)
Transportation
Unhealthy Environment
Workforce Development

7. How would you describe a healthy community?

8. Do you live **like you can**, or **like you want to**? Explain

9. What gives you hope about our region?

2019 Preguntas para Grupo de Enfoque CHNA

Spanish

1. ¿Cuáles son las mayores fortalezas de su comunidad?

2. ¿Si pudiera hacer una cosa que mejoraría la calidad de vida en su comunidad, que escogería hacer?

3. ¿Cuáles son los 3 desafíos más grandes de salud en su comunidad? Y ponga un circulo alrededor del mas importante
4. ¿Cuáles son los mayores desafíos para (escoja su grupo de edad):
    a. ¿Niños en su región? (padres respondan)
    b. ¿Adolescentes/jóvenes en nuestra región?
    c. ¿Adultos (26-59 años)?
    d. ¿Adultos mayores de edad (más de 60 años)?

5. ¿Qué problemas de salud mental o comportamiento están afectando a las personas de su comunidad?

6. Si solo pudiera escoger dos problemas, ¿cuál escogería para mejorar la salud de su comunidad? Subraye.

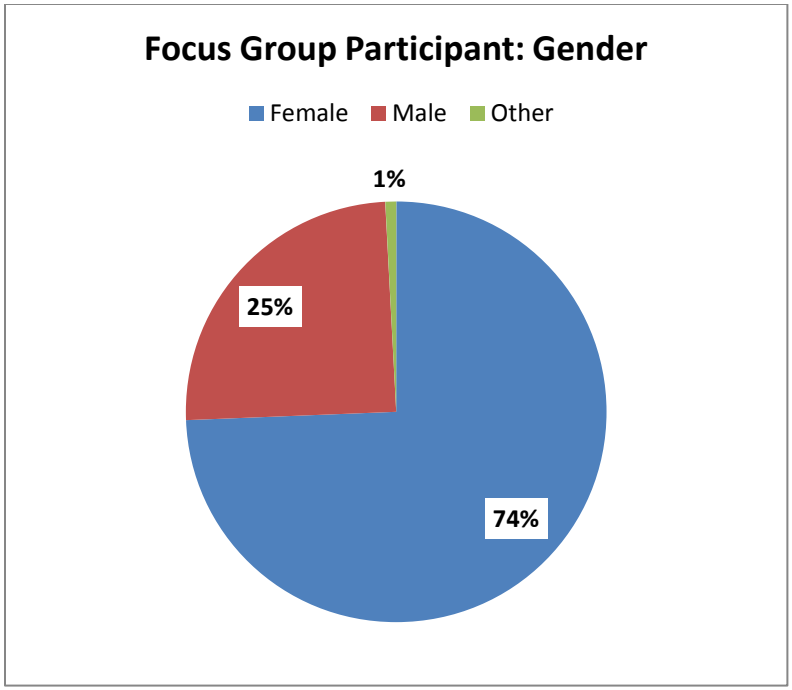
Acceso a la educación o al colegio
Acceso a servicios de salud
Salud de comportamiento (salud mental)
Costo de alojamiento/acceso financiero
Salud dental/oral
Discapacidad
Discriminación
Medio Ambiente
Falta de hogar
Inmigración
Encarcelamiento / Prisión / Cárcel
Soledad
Trabajos / Empleo
Falta de comida / hambre
Barreras de idioma
Servicios de Salud Mental (Acceso)
Parques y espacios seguros
Seguridad
Fumar
Abuso de sustancias (alcohol o drogas)
Transporte
Medio ambiente no saludable
Desarrollo de fuerza laboral

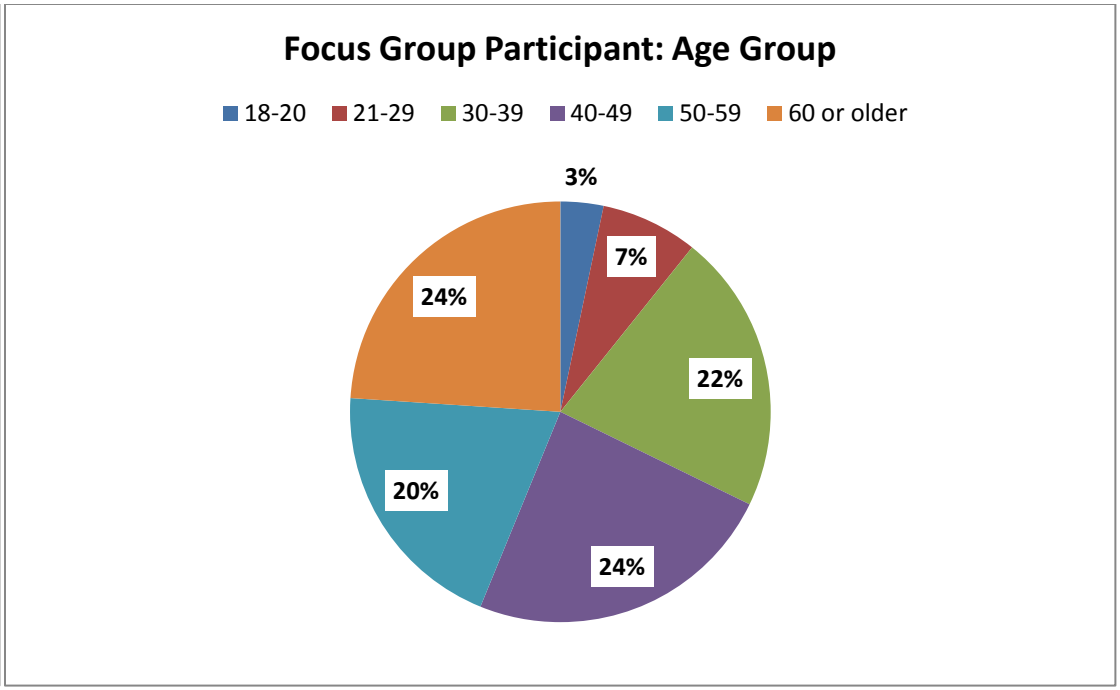
7. ¿Cómo describiría una comunidad saludable?

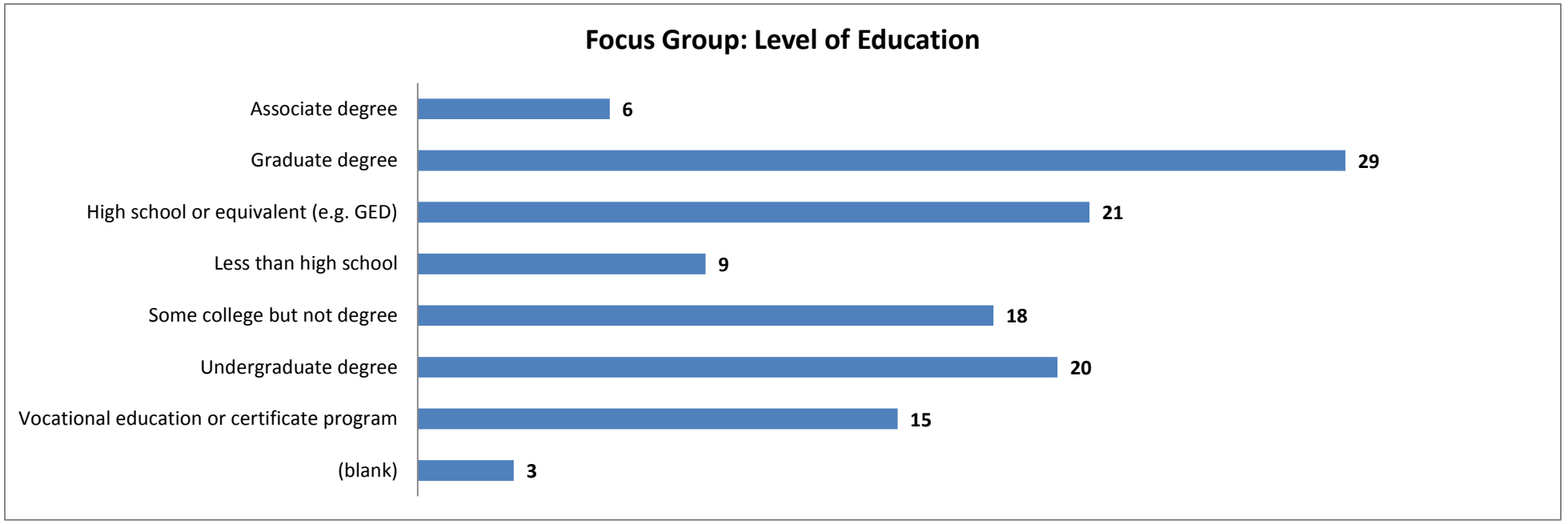
8. ¿Usted vive **como puede**, o **como quiere**? Esplique

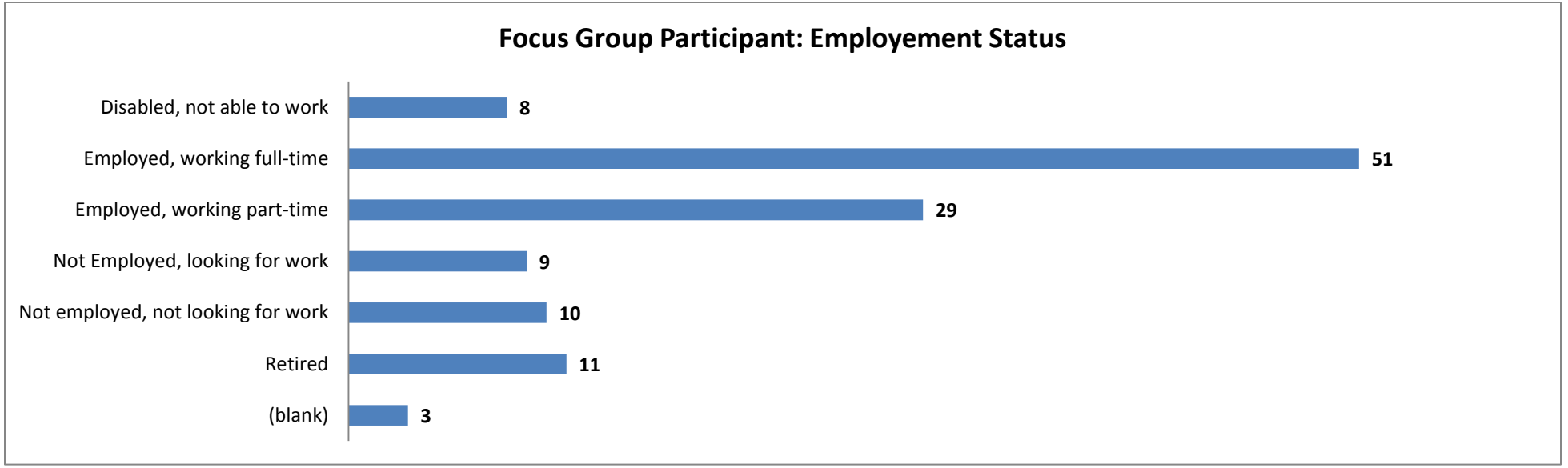
9. ¿Qué es lo que le da esperanza en nuestra región?

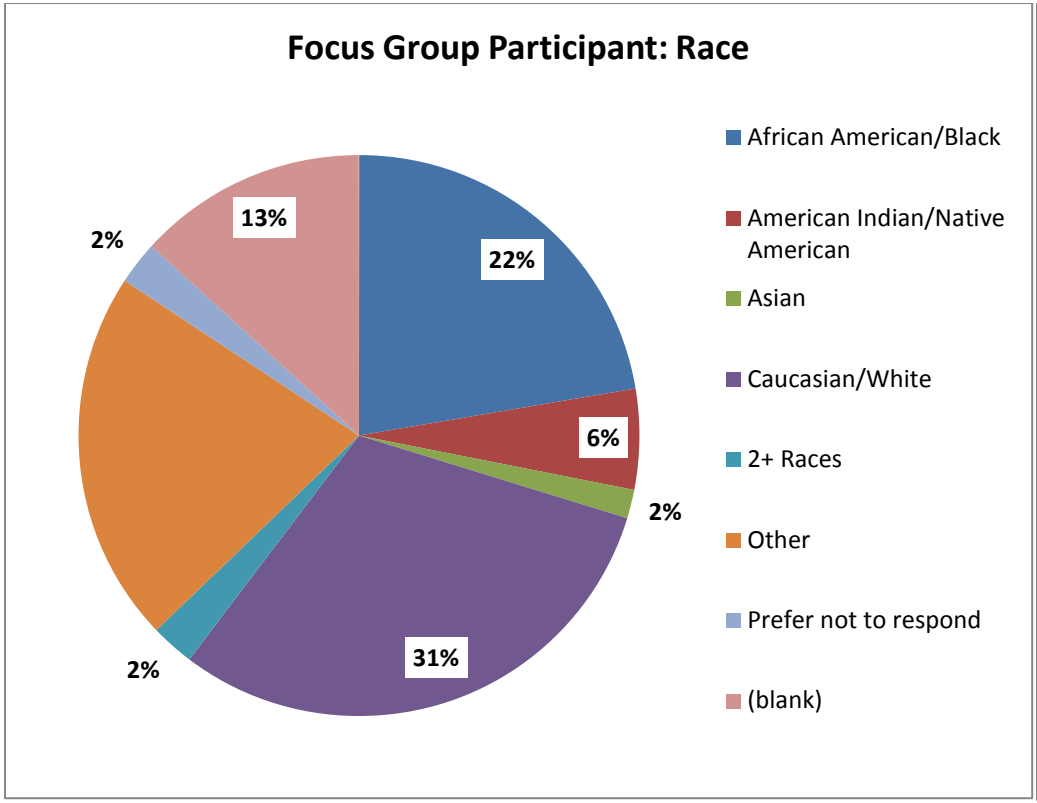
APPENDIX B – LLUH Community Conversation (Focus Group) Findings

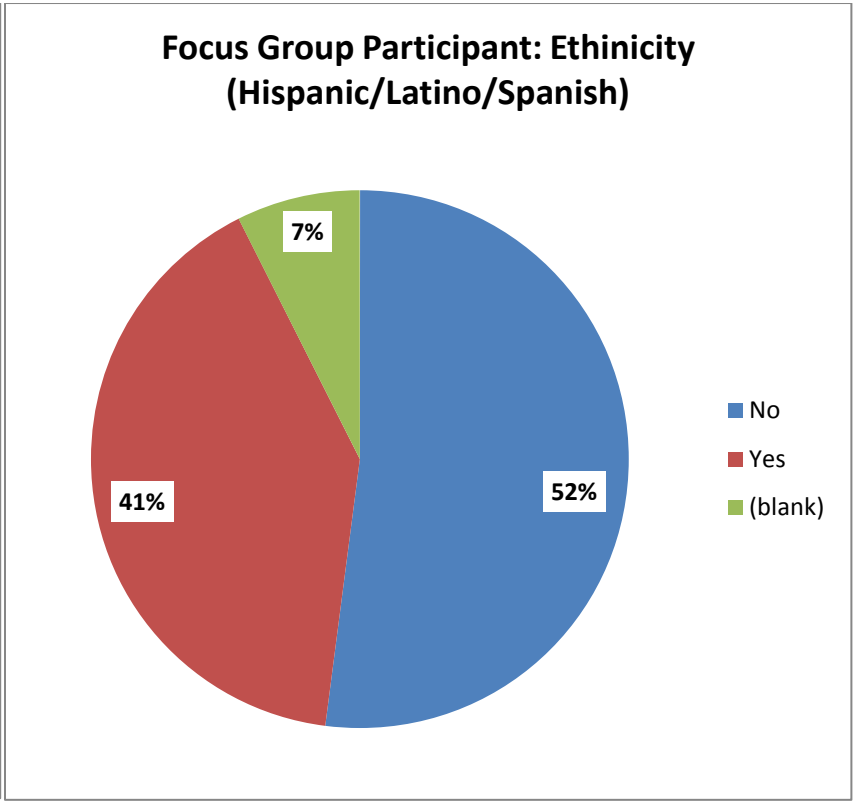


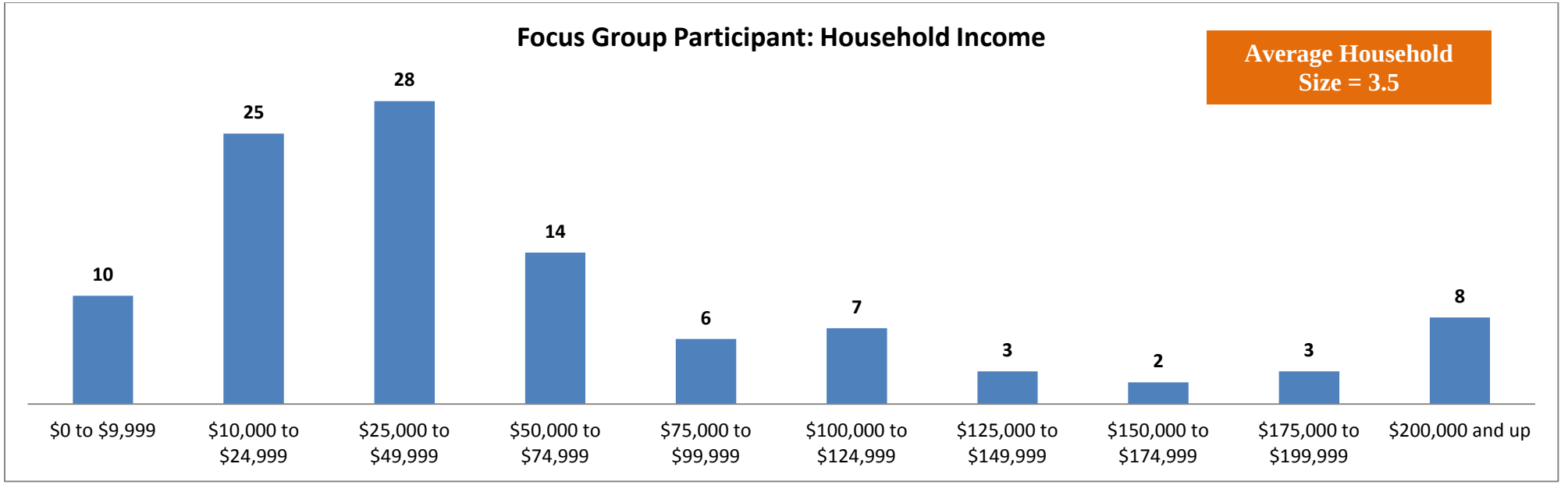


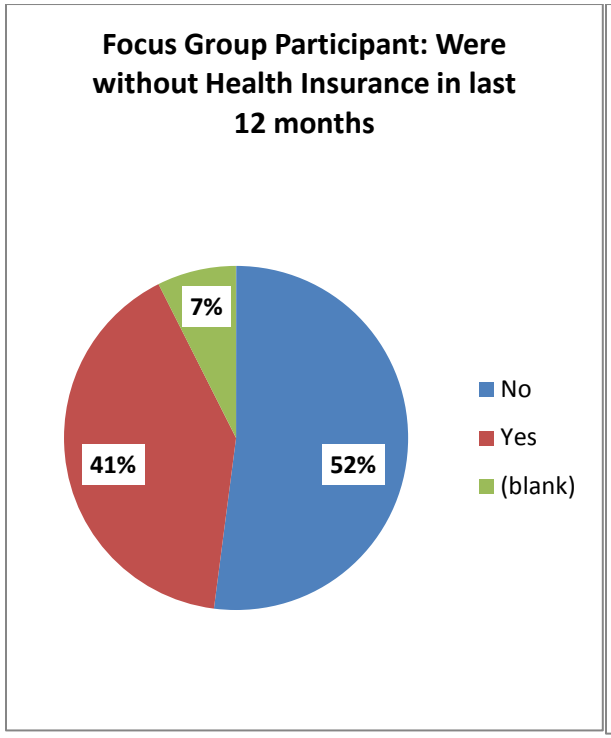


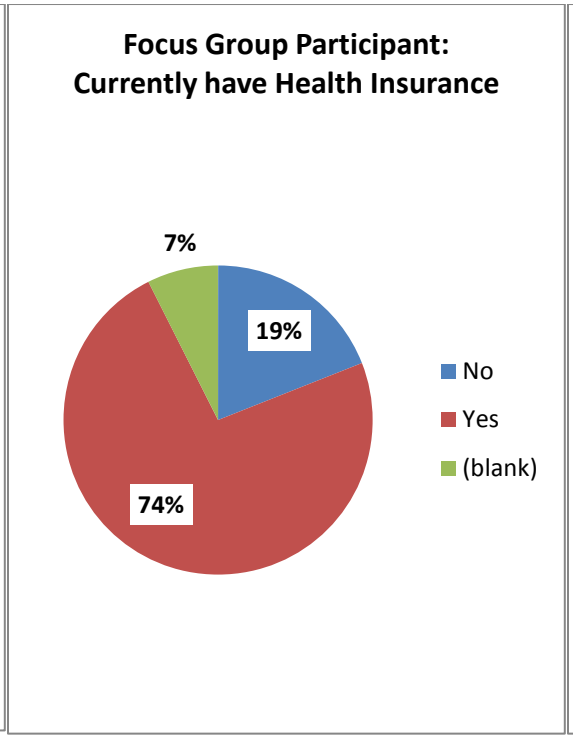

Focus Group Participant: Employement Status
Disabled, not able to work
8
Employed, working full-time
51
Employed, working part-time
29
Not Employed, looking for work
9
Not employed, not looking for work
10
Retired
11
(blank)
3

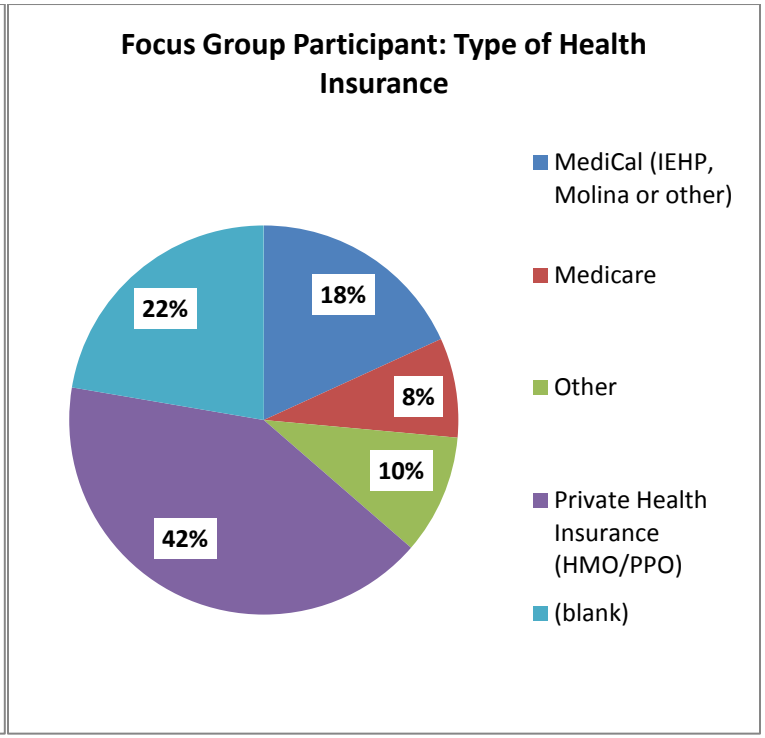

Focus Group Participant: Race
22%
6%
2%
31%
2%
2%
13%
African American/Black
American Indian/Native American
Asian
Caucasian/White
2+ Races
Other
Prefer not to respond
(blank)


Focus Group Participant: Ethinicity (Hispanic/Latino/Spanish)
52%
41%
7%
No
Yes
(blank)


Focus Group Participant: Household Income
Average Household Size = 3.5
10
25
28
14
6
7
3
2
3
8
$0 to $9,999
$10,000 to $24,999
$25,000 to $49,999
$50,000 to $74,999
$75,000 to $99,999
$100,000 to $124,999
$125,000 to $149,999
$150,000 to $174,999
$175,000 to $199,999
$200,000 and up


Focus Group Participant: Were without Health Insurance in last 12 months
52%
41%
7%
No
Yes
(blank)

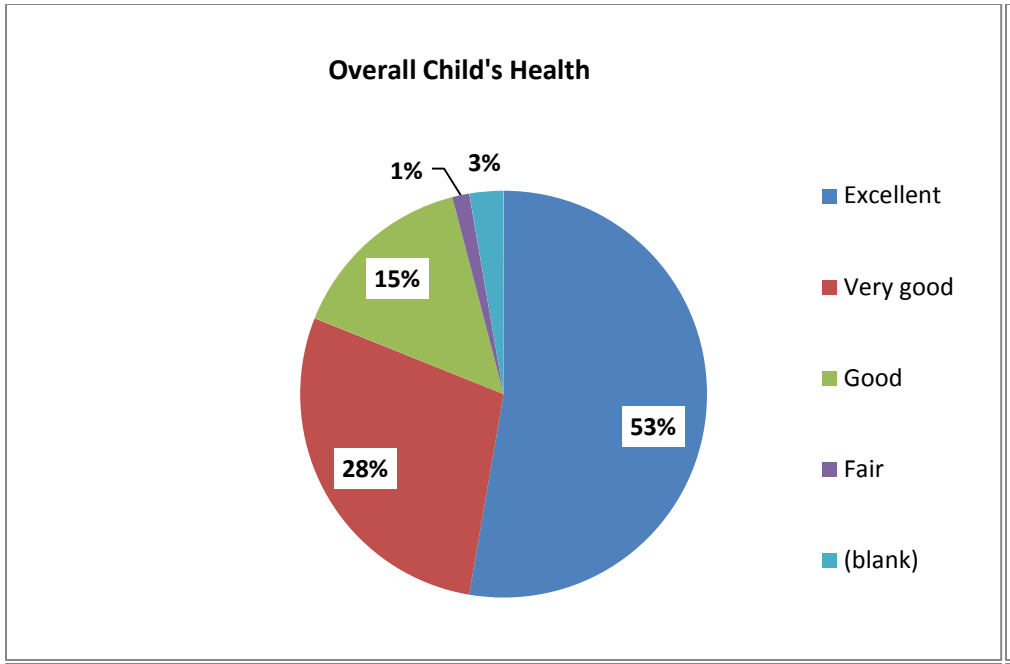

Focus Group Participant: Currently have Health Insurance
19%
74%
7%
No
Yes
(blank)

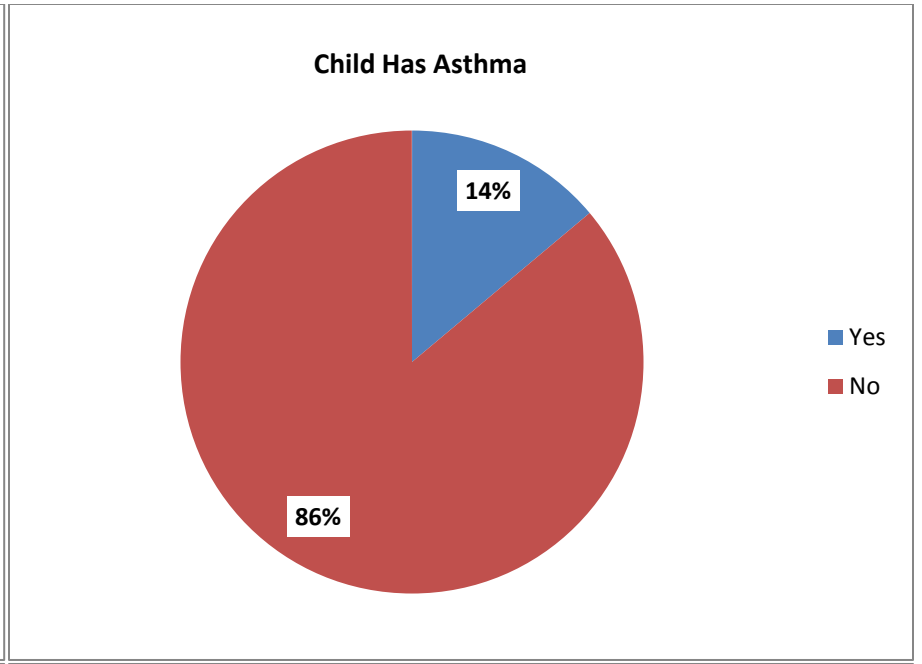

Focus Group Participant: Type of Health Insurance
18%
8%
10%
42%
22%
MediCal (IEHP, Molina or other)
Medicare
Other
Private Health Insurance (HMO/PPO)
(blank)

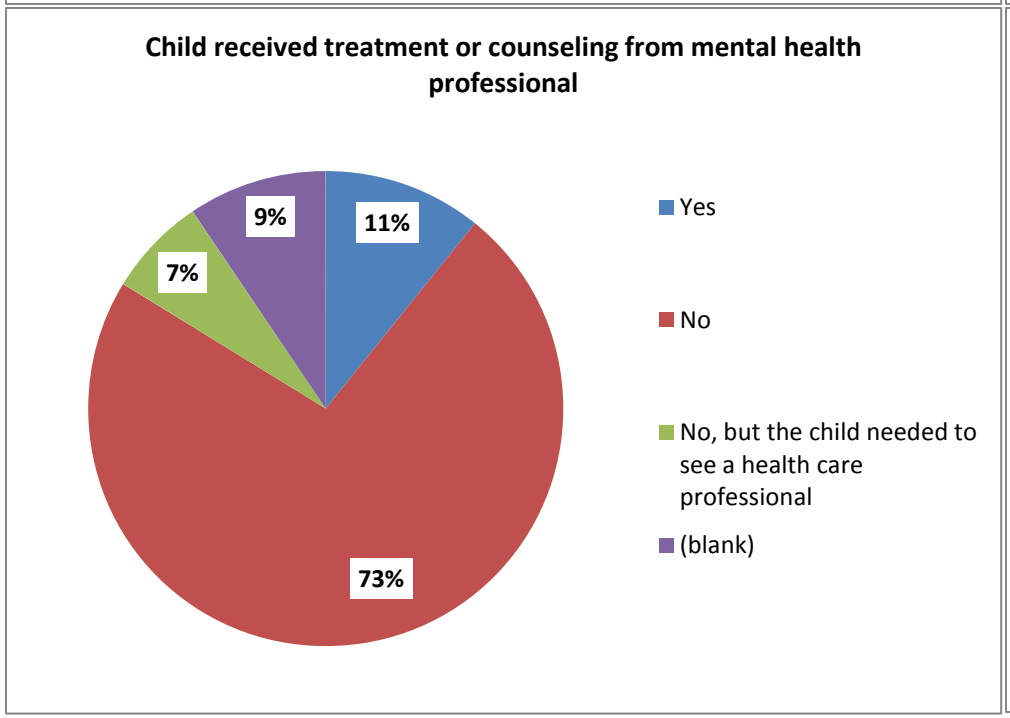
Appendix C

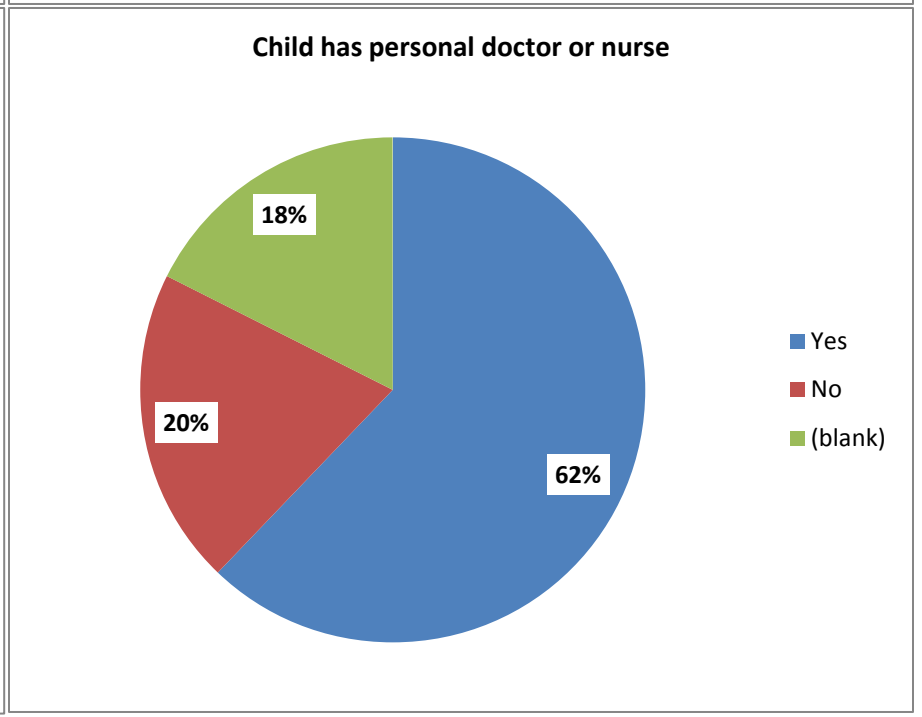
Children's Health Survey & Findings

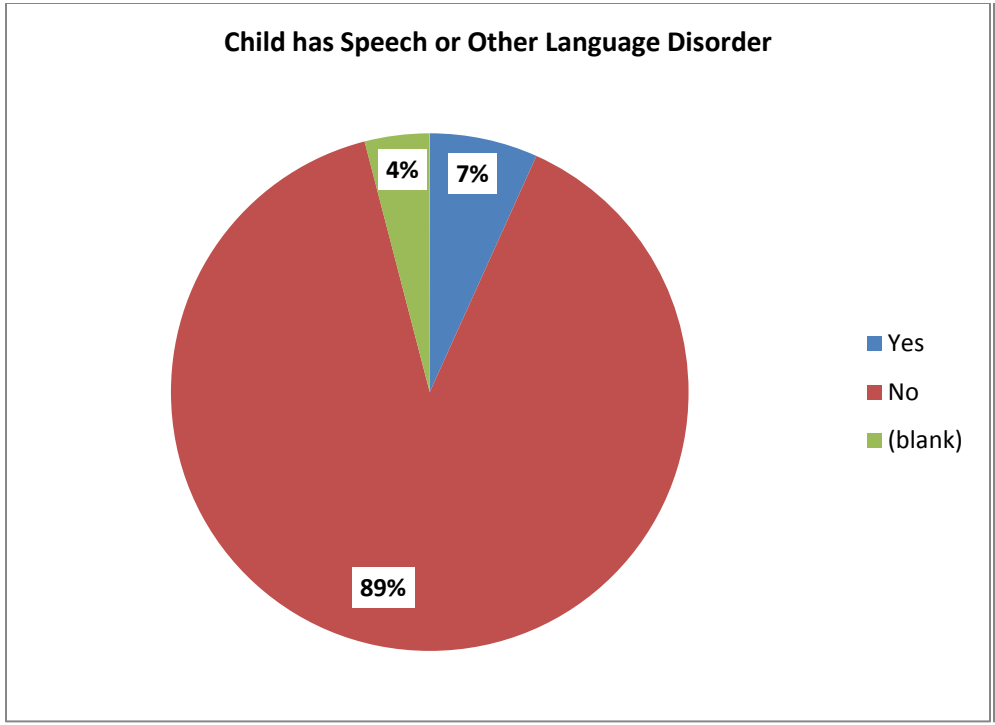
APPENDIX C - LLUH Children's Health Survey Findings

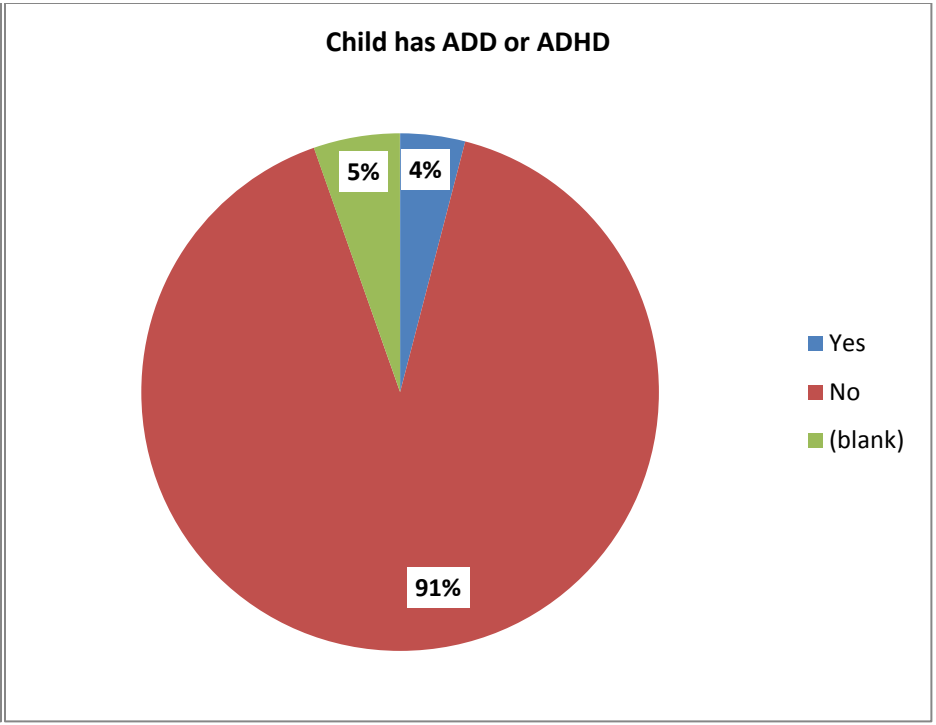


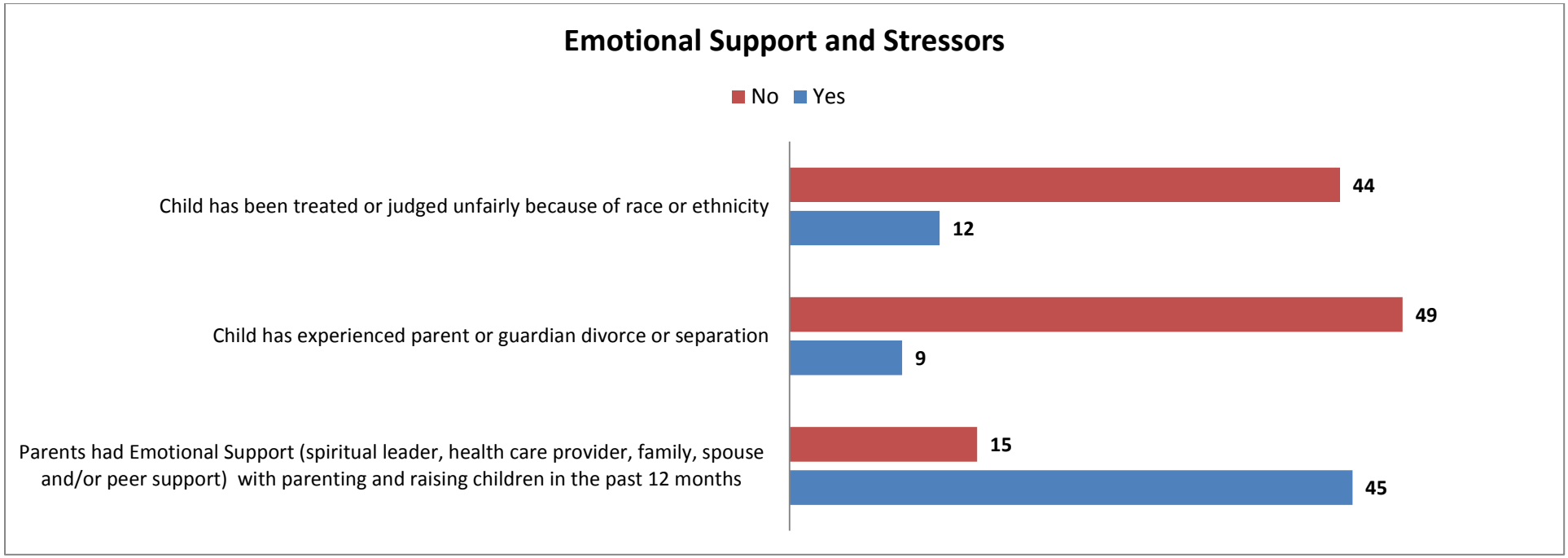


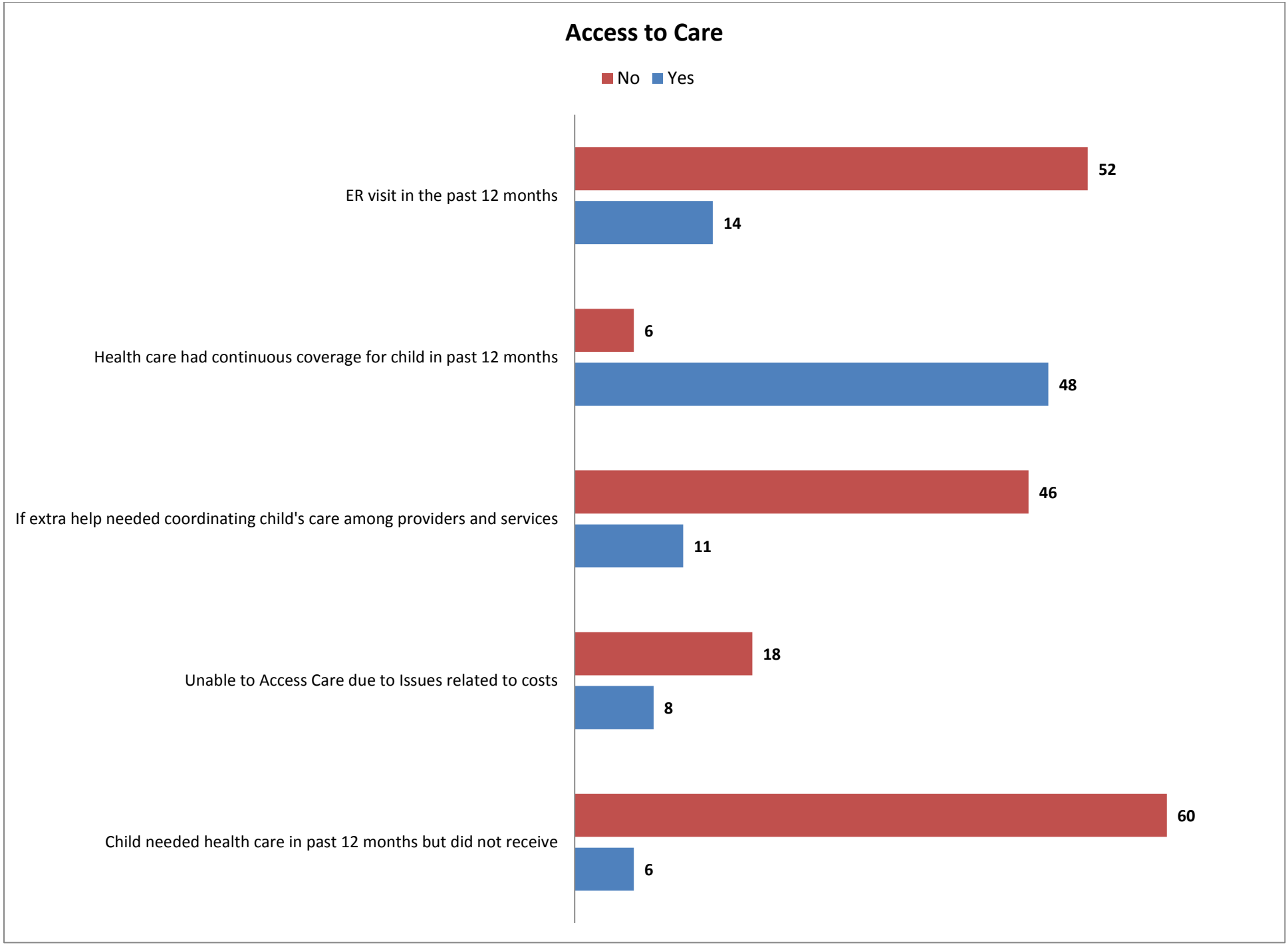


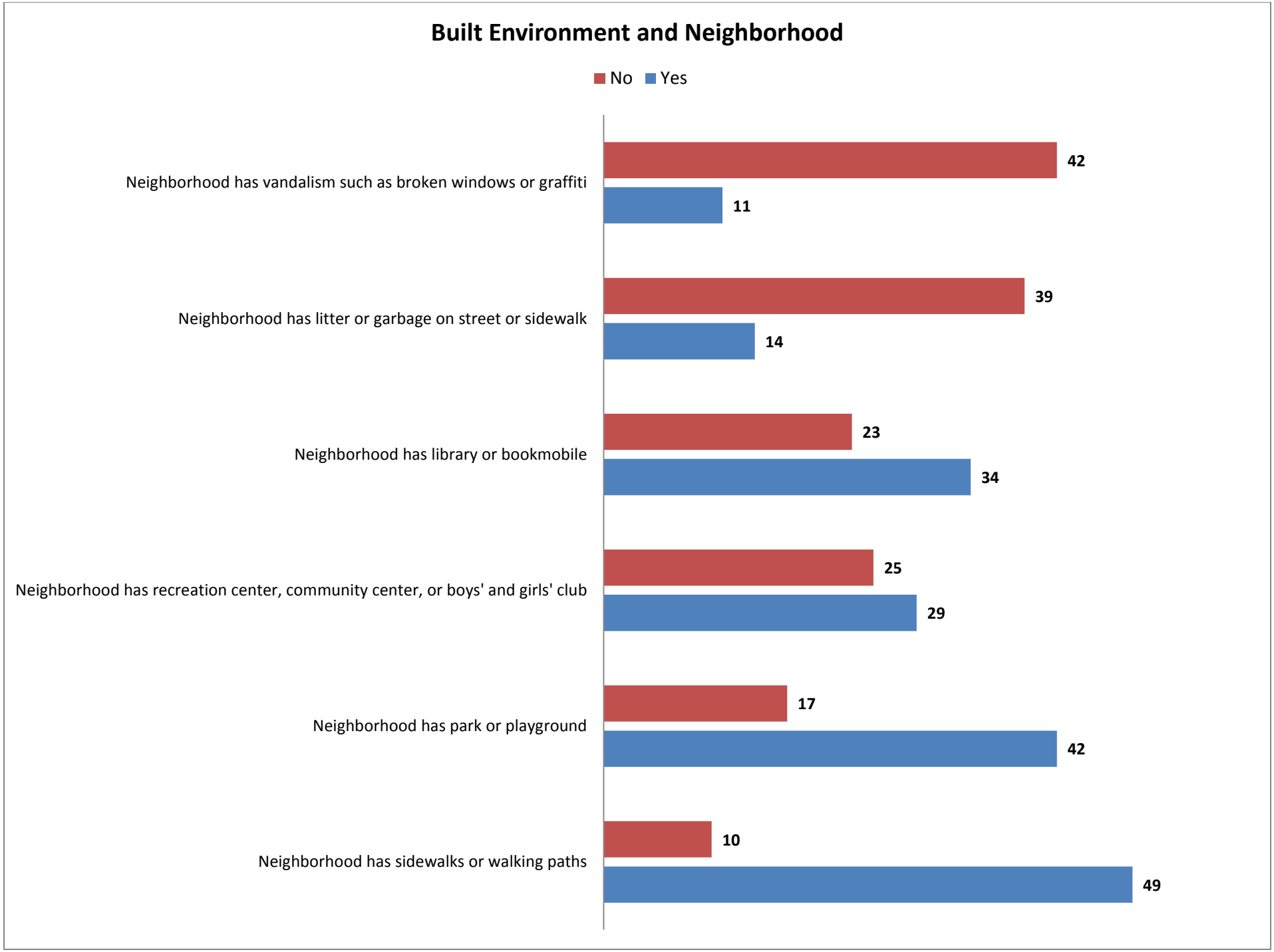


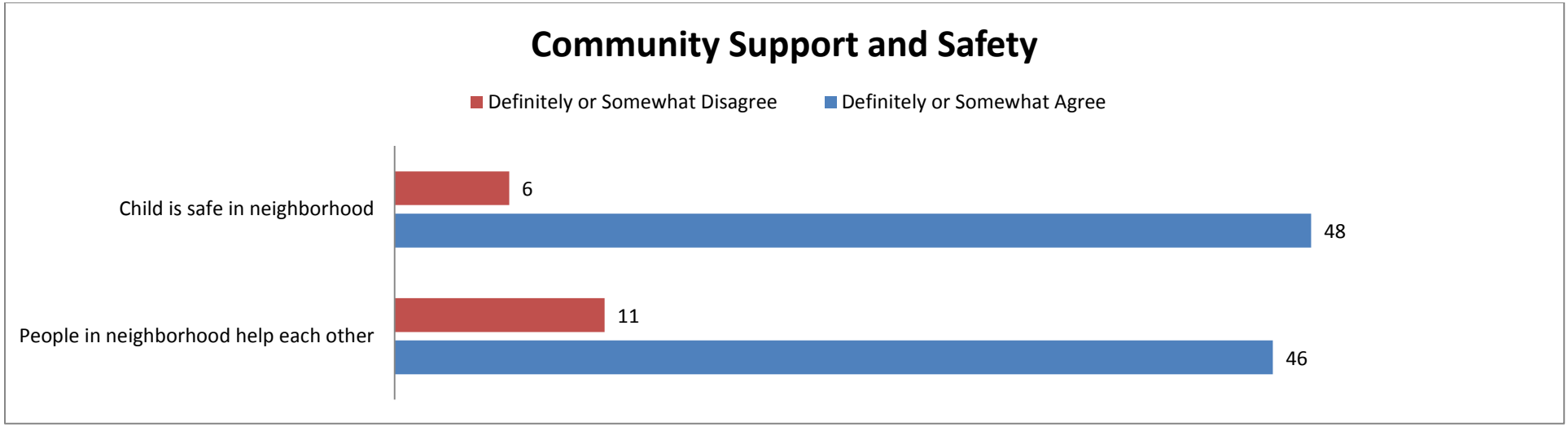

Child has Speech or Other Language Disorder
4%
7%
89%
Yes
No
(blank)

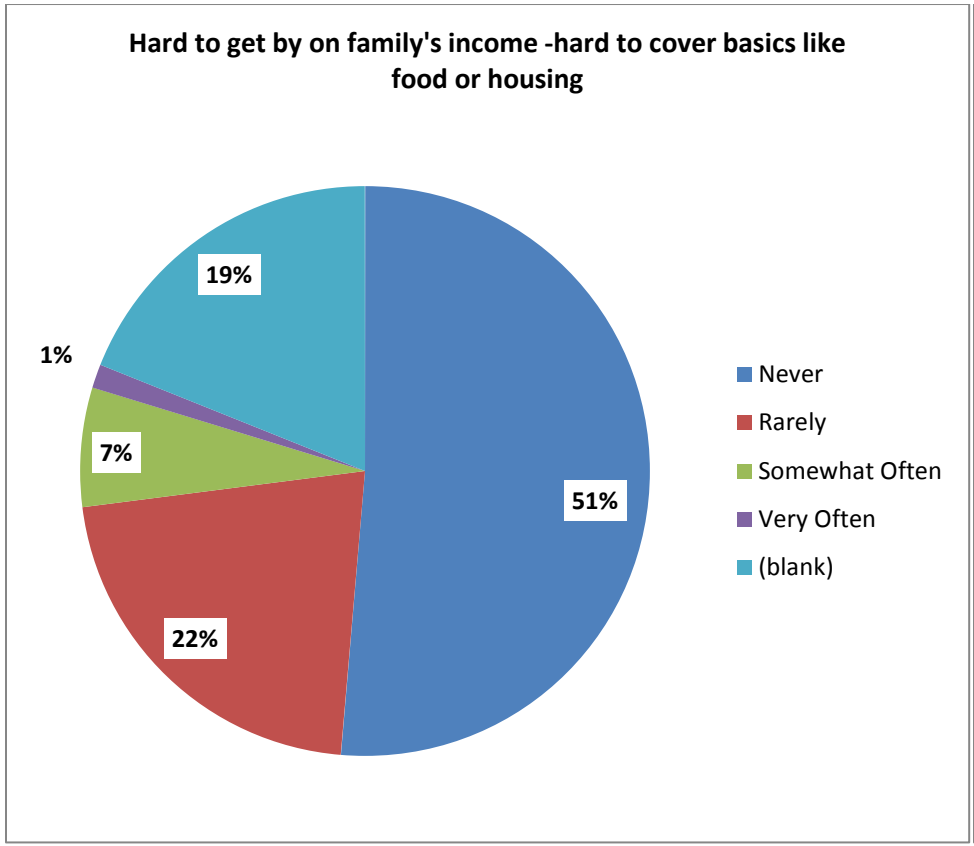

Child has ADD or ADHD
5%
4%
91%
Yes
No
(blank)

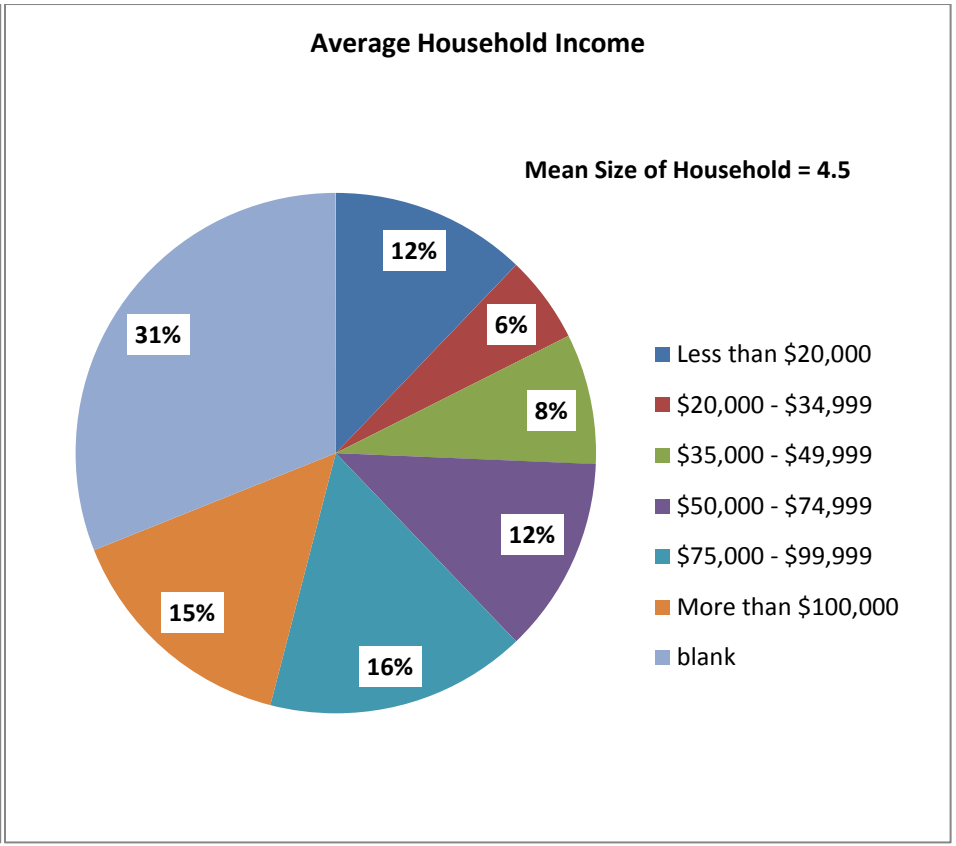

Emotional Support and Stressors
No
Yes
Child has been treated or judged unfairly because of race or ethnicity
44
12
Child has experienced parent or guardian divorce or separation
49
9
Parents had Emotional Support (spiritual leader, health care provider, family, spouse and/or peer support) with parenting and raising children in the past 12 months
15
45

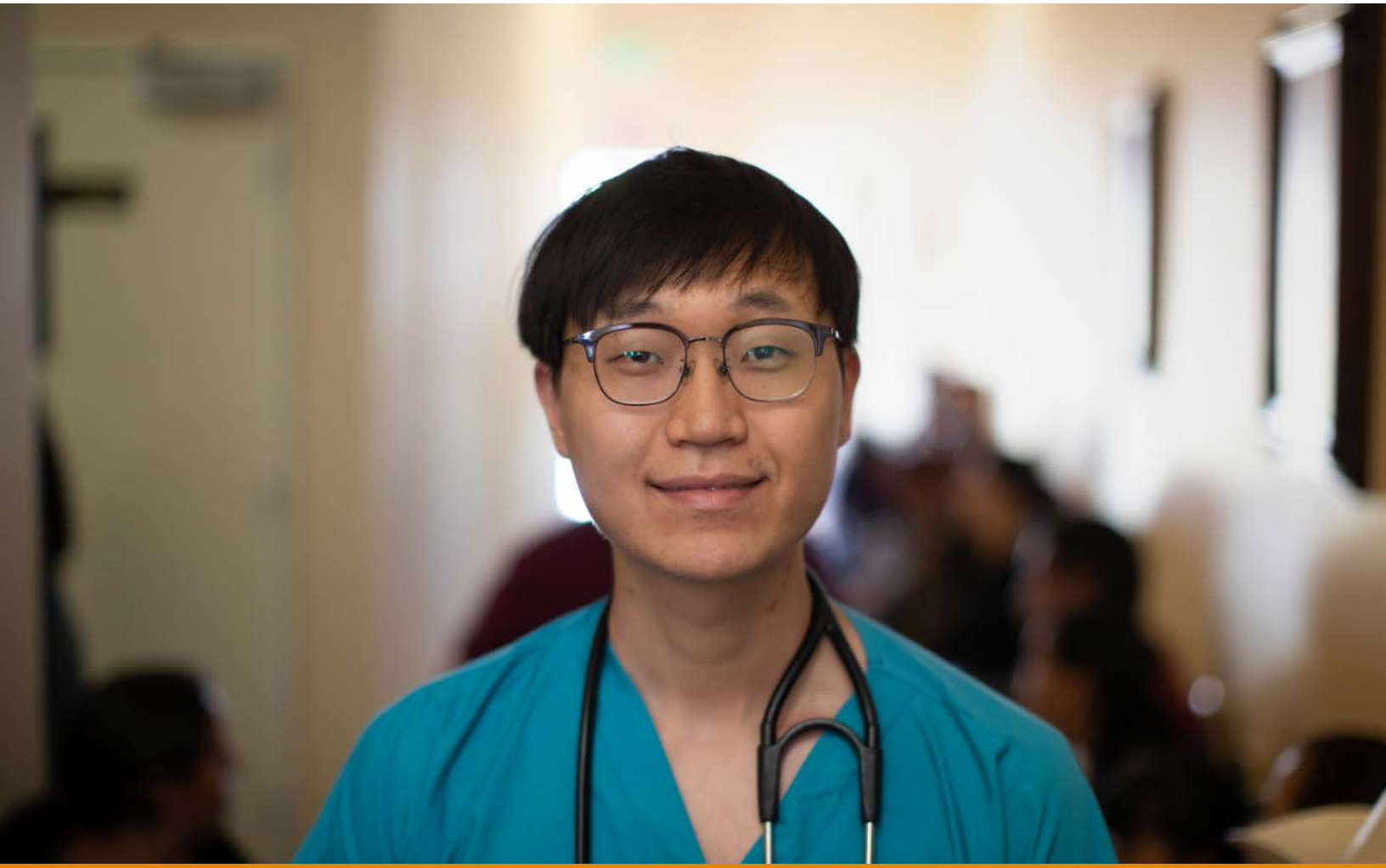

Access to Care
No
Yes
ER visit in the past 12 months
52
14
Health care had continuous coverage for child in past 12 months
6
48
If extra help needed coordinating child's care among providers and services
46
11
Unable to Access Care due to Issues related to costs
18
8
Child needed health care in past 12 months but did not receive
60
6


Built Environment and Neighborhood
No
Yes
Neighborhood has vandalism such as broken windows or graffiti
42
11
Neighborhood has litter or garbage on street or sidewalk
39
14
Neighborhood has library or bookmobile
23
34
Neighborhood has recreation center, community center, or boys' and girls' club
25
29
Neighborhood has park or playground
17
42
Neighborhood has sidewalks or walking paths
10
49


Community Support and Safety
Definitely or Somewhat Disagree
Definitely or Somewhat Agree
Child is safe in neighborhood
6
48
People in neighborhood help each other
11
46


Hard to get by on family's income -hard to cover basics like food or housing
19%
1%
7%
51%
22%
Never
Rarely
Somewhat Often
Very Often
(blank)

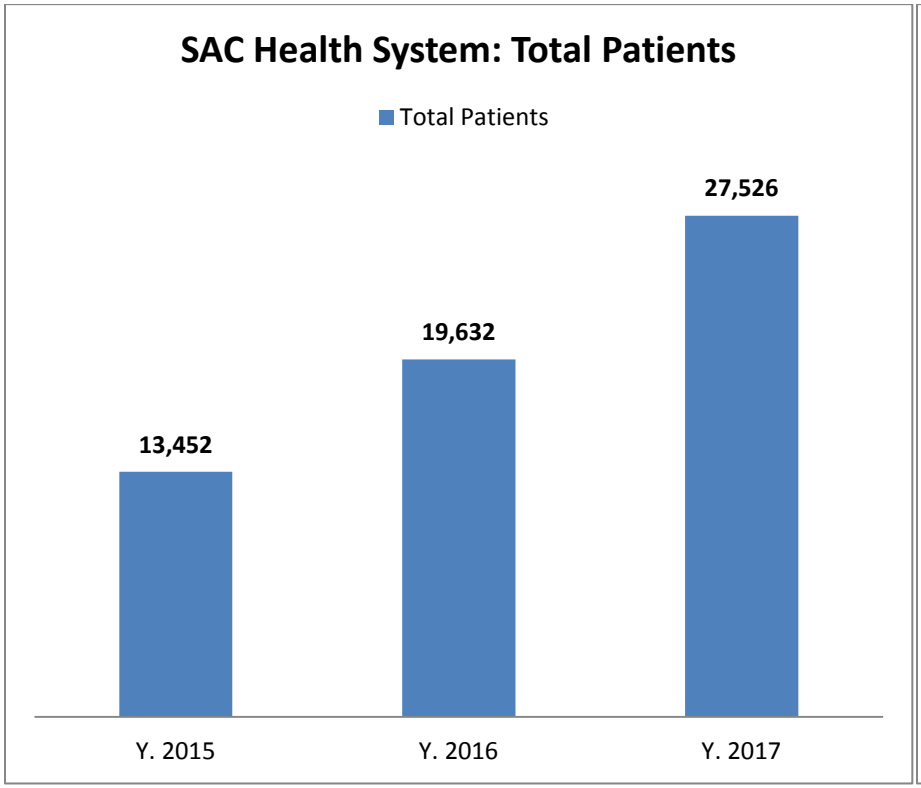

Average Household Income
Mean Size of Household = 4.5
12%
6%
8%
12%
16%
15%
31%
Less than $20,000
$20,000 - $34,999
$35,000 - $49,999
$50,000 - $74,999
$75,000 - $99,999
More than $100,000
blank

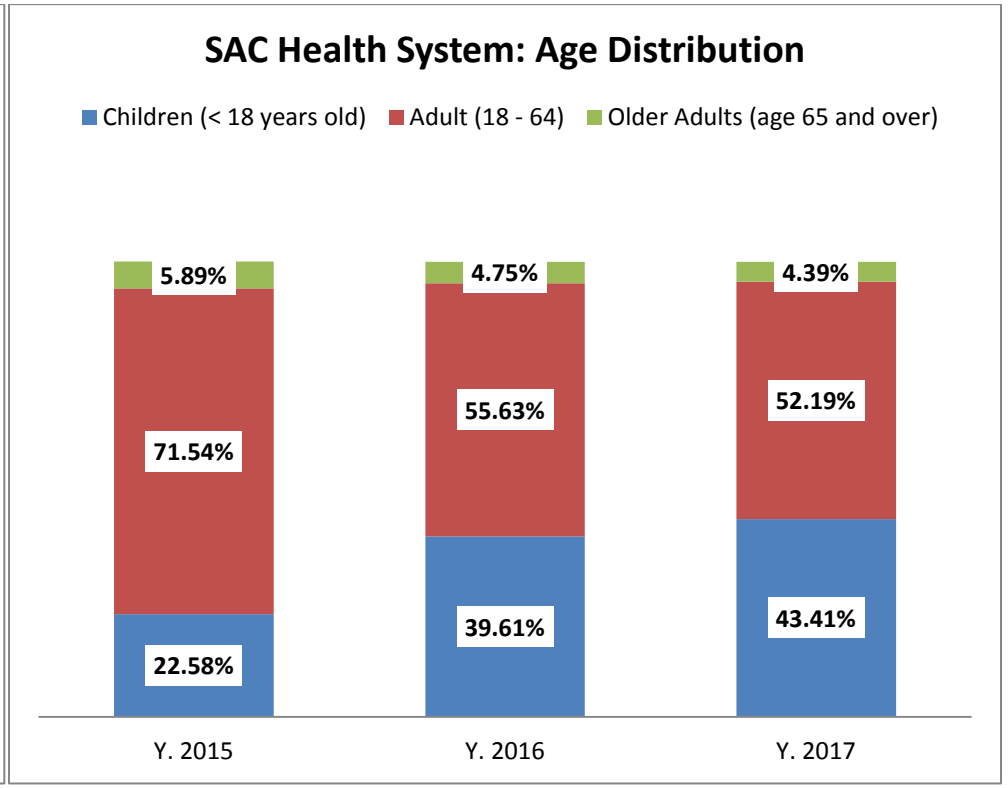


Appendix D

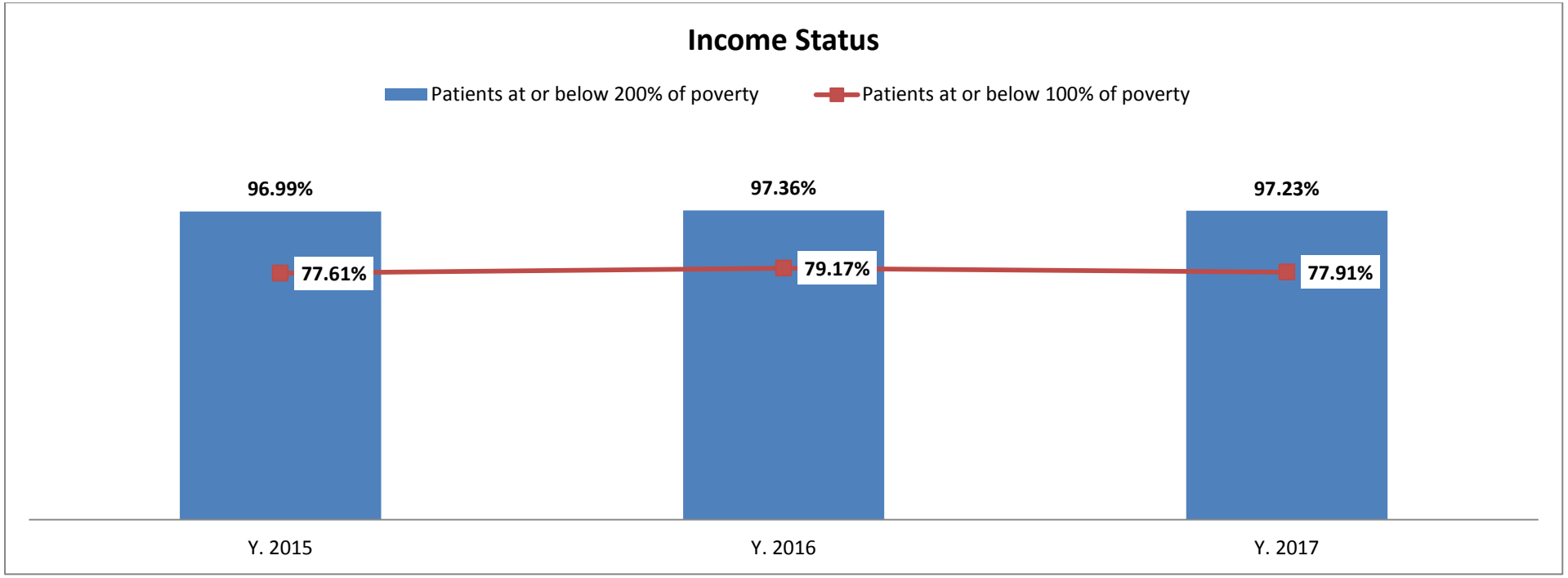
SACH Health System Data

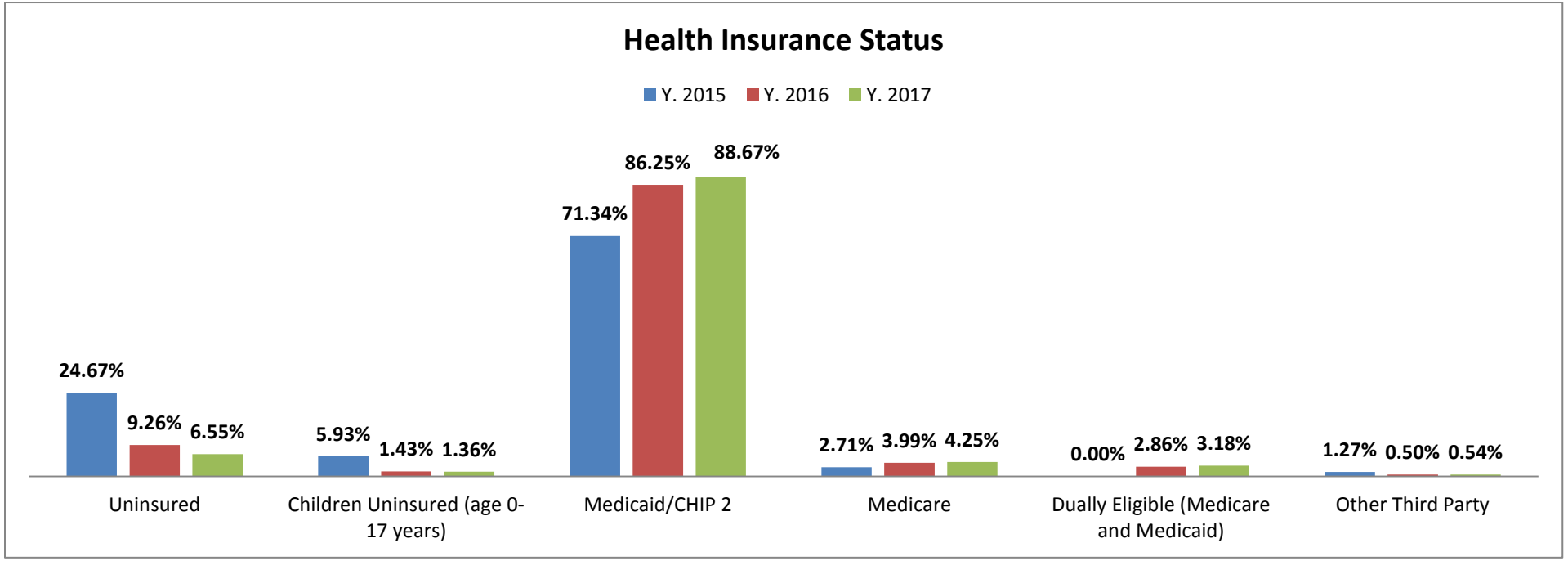
APPENDIX D - SAC Health System DATA





Patients By Race & Ethnicity	Y. 2015	Y. 2016	Y. 2017
Non-Hispanic White	25.33%	24.59%	26.49%
Hispanic/Latino Ethnicity	61.71%	60.55%	58.91%
Black/African American	12.99%	12.00%	12.21%
Asian	5.05%	3.62%	3.21%
American Indian/Alaska Native	0.93%	0.91%	0.69%
Native Hawaiian / Other Pacific Islander	0.52%	0.26%	0.29%
More than one race 1	0.06%	8.73%	1.36%


Income Status
Patients at or below 200% of poverty
Patients at or below 100% of poverty
96.99%
97.36%
97.23%
77.61%
79.17%
77.91%
Y. 2015
Y. 2016
Y. 2017


Health Insurance Status
Y. 2015
Y. 2016
Y. 2017
24.67%
9.26%
6.55%
5.93%
1.43%
1.36%
71.34%
86.25%
88.67%
2.71%
3.99%
4.25%
0.00%
2.86%
3.18%
1.27%
0.50%
0.54%
Uninsured
Children Uninsured (age 0-17 years)
Medicaid/CHIP 2
Medicare
Dually Eligible (Medicare and Medicaid)
Other Third Party

Patients By: Health Services	Y. 2015	Y. 2016	Y. 2017
Medical	90.42%	86.07%	91.11%
Dental	20.80%	12.28%	11.81%
Mental Health	6.17%	4.95%	4.14%
Substance Abuse	0.00%	-	0.00%
Vision	0.00%	1.59%	4.82%

Patients By: Medical Conditions	Y. 2015	Y. 2016	Y. 2017
Hypertension	15.62%	20.76%	17.77%
Diabetes	12.59%	16.56%	15.69%
Asthma	4.76%	5.41%	6.92%
HIV	3.92%	2.90%	0.35%
Prenatal Patients	435	881	1,183
Prenatal Patients who Delivered	289	483	778

Patients by: Chronic Disease Management	Y. 2015	Y. 2016	Y. 2017
Use of Appropriate Medications for Asthma	95.27%	89.20%	82.63%
Coronary Artery Disease (CAD): Lipid Therapy	83.33%	83.76%	64.32%
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	81.13%	81.06%	73.63%
Controlling High Blood Pressure (Hypertensive Patients with Blood Pressure < 140/90)	56.56%	64.29%	53.59%
Diabetes: Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c > 9%) or No Test During Year	33.94%	52.86%	34.88%

Source and to Access Full Report: https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=09E01185&state=CA